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

Date:-	**Thursday, 17th January, 2019**	**Venue:-**	**Town Hall, Moorgate Street, Rotherham S60 2TH**
Time:-	**10.00 a.m.**		

HEALTH SELECT COMMISSION AGENDA

1. To determine whether the following items should be considered under the categories suggested in accordance with Part 1 of Schedule 12A (as amended March 2006) of the Local Government Act 1972

2. To determine any item(s) which the Chair is of the opinion should be considered later in the agenda as a matter of urgency

3. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Minutes of the last meeting (Pages 1 - 18)

7. Communications

For Discussion

8. Refreshed Joint Strategic Needs Assessment Consultation (Pages 19 - 25)
   Rebecca Woolley, Policy and Partnerships, and Gilly Brenner, Public Health, to present

For Information

9. South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee Update

10. Healthwatch Rotherham - Issues

11. Health and Wellbeing Board (Pages 26 - 36)

12. Date and time of next meeting
Thursday, 28th February, 2019, commencing at 10.00 a.m.

Membership 2018/19

Chairman:- Councillor Evans
Vice-Chairman:- Councillor Short

Councillors Albiston, Andrews, Bird, Cooksey, R. W. Elliott, Ellis, Jarvis, Keenan, Rushforth, Taylor, John Turner, Williams and Wilson.

Co-opted Member:
Robert Parkin (Rotherham Speak Up)

Chief Executive.

HEALTH SELECT COMMISSION
29th November, 2018

Present:- Councillor Evans (in the Chair); Councillors Albiston, Andrews, Bird, Cooksey, R. Elliott, Ellis, Jarvis, Keenan, Short and Williams.

Councillor Roche was in attendance at the invitation of the Chair.

Apologies for absence were received from Councillors Rushforth, Taylor and Robert Parking (SpeakUp).

The webcast of the Council Meeting can be viewed at:-
https://rotherham.public-i.tv/core/portal/home

49. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

50. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

51. MINUTES OF THE LAST MEETING

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 18th October, 2018.

Resolved:- That the minutes of the previous meeting held on 18th October, 2018, be approved as a correct record.

Arising from Minute No. 40 (TRFT Quality Priorities 2019-20), it was noted that a collated response from the Select Commission had been sent to the Trust after Members had received the additional information and prioritised the long list. Overall the 5 priorities under clinical effectiveness had been emphasised the most particularly the Dementia Unit. The Quality Sub-Group would be able to ask further questions on the priorities when it met in January.

Arising from Minute No. 41 (Visit to Carnson House), it was noted that the visit was to be rescheduled as it had coincided with a CQC inspection.

Arising from Minute No. 42 (Child and Adolescent Mental Health Services Update), it was noted that the outcome of the Trailblazer bid was not known as yet.

52. COMMUNICATIONS

Improving Lives Select Commission

Councillor Jarvis gave a brief summary of the agenda items considered at the last meeting of the Improving Lives Select Commission as follows:-

- Increased numbers of Looked After Children
  Possible reasons for the increase
  Initiatives coming into place to counteract the numbers
  Increased management oversight
  Right Child Right Care
  Edge of Care Panel
  Foster parent recruitment
  63 Initiative
- Education Performance Outcomes
  Actions more aspirational rather than targets, so officers had been asked to come back with something sharper

Visits

Councillor Williams gave a verbal report on the visit to the Health Village, Doncaster Gate, Care Co-ordination Centre, Rotherham Hospital and the Adult Care Single Point of Access that had taken place on 13th November, 2018.

It was quite clear that all 3 teams had a passion/dedication for the role they were undertaking and the work they were providing. Clear benefits from having people from different teams together, included quick immediate help and advice and developing people's awareness and there was clear belief in this approach and that it was making a difference.

53. UPDATE ON ROTHERHAM INTEGRATED CARE PARTNERSHIP AND IMPLEMENTATION OF THE ROTHERHAM INTEGRATED HEALTH AND SOCIAL CARE PLACE PLAN

Sharon Kemp, Chief Executive, Chris Edwards, Rotherham Clinical Commissioning Group and Louise Barnett, The Rotherham Foundation Trust, gave the following short powerpoint presentation on Rotherham Integrated Care Partnership (Rotherham ICP) and the implementation of the Rotherham Integrated Health and Social Care Place Plan (IH&SC):-

Rotherham ICP Partners

- NHS Rotherham Clinical Commissioning Group
- Rotherham Metropolitan Borough Council
- The Rotherham NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Voluntary Action Rotherham
- Connect Healthcare Rotherham CICI

Rotherham ICP Place Governance

- Rotherham Together Partnership
- Rotherham Health and Wellbeing Board
- Rotherham ICP Place Board
- Rotherham ICP Delivery Team – Children and Young People, urgent Care, Community, Learning Disability, Mental Health

Rotherham ICP Place Plan: 'Plan on a Page'

- Vision
- Gaps
- Challenges
- Transformation
- Enablers
- Principles
- Partners

Rotherham ICP Place Plan Priorities

- Children and Young People
  Implementation of Children and Young Peoples Mental Health Services Transformation Plan
  Maternity and Better Birth
  Oversee delivery of the 0-19 health child pathway services
  Children's Acute and Community Integration
  Special Educational Needs and Disability (SEND) – Journey to Excellence
  Implement 'Signs of Safety' for Children and Young People across partner organisations
  Preparing for Adulthood (Transitions)
- Mental Health and Learning Disability
  Deliver improved outcomes and performance in the Improving Access to Psychological Therapies Service
  Improve Dementia diagnosis and support
  Deliver CORE 24 standards for Mental Health Liaison Services
  Transform he service at Woodlands 'Ferns' Ward
  Improve Community Crisis Response and intervention for Mental Health
  Better Mental Health for All Strategy
  Oversee Delivery of Learning Disability Transforming Care
  Support the implementation of the 'My Front Door' Learning Disability Strategy
  Support the development and delivery of Autism Strategy
- Urgent and Community
  Creation of an Integrated Point of Contact for Rotherham
  Expansion of the Integrated Rapid Response Service
  Development of an integrated Health and Social Care Team to support the discharge of people out of hospital
  Implementation of integrated locality model across Rotherham
  Develop a reablement and Intermediate Care offer
  Develop a co-ordinated approach to care home support

Key Achievements

- Urgent and Emergency Centre
  Opened July 2017 delivering an innovative integrated model to improve co-ordination and delivery of urgent care provision
- Rotherham Health Record
  Enables health and care workers to access patient information to make clinical decisions
- Delayed Transfers of Care
  Successful reduction in Delayed Transfer of Care to below national target
  Supported by the integration of TRFT Transfer of Care Team and RMBC Hospital Social Work Team to form the Integrated Discharge Team
- Ferns Ward
  Provides integrated specialist mental and physical health care expertise for TRFT patients who are physically well enough to be discharged from the acute setting but are not yet well enough to be discharged home or to residential care
- Social Prescribing
  Continued success, helping adults over the age of 18 with long term health conditions to improve their health and wellbeing by helping them to access community activities and services. During 2017 it was extended to mental health patients and is now used for Autism and social isolation

Integrated Locality Working – how are we working differently?

