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

Date:-	**Thursday, 18th January, 2018**	**Venue:-**	**Town Hall, Moorgate Street, Rotherham S60 2TH**
Time:-	**10.00 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 30th November and 14th December, 2017 (Pages 1 - 40)

For Discussion

8. Integrated Locality Evaluation (Pages 41 - 50)
   Dominic Blaydon, Associate Director of Transformation, TRFT, to present

9. Adult Social Care - Final published Year End Performance Report for 2016/17 (Pages 51 - 62)
   Nathan Atkinson, Assistant Director Strategic Commissioning to report

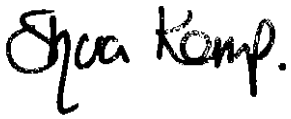
10. Local Response to Mental Health Regulations under the Policing and Crime Act (Pages 63 - 67)
    Questions to the South Yorkshire Police and Crime Commissioners – Councillor Sansome to report

For Information

11. Healthwatch Rotherham - Issues

12. Health and Wellbeing Board (Pages 68 - 79)
Minutes of meeting held on 15th November, 2017

13. Dates of Future Meetings
Thursday, 1st March, 2018 at 10.00 a.m.
12th April, 2018 at 10.00 a.m



SHARON KEMP,
Chief Executive.

Membership:

Chairman:- Councillor Evans
Vice-Chairman:- Councillor Short
The Mayor (Councillor Rose Keenan), Councillors Allcock, Andrews, Bird, R. Elliott, Ellis, Jarvis, Marriott, Rushforth, Sansome, Whysall, Williams and Wilson.

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

HEALTH SELECT COMMISSION
Thursday, 30th November, 2017

Present:- Councillor Evans (in the Chair); Councillors Andrews, Bird, R. Elliott, Jarvis, Marriott, Sansome, Short and Williams.

Councillors Clark and J Elliot attended from Improving Lives Select Commission at the invitation of the Chair.

Apologies for absence were received from Councillors Ellis, Rushforth and Whysall, Councillor Roche (Cabinet Member) and Robert Parkin (SpeakUp).

45. DECLARATIONS OF INTEREST

There were no Declarations of Interest.

46. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

47. COMMUNICATIONS

- There were no comments or questions on the papers in the information pack that had been circulated to Members.

- Councillor Jarvis provided a short update on the work of Improving Lives Select Commission. In Adult Safeguarding the Vulnerable Person's Team was already making a difference and seeing results. Some Team members had won awards, in particular for their work Supporting People who were involved in court cases.

- RMBC was considering participating in the Pause project working with mothers who had had multiple children taken into care to help them turn their lives around. From experience elsewhere many of those involved would have been likely to need Adult Mental Health Services without that support. A further update would be provided.

- The Chair highlighted recent enlightening and informative sub-group sessions looking at progress on the 2017-18 quality priorities for Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) and The Rotherham Foundation Trust (TRFT) and a useful workshop on the drug and alcohol service. A visit to Carnson House would be organised for early 2018.

48. MINUTES OF THE PREVIOUS MEETINGS HELD ON 26TH OCTOBER 2017

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 26th October, 2017. Members noted that:-

Arising from Minute No. 30 - Prescriptions
A response from Rotherham Hospital in relation to the question on prescriptions had been included in the minutes.

Arising from Minute No. 40 – Evaluation of Whole School Project and Minute No. 41 - Response to Scrutiny Review of Child and Adolescent Mental Health Services,
Further progress monitoring reports would be factored in to the 2018-19 work programme.

Resolved:- That the minutes of the previous meeting, held on 26th October, 2017, be approved as a correct record.

49. RDASH ROTHERHAM CARE GROUP TRANSFORMATION

Dianne Graham, Rotherham Care Group Director and Steph Watt, Strategic and Transformation Lead for Integrated Physical and Mental Health Projects (TRFT and RDaSH) presented an overview of the transformation work which built on the presentation at the September meeting.

Previously the service had been structured around services for older adults and services for younger adults but now the pathways were less age specific. The prevention, recovery and wellbeing approach linked in with the Council's strategic objectives and was more community focused.

Rotherham Care Group Objectives
Integrated and streamlined services for adult mental health and learning disabilities

- Where care wraps round the patient, removing age and structural barriers
- Prevention, recovery and wellbeing approach
- Delivered as close to home as possible
- With clear and timely access
- Which deliver efficiency savings

Phase 1: Completed

- Care group formation
- Leadership and management team
- Hospital Liaison Service – for mental health and learning disability, supporting TRFT on services and reducing time spent in A&E
- Dementia Local Enhanced Service (LES) - support for GPs who are supporting people with dementia and facilitating diagnosis in primary care

New place based structures had been implemented for Rotherham, Doncaster and Lincolnshire respectively, which enabled them to focus on their own localities and understand their own communities better and to work within them.

Phase 2: Update

Care co-ordination centre

- Moved to Urgent and Emergency Care Centre
- RDaSH Staff transferred and trained
- Launch January 2018 with phased implementation

Ferns: extended pilot

- Re-hab for medically fit cognitive and neuro patients
- Positive evaluation particularly from patients /carers

12 beds for patients with cognitive decline or dementia who had also been in TRFT for a physical health issue. The joint pilot with TRFT would run until April 2018 and the trust was building the business case to be able to sustain it. Patients benefitted from the extra care and more were returning home on discharge rather than to residential care.

Community Team formation

- Interim: North base: tbc South: Swallownest
- Release Howarth and Badsley Moor Lane – efficiency savings
- Co-locate with physical health and social care

Admin review

- Staff consultation November 2017
- Implementation February 2018 to align to the new structures

Unity: new patient record system

- Development phase nearing completion
- Rotherham go live: April 2017

Pathway Framework

- Prevention, recovery and wellbeing model
- Objective, resolve more, sooner
- Pathway framework:
  - Brief Interventions
  - Complex care
  - Long term conditions

Rotherham 'All Age' Clinical Pathways

Retaining specialism & expert approaches within an integrated model - based on NICE guidance and evidence around the types of intervention.

Pathway Development

- Access: to services planned and unplanned
- Acute: urgent & emergency
- Common MH disorders

- Complex emotional needs
- Early intervention in psychosis
- Group review – collation of local groups in Rotherham
- Trauma pathway - for people experiencing Post Traumatic Stress Disorder or trauma as a result of sexual or emotional abuse
- Woodstock Bower pilot - lithium prescribing pilot for dealing with patients in primary care rather than secondary care and supporting both their physical and mental health.

Social Prescribing

- Increase social activity
- Reduce social isolation and dependence
- Improve confidence and self-esteem
- Support healthy and sustainable discharges from services and create capacity

In partnership with the voluntary and community sector this was working with people with long term mental health conditions who had been in service for a long time and looking at ways to discharge them, supporting them to transition from secondary care to community activities e.g. gym, Pilates, and support into employment through community assets. People reported greater self-confidence and self-esteem and it also contributed to reducing social isolation and loneliness, which was a big issue.

Initial evaluation indicates positive outcomes

- Over 240 users from secondary mental health services
- Over 90 per cent made progress against at least one well-being outcome measures
- 48% increase in measures for all outcome scores
- Circa 50-60% discharge rate for those referred
- Highly commended at the Health Service Journal awards
- VAR submitted a bid to Department of Health Social Prescribing Fund to expand the scheme to reduce reliance on secondary services at the point of referral

Well Being Hub

- Pilot project with Rotherham United Community Sports Trust
- Combined delivery of health and wellbeing activity
- Delivered at the ground
- To be evaluated, potential to expand as a community

Joint groups with Rotherham United such as stress management were followed by a sports activity, promoting mental health and wellbeing. Good results were being achieved with people changing their lives and achieving good health outcomes. Evaluation would take place in 2018.

Next Steps

- Acute and Community Place Plan
  - Integrated Contact Centre
  - Rapid Response

  - Locality Roll Out
  - Integrated Discharge – work with TRFT, supporting reablement and care home liaison teams
  - Care Homes
- Core 24 – responding to people in crisis
- Core Fidelity
- Clinical Review – aligning staff skills to the new pathways

Following the presentations the following questions and issues were raised:

What did you see your role as being in addressing stigma around mental health problems and awareness raising around mental health with front line staff, such as techniques for appropriate communication?

- It was a responsibility and sometimes it was about having those ordinary conversations about mental health. We talked last week about using social media more, which was something that RDaSH needed to capitalise on. The trust had a Twitter account but was not yet on Facebook and social media could be used to get key messages out.
- The project with Rotherham United was a good example, as being delivered at a community facility that service providers went into, this removed the perceived stigma of going to a labelled mental health service.
- Similarly with the Place Plan, RDaSH would go into the community and into GPs to deliver. Hopefully over time this would also help to change the perceptions and dialogue about perceptions of mental health.
- Plus there were positive things happening nationally such the work of the Princes, Government investment in mental health and changes in media coverage.

What about RDaSH's wider role outside public services in awareness raising or developing training in the broader sense?

- The trust worked with Public Health, including delivery of mental health first aid training or supporting delivery for people in communities. There was the work in Wentworth Valley with publicans on how to deal with someone experiencing a mental health crisis. RDaSH did have a key role in training and support, particularly about how you might have a conversation with someone who was struggling emotionally. They also linked in with the Public Health campaign, especially around suicides, drug and alcohol issues etc.

What were the waiting times for treatments and therapies under the brief interventions and were adequate numbers of staff in post?

- For IAPT (Improving Access to Psychological Therapies) the national standard was for treatment to commence within six weeks These were available to everyone in Rotherham via their GP or by self-referral.

- For brief interventions the quicker the better and in urgent care standards were – in an emergency people needed to be seen in four hours for initial assessment and for urgent but not emergency cases within three days.
- For brief interventions and treatment the national standard of 18 weeks was too long. RDaSH were working to reduce their waiting times, for example it was a 12 week standard for assessment for memory problems but they were trying to reduce that to six weeks by March 2018.

Locality roll out – how many areas would RDaSH cover to reach the outlying areas?

- GPs had seven localities but RDaSH were looking at providing services from three bases (north, south and central) ensuring these linked across the seven.

With regards to the pathways framework, was there a safety net for people who might fall through the gaps, such as people with autism?

- Although there were three distinct pathways the intention was to provide the three within each locality, so that people could travel through the pathways, with their locality teams deciding where someone's care might be delivered, but with the teams taking ownership so no-one should fall through.
- In terms of autism specifically, RDaSH were working with their commissioners and the local authority on where they would fit within an autism strategy. People with autism could and did access RDaSH services. What the trust were trying to do was look at how they could influence the commissioning of autism services as this was still not robust enough in Rotherham. An overall autism strategy was being developed.

From the objectives for the Rotherham Care group and the need to deliver efficiency savings, could you explain the scale of those savings and also the balance between delivering the changes and protecting services whilst managing those financial efficiencies?

- For 2017-18 NHS efficiencies were £1.2m plus £500k Local Authority savings as the trust provided integrated adult mental health services. It had been a real challenge to get to a position of being able to take money out of the system at the same time as transforming the system. Some non-recurrent funding from NHS England had helped in mitigation to support the transformation programme, with a view that efficiencies would be made out of the whole system at a certain point, which was part of the NHS Five Year Forward View.
- It had been a struggle and a lot of savings had come out of the staffing structures with a leaner management and leadership team now having a bigger portfolio with fewer managers and clinical leads. RDaSH had also been supported by funding through the Better Care Fund to support change and build capacity whilst transforming, this year and next.

What was in place to measure the more qualitative feedback of the patient experience and to know how the new pathways were working for people, as the metrics were only part of the story?

- Every aspect of transformation had been subject to a Quality Impact Assessment, which looked at the impacts on service users, staff and finances, although some would not be known until the changes were embedded. The trust was trying to obtain service user feedback as they went along. In The Ferns and social prescribing they had received great feedback so they knew some of the changes made across the partnerships were delivering really good outcomes. It was important to capitalise on what was done well and do more of it.
- For staff it was difficult to go through such a large scale transformation and staff may feel less involved, so more work was needed on staff engagement. At present there had been no really negative stories and there had been regular engagement with stakeholders and service users.
- Transformation commenced with a whole system event involving patients, carers and all the providers and commissioners and the objectives seen earlier resulted from that event. The trust worked with patients and carers to test out plans as they evolved. Case studies, formal evaluations and service reviews with both qualitative and quantitative feedback had been used. As RDaSH moved to implementation of the pathways they would evaluate them all.

What was being done to identify disparities in the health of different sub-groups of service users e.g. lower rates of cancer screening amongst people with learning disability and/or autism compared to other groups, and how was this addressed in the pathways?

- This comes back to the Place Plan again and one of the benefits of working across the system and integrating physical health, mental health and social care. For people with learning disability things did tend to present hand in glove, so the more we could have multi-disciplinary teams physically co-located the easier it was to say we have a patient presenting with these needs and the expertise was together in one place.

Where do you see the potential involvement of the Health and Wellbeing Board (HWBB) in the forward progress of this?

- This was critical and the HWBB was sighted on the transformation programme. Through place based governance it was easier to check alignment of RDaSH transformation with the local authority's transformation plans and with what the GPs were thinking. People in communities needed to know that organisations were working together to provide services for them. They were also involved in developing the HWBB action plan, so it all linked in together.
- The refresh of the Health and Wellbeing Strategy had been brought forward so that was the overarching strategy and to align with the refresh of the Health and Social Care Place Plan. The transformational groups, such as the one for mental health and learning disability were working very closely together. The HSC

meeting on 14 December 2017 would be an opportunity to challenge whether the alignment was effective enough.

Did that also include the Autism Strategy and the working group that was developing it? Would it come back to HSC?

- The Autism Strategy was being led by Adult Social Care. At the moment there were overarching high level aims for the refresh of the Health and Wellbeing Strategy and ensuring a clear "home" for learning disability and autism within it this time was important. It was likely that as part of the governance the HWBB would oversee the development and delivery of the Autism Strategy. It was expected that HSC would want to see the Autism Strategy as it developed and to take account of its delivery.

Dianne and Steph were thanked for their presentation.

Resolved:-

That the progress made in phase two of the transformation plan for RDaSH be noted.

50. IMPLEMENTATION OF THE CARERS' STRATEGY - PROGRESS REPORT

Jo Hinchliffe, Adult Social Care, Liz Bent, Crossroads Care and Jayne Price, Carers Forum presented an update on the Carers' Strategy – *The Story So Far*. Sean Hill from Children's Commissioning and Kevin Hynes, Barnardo's provided additional information regarding work to support young carers.

Crossroads Care

We aim to:

- Relieve stress in the family or for the Carer of the person with the disability
- To prevent a breakdown in care or inappropriate admission into hospital or residential care
- Supplement and complement existing statutory services and work closely with them

Philosophy of Care:

Crossroads Care Rotherham respects the individuality of Carers and people with care needs and seeks to promote their choice, independence, dignity and safety.

Originally respite care was provided but activities had expanded to include activity groups, therapies and a befriending service, increasingly working with volunteers to deliver services. Traditional respite was still important but it was also about people coming together and enjoying a life outside caring.

Crossroads Care was regulated by the CQC and were proud to have been rated as outstanding, which they could not have achieved without the support of partners.

Carers Forum
Supporting & empowering Carers to be heard & achieve better outcomes

Rotherham Carers' Forum is an independent group which enables informal and family carers (unpaid), to have voice in shaping services in Rotherham.

