HEALTH SELECT COMMISSION

Date and Time :- **Thursday, 3 September 2020 at 2.00 p.m.**

Venue:- **Virtual Meeting**

Membership:- **Councillors Albiston, Andrews, Bird, Brookes, Cooksey, R. Elliott, Ellis, Evans, Jarvis, Keenan (Chair), John Turner, Vjestica, Walsh, Williams, Wilson and Yasseen)**

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

This meeting will be webcast live and will be available to view via the Council's website. The items which will be discussed are described on the agenda below and there are reports attached which give more details**.**

Rotherham Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair or Governance Advisor of their intentions prior to the meeting.

AGENDA

1. Apologies for Absence

To receive the apologies of any Member who is unable to attend the meeting.

2. Minutes of the previous meeting held on 9 July 2020 (Pages 1 - 13)

To consider and approve the minutes of the previous meeting held on 9 July 2020, as a true and correct record of the proceedings.

3. Declarations of Interest

To receive declarations of interest from Members in respect of items listed on the agenda.

4. Questions from members of the public and the press

To receive questions relating to items of business on the agenda from members of the public or press who are present at the meeting.

5. Exclusion of the Press and Public

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

6. Marmot Review - 10 Years On (Pages 14 - 82)

To consider a report exploring the progress made 10 years on from the Marmot review in respect of addressing health inequalities.

7. Carers Framework for the Future 2020-21 (Pages 83 - 108)

To consider a report providing a progress update in respect of the Carers Programme.

8. Healthwatch Update (Pages 109 - 110)

To receive an update briefing for information from Healthwatch.

9. Update from The Rotherham NHS Foundation Trust

To receive a verbal update from The Rotherham NHS Foundation Trust with respect to post Covid-19 activities.

10. Outcomes of Workshop on Covid-19 - Response and Recovery (16 July 2020) (Pages 111 - 118)

To consider a briefing report providing an overview of the recent scrutiny workshop on Covid-19 Response and Recovery that was held on 16 July 2020.

11. Urgent Business

To consider any item(s) which the Chair is of the opinion should be considered as a matter of urgency.

12. Date and time of next meeting

The next virtual meeting of the Health Select Commission will be held on Thursday, 22 October 2020, commencing at 2 pm.

Sharon Kemp.

SHARON KEMP,
Chief Executive.

HEALTH SELECT COMMISSION
Thursday, 9th July, 2020

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

Apologies for absence:- Apologies were received from Councillor John Turner.

Councillor Cusworth, Chair of Improving Lives Select Commission and Councillor Roche, Cabinet Member for Adult Social Care and Health were in attendance at the invitation of the Chair.

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

84. DECLARATIONS OF INTEREST

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

85. 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.

86. 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.

87. MINUTES OF THE PREVIOUS MEETING HELD ON 4 JUNE 2020

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 4 June 2020.

Resolved:- That the minutes of the previous meeting held on 4 June 2020 be agreed as a correct record.

88. COMMUNICATIONS

Update on Covid-19 Response and Recovery – Adult Social Care

The Strategic Director of Adult Care, Housing and Public Health provided a summary of key issues and developments in relation to the pandemic. The present position fell between response and recovery and the next month would be important to see the effects of the easements introduced by the Government on the community and the most vulnerable.

Face-to-face interactions were increasing with precautions taken through social distancing and use of Personal Protective Equipment (PPE) where appropriate but work was done remotely whenever possible, often at people's own request. In terms of the dip in demand seen at the beginning of the pandemic, this was now going back up. Some readmissions to care homes had occurred but not a significant increase, which was positive and would continue to be monitored. Carer breakdown continued to be a concern and officers were working on this at sub-regional level.

Guidance was anticipated regarding provision of day care opportunities, whether in-house or externally provided. Clarification was also being sought on respite, both in general and with regard to testing.

The process had changed again for re-testing in care homes and would be every 28 days for any person in a 65+ care home and weekly for staff. Any concerns regarding a residential care home could see testing undertaken weekly, which in turn raised concerns about provider ability to manage this. This was a national initiative through the new Care Quality Commission (CQC) portal, whereas before local stratification in terms of risk had been carried out and Rotherham would be closely monitoring this. This was a good example of still being in a state of responding, as matters were not yet stable in terms of the expectations for care homes. It was clarified that testing in care homes was paid for by health through the NHS and the Director of Public Health would also have some access to emergency testing although the detail was awaited.

The Government had formed a Social Care Taskforce comprising a wide range of organisations to have a full oversight of the situation in adult social care.

The Council was waiting for the re-testing regime to be extended to learning disability, mental health and supported living but there was an issue over capacity. If continual testing was undertaken as some people were asymptomatic then in all likelihood more positive test results would ensue.

Recovery was being undertaken slowly together with partners in terms of stepping services back up in a planned way. Some of the new ways of working would be retained as people had liked them and there was collective practice within the directorate to consider all the learning and ways to be agile, including in the contact centre. Various compliments had been received. The service worked closely with the Community Hub which had led to a lot of requests coming through, not just from those shielding, but regarding the food banks. Close monitoring would be needed should a new cohort of people come into adult social care because of the psychological impact of Covid-19; for example, on people's daily living, motivation and skills, particularly in terms of the reablement service. As the hospital returned to business as normal there would be an impact on adult care with the flow of patients out of hospital

and Association of Directors of Social Services (ADASS) had produced helpful guidance that would be considered from the Rotherham perspective. The number of Delayed Transfers of Care (DTOC) had been minimal during the pandemic, as the three-hour turnaround had worked very well and would be looked at going forward. Positively most people had gone home from hospital rather than to a residential or nursing home, with the right level of support.

Cllr Roche, Cabinet Member for Adult Social Care and Health confirmed that work was taking place to try and get day opportunities back but the lack of clear guidance regarding day opportunities and respite around the necessary precautions was unhelpful. For respite, progress was reported regarding the new facility in Conway Crescent at Herringthorpe. Registration had been obtained, virtual tours would be taking place of the premises to enable people to see what it would be like once operational and autism-friendly validation had been achieved following a review by a West Midlands autism organisation.

Members asked about readiness for a second wave in the autumn, especially with the potential for flu and additional winter pressures. Winter planning usually commenced in June and the debrief from last winter had taken place two weeks earlier. The Integrated Care System had held a stress testing event the previous week and Gold Place Group was planning for winter and such an eventuality in addition to the recovery conversation. The project to change from seven to three reablement/intermediate care pathways had been paused but would resume and would be important for the winter in terms of capacity. Learning from the past was important about what would be done differently next time with the benefit of hindsight as well as scenario planning. Emergency planning work was underway with the wider health and social care system and across the Council regarding a potential significant outbreak in the community which would cut across services and schools so potential staff deployment was looked at.

Staff had not gone into Riverside House in full teams as a precautionary measure and this would continue until a vaccine was available. For example, the six locality teams would be one in and one out for each. Reablement had initially been ok but then dipped as staff were off, similarly with hospital staff, so there was learning in how to manage such situations and staff had moved between services in an agile way. How to bring staff back in who had been shielding needed to be considered and staff anxiety was still very high, so there was ongoing work to address this. The pandemic had affected and touched us all, and there was a challenge to maintain staff morale and buoyancy, which was equally important as the system preparation for another surge. A recognition event was being planned for the whole service with the Communications team entitled “People Caring for People”.

South Yorkshire, Derbyshire and Nottinghamshire Joint Health Overview and Scrutiny Committee

It was confirmed that the next meeting would be held on 28 July 2020. One of the items on the agenda would be in regard of Children's Surgery, which NHS colleagues had indicated they wished to discuss with the Joint Committee. The link to the agenda papers would be shared with Health Select Commission (HSC) members who were requested to email the Chair and Governance Advisor with any issues or questions they wished to be raised at the meeting.

89. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

After a brief introduction by Cllr Roche, the Director of Public Health delivered a short presentation to introduce the Public Health Annual Report 2019 - The First 1001 Days.

Annual Report of the Director of Public Health (DPH)

- Statutory duty to write independent report on health and wellbeing of local population
- The annual report continues to be one of the ways in which DPH can highlight specific issues that will improve the health and wellbeing of the
  population of Rotherham
- 2018 previous Annual Report focused on 'What keeps us happy and well in Rotherham?'

Progress on recommendations from last year (2018)

1) Re-launch of Joint Strategic Needs Assessment (JSNA) – Community insight to supplement the data was impacted by Covid-19 but to note the importance of work on loneliness and isolation and focus on mental health and mental ill health. Increased focus on the local economic plan in readiness for jobs coming back and links to numbers 5 and 6.
2) Raising awareness/training mental health – positive impact of men's small grants programme.
3) Workforce development and training as part of the Thriving Neighbourhoods Strategy – Getting closer to communities and more assessment based approach
4) Support the expansion of the offer of social prescribing
5) All partners to continue to support the 'Working Win'
6) Rotherham launch of the South Yorkshire BeWell@Work Award
7) Interactive artwork at the Rotherham Show

Under Making Every Contact Count 362 people have been trained. With Five Ways to Wellbeing mental health, alcohol awareness and sleep awareness courses had all run, more health champions had been recruited and over 100 people trained in dementia awareness. 15 schools were involved.

2019 Annual Report - Focus of Report

- The First 1001 Days – A legacy for life
- Key Influencers on the First 1001 Days
- Preparing for Parenthood
- Pregnancy
- The First 2 Years of Life, including showcasing what we are doing in Rotherham

The First 1001 Days – Window of Opportunity

- Between conception and a child's second birthday
- Critical to life-long health and wellbeing
- Not every baby has the same opportunities in Rotherham
- Impact of parental behaviours
- Wider societal influences e.g. living in areas with polluted air

Recommendations
In Rotherham we will develop, jointly with all stakeholders and partners, a clear and ambitious plan to improve support for children, parents and families in the first 1001 days; key actions are outlined below.

What we can do together
Work in a partnership with our services to improve the health and wellbeing of families and their young children. In particular have a focus on:

1. Reduction in Smoking in Pregnancy rates
2. Improve diet and nutrition
3. Promote physical activity
4. Increase breastfeeding prevalence
5. Increase Ages and Stages Questionnaire -3
6. Improve air pollution
7. Support offered by Public Health Commissioned Services

The First 1001 Days, between conception and a child's second birthday, was critical to life-long health and wellbeing as it was difficult to reverse negative consequences beyond 1001 days. From the science it was known that not every baby born in Rotherham had the same opportunities as their peers for a healthy and fulfilled life, due to several parental behaviours such as smoking and drinking alcohol during pregnancy, not eating a balanced diet and taking little exercise. The well-being of the family could be influenced by wider determinants of health, including socio-economic, environment, income and inequality. Early public investment in the first 1001 days set the foundation for greater societal return on such investment, helped to reduce inequalities and should lessen the requirement for expensive interventions later in life.

Cllr Roche emphasised the JSNA was more interactive and interesting than previous iterations and that no major decision making should take place without taking account of the JSNA. Information would also feed through into ward profiles with LGA support as on the previous ones.

Members asked about the effects of living in cold houses on babies and their respiratory systems, as years ago no houses had central heating or indoor bathrooms. Not everyone living in a cold home would have respiratory problems and equally a home lacking in ventilation or that was too hot could cause problems. Dampness increased the risk of asthma and when it was cold the cilia in people's noses did not move so well which could affect the respiratory system. In damp/cold houses people tended to congregate in one room, which could have other consequences such as impacting on young people trying to do their homework. Reference was made to the Hotspots initiative which included trying to encourage people to improve their home insulation.

Assurance was given that the report and recommendations included disabled children and disabled mothers and that within the concept of universal proportionalism, there would be tailored support.

Trends for smoking and drinking showed an upward trajectory and Members questioned the likely impacts on babies, young people and parents. The advice was no alcohol in pregnancy to minimise risk as it soon passed through the placenta to the baby and thus impact on development. Women needed to have as healthy a pregnancy as possible and to reduce risks to the baby.

Meeting the target for smoking in pregnancy had been a struggle but this was one of a few that had improved during Covid-19. There was some evidence available on the impact of e-cigarettes and pregnancy but e-cigarettes were considered less harmful than other cigarettes due to the other harmful chemicals (4000+) in the latter besides the nicotine.

With regard to substance misuse, Members highlighted the proliferation of discarded nitrous oxide capsules during lockdown for the pandemic. It was agreed to respond to these concerns through a report to a future meeting.

The breastfeeding buddies initiative to encourage mums was viewed positively but Rotherham still had comparatively low numbers. Members questioned what more could be done to increase the number of women breastfeeding up to six months as recommended by the World Health Organisation. Numbers had increased but could be improved and work continued with Rotherham Hospital who were accredited under the Unicef breastfeeding friendly scheme and were going for an additional award. Rotherham sought to be a breastfeeding friendly town and to work with other towns and communities to even reach borough-wide, which was welcomed by HSC. Breastfeeding needed to be normalised and seen as Rotherham had generations in families who had never breast fed. Work with midwives continued to encourage breastfeeding whilst recognising that for many women it was difficult. Another issue was that many women returned early to work and although continuing to breast feed could be managed it was not easy.

Concerns were raised as to whether companies were still permitted to promote formula products and give free samples, including the meals in jars which were not as good as home prepared food. This would be doublechecked as the understanding was that sponsorship of leaflets or training had ceased.

Questions were asked about the ability to influence the growing trajectory of child poverty and what fell within parental and local authority control as opposed to national economic policy, plus how to exert influence at societal level. Child poverty should be addressed locally by taking advantage of the Sheffield City Region, such as grant funding, to tackle family poverty and societal issues. Challenge and Member support were still needed through Thriving Neighbourhoods and at community level. Universal proportionalism would be key.

Members requested statistics regarding the Healthy Foundations accreditation scheme for early years settings on the numbers who had achieved or were working towards each level. This data would be obtained from Children and Young People's Services. It was queried that health and safety only featured at gold level in the scheme rather than being included at the start. This would be followed up to check that it was implicit not just implied.

With the move to a whole family approach from SureStart, Members queried if this had resulted in better engagement from birth. Under SureStart certain communities of special need had been targeted but things had shifted and engagement as a whole had improved. Children's centres had really helped support the overall Public Health agenda – stopping smoking, promoting breastfeeding, weaning and bonding – and were a useful resource for prevention.

The question was asked as to whether the report was challenging enough and critical enough to the Council and all partners on the steps to tackle health inequalities. The slant of the report had been from an enabling rather than a demanding stance.

With greater understanding of the impact of Adverse Childhood Experiences (ACE), Members probed how this would now go forward into actions and stressed the need to tackle health inequalities and to push the Public Health agenda even more in light of Covid-19. Working with other directorates on the report had raised this up the agenda, certainly much more with CYPS now. There was a challenge to recognise them all individually and earlier, a need for awareness raising and then to see this reflected in commissioning. Parenting courses would be a key element and follow up, using all the means available to services to support people. Recommissioning of the 0-19 service would see it embedded in there for all community support in the multi-agency approach.

Cllr Roche referred to a recent seminar in which Marmot referred to the lost last ten years and would share the seminar slides. The Health and

Wellbeing Board would refocus on the Marmot principles as part of the recovery from Covid-19 and the refresh of the Health and Wellbeing Strategy would take account of the DPH annual report. ACEs needed to be a fundamental part as they represented the sharp end of not getting things right.

Cllr Cusworth drew attention to the connection between food poverty and child/family poverty and confirmed that the Improving Lives Select Commission were working on the issue of holiday hunger. Free school meals had been extended through the summer holidays. Key issues were how this was managed as it was fragmented at present and increased food bank reliance in economically difficult times. Updates could be shared with HSC.

Members sought greater assurance that in terms of the refresh of the JSNA, it would now act more as a driver to inform service commissioning, based on needs but also reflecting our assets, than the previous version. In addition, with a move to more sub-regional partnership working HSC asked if councils and partners taking account of and shared their JSNAs. It was more of an asset not a deficit model and all partners should take account of it to influence commissioning. One of the reasons for involving more agencies in its development had been to make it more meaningful and relevant for them. It would also inform the ward plans.

Housing was mentioned in the report but not covered in the seven areas of what we can do together but HSC's expectation was that those links were present and would continue, including with the Selective Licensing initiatives. Housing was a vital element within the Marmot principles and part of the holistic approach. It would be included in the refresh of the Health and Wellbeing Strategy. Aim 4 in the strategy was the wide reaching one and more services were now involved with the Health and Wellbeing Board, not just Public Health but every directorate and it needed that wider working to enable progress. There was also the Rotherham Place Plan.

The Chair inquired about work to be done with parents to engender good oral health when children first start cutting their teeth. Rotherham still had an oral health team that worked in children's centres and schools on tooth brushing clubs as well as awareness raising with parents. Dentists look for risks and services were exploring possibilities for further work, even possibly water fluoridation.

The DPH was thanked for presenting her report.

Resolved:-

1) That the Health Select Commission work jointly with all stakeholders and partners, to develop a clear and ambitious plan to improve support for children, parents and families in the first 1001 days, with particular support for the seven areas highlighted:

1. Reduction in Smoking in Pregnancy rates
2. Improve diet and nutrition
3. Promote physical activity
4. Increase breastfeeding prevalence
5. Increase Ages and Stages Questionnaire -3
6. Improve air pollution
7. Referrals to Public Health Commissioned Services, Get Healthy Rotherham, Drug and Alcohol Services, as well as supporting Early Years and 0-19 Integrated PH Nursing

2) That Public Health submit a briefing paper on the use of nitrous oxide and the Council's approach and policy in relation to its misuse.

90. INTRODUCTION TO NEW HEALTHWATCH

The Chair welcomed Lesley Cooper, manager of the new Healthwatch service to her first Health Select Commission meeting.

Healthwatch England (HWE) was established under the Health and Social Care Act 2012 and every local authority was obliged to commission a local Healthwatch service. The main powers and duties of the local Healthwatch were outlined for Members:

- To represent the voice of local people in health and social care matters.
- To signpost people to information on health and social care matters.
- To provide information about what people can do when things go wrong with their treatment/care.
- A have a seat on the Health and Wellbeing Board to ensure residents are involved in local decision making.
- Powers to request information from commissioners
- Powers to enter health and social care premises.
- To feed back information locally to councils and partners and nationally to Healthwatch England

The new contract commenced from 1 April 2020 when Healthwatch moved over to the Citizens' Advice Bureau. The transition happened smoothly with no loss of service due to advance planning, however the service had been affected by the pandemic in terms of delays in staff recruitment and forming the steering group. The independent complaints advocacy work was no longer part of Healthwatch's remit.

Healthwatch employed multiple means of gathering information from residents:

- Speaking to local people at community events (pre Covid-19)
- Surveys, social media and online forums
- Getting involved in national campaigns via Healthwatch England
- Healthwatch Hour (post Covid-19) – Question and Answer session

- Working in partnership with other third sector organisations, service providers and commissioners

Activity to date in the first quarter of the year was highlighted:

- Responded to residents' concerns via email and telephone (69 clients to date)
- Provided up to date information on our social media pages and website
- Kept in regular contact with commissioners and service providers
- Ran an online survey regarding Covid-19 (175 responses in 10 days)
- Fed back information to Healthwatch England on cancer services, maternity and mental health.
- Taken up our seat on the Health and Wellbeing Board.
- Appointed two new volunteers for the Steering Group, (five potential members to be interviewed next week)
- Made new contacts with established groups in Rotherham

During quarter two Healthwatch hoped to make progress and achieve the following:

- Have a Steering Group in place with work plan and priorities agreed
- Successfully recruit an Engagement Officer and Research & Campaigns Officer.
- Set up a quarterly newsletter.
- Expand the Healthwatch Hour idea to incorporate an online chat session
- Work with third sector partners to arrange some form of engagement with seldom heard groups.
- Continue to attend strategic meetings and build relationships with service providers and commissioners.
- Work with South Yorkshire & Bassetlaw Integrated Care System.
- Look at opportunities that arise from the post Covid recovery.

Future plans encompassed the #BecauseWeAllCare campaign (joint work with HWE and the CQC); outreach sessions (virtually in the first instance); post boxes for comments in all GP practices/outpatient areas and Healthwatch Hour/Healthwatch Huddles. Hospital discharges would be one of the first issues in the eight to ten month campaign.

The power to enter and view health and social care premises had not really been utilised before but would be in the future. Volunteers would run this part of the service with visits to three or four care homes each quarter and reports back to RMBC, the Clinical Commissioning Group and Public Health.

Members asked how the service connected with GPs, dentists and hospital patient groups. With libraries and community centres due to re-open they also inquired whether that would present an opportunity to promote the service and as well as gathering information including in

relation to the pandemic. Confirmation was given that once staff were in place engagement with the community would be a key aspect, including talks to community groups about what Healthwatch could offer. Newsletters, case studies and good news stories would all be used to show how Healthwatch had been able to help people.

The Chair thanked Lesley for her informative overview of the new service and looked forward to closer working in the future. It was also confirmed that Healthwatch would provide a short update on key activity and issues at each HSC meeting.

91. HEALTH SELECT COMMISSION WORK PROGRAMME 2020-21

Janet Spurling, Governance Advisor, introduced the final draft of the Health Select Commission's work programme for 2020-21 for approval. The programme reflected agenda items prioritised by HSC for 2020-21; together with issues on which the Select Commission had requested progress reports in order to scrutinise the impact of service or policy changes; plus other items delegated from the Overview and Scrutiny Management Board for monitoring.

Overall priorities for the year included:

- Covid-19 response and recovery
- Adult Social Care – development and performance
- Depression and Mental Health – all ages
- Healthy Weight
- Carers
- Health Inequalities

The programme would also take account of the response to and recovery from the Covid-19 pandemic, following the scrutiny of Care Homes in June. This would include not only the immediate response to the pandemic and any lessons learned across services and partners but also broader implications for services and for patients and service users. As many services were being delivered very differently as a result of the pandemic, it would also present an opportunity to reconsider how things might be done in the future, rather than an automatic resumption to former ways.

Appendix 2 set out the proposed membership for the Quality Subgroups for Rotherham NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust, based on last year's membership, for approval.

Members were requested to express an interest to be involved in the sub-group for Yorkshire Ambulance Service. This did not meet last year, although a broader discussion with HSC took place on a number of concerns raised with the Trust, which prompted further work for 2020-21.

HSC Members were also asked to confirm if they wished to be part of the

sub-group to scrutinise Adult Social Care Outcomes Framework performance.

Resolved:-

1) That the Health Select Commission approve the work programme for 2020-21 as set out in Appendix 1.

2) That the proposed membership for the Rotherham NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust quality sub-groups be confirmed, subject to any Membership changes agreed at Council on 22 July 2020.

3) That Members inform the Governance Advisor if they wish to be included in either of the remaining sub-groups for Yorkshire Ambulance Service and/or the Adult Social Care Outcomes Framework.

4) To note that should any urgent items emerge during the year this may necessitate a review and re-prioritisation of the work programme.

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

The Chair confirmed that this item was one of two deferred from the previous meeting due to the comprehensive scrutiny of care homes. The paper followed up on recommendations made by HSC when they had scrutinised these two important plans and showed how the feedback from Scrutiny was reflected in the final versions and in planned work.

Resolved:-
To note progress with recommendations made previously on the Rotherham Suicide Prevention and Self Harm Action Plan and the Rotherham Loneliness Action Plan.

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

The Chair confirmed that this briefing had also been deferred from the previous meeting. It was a short paper for information that brought together several requests for follow up information from items scrutinised last year, together with progress on a number of recommendations from Scrutiny. The Select Commission would be able to revisit any outstanding issues in the course of the work programme for 2020-21.

Resolved:–
Health Select Commission to note the information contained in the briefing.

94. URGENT BUSINESS

The Chair advised that there was one matter of urgent business to discuss at the meeting. This was to congratulate Governance Advisor Janet Spurling on her imminent retirement and to thank her for her work in supporting the Health Select Commission.

95. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission take place on Thursday 10 September 2020, commencing at 2.00 p.m. as a virtual meeting.

Agenda Item 6

Rotherham Metropolitan Borough Council

BRIEFING	**TO:**	Health Select Commission
	DATE:	3rd September 2020
	LEAD OFFICER:	Jacqueline Wiltschinsky, Public Health Consultant, Adult Social Care, Housing and Public Health Becky Woolley Policy Officer, Assistant Chief Executive's Directorate Anne Marie Lubanksi, Strategic Director of Adult Social Care, Housing and Public Health
	TITLE:	The Marmot Review: 10 Years On

1. Background

1.1 Published in 2010, The Marmot Review was a landmark study of health inequalities in England. The ground-breaking review confirmed governments policies focusing on the health care system and individual behaviour change approaches are not hugely effective at reducing health inequalities. To improve health for everyone and reduce inequalities action needs to be taken on the social determinants – the circumstances in which we are born, grow, live, work and age (causes of the causes of ill health). Yet a decade of austerity has seen drastic cuts to local government funding, which is tasked with funding the wider determinants.

1.2 The report outlined six policy objectives, known as the Marmot principles:

- Giving every child the best start in life
- Enabling all children, young people and adults to maximize their capabilities and have control over their lives
- Creating fair employment and good work for all
- Ensuring a healthy standard of living for all
- Creating and developing sustainable places and communities
- Strengthening the role and impact of ill-health prevention.

1.3 The new report, Health Equity in England: The Marmot Review 10 Years On, was published in February 2020, on the 10-year anniversary of the original review to explore the progress that has been made over the past decade against these policy objectives.

2. Key Issues

2.1 **Key findings**

The report explores the progress made 10 years on from the Marmot review and finds that progress against all six policy objectives has been poor. It outlines that austerity has taken its toll on all the domains set out in the original Marmot Review, and that

indicators suggest that health improvements are stalling nationally. These indicators include that:

- People can expect to spend more of their lives in poor health.
- Improvements to life expectancy have stalled and declined for the poorest 10% of women.
- The health gap has grown between wealthy and deprived areas.
- There are marked regional differences and widening health inequalities between the North and the South.
- The slowdown in life expectancy increase cannot for the most part be attributed to severe winters. More than 80 percent of the slowdown, between 2011 and 2019, results from influences other than winter-associated mortality.
- It is likely that public sector cuts have harmed health and contributed to widening health inequalities in the short term and are likely to continue to do so over the longer term. Cuts over the period shown have been regressive and inequitable – they have been greatest in areas where need is highest and conditions are generally worse.
- Only the 20-30% least deprived will receive a state pension before they develop a lifelong disability.
- Two thirds of those with lifelong disabilities in the most deprived areas have disabilities before they reach pension age. For males, years in poor health has increased from 15.8 to 16.2 since 2009, for females from 18.7 to 19.4.

2.2 These findings reflect the local picture. For example, inequalities are widening between the most and least deprived communities within Rotherham. Life expectancy is 9.9 years lower for men and 9.5 years lower for women in the most deprived areas of Rotherham than in the least deprived areas. This is demonstrated visually in the map appended to this briefing.

2.3 Additionally, health inequalities are widening between Rotherham and the national average. Rotherham is one of the 20% most deprived districts/unitary authorities in England and has moved up the rankings in terms of deprivation according to the 2019 Indices of Deprivation findings. The results within the health and disability domain were a key driver in this increase.

2.4 The increase in health and disability deprivation reflects increases in all the indicators used – years of life lost (life expectancy), illness and disability ratio (disability and sickness benefits), acute morbidity (emergency admissions) and mood and anxiety disorders. The latter shows the largest increase and is based on prescription of drugs for mental health conditions, mental health related hospital episodes and suicides. A breakdown by wards is outlined in the maps within appendix one.

2.5 Research also indicates that COVID-19 is having a significant impact upon health inequalities. At a national level, Public Health England has completed a report into "Disparities in the risk and outcomes of COVID-19". The review is a descriptive look at surveillance data on the impact of COVID-19 on risk and outcomes. It confirms that the impact of COVID-19 has replicated existing health inequalities and, in some cases, exacerbated them further, particularly for black, Asian and minority ethnic (BAME) groups. Key points from the review include:

- The largest disparity found was by age. Among people already diagnosed with COVID-19, people who were 80 or older were 70 times more likely to die than those under 40.

- Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in BAME groups than in white ethnic groups.
- These inequalities largely replicate existing inequalities in mortality rates in previous years, except for BAME groups, as mortality was previously higher in white ethnic groups. These analyses take into account age, sex, deprivation, region and ethnicity, but they do not take into account the existence of comorbidities, which are strongly associated with the risk of death from COVID-19 and are likely to explain some of the differences.

3. Key Actions and Timelines

3.1 Within appendix two, the recommendations of the Marmot Review: 10 Years on report have been summarised. Some of these require action at a national level, but there will also be actions that can be taken locally to address the findings. This appendix also maps how these recommendations currently align with the work of the Health and Wellbeing Board.

3.2 It will be a priority to continue to engage with national developments. The LGA held a seminar in June regarding the Marmot 10 years on report and the slides from this seminar are appended to the briefing note. It has also been announced that a conference will be now be taking place in Spring 2021 relating to the findings of the report, which was postponed due to the COVID-19 pandemic.

3.3 The Health and Wellbeing Board agreed for a development session to be held on 16th September 2020. The focus of this session will be on reviewing the priorities of the board considering the impact of COVID-19 as well as consideration of local health inequalities and the findings of the Marmot report. The Local Government Association will be facilitating this session.

3.4 The proposed outcomes for the development session are as follows:

- To review current priorities and consider what priorities may need to change for the Health and Wellbeing Board, when considering the long-term consequences of COVID-19.
- To confirm the key actions for the Health and Wellbeing Board to meet these priorities.
- To discuss how we prioritise health inequalities and the Marmot principles as part of our ongoing response and recovery.

3.5 Following the development session, a refreshed set of priorities will be presented at the Health and Wellbeing Board in November for approval.

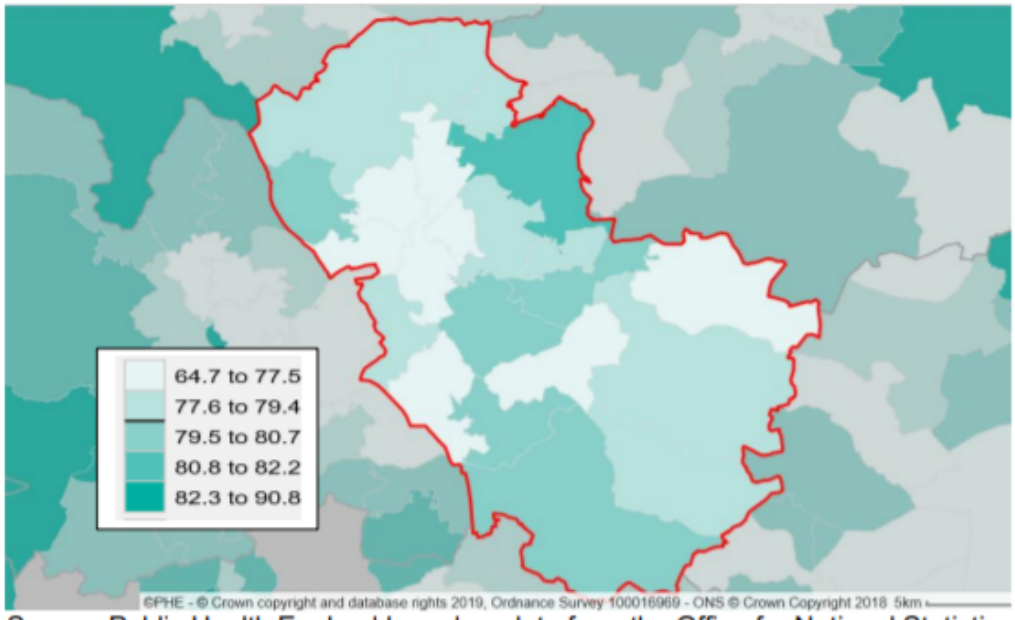
3.6 To ensure that the Health Select Commission is able to contribute towards the refresh of Health and Wellbeing Board priorities, it is proposed that members consider and respond to the following questions:

- What are your biggest concerns regarding health inequalities in Rotherham?
- Are there any emerging priorities that need to feature more highly on the agenda?
- Is there anything that we are doing differently as a result of our COVID-19 response that we would want to maintain?

4. Recommendations	
4.1	To consider the findings of the Marmot Review: 10 years on report and the recommendations.
4.2	To consider and respond to the following questions: • What are your biggest concerns regarding health inequalities in Rotherham? • Are there any emerging priorities that need to feature more highly on the agenda? • Is there anything that we are doing differently as a result of our COVID-19 response that we would want to maintain?

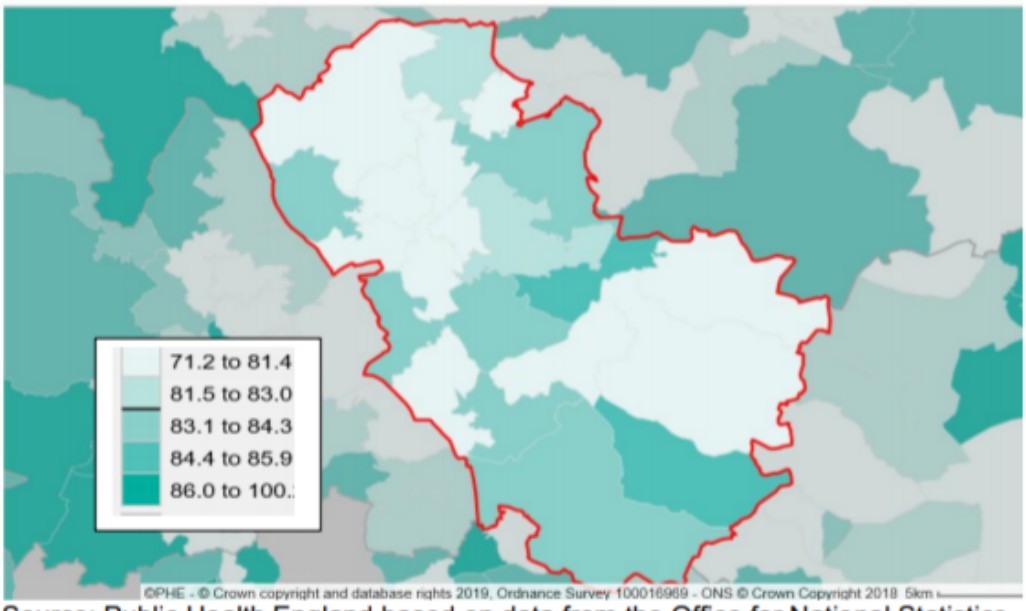
Appendix One: Maps of inequalities in Rotherham

1 Life expectancy at birth for males, 2013-2017 (years)



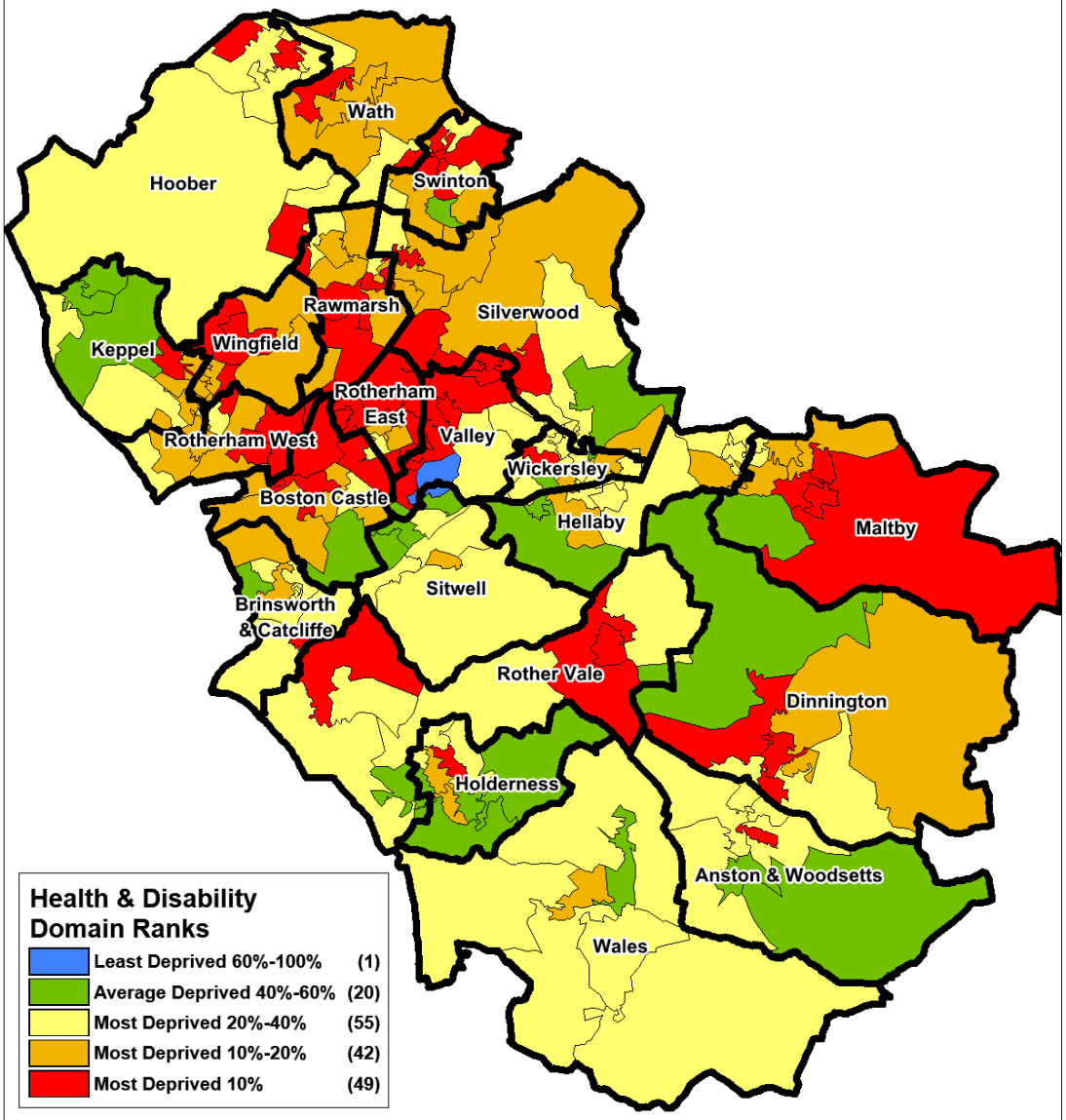
Source: Public Health England based on data from the Office for National Statistics.

1 Life expectancy at birth for females, 2013-2017 (years)



Source: Public Health England based on data from the Office for National Statistics.

Indices of Deprivation 2019
Health and Disability Domain
(Wards shown)



Appendix One: Recommendations from the Marmot Review: 10 years on

Theme	Recommendation	How this is being picked up by the Health and Wellbeing Board
Giving Every Child the Best Start in Life	Increase levels of spending on early years and as a minimum meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.	Early years has been identified as a priority within the Health and Wellbeing Strategy and the Place Plan. Key indicators relating to early years are part of the Health and Wellbeing Strategy performance framework.
	Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.	
	Improve availability and quality of early years services, including Children's Centres, in all regions of England.	Early years has been identified as a priority within the Health and Wellbeing Strategy and the Place Plan. Key indicators relating to early years are part of the Health and Wellbeing Strategy performance framework.
	Increase pay and qualification requirements for the childcare workforce.	
Enabling all Children, Young People and Adults to Maximise their Capabilities and Have Control over their Lives	Put equity at the heart of national decisions about education policy and funding.	
	Increase attainment to match the best in Europe by reducing inequalities in attainment.	Average attainment 8 score is part of the Health and Wellbeing Strategy performance framework.
	Invest in preventative services to reduce exclusions and support schools to stop off-rolling pupils.	

	Restore the per-pupil funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting).	
Creating Fair Employment and Good Work for All	Invest in good quality active labour market policies and reduce conditionalities and sanctions in benefit entitlement, particularly for those with children.	
	Reduce in-work poverty by increasing the National Living Wage, achieving a minimum income for healthy living for those in work.	
	Increase the number of post-school apprenticeships and support in-work training throughout the life course.	Employment and Skills Strategy – links drawn with the Health and Wellbeing Board, aim 4.
	Reduce the high levels of poor quality work and precarious employment.	
Ensuring a Healthy Standard of Living for All	Ensure everyone has a minimum income for healthy living through increases to the National Living Wage and redesign of Universal Credit.	
	Remove sanctions and reduce conditionalities in welfare payments.	
	Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy.	Refresh of the Sheffield City Region Strategic Economic Plan is ongoing and will inform the refresh of the Rotherham Economic Plan. Health and Wellbeing Board partners are intending on feeding into the development of both of these plans.
	Adopt inclusive growth and social value approaches nationally and locally to value health and wellbeing as well as, or more than, economic efficiency.	Employment and Skills Strategy – emphasis on health and links drawn with the Health and Wellbeing Board, aim 4.

	Review the taxation and benefit system to ensure it achieves greater equity and ensure effective tax rates are not regressive.	
Create Healthy and Sustainable Places and Communities	Invest in the development of economic, social and cultural resources in the most deprived communities	Cultural Strategy – links drawn with the Health and Wellbeing Board, aim 4.
	100 percent of new housing is carbon neutral by 2030, with an increased proportion being either affordable or in the social housing sector	A spotlight on climate change came to the Health and Wellbeing Board in January 2020. The Health and Wellbeing Board intends to continue to influence local work on climate change and receive regular updates to assure that health implications are considered.
	Aim for net zero carbon emissions by 2030 ensuring inequalities do not widen as a result	
Taking action	Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health.	
	Ensure proportionate universal allocation of resources and implementation of policies.	There are calls in the report for greater investment in the North – is there an opportunity to work with regional colleagues to speak back to national Government on this point?
	Early intervention to prevent health inequalities.	Early intervention and prevention are key principles outlined in the Health and Wellbeing Strategy.
	Develop the social determinants of health workforce. (This section outlines the important role of workforces outside public health in improving population health, and references set of resources and tools developed by Royal Society of Public Health to support other sectors to improve health and reduce health inequalities.)	Health and Wellbeing Strategy – Making Every Contact Count training.

	Engage the public. (This section outlines that there is a lack of public understanding of what drives health is a major obstacle to further progress in reducing health inequalities and increasing population health.)	The website has recently been refreshed and a Twitter account will be established. These will be utilised to engage with the public on what drives health.
	Develop whole systems monitoring and strengthen accountability for health inequalities.	The Health and Wellbeing Board is planning a session for September on health inequalities and coronavirus recovery. It has also been agreed that any briefing coming to the Health and Wellbeing Board will now need to include analysis on the implications for health inequalities.

HEALTH EQUITY IN ENGLAND: THE MARMOT REVIEW 10 YEARS ON

Michael Marmot

@MichaelMarmot

http://www.instituteofhealthequity.org/the-marmot-review-10-years-on

LGA

June 2020

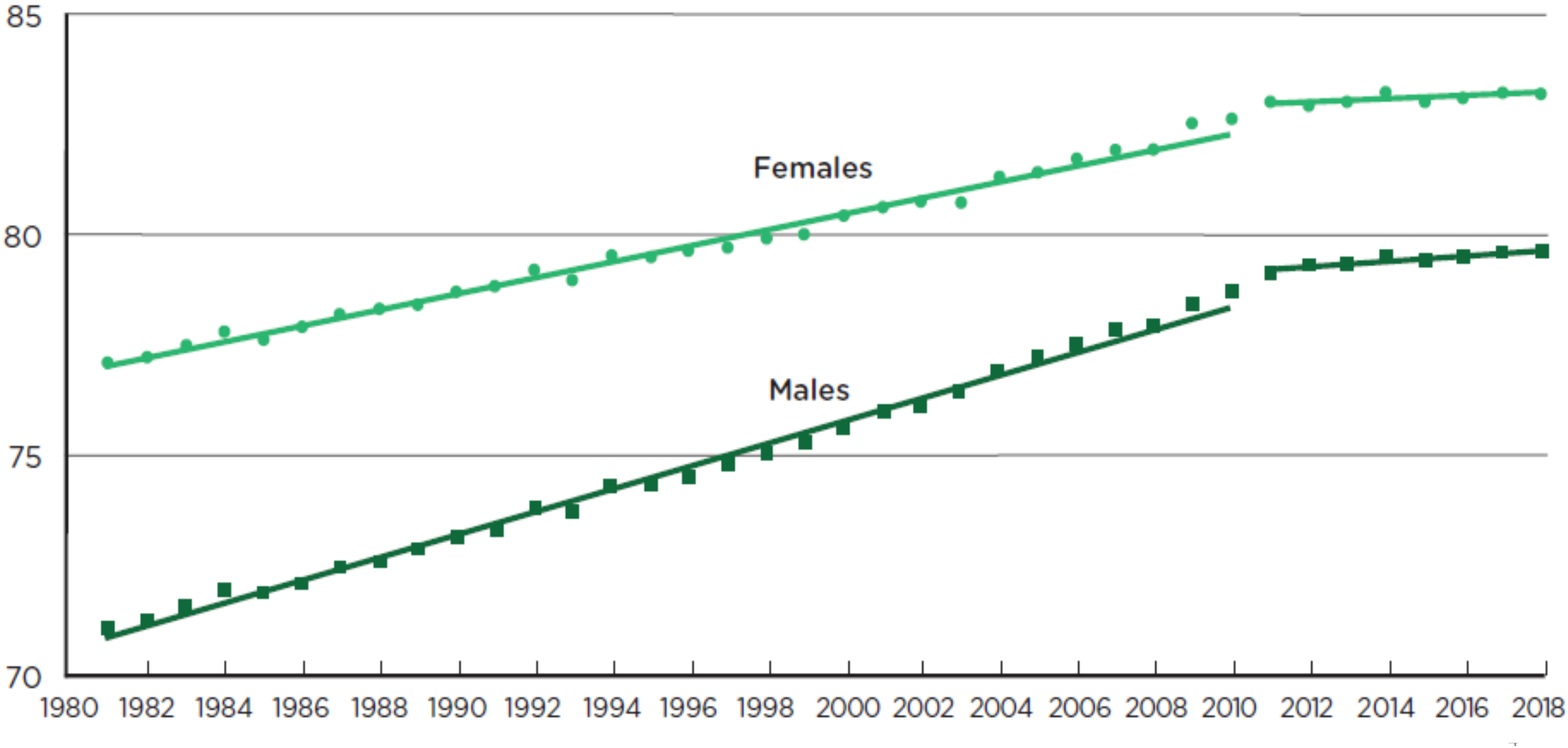
INSTITUTE of HEALTH EQUITY

HEALTH EQUITY IN ENGLAND: THE MARMOT REVIEW 10 YEARS ON

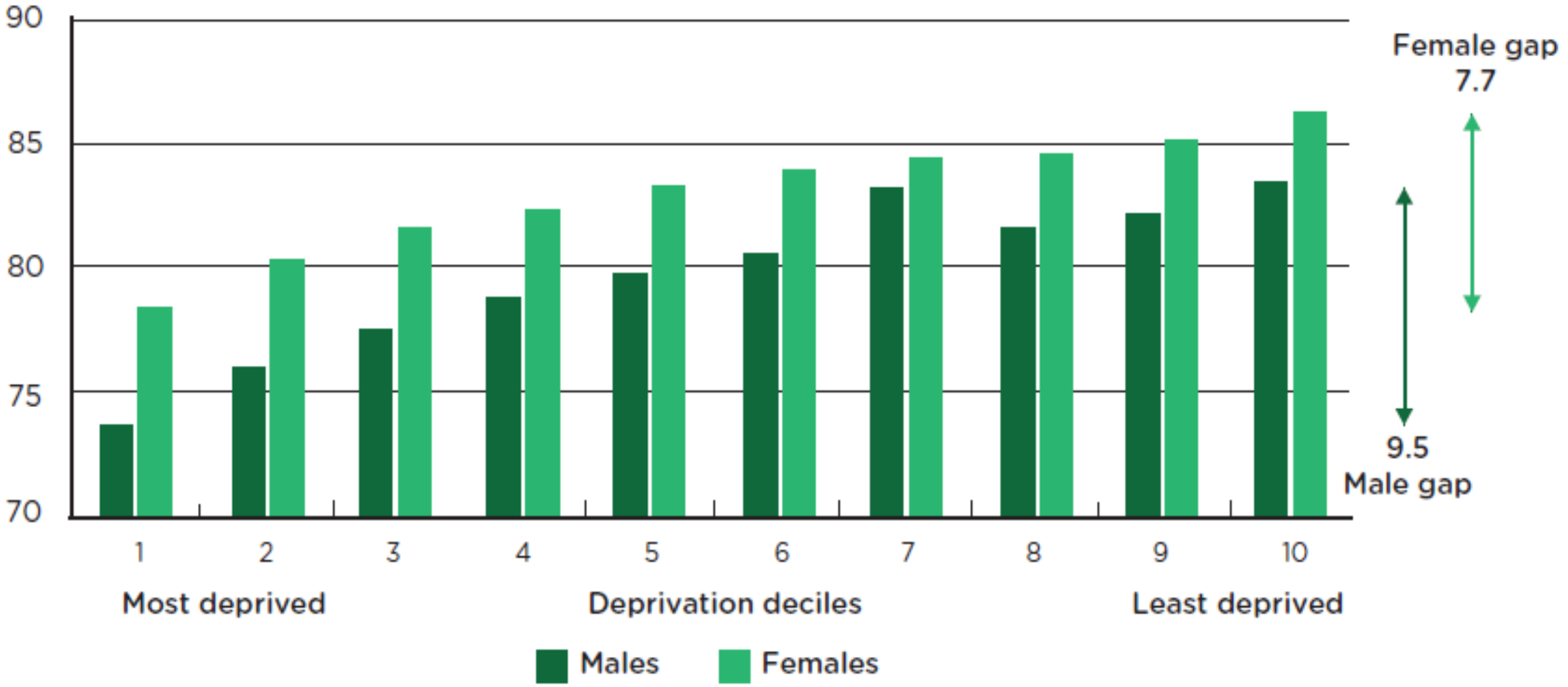
INSTITUTE of HEALTH EQUITY

"We have lost a decade. And it shows."

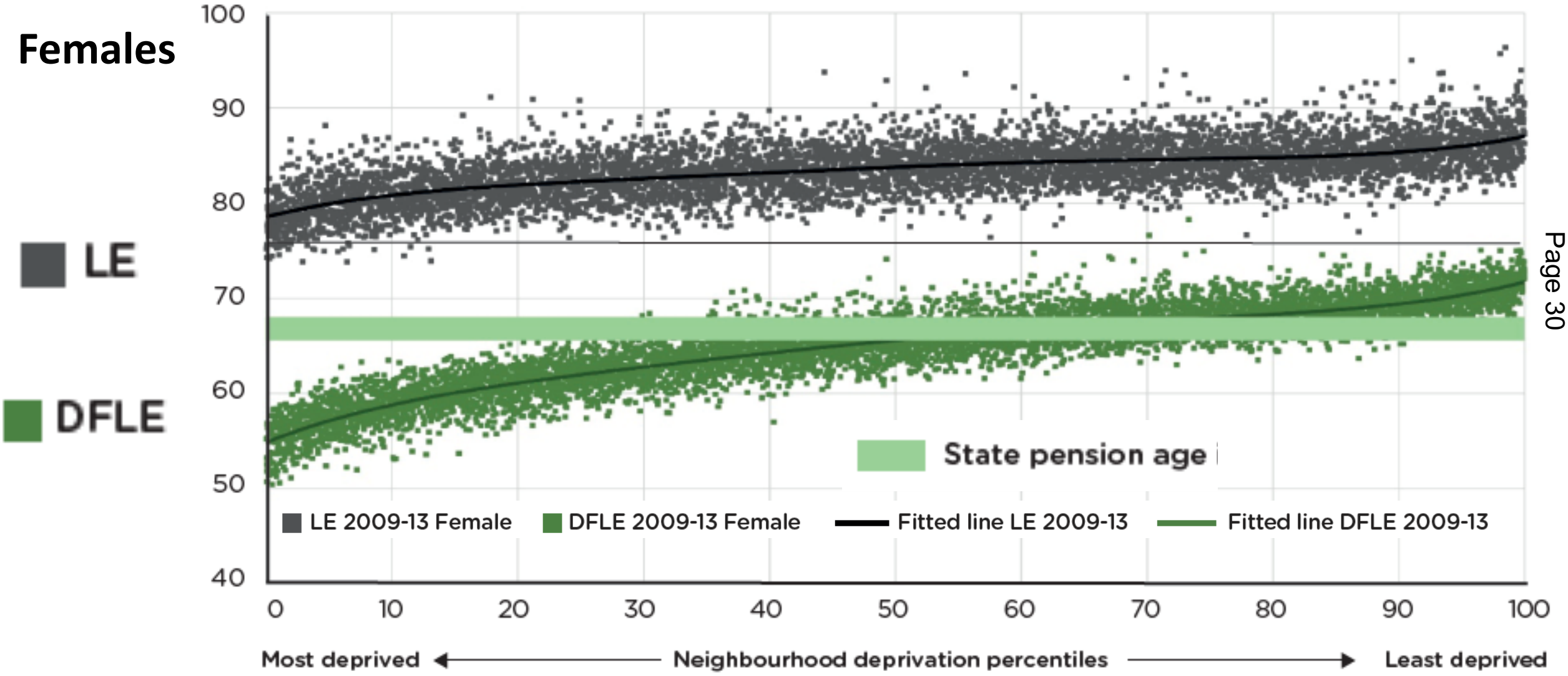
Increases in life expectancy at birth stalling in England



There are large differences in life expectancy by area deprivation in England



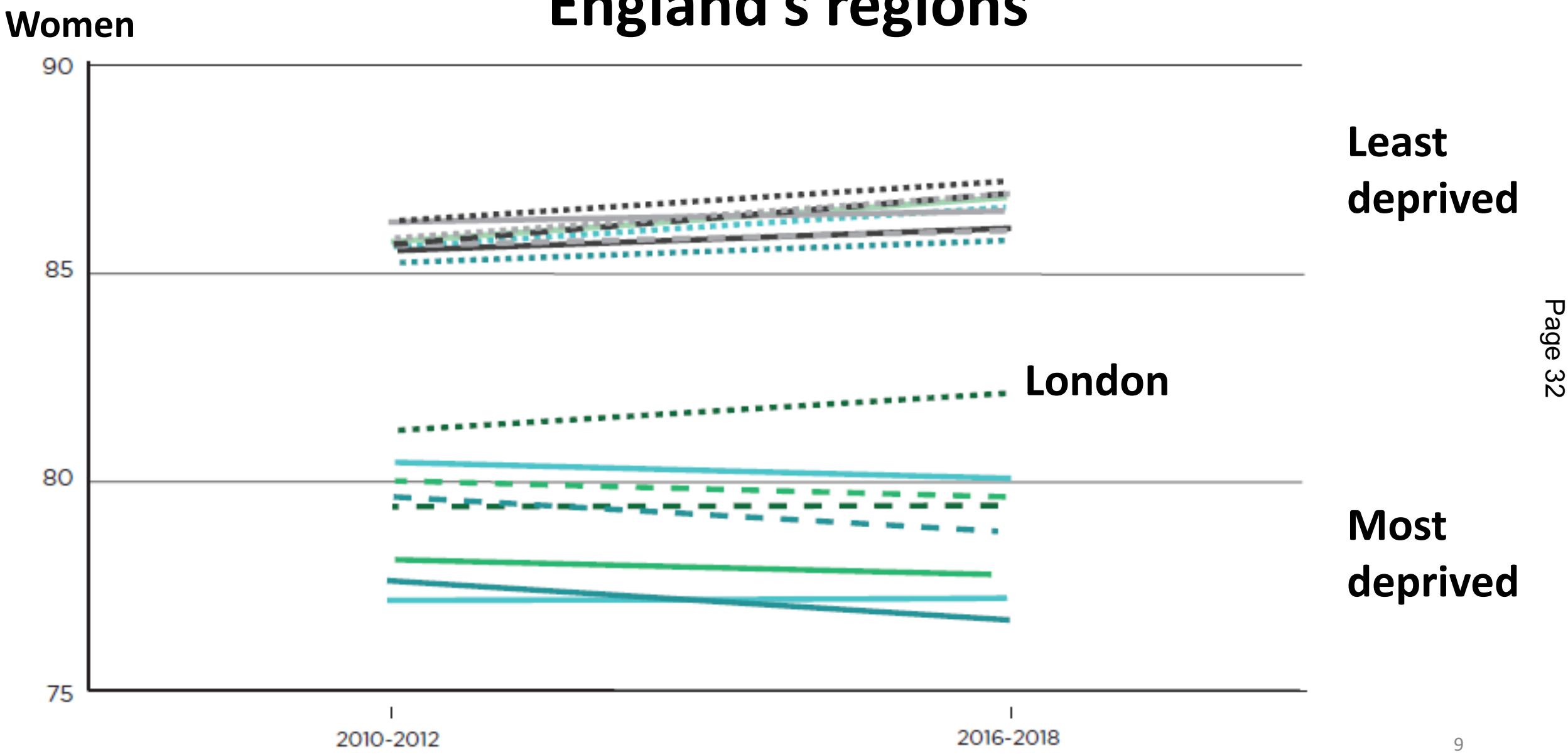
Only the least 20—30% deprived will receive a state pension before they develop a disability



The amount of life spent in good health decreased for men and women in England

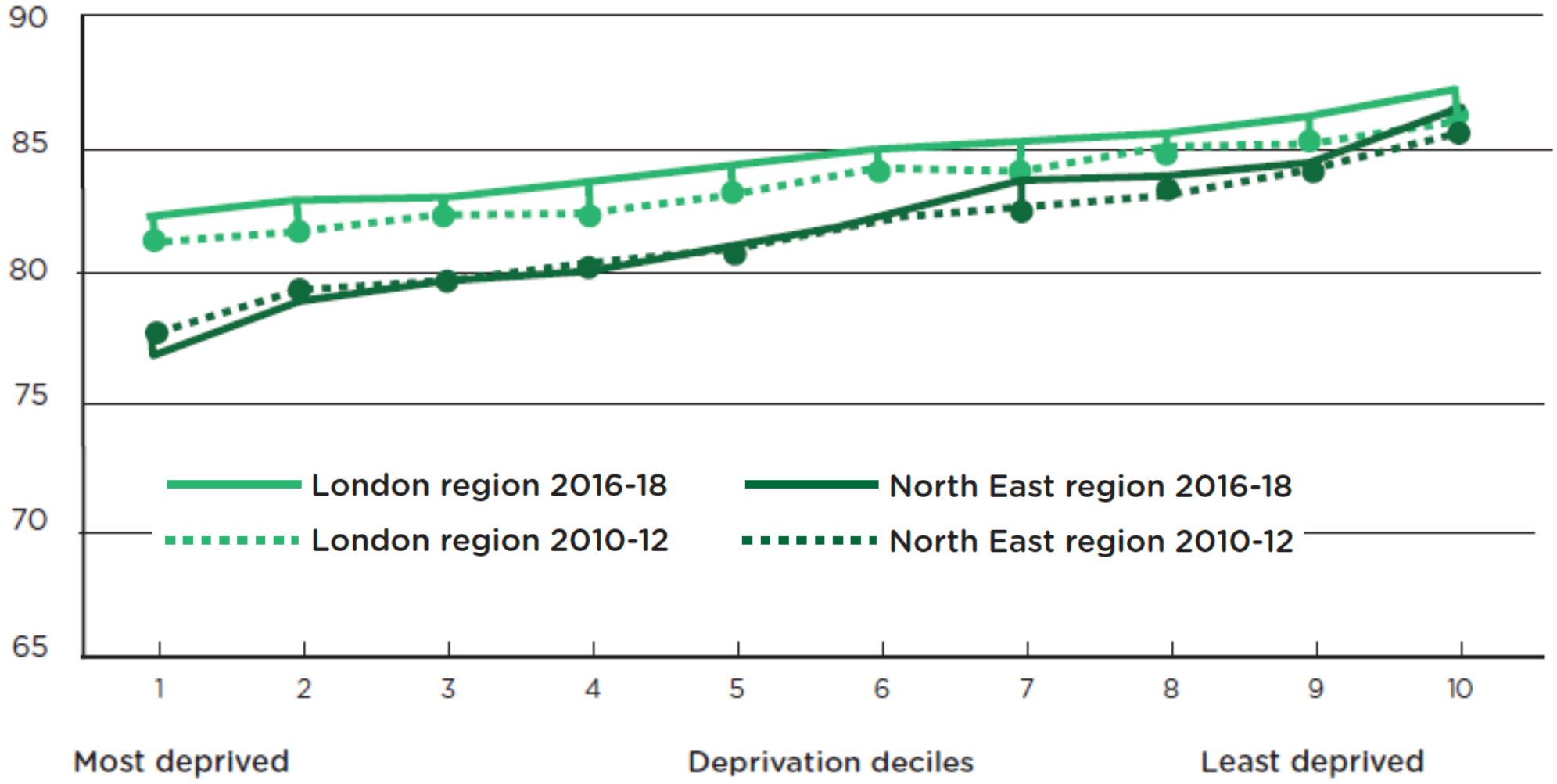
	Healthy life expectancy (HLE)	Years in poor health
Males		
2009–11	63.0	15.8
2012–14	63.4	16.1
2015–17	63.4	16.2
Females		
2009–11	64.0	18.7
2012–14	63.9	19.3
2015–17	63.8	19.4

Differences in life expectancy by deprivation widen in England's regions



Life expectancy at birth by sex and deprivation deciles in London and the North East regions

Women



INSTITUTE of HEALTH EQUITY

Fair Society, Healthy Lives: 6 Policy Objectives

A. **Give every child the best start in life**

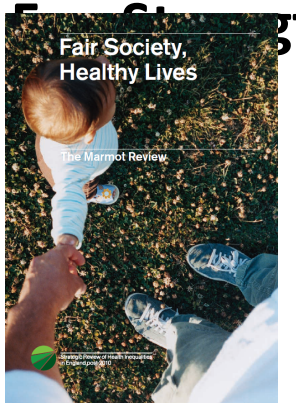
B. **Enable all children, young people and adults to maximise their capabilities and have control over their lives**

C. **Create fair employment and good work for all**

D. **Ensure healthy standard of living for all**

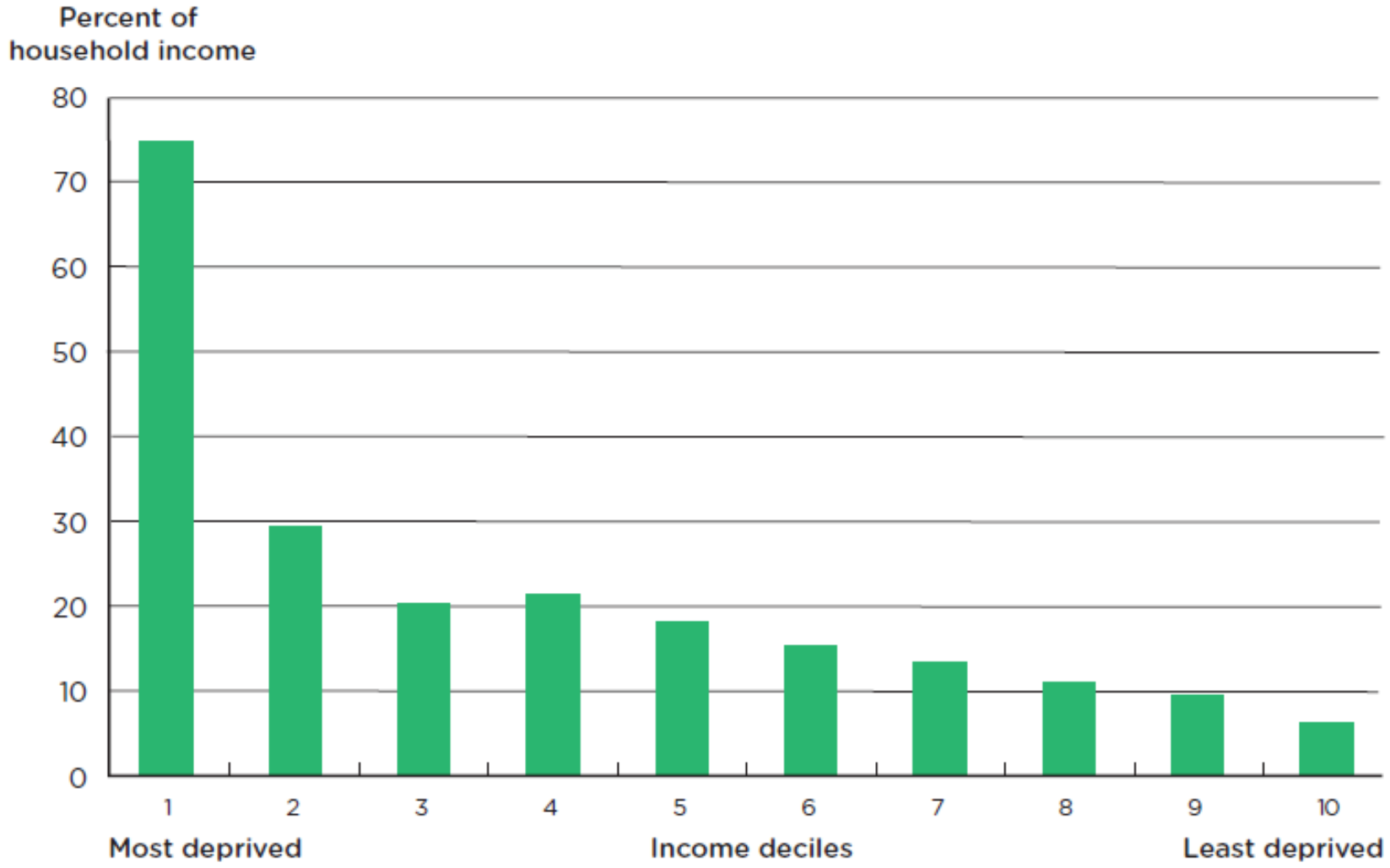
E. **Create and develop healthy and sustainable places and communities**

F. **Strengthen the role and impact of ill health prevention**

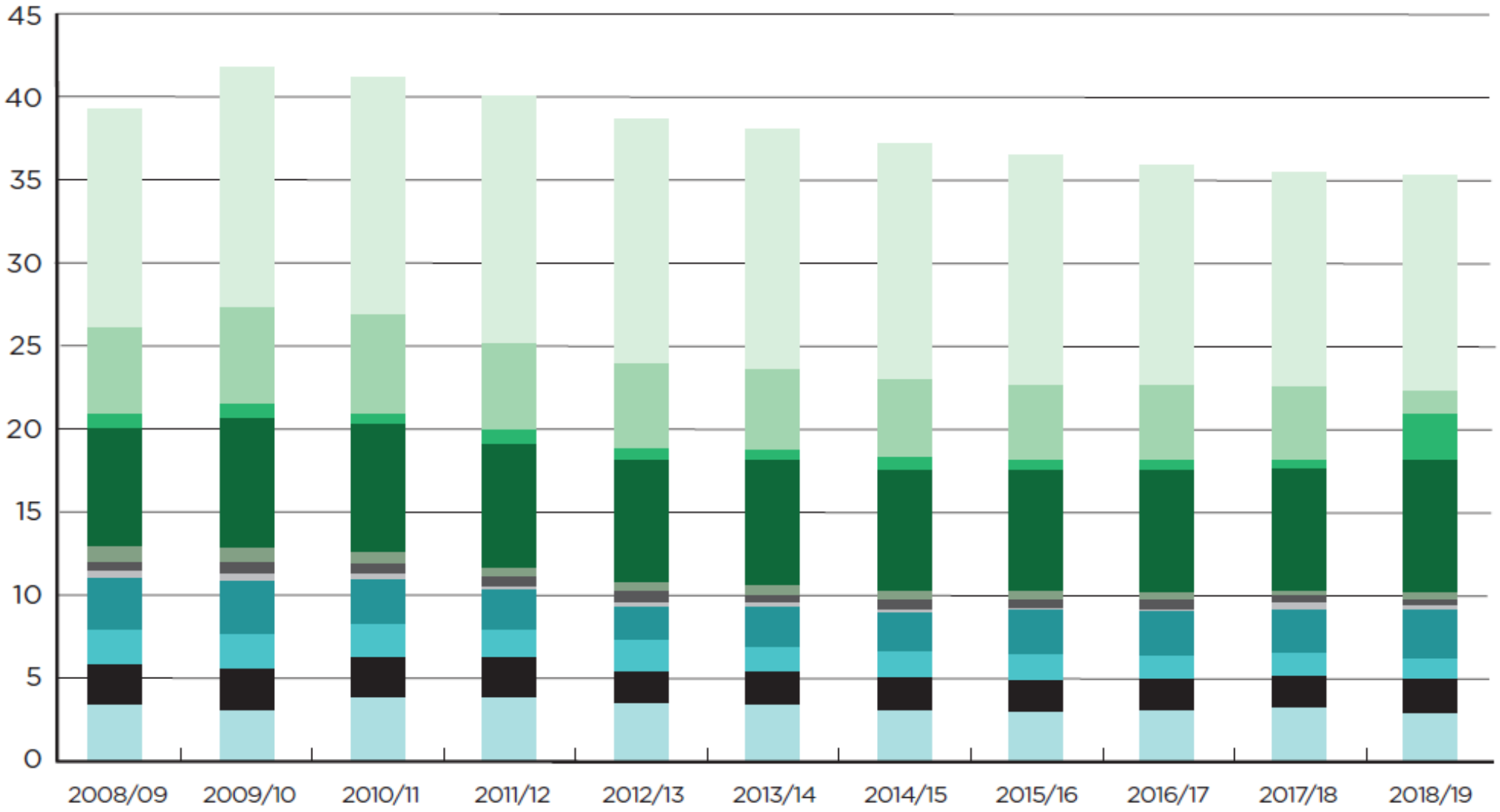


Strategic Review of Health Inequalities in England post-2010

The most deprived decile households would spend 75% of their disposable income to meet the NHS Eatwell Guide

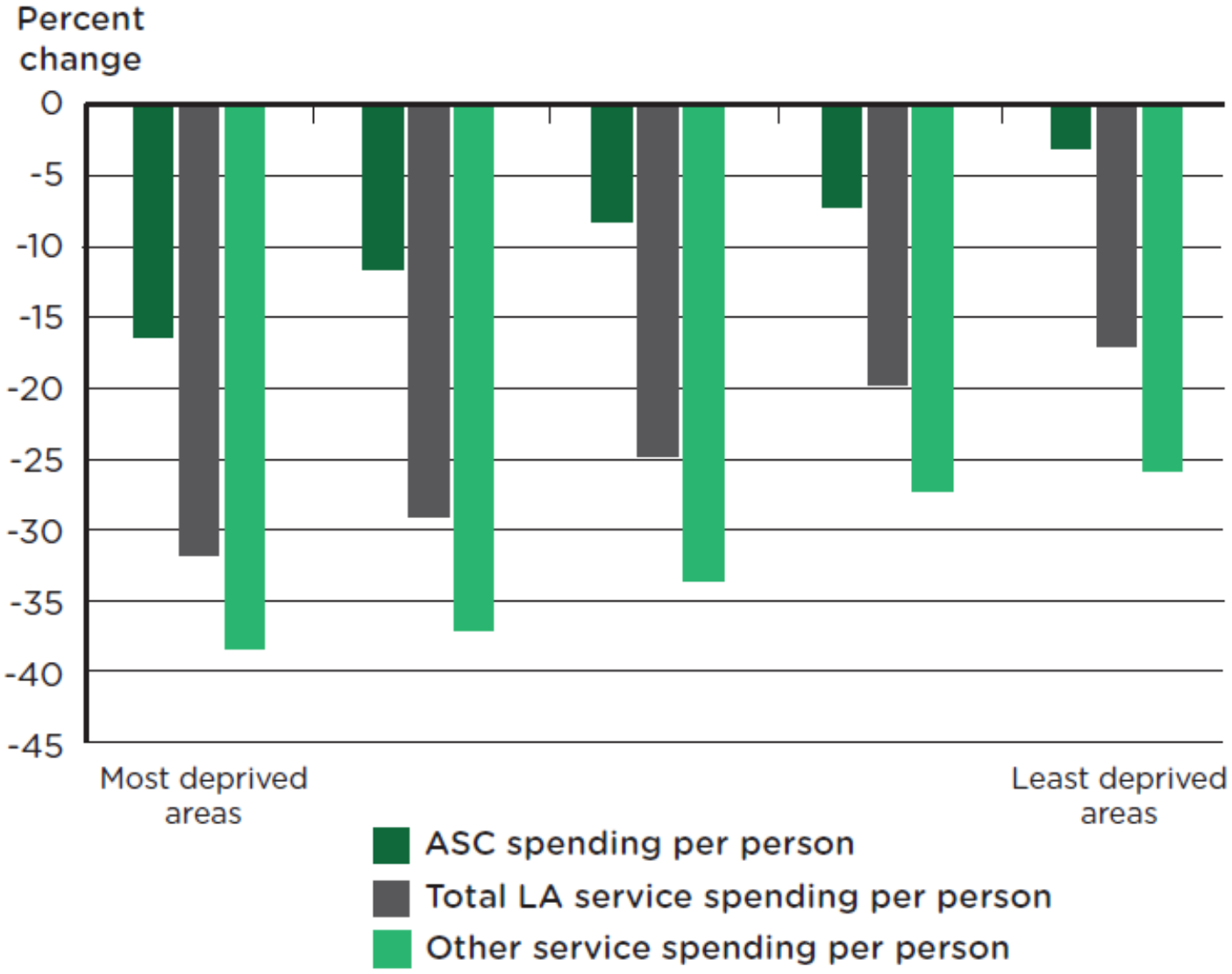


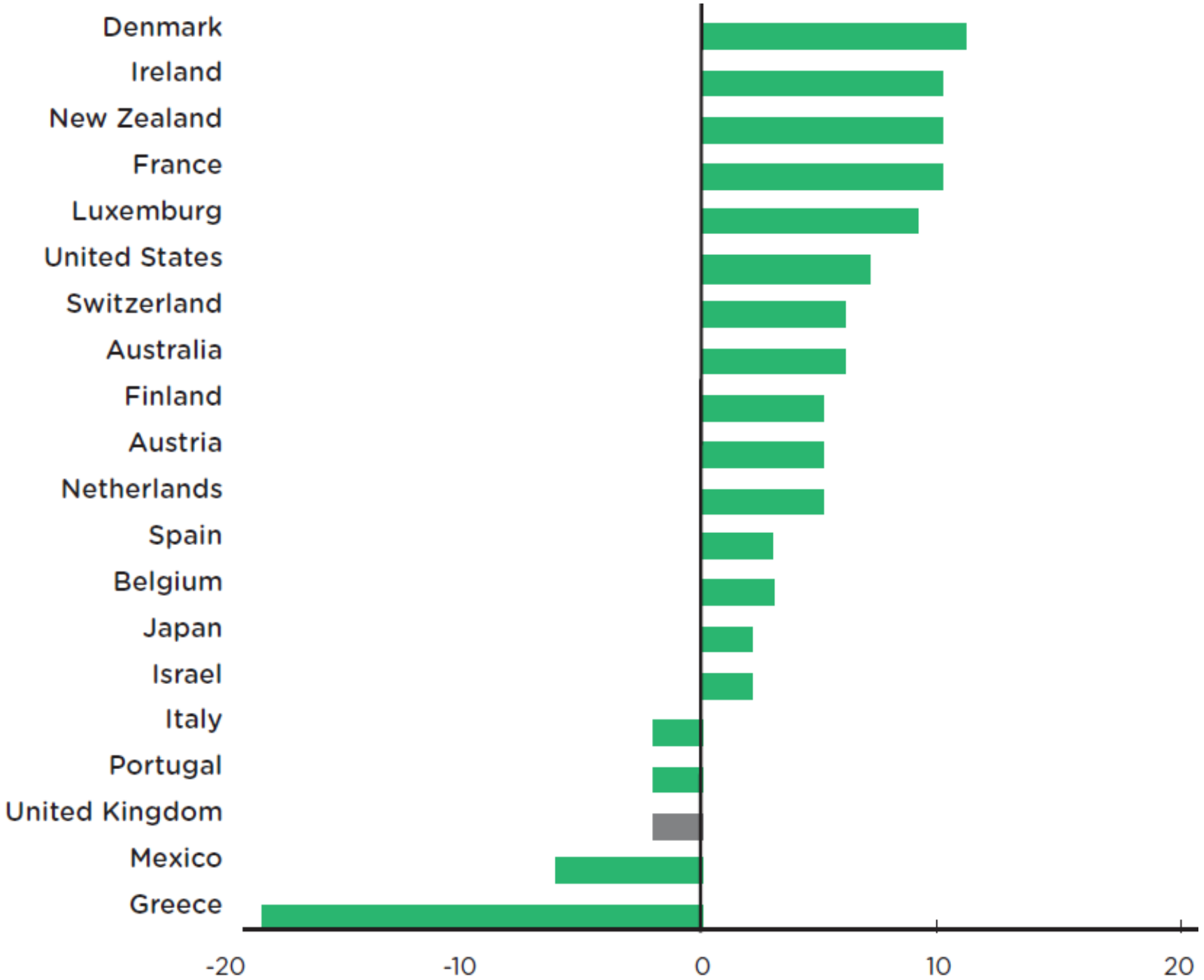
Public sector expenditure (% of GDP) declined in the UK



Expenditure by service

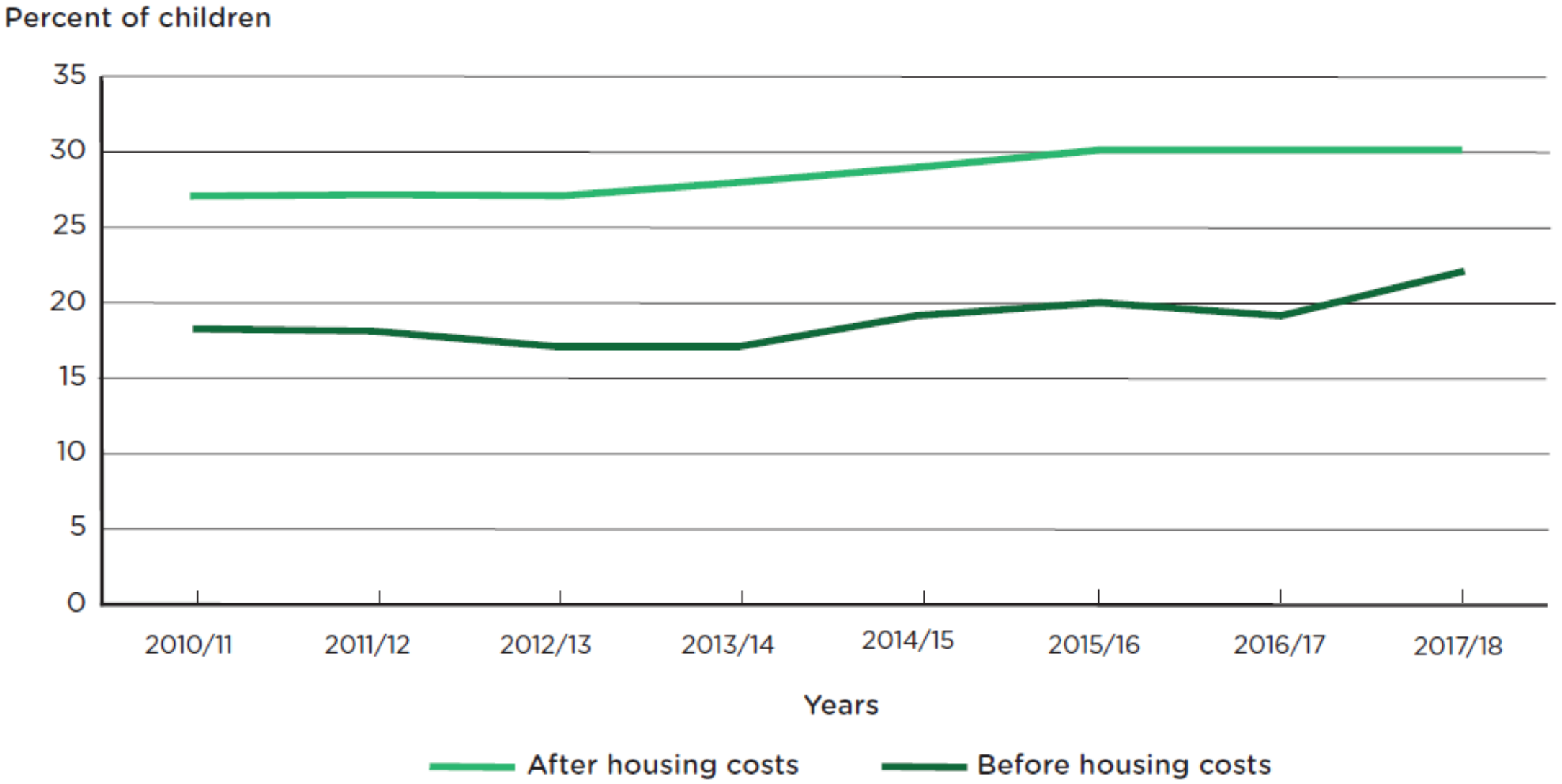
Council spending per person decreased the most in more deprived areas



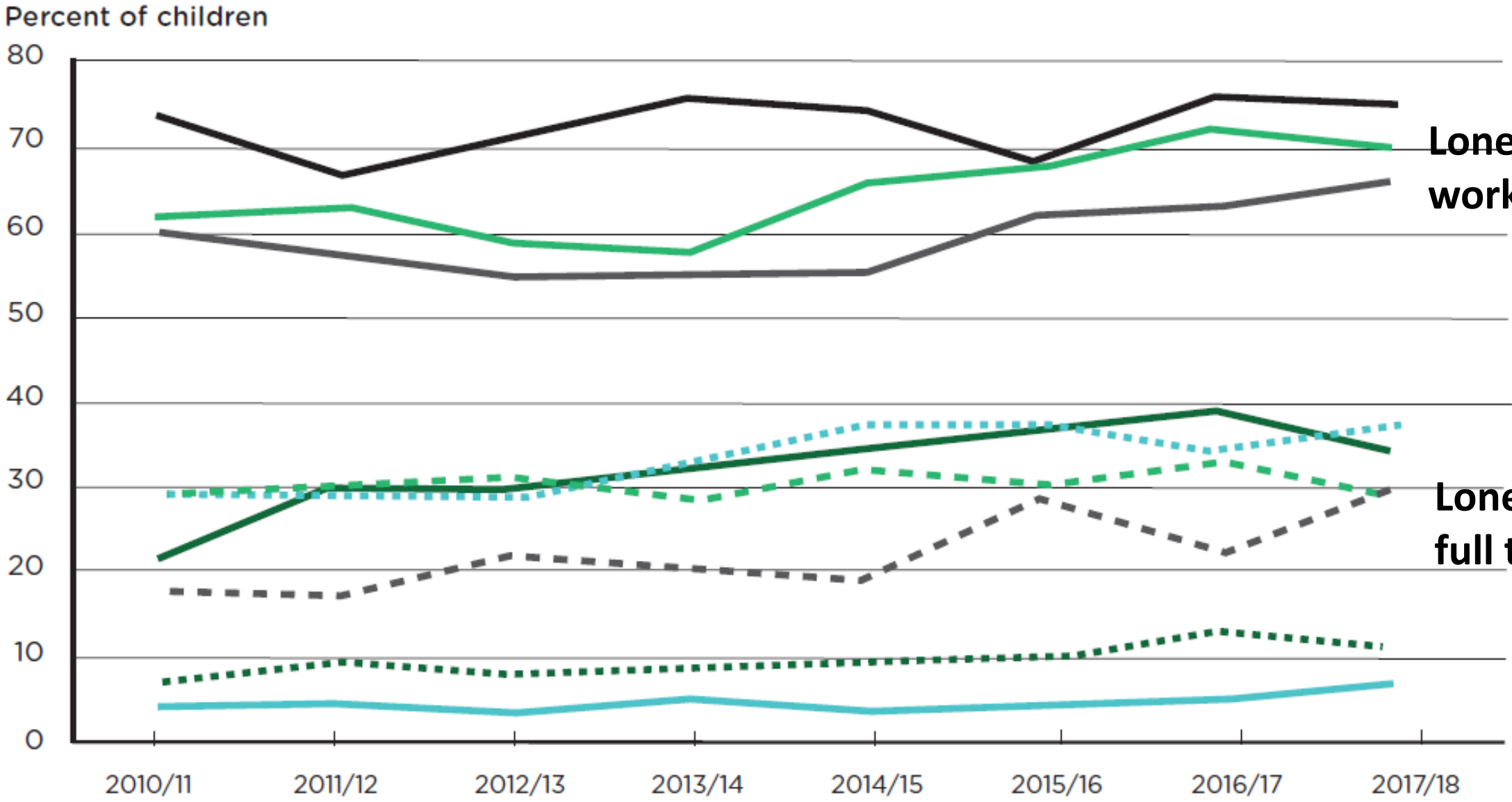


Negative wage growth in the UK 2007 - 2018

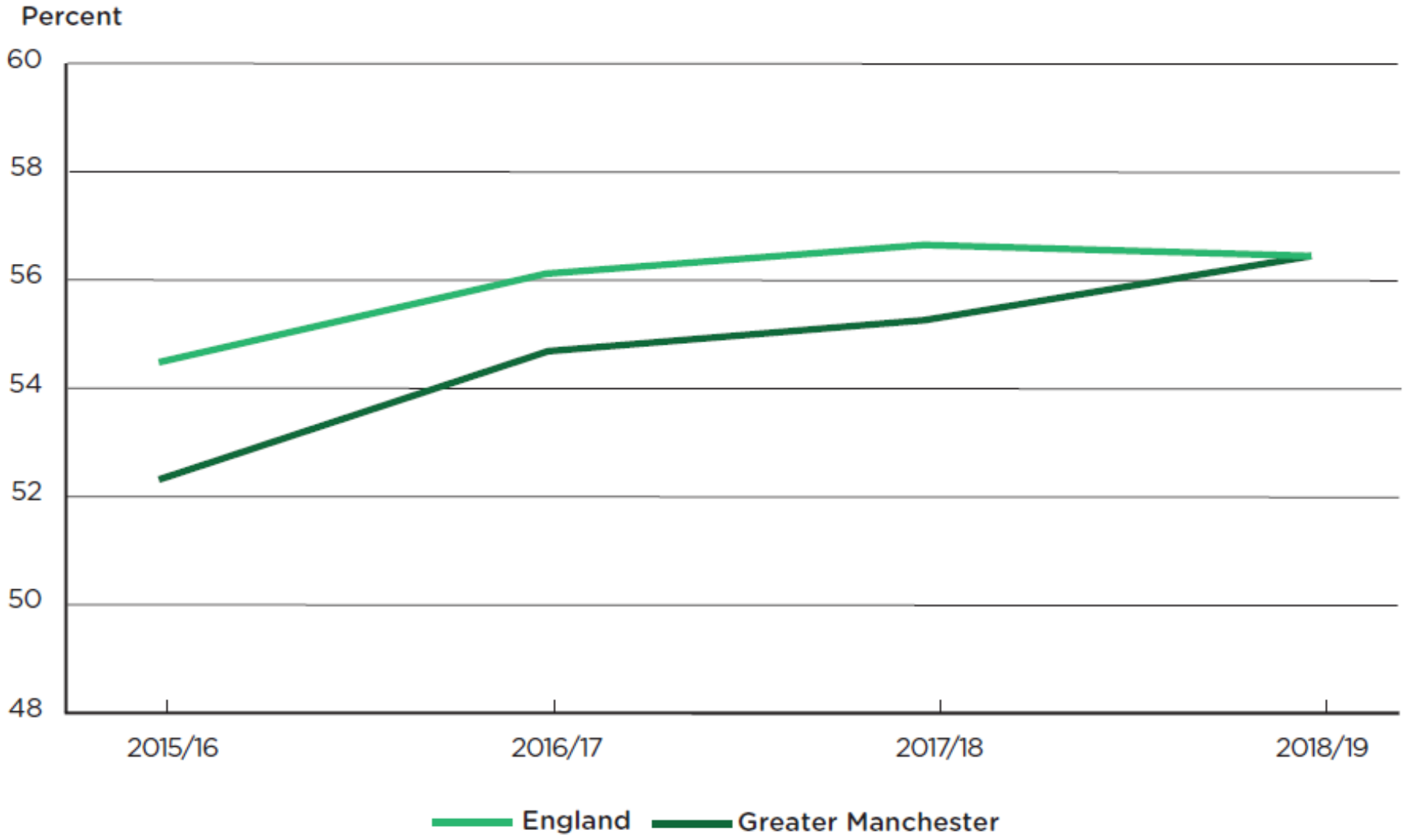
Children living in poverty before and after housing costs in England



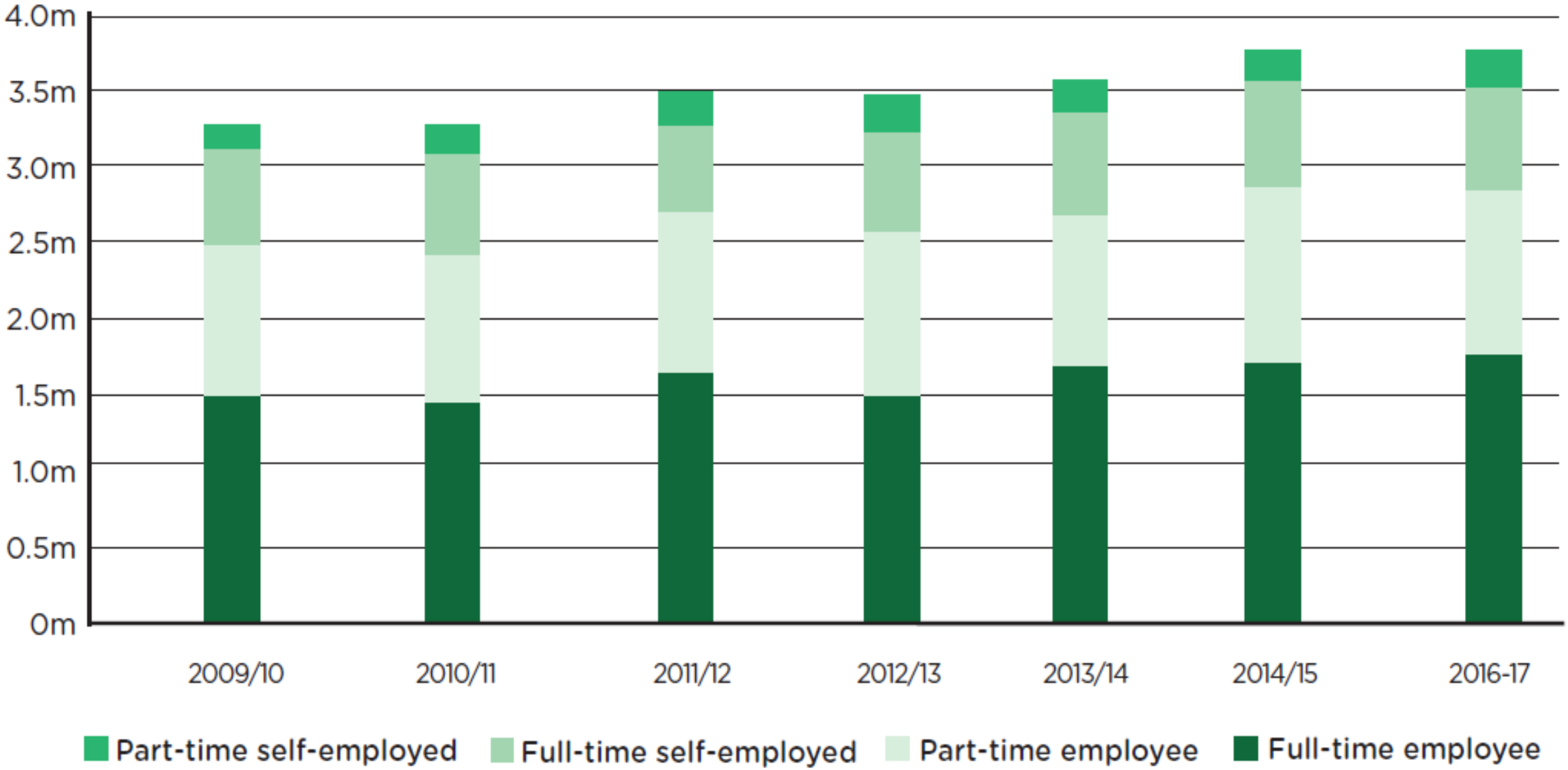
Children living in poor households by family type, UK



Low income pupils in Greater Manchester that are doing well at age 5 are increasing



Number of workers in poverty increased in the UK



More deprived families with children experienced the negative impact of tax and welfare policies the most

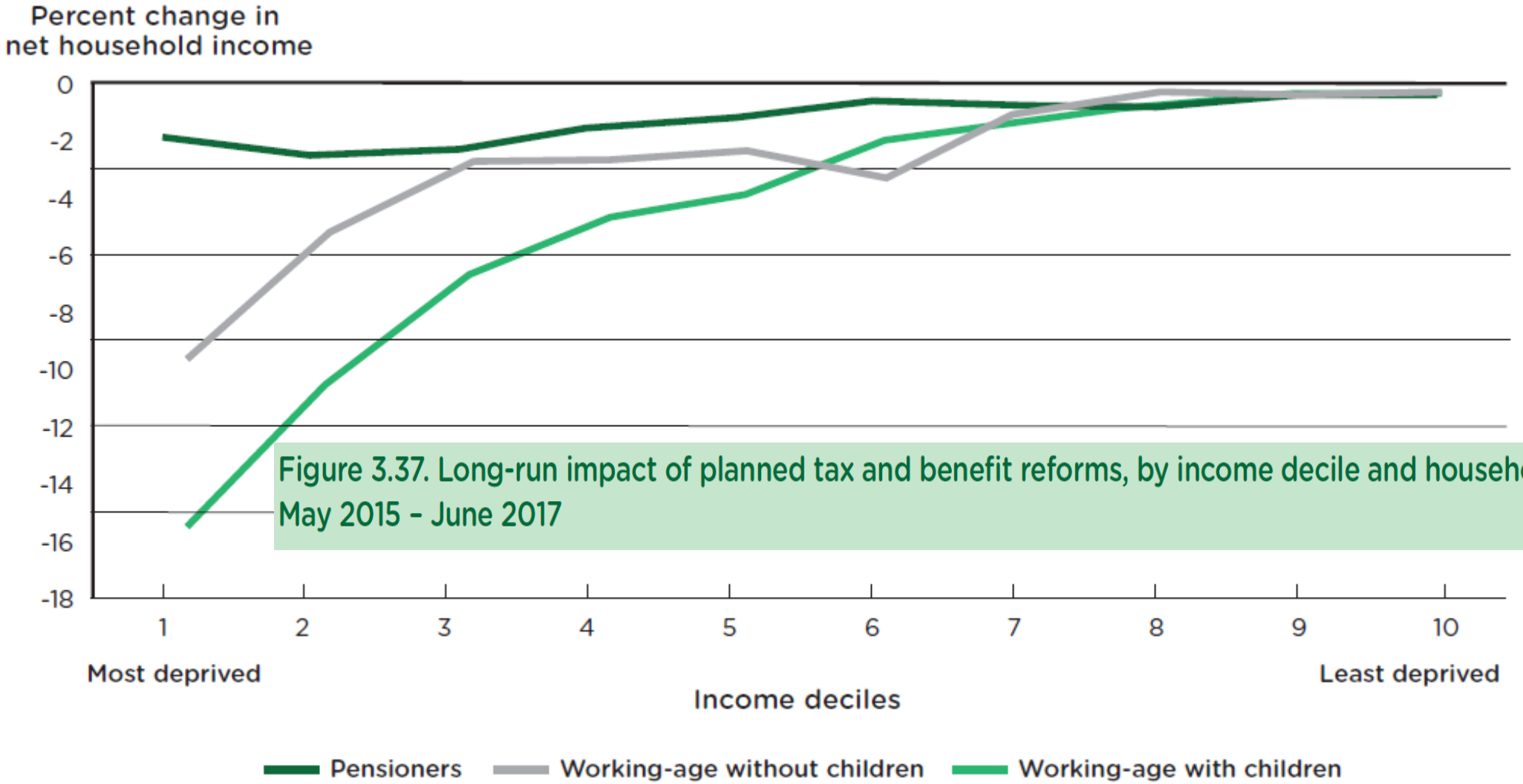
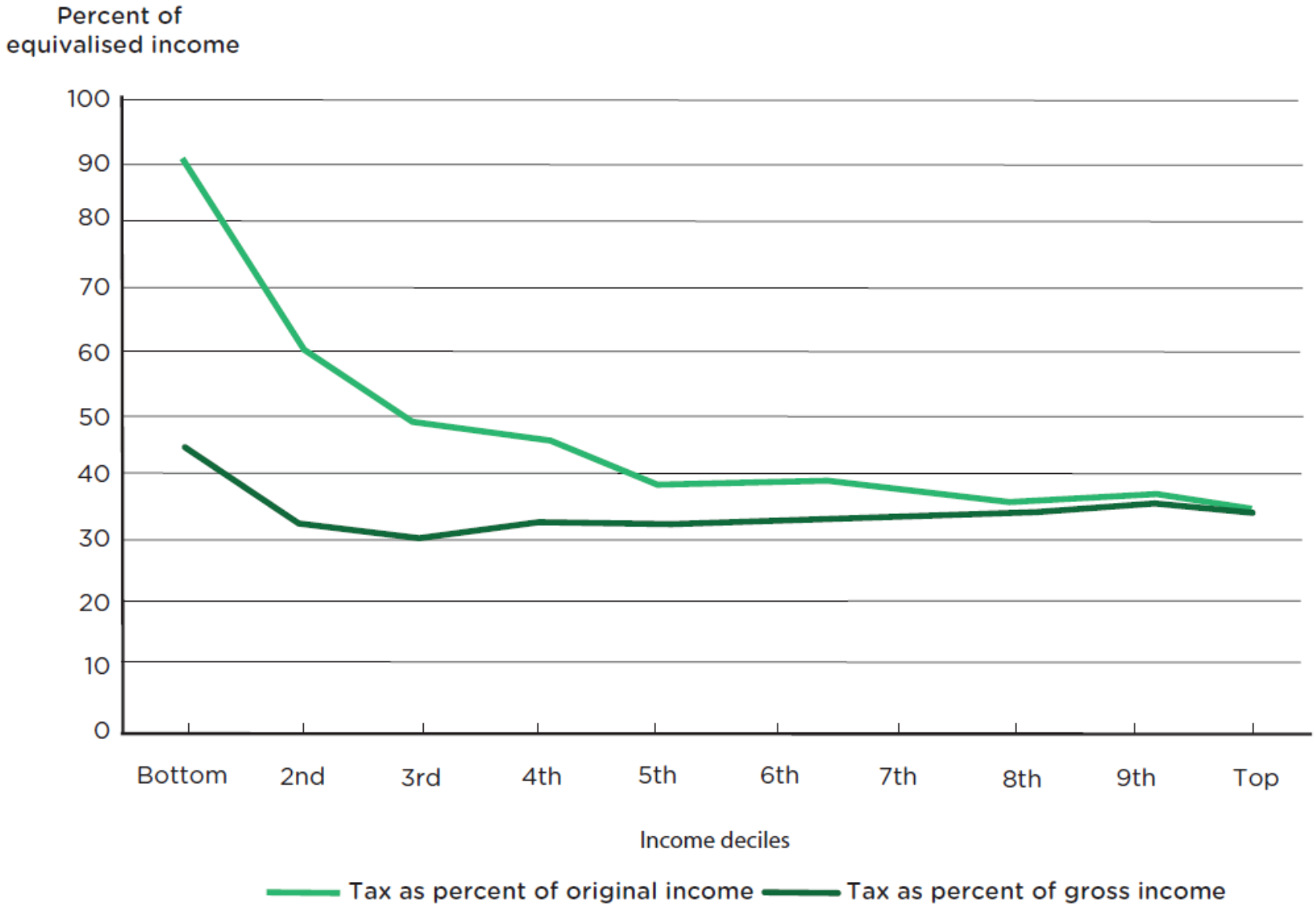
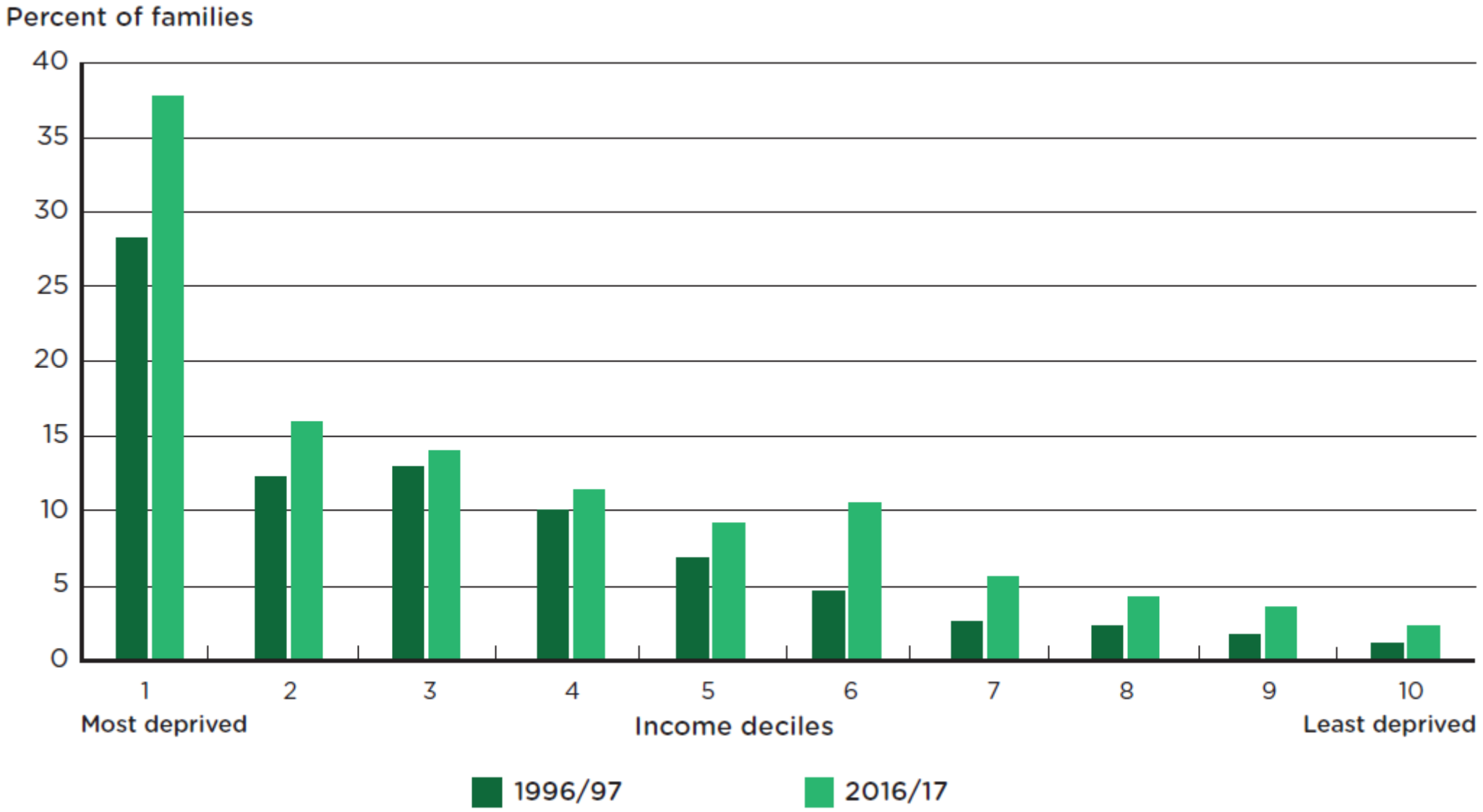


Figure 3.37. Long-run impact of planned tax and benefit reforms, by income decile and household type, UK, May 2015 – June 2017

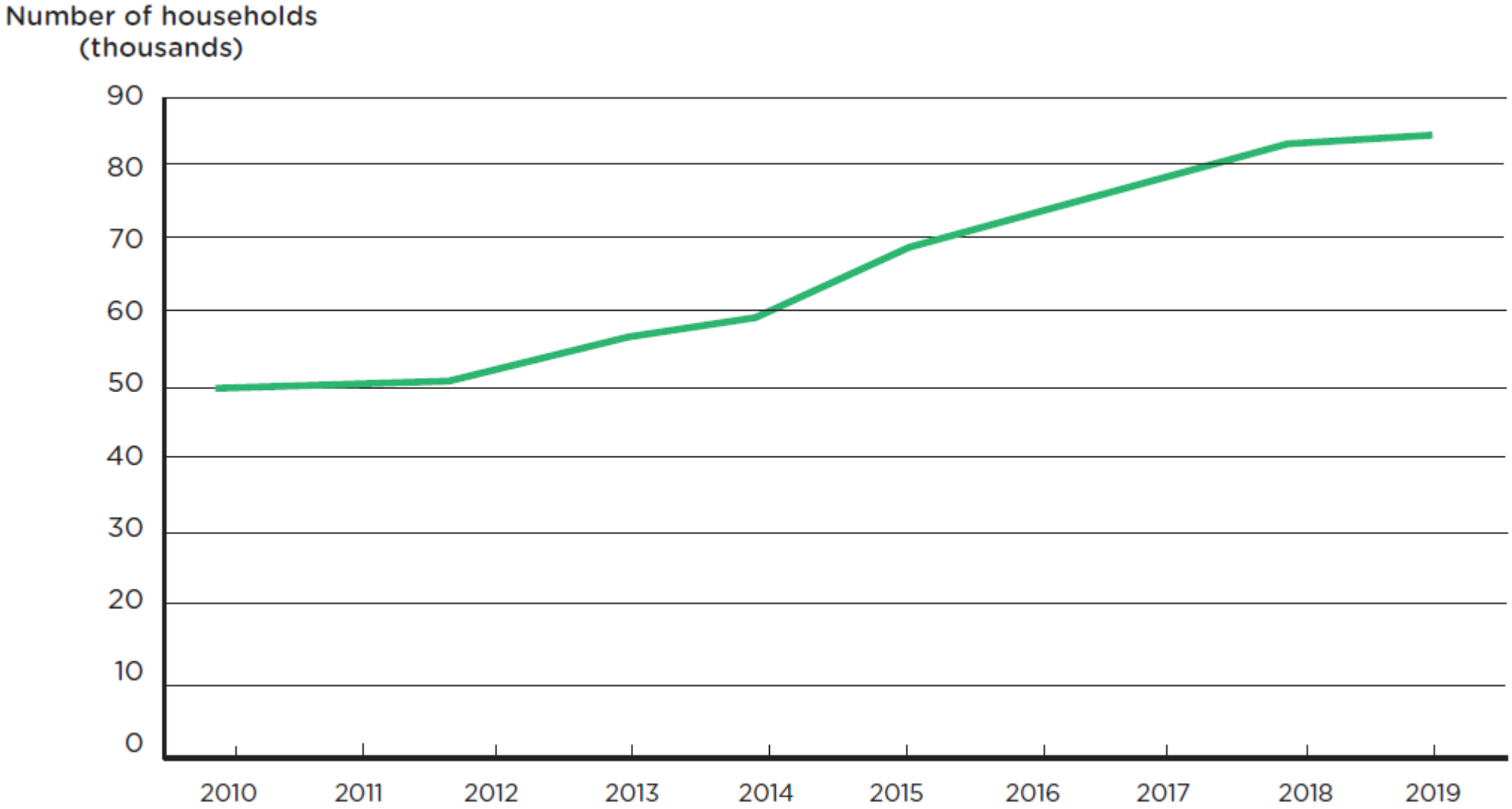
The effect of direct and indirect taxes is worse for lower income decile households



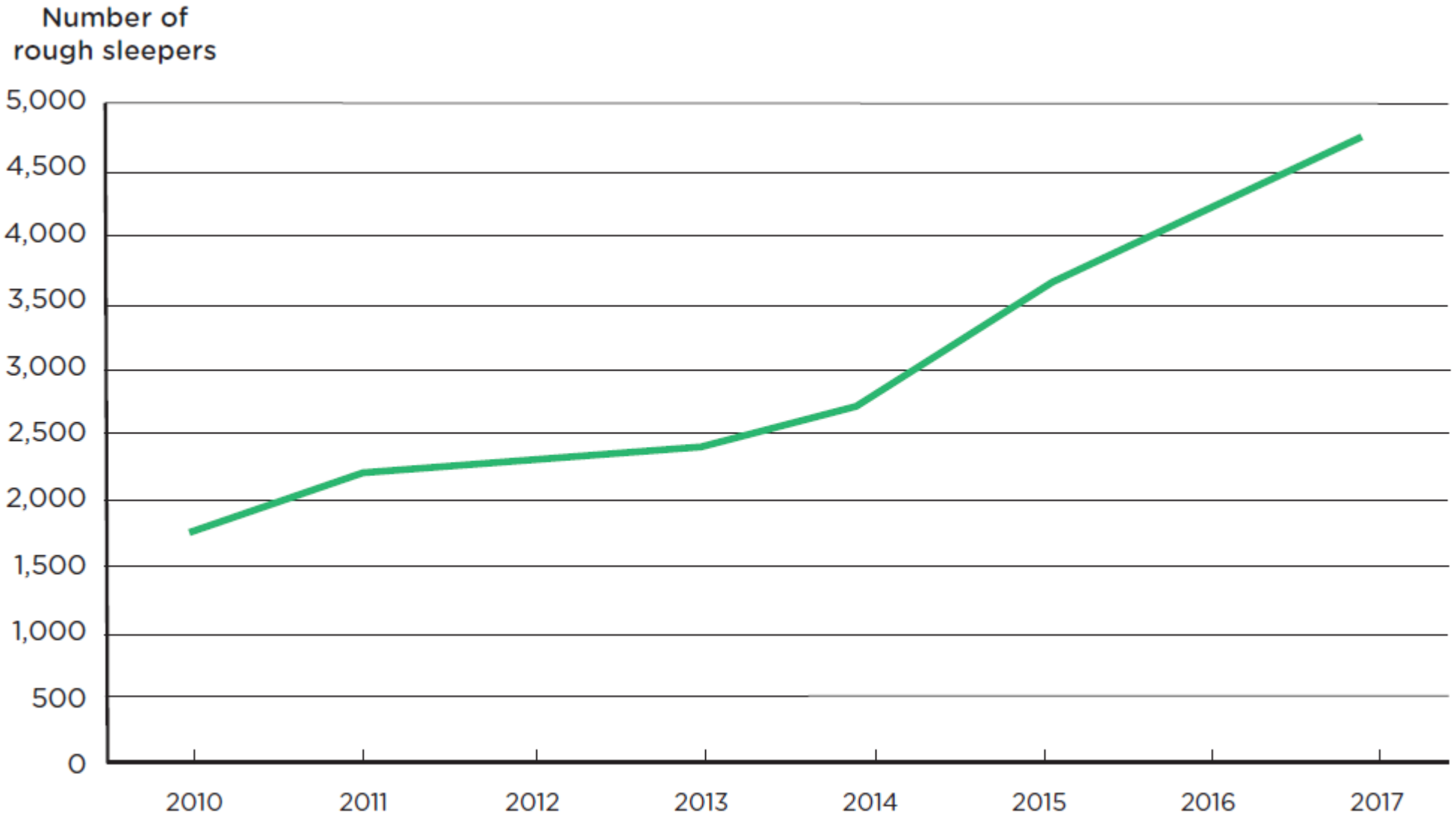
More families are spending more than one-third of their income on housing



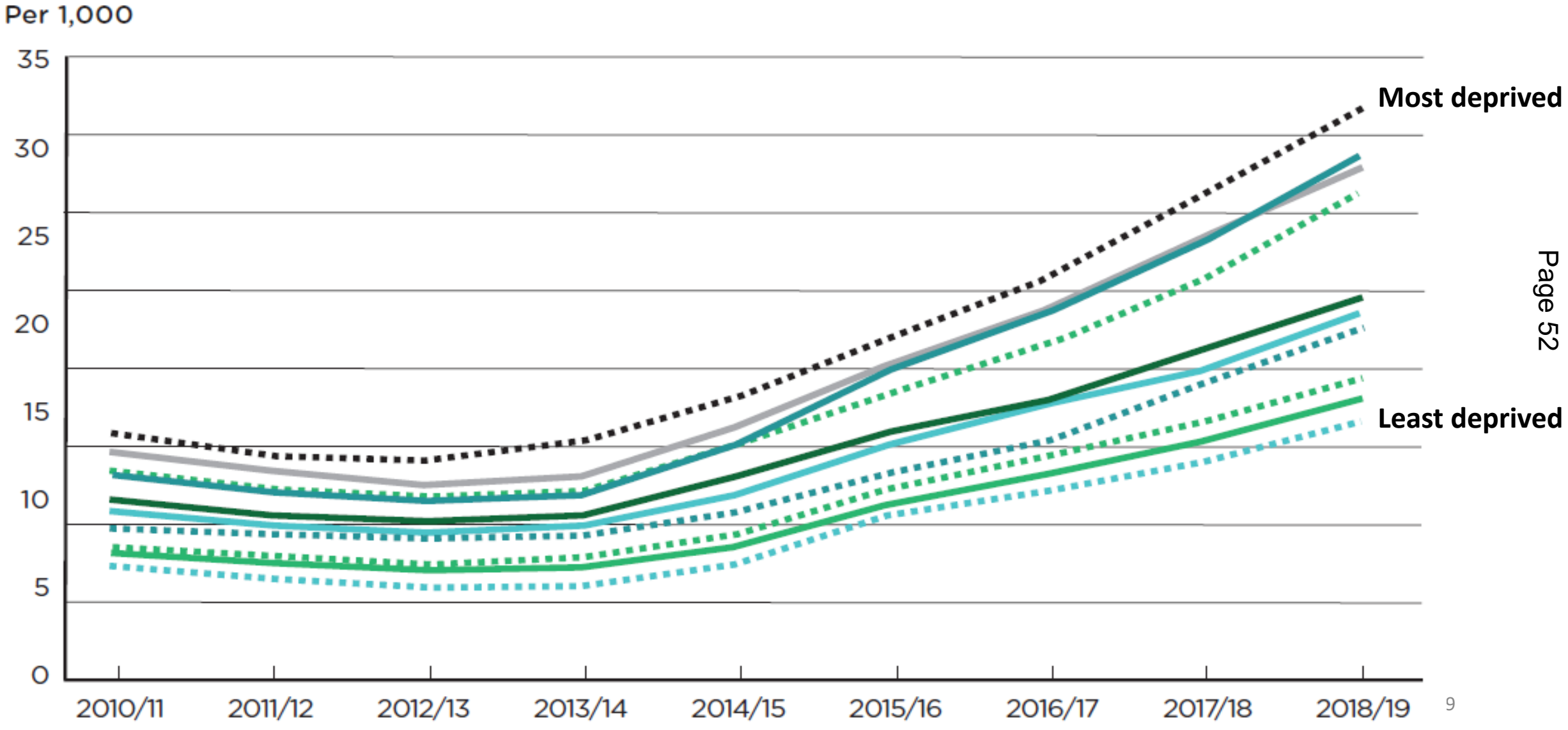
The number of households in temporary accommodation increased in England



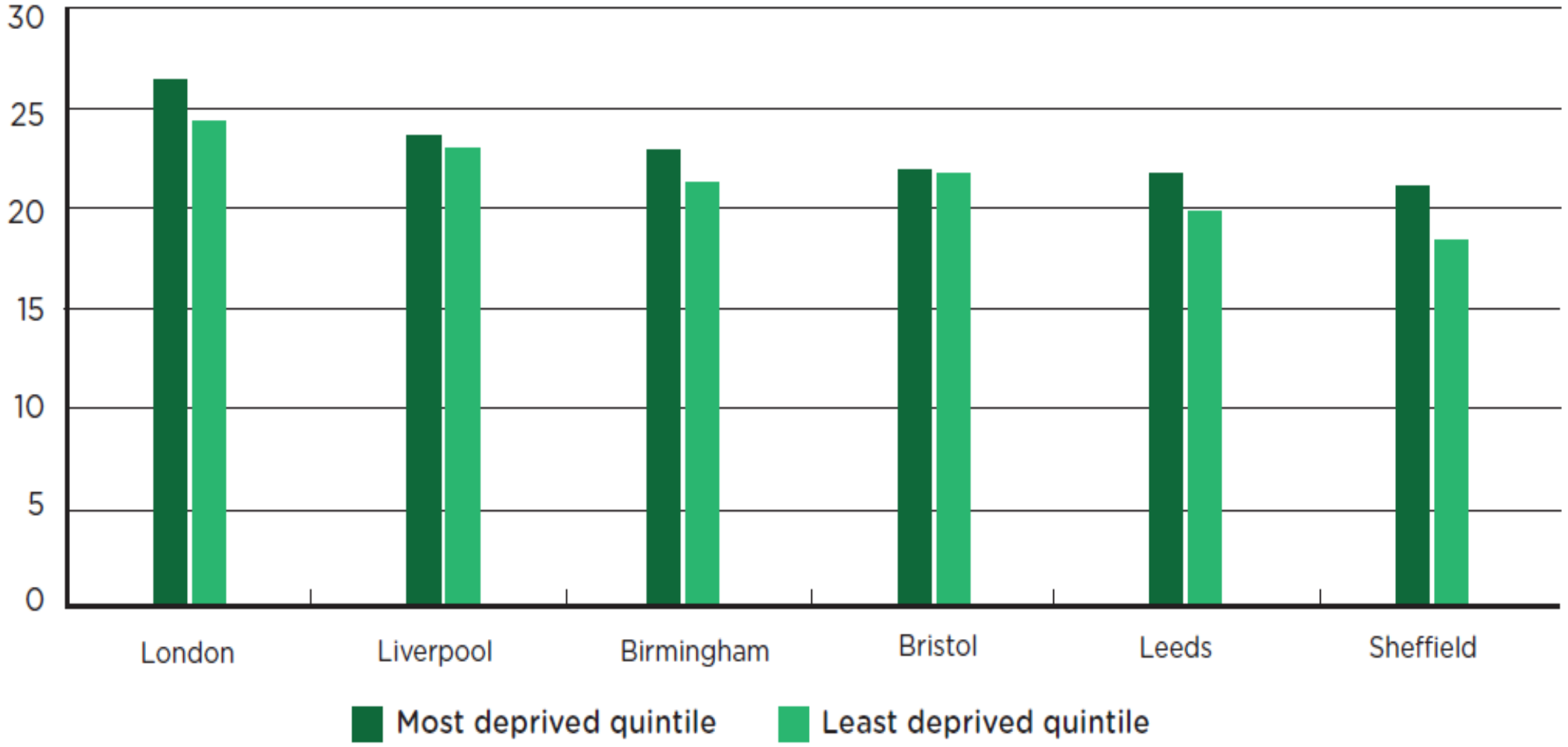
The estimated number of people sleeping rough in England tripled since the publication of the Marmot Review



After a small dip, violence increased the most for those in more deprived areas



Mean PM10 concentrations were higher in most deprived quintile in English cities



Climate Change and Health Equity

- Ensure 100 percent of new housing is carbon neutral by 2030, with an increased proportion being either affordable or in the social housing sector
- Aim for for net zero greenhouse gas emissions by 2030, ensuring inequalities do not widen as a result.

- “a wellbeing approach can be described as enabling people to have the capabilities they need to live lives of purpose, balance, and meaning for them.”

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Amartya Sen?

- “a wellbeing approach can be described as enabling people to have the capabilities they need to live lives of purpose, balance, and meaning for them.”

Amartya Sen?

No

INSTITUTE of HEALTH EQUITY

Marmot, COVID-19 and Health Inequalities in Coventry

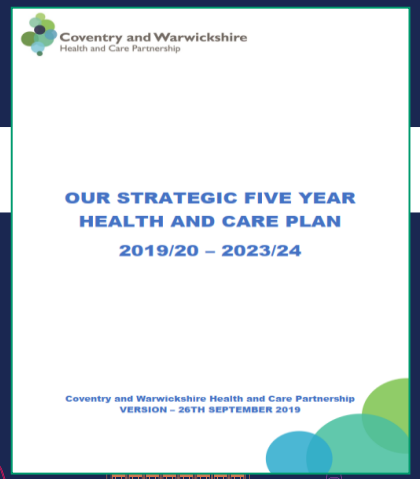
Liz Gaulton, Director of Public Health and Wellbeing
Coventry City Council

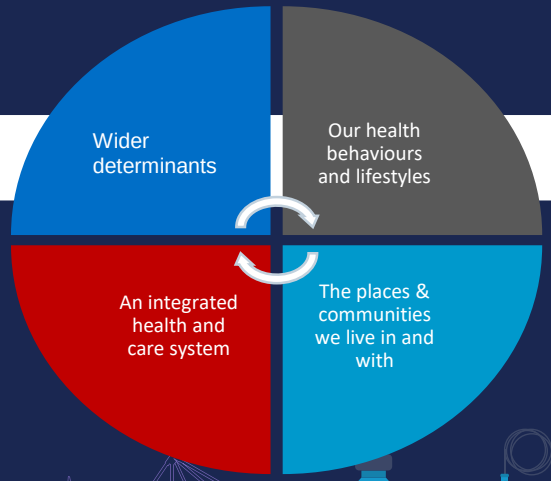
What's the story?

- 2012 - Coventry identified as one of seven pilot areas for Marmot approach to address significant health inequalities and life expectancy – based on Sir Michael Marmot 2010 report, Fair Society, Healthy Lives.
- The Marmot Steering group established - broad range of partners
- Ethos of system wide thinking has embedded the 6 Marmot principles
- In 2016 Coventry City Council, UCL and Public Health England committed to working together for a further three years with two key priorities – Action Plan 2016-19
- 2018 - Agreement across partners to incorporate and lead the work identified within the Poverty Summit held in November 2018
- 2019 On-going commitment to continue with our Marmot approach embedding it within our Health and Wellbeing Strategy
- DPH Annual Report 2019 – Bridging the Gap focused on inequalities and Marmot
- 2020 Evaluation of the impact on Coventry was published alongside the "Marmot Review –10 Years On"

Our journey so far

Our aim: to galvanise effort, expertise and resource to stimulate a step change in commitment to reducing health inequalities across the Health and Wellbeing system





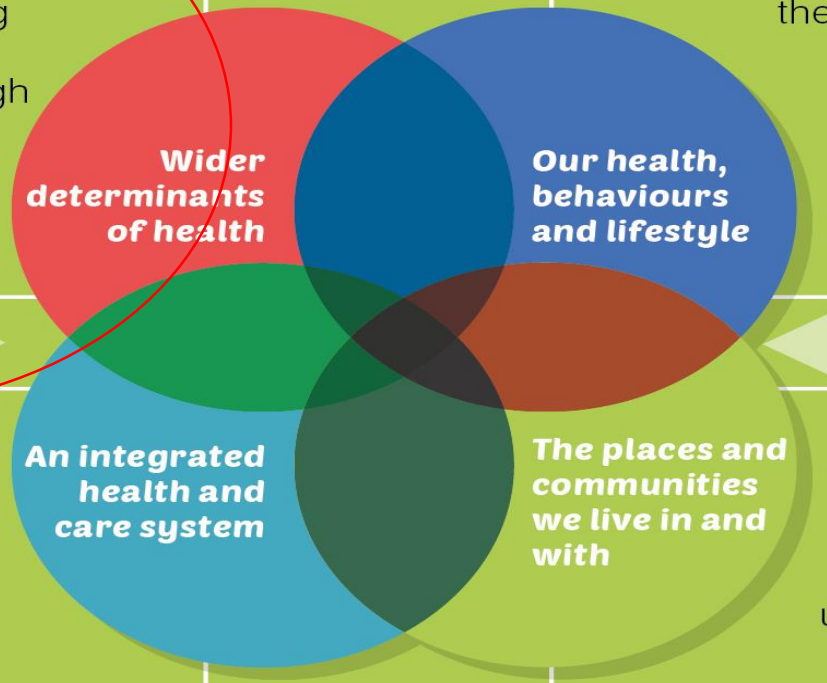
Health and Wellbeing Strategy 2019- 2023

Our population health framework

Strategic ambitions

- People are healthier and independent for longer
- Children and young people fulfil their potential
- People live in connected, safe and sustainable communities

Embedding the Marmot city approach by working in partnership to tackle health inequalities through addressing the social determinants of health



Aligning and coordinating the prevention programs across the system to maximise impact and tackle barriers to healthy lifestyle choices

Health and social care commissioners and providers working together to commission and deliver services in Coventry

Working together in our places and with our communities to mobilise solutions informed by our understanding of local assets from our place based JSNAs

Short-term focus

- Loneliness and social isolation
- Young people's mental health
- Working differently with communities

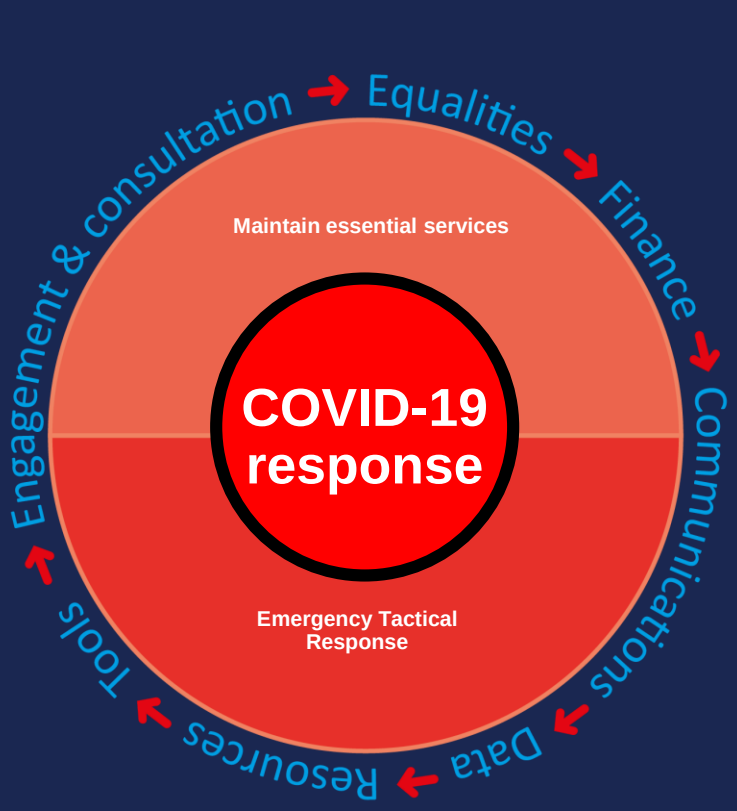
Our shared values and behaviours

prioritising prevention • listening and strengthening communities • coordinating services • sharing responsibility

Then the first case of COVID-19 in England was identified….

Our Emergency Response – mitigating the impact of COVID-19 on the more deprived communities

- We have built on the existing Marmot partnership work and mobilised quickly as a system to respond to COVID-19
- Food Network established with 1,000 people being fed and 500 further Social Supermarket parcels each week (twice the level pre-COVID-19).
- Innovative data sharing between the Council, hospitals, primary care to identify and support vulnerable groups of the city
- Established a Community Network consisting of local volunteers to support local people in their area
- Migrant Health Champions have been supporting their communities and disseminating messages alongside Public Health
- Supported places of worship and faith groups to adjust their religious practice and behaviours in light of COVID-19
- Temporary accommodation of rough sleepers and homeless
- Test and Trace – CWS as one of 11 national 'Beacons' to rapidly develop and test Local Outbreak Control Plans.


Engagement & consultation
Equalities
Finance
Communications
Data
Resources
Tools
Maintain essential services
COVID-19 response
Emergency Tactical Response


Business Continuity and Recovery
Engagement & consultation
Equalities
Finance
Communications
Data
Resources
Tools
Critical Service Analysis
Workforce requirements
Phased Re-opening
Current Areas of Focus
Pillar Scoping


Engagement & consultation
Equalities
Finance
Communications
Data
Resources
Tools
Business Continuity and Recovery
Organisational Culture & Design
Political Leadership & Governance Support
Financial management
A One Coventry Approach to Reset and Recovery
Working with Communities and new Social Economies
Regeneration & The Economy
Health & Wellbeing

Our Approach to Resetting Health and Wellbeing

- Build on our learning and experience and focus on the opportunity to reform, re-imagine and re-invent.
- Work as a whole system, in order to address longstanding issues and challenges in our city using a One Coventry approach
- Need to focus on where support has greatest impact, taking account of nuances across the city and be action-led
- Delivery at pace to continue, with focus on goals not processes
- We are keen to re-shape **with**, and not to, our residents and partners.

Resetting our health and wellbeing focus – key priorities

Areas of focus:
- Reducing health inequalities:
  - Understanding and mitigating the impact on specific groups, eg BAME, vulnerable households
- Jobs and employment for vulnerable groups
- Supporting our most vulnerable groups, eg migrant communities, homeless
- Air quality

Wider determinants

Our health behaviours and lifestyles

Areas of focus:
- Sustainable travel
- Physical activity
- Obesity
- Workplace well-being
- Smoking/alcohol/substance misuse
- Mental health
- Domestic abuse

Areas of focus:
- Infection prevention and control for all care environments
- Long term conditions
- Test and Trace
- General health protection:
  - Imms and vacs
  - Screening programmes

An integrated health and care system

The places & communities we live in and with

Areas of focus:
- Operation Shield
- Social isolation and loneliness
- Working differently with the VCOs/ our communities
- Primary care information sharing

Enabling activities
- JSNA – understanding our communities and using emerging data relating to covid and inequalities
- Staff capacity
- Developing our PHM approach to support COVID-19 response and recovery planning
- Re-thinking our commissioning strategy so that it is more flexible/responsive to emerging trends

Continuing to support our more vulnerable communities

- A focus on inequalities and disparities across the Coventry place, taking into account findings from the PHE Report, COVID-19: Review of Disparities in Risks and Outcomes
- Local Outbreak Control Plan includes an emphasis on inequalities and disparities
- Conducting a COVID -19 impact assessment to understand how COVID -19 has impacted on all our residents and the city
  - Health inequalities
  - Focus on residents with a protected Equality characteristics
  - Economy
  - Transport
- Conducting Equality Impact Assessments on all our services to understand the impacts on both residents and staff – Coventry has added deprivation.
- A key theme embedded across the whole of the Council's approach to reset/recovery
- Continue to work in partnership to reduce the long term harm and inequalities caused by COVID -19

HWBB REFRESH - tackling health inequalities

Health Select

3rd September

Background

- Published in 2010, The Marmot Review was a landmark study of health inequalities in England.
- The ground-breaking review confirmed governments policies focusing on the health care system and individual behaviour change approaches are not hugely effective at reducing health inequalities.
- To improve health for everyone and reduce inequalities action needs to be taken on the social determinants – the circumstances in which we are born, grow, live, work and age (causes of the causes of ill health).
- Yet a decade of austerity has seen drastic cuts to local government funding, which is tasked with funding the wider determinants.

Marmot Principles

The report outlined six policy objectives, known as the Marmot principles:

- Giving every child the best start in life
- Enabling all children, young people and adults to maximize their capabilities and have control over their lives
- Creating fair employment and good work for all
- Ensuring a healthy standard of living for all
- Creating and developing sustainable places and communities
- Strengthening the role and impact of ill-health prevention.

The new report, Health Equity in England: The Marmot Review 10 Years On, was published in February 2020. The key findings were:

People can expect to spend more of their lives in poor health.

Improvements to life expectancy have stalled and declined for the poorest 10% of women.

Only the 20-30% least deprived will receive a state pension before they develop a lifelong disability.

The health gap has grown between wealthy and deprived areas.

There are marked regional differences and widening health inequalities between the North and the South.

The slowdown in life expectancy increase cannot for the most part be attributed to severe winters. More than 80 percent of the slowdown, between 2011 and 2019, results from influences other than winter-associated mortality.

Two thirds of those with lifelong disabilities in the most deprived areas have disabilities before they reach pension age.

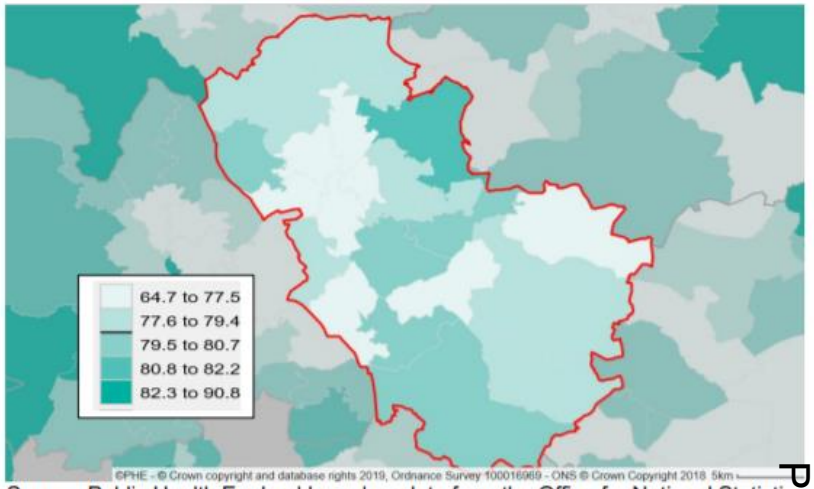
For males, years in poor health has increased from 15.8 to 16.2 since 2009, for females from 18.7 to 19.4.

It is likely that public sector cuts have harmed health and contributed to widening health inequalities in the short term and are likely to continue to do so over the longer term. Cuts over the period shown have been regressive and inequitable – they have been greatest in areas where need is highest and conditions are generally worse.

Locally ……

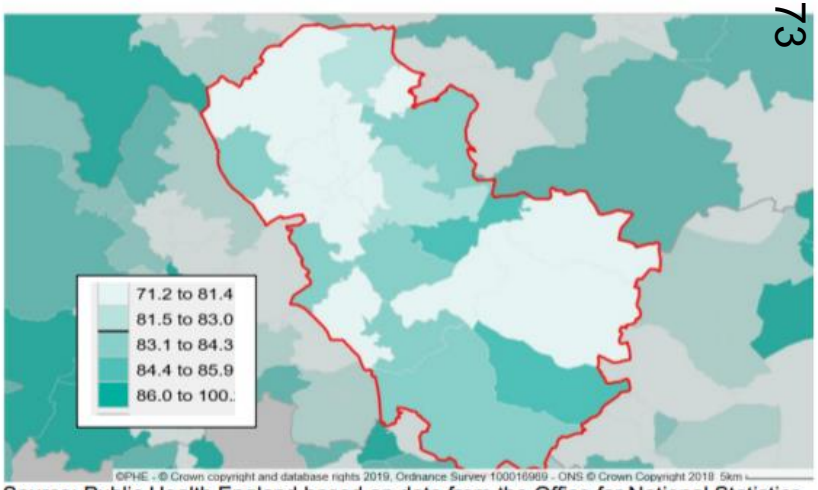
- The Marmot review findings reflect the local picture.
- Life expectancy has stalled in Rotherham and remains below the national average.
- Inequalities are widening between the most and least deprived communities within Rotherham, particularly for women.
- Life expectancy is 9.9 years lower for men and 9.5 years lower for women in the most deprived areas of Rotherham than in the least deprived areas.
- Comparatively, in 2010, life expectancy was 9.3 years lower for men and 6.6 years lower for women in the most deprived areas of Rotherham than in the least deprived areas.

[1] Life expectancy at birth for males, 2013-2017 (years)



Source: Public Health England based on data from the Office for National Statistics.

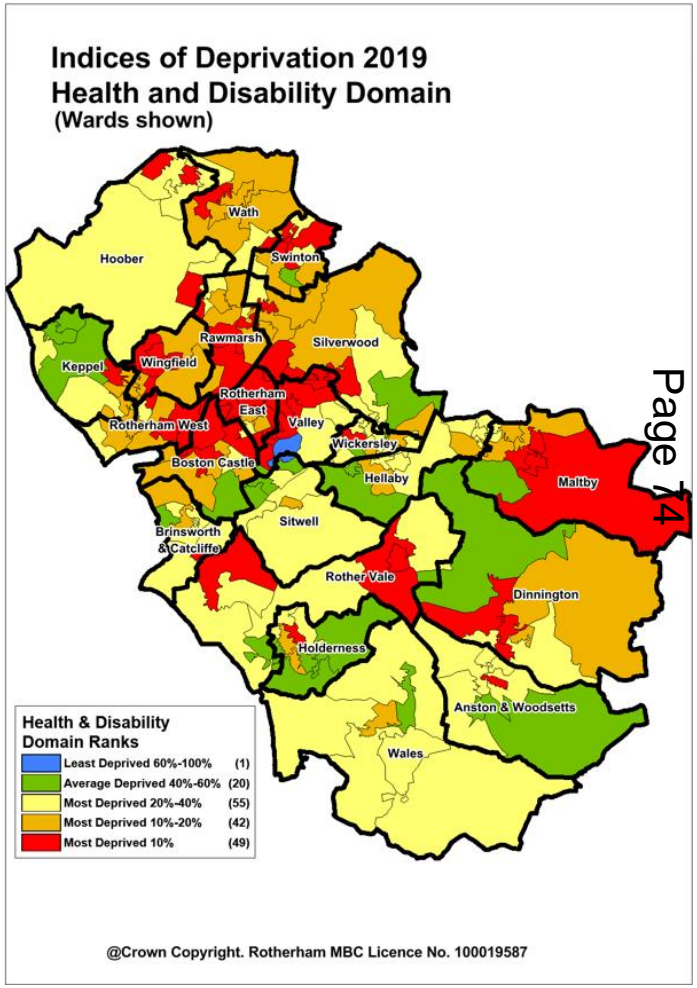
[1] Life expectancy at birth for females, 2013-2017 (years)



Source: Public Health England based on data from the Office for National Statistics.

Locally ……

- Rotherham is one of the 20% most deprived districts/unitary authorities in England and has moved up the rankings in terms of deprivation according to the 2019 Indices of Deprivation findings.
- The results within the health and disability domain were a key driver in this increase.
- Men in Rotherham can expect to have a disability free life expectancy of 57.9 years and women 56.3 years, compared to a national average of 62.9 years and 61.9 years respectively.



COVID-19

- Research also indicates that COVID-19 is having a significant impact upon health inequalities.
- At a national level, Public Health England has completed a report into “Disparities in the risk and outcomes of COVID-19”. The review is a descriptive look at surveillance data on the impact of COVID-19 on risk and outcomes.
- Key findings from the report are detailed on the next slide, however, note that some data is provisional and further analysis is needed.
- Also, note that much of the analysis covers the time frame up to 8th May, when most testing was being offered in hospital to those with a medical need. Thus any disparities may reflect differences in the need to present to hospital or the likelihood of being testing in addition to any differences in the risk of contracting the infection.

The key findings of this report were:

Age

COVID diagnosis rates increased with age for both sexes.

Those over 80 years old with a positive test were 70x more likely to die when compared with those under 40.

Sex

Working age males diagnosed with COVID were twice as likely to die as females.

Geography

Local authorities with the highest diagnoses and deaths were mostly urban.

Death rates in the highest region (London) were 3x higher than in the lowest region (South West).

Deprivation

Those who live in deprived areas have higher diagnosis and death rates than those in less deprived areas.

Mortality rates from the most deprived areas were double those of the least deprived areas (both sexes).

Ethnicity

Death rates highest among people of Black and Asian ethnic groups.

Effect of comorbidities is significant – when included, the ethnicity difference in risk of death amongst hospitalised patients is greatly reduced.

Care Homes

Deaths in care homes accounted for 27% of deaths up to 8th May.

There have been 2.3x the number of expected deaths in care homes (20,000 extra deaths).

Inclusion Health Groups

Comparatively larger increase in deaths among people born outside the UK and Ireland.

Potential that much higher diagnosis rate amongst rough sleepers compared to general population (poor quality data).

Occupation

Increase in deaths for those working in health and social care, plus men working as taxi drivers or in public transport, sales assistants and low skilled workers in construction/processing plants.

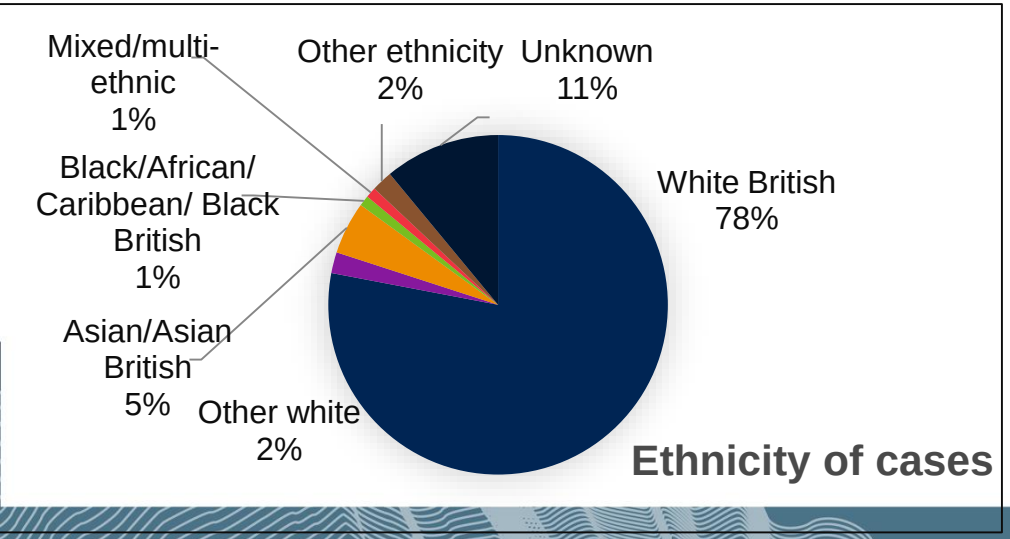
Further analysis needed due to small number of deaths for many occupations.

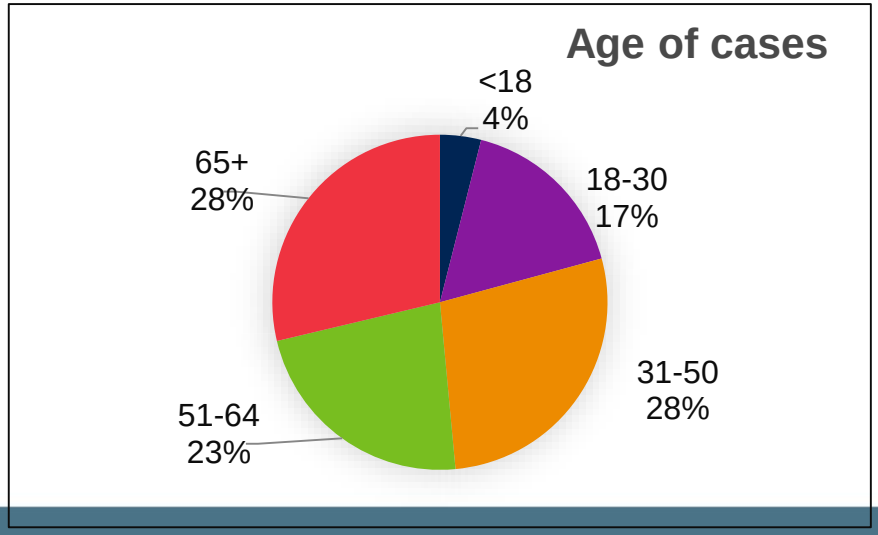
Comorbidities

Among deaths with COVID-19 mentioned on the death certificate, a higher percentage mentioned diabetes, hypertensive diseases, chronic kidney disease, chronic obstructive pulmonary disease and dementia than all cause death certificates.

COVID-19 infection in Rotherham

- 2,180 cases in Rotherham (cumulative rate: 821 per 100,000 to 27th August)
- Since NHS Test and Trace (open access testing launched 28th May):
  - Total tests: 82,755 (4,242 positive, 74,567 negative, 3,966 void)
  - 38% male, 58% female, 3% unknown
  - 50% cases from postcodes in IMD deciles ranked 1-3 (most deprived)





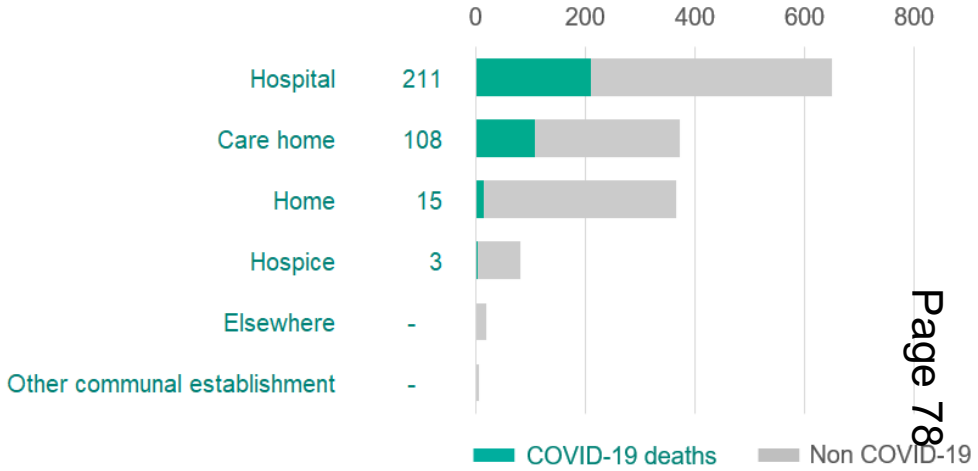
COVID-19 deaths in Rotherham

- 337 COVID deaths up to 17th August
- 33% of deaths occurring in hospitals mentioned COVID, compared to 29% of those in care homes, 4% at home and 4% of those in hospices.
- 63% of COVID deaths occurred in hospital, 32% in care homes.

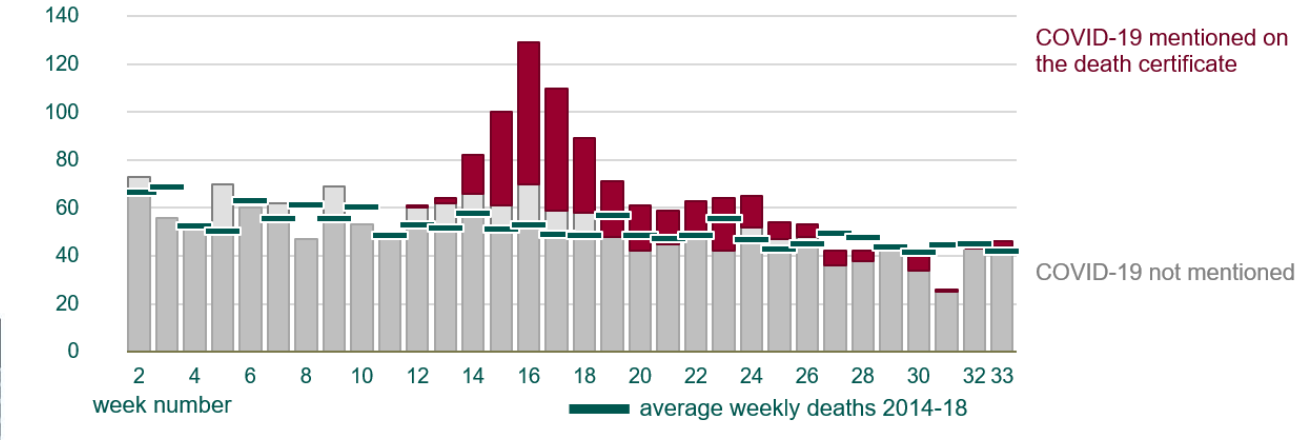
Registered deaths for Rotherham from 20 March 2020 up to 14 August 2020

2020 Deaths by place of death (cumulative numbers) for deaths registered from the week ending 20 March 2020 up to 14 August 2020, Rotherham

Place of death - count where COVID-19 mentioned on the death certificate



All deaths in 2020 by week, with proportion where COVID-19 is mentioned



ONS - Deaths registered weekly in England and Wales, provisional

Social determinants context

Impact of lockdown on health behaviours – e.g. mental health

School closures, loss of education, issues with exam results, changes to university provision/availability

Disruption to community/social interaction

Public transport impact
Cycling opportunities

Reduction in commuting, less air pollution

Job losses, furlough, zero hours contracts, changes to work availability

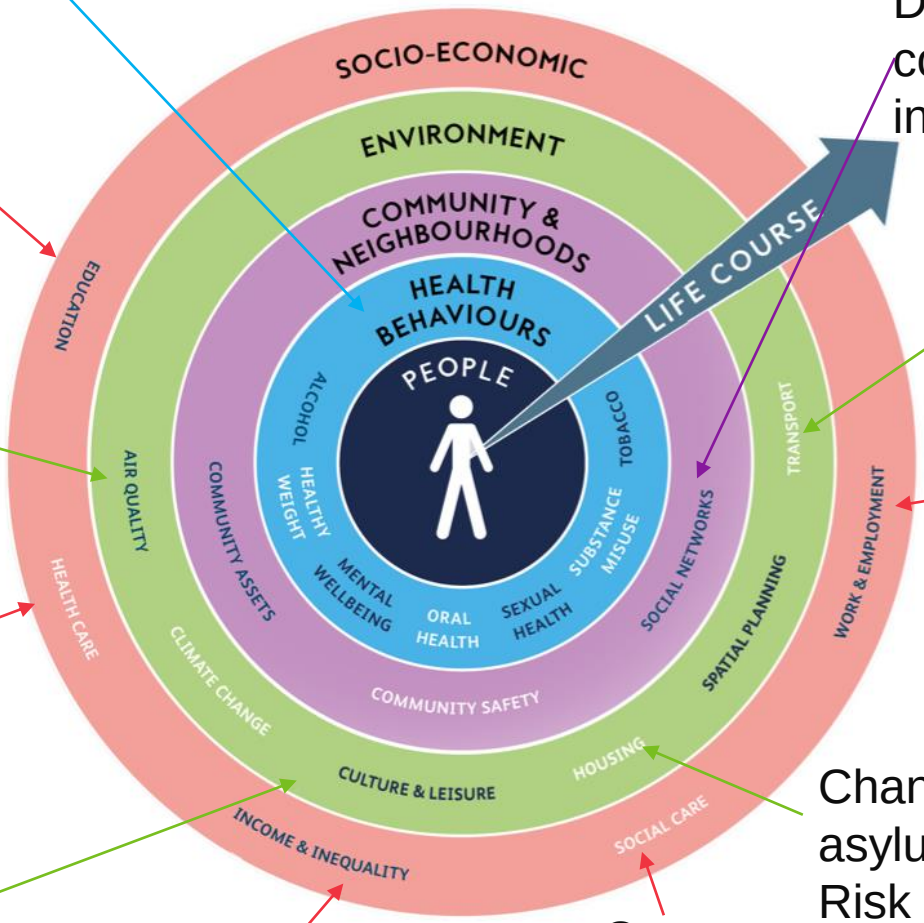
Disruptions to health care provision, delays to care, avoidance of care

Changes to homeless, asylum seeker provision
Risk of rent/mortgage problems due to loss of earnings

Disruption to/loss of culture and leisure activities. Increased use of outdoor space

Unequal covid impact

Care home impacts



Recommendations of the Marmot Review: 10 Years On Report

- The report makes recommendations with regards to tackling health inequalities, structured around the Marmot principles and an additional category: ‘Taking Action’
- The existing Health and Wellbeing Strategy draws from the Marmot principles. Examples of alignment include:
  - Aim 1: All children get the best start in life and go on to achieve their potential – focus on the early years, skills
  - Aim 4: All Rotherham people live in healthy, safe and resilient communities – focus on the wider determinants of health including skills and employment, climate change, culture, housing
  - Developing the ‘social determinants of health workforce’ – Making Every Contact Count Training
  - Early intervention
  - Public engagement, particularly in terms of what drives health
  - Whole systems monitoring and accountability for health inequalities

HWBB

The Health and Wellbeing Board agreed for a development session to be held on 16th September 2020. The focus of this session will be on reviewing the priorities of the board considering the impact of COVID-19 as well as consideration of local health inequalities and the findings of the Marmot report. The Local Government Association will be facilitating this session.

The proposed outcomes for the development session are as follows:

- To review current priorities and consider what priorities may need to change for the Health and Wellbeing Board, when considering the long-term consequences of COVID-19.
- To confirm the key actions for the Health and Wellbeing Board to meet these priorities.
- To discuss how we prioritise health inequalities and the Marmot principles as part of our ongoing response and recovery.

Following the development session, a refreshed set of priorities will be presented at the Health and Wellbeing Board in November for approval.

Recommendations to Health Select

To ensure that the Health Select Commission is able to contribute towards the refresh of Health and Wellbeing Board priorities, it is proposed that members consider and respond to the following questions:

- What are your biggest concerns regarding health inequalities in Rotherham?
- Are there any emerging priorities that need to feature more highly on the agenda?
- Is there anything that we are doing differently as a result of our COVID-19 response that we would want to maintain?

Rotherham Metropolitan Borough Council

Public Report
Health Select Commission

Committee Name and Date of Committee Meeting
Health Select Commission – 03 September 2020

Report Title
Carers Programme

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

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

Report Author(s)
Jo Hinchliffe
Adult Care Housing and Public Health - Service Improvement and Governance Manager
jo.hinchliffe@rotherham.gov.uk

Ward(s) Affected
Borough-Wide

Report Summary.

On the 21st October 2019 we introduced new a way of working to ensure a consistent, robust and sustainable Pathway; our work with carers is defined via a “sub-pathway” and in March 2020 plans were shared with the Health and Wellbeing Board explaining how we anticipated we would deliver a carers programme.

The council offer is part of a wider system approach and carers have been added to the Rotherham Health and Social Care Place Plan as a key area of focus, recognising the importance they play and very much highlighted by Covid-19.

This report offers an update to the Health Select Commission on the Carers Programme and provides information on the reprofiled timeline for the associated project work.

Recommendations

1. The Carers Strategy review work will begin at the end of September 2020 and will result in a new strategy scheduled to launch June 2021

2. As a result of the response to Covid 19 some work has occurred around the mapping of services and the ASC pathway; this will continue and result in a refresh of the policy and guidance by December 2020.

3. Work will be undertaken to plot out the recovery activity needed for the Carer Centres and alongside a strategic review and impact assessment of the facility will commence at the end of September.

4. We will look to expand the work on the Unpaid Carers Group particularly the engagement approach undertaken to maintain conversations throughout the Covid 19 emergency response and think about ways of increasing digital connectivity and skills for carers.

List of Appendices Included
Appendix 1 Presentation Slide Deck

Background Papers
Caring Together the Rotherham Carers Strategy 2016-2021

Consideration by any other Council Committee, Scrutiny or Advisory Panel
None

Council Approval Required
You should refer to Appendix 9 of the Constitution – Responsibility for Functions – to check whether your recommendations require approval by Council, as well as Cabinet or a committee. You should take advice from Democratic Services if you are not sure.

No

Exempt from the Press and Public
No

Carers Programme

1. Background – New Adult Care Pathways

1.1. Rotherham's Adult Social Care Pathway puts the person at the centre of everything we do. For us to do our best work, every process, every interaction and every outcome must have the person at the core.

1.2. On the 21st October 2019 we introduced new a way of working to ensure a consistent, robust and sustainable Pathway; our work with carers is defined via a “sub-pathway” and in March 2020 plans were shared with the Health and Wellbeing Board explaining how we anticipated we would deliver a carers programme.

1.3. Furthermore, there is a requirement to review our Adult Social Care - Carer Assessment and Eligibility Policy Guidance for Carers as well as refreshing the existing Rotherham Carers Strategy.

1.4. With the introduction of the sub-pathway and the need to review the key policy and strategy documents a high-level action plan was devised to provide a framework for future work. This will ensure we deliver a quality customer journey and provide the right level of support for carers.

1.5. The council offer is part of a wider system approach and carers have been added to the Rotherham Health and Social Care Place Plan as a key area of focus, recognising the importance they play and very much highlighted by Covid-19.

1.6. The week after the information was presented to the Health and Wellbeing Board the council mobilised resources appropriate for the management of the Covid 19 Pandemic and this had significant impact on the proposed programme timeline.

1.7. However, out of adversity came opportunity and although the programme timeline was considerably compromised several actions have been progressed. Having to work extremely quickly in significantly different ways meant partnerships had to be even stronger to ensure carers were fully supported in the most difficult of situations.

2. Where were we at? (Pre-Covid 19)

2.1. The Survey of Adult Carers in England 2018-19 is a national survey carried out by the NHS Digital for Health and Social Care. 362 out of a sample of 813 carers responded to the survey, which is a response rate of 44.5%.

2.2. All local authorities with social services responsibilities are required to take part. The purpose of the survey is to find out; if services received by carers are helping them in their caring role, about the carer's life outside of caring and carer's perception of services provided to the cared for person.

2.3. Carer Survey Recommendations:

1. Develop processes to enable a smoother transition from children to adult services.
2. Develop consistency in our approach i.e. dedicated case worker from point of contact throughout.
3. Strengthen our information and advice offer to ensure it reaches its target audience and is fit for purpose.
4. Introduction of the Target Operating Model (ASC Pathway) should ensure that advice and support is available before the situation becomes critical.

3. What we needed to do?

- Update the carer profile (Inc Young Carers) who are our carers?
- Review of the current carer strategy – complete an impact assessment via focus group work.
- Assistive Technology Offer - ensure carers are embedded with the strategic plans.
- Assessment process reviewed to ensure the sub-pathway is pitched correctly.
- Carer Journey – mapped to inform policy guidance changes.
- Carers Centre - impact assessment.
- Partnership Boards - review Terms of Reference and map to the carer strategy delivery.
- Information Offer - scope it out.
- Carer services - asset mapping of what is out there.
- Activity and events planned for 2020-21.
- Training prospectus refreshed for new financial year.

4. What has been happening through the Covid 19 Period

4.1. Due to the repositioning of council resources a number of key projects / services were paused. The original plan for Quarter 1 was superseded by the Covid 19 emergency response. Working with carers however was even more critical and so it was appropriate to ensure all attention was directed to supporting carers through the Covid 19 period. This was done by setting up the Unpaid Carers Group.

4.2. This group came together to focus energy and resources on helping our unpaid carers, both adults and young people; and to develop solutions for support in a very challenging environment. Virtual groups were set-up with the aim of looking at getting information out to carers and to also to set-up the carers grant scheme.

Carers Grant = £50k in grants which was a significant investment from Cabinet for carers during Covid 19 pandemic period. The approach was co-produced with carers and is facilitated by Crossroads

5. How will we progress?

5.1. **Key Objectives to progress from the end of Quarter 2:**

- ❑ We will map the carer experience and ensure the carers programme addresses any gaps.
- ❑ We will ensure effective communication processes are in place to fully support carers.
- ❑ We will refresh our understanding of the profile of carers in Rotherham in the light of Covid 19.
- ❑ We will invite reps from the Unpaid Carers Group to become members of the Carer Programme Project Group.
- ❑ We will continue to progress the Carers Grant work

6. Other considerations:

6.1. The Carers Strategy review work will begin at the end of September 2020 and will result in a new strategy scheduled to launch June 2021, which still means we are within the timeframe of the existing strategy lifespan.

6.2. As a result of the response to Covid 19 some work has occurred around the mapping of services and the ASC pathway; this will continue and result in a refresh of the policy and guidance by December 2020. (A Sub-group will be set-up to look at young carers and how they transition into the ASC pathway.)

6.3. As per the government guidance and in line with council recovery principles the Carers Centre is not currently accessible – work will be undertaken to plot out the recovery activity needed. Alongside a strategic review and impact assessment of the facility will commence at the end of September with a report due by December 2020.

6.4. To support carers through the Covid 19 crisis a Carers Information Pack was produced by the council and signed-off by partners. This work will be

maximised; we will look to expand this approach and think about ways of increasing digital connectivity and skills for carers. This will be alongside all the traditional options for sharing and communicating information, advice and guidance.

6.5. The programme will be subject to check and challenge via the ASC Project Assurance Meeting and will feed into the Health and Wellbeing Board each quarter.

Accountable Officer(s)
Jo Hinchliffe, Service Improvement and Governance Manager

This report is published on the Council's website.

Adult Social Care

Health Select Committee

Carers – Framework for the Future

August 2020

Carers - Framework for the Future 2020-21

Rotherham's Adult Social Care Pathway puts the person at the centre of everything we do. For us to do our best work, every process, every interaction and every outcome must have the person at the core.

On the 21st October 2019 we introduced new a way of working to ensure a consistent, robust and sustainable Pathway; our work with carers is defined via a "sub-pathway" and in March 2020 plans were shared with the Health and Wellbeing Board explaining how we anticipated we would deliver a carers programme.

Furthermore, there is a requirement to review our Adult Social Care - Carer Assessment and Eligibility Policy Guidance for Carers as well as refreshing the existing Rotherham Carers Strategy.

With the introduction of the sub-pathway and the need to review the key policy and strategy documents a high level action plan was devised to provide a framework for future work. This will ensure we deliver a quality customer journey and provide the right level of support for carers.

The council offer is part of a wider system approach and carers have been added to the Rotherham Health and Social Care Place Plan as a key area of focus, recognising the importance they play and very much highlighted by Covid 19.

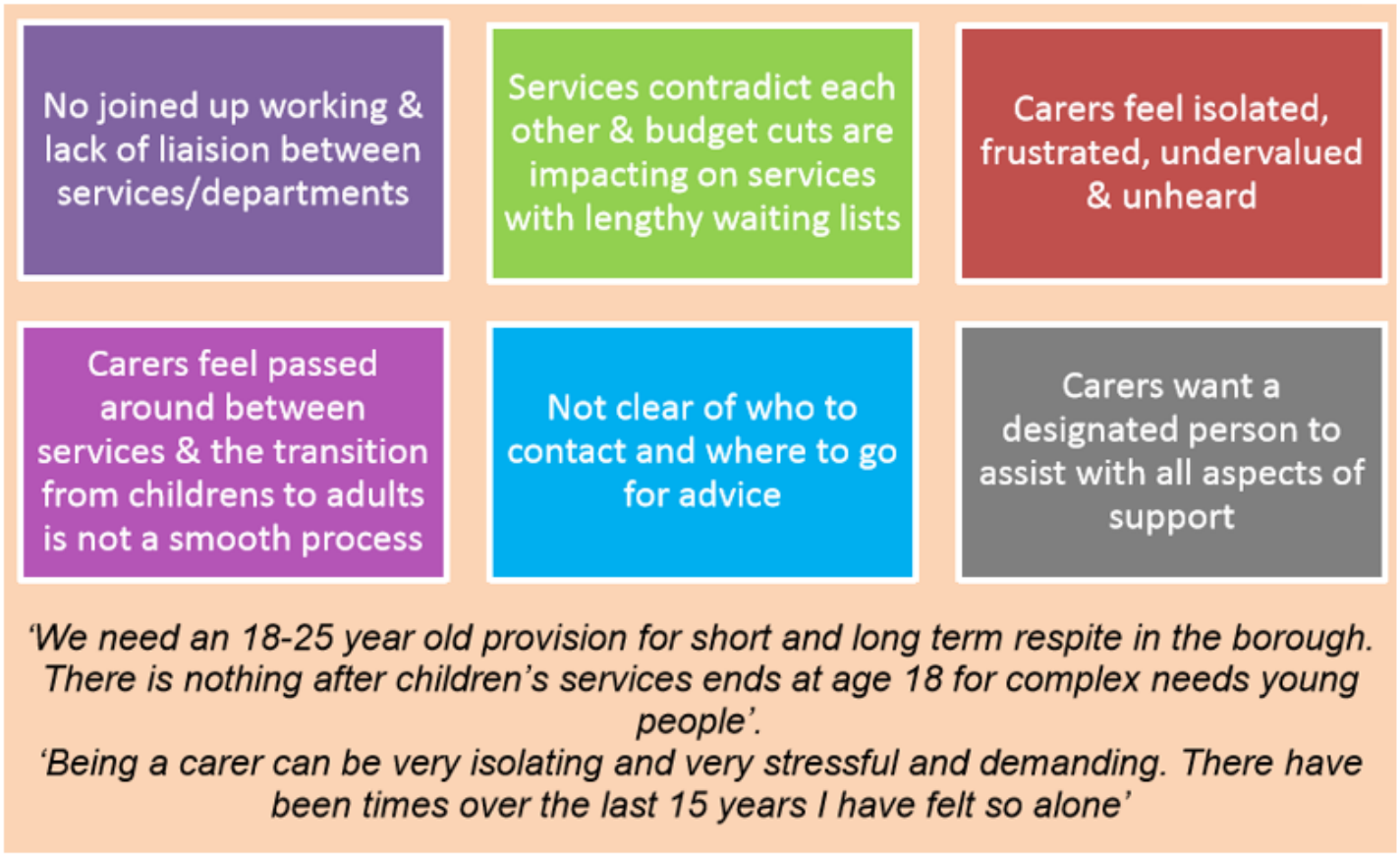
The week after the information was presented to the Health and Wellbeing Board the council and partners mobilised resources appropriate for the management of the Covid Pandemic and this had significant impact on the proposed programme timeline.

However, out of adversity came opportunity and although the programme timeline was considerably compromised a number of actions have been progressed. Having to work extremely quickly in significantly different ways meant partnerships had to be even stronger to ensure carers were fully supported in the most difficult of situations.

We are now in a position to look at what has been achieved and to refresh the original programme timelines. We have a moment to build upon the sterling work that has happened whilst all services were deploying their emergency plans.

**For the purposes of this document a 'carer' means an adult aged 18and over who provides or intends to provide help to another adult. An adult who provides care under a contract or as voluntary work will not be regarded as a carer.*

Where we were at? *(Information presented to Health and Wellbeing Board 11th March 2020)*



Carers Survey Report July 2019

What we needed to do?

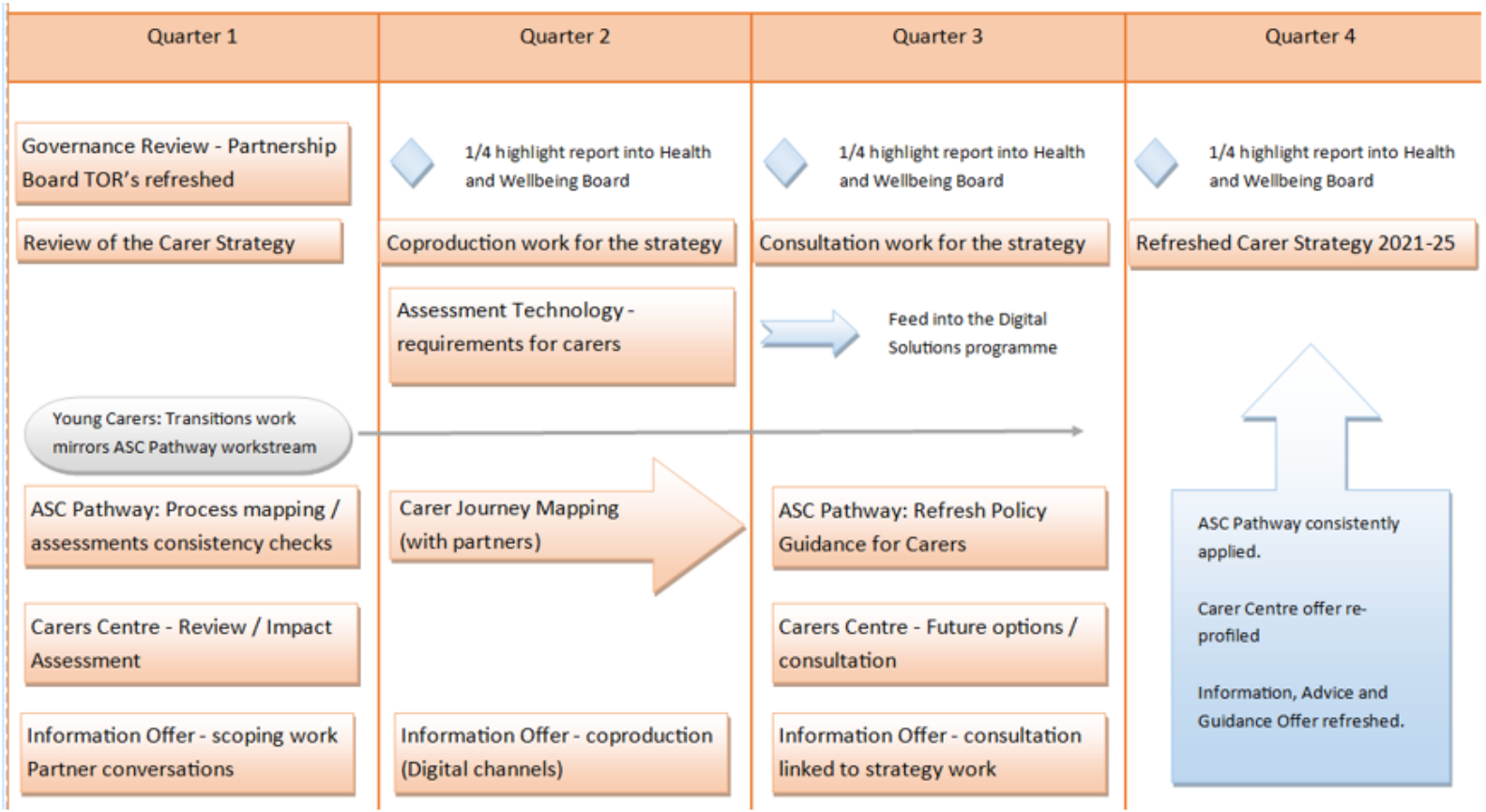
(Information presented to Health and Wellbeing Board 11th March 2020)

Things to consider: Carers Survey Analysis
Briefing Note: July 2019
Recommendations:
•Develop processes to enable a smoother transition from children's to adult's services.
•Develop consistency in our approach i.e. dedicated case worker from point of contact throughout.
•Strengthen our information and advice offer to ensure it reaches its target audience and is fit for purpose.
•Introduction of the TOM Model should ensure that advice and support is available before the situation becomes critical.

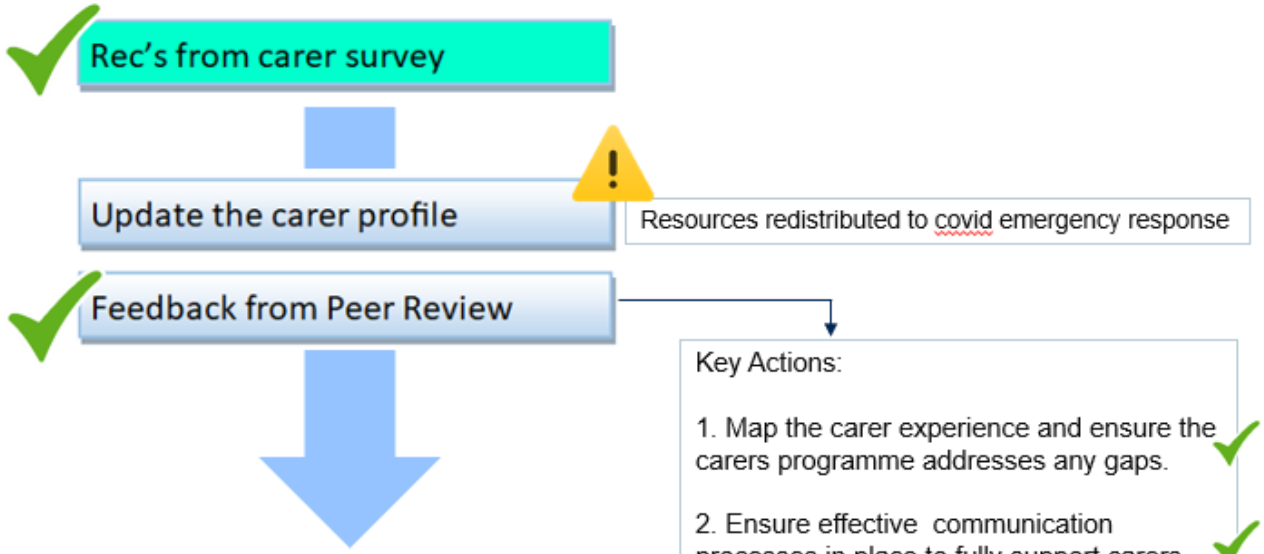
Things to do:
•Update the carer profile (Inc Young Carers)
•Review of the current strategy - impact assessment / focus group work
•AT Offer - carers embedded with in
•Assessment process reviewed and recommendations made
•Carer Journey - mapped
•Carers Centre - impact assessment
•Partnership Boards - review TOR
•Information Offer - scope it out
•Carer services - asset mapping of what is out there
•Activity and events planned
•Training prospectus

Things to aim for:
•We will commit to improving how carers are involved in the production and design of services.
•We will make sure carers feel informed about and involved in the conversations surrounding the person they care for.
•We will look at how to widen personal budgets.
•We will work with employers to raise awareness of flexible working policies.
•We will support carers taking a break from caring.
•We will make it easy for carers to get the right information at the right time.
•We will ensure carer assessments incorporate solutions that include friends, family and the wider community.

Proposed Implementation Plan 2020-21 (BEFORE Covid 19)

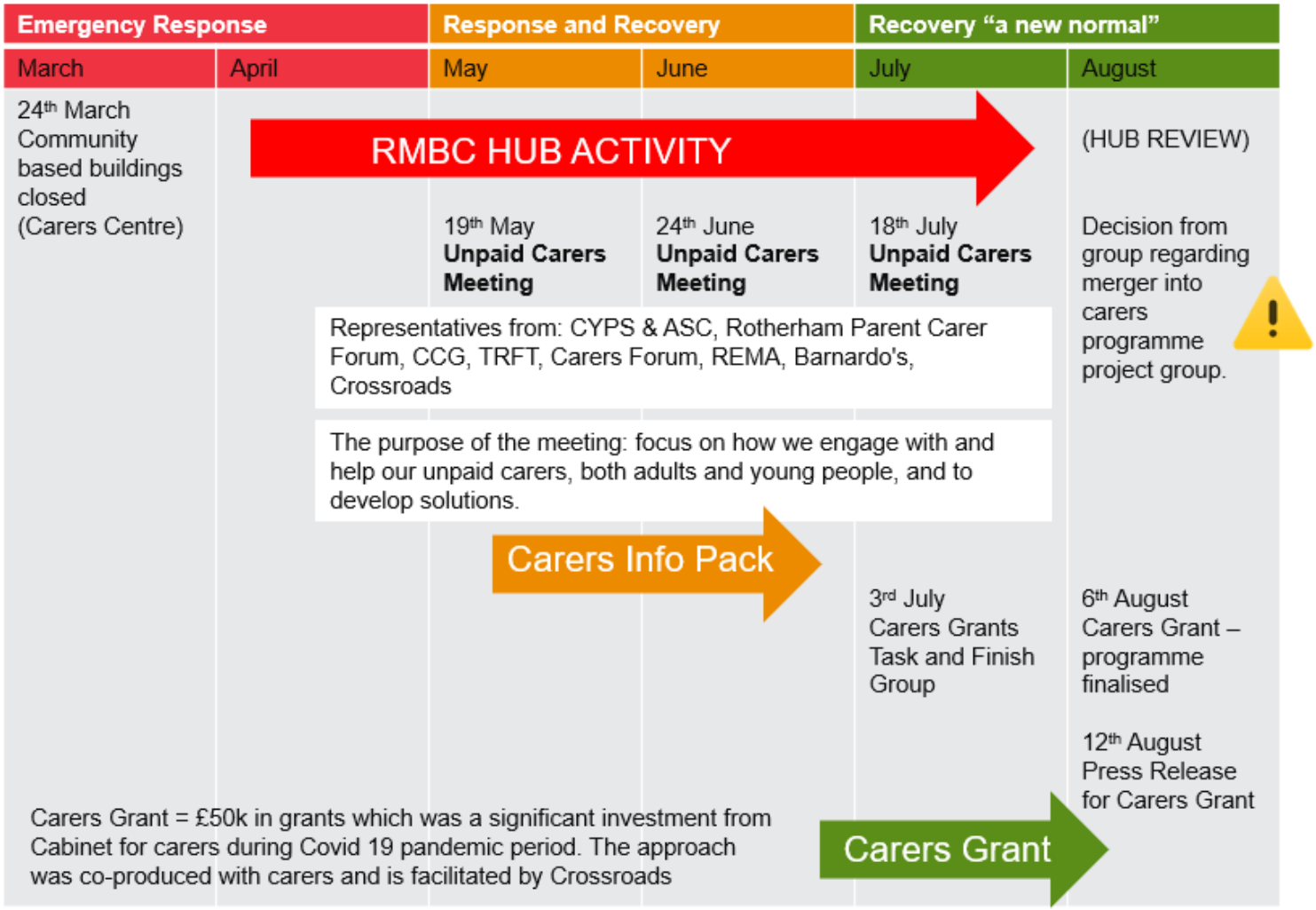


Getting things going… well almost!

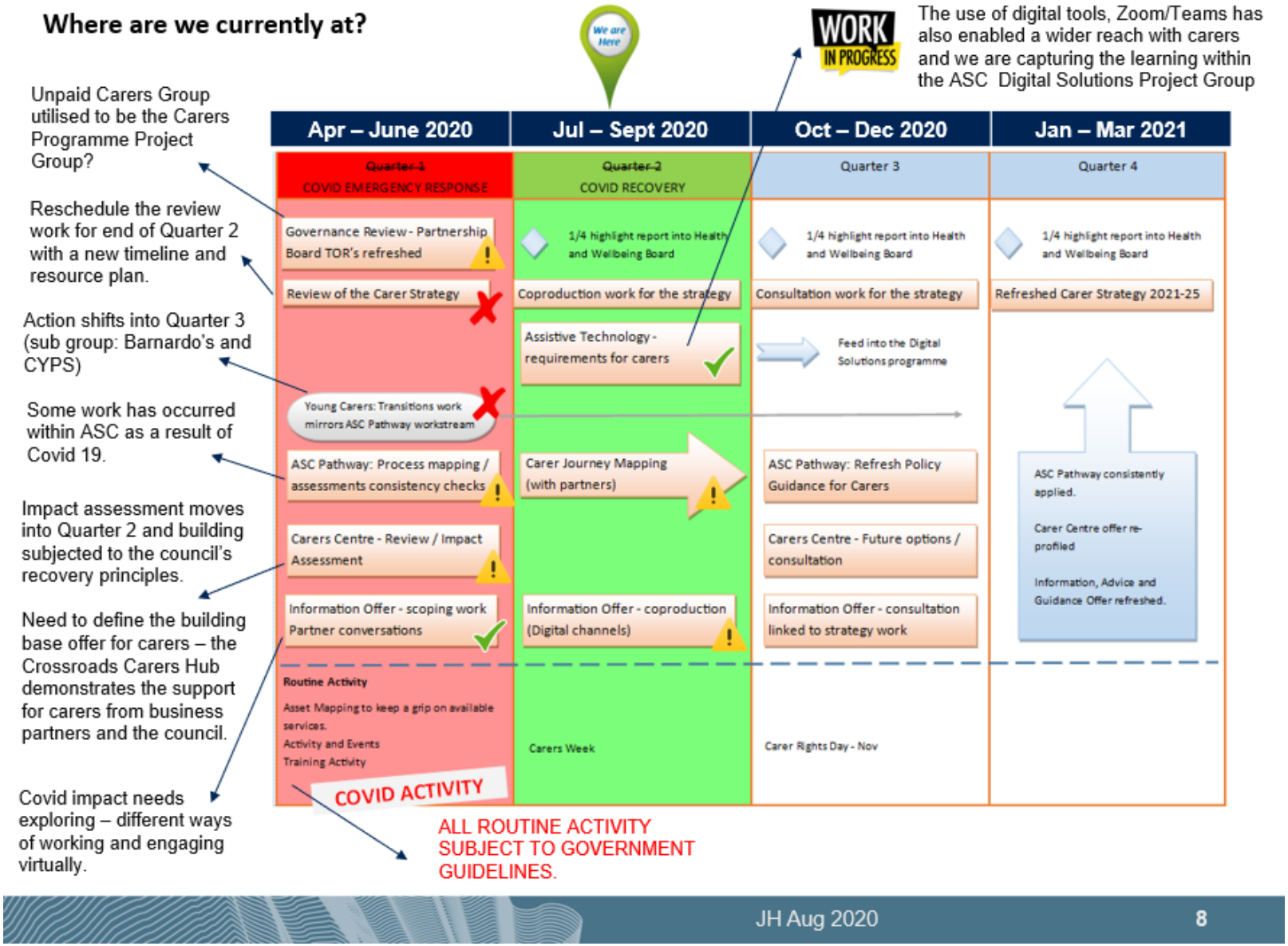


Proposed Timeline of Activity 2020-21
Start-up activity Feb-Mar 2020: • Scoping work (Reported into SMT 5th March) • Business case to DLT (10th March) • Health and Wellbeing Board update 11th March 2020 • Project group set-up (Reports into Project Assurance Meeting from 19th March) • Programme - Implementation Plan (Signed off at Project Assurance Meeting on the 19th March)

Covid 19 High Level Timeline



Where are we currently at?



Getting things back on track – programme refresh August 2020

Quarter 2 July, Aug, Sept 2020	Quarter 3 Oct, Nov Dec 2020	Quarter 4 Jan, Feb, Mar 2021	Quarter 1 Apr, May, June 2021
PMO: Governance Reset: Establish Carers Programme Project Group - reports into ASC Project Assurance Meeting (PAM) 17th Sept & then into Health and Wellbeing Board	Monthly Project Group Meeting with highlight Report to PAM: 15th October 19th November 3rd December 1/4 highlight report to Health and Wellbeing Board	Monthly Project Group Meeting with highlight Report to PAM 1/4 highlight report to Health and Wellbeing Board	Monthly Project Group Meeting with highlight Report to PAM 1/4 highlight report to Health and Wellbeing Board
WS1: Review of the Carer Strategy	Coproduction work for the strategy	Consultation work for the strategy	Refreshed Carer Strategy
WS2: Assistive Technology (AT) requirements for carers feeding into the Digital Solutions Programme	Engagement activity (Sandi Whiting)	AT pathway proposed and out to consultation.	AT Carer Offer launch
WS3: ASC Pathway: Process mapping / assessments consistency checks Young Carers: transition work mirrors ASC Pathway	Carer Journey Mapping (with all partners) ASC Pathway: Refresh Policy / Guidance for Carers		ASC Pathway consistently applied.
WS4: Carers Centre - Review / Impact Assessment	Carers Centre - future options / consultation	Decision making	Carer Centre offer re-profiled
WS5: Information Offer - scoping work (Partner conversations)	Coproduction work (Digital channels)	Consultation linked to the strategy work	Information, Advice and Guidance Offer refreshed.
Routine Activity: Training Programme for carers / staff Support for carers through covid (Carers Grant) Regular and sustained communications (Diane Clarke) Activity and Events (Carers Week / Carer Rights Day)			

How we will progress – a summary

Key Objectives:

- We will map the carer experience and ensure the carers programme addresses any gaps.
- We will ensure effective communication processes are in place to fully support carers.
- We will refresh our understanding of the profile of carers in Rotherham in the light of Covid 19.
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The programme will be subject to check and challenge via the ASC Project Assurance Meeting and will feed into the Health and Wellbeing Board each quarter.

Adult Social Care

Health Select Committee

Carers – Framework for the Future

August 2020

Carers - Framework for the Future 2020-21

Rotherham's Adult Social Care Pathway puts the person at the centre of everything we do. For us to do our best work, every process, every interaction and every outcome must have the person at the core.

On the 21st October 2019 we introduced new a way of working to ensure a consistent, robust and sustainable Pathway; our work with carers is defined via a “sub-pathway” and in March 2020 plans were shared with the Health and Wellbeing Board explaining how we anticipated we would deliver a carers programme.

Furthermore, there is a requirement to review our Adult Social Care - Carer Assessment and Eligibility Policy Guidance for Carers as well as refreshing the existing Rotherham Carers Strategy.

With the introduction of the sub-pathway and the need to review the key policy and strategy documents a high level action plan was devised to provide a framework for future work. This will ensure we deliver a quality customer journey and provide the right level of support for carers.

The council offer is part of a wider system approach and carers have been added to the Rotherham Health and Social Care Place Plan as a key area of focus, recognising the importance they play and very much highlighted by Covid 19.

The week after the information was presented to the Health and Wellbeing Board the council and partners mobilised resources appropriate for the management of the Covid Pandemic and this had significant impact on the proposed programme timeline.

However, out of adversity came opportunity and although the programme timeline was considerably compromised a number of actions have been progressed. Having to work extremely quickly in significantly different ways meant partnerships had to be even stronger to ensure carers were fully supported in the most difficult of situations.

We are now in a position to look at what has been achieved and to refresh the original programme timelines. We have a moment to build upon the sterling work that has happened whilst all services were deploying their emergency plans.

**For the purposes of this document a ‘carer’ means an adult aged 18and over who provides or intends to provide help to another adult. An adult who provides care under a contract or as voluntary work will not be regarded as a carer.*

Where we were at? *(Information presented to Health and Wellbeing Board 11th March 2020)*

No joined up working & lack of liaision between services/departments	Services contradict each other & budget cuts are impacting on services with lengthy waiting lists	Carers feel isolated, frustrated, undervalued & unheard
Carers feel passed around between services & the transition from childrens to adults is not a smooth process	Not clear of who to contact and where to go for advice	Carers want a designated person to assist with all aspects of support

'We need an 18-25 year old provision for short and long term respite in the borough. There is nothing after children's services ends at age 18 for complex needs young people'.

'Being a carer can be very isolating and very stressful and demanding. There have been times over the last 15 years I have felt so alone'

Carers Survey Report July 2019

What we needed to do?

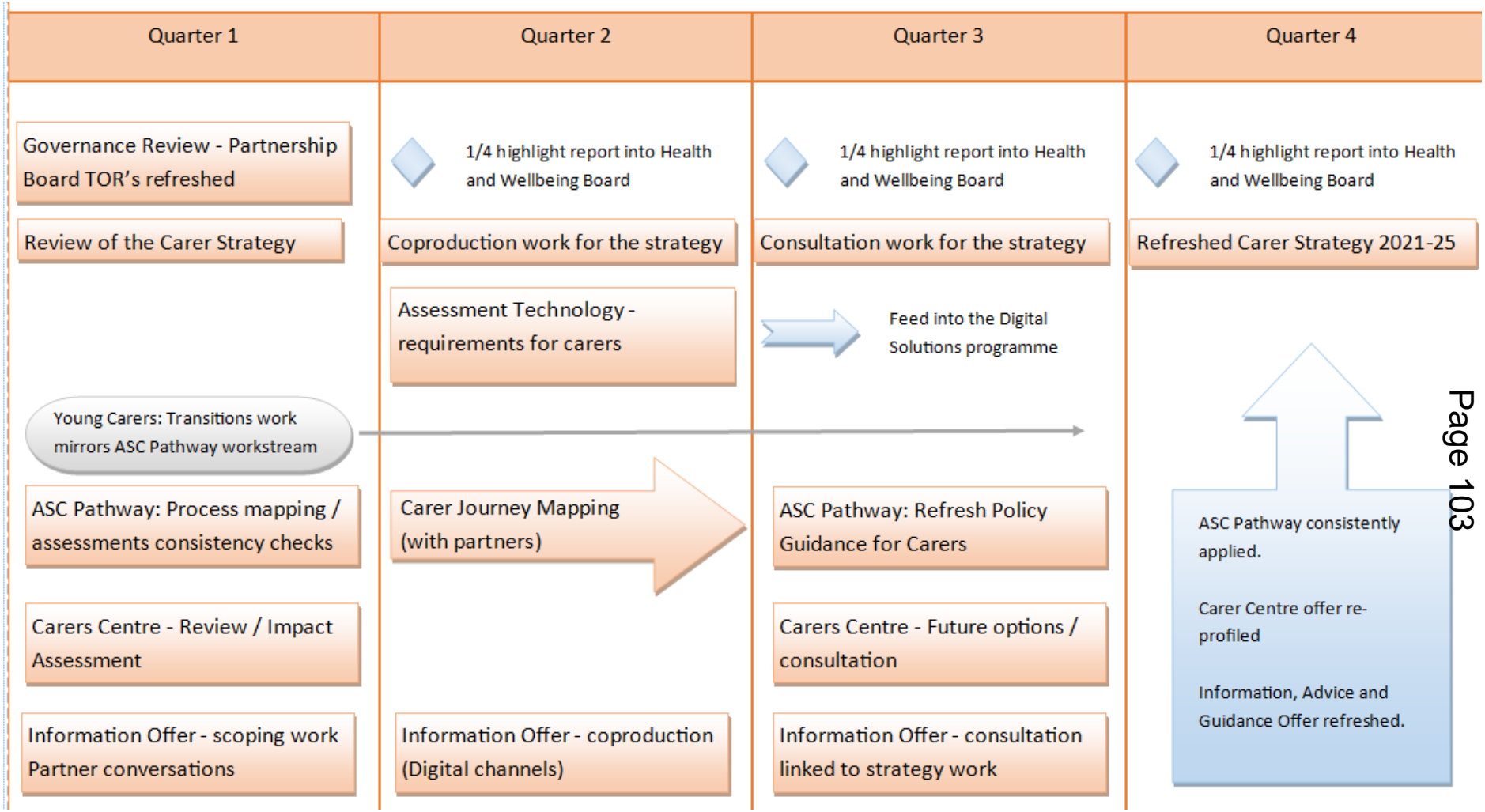
(Information presented to Health and Wellbeing Board 11th March 2020)

Things to consider: Carers Survey Analysis
Briefing Note: July 2019
Recommendations:
- Develop processes to enable a smoother transition from children's to adult's services.
- Develop consistency in our approach i.e. dedicated case worker from point of contact throughout.
- Strengthen our information and advice offer to ensure it reaches its target audience and is fit for purpose.
- Introduction of the TOM Model should ensure that advice and support is available before the situation becomes critical.

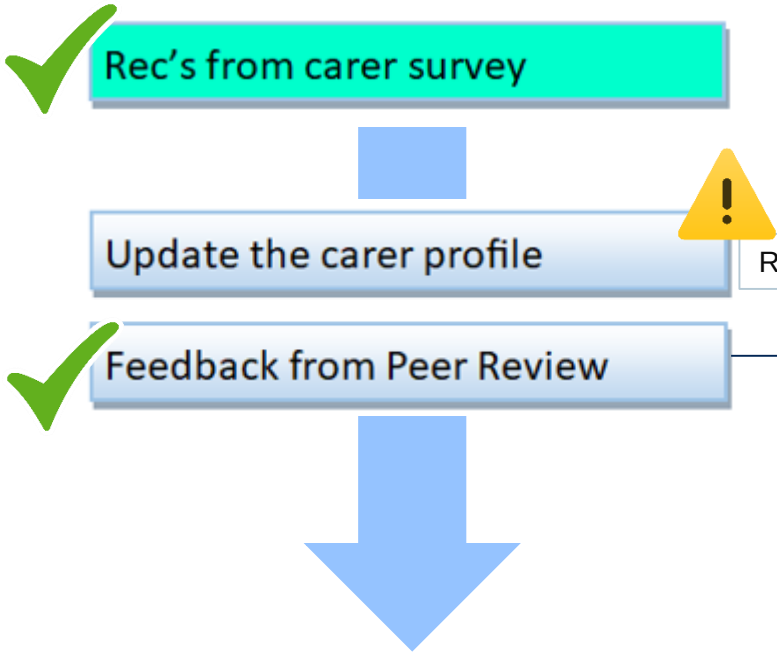
Things to do:
- Update the carer profile (Inc Young Carers)
- Review of the current strategy - impact assessment / focus group work
- AT Offer - carers embedded with in
- Assessment process reviewed and recommendations made
- Carer Journey - mapped
- Carers Centre - impact assessment
- Partnership Boards - review TOR
- Information Offer - scope it out
- Carer services - asset mapping of what is out there
- Activity and events planned
- Training prospectus

Things to aim for:
- We will commit to improving how carers are involved in the production and design of services.
- We will make sure carers feel informed about and involved in the conversations surrounding the person they care for.
- We will look at how to widen personal budgets.
- We will work with employers to raise awareness of flexible working policies.
- We will support carers taking a break from caring.
- We will make it easy for carers to get the right information at the right time.
- We will ensure carer assessments incorporate solutions that include friends, family and the wider community.

Proposed Implementation Plan 2020-21 (BEFORE Covid 19)



Getting things going… well almost!



Resources redistributed to covid emergency response

Key Actions:

1. Map the carer experience and ensure the carers programme addresses any gaps.

2. Ensure effective communication processes in place to fully support carers.

Proposed Timeline of Activity 2020-21

Start-up activity Feb-Mar 2020:

- Scoping work (Reported into SMT 5th March)
- Business case to DLT (10th March)
- Health and Wellbeing Board update 11th March 2020
- Project group set-up (Reports into Project Assurance Meeting from 19th March)
- Programme - Implementation Plan (Signed off at Project Assurance Meeting on the 19th March)

Covid 19 High Level Timeline

Emergency Response		Response and Recovery		Recovery "a new normal"	
March	April	May	June	July	August

RMBC HUB ACTIVITY

24th March Community based buildings closed (Carers Centre)

(HUB REVIEW)

19th May **Unpaid Carers Meeting**

24th June **Unpaid Carers Meeting**

18th July **Unpaid Carers Meeting**

Decision from group regarding merger into carers programme project group.

Representatives from: CYPS & ASC, Rotherham Parent Carer Forum, CCG, TRFT, Carers Forum, REMA, Barnardo's, Crossroads

The purpose of the meeting: focus on how we engage with and help our unpaid carers, both adults and young people, and to develop solutions.

Carers Info Pack

3rd July Carers Grants Task and Finish Group

6th August Carers Grant – programme finalised

12th August Press Release for Carers Grant

Carers Grant = £50k in grants which was a significant investment from Cabinet for carers during Covid 19 pandemic period. The approach was co-produced with carers and is facilitated by Crossroads

Carers Grant

Where are we currently at?

Unpaid Carers Group utilised to be the Carers Programme Project Group?

Reschedule the review work for end of Quarter 2 with a new timeline and resource plan.

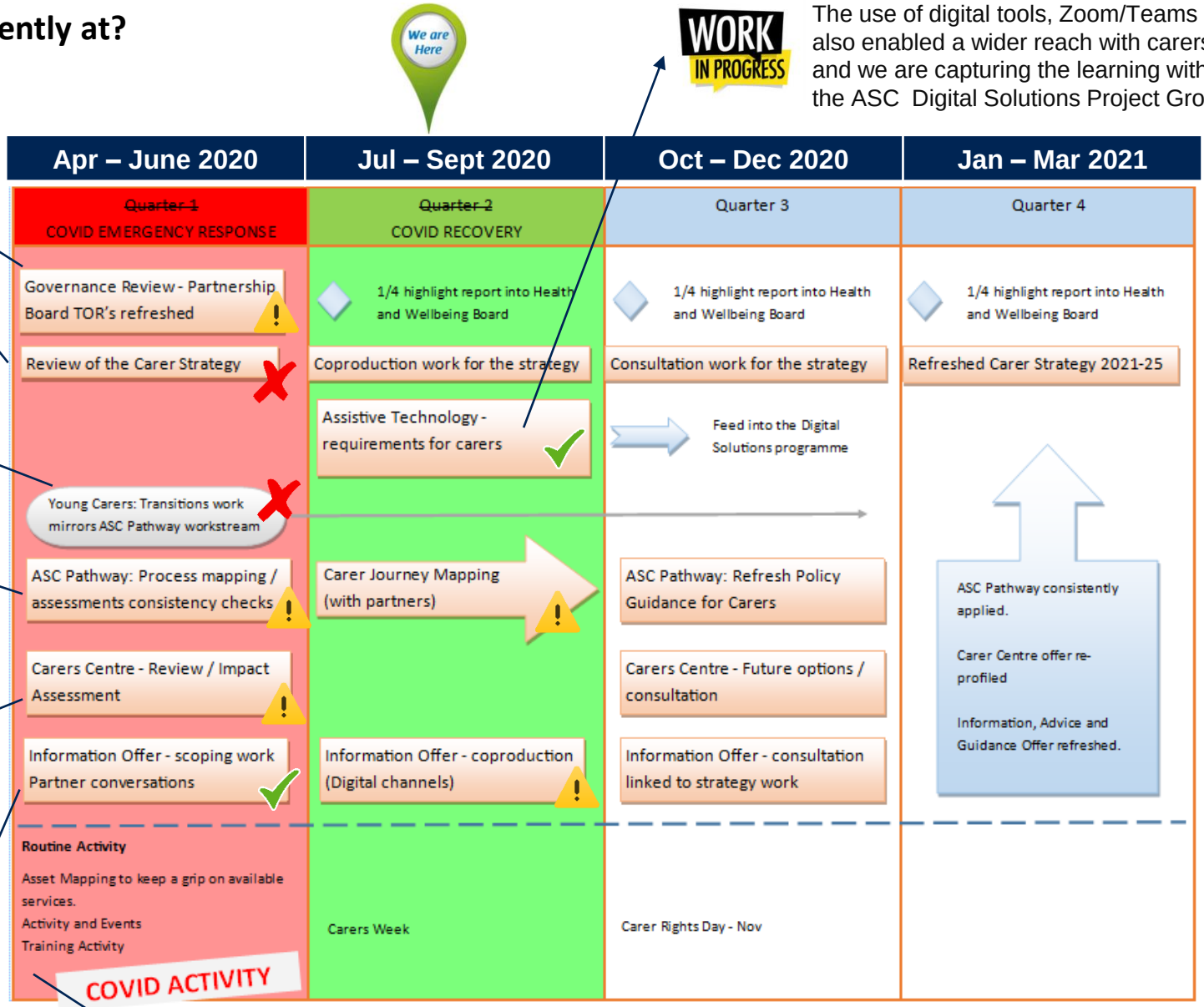
Action shifts into Quarter 3 (sub group: Barnardo's and CYPS)

Some work has occurred within ASC as a result of Covid 19.

Impact assessment moves into Quarter 2 and building subjected to the council's recovery principles.

Need to define the building base offer for carers – the Crossroads Carers Hub demonstrates the support for carers from business partners and the council.

Covid impact needs exploring – different ways of working and engaging virtually.



The use of digital tools, Zoom/Teams has also enabled a wider reach with carers and we are capturing the learning within the ASC Digital Solutions Project Group

ALL ROUTINE ACTIVITY SUBJECT TO GOVERNMENT GUIDELINES.

Getting things back on track – programme refresh August 2020

Quarter 2 July, Aug, Sept 2020	Quarter 3 Oct, Nov Dec 2020	Quarter 4 Jan, Feb, Mar 2021	Quarter 1 Apr, May, June 2021
PMO: Governance Reset: Establish Carers Programme Project Group - reports into ASC Project Assurance Meeting (PAM) 17th Sept & then into Health and Wellbeing Board	Monthly Project Group Meeting with highlight Report to PAM: 15th October 19th November 3rd December 1/4 highlight report to Health and Wellbeing Board	Monthly Project Group Meeting with highlight Report to PAM 1/4 highlight report to Health and Wellbeing Board	Monthly Project Group Meeting with highlight Report to PAM 1/4 highlight report to Health and Wellbeing Board
WS1: Review of the Carer Strategy	Coproduction work for the strategy	Consultation work for the strategy	Refreshed Carer Strategy
WS2: Assistive Technology (AT) requirements for carers feeding into the Digital Solutions Programme	Engagement activity (Sandi Whiting)	AT pathway proposed and out to consultation.	AT Carer Offer launch
WS3: ASC Pathway: Process mapping / assessments consistency checks Young Carers: transition work mirrors ASC Pathway	Carer Journey Mapping (with all partners) ASC Pathway: Refresh Policy / Guidance for Carers		ASC Pathway consistently applied.
WS4: Carers Centre - Review / Impact Assessment	Carers Centre - future options / consultation	Decision making	Carer Centre offer re-profiled
WS5: Information Offer - scoping work (Partner conversations)	Coproduction work (Digital channels)	Consultation linked to the strategy work	Information, Advice and Guidance Offer refreshed.
Routine Activity: Training Programme for carers / staff Support for carers through covid (Carers Grant) Regular and sustained communications (Diane Clarke) Activity and Events (Carers Week / Carer Rights Day)			

How we will progress – a summary

Key Objectives:

- We will map the carer experience and ensure the carers programme addresses any gaps.
- We will ensure effective communication processes are in place to fully support carers.
- We will refresh our understanding of the profile of carers in Rotherham in the light of Covid 19.
- We will invite reps from the Unpaid Carers Group to become members of the Carer Programme Project Group.
- We will continue to progress the Carers Grant work

Other considerations:

The Carers Strategy review work will begin at the end of September 2020 and will result in a new strategy scheduled to launch June 2021; which still means we are within the timeframe of the existing strategy lifespan.

As a result of the response to Covid some work has occurred around the mapping of services and the ASC pathway; this will continue and result in a refresh of the policy and guidance by December 2020. (A Sub-group will be set-up to look at young carers and how they transition into the ASC pathway.)

As per the government guidance and inline with council recovery principles the Carers Centre is not currently accessible – work will be undertaken to plot out the recovery activity needed. Alongside a strategic review and impact assessment of the facility will commence at the end of September with a findings report due by December 2020.

To support carers through the Covid 19 crisis a Carers Information Pack was produced by the council and signed-off by partners. This work will be maximised and we will look to expand this approach and think about ways of increasing digital connectivity and skills for carers. This will be alongside all the traditional options for sharing and communicating information, advice and guidance.

The programme will be subject to check and challenge via the ASC Project Assurance Meeting and will feed into the Health and Wellbeing Board each quarter.

Agenda Item 8

Rotherham Metropolitan Borough Council

BRIEFING	**TO:**	Health Select Committee
	DATE:	27th August 2020
	LEAD OFFICER:	Lesley Cooper Service Manager Healthwatch Rotherham 01709 717130
	TITLE:	Information for the Health Select Committee from previous scrutiny

1. Background

1.1 Following the introduction to the new Healthwatch Rotherham Service at the July 2020 meeting it was agreed that a short update on activities and key issues would be provided at each HSC Meeting

2. Key Issues

2.1 **Formation of a Steering Group**

We have recruited 5 volunteers from various backgrounds who form our Steering Group, to date we have held 2 meetings where a three year work plan 2020/23 has been agreed along with priorities for the remainder of 2020/21 which are

- Mental health issues arising as a result of Covid-19
- Changes made to healthcare services during Covid-19, what has worked and what hasn't
- Adult Social Care

Within each of the priorities we will look at what impact they have on our BAME communities.

2.2 **Recruitment of Staff**

A recruitment drive took place in July with interviews mid August and we have successfully appointed an Engagement Officer and an Information and Research Officer, both will take up their positions on Monday 5th October 2020

2.3 **Engagement Work**

Face to face engagement is still currently on hold and we continue to use digital platforms and telephone calls to gather our information. We have seen an increase in calls coming into the service during Q2 (double the ones received in Q1) these have been on a variety of issues mainly related to Covid (lost property whilst in hospital, testing sites and access to GPs) We have also been involved in #BecauseWeAllCare which is a joint campaign being run by Healthwatch England and the Care Quality Commission, the first focus has been on hospital discharge where we have directed residents to the national survey and collected case studies locally. We are looking at producing a report of these findings during September.

3. Key Actions and Timelines	
3.1	**Connecting with GP, Dentist and Hospital Patient Groups** Work has already begun ahead of the Engagement Officer taking up their position, contact has been made with the PCN Clinical Director and we will be looking at how we can work together. Healthwatch already has a presence on the Patient Experience Group at TRFT and more recently we have been speaking to the new Engagement and Inclusion Lead at TRFT and already have shared information and ideas on a number of projects including the discharge from hospital and the introduction of virtual consultations. We feedback any information regarding dentistry to Healthwatch Yorkshire & Humber who sit on the Dental Commissioning Executive meeting for NHSE, in addition to this we are in touch locally with clinical advisors from NHSE&I and receive regular updates on the service which we can pass onto residents.
3.2	**Healthwatch Newsletter & Healthwatch Hour** Producing a newsletter and the setting up of the Healthwatch Hour (an online engagement activity) will form part of the workplan for the new Engagement Officer and will now be produced in Q3.
3.3	**Medical Student Placement** During November/December Healthwatch will have two medical students from Sheffield University on placement – this year due to the pandemic it will take place virtually and we will be tasking the students with two pieces of work based on loneliness and obesity in the borough which they will be able to research and produce a report including recommendations to service providers and commissioners.
4. Recommendations	
4.1	Health Select Commission to note the information contained in this briefing.

Agenda Item 10

Rotherham Metropolitan Borough Council

BRIEFING	TO:	Health Select Commission
	DATE:	3 September 2020
	LEAD OFFICER:	Katherine Harclerode Governance Advisor, Assistant Chief Executive's Directorate 01709 254352
	TITLE:	Outcomes of Workshop on Covid-19 – Response and Recovery (16 July 2020)

1. Background

1.1 **Present**: Cllrs Keenan (Chair), Albiston, Andrews, Bird, Cooksey, R Elliott, Jarvis, Short, Vjestica and Walsh

1.2 **Apologies**: Cllrs Ellis, Roche and John Turner

1.3 **Attendees**: Ian Atkinson - Rotherham Clinical Commissioning Group (RCCG)
Jacqueline Wiltschinsky – Public Health, RMBC
Michael Wright - The Rotherham Foundation Trust (TRFT)

1.4 **Purpose of the session**

1) To seek assurances regarding current activity in response to the Covid-19 pandemic and preparedness for any second wave.

2) To consider and comment on plans and activity for the recovery or re-set from the pandemic.

1.5 **Information**

A presentation set the context through a reminder of the time frame of key measures introduced by the Government in response to the pandemic. It also covered the signs and symptoms of Covid-19, what people should do if they had a positive test result and the guidance on self-isolation. An overview of the current position in Rotherham provided headline and comparative data. Details of the commencement of an enhanced testing strategy to prevent further transmission of infection were outlined.

Two short briefing papers summarised the changes that had been required across TRFT Acute and Community Services and to General Practice in Rotherham since the announcement of the level four national emergency in relation to Covid-19.

A third briefing in a similar vein from Rotherham Doncaster and South Humber NHS Trust has been shared with the Health Select Commission (HSC) and will inform a separate workshop on mental health in September.

Issues raised specifically in relation to children and young people's mental health and the impact of Covid-19 have been responded to in a short paper. This will be linked in with work by Improving Lives and to the update to HSC in December on the Mental Health Trailblazer pilot in schools and Child and Adolescent Mental Health Services.

2. Key Issues	
2.1	The situation in Rotherham, as across South Yorkshire, was one of higher infection rates than in other parts of the country at the time of the workshop, but partners had a good overview and closely monitored the data in order to be able to respond to any outbreaks or clusters and to identify any potential surge in infections. The Local Outbreak Engagement Board and the Health Protection Board were up and running and the Outbreak Control Plan had been peer reviewed, agreed and published, supported by a communications plan.
2.2	As infection rates were not reducing as quickly as partners would like to see, Public Health England and national leaders had given permission to use enhanced testing across South Yorkshire, making testing available to everyone, including testing residents without symptoms. The aim was to identify new cases earlier and to accelerate the decline in new cases. The key message was for the need to self-isolate even if people had no symptoms if they had a positive test result. Enhanced testing would be carried out in centres at Herringthorpe Stadium car park and the ex-bus depot on Midland Road and would concentrate on five areas: – Testing contacts of identified cases – Making testing as easily accessible as possible – Offering asymptomatic testing – Providing wider scale testing in workplaces with more than one case – Continue with other testing programmes (care homes etc)
2.3	The pandemic has led to significant changes in primary care and at Rotherham Hospital as partners had to adapt swiftly to meet the urgent demands of the Covid-19 pandemic. Models of delivery of care needed to be changed to ensure the safety of both patients and staff. In Rotherham this has been facilitated by the excellent place-based relationships and good partnership working, developed over several years. Good relationships also existed between the CCG and the 30 practices, which had been helpful when changes started to be made to managing patient care.
2.4	National direction set out specific requirements for hospitals, with TRFT instructed to: • Discharge all medically fit patients • Cancel all non-urgent operations from mid-April • