HEALTH SELECT COMMISSION
Thursday, 4th June, 2020

Present:- Councillor Keenan (in the Chair); Councillors Albiston, The Mayor (Councillor Jenny Andrews), Bird, Brookes, Cooksey, R. Elliott, Ellis, Jarvis, Short, John Turner, Vjestica, Walsh and Williams.

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

72. DECLARATIONS OF INTEREST

There were no declarations of interest in respect of any of the items of business on the agenda.

73. EXCLUSION OF THE PRESS AND PUBLIC

The Chair advised that there were no items of business that would require the exclusion of the press or public from the meeting.

74. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

No questions had been received from members of the public or press in respect of matters on the agenda for the meeting.

75. MINUTES OF THE PREVIOUS MEETING HELD ON 20 FEBRUARY 2020

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 20 February 2020.

Resolved:- That the minutes of the previous meeting held on 20 February 2020 be agreed as a correct record.

76. COMMUNICATIONS

Information Pack
Contained within the information pack circulated to Members were:-

- Briefing on Urgent Dental Care
- Briefing on COVID-19 from Andrew Cash
- Link to Health and Wellbeing Board papers
    - final draft Rotherham Integrated Health and Social Care Place Plan
    - final draft Rotherham Loneliness Plan
    - Quarter 3 Rotherham Integrated Health and Social Care Place Plan Performance Report.
- Fitter, Better, Sooner – patient weight management/smoking cessation prior to elective surgery.

Members were requested to submit any comments or questions on these items to the Governance Advisor.

South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee
No date had been agreed for the next meeting but the Joint Committee would resume to consider possible changes to gluten free prescribing, which had previously been deferred.

77. ADULTS 65+ RESIDENTIAL AND NURSING CARE HOMES - QUALITY REVIEW

Cllr Roche, Cabinet Member for Adult Care and Health introduced the item and confirmed that Rotherham care homes, of which only two were Council homes, were now rated third best in Yorkshire. This was positive progress although room for further improvement still existed. Undeniably Covid-19 had had an impact on care homes in Rotherham and he stated his thanks and admiration for staff working in care homes and said that thoughts were with those who had lost a loved one or family member.

Presentation

Context

- 36 Care Homes (Adults 65+) including 2 in-house
- 2 market exits since 2018 Greasbrough Nursing and Residential Home (contract termination-poor quality) Clifton Meadows (business decision)
- 3 market entries - Jubilee - Greasbrough, Roche Abbey - Maltby, Clifton Meadows - Clifton
- Significant bed capacity - 1849 (including in-house/temporary beds)
- 483 Vacant – 26% on 22nd May 2020 (164 in general residential, 92 in general nursing, 171 in dementia residential and 56 in dementia nursing)

Current Position

- Only 48% placements funded by the Council
- 22% of beds occupied by self-funding residents – still support from Council
- 30% from out of borough
- 50% charge a top up fee (10% in 2015/16)
- Demographic is changing, with the average age entering care increasing to 85 years (83 in 2015/16).
- The average length of stay is 2-3 years (3-4 years in 2015/16).
- Increase occupancy in Nursing type provision (90% occupancy) - people living longer - complex needs
- Market expansion in nursing beds 92 beds and 20 temporary (Covid-19)
- 11% increase in vacancy factor since Covid-19

Challenges to Care Homes due to Covid-19

Initial challenges at the start of the pandemic:
- Implementation of the 3 hour discharge process from hospital
- lack of testing for staff and residents
- high rates of staff absence
- lack of Personal Protective Equipment (PPE)
- care home deaths not being captured in the national data
- digesting and responding to frequently changing guidance regarding outbreaks, PPE use and infection control – support from RMBC

Challenges now are:
- implementing the new testing regime
- high levels of voids
- limited self funder market
- longer term financial viability of care homes
- ensuring that support extends beyond older people (current national guidance limits primary action to this group) – learning disability, neuro-rehab and mental health

Additional Support due to Covid-19

- Named Council lead officer - Contract Compliance Team and Public Health Officers
- Clinical lead - GP - Community Health Team
- Clinical Contract Quality Officer – Care Home Liaison Service (NHSRFT)
- Staff testing
- Whole home testing for staff and residents
- Supply of PPE – now improved through supply chains but some concerns re costs plus Council some stock with which able to assist providers
- Council's website - bespoke section for providers i.e. web form to request PPE/information/support/resources
- Rotherham Skills Academy to meet their immediate recruitment and training needs for adult social care workers (to go live in two weeks)
- CQC - Emergency Support Framework - collaboration
- Training package based on Public Health England guidance for PPE, Infection Prevention and Control and Covid-19 swabbing/testing
- Sheffield University provided 35 sim enabled phones to enable video calling – residents/family
- Multi-disciplinary team clinicians/Public Health/commissioning video conferencing
- "Listening Ear" service – bereavement support
- Payment £15,000 to support additional expenditure incurred as a result of Covid-19
- £100,000 contingency fund
- Infection Control Fund – £2.3m grant for all CQC registered care homes in the borough (all age - 84 in total)

Whole Care Home Testing

- 10 May 2020 - the national digital portal was launched to support all care homes to be tested by June 2020.
- The Director of Public Health, CCG Chief Nurse and the Director of Adult Care Services were tasked with supporting testing across Rotherham.
- Care home testing will be prioritised according to risk i.e. where there is an outbreak or where staff absence is problematic.
- All older people's care homes across Rotherham will be included regardless of the source of their funding.
- The Director of Public Health will be referring care homes to NHS England for testing on a weekly basis as per NHS England's directive.
- Local needs will be captured via a daily tracker.
- An evidence-based methodology informs who is prioritised for testing and support:
  - size of the care home
  - numbers of staff
  - whether the care home is nursing or residential
  - current staff sickness rates
  - current bed occupancy
  - current infection rates and presence of Covid 19
  - testing already undertaken of residents and staff (if this is the case)
  - geographical areas to take advantage of mutual aid where possible

CQC ratings

3 slides showed current ratings for care homes in Rotherham and an improving trend. Contract Compliance Officers remained vigilant on ones rated as requiring improvement, which all had action plans. Escalation if needed would include health partners in a multi-disciplinary approach.

CQC data - Access to care

- Percentage change in residential home services - Rotherham figures indicate a 5% or greater decrease in the number of people accessing residential care
- Percentage change in nursing home services - Rotherham figures indicate a 1% or greater decrease in the number of people accessing nursing care
- Percentage change in residential home beds - Rotherham figures indicate a 5% or greater decrease in the number of residential care beds available
- Percentage change in nursing home beds - Rotherham figures indicate the number of nursing beds remains stable

The Care Home of the Future

- Care home market is essential where it is not appropriate or safe for a person to remain in their own home.

- Shift in market to facilitate hospital admission avoidance, discharge and flow to contribute to managing year-round pressures/demand through the provision of intermediate care, reablement and winter pressure beds from the independent sector.
- To develop more effective community multi-disciplinary working to support people to be at home for longer (or following hospital discharge), based on the philosophy of 'Home First'
- Prevention and early intervention with a recovery model of reablement and rehabilitation for all age groups

Approach to Quality

- Healthwatch - Citizens Advice Rotherham and District
- RMBC - Public Mental Health and Emotional Wellbeing COVID 19.
- TRFT - Patient Experience Group.
- Rotherham Safeguarding Adults Board.
- Health & Wellbeing Board.
- Rotherham Advocacy Service – Absolute Advocacy: canvas independent views on health and social care in addition to advocacy
- Meet people 1:1 group sessions, surgeries, attend events, use social media and technology.

Quality Strategy
Making it Real - people with care, treatment and support needs:

- Six themes to reflect the most important elements of personalised care and support.
- 'I statements' that describe what good looks like from an individual perspective.
- 'We statements' that express what organisations should be doing to make sure people's actual experience of care and support lives up to the I statements.

Members explored the following themes after hearing the presentation.

Stability regarding testing
The Strategic Director was the lead for the South Yorkshire Local Resilience Forum cell and confirmed that although testing remained challenging plenty of capacity for testing existed across the system, with two routes available. Pillar 1 was via Rotherham Hospital where a pathway had been established early on for Council and provider staff and Pillar 2 via Doncaster Airport where staff could make their own referral. Confusion existed with regard to the pathways, compounded by mobilisation of units managed by the military, such as the one at New York Stadium for a few days. Testing and home testing kits were available for staff who had difficulty in driving to the hospital or other sites.

Testing was mainly self-testing by a throat swab, with only hospital tests undertaken by a clinician. A high number of false tests were recorded and people had to be assisted in how to do them correctly. An additional challenge was how the virus worked as people could still have bacteria in

the back of their throat after two weeks, showing a positive test but no longer infectious. This led to dilemmas about how safe people felt in being in a particular environment.

NHS England (NHSE) input was in regard of testing care homes one by one, which was also a challenge. Some care homes had been proactive and this issue was prioritised weekly depending on what was happening in a care home.

Access to testing for residents and staff with the rollout to all care homes

A return for 29 May 2020 had to confirm that every care home had been offered testing and Rotherham had included mental health and learning disability even though the list was confined to older people. It was because the belief was that anyone who lived in a care home should have access to testing. Issues existed around capacity to consent to a test or refusal. There was a process as a deprivation existed in doing something physically to someone who was quite poorly and potentially did not understand what was happening. Challenges for providers with people with dementia type illnesses were around testing, social distancing, PPE, residents staying in their own room if needing to self -isolate and also decisions made for people on end of life care who may have chosen to remain in the care home rather than going to ICU for ventilation. It remained important to have that personalised care.

Testing for older people was approximately over four weeks to cover all services. Officers looked at what had been carried out and then prioritised care homes where people were receiving nursing care or had symptoms of dementia, and on levels of infection in the home, which were then referred to the Department of Health for the testing to be undertaken. Several care homes had registered themselves on the on-line portal and the Council had referred around half the older people's care homes and were monitoring when the tests were carried out and the results. Learning disability care home testing was imminent once the go ahead was given, plus under 65s and mental health, so there would be no further delay as people were anxious about it.

Infection control

It could not be said that this had stabilised as there were a number of unknowns with regard to the virus and things emerging daily. Work was taking place with the Director of Public Health and Community Physician and PPE training included videos of how to put on and remove PPE correctly. Transmission was possible through staff and monitoring was in place regarding the percentage of staff who had tested positive or who were self-isolating with symptoms or because family members showed symptoms, and this would endure.

Preparedness for another spike or second wave

Assurance was sought that officers were confident the system was geared up to deal with another wave. There had been a lot of learning

and a document developed for scenario testing and how things would be done differently if it started up again. Partners were in a strong position but the caveat was that it would be different again next time; it had hit the most vulnerable and those with certain conditions and by default sadly the people in the care homes would also have changed. The system was as prepared as possible but there were unknown aspects.

Discharge from hospital for convalescents to care homes
Learning at all levels was continuing and as always with the benefit of hindsight and acquired knowledge some things would have been done differently. Preparatory work had been carried out for going forward due to concern about potential outbreaks. A plan would be going to Elected Members in the coming weeks. Planning was underway for activity whether it could be small outbreaks in care homes, communities or more widely. There were still many unknowns and the knowledge had changed over the last few months.

The Local Authority as a system had to respond by 29 May 2020 with its care home plan, with formal feedback expected the following week. There would be further work to do but initial feedback had been positive which officers felt should give confidence to Elected Members about what had been done with plans in place very early before many counterparts.

Multi-agency group meetings took place several times a week, including learning disability and mental health, and staff were proactively monitoring against all data to identify any trends and issues in care homes and contacting them where any issues were identified.

Pre-discharge testing at the hospital
Verification was sought on whether people were only discharged following a negative test and if there had been problems linked to this. Learning, guidance and challenges had been almost daily and care home meetings took place seven days a week in the first two months of Covid-19. Changes were made to the guidance part way through and when it stated that people had to be tested before discharge Rotherham Hospital enacted testing straight away. 20 beds were quickly commissioned in one care home to have a Covid-19 positive pathway for people who were unwell, with reference to the Mary Seacole initiative mentioned below.

One challenge was the length of time people may be asymptomatic, possibly for several days, which led to a changed approach on staffing, delivery and to work with care homes to get them to consider that pre-time before symptoms. The time frame initially was one of a three week potential virus but some patients were in critical care and having ventilation for three weeks.

Nursing homes and isolation
Members questioned the degree to which nursing homes had created internal Covid-19 wards or sections to isolate residents and protect staff and other residents. Much depended on the size and layout of the care

home and some had set up specific areas, whereas in others it was self-isolation in the person's room. Where possible "hot and cold" sites were set up and care homes had been supported and given advice on how best to do it in their own specific environment.

On staffing there had been a degree of pragmatism and staff turnover was high, and there were issues with using agency staff. Separate staffing teams had been set up in care homes (and in RMBC) to balance this off. It was difficult initially when test results were not coming back fast but Rotherham Hospital was doing them quickly and becoming more rapid.

Care for people with disabilities
Assurance was given that if anyone had care and support needs, regardless of their age or impairment, they would be assessed in the same way as before the pandemic. The reablement team were still going out and working with people, with the appropriate PPE.

Safe staffing levels in care homes
Acknowledging some of the problems with staffing, Members probed into whether regular updates on staffing levels were provided and if there had been any concerns about the safety of residents, especially in more complex cases with a higher ratio of staff to residents.

Martin Hopkins' staff were in daily, regular contact with all the care homes and the relationships and trust were there to share relevant information both ways. Care homes recognised that the Council needed to understand their staffing ratios and concerns in order to support them. Each care home had a linked member from the Commissioning Team who acted as their conduit. The team facilitated the move of a staff member from one care home with extra capacity to another that had a staffing shortage. Officers confirmed they had not yet reached a stage of being unduly concerned about staff sickness absence levels but if the trajectory at the start of the pandemic had continued then there would have been. Above 25% would lead to problems, and at times it had been close to this in some establishments, but higher numbers of staff were now back in the workplace, with absence levels therefore much lower.

In response to a question as to whether the staff to resident ratio had ever been out of guidance, it was pointed out that the Registered Manager in a care home was the legal entity regarding safe operation. Data was collected on staff and the reasons for absence, on staff who had tested positive and more recently on staff who had been tested for the virus, including in RMBC care homes. Questions would be asked of any home that had a high degree of staff absence. All contingency plans had been reviewed and approved, modelled on staffing reductions at 25%, 30% and 50%, as in RMBC at the start of the pandemic. A categoric yes or no could not be given but significant monitoring took place and contingency plans were enacted very early. Officers had also spoken with homes about not sharing agency staff because of the transmission risk.

Financial support for care homes
Members asked if this meant care homes would now say they were in a better financial situation, given the impact of a vacancy rate around 26%.

The grants had been well received but as seen in the national media provider associations and some providers had made representations about longer term funding requirements and also referenced the financial climate over the last ten years. Fee uplifts has been provided in Rotherham and officers worked within the budget available to support the establishment but divergent views on the level of funding were expected. In terms of Government pandemic monies, the Council had sought to support care homes, not only in a direct non-cashable way, but also through direct contact and support from staff and health colleagues. Support from the named GP for each care home had been appreciated by the sector. Further potential funding was not known at this stage.

Care home entry
As the trend showed later entry into care homes and shorter stays, the question was asked if this indicated successfully supporting people at home for longer. It was confirmed that part of the overall plan for Adult Care had been to reduce the number of care home residents by supporting people to live more independently at home for longer and overall numbers had fallen from 1,200 to around 800 in the last few years. Sadly, some of the change was attributable to Covid-19.

Surprisingly, across Yorkshire and Humber expected demand for social care support had been lower than anticipated until a slight recent increase. In part this was because family members who had been furloughed had been in a position to provide support at home where unable to do so before, including for domiciliary care, but that was beginning to change. Uncertainty existed regarding the trend and it would be monitored but Rotherham was no different to elsewhere in South Yorkshire.

In terms of 30% of placements being out of borough and whether this had fluctuated with the crisis, this was data from March when the update had been due originally. It had not really been collected recently with the focus elsewhere but the assumption was that the position would have shifted.

Government guidance
Members recognised that this presented a major challenge as it was announced at night and expected to be implemented from the next day with health and care partners having no prior knowledge of what would be announced. PPE guidance had been very complicated from the start in terms of understanding when to use and when not to use PPE. Some of this had been driven by distribution lines and some by still developing an understanding of transmission rates. Staff had not used repellent goggles and visors before.

Audit trail

Assurance was sought that the Council had clear timelines and data to marry up activity with Government guidance as issued or changed. Care homes had action plans and logs for older people 65+, learning disability and mental health. Every time a change was made in our approach, a clear audit trail of everything done was in place to give assurance to ourselves, Members and anyone else who might ask and to show the decision-making on changes to the approaches. Cllr Roche verified the robust and thorough audit trail and detailed information provided with sitrep and surveillance data and confirmed that everything was formally minuted to provide additional assurance on this point.

Probing further beyond RMBC data, Members asked about data on what others did and where and when the problems/issues had occurred. As it sounded very reactive to Government announcements, a follow up point was whether there had been scope to do what we thought was right for our local circumstances. Assurance was given that what was done was from a Rotherham perspective and with staff having good knowledge of our local provider market this facilitated knowing where to deploy extra resource. It was a question of interpretation of the guidance and was very evidence based. Nursing staff dedicated to care homes had been involved in all the training and the continuity and local deployment was integral to how this was managed and what was right for an individual care home.

Care home deaths

Officers were asked if they had data on deaths in local care homes over the last three months and how this compared with the number of expected deaths for the period. Originally figures reported nationally were only for hospital deaths from Covid-19 but that had changed to include all deaths. Sadly, people had potentially died from Covid-19 before much was known about it. This information was part of the Public Health data surveillance captured through the local and the South Yorkshire surveillance cells. An update could be provided at the next Health Select meeting when the Director of Public Health would be able to attend and provide a full picture and set the context of collecting different data at different times.

Community confidence

Members were concerned with regard to the challenge of instilling confidence in people if they had to go in a care home and felt fearful. This was acknowledged as a concern for Adult Social Care, whether for respite or long term support. A South Yorkshire-wide communications plan for care homes was under development as it was the same for all local authorities to help people understand that care homes were as safe as they could make them. PPE supplies were better now and wearing masks had become more of the norm for staff. Another concern was in the case of carer breakdown.

Care Home of the future and integration of health and social care
Attention was drawn to the Mary Seacole initiative for hospitals for rehabilitation and recovery which echoed the past in terms of convalescent hospitals and could be similar to a small community hospital. Recovery time from Covid-19 was longer than anticipated but it was not yet clear if there would be one in South Yorkshire or Rotherham. People did recover better at home in their own environment and it was the intention that people returned home once they recovered.

A video from NHSE through the Care Home group showed the recovery of people from Covid-19. It was a good message but one flaw to report back was that people giving care from less than 2 metres distance were not wearing PPE.

Members were positive about the approach to quality but commented that it was dependent upon people's willingness to give their opinions. This prompted a further question on capturing the service user voice in care homes, including in the care home of the future, as this had been an issue explored at the previous care home update.

Business as usual was not taking place and no Care Quality Commission (CQC) inspections were being undertaken. As the regulator, the CQC was the body to test out the voice of the user and knew what they would expect to see and hear in care homes, with a framework for how would undertake their inspection regime. Martin Hopkins' team would normally also go out and talk to people about how it feels and moving forward would have to look at how that was captured in a different way. Multi-disciplinary input provided a good sense from residents of what was happening and staff learning too was a part.

The new Healthwatch contract commenced from 1 April 2020 at what was obviously a difficult time but had done well using digital resources to make connections with people. More could be done to develop capturing the resident voice and feeding back on quality and the new contract would help to strengthen what had been happening before.

Under the Quality Matters agenda the "I/We" statements would inform what good looked like and the new contract for advocacy would support people to be heard, including those living in care homes. Surgeries and one-to-one meetings would take place, using the voluntary and community sector to have that contact. For issues in particular care homes letters had gone out and people have been reassured that the Council retained an oversight during this period of Covid-19 lockdown. Officers were asking care homes about their preparations for when lockdown was lifted and measures to recover and restore so relatives would be able to visit.

CQC
Having touched on CQC earlier, more detail was requested regarding what was happening with the CQC and if extra assurance was needed

from our side. Officers had met with Julia Gordon, CQC inspection manager for the area and discussed any pertinent issues in relation to any individual care home and the sitrep data. The Contract Compliance team also had good links with the CQC inspectors. CQC were putting in place an emergency support framework for contact with care homes and would undertake a mini assessment of the situation which Contract Compliance officers could view and any issues could be dealt with through this link. Dialogue took place with colleagues in district nursing and the hospice services who were regularly going into care homes, so a good discussion network was in place providing oversight.

Quality Board

The Chair asked how the work of the Quality Board been progressing, especially Quality Matters and the Leadership Academy, prior to the pandemic. The Quality Board membership comprised a range of partners and was a good forum for sharing intelligence. Initial discussion had focused more at a micro level around individual establishments but was moving forward towards becoming more strategic. The aspirations for implementing Quality Matters remained but it was in its infancy and had not progressed as quickly due to the pandemic.

Quality Matters was more of a national or regional approach with CQC Skills for Care and Think Local Act Personal (TLAP). Common data sets were being looked at for monitoring across services and meeting the reporting requirements of the various bodies. Ideas for improvements in monitoring quality had been put forward, which included leadership. Data capture and collation systems had also been explored, including systems available commercially. The advocacy service was involved in monitoring quality and improved relationships had developed across health partners in terms of their work on enhanced health in care homes.

Registered Manager turnover

Members highlighted the importance of having good managers in post in these difficult times and inquired if the longstanding issue of Registered Manager turnover had been addressed. The Leadership Academy/Registered Managers had been discussed with the Learning and Development team and would be picked up when things were stepped down in relation to Covid-19.

Intermediate care/reablement

As this was a key element in service transformation the question was raised as to whether it would be able to progress alongside the work in care homes with what was happening regarding staffing and capacity with Covid-19. The work had been paused for now with staff doing different things but later in June or in July the integrated place plan would be reviewed and priorities redefined for the remainder of this year and ones to carry forward to next, so a further update could follow in August.

Officers were thanked for their good, informative presentation, comprehensive answers and attendance at the virtual meeting.

Resolved:

1) To note the information provided in the presentation.

2) To receive a detailed presentation of the surveillance data at a future meeting.

3) To have a further update, to include intermediate care and reablement, after August.

4) That HSC record its thanks formally to staff for their work and dedication during the Covid-19 pandemic.

78. LOCAL AUTHORITY DECLARATION ON HEALTHY WEIGHT

The Cabinet Member introduced this item by talking about the change in emphasis around the significant problem of obesity in Rotherham. Previous focus had been on Tier 3 and when people had already become obese, whereas now the attention was on earlier interventions and joined up thinking across all services, linked to the wider determinants of health. The plan was a living document and any suggestions from Health Select could be incorporated.

Kate Green from Public Health confirmed that the Council had adopted and signed the declaration in January 2020. Not all actions had been carried out but it set out a clear statement of intent, including to influence policy, service delivery and partners to work towards healthy weight being the norm in Rotherham. Work had paused due to Covid-19 and the original timeline would be reviewed but it would form part of the recovery. The table in the appendix would be updated as the original commitments had been reviewed and amended.

Robin Ireland from Food Active delivered the following presentation.

- The impact of obesity
- Statistics showing prevalence of obesity linked to deprivation and excess weight among children
- The background to the Healthy Weight Declaration (HWD)
- The 14 Commitments
- Examples from elsewhere – Blackpool/Cheshire West and Chester
- The Partner Pledge (Cheshire West and Chester Council) - contains a set of commitments which organisations pledge to work towards to impact on the health and wellbeing of their staff, clients and the wider community and aims to support the actions of the Council's Declaration.
- The NHS Declaration - provides NHS organisations with an opportunity to state their commitment to supporting patients and staff to achieve a healthy weight

Covid – 19 and Healthy Weight

- WHO has highlighted non-communicable diseases (NCDs) as a risk factor for becoming seriously ill with COVID-19
- Obesity may be a risk factor for developing more severe Covid-19 complications, requiring hospitalisation and critical care.
- Obesity is commonly associated with decreased immune function = greater risk
- Emerging evidence suggests men with obesity are more at risk
- As obesity class increases, the risk of mortality increases. More than double with BMI of over 40 – independent of co-morbidities.
- People with obesity may be of lower socioeconomic status, race/ethnicity, poorer diets etc – implications on metabolic affects.
- Affects access to/availability of treatment for obesity – particularly those who have experienced weight stigma and may feel a sense of guilt for using NHS resources.

Food Active – a North West Response

- A collaborative programme launched by the North West Directors of Public Health in November 2013 to tackle increasing levels of obesity.
- Focusing on population-level interventions which take steps to address the social, environmental, economic and legislative factors that affect people's ability to change their behaviour.
- Less victim blaming, more environment framing

What are the Local Authority Declarations for?

- **Strategic leadership**: creates an opportunity for senior officers and politicians to affirm their commitment to an issue
- **Local awareness**: shines a light on importance of key activities internally and externally
- **Driving activity**: a tool for staff to use to create opportunities for local working

Review and Refresh of the HWD

The commitments

We consulted with current adoptees of the HWD and ran a small task and finish group.

- the standard commitments have increased in number from 14 to 16
- a small number of new commitments have been introduced - covering climate change, place-based approaches, partnerships, and a wider whole-systems approach to obesity
- some of the commitments have been amalgamated
- revision to some of the wording
- the commitments are now listed under key themes

Supporting materials

The revised HWD is due to be launched in early July and will be supported by a range of materials and resources including:

- Updated evidence briefing that underpins the commitments – this reflects the outputs of the consultation in a little more detail,

specifically linking through to the current policy context and new evidence.
- Updated support pack and Monitoring & Evaluation (M&E) Framework
- New Audit Tool (lighter touch M&E tool)
- HWD communications guidance (with specific reference to weight stigma)
- Briefings from cross-council communication
- A series of posters, infographics and social media assets
- New branding (no more scales)

What is in the LA gift
- Planning and licencing
- Activities/businesses on local authority premises
- Leading by example, setting the tone
- Influencing partners, e.g. via the Health and Wellbeing Board
- Advocacy
- Campaigns

Members welcomed this positive initiative and asked whether any metrics had been developed in the North West to measure the effectiveness of this type of initiative or if Food Active could suggest any suitable metrics.

A monitoring and evaluation system was under development with the intention of looking at the different parts of the commitments and which worked well to enable sharing and comparison between local authorities. Some quick wins were possible but other issues such as vending machines were proving to be difficult to tackle. Food Active also worked with Public Health England and linked in with their work. The overarching aim was to reduce obesity, which would take a while to turn around, and to see changes in the results of the National Child Measurement Programme.

Local evaluation would take place but it was difficult to capture and would take time to come through. The intention would be to use the Food Active tool in Rotherham and as the action plan was developed to consider how that could be monitored to gauge success. Comparison with other areas would be undertaken, together with a review of good practice from local authorities who had already adopted the declaration.

It was clarified that the information pack would not include dietary advice or diet sheets as the emphasis was on policies and what the Council could put in place before people became overweight. The focus was directed towards work at population level rather than individual level. Nevertheless, the declaration would form part of a much wider plan around healthy weight in Rotherham. The other facet would be the weight management services through Get Healthy Rotherham who provided support and advice for people to lose weight in terms of healthy eating and exercise. Both aspects were necessary, working together and Get Healthy Rotherham was up and running providing advice by telephone

and working mainly on a one-to-one basis.

Commitment 1 was considered a laudable aim to encourage healthier options and portion sizes but Members felt that in Rotherham this should be about providing people with options rather than compulsion. Particularly given the previous experience and media coverage of a school that changed its food offer radically in a move that proved very unpopular with students and their families.

The problem was that most of the widely promoted options were the unhealthy ones. Another approach would be more by stealth though removing some of the unhealthy options or introducing smaller portions. Changes had to be managed carefully and discussed with people.

Cllr Roche confirmed that a previous attempt to impose restrictions on new takeaways opening near schools had been overturned but through work with Planning it was hoped to be more successful the second time. Other councils had had some success in this area and learning from their approaches would be helpful.

Members highlighted that knowing how to present things to children and families was important. With this in mind they inquired if there been progress in introducing this type of planning into the system overall rather than actions by individual schools i.e. to infiltrate them gradually and respectfully.

It was more difficult to influence schools, especially now with academies but dialogue was taking place with education staff regarding engagement with schools. A number of schools did buy into the School Improvement Service and that was a potential means of engaging about what was on offer. The Schools Catering Service had already revisited its offer, including an audit of desserts which led to the removal of a number with a high sugar content. Secondary schools were more difficult and it was also a question of engaging with young people to see what options they would like. At a session with Rotherham Youth Cabinet young people said they would like healthier options and asked about options available for students who had free school meals or who were on a limited budget who might go for the most filling options rather than the healthiest choices.

Experience of working with populations that might have major cultural differences, with some possibly experiencing greater disadvantages, was highlighted. These were acknowledged as issues to pick up and work on with schools and where Members could feed in any thoughts or ideas.

Regarding takeaways, Members inquired as to how receptive local businesses might be to making the suggested changes, especially in the current economic climate. This workstream had not really started fully but there were thoughts of linking in with Environmental Health, potentially when they inspected fast food premises. It was about offering healthier alternatives, considering portion sizes, especially when aimed at children,

and how food was cooked, not removing everything and would be on a voluntary basis. At this stage it was difficult to gauge how receptive they might be to change and it would be a challenge.

Robin Ireland confirmed that it could be done, with good practice to learn from but needed resources. Salt content was a major concern in much takeaway food and sometimes it was a question of training or advice for businesses on how things could be done differently and more healthily, as fast food did not have to be unhealthy. Blackburn with Darwen Council were engaged in a Trailblazer project working with their takeaways and this was not purely about removal or reduction of unhealthy options but also promotion of healthy ones. Blackpool had a healthier takeaways scheme which was promoted on the Council website.

With regard to Commitment 10 – supporting the health and wellbeing of LA staff - Members wondered whether this could include more of the therapeutic and mental health side as well as diet and exercise as it presented a good opportunity for significant cultural change.

Some activity on small things had taken place, such as encouraging people to use the stairs but scope existed to do more. Two officers in Public Health led on the work and more could be done potentially with Human Resources on policy, procedures and culture to encourage healthier choices and how to make them easier to access. It was also a question of how to support staff working at home to look after both their physical and mental health. Information and resources were available on the intranet and internet and staff were signposted to these. Any other suggestions from Members were welcomed.

It was recognised that various good initiatives were included but that some issues needed to be addressed more at the national level. Officers were asked about garnering other local authorities nearby to influence and wield pressure nationally.

Food Active was a member of the Obesity Health Alliance, therefore by working with them Rotherham added to how Food Active contributed at a wider level. Issues such as promotion of unhealthy products during the pandemic could only be dealt with nationally and Food Active felt they should advocate strongly against junk food marketing. Learning and links across Yorkshire and Humber, including all the Directors of Public Health, and mutual support from Councils all contributed towards this.

Regarding linking this work to the Neighbourhood Strategy and ward plans, this was viewed as something to work on, including consideration of how to engage communities and ask them what they would like to see the Council doing to support them to make these healthier choices. Most ward plans had identified health as an issue so another area where support from Members would be crucial.

Officers were thanked for their interesting and informative presentation.

Resolved:-

1) To note the information provided about the declaration and that the Council formally adopted this on 20 January 2020.

2) To schedule the updated plan to come back to the Select Commission at an appropriate time.

79. INITIAL WORK PROGRAMME ITEMS FOR 2020-21

Janet Spurling, Governance Advisor introduced an initial draft of the Health Select Commission's work programme for 2020-21 for discussion. The work programme needed to address key policy and performance agendas, with a clear emphasis on adding value, leading to improved outcomes for the people of Rotherham. It should also be focused on issues that Scrutiny would be able to influence.

Central to the work programme would be transformation of health and social care services, a longstanding and continuing focus for Scrutiny over several years. NHS provider performance would be scrutinised through the Quality Reports and updates in respect of particular service areas. Adult Care and Public Health Outcome Frameworks enabled progress in Rotherham to be gauged year on year and benchmarked nationally and regionally. Addressing health inequalities in the borough, through health and social care strategies and plans, and by looking at the wider determinants of health, was an issue that the Select Commission had frequently highlighted and would continue to explore. In addition, the work programme would have to take account of the response to and recovery from the Covid-19 pandemic.

The initial work programme in Appendix 1 reflected agenda items on which the Health Select Commission had requested progress reports for 2020-21 in order to scrutinise the impact of recent service or policy changes, such as Ophthalmology Services. It also included items delegated from the Overview and Scrutiny Management Board for monitoring, such as the impact of implementation of the new Home Care and Support Services Contract.

More direct public involvement in scrutiny work was acknowledged as an area to develop further and HSC expected to see qualitative evidence of the impact of service changes and transformation, in addition to the quantitative data and metrics.

Key priorities in the work programme would include:

- Intermediate Care and Reablement
- Depression and Mental Health
- Support for Carers
- Covid-19 Response and Recovery
- Respiratory Services

- Residential and Nursing Care Homes

It was noted that membership of the Quality Sub-groups for each of the NHS Trust Providers would be based on the previous year's membership to retain the knowledge developed by Members of those health partners' services.

Following discussion, it was agreed to undertake a spotlight review of issues arising from the impact of Covid-19 on adult and older people's mental health later in the year, linking in with the preliminary information on prevalence of depression scrutinised the previous year.

The Chair proposed that the meeting in July should be a standard formal meeting if items could be brought forward, with scrutiny of issues arising from the Covid-19 pandemic considered in a separate in-depth workshop session, with the outcomes reported back at the meeting in September.

Resolved:-

1) That the initial work programme be noted with the priorities agreed for 2020-21 as discussed.

2) That the July meeting be a formal meeting to include agenda items that could be brought forward.

3) That a workshop session be arranged in July for scrutiny of issues arising from the Covid-19 pandemic.

80. BRIEFING - FOLLOW UP TO SCRUTINY OF ROTHERHAM LONELINESS AND SUICIDE PREVENTION AND SELF HARM ACTION PLANS

The Chair announced this item would be deferred until the next meeting.

81. BRIEFING - INFORMATION FOR HEALTH SELECT COMMISSION FROM PREVIOUS SCRUTINY

The Chair announced this item would be deferred until the next meeting.

82. URGENT BUSINESS

The Chair advised that there were no matters of urgent business to discuss at the meeting.

83. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission take place on Thursday 9 July 2020, commencing at 2.00 p.m. as a virtual meeting.