We aim to work together as a strategic partner with Local Authority, Health Service, Voluntary and Communities organisation, charities and groups as an equal partner, participating and influencing local decision making on services for carers and their families.

Carers Forum meets on the 1st Wednesday of each month between 12 noon - 2.00 pm

The Forum, comprised of unpaid volunteers, had been relaunched to get into the 21st century and had a website plus Facebook and Twitter accounts with this virtual presence helping carers who were unable to attend meetings. The group was solvent after accessing external funding. A key focus was promoting carers wellbeing such as encouraging people to have flu vaccinations and through sessions on destressing and mindfulness. It also acted as a two-way conduit for information and a mechanism was in place for raising concerns through an issue log.

Caring Together Strategy
Our aims are:

- That every carer in Rotherham is recognised and supported to maintain their health, wellbeing and personal outcomes.
- To ensure carers are supported to maximise their financial resources.
- That carers in Rotherham are recognised and respected as partners in care.
- That carers can enjoy a life outside caring.
- That young carers in Rotherham are identified, supported, and nurtured to forward plan for their own lives.
- That every young carer in Rotherham is supported to have a positive childhood where they can enjoy life and achieve good outcomes.

Four key priorities for supporting carers (National Carers Strategy DoH 2014)

- Identification and recognition
- Realising and releasing potential
- A life alongside caring
- Supporting carers to stay healthy

Rotherham Context
Profile of carers based on 2011 census data
For 2016 Rotherham had increased by approximately 600 carers since then. 9000 people p.a. in Rotherham become first time carers, so there were many people with multiple roles and the picture fluctuated over time.

Strategy Outcomes
Our ambitions are:
To achieve our aims we need to build stronger collaboration between carers and other partners in Rotherham, and recognise the importance of whole family relationships.

We want to lay the foundations for achieving these partnerships and set the intention for future working arrangements.

We want to do something that makes a difference now … whilst working in partnership with formal services, working together with people who use services and carers.

- **Outcome One:** Carers in Rotherham are more able to withstand or recover quickly from difficult conditions and feel empowered.
- **Outcome Two:** The caring role is manageable and sustainable.
- **Outcome Three**: Carers in Rotherham have their needs understood and their well-being promoted.
- **Outcome Four**: Families with young carers are consistently identified early in Rotherham to prevent problems from occurring and getting worse and that there is shared responsibility across partners for this early identification.
- **Outcome Five**: Our children are recognised and safeguarded in their challenging role and receive appropriate intervention and support at the right time.
- **Outcome Six**: Children and young people in Rotherham that have young carer roles have access to and experience the same outcomes as their peers.

Putting the strategy into action …..
Making it Happen – Caring Together Delivery Plan
Qualitative measures
Quantitative measures

Headline Statistics
- Carers resilience are working with approximately 480 carers per year, prior to Carers Resilience Service these carers may have remained hidden

- Carers Resilience Service hosts 23 carers clinics per month across different Rotherham surgeries, last year we met with 365 carers across all disabilities
- Carers Resilience Service works with 37 surgeries across Rotherham promoting the needs of carers to surgery staff and GPs
- From our work with the surgeries we know that all have a Carers Register but these are operational to different degrees of usefulness.
- Number of customers and Number of customers with an open main carer
- Number of customers by age column split by age of carer - In terms of the health and wellbeing of carers this showed cohorts of quite old people whose carer was quite old as well.

The Carers Resilience Service was led by Crossroads Care and had been in place for about two and a half years, making a terrific difference for carers in Rotherham. It picked up carers at the beginning of their caring role, recognising their different needs over time. Due to the funding it was limited to carers of people with dementia but a bid was being developed, working with the Local Authority, to the Social Investment Bond to try and roll out to older carers as well and ideally it should be for all.

Funding bids needed supporting evidence to back them up, meaning there was a need for statistics and data. The VCS would be working with the Single Point of Access to pick up data on carers to support bids.

Young Carers Service Delivery

- 55 young carers and their families supported this quarter
- 169 face to face contacts
- 13 Group sessions
- 14 cases brought to closure
- Young people included 17 Male and 38 Female
- 9 young people came from BME communities, equating to 17% of young people supported

Members were informed that the Young Carers Service delivered by Barnardo's had recently moved from Doncaster to the Rotherham branch. It would become more of a partnership arrangement looking at all the current services delivered in Rotherham and whether they meet need, asking questions around what young carers required and how best to do it. Young carers were all individuals, all with different issues in their lives so services were needed that could respond to individual needs and create independence not dependency on services.

Since September Barnardo's had asked the national Barnardo's audit team to look at how the service operated so that nothing was overlooked. They had also had support for a Theory of Change workshop from the University of Bedfordshire. It had been a good time to take stock of current services, especially improving links to other agencies as before Barnardo's had operated more in a silo. It had been a positive start but they were only eight weeks in.

Achievements so far ….

- Carers Week 2017
- Crossroads Care Garden Party
- Grassroots Giving winner
- Carers Rights Day 24 November 2017
- The service continues to raise awareness of the Young Carers' Card in schools. At present this is mainly done through contact and visits with Head of Year contacts within schools.
- Supported by the Voice & Influence Partnership to host an event at the Carlton Park in July 2017 which enables young people to voice their feelings and hopes for the children and young people in Rotherham.
- Young Carers Council continues to be active members of the Different but Equal Board.

Next steps …

- Carers Forum – Sustainability Plan
- Events and Activity Plans
- Consolidation of a carers offer – real and tangible
- Strengthen the Caring Together Delivery Group to increase the distance of travel against the action plan

As the Carers Forum was comprised of people who were carers first and foremost there was a worry about whether it would continue if the present people were no longer involved and it was a struggle to get people involved and do things. An aim would be for it to become self-sustaining and not dependent on a small number, but resourcing back office functions was difficult.

One of the key aims of the strategy was reaching out to hidden carers and although the virtual side was good they would like to undertake more physical outreach going out to where carers are. It would be good to free up some time for people to go out and do events or some outreach work, which helped to raise the profile of carers. The Forum was also an umbrella organisation where other groups such as Headway, Carers for Carers and the Rotherham Parent Carers Forum could come together.

The Strategy steering group was ready for a refresh against the Terms of reference as membership had changed over time with people joining and leaving. Dialogue was taking place with Children and Young People's Services and Barnardo's in order to have the right mix of partners involved and be accountable.

A lot had been included in the delivery plan and it was a case of trying to group the 21 actions into key themes and drilling down what was needed in terms of actions. Some actions would still be red or amber on RAG ratings and it was about converting more of these into green and looking at the reds and exploring reasons why. It was a work in progress and

needed a refresh. Some elements had movement, especially qualitative ones like events, but the quantitative measures needed to be worked on and partners were realistic about the current position.

Questions ensued with the following issues raised by Members:-

How much information did you get back from GPs on carers as in my practice I have never been asked about being a carer, or seen any information?

- All surgeries had a register of carers so it was interesting that you had not been asked. The registers needed to be worked on and kept up to date and by having workers in there every week the message was going out.

Regarding outreach, Maltby Town Council held information days so there would be an opportunity there.

Would it be feasible to set up carers base groups in other areas of the borough for carers who could not travel into Rotherham i.e. locality based smaller groups?

- This would be a good way forward and had been talked about but it came down to resources. It would be great to encourage local satellite groups to collect, share and channel information and make more hidden carers come forward and feel they had a voice. Back filling for carers would be key.

You mentioned supporting 55 young carers – how were young carers identified and what was the role of Early Help?

- Conversations had taken place between the previous manager of the Barnardo's service, children's commissioning and heads of service in Early Years around the strategy and there had been input from the Early Help team. Children's commissioning had spoken with Early Help earlier that week about work taking place to increase the number of Early Help assessments and identification of young carers. One of the main themes for the work that will come out of the review of the current Barnardo's service is the importance of assessment and identifying the needs of young carers. There was a clear plan with Barnardo's going forward as part of a partnership arrangement and within that the voice of young people would be included, as the service was a key element of children's services.
- The Young Carers Council (YCC) had been supported by Barnardo's for many years. Two representatives from Barnardo's had attended the most recent Carers Forum meeting, including one longstanding practitioner, and had first-hand knowledge of representing those young people's views. Regarding detection or recognition of unknown young carers GPs surgeries would be a good place to bolster that to ask for those children to be actively searched for and also questions to schools asking them about identification.

Who represented young carers on the Carers' Forum, did they not represent themselves?

- Not at present as it met during school time, which was an issue and was why they wanted to make sure that in the first instance they had representation from someone who worked very closely with young carers. The issue had been raised by Barnardo's who were passionate about getting the real voice round the table and it was important to have a clear way in and to maximise the expertise of the YCC in the whole process.

The voice of the child was essential to every strategy in Rotherham and if the meetings were at a time when young people could not attend then perhaps the times of the meetings, or some of the meetings, should be changed.

What input had young carers themselves had to this strategy?

- The officers present had not been involved in the development phase of the strategy but were aware of conversations to ensure that their voice was captured. Invites had gone out to Barnardo's and children's services but there had not been any children in attendance at strategy group meetings, which were all day time meetings.

You mentioned working with carers whose caring role is coming to an end, do you offer any support post-caring as there might be carers who might then need care themselves?

- Two years ago lottery funding had been obtained for five years for building carer resilience but it needed to be sustainable. Carers benefited from peer support in activity groups and when caring came to an end if they had not been involved in any activities they often became isolated. Carers had a lot of experience and also often transferable skills and there were opportunities to volunteer to support other carers. Carers also formed friendships and could form their own groups.

Did the work with GPs include ones whose practice was registered outside the borough but with patients who were Rotherham residents on their list?

- The service was funded to work with every GP in Rotherham and if the carer was registered with a Rotherham GP but lived over the border they would still be supported. Services were tied only to the practices in the borough.
- Officers would follow up with Rotherham CCG for clarification on this issue.

The action plan mentioned reducing exclusions for the young carer cohort. How big an issue was this?

- If a student with a Young Carer's Card was late for school due to their caring role this would be taken into consideration and it was recognised that some young carers had very complex lives.

- There were no statistics to hand so this would be followed up with a response.

What is meant by cases coming to closure?

- The number of cases that Barnardo's had worked with where it had been agreed after a period of time with the young person, their family and the referring agency that all signposting and adjustments had been completed. For example liaison with school to make relevant staff aware that the child may occasionally be late and could show their card rather than explaining everything from scratch again.

Regarding governance, what arrangements were there for oversight of the strategy and action plan?

- Governance was key and as mentioned earlier the terms of reference needed to be revisited, including a review of where the strategy group were feeding into. From an adult social care perspective there was the improvement group with a governance structure there to feed into but a clear steer was needed overall given the complexity with the various partners involved. It was agreed that this was something that needed to be worked on.

Was Barnardo's now part of the delivery group?

- Yes they were again now.

Actions 15-21 had no timescales or performance measures, so would these be added otherwise how would it be evidenced what work was taking place?

- This would be part of the refresh and it needed to be more of an accountable document. Actions flagged as ongoing were also a concern as it was unclear if they were part of an action plan to deliver an agreed action plan to deliver a specific piece of work or routine activity.

Partners were thanked for their presentation and contributions.

Resolved:-

(1) That the action plan be updated to become SMART with clear lead officers, performance measures and timescales for all actions.

(2) That a clear focus be given to ensuring the voice of young carers is captured and informs implementation of the strategy, including by linking in with the Young Carers Council.

(3) That further work with GPs be undertaken to ensure they are identifying young carers and including them in their carers register.

(4) That work with schools continues to identify and support young carers.

(5) That a detailed progress report be presented to the HSC in March 2018 on implementation of the delivery plan.

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

The Health Select Commission received a short verbal update from the Scrutiny Officer.

Hyper acute stroke
The Joint Committee of Clinical Commissioning Groups (JCCCG) met on 15th November 2017 to consider the business case and make a decision on the proposals for hyper acute stroke services. The executive summary of the business case, link to the full business case and powerpoint presentation to the JCCCG meeting had been included in the Members' information pack.

The unanimous decision was to support the proposed option to cease providing hyper acute stroke services at Barnsley and Rotherham hospitals. There would be a phased implementation to ensure patient safety and to ensure that the changes were manageable for the hospitals. Implementation would be closely monitored by the JCCCG and by the JHOSC. The service would be decommissioned in Rotherham from July 2018 and in Barnsley by January 2019 with hyper acute stroke services provided in Sheffield, Doncaster, Chesterfield and Wakefield. The new model required approximately £1.8m investment for tariffs and patient transport and the pathway would include thrombectomy.

Hospital services review
The purpose of the review was to explore how services could be delivered to ensure local people had access to safe, high quality care provided by the most appropriate healthcare professionals and in the best place. The key was future proofing and sustainability of services. It was very important to reiterate that the review was not looking at closing any of the current general hospitals in South Yorkshire, Bassetlaw or Chesterfield.

The five services in scope were:

- Urgent and Emergency Care
- Maternity
- Gastroenterology including endoscopy
- Stroke care - early supported discharge and rehabilitation
- Hospital services for children who are particularly ill

Consultation had commenced in the summer and there would be a public event on 6th December 2017 at The Source, Meadowhall. There would also be other opportunities for local people to get involved, including an event for Elected Members in January 2018.

JHOSC

The next meeting would take place on 11th December 2017 and the agenda would include progress on implementing the changes in children's surgery and anaesthesia agreed earlier in the year; an update following the decision on hyper acute stroke care; and an update on the Hospital Services Review.

The agenda would be published on 1st December 2017 and HSC members were asked to submit any questions to the Chair by 7th December.

52. HEALTHWATCH ROTHERHAM - ISSUES

There were no issues to report.

53. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 14th December, 2017, commencing at 10.00 a.m.

HEALTH SELECT COMMISSION
14th December, 2017

Present:- Councillor Evans (in the Chair); Councillors Andrews, R. Elliott, Jarvis, Marriott, Rushforth, Sansome, Short, Whysall and Williams.

Apologies for absence were received from Councillors Bird and Ellis and Robert Parkin (Rotherham Speakup).

54. DECLARATIONS OF INTEREST

There were no Declarations of Interest.

55. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

56. COMMUNICATIONS

The Chair informed the Commission that The Rotherham Foundation Trust (TRFT) would be holding a stakeholder event on 31st January to discuss their quality priorities for 2018-19. Further details would follow.

The Joint Health Overview and Scrutiny Committee meeting scheduled for 11th December 2017 had been cancelled due to the inclement weather so there would be no updates until the new year.

57. REFRESH OF THE HEALTH AND WELLBEING STRATEGY AND THE INTEGRATED HEALTH AND SOCIAL CARE PLAN

Councillor Roche, Cabinet Member for Adult Social Care and Health and Terri Roche, Director of Public Health delivered a detailed presentation on the Rotherham Health and Wellbeing Strategy 2018-25 and the Integrated Health and Social Care Place Plan (IHSCP). Ian Atkinson and Lydia George from Rotherham Clinical Commissioning Group were also in attendance to provide additional information regarding the IHSCP.

The IHSCP was Rotherham's local plan within the wider South Yorkshire and Bassetlaw (SY&B) Sustainability and Transformation Plan, now known as the Accountable Care Partnership (ACP).

Rotherham Health and Wellbeing Strategy 2018-25

Purpose of session

- Provide an overview of the current strategy and why a refresh is needed
- To outline key data and intelligence
- Present a framework for the refreshed strategy for scrutiny to consider

- Provide an overview of how the Integrated Health and Social Care Place Plan aligns to the new strategy
- Present a timeline and next steps

Health and Wellbeing Board (HWBB)

- Statutory board since 2011 – sub-committee of the council
- Includes statutory members, plus providers on the Rotherham board
- Duty to prepare Joint Strategic Needs Assessment (JSNA) and local Health and Wellbeing Strategy (HWBS)
- Duty to encourage integrated working between health and social care commissioners
- Provides a high-level assurance role; holding partners to account for delivery

Membership of Health and Wellbeing Boards (HWBB) varied across the country and Rotherham HWBB was deliberately quite large in order to develop the partnerships with all local key providers. The Council had previously been criticised for its lack of partnership with health partners, which had been addressed with excellent relationships now with the Clinical Commissioning Group (CCG) and Rotherham Hospital.

The JSNA summarised key features about Rotherham and informed the local HWBS.

Integrated working was going exceedingly well, with joint posts and joint commissioning developing, for example in midwifery.

The role of the HWBB was now primarily a strategic one, although it did provide high level assurance. The board focused on what was best for Rotherham rather than coming from individual organisational perspectives.

Health and Wellbeing Strategy

- Sets strategic priorities of the HWBB
- Not intended to include everything that all partners do
- Based on intelligence from the JSNA and other local knowledge
- Enables commissioners to plan and commission integrated services
- Service providers, commissioners and local voluntary and community organisations all have an important role to play in identifying and acting upon local priorities

Health and Wellbeing Strategy 2015-18 Principles

- Shared vision and priorities
- Enables planning of more integrated services
- Reduces health inequalities
- Translates intelligence into action - JSNA and information from partners. One example last year was partners sharing concerns about care homes and this area was now working better, for example with a nominated GP attached to each care home.

From when Commissioner Manzie had been in post there had rightly been a strong stress on children, and children would still be a key part, but other elements and health inequalities needed to be worked on and included.

Need for a refresh …

- Existing strategy runs until end of 2018 – but number of national and local strategic drivers now influencing the HWBB
- An early refresh ensures the strategy remains fit for purpose, strengthening the board's role in
  - high level assurance
  - holding partners to account
  - influencing commissioning across the health and social care system, as well as wider determinants of health
  - Reducing health inequalities
  - Promoting a greater focus on prevention
- LGA support to the HWBB:
  - Self-assessment July 2016
  - Stepping Up To The Place workshop September 2016
  - Positive feedback given about board's foundation and good partnership working
- The current strategy was published quickly after the board was refreshed (September 2015)
- Now in stronger position to set the right strategic vision and priorities for Rotherham

The refresh would help to move at a faster pace with greater emphasis on prevention and early intervention, which was the key to what the HWBB were trying to do. For example, weight management at Tiers 3 and 4 was high cost but if this was tackled earlier it was both more effective and cheaper and achieved more long-term benefit.

The Place Board was one of the key drivers for the change and as partners in Rotherham worked well together it was decided to bring things together under the HWBB rather than the Place Plan being a separate entity.

Joint Strategic Needs Assessment

- Ageing population – rising demand for health and social care services
- More people aged 75+ living alone, vulnerable to isolation
- High rates of disability, long term sickness (more mental health conditions) and long term health conditions e.g. dementia
- Need for care rising faster than unpaid carer capacity
- High rates of smoking and alcohol abuse, low physical activity & low breastfeeding
- Rising need for children's social care, esp. related to safeguarding
- Relatively high levels of learning disability
- Growing ethnic diversity, esp. in younger population, with new migrant communities

- Growing inequalities, long term social polarisation
- High levels of poverty including food and fuel poverty, debt & financial exclusion

Inequalities in Life Expectancy
Graphs showing Life Expectancy at Birth and Healthy Life Expectancy for Rotherham and England – males and females.

Proposed refreshed strategy
- Sets strategic vision for the HWBB – not everything all partners do, but what partners can do better together
- Includes 4 strategic 'aims' – shared by all HWBB partners
- Each aim includes small set of high-level, shared priorities
- Which the Integrated Health and Social Care Place Plan 'system' priorities will align to

Strategic aims
Aim 1. All children get the best start in life and go on to achieve their potential and have a healthy adolescence and early adulthood

Aim 2. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

Aim 3. All Rotherham people live well and live longer

Aim 4. All Rotherham people live in healthy, safe and resilient communities

Consultation and engagement
- HWBB received proposal for refresh September 2017 and framework November 2017
- IHSC Place Board received an update September 2017
- New framework shared with HWBB sponsors and theme leads for comments
- Health Select Commission December 2017
- All partners to consider taking through their own governance structures Nov – March 2018
- VAR audience with to take place January 2018
- Consider what other stakeholder engagement may be needed…

The final version of the strategy was due in late February 2018, and would go to Cabinet for endorsement before the final approval from the HWBB on 14th March. It would be a living document but not undergoing a full refresh for three years.

Integrated Health and Social Care Place Plan

Integrated Health and Social Care Place Plan (IHSCP)
Current Place Plan agreed November 2016
Work taking place to re-align with the refreshed HWBS

How the Rotherham Health and Wellbeing Strategy and Integrated Health and Social Care Plan will align

- Structure for overall strategy and delivery
- Structure charts for strategic HWBS aims 1,2 and 3 and the HWBS priorities under each aim and how these then linked to the Place Plan Transformation Groups and their respective priorities to help deliver. Prevention and early intervention were key elements in everything. Aim 1 merged the previous two aims for children in one.
- Structure chart for strategic HWBS aim 4 and the HWBS priorities under each aim and how these link in with other workstreams/strategies as they are not directly aligned with the Place Plan.

The Rotherham Care Record (RCR) shared between partners would be a key step forward in integration. The governance arrangements were key in ensuring integration and communication between partners and working effectively together. As part of the delivery of the IHSCP, which was a true partnership approach, there were three transformational groups chaired by very senior managers to ensure this work happened. It was an integrated approach and integrated effort to deliver effectively together.

HWBS Aim 1 – All children get the best start in life and go on to achieve their potential and have a healthy adolescence and early adulthood

HWB Priority 1 Ensure every child gets the best start in life (preconception to age 3) – includes pre-conception, healthy pre-pregnancy and pregnancy – lifestyle including smoking and alcohol consumption, health, diet and seeing a midwife early (cross reference to Marmot).

HWB Priority 2 Improve health outcomes for children and young people through integrated commissioning and service delivery – linked back to previous HSC work when the under 5s and school nursing services were brought together in the integrated 0-19 service, delivered through effective health visiting and school nursing, bringing in other services as appropriate.

HWB Priority 3 Reduce the number of children who experience neglect – lot done on safeguarding and looked after children and now the focus would be on neglect as this can lead to children and young people becoming looked after, with support offered at an early stage.

HWB Priority 4 All children and young people are ready for the world of work - universal proportionalism and the need to be brave in terms of what level of resource goes to different groups of people. Everyone gets some resource but some groups might get more to help them to achieve at school and feel confident and enabled to get into good employment.

The transformation group, chaired by Ian Thomas, would oversee delivery of the 0-19 contract (but not undertake contract management), ensuring real added value.

Children's acute and community integration – 14-16 year olds having a choice of admission to an adult or children's ward and ensuring that either was able to meet their clinical needs as Rotherham hospital is too small to have an adolescent ward.

HSC already had a good knowledge and overview of implementation of the local CAMHS transformation plan which needed to continue.

Embedding children's voice - reality not tokenism. Linked in with Children and Young People's (C&YP) Partnership Board.

HWBS Aim 2 − All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

HWB Priority 1 Improve mental health and wellbeing of all Rotherham people
HWB Priority 2 Reduce the occurrence of common mental health problems
HWB Priority 3 Improve support for enduring mental health needs including dementia

It was important to note this was mental health not mental illness as good mental health was an enabler and helped to promote good quality of life. Levers included the Better Mental Health for All Strategy and the Suicide Prevention Action Plan and also good work at a local level. Dementia still needed to be included. It involved early identification and treatment of common mental health problems and support for people with enduring conditions. The key was getting more people behind it to commit to delivery.

The Suicide Prevention Action Plan needed to include communities so people were confident to ask questions, knew where to refer people and could talk about mental health in a much more open way. HSC were already familiar with the Rotherham Doncaster and South Humber (RDaSH) transformation plan and changes at Woodlands. It was about a good balance across prevention, early intervention and treatment at the right level.

HWBS Aim 3 − All Rotherham people live well and live longer

HWB Priority 1 Prevent and reduce early deaths from the key health issues for Rotherham people such as cardiovascular disease, cancer and respiratory disease - reflected lifestyle related issues and the industrial legacy. It included working with primary care to ensure people attended screening and to catch people earlier, both to prevent ill health and to ensure treatment was more effective.

HWB Priority 2 Promote independence and enable self-management and increase independence of care for all people – social care offer to enable people to remain more independent but being confident about self-care knowing they had access to support/advice when needed.

HWB Priority 3 Improve health outcomes for adults and older people through integrated commissioning and service delivery ensuring the right care at the right time – through working with the CCG there were already seven joint commissioning posts. Partners were looking to commission things more effectively together, so no silos and no residents slipping through the gaps. Levers included Making Every Contact Count (MECC) with all front line staff being confident to have some of these conversations about lifestyles and knowing where to signpost people. The Wellness Service would be a one stop shop for that as well.

Priorities that sit under the transformation group, with prevention and early intervention key to all were:

- Improving the reablement and intermediate care offer so that people had their physio and were back in their own environment
- Integrated locality model roll out – HSC would be scrutinising the evaluation in January - what had worked well, what needed to be done differently and how we could make that happen
- Single point of contact for care needs – hub
- Autism – further deep dives into needs analysis needed
- Transforming Care – not easy but partners were trying to overcome barriers around who pays for what and different targets, including by seeking advice from elsewhere and lobbying central government to reduce some of the restrictions
- Expand Integrated Rapid Response - so people had a timely, quick response when needed
- Integrated Discharge Teams - Home First Home Safe
- Co-ordinated approach to care home support

HWBS Aim 4 − All Rotherham people live in healthy, safe and resilient communities

HWB Priority 1 Increase opportunities for healthy sustainable employment
HWB Priority 2 Ensure planning decisions consider the impact on health and wellbeing
HWB Priority 3 Ensure everyone lives in healthy and safe environments – influencing the housing strategy and making sure people are in warm, sustainable and safe homes. Domestic abuse was a priority for the Safer Rotherham Partnership and it was important that front line staff were aware of the signs and how to access support.
HWB Priority 4 Increase opportunities for all people to use green spaces – new Cultural Strategy included sport, leisure and green spaces.

No prevention was possible without working on the environment as a whole, as the wider determinants of health were a key reason behind the inequalities in life expectancy, so aim 4 was important, as was having housing fully on board.

Priority 1 was about getting people into employment but also ensuring that employment was as sustainable and health promoting as it could be. Funding had been obtained through Sheffield City Region for employment support workers working in a holistic way with people facing barriers to work to try and help them into work. They would also be working with people at risk of losing employment through musculo-skeletal or mental health conditions to try and keep them in work. Terri Roche chaired the local implementation board and it was a good opportunity to work with people in a different way. Work can have a massive role in improving people's health but with the changes in benefits it was important to ensure people were getting a reasonable wage and in sustainable employment.

What next …

- Full draft of strategy and IHSC Place Plan to be presented to HWBB 10 January 2018
- Continue to gather comments and feedback from stakeholders up to March 2018
- CCG Governing Body, IHSC Place Board and Cabinet to endorse strategy and IHSC Place Plan February/March 2018
- IHSC Place Board to sign off IHSC Place Plan March 2018
- HWBB to sign off strategy by April 2018

Questions for scrutiny

- Are the strategic aims and priorities clear about what they mean?
- Is there anything missing or needs more emphasis?
- Reducing loneliness and isolation is an emerging issue in the JSNA – how do we ensure this is addressed through the strategy?
- How can elected members, partners and residents work together to help deliver the strategy aims within neighbourhoods?

"**Prevention Matters**"

- The Local Government Association (LGA) will be running a workshop looking at how elected members can improve the health of their communities
- Taking place over two half days: 15th and 16th February 2018 - ideally people would attend both sessions as the first would be the LGA talking about prevention and public health and the second would focus on the local ward profiles.

Discussion ensued on the presentation with the following questions and issues raised:-

Whilst agreeing with the principles, my concern is the achievability of the aims, which are deep and demanding, including concerns around the finance available and the level of achievability. On a rating of one to ten what was the likelihood of achievability?

- There had been financial cutbacks but the key funding for the HWBB priorities was from the CCG not the Local Authority. There were also Better Care Fund and Improved Better Care Fund (IBCF) monies of around £20m. As the SY&B ACP was a pathfinder extra money was also available to drive that forward. The belief was that the aims were deliverable but the pace could alter depending on funding availability. For example, whether locality working would move to seven health villages across the borough all at once or on a staggered basis. Other health partners were eligible to bid for funding that the Council could not, for example for mental health. Undeniably there was a lot to do but it was a good team and a good partnership. 8.5 out of 10.

- Aims should be ambitious and the important point here is that if we were talking about outcomes based accountability it was what were we going to do to turn the curve? The strategy would run until 2025 and some of the issues, such as the difference in life expectancy, would take much longer, even generations, to turn around. On delivery it was finding the key things that could be done that would make the most difference and committing with partners to address those, things that would be amenable to change over time. For example, breastfeeding also included longer term health benefits and we were working with the midwives and the hospital trust to see how breast feeding could be improved and then we would need to work with our communities to see how people could be helped to sustain breastfeeding. We would not be able to achieve absolutely everything but it was important to agree on some key things to take us on that journey. It was a case of whether the committee felt we should have ambitious aims with clear plans underneath of how we would work towards them.

- IBCF money did come to the Council but the key metric was reducing Delayed Transfer of Care (DTOC), and although the main driver was the hospital, if the targets were not met money was taken away. Targets had easily been met this year and confirmed by NHS England.

- Within the system everyone was under financial pressure but the step change that we were witnessing in the borough, with the strength of our HWBB and also our place-based approach, was that increasingly we were seeing “how could we best use the Rotherham pound?”, whether the money was flowing down from the local authority or the CCG, in terms of how we deliver our strategy. So we were not pulling away from each other on strategy but aligning that and trying to make the resource follow. That did not provide an answer on deliverability but provided assurance on working increasingly together on both the

commissioning side and the provider side in trying to achieve our plan.

It was really pleasing to see the aspiration and the depth in these aims and it was good to aim high. Aspiration should be built into everything we do in Rotherham and it was a positive sign that the work of the HWBB in putting this together reflects that. HSC would be giving this due consideration and scrutiny and the Chair requested that the committee see the final draft, which would probably be in February.

You mentioned life expectancy in Hellaby ward, would the forthcoming boundary changes skew the health data at ward level as the changes mean losing part of Wickersley which is a more affluent area?

- Yes, the formulae would have to be recalculated again following the boundary changes as data was at ward level. Measuring life expectancy was a statistical calculation and when the populations changed recalculations would be made as soon as possible, as the changes will bring together some very affluent and some very deprived areas. Similarly the gender profile would need to be recalculated.

- Recognising that pockets of real deprivation existed in wards not classed as deprived overall, it was important to try and capture data below ward level.

How do we manage or challenge fast food outlets and schools to ensure greater influence or governance regarding what we want to achieve on obesity?

- Other Local Authorities have implemented planning rules which say no fast food outlets within a certain distance from schools. It was suggested here but challenged successfully on appeal by a fast food company. It had been raised again with Planning and the Strategic Director was looking at other ways to tackle this. Some evidence did suggest there was a limit as to how far people would be prepared to walk to get fast food so if fast food outlets were located beyond that they would be less likely to go. Creating a healthy environment overall to help people make healthier choices was covered in the strategy in aim 4 but it would be a challenge going forward as some of the big fast food outlets had very robust legal support.

Would the Autism Strategy be coming back to HSC?

- It was under development with a working group established that included Healthwatch. It was still early days but there was no reason why it could not come to HSC if the committee wished to see it.

From the previous HWBS, to what degree are we reinventing the wheel and is there a need to look at what we were doing previously and what we are doing now to try and pull them both together to have a strategy that is achievable?

- The draft proposals did take account of the existing strategy and what was still relevant and needed to be taken forward or needed further work, so it was not a case of reinventing the wheel. Many of the aims would have happened anyway, for example we needed to influence the SEND and CAMHS plans and although there were a number of other strategies the intention was to bring them together through an integrated approach with all services working together. The C&YP partnership plan would have existed without the HWBB but now it was part of it this allowed that integrated approach.

- This was a refresh of the strategy so people familiar with the current one would see aims that needed to continue because some of the things we still needed to do and were not going to change. It was hard but needed to be there. It was a refresh building on what we had before and learning from that rather than starting again. The key was consistent effort on some key priorities over a longer period of time

With regard to older people's aspects and reducing loneliness and isolation, what approach would be taken to contacting people who we think this might apply to without causing offence? And how do older people also fit in with green spaces and age friendly Rotherham?

- Loneliness was becoming increasingly important as seen in the Jo Cox report and the impact on health approximated to smoking 15 cigarettes per day. It was felt important to talk to partners first to check what was already happening and Members were recently given a leaflet from Rotherham Older People's Forum about their activities. Befriending services, social prescribing and luncheon clubs were happening but not everyone knew what was available. Information collation would take place followed by a meeting early in 2018 to consider what was in place and the gaps, then what to do. Funding from the IBCF from April onwards would help take this forward.

- Reviewing the evidence showed trigger points such as key life events such as retirement or bereavement could make people more lonely, and more awareness raising was needed about this with people needing to be confident and better at talking about, it in the same way as for mental health. In addition to the mapping work there was also ward work such as that in Wingfield where loneliness had been prioritised. An asset based approach with communities and the powerful impact of word of mouth about activities taking place was important and this was also perhaps a challenge back to Elected Members in their ward role. Loneliness was intergenerational, not only affecting older people, and carers also experienced isolation.
- In terms of age friendly borough, activities within the child friendly borough workstream were complementary for older people and would be revisited. Actions on loneliness, having the conversations and community cohesion would play a part.

- Some places had introduced a badge system saying “you can talk to me”. Befriending was an important step but not a long-term answer, hence the need to change a person’s long-term involvement in things and the community approach.

How did the carers’ strategy dovetail with the HWBS and how did you see the two joining together?

- It was probably not as explicit as it ought to be and consideration was needed about how it was embedded in the assurance process, for example how the HWBB and HSC worked together, but it could be stronger within it.

- Cllr Roche also agreed it could be strengthened but stated that it needed to go back to the HWBB.

Referencing the work done by HSC last year, it would be nice to see more detail around the housing strategy and specialist housing, including what percentage would be specialist housing.

- This came under aim 4 and it was still early days but the HWBB had received a presentation from Housing and discussed how this fitted in, including decent homes and housing design fit for purpose for the life course, such as wheelchair access. The right design helped to save on adaptations later and contributed to the key aims of increasing independence and choice.

- Improving Places Select Commission led on scrutiny of the implementation of the Housing Strategy and any key issues would be fed back to HSC.

Has there been an opportunity yet to consider the impact of universal credit as this keeps cropping up in housing, health and on Improving Lives?

- It was early days but with the pilots prior to roll out officers were trying to calculate the numbers of people potentially affected and how the Council might be able to mitigate for that when it was a national programme coming in.

- Members had been briefed on the key aspects and it was a concern. As were possible changes to funding for housing to support people experiencing domestic abuse which were going through parliament.

Looking at gathering data on reducing loneliness and isolation, how many partners were you looking at? Could parishes be involved as they did a lot of good work and had a number of groups?

- More people who could suggest things so this could grow as a movement was good. After the small sharing event by starting working in communities hopefully more people would become involved in like a ripple effect. We could also work with others such as hairdressers and publicans in the long term so they feel confident about this. Parishes would be a good group to consider.

Loneliness is a big issue for retired people and people who are out of work. Volunteering can be a good opportunity to improve mental health and people in our community have a lot of skills that are often under-used.

- Agreed and we had seen elsewhere and in the past examples of older people going into schools and passing on their skills and experience. Another example being considered from the Netherlands was where university students had a room free of charge in a care home in return for some time spent each week talking with and befriending the residents, so everyone benefitted.

Education and awareness raising with residents on the health and care system.

Councillor Roche and the officers were thanked for their presentation and contributions.

Resolved:-

(1) That the final draft Health and Wellbeing Strategy be circulated to the Commission in February 2018.

(2) That Aim 4 should strengthen and embed becoming an age-friendly borough.

(3) That the links and governance for delivery of the Carers' Strategy be strengthened and made more explicit within the Health and Wellbeing Strategy.

(4) That partners consider working with Parish Councils on tackling loneliness and isolation.

(5) That information on the implementation of the Housing Strategy with regard to specialist housing be reported back to the Commission from Improving Places.

(6) That the Autism Strategy is considered at a future Health Select Commission meeting.

58. RCCG COMMISSIONING PLAN 2018-19

Ian Atkinson, Deputy Chief Officer, Rotherham Clinical Commissioning Group gave a presentation on the review of the CCG's Commissioning Plan for 2018-19. Extensive consultation had been undertaken when the 2015-20 plan had been developed but the CCG had a statutory duty to update its plan.

After earlier discussion of the strategic priorities across the Rotherham health and care system with the HWBS and the IHSCP, this focused on the CCG's plans and how Members would see joined up working on how

the CCG planned to prioritise spending the healthcare pound across the borough.

Presentation Overview

1) Where we are now:
– Financial position
– Demographic Challenge.
– Our Current Priorities, Delivery and Performance
2) The plan, and how we put it together
3) Review of priority areas
4) PPG Feedback

Finance Allocation

- 17-18 £399 million
- Savings of £75million over 5 years 2015-20
- 17-18 savings of £15.9million
- 18-19 and beyond awaiting settlement following Autumn statement

There was an efficiency challenge but no cuts in allocation and the CCG expected a small uplift for next year, although final confirmation would be in the new year.

Where we spend our money

48% Acute Care – hospital based, planned or urgent
12% Prescribing - nearly £30m p.a.
10% Primary Care
9% Mental Health
9% Community – district nursing, physiotherapy and occupational therapy
9% Joint commissioning including the LA and CHC
2% Corporate
1% Central Budgets

The CCG were seeing a reduction in spending on acute care which had previously been around 51% and was in line with the strategy to provide more care in a community based setting. Spending on mental health had increased around national requirements linked to the parity of esteem agenda.

System efficiency

Graph showing 2017-18 efficiency schemes
£75m over 5 years, £15m 17-18
2017-18 efficiency schemes were:

- Corporate savings
- Planned care - reducing unnecessary referrals to hospital and improving pathways and guidelines through GP colleagues. Introduction of clinical thresholds. Reducing unnecessary follow up activity where best practice suggests it was not needed.
- Urgent care - wrapping care around the person, reducing urgent admissions and where possible supporting people in the community.
- Mental health

- Medicine management – waste management and repeat prescribing schemes, but challenged by drug costs which were volatile.
- Continuing healthcare
- Hospital payment system – national tariffs were set for each hospital episode with inflation included and then the efficiencies taken out that the hospital had to make.

The efficiencies were on track so the CCG expected to deliver a balanced position.

Changing demographics

- Rotherham is the 52nd most deprived out of 326 districts
- 50,370 Rotherham residents (19.5%) live in the most deprived 10% of England (this has increased)
- Rotherham has 8,640 residents (3.3%) in Ferham, Eastwood, East Herringthorpe and Canklow living in the most deprived 1% of England.

2015-20 Priority Areas

Strategic aims – The CCG strategic aims seek to address all five Health and Wellbeing Board Strategic Aims across all life stages and for all communities, both geographical and communities of interest.

1 Primary Care
2 Unscheduled Care
3 Transforming Community Services
4 Ambulance and Patient Transport
5 Clinical Referrals
6 Medicines Management
7 Mental Health
8 Learning Disabilities
9 Maternity and Children's Services
10 Continuing Health and Funded Nursing Care
11 Palliative Care
12 Specialised Services
13 Joint working – local and regional
14 Child Sexual Exploitation
15 Cancer

Most priorities fed directly into the IHSCP although the CCG also had a wider remit, like other statutory organisations, on other areas that were less closely linked to the place plan such as palliative care, cancer targets, and continuing health and funded nursing care. A delivery plan and key performance indicators sat below and were monitored quarterly.

Strategy delivery

- Planned Care - contained growth in referrals and our system is in the top 10% nationally for 18 week performance.
- Urgent Care - New Urgent and Emergency Care Centre now open and now refining the model and ways of working. Focus on improving performance

- Primary Care - 31 practices now inspected by CQC, 27 rated good four require improvement. Primary Care access data suggests best in South Yorkshire. Update due to HSC in March.
- Mental Health – Talking Therapies (referred to as IAPT) high performing in access, treatment and outcomes, having moved into top quartile. Dementia diagnosis rates highest in Yorkshire & Humber and now it was a focus on onward care and care in the community as Rotherham still had rather a historic model.
- Child and Adolescent Mental Health – CQC rated as good. Improved access times, ongoing journey of improvement with HSC having a good oversight and recommendations progressing.
- Delayed Transfer of Care – System wide success, although it had been a challenge and performance was currently 1.8% (national target below 3.5%). IBCF monies have supported some real transformational work.

The plan and how we put it together

- RCCG has to have an up to date commissioning plan
- Our GP Members, the 31 practices, recommend the plan for approval by our Governing Body
- This year we are aligning the Rotherham Place Plan & Health and Well Being Strategy.
- In the process, we include: CCG member practices & stakeholders, patients and the public
- Our Governing Body and Clinical Executive have already reviewed the existing Plan and have endorsed the continuation of existing priority areas

The review did highlight support for care homes to prevent hospital admissions and a need for better coordination between the various services commissioned that supported care homes.

Refreshing our plan

To date GP Members, Patients groups and the PPG forums have supported the CCG in giving feedback around many of the 15 priority commissioning areas;

In particular we would welcome further views regarding our proposed approach for the following strategic priority areas:

- Urgent care – National drive to integrate, linking 111/Out of Hours and urgent access to Primary Care – Urgent Care Model for centre by 2020.
- Primary care – 7 day Access – big push for 7:7 and evenings. Capital development at Waverley and new GP. Workforce - issues with GPs and a need to utilise the wider skill mix.
- Mental health
  - Talking Therapies

  - Crisis care, known as Core 24, in the urgent care centre and community crisis care.
  - Dementia - community diagnosis by GPs is positive. The follow up is through the memory service provided by RDaSH but it could be GPs for ongoing care if trained appropriately. Support for carers of people with dementia.
- End of life care – Care in Community. Work with hospice, hospice at home services across the borough and into care homes to keep people in the community setting as far as possible.
- Maternity and children – Better Births national strategy, probably consultation in next year or so across SY&B.
- Care homes – Support to prevent admission

Things had moved on in the last two years with the publication of the Five Year Forward View for Primary Care and the Five Year Forward for mental health plus the system changes at local level. These were the main proposed changes with a detailed consultation document underpinning these that could be circulated so the HSC could go into the 15 priorities in more depth. It covered what the CCG had said it would do, what it had done and what it planned to do.

Other sections in the plan

The following list are areas not covered in the presentation but are very important to the CCG, feedback is welcome:

- Health & Wellbeing Strategy
- Joint Strategic Needs Assessment
- Medicines Management
- Continuing Care & Funded Nursing Care
- End of Life Care
- Ambulance & Patient Transport Services
- Specialised Commissioning
- Public Involvement & Promotion of Choice
- Health Inequalities
- Statutory Responsibilities
- Efficiency
- Finance
- Information Management & Technology
- Communication
- Performance & Assurance
- Risk
- The prevention of Child Sexual Exploitation will remain a priority

What does this all mean?

- Increasing and significant financial challenge for local health and social care economy.
- RCCG will work with partners across the Rotherham Place, to best meet the needs of the Rotherham population.
- Generally, and where this is better for patients, RCCG wants to move services from Secondary (hospital) to Community/Primary Care.
- CCG wants to commission services in Rotherham.

- Where patient quality and outcomes can be improved, we will consider commissioning on a geographical area

Feedback from stakeholders
The CCG welcomes all feedback and any comments can be sent via the CCG email address Rotherhamccg@rotherham.nhs.uk

The current 2016/17 Commissioning Plan is available at http://www.rotherhamccg.nhs.uk/our-plan.htm

The first draft version of the 2018/19 Commissioning Plan will be circulated to stakeholders for comment mid-January.

CCG transformation capacity is finite so it is important that if new initiatives are prioritised some exiting initiatives are stopped.

The following questions were raised by Members following the presentation:

Could you update us on how we are performing against the 4-hour A&E target even though it is still early days for the new centre? And if we are not meeting the target what were the problems associated with it?

- It had been a challenge to meet the 95% target as under the previous configuration before the new centre opened they had worked for the last two winters out of a decanted ward. Although the new centre opened in July they were still challenged, averaging around 85% year to date but the focus was there to get performance up. They had seen improvements in the last couple of weeks, averaging 90% in line with other hospitals in South Yorkshire and nationally.

- Key challenges were bedding in a new facility and new ways of working with triage and flow through of patients. Flow in and out of the hospital was closely scrutinised. The A&E Delivery Board met monthly and had significant focus and support across the system to improve performance.

Would it be possible to have information on the CQC ratings for the 31 GP practices so that Members could look at the surgeries in their own wards and see how they were doing?

- All the information was in the public domain and a summary for the 31 practices would be provided.

With regard to DTOC, could savings from one area go elsewhere in the system, for example to mental health, or were they ringfenced?

- What they were trying to do was improve the flow of patients through the hospital so that as soon as they were well they would go home to their normal place of residence or to other supported care if required.
- When patients were admitted to hospital there was a tariff for each admission of between £1000 and £2000 and the key was reducing the length of stay when someone was medically fit, prioritising patient

health and the quality of care. By that point the payment had already been made within the system so the focus was on the patient flow, both for the quality of care for the patient and for other patients who needed to come in to the hospital. In terms of driving efficiency there were efficiencies if the length of stay could be reduced but taking out money directly around length of stay would certainly be a challenge.

What was the level of savings from actions taken on medicines management following the conference approximately 18 months ago?

- The three areas involved were medicines waste, practice repeat prescribing and using the most cost appropriate drugs at any one time. The £3m referred to was an aggregate of savings across all three and the breakdown was in the public domain as savings were reported to the governing body.

- All three were considered successful including positive feedback from the public on the first two as many people had unwanted stocks of medicine due to unnecessary automated prescriptions.

Did the primary care budget include claims for compensation?

- The budget was for the core GP contract and any additional enhanced services provided by GPs. To discuss further following the meeting.

Following previous scrutiny work by HSC on improving access to GPs can you tell us if access has improved?

- This had been a focus with extended hours and the three Saturday satellite hubs established in response to local need and the national direction. The CCG's primary care committee was considering how this could be extended to seven days to include Sundays and their work would conclude in the new year.

- As mentioned earlier we are high performing and data could be provided on the availability of slots, although this will be covered in more depth in the March update.

Can you give an update on the new GP for Waverley as with increased houses going up this is creating additional pressure on the existing GP practice?

- This is currently out to tender and the procurement process is due to close shortly. Mobilisation would follow but the precise date would have to be confirmed as it linked in with the new building, but there would be a new practice within the next 12 months.

Ability to provide seven day cover if there were only two GPs in a practice.

- The 2000 responses received for the recent CCG survey was positive in terms of engagement. With the workforce challenges we could not expect all GPs to be 7:7, either locally or nationally. Proposals would be more at scale in the system based around the hub model to ensure

seven day population cover. Plans are being developed and will be reported back in March.

With the reduction in nursing home places compared to residential care places, would patients be able to be placed appropriately in residential care homes if these did not have nurses on site?

- This was a challenge within our system and the strategy for both nursing and residential care was about supporting people in the community and in the care setting as far as possible, working with the local authority. Pressures on nursing homes to have beds and available beds was significant. The challenge regarding nursing capacity in the system was acknowledged including for step up/down, to avoid hospital admissions and support hospital discharge.

Would there be a need to keep revisiting capacity for dementia follow up post diagnosis?

- With high diagnosis rates and population projections we would expect to diagnose more people with dementia, so part of the strategy is to work with primary care colleagues to do that, placing it at the heart of community care. The existing resource for dementia follow up is not insignificant but we may need to change how families and carers are supported. We probably would need to invest in post diagnostic support in the community, using GPs and community services to deliver that. For more complex needs central provision would still be needed to try and keep individuals within their community setting and their homes. Dementia is central to mental health and is frequently discussed.

Did the RCCG plan support the aims of Public Health for prevention?

- The Rotherham pound was finite but where the CCG could it would invest in and support on prevention. It was very clear from the Place Board that prevention was at the heart of the place plan.

Could you give an update on the Rotherham Care Record?

- This was a positive development and was a clinical system interface that would enable clinicians to have appropriate access to patient records. For example if a patient came to the Urgent and Emergency Care Centre, with appropriate permissions, clinicians would be able to see some of the activity from primary care or mental health, providing a good understanding of the patient's needs so they could offer the best support.

- The information governance and IT behind developing the record was significant. The right information governance for data sharing was in place, privacy impact assessments had been undertaken and the data sharing agreement developed, which had been endorsed by the Place Board in September. The CCG, RMBC, TRFT and RDaSH were taking the agreement to enter into the RCR through their governance processes by the end of December 2017 with a view to starting to flow data in February.

There had been a significant performance improvement on DTOC in the last few months, how had this been achieved so rapidly?

- We had been at 6% earlier in the year making us an outlier in the Yorkshire and Humber. RMBC commissioned an external review providing an independent view of our system which resulted in all partners signing up to a range of actions and recommendations. The Council also committed a significant part of the IBCF to supporting DTOC, which was positive for the system as it was seen as new money.

- Key things worked on were information sharing, looking at flows of patients and integration of discharge teams from care and health, which were bedding in well. The issue was to sustain this position over winter, which would be a challenge.

Ian was thanked for his presentation.

As the commission had become inquorate during the meeting, Members agreed rather than resolved to:-

(1) Note the six strategic priority areas.

(2) Receive the final draft of the 2018-19 Rotherham Clinical Commissioning Group Commissioning Plan in January 2018.

59. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 18th January, 2018, commencing at 10.00 a.m.

Arising from Minute 58 RCCG – Commissioning Plan 2018-19

The following information was received after the meeting.

- Good * indicates an area that was previously "requires improvement" (Req Imp)
- Thorpe Hesley – the outcome from their revisit in late 2017 has not yet been advised

OVERVIEW OF CQC VISITS IN ROTHERHAM LAST UPDATED 08/01/2018

	Report Date	Insp Date	Overall	Safe	Effective	Caring	Responsive	Well Led	Review Date
Shakespeare Rd	17.08.17	06.07.17	Good *	Good *	Good	Good	Good	Good *	
Gate	22.06.17	17.03.17	Outstanding	Good *	Good	Outstanding	Outstanding	Good	
York Rd	15.10.15	03.06.15	Good	Good	Good	Good	Good	Good	
Brookfield	29.09.17	16.08.17	Good *	Good *	Good *	Good	Good	Good *	
Broom Valley	11.04.17	09.03.17	Good	Good *	Good	Good	Good	Good	
Woodstock	30.07.15	09.06.15	Good	Good	Good	Good	Good	Good	
St Anns	07.07.17	27.04.17	Good	Good	Good	Good	Good	Good *	
Greasbrough	11.04.17	15.02.17	Good	Good *	Good	Good	Good	Good	
Queens	30.01.17	08.11.16	Good	*Req Imp*	Good	Good	Good	Good *	
Magna	06.09.17	27.07.17	Good *	Good *	Good	Good	Good	Good *	
Clifton	24.03.17	20.02.17	Good	Good *	Outstanding	Good	Good	Good	
Greenside	23.07.15	24.06.15	Good	Good	Good	Good	Good	Good	
Parkgate	06.08.15	09.06.15	Good	Good	Good	Good	Good	Good	
Rawmarsh	01.12.16	21.09.16	Good	Good	Good	Good	Good	Good	
Village	06.03.17	24.01.17	Good	Good *	Good	Good	Good	Good	
Manor Field	24.03.17	24.01.17	Good	Good *	Good	Good	Outstanding	Good	

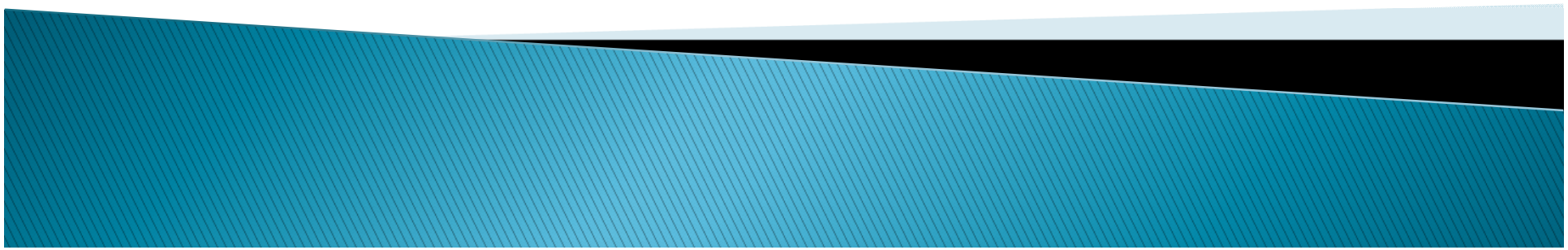
Braithwell (Nee Shrivastava)	04.05.17	23.02.17	Good	Good *	Good	Good	Good	Good	
Crown St	18.02.16	02.12.15	Good	Good	Good	Good	Good	Good	
Broom L	29.09.17	09.08.17	Good	Good *	Good	Good	Good	Good	
Blyth	12.09.16	21.07.16	Good	Good	Good	Good	Good	Good	
Market	28.01.16	18.11.15	Good	Good	Good	Good	Good	Good	
High St	17.08.17	17.07.17	Good	Good *	Good	Good	Good	Good	
Thorpe Hesley	16.02.17	07.12.16	*Req Imp*	*Req Imp*	Good	*Req Imp*	Good	*Req Imp*	Re-inspection report awaited
Dinnington	29.06.17	10.04.17	Good	*Req Imp*	Good	Good	Good	Good	
Treeton	15.10.15	16.06.15	Good	Good	Good	Good	Good	Good	
Brinsworth	09.05.17	14.03.17	Good	Good *	Good	Good	Good	Good	
Swallownest	11.08.17	21.06.17	Good	Good *	Good	Outstanding	Good	Good	
Stag	10.08.17	27.06.17	Good	Good *	Good	Good	Good	Good	
Wickersley	28.04.17	09.03.17	Good	Good	Good	Good	Good	*Req Imp*	
Morthen	02.06.17	19.04.17	Good	Good *	Good	Good	Good	Good	
Kiveton	24.03.17	20.02.17	Good	Good *	Good	Good	Outstanding	Good	

Integrated Locality Evaluation

Health Select Commission 18th January 2018

Nathan Atkinson
Assistant Director of Strategic Commissioning, RMBC

Dominic Blaydon
Associate Director of Transformation, TRFT



The Health Village Integrated Locality Pilot

- Commenced July 2016
- Integrated locality team serving the adult population – aged 64 plus
- Based at The Health Village, Doncaster Gate (2 GP Practices – Clifton & St. Anne's) supporting 35,949 residents
- Multi-agency team – predominately TRFT staff with a small number of Adult Care, Mental Health and Voluntary Sector staff

Overarching Aims for cohort of Adults 64+

- Reduce hospital admissions
- Reduce length of stay in hospital
- Reduce cost of health and social care
- Reduce duplication
- Improve communication
- Develop a holistic approach to care

Purpose of Evaluation

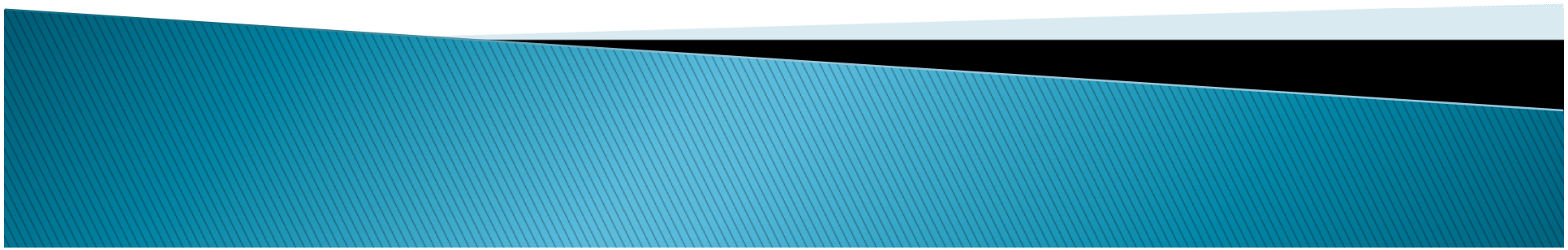
- Has the pilot contributed to attainment of key aims?
- Impact of the pilot service model
- Can the service model be replicated?
- Recommendations for future implementation

Work Done So Far by Grounded Research@RDaSH

- Literature search and evaluation complete
- Compilation of background information
- Interviews and focus groups carried out
- Dataset analysis
- Final evaluation due on 31st January 2018

Key Learning thus far

- Development of an MDT approach is effective
- Separation of planned and unplanned care works well
- Benefits of co-location to all partners
- Enables the identification of high-risk patients in a holistic way
- Encourages a culture of service improvement – bottom up
- Has stimulated further work to simplify referral pathways
- IT and information governance issues partially resolved



Key Metrics (People over 64 years)

Key Performance Indicators

- Non-elective admissions
- Non-elective bed-days
- Length of stay

Contra-Indicators

- Discharge destination
- Elective bed-days

Conclusion

Learning

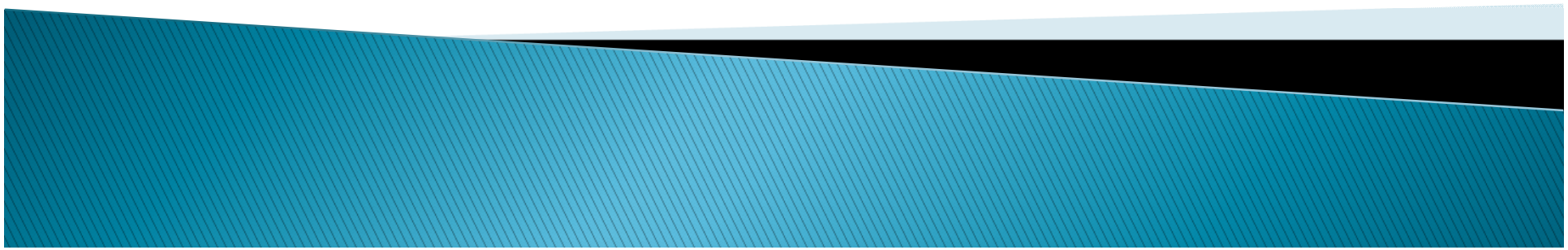
- Positive TRFT acute activity impact
- Reduces duplication and fragmentation
- Improves communication across the system
- Provides a more holistic approach
- Improves the interface with primary care
- Provides opportunities for reablement
- Allows for better integration of referral pathways
- Splits planned and unplanned care
- Has informed the future footprint based on 7 GP practice clusters

Challenges

- Systemic impact unclear especially for Adult Care/Mental Health
- Further test of concept required at larger scale
- Integration of IT & Governance
- Capacity within the system
- Managing variation to match local requirements
- Embedding required change across the system
- Consideration of a whole family approach
- Building in prevention and early intervention

Implementation

Service model presented to ACP Board	Q4 - 2017/18
Consultation carried out and completed	Q1 - 2018/19
Implementation Plan developed	Q1 - 2018/19
Separation of planned/unplanned care complete	Q2 - 2018/19
Phase 1 implementation of integrated localities	Q4 - 2018/19



Any questions

Rotherham Metropolitan Borough Council

Public
Health Select Commission Meeting

Summary Sheet

Council Report
Health Select Commission, 18th January 2017

Title
Adult Social Care – Final published Year End Performance Report for 2016/17

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)
Charna Manterfield, Senior Performance and Data Officer, Assistant Chief Executives Office

Tel: 01709 255344 **E-mail:** charna.manterfield@rotherham.gov.uk

Ward(s) Affected
All

Executive Summary

This report updates the previously reported provisional year end 2016/17 Key Performance Indicator (KPI) results for the Adult Social Care (ASC) elements of the Directorate, following release of national benchmarking data.

This update completes the final requested action from the meeting of the Health Select Commission on 20th July 2017 where it was resolved:

(2) That a further report be presented to the Health Select Commission January 2018 meeting, showing the final submitted detailed results and analysed benchmark comparisons against regional and national data due to be published from late Autumn 2017.

The Council has seen mixed performance across the range of twenty eight national Adult Social Care Outcomes Framework (ASCOF) measures reported in 2016/17. 11 out of 27 comparable measures are recorded as maintaining or improving since 2015/16. Continued improvements have been evidenced in indicators which demonstrate better outcomes for people and increasing satisfaction levels.

2016/17 performance includes one new indicator based on the Adult Social Care User Survey and four indicators from the biennial Adult Carer's Survey. Both the Adult User and Carer's surveys are sent out to a proportion of service users and their carers to understand their experiences of the care and support provided. Responses to some of these questions contribute towards a number of the ASCOF Indicators.

However, it should be recognised that in some of the areas of improvement when compared to the now published national data, shows that the Council performance continues to be below that of regional neighbours or that the improvement has been from a low baseline.

Recommendations

That members of Health Select Commission:

Note the content of final published year end performance results.

List of Appendices Included

Appendix 1 - Table 1 Rotherham MBC - Final ASCOF year-end table

Background Papers

Health Select Commission 20th July 2017

Adult Social Care - Provisional Year End Performance 2016-17

National benchmarking analysis referenced from published files.
http://digital.nhs.uk/catalogue/PUB30122

IPC Demand Management summary
https://ipc.brookes.ac.uk/publications/six_steps_to_managing_demand_exec_summary.html]

Consideration by any other Council Committee, Scrutiny or Advisory Panel

No

Council Approval Required

No

Exempt from the Press and Public

No

Title: Adult Social Care – Final published Year End Performance Report for 2016/17

1. Recommendations

That Members of Health Select Commission:

1.1 Note the content of final published year end performance results.

2. Background

2.1 Each Council with Adult Social Services Responsibility (CASSR) have to submit relevant national statutory returns to NHS Digital throughout the reporting year. Most but not all 'returns', reflect the activity for the financial year end and are submitted during the May/June period.

2.2 From the data/activity submitted, NHS Digital are able to publish a range of performance reports of which include ASCOF; The measures contained within ASCOF detail how well the Council and its partners are working to achieve the outcomes which matter most to people.

2.3 2016/17 has seen the implementation of the new social care case management system "Liquidlogic" which went "live" in December 2016 and data to fulfil statutory returns has been extracted and quality assured from this new system.

2.4 Targets set for 2016/17 were constructed to either maintain (where performing well) or deliver continued improvement to allow for the anticipated impact of new structures, systems and changes to service delivery.

2.5 Contained within the report (see Appendix 1) is a refreshed final table, of year end performance, which also shows Direction of Travel and relative benchmarking positions against comparative councils in Yorkshire and Humber (Y&H) region and national rankings.

2.6 Analysis of the Direction of Travel data (see Appendix 1) shows that from the 28 ASCOF measures outcomes: 8 improved, 3 maintained performance and 16 declined (one indicator was new for 2016/17). Whilst a number of indicators declined in performance when compared to the previous year; there were some improvements in regional and national rankings in some indicators (see Appendix 1). The charts below demonstrate how Rotherham's performance on ASCOF measures compares both nationally and regionally.

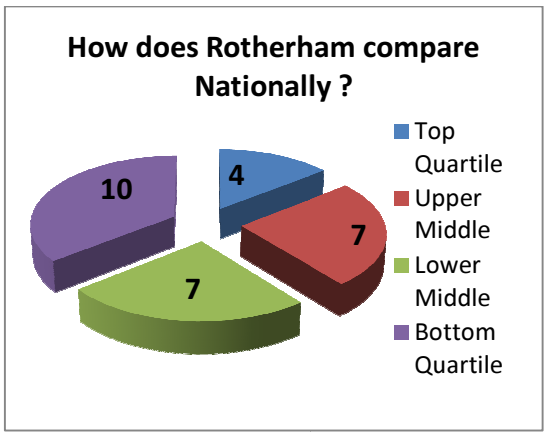


Chart1: No of ASCOF Measures by National Quartile

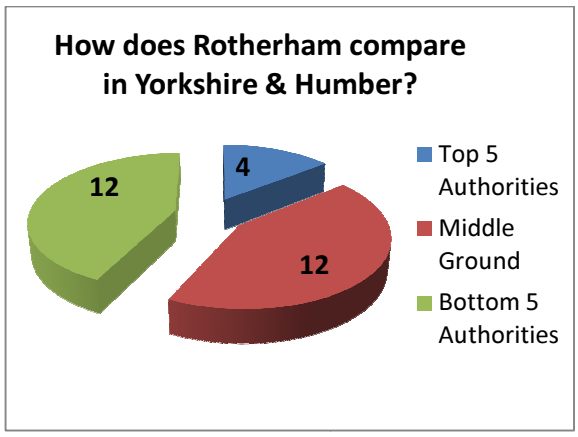


Chart 2: No of ASCOF Measures by Yorkshire and Humber ranking

2.7 Overall the Council's year end performance and benchmarking analysis needs to be considered against the context of:

- Delivery against the suite of actions contained in the Adult Care Improvement Plan
- Embedding requirements of the Care Act 2014.
- Developing the prevention and early intervention agenda
- Embedding of strength based approach in Assessment and Care Management.

2.8 The role of Performance and Intelligence will be key in supporting the transformation of Adult Care.

In order to drive through continuous improvement requires a re-focussed towards Business Intelligence activity. The performance function have developed a performance dashboard which provides improved cohort data, detailed activity data to monitor and track caseloads, data relating to demand management and analysis of core activity (including Safeguarding) as we look to effectively manage demand, manage budgets and implement change whilst ensuring "Every adult secure, responsible and empowered" (Corporate Priority 2) . We need to:

- Deliver the Adult Care Improvement Plan
- Move from traditional models to prevention and improved demand management models.
- Continue strong partnership working with NHS and Voluntary Community Sector.
- Improve provision of good information and advice.

2.9 Demand for services is increasing and we must implement changes to effectively manage resources:

- The Council commissioned research from reputable external consultants using anonymised Adult Care data in November 2017 to gauge anticipated future demand. From this profile, the consultants projected an increase in demand of referrals by 60 per month overall. Based on current proportions of people that go on to receive services this could translate into the equivalent of a 4% increase on the current customer baseline.

- In Rotherham, over 70% of new referrals result in no formal services being provided, with most of these signposted to other services. This profile is quite different to other authorities regionally and nationally, and could suggest that there is an opportunity to reduce unnecessary contact at the front door.

- Rotherham support 80% more than the national average of people aged 18-64 and 30% more than the national average of people aged 65 and over.

3. Key Issues

3.1 Performance Highlights 2016/17

3.1.1 From the 28 national final ASCOF year-end performance measures published data.

- **30%** (8 of 27) ASCOF measures are showing improvement.
- **19%** (5 of 27) 2016/17 targets being met.

Performance on Delayed transfers of care (Dtoc) attributable to Social Care or both NHS and Social Care continued to improve despite well documented increases nationally. Despite a slight decrease in performance on the indicator which measures total delays from hospital, Rotherham's performance improved nationally.

Rotherham's performance on outcomes for people after a period of short term support (Reablement) remained in the top 3 of all Yorkshire and Humber authorities with over 80% of all individuals completing reablement being able to live independently within their own home without any formal support in place.

Areas of performance which continue to challenge include supporting individuals in receipt of services with Learning Disabilities and Mental Health needs to gain and sustain paid employment. Performance on indicators which demonstrate how care and support is personalised continue to place Rotherham in the bottom 3 of Yorkshire and Humber authorities. The embedding of strength based

approach to care and support together with market shaping activity should deliver improvement.

It is worth noting that a high proportion of indicators resulting from responses to both the Adult Carer's and User Surveys declined in 2016/17 against a continued positive direction of travel in previous years. Satisfaction of service users and carer's remains high when compared to regionally and nationally; Rotherham ranks 5th of 15th Yorkshire and Humber authorities on both service user and carer satisfaction. Actions within the improvement plan will resolve issues detailed within surveys specifically with regards provision of information and advice, improving social contact and improving communication with service users and carers. Additional questions were added to the service user survey to gain a better understanding of why they did not feel safe, responses gathered from this question were linked to fear of crime and going out unaccompanied in their neighbourhood and a fear of falling within their home.

The decline in performance could also be attributed to survey "fatigue", the national surveys were conducted alongside a survey by our mental health partner and large scale consultation event with learning disability service users and their Carers.

The Council sent out over 1000 user surveys to customers and 700 survey's to Carers and had over 39% (Users), 47%(Carers) returned. The 2017/18 national user survey will be issued in January 2018.

3.1.2 Adult Social Care activity provided or arranged by Local Authorities covers a wide range of services including Long Term and Short Term care and support to carers. Service users may take a variety of different pathways through the system, according to their needs, and information regarding the provision of this care is captured in the Short and Long Term (SALT) return. The SALT return is useful in identifying demand management activity and monitoring attrition rates of those in receipt of long term support.

- Data shows that numbers of new clients requesting support from the Council remains high, although there was a decrease in requests from older people. Equivalents of 34 new requests per day were received in 2016-17.

- Nationally, 24% of all new requests for people aged 65 and over are received in relation to hospital discharge. The figures in Rotherham are much lower at 9% which may indicate that close partnership working between the council and NHS is effectively signposting patients and preventing requests for support being received.

- Of those requests received; the numbers of working age adults signposted or provided with information and advice is much higher (85%) than those received from older people (46%). This may be in part due to prevent, delay, reduce initiative which ensures individuals are supported to live independently within their own home. There is further scope to improve as numbers of older people who go on to receive long term support (service) is much higher at 11% than the Yorkshire and Humber average of 6%.

- The number of people receiving long term services increased by 2.6% in 2016-17. Rotherham supports the highest number of people per 100,000 population in Yorkshire and Humber region. The number of working age people supported is significantly higher than both the national and regional averages this is in part due to the high numbers supported with a mental health need (44% of all working age service users, the national average is 18%); given this disparity we have engaged with our mental health partner to both understand and quality assure this data which has resulted in a significant number of individuals being identified as having no social care need which will reduce numbers to being in line with other authorities.

- National data suggests that 74% of people receiving long term support were in receipt of services for over 12 months. Comparative data for Rotherham is 61% (a positive effect due to the high numbers accessing services).

Conclusion

- Historical practices in Rotherham of meeting need by the provision of service is negatively impacting performance and limiting in the short term improvement across the suite of indicators. Benchmarking indicates that other councils have a better established strength based approach, more effectively managing demand at “front door” and have alternatives to traditional service provision. This where successful, is reducing demand for service or services are being delivered more innovatively and personalised to the needs of the service user.

- Continued delivery of the suite of actions contained within the Adult Care Improvement plan will enable individuals to be supported to live independently for longer without accessing formal services which will further deliver an improved direction

of travel in terms of performance creating a Rotherham more comparable with the national and regional picture. Actions taken thus far which include to co-location of therapy and voluntary services organisations within the “front door” team Single Point of Access has seen a decline in numbers of new requests passed through for assessment/review due to better signposting/provision of information and advice and a reduction in size of care packages for new/existing service users due to joint working with therapy teams to issue assistive technology/equipment earlier.

3.1.3 Safeguarding Adults Collection (SAC)

- 2016-17 was the second submission of the statutory Safeguarding collection (SAC) which collates data relating to safeguarding concerns, safeguarding enquiries, abuse types and making safeguarding personal.

- The number of individuals involved in Section 42 Safeguarding Enquiries (per 100,000 population) increased Nationally and Regionally. Rotherham data on enquiries decreased slightly from 275 to 260. Neighbouring authorities performance is as follows; Barnsley - 204, Doncaster - 247 and Sheffield – 269. Rotherham data on S42 enquiries remains above the Regional and National average although there has been a slight decrease in 2016-17. Engagement activity within Yorkshire and Humber (ADASS) has identified some areas of inconsistency with recording of Safeguarding data which may have resulted in significant increases for some authorities in 2016-17; Rotherham data and processes were not impacted by the identified issues.

- Making Safeguarding Personal (MSP) data; of authorities who responded, individuals were asked what their outcomes were in 71% of enquiries in Yorkshire & Humber. In Rotherham 92% of individuals were asked what their outcomes were which provides good evidence that MSP is embedded in practice. 86% of these individuals had their outcomes either fully or partially met which is comparable with Yorkshire & Humber average of 87%

3.2 How will the Council use the information?

3.2.1 The information is already being used in conjunction with additional measures contained within the Council Plan to better understand demographics, service cohorts and inform in year Adult Care

2017/18 performance reporting. By using available data more “intelligently” we are able to better inform service planning, predict future demand and shape commissioning activity to meet service needs.

3.2.2 **Future reporting**:

Continued development of the “Insight” dashboard to support and strengthen robust performance management arrangements.

In response to challenges posed by unallocated assessments and the emergence of the Adult Care Improvement Plan during the summer of 2017, the Performance and Intelligence function have developed reports which have assisted in ascertaining the baseline position for assessment and review performance. This has enabled a dashboard to be built to provide real time information to identify trends and issues.

Work has commenced to understand the Adult Care customer base and profile reports have been developed to cover the following areas:

1) Customers with a community based service

2) Customers in a residential placement

3) Customers profiles for both age groups and the Primary support reasons.

The next step is to further develop the reporting to understand the attrition rates for both the cost and number of on service this will allow more accurate predictions on future spend. This will add to the reports already developed which use ONS population prediction to give an indication on the future demand. Effective demand management will be crucial to manage the Adult Care budget and to inform future budget setting processes. The reporting functionality will be based around the tests contained within the Institute of Public Care’s Six Steps to Managing Demand in Adult Social Care.

Working collaboratively with Yorkshire and Humber authorities will continue as part of ADASS sector led improvement to identify shared risks and challenges. Further analysis of data collated in the performance and risk dashboard to identify and share best practice. Examples of which include sharing learning and knowledge of improving information and advice, better monitoring of delayed transfers of care and developing region wide protocols in relation to ensuring accuracy in recording of safeguarding activity.

4. Options considered and recommended proposal

4.1 Members of the Health Select Commission note the contents of the report covering the period 2016-17.

5. Consultation

5.1 None

6. Timetable and Accountability for Implementing this Decision

6.1 None

7. Financial and Procurement Implications

7.1 None

8. Legal Implications

8.1 None

9. Human Resources Implications

9.1 None

10. Implications for Children and Young People and Vulnerable Adults

10.1 None

11 Equalities and Human Rights Implications

11.1 None

12. Implications for Partners and Other Directorates

12.1 None

13. Risks and Mitigation

13.1 None

14. Accountable Officer(s)

Approvals Obtained from:-

Anne Marie Lubanski, Strategic Director Adult Care and Housing

Nathan Atkinson, Assistant Director Strategic Commissioning

Appendix 1 - Final Year End ASCOF (inc Benchmarking)

Key	
Indicator ID	National ASCOF reference. Those indicators prefixed with * are captured from survey responses. Indicators prefixed with # are collated from NHS data.
ASCOF Measure	Provides a description of what the detail/data the measure relates to.
Good Performance	Indicates whether good performance is measured by a lower or higher score.
Direction of Travel	Depicts improvement, decline and maintanence of performance.
Rank	Details where Rotherham ranks nationally and in the Yorkshire and Humber region.

Indicator ID	ASCOF Measure	Good Performance is	2016/17	2015/16	Direction of Travel	Y & H Rank 2016/17	Y & H Rank 2015/16	Direction of Travel	National Rank 2016/17	National Rank 2015/16	Direction of Travel
* ASCOF-1A	Social Care related quality of life	High	18.8	18.8	⇔	12	13	⇧	109	100	⇩
* ASCOF-1B	Proportion of people who use services who have control over their daily life	High	77.3	74.1	⇧	9	10	⇧	82	104	⇧
ASCOF-1C Part 1A	Proportion of Adults receiving long term community support who receive services via self-directed support	High	78.30%	75.70%	⇧	13	14	⇧	134	132	⇩
ASCOF-1C Part 1B	Proportion of Carer's in receipt of carer specific services who receive services via self-directed support	High	6.02%	29.20%	⇩	14	14	⇔	147	141	⇩
ASCOF-1C Part 2A	Proportion of Adults on service receiving direct payments	High	19.20%	17.50%	⇧	13	13	⇔	129	132	⇧
ASCOF-1C Part 2B	Proportion of Carers on service receiving direct payments	High	1.20%	29.20%	⇩	15	13	⇩	149	122	⇩
* ASCOF-1D	Carer Reported Quality of Life	High	7.8	-	⇩	9	-		46	-	
ASCOF-1E	Adults with learning disabilities on long term service in employment	High	4.40%	5.60%	⇩	11	7	⇩	91	73	⇩
# ASCOF 1F	Adults receiving secondary mental health services in employment	High	3.00%	5.20%	⇩	14	8	⇩	128	99	⇩
ASCOF-1G	Adults with learning disabilities on long term service in settled accommodation	High	78.20%	78.40%	⇔	10	9	⇩	69	66	⇩
# ASCOF 1H	Adults receiving secondary mental health services in settled accommodation	High	80.00%	74.60%	⇧	4	4	⇔	20	40	⇧
* ASCOF-1Ii	Proportion of people who use services , who reported that they had as much social contact as they would like	High	45.40%	45.50%	⇔	10	10	⇔	80	73	⇩
* ASCOF-1Iii	Proportion of carers, who reported that they had as much social contact as they would like	High	37.30%	-	⇩	9	-		46	-	
* ASCOF-1J	Adjusted Social care-related quality of life – impact of Adult Social Care services	High	37.80%	-	n/a	14	-		127	-	

Indicator ID	ASCOF Measure	Good Performance is	2016/17	2015/16	Direction of Travel	Y & H Rank 2016/17	Y & H Rank 2015/16	Direction of Travel	National Rank 2016/17	National Rank 2015/16	Direction of Travel
ASCOF-2A Part 1	Permanent admissions to residential and nursing care homes (18-64) per 100,000 population	Low	18.1	20.03	⇧	14	13	⇩	125	133	⇧
ASCOF-2A Part 2	Permanent admissions to residential and nursing care homes (65+) per 100,000 population	Low	653.9	808.10	⇧	9	12	⇧	91	122	⇧
ASCOF-2Bi	Proportion of older people (65+) who were still at home 91 days after discharge (effectiveness of the service)	High	87.50%	89.60%	⇩	7	4	⇩	44	30	⇩
ASCOF-2Bii	Proportion of older people (65+) who were still at home 91 days after discharge (offered the service)	High	1.80	1.67	⇧	10	12	⇩	116	127	⇧
# ASCOF-2C part 1	Average delayed transfers of care from hospital per 100,000 population	Low	8.80	8.30	⇩	8	6	⇩	52	53	⇧
# ASCOF-2C-Part2	Average delayed transfers of care from hospital which are attributable to adult social care or both health and adult social care per 100,000 population	Low	1.30	1.60	⇧	6	4	⇩	27	31	⇧
ASCOF-2D	The outcomes of short-term support: sequel to service	High	81.40%	86.10%	⇩	3	2	⇩	48	27	⇩
* ASCOF-3A	Overall satisfaction of people who use services with their care and support	High	68.40	70.00	⇩	5	2	⇩	33	13	⇩
* ASCOF-3B	Overall satisfaction of carers with social services	High	42.90	-	⇩	5	-		33	-	
* ASCOF-3C	The proportion of carers who report that they have been included or consulted in discussions about the person they care for	High	68.50	-	⇩	13	-		91	-	
* ASCOF-3D part 1	The proportion of people who use services who find it easy to find information about support	High	73.40	78.30	⇩	9	4	⇩	81	27	⇩
* ASCOF-3D part 2	The proportion of carers who find it easy to find information about support	High	64.50	-	⇩	10	-		75	-	
* ASCOF-4A	The proportion of people who use services who feel safe	High	61.20	65.90	⇩	14	13	⇩	147	115	⇩
* ASCOF-4B	The proportion of people who use services who say that those services have made them feel safe and secure	High	80.60	84.50	⇩	14	12	⇩	127	88	⇩

Briefing paper for Health Select Commission 18 January 2018

Local Response to Changes to Mental Health Regulations under the Policing and Crime Act

Introduction

New regulations under the Policing and Crime Act 2017 (PACA) came into force on 11 December 2017 that amended Section 136 of the Mental Health Act 1983. Section 136 is an emergency power which allows the police to take a person to a place of safety, if a police officer considers the person is experiencing mental illness and in need of immediate care. The purpose is to enable an assessment of the person's mental health in order to make appropriate arrangements for their care.

Places of safety are often A&E departments in hospitals, but in some cases where there is known risk under Section 136 people may be taken directly to a mental health provider. Three mental health trusts provide services in South Yorkshire including Rotherham Doncaster and South Humber NHS Foundation Trust.

Questions to the South Yorkshire Police and Crime Commissioner (PCC)

Following a discussion with health partners about the new regulations and the importance of a clear and consistent response from the South Yorkshire Police, it was decided that the best way forward was to ask questions directly to the PCC through the South Yorkshire Police and Crime Panel.

The questions below were on the agenda on 15 December 2017 and the full response is included in Appendix 1.

- How will SYP ensure standard practice across the South Yorkshire force when dealing with mental health crisis situations? We have heard there are different responses to similar situations across South Yorkshire in relation to section 136 detentions.

- Do you think the changes to the PACA will mean that people with mental health issues receive a poorer response when in crisis? For example we have been informed it sometimes takes a long time to transport someone to a mental health hospital or section 136 suite if the police and ambulance service are reluctant to help?

- How will the police force support incidents of aggression or crime within mental health wards?

Recommendations for HSC

Members of Health Select Commission are asked to:

- Note the response of the South Yorkshire Police and Crime Commissioner.

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

Appendix 1 **Response from Police and Crime Commissioner**

- **How will SYP ensure standard practice across the South Yorkshire force when dealing with mental health crisis situations? We have heard there are different responses to similar situations across South Yorkshire in relation to section 136 detentions.**

South Yorkshire has recently appointed Superintendent Dan Thorpe as the Strategic Mental Health Lead, who was the Metropolitan Police Service Mental Health Lead for a number of years, supporting the then National Police Chiefs' Council (NPCC) Lead for Mental Health, Commander Christine Jones who helped develop the Mental Health Crisis Care Concordat.

Levels of support for people detained under S136 of the Mental Health Act and police officers can vary across SY because the three mental health trusts (SWYFT, RDASH, SHSC) offer different support. In some areas, for example, places of safety have been suddenly closed and officers have had to find alternatives, which causes delay. This is despite S140 of the Act placing a duty on Clinical Commissioning Groups/Local Health Boards to give notice to local social services saying what emergency arrangements are in force in cases of emergency.

However, SYP have been working hard with NHS colleagues from across the County to continually improve aspects of mental health care provision, including getting access to the most appropriate service at the right time, which includes a MH crisis response.

South Yorkshire Police introduced a Strategic Mental Health Partnership Board, which has been operating now for nearly two years. The meeting sits bi-monthly to help SYP to work closely with strategic health partners in the interests of those affected by mental ill health. As an example the Board has kept those aged under 18 years, who are detained under S136 Mental Health Act, out of police cells (mandatory since 11 December 2017). Over the last 2 years, no under 18's have been taken to a police cell. The board has also been working to achieve 24/7 Mental Health Crisis support for police officers through Single Points of Access or Triage services, which are now in place across the County.

Superintendent Thorpe is revising the Strategic Mental Health Partnership Board and has recently met the Chief Executive of RDASH MH Trust – Kathryn Singh - who has agreed to joint chair the Board. This is important when increasing MH demands are placing pressure on both police and a range of NHS services. Kathryn and Dan are currently reviewing the priorities of the Board and how this could link in with existing Countywide NHS work streams. As an example, one of the priorities of the Board is to examine existing Mental Health Crisis pathways, including the pathway for S136 and to create a Countywide Health Based Place of Safety specification that will introduce a consistent service across the County, something Supt Thorpe achieved in London across 10 Mental Health Trusts and 32 Local Authorities.

If preventing a mental health crisis is a central goal of mental health services; preventative services must be in place across the urgent care pathway and within the community to prevent a crisis occurring.

With S136 demand increasing by 33% over the last year, there is a collective need to understand this demand and work collectively on early interventions, identifying those who are high intensity users of service and creating joint management plans to better support these individuals and reduce demand. This will become a priority for the board in 2018.

Supt Thorpe has also introduced a SYP wide Mental Health Escalation Log, which enables police officers to escalate incidents and issues which have not gone well, or which identify areas for improvement concerning mental health crisis incidents. This provides a valuable countywide overview, which can be broken down into District/Trust areas. The log is regularly shared with strategic partners so that collectively SYP and the NHS can identify trends, repeated issues, which may influence how services are commissioned in the future.

- **Do you think the changes to the PACA will mean that people with mental health issues receive a poorer response when in crisis? For example we have been informed it sometimes takes a long time to transport someone to a mental health hospital or section 136 suite if the police and ambulance service are reluctant to help?**

A person experiencing a mental health crisis should receive the best possible care at the earliest possible point. The legal changes introduced to S135/S136 Mental Health Act via the Police and Crime Act 2017, are intended to improve immediate service responses to people who need urgent help with their mental health, particularly in cases where police officers are the first to respond. However, it has been acknowledged by SYP, that health partners are under considerable strain and pressure to deliver various crisis services whilst seeing increasing demand with corresponding challenges around budgets.

The changes to the MHA are varied and may present both opportunities and consequences. For example, the application of S136 has now been widened in respect of where the power can be exercised. This will assist officers from the British Transport Police who regularly respond to people in MH crisis attempting to commit suicide on railway tracks. These are private places and prior to 11 December 2017, BTP officers have been unable to exercise their powers under S136.

So whilst there are a number of areas where this power can now be utilised, an unintended could be that we see a sharp or continual rise of S136 demand which may have a knock on effect as to the capability of the NHS to cope with this potential increase.

Another example of how this will improve the response, relates to the use of police cells, which can now only be used in exceptional circumstances. As such, it will be unlawful for police cells to be used unless the circumstances are compliant with the stipulated regulations which are very specific. Consequently, this will result in more adults being taken to health-based places of safety rather than a police cell.

However, Mental Health Based Places of Safety within the county often experience challenges around resourcing or being able to manage more than one patient at a time, meaning officers and health partners may need to find urgent alternatives, which may just be the nearest Emergency Department.

That said, the overarching aim is to improve the response to those in need of a crisis response and the legislation has been produced with this in mind.

In respect of transport, Yorkshire Ambulance Service (YAS), (as are all Ambulance Services within the UK), are commissioned to provide a transportation service for all individuals detained under S136. They are required to transport them to the nearest, suitable and available health based place of safety. As previously alluded to, SYP do recognise the pressures on colleagues from YAS, who are frequently unable to provide an ambulance to support such requests. Recent analysis of S136 transportation methods in Doncaster evidenced that around 60% of cases were transported by ambulance and the remaining 40% were transported by police vehicle.

In all cases in South Yorkshire, If someone is detained under S136 Mental Health Act, they will have to be transported to the nearest place of safety. If an ambulance is unable to support SYP due to a lack of resources, then SYP will transport the patient. The challenge is the availability of resourcing which is often outpaced by demand, rather than a reluctance to support someone in need of help.

- **How will the police force support incidents of aggression or crime within mental health wards?**

Whilst working in the Metropolitan Police Service, Superintendent Thorpe helped to introduce the National Mental Health Restraint Expert Reference Group. This was chaired by Lord Carlile of Berriew CBE QC. In January 2017, the first Memorandum of Understanding regarding the Police use of restraint in Mental Health & Learning Disability Settings was published. Prior to this, there was no clear national position regarding when the police can be asked to attend mental health and learning disability settings and for what reasons.

Health providers have a duty to undertake, implement and review risk assessments for all the services they provide. The police do not have specific powers to restrain a patient for the purposes of medical treatment regardless of whether the treatment is in the patient's best interests. In situations where the police are called for emergency assistance, the circumstances should be assessed on its merits.

The risks associated with restraint are significant. SYP officers should not be called to undertake restrictive practices connected to purely clinical interventions (e.g. taking fluid samples, administering injections/medication) unless exceptional factors apply.

SYP will support colleagues in health services with incidents where:

- There is an immediate risk to life and limb;
- There is an immediate risk of harm;

- Serious damage to property;
- Offensive Weapons are involved;
- Hostages

No assumption should be made by the police that any incident involving any patient will always be a matter for healthcare staff alone; or that offences committed by a patient cannot or should not be investigated or prosecuted.

HEALTH AND WELLBEING BOARD
15th November, 2017

Present:-

Councillor D. Roche	Cabinet Member, Adult Social Care and Health **(in the Chair)**
Chris Edwards	Chief Operating Officer, Rotherham CCG
Naveen Judah	Healthwatch Rotherham (representing Tony Clabby)
Sharon Kemp	Chief Executive, RMBC
Councillor J. Mallinder	Chair, Improving Places Select Commission
Rob Odell	South Yorkshire Police
Dr. Jason Page	Governance Lead, Rotherham CCG
Zena Robertson	NHS England (representing Carole Lavelle)
Terri Roche	Director of Public Health, RMBC
Ian Thomas	Strategic Director, Children and Young People's Services
Janet Wheatley MBE	Chief Executive, Voluntary Action Rotherham

Report Presenters:-

Bev Pepperdine	Performance Assurance, RMBC
Christine Cassell	Independent Chair, Rotherham Local Safeguarding Children Board
Steve Turnbull	Public Health, RMBC

Also Present:-

Sam Barstow	Head of Service, Community Safety, Resilience and Emergency Planning
Dominic Blaydon	Rotherham Foundation Trust
Jacqui Clark	Early Intervention and Prevention, RMBC
Lydia George	Rotherham CCG
Kate Green	Policy and Partnership Officer, RMBC
Shafiq Hussain	Voluntary Action Rotherham
Giles Ratcliffe	Public Health, RMBC
Hayley Richardson-Roberts	Communications, RMBC
Janet Spurling	Scrutiny Officer, RMBC
Sarah Watts	Strategic Housing, RMBC
Dawn Mitchell	Democratic Services, RMBC

Apologies for absence were received from Tony Clabby (Healthwatch Rotherham), Dr. Richard Cullen (Rotherham CCG), Councillor Evans, Carole Lavelle (NHS England), Councillor Short, Kathryn Singh (RDaSH) and Councillor Watson.

37. JANET WHEATLEY MBE

The Board congratulated Janet Wheatley who had attended Buckingham Palace the previous day for the award of her MBE by Her Majesty the Queen.

38. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

39. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

40. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board held on 20th September, 2017, were considered.

Resolved:- That the minutes of the previous meeting held on 20th September, 2017, be approved as a correct record.

41. COMMUNICATIONS

(1) Janet Wheatley reported that the Shadow Secretary of State for Health, Jon Ashworth, was to visit Voluntary Action Rotherham on 1st December, 2017, to talk about Social Prescribing.

Janet would forward details to Board members.
Action:- Janet Wheatley

(2) Voluntary Action Rotherham had been nominated for their Supporting Self-Care at the Health Services Journal awards.

42. REFRESHING THE LOCAL HEALTH AND WELLBEING STRATEGY AND INTEGRATED HEALTH AND SOCIAL CARE PLACE PLAN

Further to Minute No. 29 of the meeting held on 20th September, 2017, Terri Roche, Director of Public Health, presented an update by way of a powerpoint presentation on the progress being made in relation to the refresh of the local Health and Wellbeing Strategy and alignment to the Integrated Health and Social Care Place Plan (Place Plan). The presentation included:-

Health and Wellbeing Strategy 2015-18 Principles
- Shared vision and priorities
- Enables planning of more integrated services
- Reduce health inequalities
- Translates intelligence into action

Need for a Refresh
- Existing Strategy runs until the end of 2018 but a number of national and local strategic drivers were now influencing the Health and Wellbeing Board
- An early refresh ensured the Strategy remained fit for purpose, strengthening the Board's role in:

High level assurance
Holding partners to account
Influencing commissioning across the health and social care system as well as wider determinants of health
Reducing health inequalities
Promoting a greater focus on prevention

- LGA support to the Health and Wellbeing Board
  Self-assessment July, 2016
  Stepping Up To The Place workshop September 2016
- Positive feedback given about Board's foundation and good partnership working
- The current Strategy was published quickly after the Board was refreshed (September 2015)
- Now in stronger position to set the right strategic vision and priorities for Rotherham

Joint Strategic Needs Assessment

- Ageing population – rising demand for health and social care services
- More people aged 75+ living alone, vulnerable to isolation
- High rates of disability, long term sickness (more mental health conditions) and long term health conditions e.g. Dementia
- Need for care rising faster than unpaid carer capacity
- High rates of smoking and alcohol abuse, low physical activity and low breastfeeding
- Rising need for Children's Social Care especially related to Safeguarding
- Relatively high levels of learning disability
- Growing ethnic diversity especially in younger population with new migrant communities
- Growing inequalities, long term social polarisation
- High levels of poverty including food and fuel poverty, debt and financial exclusion

Proposed Refreshed Strategy

- Sets strategic vision for the Health and Wellbeing Board – not everything all partners do but what partners can do better together
- Includes 4 strategic 'aims' shared by all Health and Wellbeing partners
- Each aim includes small set of high level shared priorities
- Which the Integrated Health and Social Care Place Plan 'system' priorities will align to

Strategic Aims

Aim 1

- All children get the best start in life and go on to achieve their potential and have a healthy adolescence and early adulthood

HWB Priority 1	Ensure every child gets the best start in life (pre-conception to age 3)
HWB Priority 2	Improve health outcomes for children and young people through integrated commissioning and service delivery
HWB Priority 3	Reduce the number of children who experience neglect
HWB Priority 4	Education

Aim 2

- All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

HWB Priority 1	Improve mental health and wellbeing of all Rotherham people
HWB Priority 2	Reduce the occurrence of common mental health problems
HWB Priority 3	Improve support for enduring mental health needs including Dementia

Aim 3

- All Rotherham people live well and live longer

HWB Priority 1	Prevent and reduce early deaths from the key health issues for Rotherham people such as cardiovascular disease, cancer and respiratory disease
HWB Priority 2	Promote independence and enable self-management and increase independence of care for all people
HWB Priority 3	Improve health outcomes for adults and older people through integrated commissioning and service delivery ensuring the right care at the right time

Aim 4

- All Rotherham people live in healthy, safe and resilient communities

HWB Priority 1	Increase opportunities for healthy sustainable employment
HWB Priority 2	Ensure planning decisions consider the impact on health and wellbeing
HWB Priority 3	Ensure everyone lives in healthy and safe environments
HWB Priority 4	Increase opportunities for all people to use green spaces

Consultation and Engagement

- Health and Wellbeing Board and Place Board received proposal in September 2017
- Framework shared with Board sponsors and theme leads for comments
- Health Select Commission December 2017
- All partners to consider taking through their own governance structures November-March 2018
- Consider what other stakeholder engagement may be needed
- Following approval at Health and Wellbeing Board, work will progress with Board sponsors/theme leads on the Strategy detail
- Full draft of Strategy and Place Plan to be presented to Health and Wellbeing Board on 19th January 2018
- CCG Governing Body, Place Board and Cabinet to endorse Strategy and Place Plan February 2018
- Place Board to sign off Place Plan March 2018
- Health and Wellbeing Board to sign off the Strategy March/April 2018

Discussion ensued with the following issues raised/clarified:-

General

- The refresh should streamline the process and not result in extra meetings
- Each Aim was not in isolation and did have linkages to each other
- Loneliness and Isolation did not just affect the older generation. It potentially fitted all the Aims but needed to be "anchored" in 1

Aim 1

- More work to be done on the ante-natal pathway particularly
- Continued investment in Early Years but more work to be done through Children's Centres, GPs and Post-Natal Services
- Priority 3 – should include the word "abuse" in all its forms i.e. physical, emotional and sexual
- Embedding the voice of the child
- Linkages to delivery mechanisms around the SEND agenda
- Raising aspirations and developing self-esteem and self-motivation
- Consideration of inclusion of adverse events in a child's life, such as bereavement, and learning from CSE referrals and parental capacity to change
- Work of the Child Death Overview Panel and the adverse issues affecting children and some of the motivating factors that had been identified
- The need for linkage to the Foundation Trust's Strategy regarding transition from Children to Adult Services
- No reference to Looked After Children or childhood obesity/lifestyles

Aim 2

- The Mental Health and Wellbeing Strategy to be revisited by the Transformational Group regarding what work needs to take place
- Need to link to the ageing population
- Autism, although linkages with all the Aims, had to be based in 1 in order for someone to have responsibility – Aim 3 was too big
- Learning Disabilities should be included
- Suggestion that the title should be changed to "all Rotherham people enjoy the best possible wellbeing and mental health"

Aim 3

- Suggestion that the overall aim title should be changed to "all Rotherham people live well and live longer in better health" and possible inclusion of the word "safely"?
- Did Priority 5 fit better into Aim 4?

Aim 4

- Pleasing to see Housing fitting into an Aim (Aim 4)
- Suggestion that the Strategic Director of Regeneration and Environment be added to the Board membership
- Further work required on the priorities to ensure alignment with the Safer Rotherham Partnership
- Suggestion that Loneliness should sit within Aim 4 taking into the community resilience perspective

Resolved:- (1) That the proposed framework of aims and priorities for the Health and Wellbeing Board, taking into account the comments made in the meeting, be approved.

(2) That a discussion take place at the Executive Board with regard to the addition of the Strategic Director of Regeneration and Environment to the Board membership.

(3) That Loneliness be included within Aim 4.

(Dominic Blaydon, Sam Bairstow, Lydia George Shafiq Hussain, Giles Ratcliffe and Sarah Watts left following discussion of this item.)

43. LOCAL SAFEGUARDING CHILDREN BOARD ANNUAL REPORT

Christine Cassell, Chair of the Rotherham Local Safeguarding Children Board, presented the Board's annual report 2016-17 with the aid of a powerpoint presentation, which outlined the role of the Board, its relationship to the Health and Wellbeing Board and the context for the 2016-17 annual report which was:-

- Children and Social Work Act 2017
- Continuing austerity
- Increasing demands and expectations on public services that safeguard children
- Brexit
- Excellent commitment from partners locally to working together to improve the way that Rotherham children are kept safe

Rotherham LSCB Report 2016-17
Key messages about services and how they work together:-

- Responses to children and families generally more timely
- Early Help – better co-ordinated offer to families with good feedback. Needs more multi-agency partner involvement
- Assessment of risk or harm – issues in multi-agency practice
- Looked After Children – initial health assessments and missing episodes children out of Rotherham
- Neglect – high percentage of cases include elements of neglect – associated with parental issues of domestic abuse, mental ill health and substance misuse

Priorities for 2017-19

- Early Help
- Neglect
- Safeguarding Looked After Children
- Child Sexual Exploitation
- The effectiveness of multi-agency decision making when a child is at risk of harm
- Evidence of the child's voice will be expected in all the above

Safeguarding is Everybody's Business

- Council
- Statutory and non-statutory partners
- Voluntary and community organisations
- The wider community

Changes to LSCBs

- Statutory guidance now out for consultation
- Statutory requirement for LSCBs abolished
- Local Authority, Health and Police become jointly responsible for the local Safeguarding arrangements to replace LSCBs
- Challenge will be to ensure robust arrangements that engage the wider partnership e.g. schools

What should the HWB Board do?

- Ensure a Safeguarding focus in commissioning decisions
- Support LSCB priorities through the implementation of the Health and Wellbeing Strategy

- Undertake Safeguarding impact assessments on major budget and organisational change
- Report back to the LSCB, through the local protocol arrangements, on the impact of its work in support of LSCB priorities

It was noted that quarterly meetings took place between the Chair of the Children and Young People's Partnership, Independent Chairs of the Adults and Children's Boards, Chair of the Health and Wellbeing Board and Chair of the Safer Rotherham Partnership, where the effectiveness of the Safeguarding Partnership Protocol was discussed and how they could continue to improve linkages between Boards and challenge each other where appropriate.

Discussion ensued with regard to the proposed abolition of LSCBs which was currently out to consultation. It was felt that the tripartite response without an Independent Chair would result in it being no one agency's responsibility. Locally, areas could determine their own arrangements and it would depend upon local areas developing strong and robust arrangements rather than those robust arrangements being specified by the centre. South Yorkshire Police had already submitted their response to the consultation.

It was felt that there was no reason why there could not still be an Independent Chair as other working parties/Improvement Boards had.

The LSCB would be considering its response to the consultation documents at its meeting in December.

Christine was thanked for her report and the work of the Board.

Resolved:- (1) That the Rotherham Local Safeguarding Children Board's annual report 2016-17 be noted.

(2) That Rob Odell share with the Board the consultation response submitted by South Yorkshire Police.
Action:- Rob Odell

(3) That the Health and Wellbeing Board's concerns with regard to the proposed abolition of LSCBs be placed on record.

(4) That all agencies be urged to respond to the consultation.

(5) That the issue be raised at the Safeguarding Partnership Protocol Joint Chairs meeting that Kathryn Singh was due to Chair on 28th December, 2017, with a suggestion that a joint Partnership response be submitted.
Action: Sharon Kemp

44. ETHICAL CARE CHARTER

Jacqueline Clark, Head of Service Early Intervention and Prevention, presented the Council's Independent Living and Support Service (ILS), Strategic Commissioning and its contracted home care providers' current position against UNISON's suggested 3 stages of implementing the Ethical Care Charter.

UNISON had drawn up the Ethical Care Charter, aimed to 'establish a minimum baseline of safety, quality and dignity of care by ensuring employment conditions which (a) do not routinely short change clients and (b) ensure the recruitment and retention of a more stable workforce through more sustainable pay, conditions and training levels', as a result of a national survey they had commissioned in June/July 2012.

UNISON had called for Councils to commit to becoming Ethical Care Councils by adopting the Charter and only commission homecare services which adhered to the Charter. They had suggested that implementation of the Charter be conducted in 3 stages and had produced guidance for Councils and providers.

The report set out the Authority's current position against the 3 stages of implementing the Charter.

Resolved:- That the report and progress of the Authority in implementing the Charter be noted.

45. DELAYED TRANSFER OF CARE

Chris Edwards, Chief Operating Officer RCCG, reported that this item had been included on the agenda due to a rise in the number of Delayed Transfer of Care (DTOC) cases. However, the situation had since started to improve.

The Rotherham System-Wide Escalation Plan 2017/18, which included Winter planning, was included on the agenda at Minute No. 49 below. The Plan set out the winter planning arrangements for health and social care in Rotherham including resources and capacity put in place to manage the impact of winter pressures.

The Chairman stated that DTOC was a key metric within the Better Care Fund and one that the Government took particular note of.

Resolved:- (1) That the Integrated Health and Social Care Delivery Group examine Delayed Transfer of Care at their next meeting.

(2) That should there be a "red alert" on the system for Delayed Transfers of Care, that a report be submitted to the Health and Wellbeing Board as a matter of urgency.

Action:- Chris Edwards/Louise Barnett

46. LIFESTYLE SURVEY

(This item was considered in the closed part of the meeting due to it not being placed in the public arena until January 2018.)

Bev Pepperdine, Performance Assurance Manager, presented the key findings from the 2017 Borough-Wide Lifestyle Survey report and the pilot report for Newman Special School.

The report also set out the plans to distribute the survey results to schools, to Boards and ongoing actions supporting the lifestyle survey results by partners.

Attention was drawn to the sections relevant to the Board.

Discussion ensued with issues raised regarding:-

- Dental visits
- Young carers
- Non-participating schools
- Work with Public Health

Resolved:- That the report be noted.

47. PHARMACEUTICAL NEEDS ASSESSMENT

Stephen Turnbull, Speciality Registrar Public Health, gave the following powerpoint presentation on Mapping the Pharmaceutical Needs Assessment:-

PNA Mapping Regulations

- Schedule 1: Para 7
  A map that identifies the premises at which pharmaceutical services are provided in the area of the Health and Wellbeing Board
- Part 2: Para 4(2)
  Each Health and Wellbeing Board must, in so far as it practicable, keep up-to-date the map which it includes in its Pharmaceutical Needs Assessment

SHAPE Tool

- Strategic Health Asset Planning and Evaluation
- Free to use application for NHS and local authorities
- Web-based: automatically updates background information
- Enables more analysis e.g. populations, indicators, access to services, service gaps etc.

Uses in the Draft PNA

- Mapping pharmaceutical services
- Calculating access by walking time and driving time
- Calculating access to pharmaceutical services not in Rotherham
- Mapping service provision by population and/or indicators e.g. needle exchange by crime deprivation, Emergency Hormonal Contraception by female population 18-29 and 30-44 year olds and small area analysis

Next Steps Exploring

- Automate data collection
- Generic log-in
- Additional datasets e.g. Health Indicators, Local Plan
- Other assessments e.g. oral health

The Board had to approve the 2018 Rotherham PNA by 1st April, 2018, the date it was legally due for renewal. The consultation period would commence shortly for a period of 60 days, however, this would be extended due to the Christmas period falling within the timeframe. The final PNA would be submitted to the Board in March, 2018 in order to meet the publication deadline.

The process included formal consultation with specific stakeholders. It was suggested that Rotherham's consultation would also include the CCG, VAR and South Yorkshire Police. It was also noted that each GP surgery had a Patient Participation Group which then had an overarching meeting from time to time who it may be worthwhile discussing the issue with.

The 4 South Yorkshire authorities were working together, led by Rotherham, to produce the 4 separate PNAs covering South Yorkshire. A South Yorkshire PNA Steering Group had been established to take this forward comprising the relevant PNA lead from each local authority.

Resolved:- (1) That the planned timetable for consultation and for the final document to be submitted to the Health and Wellbeing Board be approved.

(2) That the additional consultees highlighted above be included in the consultation.

48. ENGAGING THE PUBLIC IN THE HEALTH AND WELLBEING BOARD

This item was deferred until the January Board meeting.

49. THE WINTER PLAN

The Rotherham System Wide Escalation Plan 2017/18 (including Winter Planning) was submitted for the Board's information which set out Winter planning arrangements for health and social care in Rotherham including resources and capacity put in place to manage the impact of Winter pressures.

The Plan incorporated Rotherham's response to the National Cold Weather Plan, updated in 2016, which helped prevent the major avoidable effects on health during periods of cold weather in England.

The Rotherham CCG, along with other local CCGs, was required to provide assurance to NHS England regarding year-round and Winter planning across the Rotherham health and social care community. The report, alongside the baseline assessment and ongoing highlight reporting from the Rotherham A&E Delivery Board, aimed to provide that assurance.

50. CAMHS LOCAL TRANSFORMATION PLAN

The Board noted the October 2017 refresh of the Local Child and Adolescent Mental health Services (CAMHS) Transformation Plan for Rotherham.

51. DATE AND TIME OF NEXT MEETING

Resolved:- That a further meeting be held on Wednesday, 10th January, 2018, venue to be confirmed.