- A joint culture of prevention
- 'Blurring' of professional boundaries
- New ways of supporting Primary Care enhanced by Rotherham Health Record
- Enhanced Social Care Assessment and Care Management
- Proactive Primary Care Programme
- Management of Long Term Conditions
- Focus on the needs of physical and mental health
- Work into hospital based services to reduce length of stay
- Improved opportunities for post discharge follow-up
- Re-alignment of GP practices across 7 localities
- Community Nursing working directly into 7 localities configures around Primary Care
- Adult Social Care and Community Health Teams (including Mental Health) working across 3 partnerships North, Central and South – aligning to 7 Primary Care Populations

Better Mental Health for All

- Rotherham Five Ways to Wellbeing launched May 2018
- International interest in the Rotherham Five Ways to Wellbeing video (https://www.youtube.com/watch?v=jb5NqV2bqGI&feature=youtu.be)

Child and Adolescent Mental Health Services (CAMHS)

- Extensive service change has led to substantial improvement in both assessment and treatment

Challenges and Opportunities to delivering the Place Plan

- Resources – capacity and capability to deliver the transformation
- Relationships – partners, public, organisational reputation, changing behaviours
- Research – challenge of transformation, impact of national and local policy, innovations

What Next

- Continue to deliver on the transformation set out in the Place Plan
- Providers working closer together across Rotherham (Provider Alliance)
- Explore and scope opportunities for joint workforce plans across Rotherham ICP partners
- Continue to monitor implementation of the Place Plan through the Performance Report

Also attached was the ICP performance report for Quarter 1.

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

- The minutes of the Place Board were submitted to the Health and Wellbeing Board, which also looked at broader issues including the wider determinants of health. Winter pressures were dealt with in a system approach

- The Place Board met on a monthly basis and was open to the press and public. It was the only Board that was open to members of the public and allowed to ask questions at the beginning of the meeting. There were at least 3-4 people who attended as well as some campaign groups

- The Memorandum of Understanding set out how the partners would work together as organisations. It was not a legal partnership but a partnership entered into because it was known that by working together they could provide a better service to the residents of Rotherham

- Rotherham Health Record – the partnership had challenged everything done and driven through the changes for the benefit of Rotherham patients. However, there were 2 GP systems in operation in Rotherham and GPs could choose which one to operate. Attempts were being made to promote the use of System 1 which all Community Services used

- Recognition that probably achieve better out of hospital services based in the locality. Discussions were still taking place as to the how and each locality was different. It was hoped a model would be ready for 1st April 2019

- The CAMHS Service was much improved with access comparing favourably across South Yorkshire

- TRFT was working very closely with the universities and colleges so there was an opportunity for people to enter health care, particularly in the nursing area, at any age, through any route and was a pilot organisation in terms of taking that forward. Rotherham currently had those associate nursing colleagues within the organisation

- There was some national funding available through different routes to support training and then the Trust employed people who undertook those roles so they received support both through the work place and the student experience depending upon which type of education they were undertaking. Through the workforce plan the Trust, together with partners across South Yorkshire and more widely, could try and influence the number of places available and how that was shaped for the future

- A visioning event had been held regarding the possibility of converting an old caretaker's house within the Wingfield Ward into a nursery unit to deal with SEND/primary aged mental health problems. Advice was now needed as to who to contact to pursue the matter

- Partner organisations were working together on the Mental Health Services and currently challenging the Government about some of the funding received particularly for primary schools and secondary schools

- There was recognition around closer work on Mental Health Services with schools. If successful the Trailblazer bid would provide investment in schools which would allow big differences to be made in working in a more integrated way

- Access to the CAMHS Service had increased significantly with extra capacity put into the Service. The Service was now dealing with referrals from GP surgeries significantly better than previously although some of the pathways were still not where one would want resulting in waits for specialist areas

- CORE24 would be an enhanced service based in the Urgent and Emergency Care Centre at the Hospital and implementation was a national requirement, with Rotherham one of the Trailblazer areas. However, workforce was an issue for Rotherham and implementation

had been expected this quarter but had slipped due to significant problems in recruitment of staff. All staff were now in post and the enhanced Service would commence on 7th January, 2019

- Currently there was a 4 weeks wait from GP referral for assessment. If there was a crisis in the intervening period the client would be referred to the Crisis Team

- Clarification was sought with regard to the Crisis Services for CAMHS as opposed to Adult Services

- CORE24 would be an enhanced service based in the Urgent and Emergency Care Centre at the Hospital

- The jointly funded post, referred to in CH1.5, which was due to start in September 2018, was related to the Trailblazer bid the outcome of which was still awaited

- Significant investment been made in NHS ICT systems over the years with still more work needed to be done for it be fully interoperable. There was a digital plan for Rotherham and work was taking place to get the Rotherham Healthcare Record to work with the aid of innovative technology which allowed Rotherham professionals to see the record of Rotherham patients

- Better Births was a requirement by 2021 for Rotherham to come up with some key requirements to transform Maternity Services. It would have to offer 3 different types of setting for births and continuity of care for up to 50% of mothers. Rotherham currently had a quite small home birthing service and would look to enhance it. Nationally, data stated that approximately 10% of mums wanted to access a home birthing service and 40% of mums would wish to access a Midwifery-led Service. The current draft plan would look to have an “alongside midwifery-led unit” based at the hospital, an environment that was midwife-led but close enough to consultants if needed, and also have a consultant-led service as there currently was. There would be investment in the Service in the coming year to facilitate the developments. The final plan was expected in April 2019 and could come back to HSC for feedback

- As part of the South Yorkshire and Bassetlaw Integrated Care System, notification had been received of funds to help transform services over the next 3/4years. The funding would be for the retraining of staff, recruitment of new professionals, different ways of working and resources to develop the transformation plan. The funds would be one-off for 3 years

- The Mental Health 3 KPIs that were red:-

  Improving Access to the Psychological Therapy Service - increase the number of trained staff and performance had improved significantly – now on track in Quarter 3
  Urgent Response - tied in with CORE24 development – once all the staff were in post and rolled out live it should be on track
  Length of Stay on Ferns Ward – the model of Ferns was about reducing the overall hospital inpatient stay. The target was to stay in Ferns once transferred from the Hospital Trust was taken into consideration. The evaluation had come out very positive in terms of the patient and carer experience, quality of live and living independently with supporting packages in place. This would be taken into consideration for the new model and would be discussed with TRFT and the RCCG. The length of stay may increase when all factors are taken into account

- The recruiting of staff for Urgent Response was difficult and even more so with the extra challenge of initiatives such as CORE24 and perinatal work that required staff that had very specialised skills and everyone recruiting from a relatively small pool

- There was a range of drop-in support and activities taking place in Ferns. There was the opportunity for ex-patients to come back into the use for ongoing support

- The 4 week wait from GP referral to assessment was the time contracted with RDaSH. In Sheffield it was 6 weeks. However there appeared to be some disconnect between the information presented and anecdotal evidence from colleagues on the ground

- Rigour of the performance data:-

  RCCG - there was a legal requirement for providers on how they recorded data and waiting times. RCCG quoted the data they were provided with

  TRFT - had a series of documents that specified how it should collate and capture data and well as some local data which the Trust defined for themselves and captured. The Trust had developed an internal data quality kite mark with 6 elements that enables it to understand what the source of that information was, understand the definition, how it was pulled together and how reliable it was and presented the kite mark against each Indicator that was seen at Board level. That gave a level of confidence as to how robust the performance information was. The aim was to be “green” on all kite marks against every piece of data in the organisation and it was prioritised in order of importance in terms of reporting

RDaSH - Mental Health Services had national guidance on reporting mechanisms which stated what could be included and not and how things could be counted. RDaSH had moved to System 1 so all the reporting was pulled out from the system and no manual collection of data, making it clearer what was recorded where and how

- Concerns were raised about access to GPs, obtaining appointments and being able to address a patient's health needs holistically and any knock on impact on the UECC

- There was a national shortage of GPs. Roughly the national average was 58 GPs per 100,000 population; Rotherham had 58.6 compared with 70 in Sheffield

- Last year Rotherham was the only one to have a full GP trainee scheme in Yorkshire and Humber. However, once trained they did not have to stay in Rotherham and could move where ever they wanted

- RCCG had to carry out a national survey, Rotherham Patient Report. Out of the 5 South Yorkshire communities Rotherham had the highest satisfaction rates. Whilst comparing, additional GPs could not be found so the solution adopted was that of a different workforce i.e. Physio First, pharmacists in practice, Physician Associates. It was found that fewer patients would see their GP and would try other professionals such as an Advanced Nurse Practitioner. Primary Care was changing and it was not just GP services but the wider primary care services

- GP Practices were different; some had open access/appointments/telephone triage. One of RCCG's solutions had been an additional 132 GP hours' time that anyone could book into at different hubs – 3 different GPs covering Rotherham on a shift system. It consisted of planned appointments that anyone could book into. This had come into operation in November and was available to everyone at every practice. People would book an appointment through their own practice

- An appointment had not been made to the post of lead officer who would be responsible for the implementation of the Joint Preparation of Adulthood Action Plan. A number of changes had been made to the method of dealings with some of the transition services both as a partnership and internally as a council. There was now a workforce lead for the Council who was also acting as the lead across the whole Integrated Place Plan in an attempt to bring together the workforce challenges. There was a theme across some of the red indicators of accessing staff with the right skills and availability

- There were some key challenges around the workforce that would need to continue to be addressed some of which would involve doing things differently with the universities and college and being creative with the use of funding such as the apprenticeship levy

- A piece of work had started with the Mental Health and Learning Disability Transformation Board looking specifically at suicide prevention and reviewing the recent cases of suicide. Rotherham was an outlier in terms of suicide. Training plans were in place to train front line staff

- There would be a specific piece of work through the delivery group to look at some of the issues of suicide. Rotherham had been shown as an area of good practice in its suicide prevention work, however, the suicide rates were still increasing. It was seen as a key area to examine and Public Health was very driven. Rotherham was to receive ISC funding and Housing were looking at suicide rates in Council housing. Work was taking place on reviewing and trying to tie up the 5 Ways of Mental Wellbeing into near misses and having a much clearer pathway for organisations to look at near misses alongside involvement of GPs

- The review of training requirements for care home staff to enable effective delivery of service had been led by the TRFT and Adult Services in terms of contract compliance to identify where there were issues. It had been identified that the turnover of staff made it really challenging to retain the information given during training, so the focus would be on the individual and that the individual's care plan was very clear about how their care and treatment was delivered. That had shown a real difference to the sustainability of good care for that individual rather than it being about teaching staff

- Clarification was sought about Rotherham Opportunity College and availability of placements

Resolved:- (1) That the general update on the Rotherham Integrated Care Partnership and Integrated Social Care Place Plan be noted.

(2) That the Select Commission continue to monitor progress.

(3) That when the Scorecard for Quarter 2 becomes available it be submitted to the Select Commission for further scrutiny in the Performance Sub-Group.

(4) That the crisis arrangements for the CAMHS Services be clarified and reported back to the Select Commission.

54. ROTHERHAM CGL DRUG AND ALCOHOL TREATMENT AND RECOVERY SERVICE

Lucy Harrison, CGL, and Anne Charlesworth, RMBC, Matt Pollard, RDaSH, gave the following powerpoint presentation:-

Successful Opiate completions
Defined by Public Health England as:-

- Drug free, alcohol free or occasional user (not opiate/crack) discharges in the previous 12 months as a proportion of all clients in treatment in that period (latest treatment journey used)

Representations defined by Public England as:-

- All drug free, alcohol free and occasional user (not opiate/crack) discharges 6-12 months ago who have re-presented within 6 months as a proportion of all drug free, alcohol free and occasional user (not) discharges 6-12 months ago (latest treatment journey used)

Rotherham's Performance
Since April 2018 – contract commencement

Month	Opiate successful exists	Representations
April	5	2 (June & September)
May	7	0
June	1	0
July	4	0
August	1	0
September	2	0
October	9	0

Our Approach: Evidence based optimised prescribing

- Staff training and education events – using data and service information
- Medication dose review for all Service users – highlighting those on 30 ml Methadone or less daily or 6 mg Buprenorphine or less daily and not using illicitly on top
- Reduction and detox options discussed with Service users
- A number of models of detox and reduction – Service user lead and clinically safe – our primary detox offer is a 2 week front loaded Buprenorphine detox with intensive wraparound PSI and clinical support – detox takes 12 weeks from commencement to completion
- Engagement with Shared Care Practices – same offer with GPs offering the detox or a reduction (less than 12 weeks) this is supported by the Shared Care Worker in the practice
- A clear offer for sustained recovery through Foundations of Recovery and support from peer mentors, Mutual Aid and the recovery service

Our Target

- To continue to support Service users through a range of clinical and psycho-social interventions aimed at supporting individuals to successfully exit patterns of addiction and ongoing prescribing into sustained and positive recovery and abstinence from opiates and medication
- To deliver on Rotherham's ambition to pull the rate of recovery from opiate dependence up to that in comparable areas of England – 1.5% year on year is the improvement needed to do this but starting from a challenging position

Discussion ensued with the following issues raised/clarified:-

- CGL had found that some of the users were on an suboptimal dose i.e. they were on a dose of Methadone of 50-45 ml which meant that they were buying Heroin illicitly on top of their Methadone prescription. This stopped them from engaging in treatment, they may be committing crimes and it was quite unsafe and could actually contribute to the risk of drug related death. Those Service users were not detox or reduction ready because they were still using opiates illicitly on top of a prescription so their Methadone dose had been increased. There was a clinical intervention where their use on top of their prescription was discussed, review their dose and look to increase that to a dose that helped that person physically so they would not need to use Heroin on top. When the Service was confident that that person was stable they would be reviewed and look to reducing the prescription to 30 ml

- There were a number of different clinical approaches depending upon the Service user and where they were on their recovery journey i.e. whether they had an illicit dose on top, health needs etc. and discussed with a clinician as to whether they were detox appropriate

- There were a large number of users on 40 ml or less and not using illicitly so they would be the next cohort of Service users to be worked with

- The targets in the CGL contract with regard to waiting times were the same as those in the previous contract i.e. to see someone within 21 days of presenting to the Service. The contract record had always been excellent. If there was a dip in performance when analysed it was usually due to a couple of people who had not kept their appointment due to holidays etc. There was the ability to drill down in the numbers in more detail

- The availability of Service had increased to include 2 late nights a week and a Saturday morning to ensure there were less barriers for those who worked being able to access the Service

- The issue of Spice usage was known across South Yorkshire but was more prevalent in Doncaster and Barnsley than probably Rotherham and Sheffield. It was something that was monitored with the Service provider regularly, however, there was no visible Spice issue and users were not coming into the Service at the moment nor had it been seen through the Community Safety elements. CGL had a package in place for Spice users with different interventions workers could offer and a clinical prescribing package

- The use of Spice was most prevalent in prison and rough sleepers. It was felt that, due to Rotherham having a smaller cohort of rough sleepers, this was partly why the numbers were not being seen as they were in the bigger cities

- The transition of Service to CGL had been extremely smooth, facilitated by RDaSH, and had picked patients up very quickly. The contract was now 6 months in. There was still concern regarding the number of opiate exits to meet the annual target, however, it was acknowledged that it had to be a safe service and that it took a little longer. CGL had responded by offering a quicker detox package

- CGL had had an unannounced CQC inspection the previous week. A meeting was taking place later to discuss the initial feedback

- The performance report demonstrated the level of detail that could be achieved with the Service. All Drug Services across the country had to feed into the National Drug Treatment Monitoring System (NDTMS). If a Service user presented themselves to any Service in the country/prison service it would be seen through the NDTMS as all the systems were linked up across the country. It was a very complex system where you could see patterns. There were persistent areas that had performed really well under RDaSH, some of the reds were quite arbitrary and the figures not as bad when drilled down. It was known what the key areas were e.g. more work requiring on making sure Service users had their vaccinations for Hepatitis, waiting times for non-opiate users and those Service users who had been in receipt, of treatment for a long time

- There was a lot of fear in the opiate using population that if they left treatment and the treatment offer on the table 5-10 years ago they would never get the same treatment offer again. This was a real fear and driving force in people not leaving treatment

- CGL also included a narrative report which gave more of the Service user voice. This could be shared with the Select Commission

- The Service User voice was really important and would be in the CQC feedback. They interviewed 18 Service users during their inspection. Service users were spoken to, feedback mechanisms for Service users and they get feedback from Service Manager. It was a peer-led

service so if someone went to the front door they would be met by Service users that had been through the system and who were really helpful in gathering feedback and giving a warm welcome and removing any stigma

- A client's mental capacity was assessed at assessment where they would be asked questions and given the opportunity to disclose anything that had impacted on them. It was not measured but there was anecdotal evidence and national figures around the number of female users that had been sexual abused as children and Adult Service users that had been through the care system at some point. All workers had worked in substance misuse for a number of years and knew how to ask the questions and refer to the relevant support systems

- The manager was a member of the Suicide Prevention Working Party and the service had a toolkit that could be used to support service users

- Deaths of Service users was closely monitored and fed in through Adult Safeguarding. The outstanding feature of the deaths since the previous report in September had been a number of people that died in Rotherham Hospital of a number of long term conditions many of which related to alcohol. There had been one incident of a Service user's suicide

- CGL offered predominantly urine screening as part of the Service offer but could offer oral testing and Spice could be included

- There was a national alert system around strong, weak or contaminated batches of drugs. Over the past 2 years there had been an increase in incidences of Heroin mixed with Fentanyl which had been the cause of a number of drug related deaths in the North-East of the country. There was a Fentanyl approach within the organisation and it would be reported through the system

- Clear pathway for those with substance misuse issues and mental health issues following from the recommendations of the scrutiny review

- RDaSH and CGL had been working to ensure the pathways were correct between the Services. A significant number of those who presented to substance misuse services would have additional mental health and physical health needs and a number who presented to secondary care mental health services used substances. There was a very clear responsibility for mental health services provided by RDaSH where people had significant mental health needs to be the lead agency in supporting users and care planning

- If someone was in contact with Mental Health Services and subject to a Care Programme Approach (CPA), they would have a whole plan of care around them including contact numbers for emergency services, Crisis and, if were being encouraged to access CGL Services, CGL staff would be encouraged to support them in that process. It was part of the role of the Care Co-ordinator to hand hold

- Rotherham also had involvement of GPs through the Shared Care approach for opiate use treatment and clear pathways for referral or self-referral to IAPT. They were still working on the front end part and would have a joint training programme for staff to bring everything together

- As part of the initial risk assessment process and ongoing risk assessment review for Mental Health Services was to ask questions about domestic relationships/any difficulties with relationships. Often tactfully phrased but the point was to find out whether there were any immediate risks both in terms of safeguarding and whether there was historical stuff that needed to be dealt with. This would link to with work on suicide prevention and impact of past trauma or abuse

- CGL asked questions regarding domestic abuse and perpetrators but in a very tactful way and they did have perpetrator programmes that could be delivered if they had the numbers. The data was not reported on the scorecard but was collated on the system

- CGL was also a member of the MARAC.

Anne, Lucy and Matt were thanked for their presentations.

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

(2) That a monitoring report be submitted to the Select Commission in June 2019.

55. UPDATE ON HEALTH SELECT COMMISSION WORK PROGRAMME 2018-19

Janet Spurling, Scrutiny Officer, presented an update on the Select Commission's work programme for 2018-19 providing options for potential spotlight reviews and for the work of the Performance Sub-Group.

Discussion included:-

Select Commission/Spotlight Reviews
Further update on RDaSH Estate Strategy
Enablement/Reablement
Transition from Children's to Adult Social Care Services – joint work with Improving Lives Select commission
Local Maternity Plan
Potential Service changes at Rotherham Community Health Centre on Greasbrough Road
Implementation and impact of Service Changes
Changes to Intermediate Care and Learning Disability Services

Performance Sub-Group
Joint Outcomes Framework for Locality Working
Urgent and Emergency Care Centre measures
Rotherham Integrated Health and Care Place Plan measures - Quarter 2 Scorecard
Implementation and impact of Service Changes

Following from the issues raised earlier in the meeting around primary care, reference was made to the previous scrutiny review that had looked at Access to GPs and the information provided for the meeting in March 2018. Localised data sets including disaggregation by equality protected characteristics would be useful and more information about how the appointments in the three hubs are communicated to patients.

Members suggested other potential items for the work programme - data around suicides and suicide prevention work and autism provision for primary aged children, including possible visits to other local authorities including Sheffield.

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

(2) That the link to the National Survey of Patients be circulated to Select Commission Members.

(3) That the summary of the previous Scrutiny Review of GPs be circulated to Members.

(4) That Members send Key Lines of Enquiry regarding General Practice to Janet Spurling, Scrutiny Officer, in preparation of the February meeting.

56. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

Resolved:- That the Chair extend an invitation to Tony Clabby, Chair, Healthwatch Rotherham, to attend the meeting.

57. SOUTH YORKSHIRE, DERBYSHIRE, NOTTINGHAMSHIRE AND WAKEFIELD JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE UPDATE

The Chair gave an update for the South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee by confirming:-

- JHOSC had met in October the agenda for which had included the SY&B ICS and the next steps in response to the Hospital Services Review recommendations through a strategic outline business case

- Members had emphasised the importance of public engagement and improving communication

- Assurance had been sought that the plans would be delivered within resources and that they would address health inequalities and the variations in performance between hospitals

- Further information was required and provided after the meeting and could be shared with the Select Commission i.e.

  Progress update on changes to Hyper Acute Stroke and non-specialised Children's Surgery and Anaesthesia
  Communications and engagement plan
  More information with regard to the workforce issues raised in the Hospital Services Review

- The next meeting would be held in January/February 2019

In relation to the South Yorkshire and Bassetlaw Integrated Care System the cover report had stated that "Integrated care system leaders gain greater freedoms to manage the operational and financial performance of services in their area".

Clarification had been sought as to what was meant by "greater freedoms".

From the Memorandum of Understanding agreed nationally this meant that local systems that were working well had greater freedom in how they ensured extra funding and support got to where it was needed in local communities.

Resolved:- That the information be noted.

58. HEALTH AND WELLBEING BOARD

Consideration was given to the submitted minutes of the Health and Wellbeing Board held on 19th September, 2018.

Resolved:- That the minutes of the Health and Wellbeing Board held on 19th September, 2018, be noted.

59. DATE AND TIME OF NEXT MEETING

Resolved:- That a further meeting be held on Thursday, 17th January, 2019, commencing at 10.00 a.m.

REPORT FOR ROTHERHAM HEALTH SELECT COMMISSION

Date of meeting:	**17th January 2019**
Title:	**Refreshed Joint Strategic Needs Assessment consultation**
Directorate:	**Adults, Care, Housing and Public Health**

1. Summary

1.1. The current Rotherham Joint Strategic Needs Assessment (JSNA) is due a refresh. This provides an opportunity to consider rationalising the content, making it a better fit to drive current priorities and ensuring it is more meaningful to commissioners, service providers, partners and decision-makers.

1.2. The purpose of a JSNA is to capture and share data and analytical context about the population of Rotherham with regard to the wide range of influencers on health and wellbeing. The JSNA should inform and influence strategy and thereby drive improvement in health and wellbeing of the population.

1.3. To fit with an asset-based approach, there is a need to re-balance 'needs' versus 'strengths' based indicators (by including what is strong, not just what is wrong) and to better include community voice by actively involving more partners in co-production.

1.4. In order to determine what the refreshed JSNA should look like, all partners have been actively encouraged to participate in a consultation process to shape the design. It is anticipated that the Health Select Commission will give a considered response to the consultation.

2. Recommendations

That the Health Select Commission:

1. Agree to participate in the consultation regarding the redesign of the JSNA.
2. Note the plan to redesign the JSNA, making any recommendations on the proposed approach.

3. Background

3.1. The purpose of a JSNA is to drive improvement in the health and wellbeing of the local community and reduce inequalities for all ages. It is not a stand-alone product, but a continuous process of strategic assessment, which should then inform planning, in order to develop local evidence-based priorities for strategies and commissioning and ultimately help to determine what decisions and actions the Council, local NHS organisations and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.

3.2. In the statutory guidance[1], it is clear that local authorities and CCGs have equal and joint duties to prepare JSNAs through the Health and Wellbeing Board. The responsibility falls on the Board as a whole and their success depends upon all members working together throughout the process. However, best practice involves co-production with a range of partner organisations, such as the voluntary/community sector and including public voice.

3.3. The Rotherham JSNA was redesigned as an online resource in 2013, replacing the former fixed document format of 2011. Following a period of consultation, the Health and Wellbeing Board signed off the final version of the JSNA in February 2014. The JSNA was subject to a review in 2015/16 and in June 2016, the Board agreed that it be subject to further review to improve the content and format in 2016/17.

4. The current JSNA

4.1. The JSNA website is hosted by the Council's website at:
http://www.rotherham.gov.uk/jsna/

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

4.3. The content is arranged under the home page and 7 sections:

- Home page – provides background to the JSNA, a link to the Health and Wellbeing Strategy, priorities, overview of key issues and downloads.
- People – information about Rotherham's population including numbers, age, gender, ethnicity and information about specific communities of interest
- Places – information about the environment, housing, transport, and profiles of the borough, wards and other localities
- Economy – information on poverty, deprivation, economy and labour market
- Staying Safe – safeguarding for children and adults, crime, domestic abuse, sexual abuse and CSE

[1] Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, 2012
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/223842/Statutory-Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing-Strategies-March-2013.pdf

- Healthy living – epidemiological information about lifestyles and behaviours such as tobacco use, alcohol misuse, substance misuse, teenage pregnancy, obesity (inc. eating habits and physical activity) education, and inequalities
- Ill health - epidemiological information about the major causes of disease and infirmity in Rotherham
- Services – describes a range of health and social care services with information on performance and user satisfaction

JSNA users can drill down from each of these sections to find relevant information, for example information on Education can be accessed under 'People' then 'Children and Young People'. There is a search tool to help users find information using key words. For every topic, the JSNA provides answers to three questions:

- Why is this an issue?
- What is the local picture and how do we compare?
- What is the trend and what can we predict will happen over time?

5. Key Issues: Why review the JSNA?

5.1. The time seems right to refresh the JSNA, considering the content, format and production since anecdotal evidence suggests the current JSNA is not widely used, presumably because it is not meeting the needs of commissioners, service providers, or the voluntary/community sector.

5.2. The launch of the Thriving Neighbourhoods strategy[2] sets out a new asset-based way of working which places communities at the heart of everything we do. To work in a truly asset focused way, would require a change in emphasis from 'troublesome' indicators (needs and problems) to include a better balance of 'heartening' indicators (assets, strengths, social capital, protective factors). By simply changing the way in which indicators are presented, such as talking about emotional wellbeing rather than mental illness, changes the starting point for strategy and policy development from focusing on need to starting with building on existing strengths.[3] The JSNA proposal in 2013 included a "register of assets" which was never implemented so now would be the opportunity to re-dress that gap.

5.3. Previously the JSNA has been primarily owned and maintained by RMBC. It is really important that if it is to be meaningful and used by a wider audience, that partners are actively involved in contributing data and contextual analysis. We are not currently for example, using the wealth of data collected by the voluntary sector that could better help us understand our communities. Alongside this, the JSNA should provide a rich resource of information to support the voluntary sector in evidencing information about their local community for funding bids etc.

5.4. It is now more popular to present data and analysis in a more pictorial format, using infographics rather than paragraphs of text and tables. This can help

[2] Thriving Neighbourhoods Strategy
[3] Bewsher, H. 2016 Half-full or half-hearted? How can asset-based approaches to Joint Strategic Needs Assessment be implemented more effectively?
http://observatory.kirklees.gov.uk/Custom/Resources/Helen_Bewsher_MPH_Dissertation_2016.pdf

make information more accessible to a wider audience, more impactful and quicker to assimilate.

5.5. The JSNA and data and intelligence provision, such as producing health needs assessments, needs to be a joined up and sustainable approach. Having information available online enables users to access easily and keeps resources in a common location. It also enables links to be made to other key documents, such as strategies, and resources, such as the Rotherham Gismo directory[4].

6. Options considered and recommended proposal

6.1. No specific design is proposed at this stage, as the consultation is crucial in determining the most appropriate design to meet the needs of users. Components of the design to be decided include the structure of sections, the type of content display (photographs, maps, infographics, spinecharts, graphs, tables, text preferences) and the thematic content.

6.2. It is proposed that key interested representatives from organisations are identified or confirmed through the consultation who will then form part of a working group of authors who contribute to the JSNA on an ongoing basis.

6.3. In order to provide the required level of data and accompanying contextual information within current capacity, it is suggested that the JSNA comprises of strategic overview of key areas at a Rotherham level and as ward profiles, and that depth for certain priority topics is added according to priority. It is proposed that the JSNA author group will support the provision of more in-depth data (such as through a needs assessment process) where a priority is agreed. Prioritisation will be determined where there is a defined current use and demand for information, where there is a sponsor who can lead a topic-specific working group to support collation of the required information.

7. Consultation

7.1. Consultation questions are attached in appendix A.

7.2. The consultation was also made available to complete online through the RMBC consultations section of the website – (this closed on January 14th 2019.)

[4] https://www.rotherhamgismo.org.uk/

8. Timetable and Accountability for Implementing this Decision

8.1. The proposed timeframe for revision of the JSNA is as follows:

November 2018	Draft consultation to Health and Wellbeing Board
December 2018	Consultation launched
January 2019	Consultation closes
January 2019	Working group established
March 2019	Draft structure of new JSNA design finalised and timetable of content confirmed Approval of final content and process of JSNA by Health and Wellbeing Board
May 2019	Revised JSNA published online (not all content will be available at this time)

8.2. Accountability for the JSNA is the Health and Wellbeing Board. However, responsibility for oversight of the redesign and content will be the Public Health team at RMBC.

9. Financial, Workforce, Equalities and Partner Implications

9.1. No additional costs are anticipated for the refresh of the JSNA, which will be produced under current work programmes with current staff capacity and utilising the RMBC website and IT capabilities. However, additional support will be required from RMBC IT to facilitate new website hosting capabilities.

9.2. It is envisaged that the new JSNA would have improved intelligence on equalities and support continued efforts to improve equalities for residents in Rotherham.

9.3. All partners are actively encouraged to engage with the JSNA, contributing data and adding contextual analysis as appropriate and by using the intelligence provided to drive strategy, plans and service delivery to ultimately improve the health and wellbeing of people in Rotherham.

10. Contacts

Gilly Brenner, Consultant in Public Health
Gilly.Brenner@rotherham.gov.uk

Terri Roche, Director of Public Health
Teresa.Roche@rotherham.gov.uk

Appendix 1. Consultation questions

1. When did you last look at the JSNA?
   A. Never, as far as I can remember
   B. A long time ago, probably over a year ago
   C. Within the last year
   D. Fairly recently
      - Please explain why or for what purpose you used it last or haven't used it:

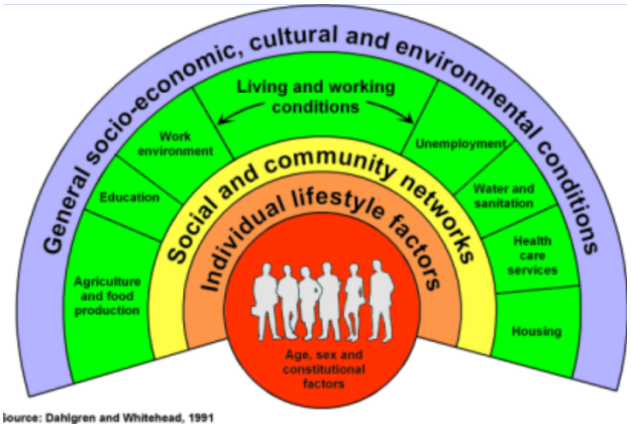
2. The JSNA is unfortunately unlikely to fulfil everyone's requirements in terms of providing detailed local data on a huge range of themes. Therefore it is important that we gain consensus on the main purpose of the JSNA in Rotherham and how it will be used.
   What do you think is the most important use for the JSNA?
   A. Informing strategy and high level planning
   B. Informing service commissioning and detailed service planning
   C. As a single place in which to look for any data about Rotherham
   D. Other – please give an example
   E. I'm not sure I really think it is important to have a JSNA

3. The current proposal is to change the emphasis of the JSNA to better fit with the 'Thriving neighbourhoods' approach, considering what is already strong in Rotherham communities. This helps us to consider how we can build on that, rather than starting from the point of trying to meet perceived need.
   How important is it to you that the JSNA captures assets as well as needs (what is strong, as well as what is wrong)?
   A. Very important – I think assets should be a key component
   B. Important
   C. Not important
   D. I think it should continue to focus solely on need

4. Currently the JSNA is text based, with some downloadable reports that also contain maps or graphs, such as the ward profiles. It is important that the JSNA provides accessible and meaningful information in a way in which it can be easily used.
   What is your preferred format for the presentation of the data and contextual information? Please rank in order of preference
   A. Text with tables
   B. Infographics
   C. Graphs
   D. Maps
   E. Spinecharts
   F. Other – please give details

5. In order to provide the required level of data and accompanying contextual information within current capacity, it is suggested that the JSNA comprises of strategic overview of key areas at a Rotherham level and as ward profiles. Depth for certain priority topics will then be added according to priority. It is proposed that the JSNA author group will support the provision of more in-depth data (such as through an assets/needs assessment process) where a priority is agreed. Prioritisation will be determined where there is a defined current use and demand for information, and where there is a sponsor who can lead a topic-specific working group to support collation of the required information.
   Do you agree with this proposal?
   A. Yes
   B. No
      - Please describe an alternative proposal or your objections if you said No.

6. There are lots of different influencers of the health and wellbeing of the population. Whilst we will endeavour to ensure a good search function is included, the JSNA needs to have an overall structure that is intuitive to make it easy to find what information you are looking for. What structure would you find easiest to navigate?



Source: Dahlgren and Whitehead, 1991

   A. Current structure (People, Places, Economy, Staying Safe, Healthy Living, Ill Health and Services) with enhancements (such as inclusion of assets)
   B. A simpler headline structure, such as Population demographics, Communities of interest (children, vulnerable/equality-related groups), and Influencers on health (economy, education, crime etc)
   C. Sections relating to the theme boards that sit under the Rotherham Together Partnership (Community Safety, Children and Young People, Business Growth, Strategic Housing, Building Stronger Communities, Ambition Rotherham Place, Integrated Health and Social Care Place)
   D. Other – please describe

7. We would like to have a good understanding of what indicators and data we hold locally as partners that could be shared or would add context and value to a Rotherham JSNA. Please give examples of any useful information you, as a service or organisation, collect that could potentially be analysed and shared.

8. In order to develop the headline strategic overview it would be helpful to better understand the priorities and needs of those who intend to use the JSNA. Please give your contact details if you would like to be further involved in redesign process, or as an author or data provider for future content.

9. Please add any other comments.

HEALTH AND WELLBEING BOARD
21st November, 2018

Present:-

Councillor David Roche	Cabinet Member, Adult Social Care and Health **(in the Chair)**
Tony Clabby	Healthwatch Rotherham
Chris Edwards	Chief Operating Officer, Rotherham CCG
Carole Lavell	NHS England
Anne-Marie Lubanski	Strategic Director, Adult Care, Housing and Public Health
Dr. Jason Page	Governance Lead, Rotherham CCG
Jon Stonehouse	Strategic Director, Children and Young People's Services
Janet Wheatley	Voluntary Action Rotherham

Also Present:

Miles Crompton	Performance, Intelligence and Improvement, RMBC
Lydia George	Rotherham CCG
Gordon Laidlaw	Communications Lead, Rotherham CCG
Phil Morris	Business Manager, Rotherham Local Safeguarding Children's Board
Councillor Short	Vice-Chair, Health Select Commission
Becky Woolley	Policy and Partnership Officer, RMBC

Report Presenters:

Christine Cassell	Independent Chair, Rotherham Local Safeguarding Children's Board
Gilly Brenner	Public Health Consultant, RMBC
Nick Leigh-Hunt	Public Health Consultant, RMBC

A member of the public.

Apologies for absence were received from Councillors Mallinder and Watson, Sharon Kemp (RMBC), Terri Roche and Kathryn Singh (RDaSH).

25. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

26. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

The member of the public present at the meeting did not wish to ask any questions.

27. MINUTES OF THE PREVIOUS MEETING HELD ON 19TH SEPTEMBER, 2018

The minutes of the meeting of the previous meeting of the Health and Wellbeing Board held on 19th September, 2018, were considered.

Resolved:- That the minutes of the previous meeting held on 19th September, 2018, be approved as a correct record.

Arising from Minute No. 15(4) (HWB Strategy Aim 4 Update), it was noted that a very successful event had been held recently at Voluntary Action Rotherham attended by a wide range of providers and voluntary groups.

Arising from Minute No. 15(6) (Housing Strategy Refresh), it was noted that Public Health had been included in the work with regard to health inequalities.

Arising from Minute No. 16(5) (HWB Strategy Aim 2 Update), it was noted that extra funding had been received from the South Yorkshire and Bassetlaw Integrated Care System and was a joint project between the RCCG and the Council. An update would be provided as the project developed.

Arising from Minute No. 18 (Rotherham Integrated Care Partnership Agreement), the Agreement had been signed off in consultation with the Chair.

Arising from Minute No. 16 (Better Mental Health For All), it was noted that the Trailblazer funding process had not been finalised as yet but a report would be submitted in due course.

28. COMMUNICATIONS

(1) An email link had been circulated to all Board members with regard to the LGA case study of Rotherham Health and Wellbeing Board.

(2) A joint HIV awareness raising event was to be held on 30th November in Riverside House.

29. LOCAL SAFEGUARDING CHILDREN BOARD AND SAFEGUARDING ADULTS BOARD ANNUAL REPORTS 2017/18

Rotherham Local Safeguarding Children Board

Christine Cassell, Chair of the Rotherham Local Safeguarding Children Board, presented the Board's annual report 2017-18 outlining the role of the Board, its relationship to the Health and Wellbeing Board and the context for the 2017-18 annual report which was:-

- Governance and accountability arrangements
- Effectiveness of arrangements to keep Rotherham children safe
- Learning and Improvement Framework
- Safer Workforce
- Strategic Priorities for 2016-18

Christine drew attention to the following issues:-

- There had been a number of external inspections which were a very important part of the checking of the safeguarding system in Rotherham. The outcomes reflected the significant improvement particularly in Children's Services over a very short period of time

- The improvements in other agencies were to be celebrated across the safeguarding system and the staff involved should be congratulated

- There were still further improvements to be made, as highlighted in the inspection reports, and the work of the Board itself highlighted areas where there was a need for further safeguarding improvement

- It was a particularly important time in the improvement journey that Rotherham and its partners were working to ensure that safeguarding really was at the heart of the work that took place across the partnership as well as the good practice and further improving practice was embedded into day-to-day work

- Demand was challenging whilst budgets were reducing. This was a national issue

- The problem in Rotherham was exasperated by the effective multi-agency working on complex cases and by the impact of the investigations that were ongoing through Operation Stovewood. Once the perpetrators were detected through the investigations and prosecutions commenced, it had implications for any children of those families. Whilst the exact number of perpetrators' children could not be predicted, there would be large numbers of children where consideration had to be given to their safety within the family context

- The effect of management of demand would be something that the Board would continue to monitor whilst supporting and continuing to challenge

- The specific areas that the Board would be driving for improvement immediately included neglect and potential links between neglect and poverty, effective Early Help Services, continued focus on CSE but to widen the scope to look at other forms of exploitation of young people and their vulnerabilities

- Continued development of the work established through the protocol across the Local Safeguarding Children and Adults Boards and focus on safeguarding in Rotherham

- The need to collectively improve the understanding of communities and target support services appropriately and aim to increase the resilience of local communities

As a consequence of the Children and Social Work Act and subsequent Statutory Guidance, LSCBs would cease to exist in their current form; there would be a different arrangement for the safeguarding of children and the 3 key partners – Health through the CCG, Police and the Local Authority – who would be required to design new multi-agency safeguarding arrangements which would have more flexibility than currently prescribed for LSCBs. A working group had been established and currently working up proposals for the way the new arrangements would work. The commitment from the 3 partners with the new arrangements would build on the strength of the current partnership and make further improvements in the work of protecting children across Rotherham.

A discussion ensued with the following issues raised/clarified:-

- Although the survey that had shown a decline in the number of young people who felt safe was a perception survey and not always accurate, it needed to be taken seriously and explore with the young people why they had those views. Sometimes young people gave messages that were not very comfortable but work was needed to look into what had led them to make those comments

- Work would take place with statutory groups with regard to their attendance at and commitment to the Board. Consideration would be given to the structure and attendees as part of the new arrangements

Rotherham Safeguarding Adults Board Annual Report 2017/18
Anne-Marie Lubanski, Strategic Director, Adult Care, Housing and Public Health, presented the Rotherham Safeguarding Adults Board 2017/18 Annual Report.

During 2017/18 the Board had continued to work to promote and protect vulnerable adults in Rotherham and had met bi-monthly to ensure the hard work of the previous year was built upon and that all partnership working was developed and strengthened in the sub-groups.

Anne-Marie highlighted:-

- The shared work area in terms of ensuring Adults and Children's safeguarding

- The Local Safeguarding Adults Board was still in its infancy and was working on making sure the foundations were correct and the partnership working

- The Board had responsibility for those who worked in a significant provider area and had to ensure it had the challenge and processes as well as the appropriate representation on the Board

- The Board would continue to create policies and procedures and the South Yorkshire footprint. Work was already taking place to ensure that the policy and procedures within the statutory organisation were tied into that of the Board

- Work still ongoing on an agreement with regard to the setting of thresholds for vulnerable adults

- Work was taking place on modern slavery and human trafficking which crossed over particularly with the Children's Board and the Safer Rotherham Partnership and would be a continued priority for 2018/19

- The case studies included within the report gave a clear indication of what the organisations were undertaking as well as the journeys but also the good work and the areas that needed to be developed further

- 2 Safeguarding Adult Reviews had taken place and action plans developed. There had been positive learning about how to work together

Discussion ensued with the following issues raised/clarified:-

- The increase in the number of Section 42 enquiries would be a mixture of more cases coming through and improvement in recognising them. Following any awareness raising there tended to be a rise in the number of referrals

- The Mental Capacity Act and Deprivation of Liberty Safeguards sat outside safeguarding but it was important that Safeguarding Boards had linkage to it. There had been a decrease in the number of authorisations granted and not granted to that of 2015/16. It was an area that was monitored

- The Mental Capacity Act and Deprivation of Liberty Safeguards were very technical. A provider with a 60 bed facility may submit 60 DOLS potentially unnecessarily because they had a statutory duty to request a standard variation order to cover that. Some homes would include everyone and then sift through as to who actually required one. It was a challenge to all local authorities and the health environment

Christine and Anne-Marie were thanked for their reports.

It was noted that Sandi Keene, Independent Chair, would be stepping down from the position in 2019.

Resolved:- That the Rotherham Local Safeguarding Children Board and the Rotherham Local Safeguarding Adults Boards' annual reports 2017-18 be noted.

30. REFRESHED JOINT STRATEGIC NEEDS ASSESSMENT CONSULTATION

Gilly Brenner, Consultant in Public Health, reported that the current Rotherham Joint Strategic Needs Assessment (JSNA) was due to be refreshed. This provided an opportunity to consider rationalising the content, a better fit to drive current priorities and ensuring it was more meaningful to commissioners, Service providers and partners.

All partners were actively encouraged to participate in a consultation process to shape the design and that Board members provide a considered response to the consultation.

It was proposed that key interested representatives from organisations be identified/confirmed through the consultation who would then form part of a working group of authors who contributed to the JSNA on an ongoing basis.

In order to provide the required level of data and accompanying contextual information within current capacity, it was suggested that the JSNA comprise of strategic overview of key areas at a Rotherham level and at Ward profiles and that depth of certain priority topics was added according to priority. The JSNA author group would support the provision of more indepth data where a priority was agreed. Prioritisation would be determined where there was a defined current use and demand for information and where there was a sponsor who could lead a topic-specific working group to support collation of the required information.

An interactive presentation was given allowing Board members to express their views on the proposal which included:-

- The Ward profiles drawn up by the Authority last year should be shared with a wider audience but would need to be tweaked to take account of the Health localities

- Recognition required of the Integrated Social Care Partnership and the Sheffield City Region in the context of bidding documents

- Did the current structure of the document exclude people if they felt they did not belong within the particular headings?

- The document would only be available electronically with the ability for the reader to save/print certain sections themselves

Resolved:- (1) That the proposal of a refresh of the JSNA be approved.

(2) That senior managers from a wide range of partner organisations be encouraged to be involved in the strategic and policy design and commissioning or service delivery and take part in the consultation to ensure the revised JSNA was meaningful, well used and fit for purpose.

(3) That discussions take place between Miles Crompton and Chris Edwards with regard to the Ward profiles to take account of the Health localities.
Action:- Miles Crompton/Chris Edwards

(4) That the link to the document be circulated to enable Board members to forward to relevant colleagues to ascertain their views.
Action: Gilly Brenner

(5) That key contact details for each organisation be forwarded to Gilly Brenner.
Action:- All Board members

(6) That the Kirklees JSNA be circulated to Board members for information.
Action:- Becky Woolley

31. UPDATE ON THE HEALTH AND WELLBEING STRATEGY AIMS 1 AND 3

Aim 1: All children get the best start in life and go on to achieve their potential
Jon Stonehouse, Strategic Director, Children and Young People's Services, together with Collette Bailey, Head of Locality, presented an update in relation to Aim 1 of the Health and Wellbeing Strategy 2025 focussing on Priorities 1 and 2 :-

Priority 1 – Ensuring every child gets the best start in life (pre-conception to age 3)
Priority 2 – Improving health and wellbeing outcomes for children and young people through integrated commissioning and service delivery

With the aid of a powerpoint presentation, following the principles of Signs of Safety, the Board considered:-

What's working well
What are we worried about
What needs to happen

Discussion ensued with the following issues raised/clarified:-

- The 3 months consultation on the SEMH Strategy would commence in January 2019 and would include the Board

- A postholder had recently been appointed to develop the Joint Obesity Strategy

- Public Health had already commissioned Obesity work particularly for children above the age of 8 years and their families. It was focussed mainly in the Public Health arena but also within the Early Help offer putting together programmes with parents around healthy eating, weaning and early years diet. The other main arena was within the education system with schools now addressing it through PHCP. There were a number of strands that could have influence at low/no cost although it was acknowledged that there had been difficulties in the past particularly in relation to Obesity Services

- Healthwatch Rotherham had recently published a review of CAMHS recommending the removal of Autism from the Service and commissioning a standalone Autism Service to replace what currently was not working within CAMHS. The RCCG had recognised the difficulties with Autism Pathway and was a top priority

Aim 3: All Rotherham people live well for longer

Nick Leigh-Hunt, Public Health Consultant, presented an update in relation to Aim 3 of the Health and Wellbeing Strategy 2025.

With the aid of a powerpoint presentation, following the principles of Signs of Safety, the Board considered:-

What's working well
What are we worried about
What needs to happen

Discussion ensued with the following issue raised/clarified:-

- Consideration of targeting occupations/work place settings to improve the uptake of health checks

Discussion ensued on the issue of Board Sponsors and Lead Officers and the rationale for the previous decision with regard to Board Sponsors. It was felt timely for a refresh of the Board Sponsors for each of the Strategy Aims.

Resolved:- (1) That the progress made against Aims 1 and 3 be noted.

(2) That an update be provided at the next meeting on Obesity.
Action:- Terri Roche

(3) That an email be sent to Board members regarding Board Sponsors for the Health and Wellbeing Strategy Aims and discussed further at the January 2019 meeting.
Action:- Becky Woolley

32. HEALTH AND WELLBEING STRATEGY - DRAFT PERFORMANCE FRAMEWORK

Becky Wooley, Policy and Partnership Officer, reported that a performance framework was being developed to measure the delivery of the Health and Wellbeing Strategy (Minute No. 6 of 11th July, 2018 refers).

Attached to the report was the first draft of the framework which included a longlist of potential indicators. It was envisaged that the final performance framework would be in the form of a scorecard and would include approximately 3 high level indicators for each Aim with clear targets set for 2025.

Resolved:- (1) That the approach of the performance framework be endorsed.

(2) That Board members consider the longlist of potential indicators and notify Becky Woolley of their thoughts by 14th December.
Action:- All Board Members/Becky Woolley

(3) That the full performance framework be submitted to the January 2019 Board meeting with performance updates submitted to future Board meetings.

33. ACTIVE FOR HEALTH

Amy Roden, Public Health, and Dr. Simon Nichols, Sheffield Hallam University, gave the following powerpoint presentation on insights from the Rotherham Active for Health Research Projects 2015-2018:-

What is Active for Health (AFH)

- A safe and robust multi-condition sport and physical activity project linking healthcare services to community physical activity opportunities. With the aim to facilitate long term adherence to sport and physical activity to aid recovery and condition management

Why was Active for Health developed

- Research evidence for long term conditions and physical activity
- Need and demand locally
- Specific activity for inactive patients e.g. cancer, cardiac and heart failure, COPD, falls, stroke, MSK lower back pain
- Evidence and models from previous Falls pilot work
- Opportunity to access large pilot funding pot – Get Healthy Get Active for piloting projects with physical activity/long term conditions

The 'Active for Health' Programme
Step 1 Rehabilitation
- Lead exercise professionals work with patients in health care services to motivate referrals into step 2

Step 2 Moving on
- 12 week condition specific physical activity programme. Delivered by level 4 instructors

Step 3 Keeping active
- Maintenance sessions aimed at continuing recovery

How the programme was delivered – what's different
- Level 4 exercise specialists to ensure patients gained condition specific physiological outcomes
- Procured the service – 2 providers, 2 reasons; more effective management/long term sustainability
- Borough-wide community based approach
- Linked into relevant local, regional, national programmes to enhance delivery at local level (clinical champions, SPS, Health trainers)

The evaluation of Active for Health
"To what extent the Active for Health Pathway is effective and cost effective in supporting and sustaining inactive individuals into physical activity opportunities/sport"
Primary Outcomes
- Physical activity change
- Cost benefit/health service utilisation

Secondary Outcomes
- Quality of life
- Patient and stakeholder experience

Sustainability – What's happening with the project now?
- Sustainability plan
- Provision will continue
- Funding secured for Falls and Cancer programme 2018/19
- Providers will continue to offer a modified service for all other conditions
- Final research report – December 2018

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

- Someone diagnosed with Cancer and clinically obese would be referred through their GP or other health care professional. Cancer Nursing Teams at the Hospital had signposted patients

- The Cardiac referral form was very complicated and time consuming for a GP to complete and felt that the information required was out of proportion for patients to get exercise. However, it was the level of

information required in terms of medication, condition etc. before an instructor could set an exercise programme. This level of information only applied to cardiac patients

- The programme had known of the patients that needed activities to be delivered in community-based facilities and had linked them up into other activities. It had to also look at the differences between getting generally inactive people active

- Active for Health was trying to do things differently and connect everything together. There was no real shortage of opportunities to undertake physical activity but the big change for Active for Health was to get the clinicians and hospitals to work with it

- Across the whole of the project the retention rates after 3 months were 60-70%. The reasons for drop outs would be included in the final report.

Amy and Simon were thanked for their presentation.

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

(2) That when produced, Amy Roden provide Becky Woolley with the final report for circulation to the Board.
Action:- Amy Roden/Becky Woolley

34. ROTHERHAM HOSPICE QUALITY ACCOUNT

The Rotherham Hospice Quality Account 2018 was submitted for information.

35. ROTHERHAM INTEGRATED CARE PARTNERSHIP PLACE PLAN - PERFORMANCE REPORT: QUARTER 1.

The Quarter 1 performance of the Rotherham Integrated Care Partnership Place Plan was submitted for information.

36. MINUTES OF THE ROTHERHAM INTEGRATED CARE PARTNERSHIP HELD ON 3RD OCTOBER, 2018

The minutes of the Rotherham Integrated Care Partnership Place Board held on 3rd October, 2018, were noted.

37. DATE AND TIME OF NEXT MEETING - WEDNESDAY, 23RD JANUARY, 2019, COMMENCING AT 9.00 A.M.

Resolved:- That a further meeting be held on Wednesday, 23rd January, 2019, commencing at 9.00 a.m. venue to be confirmed.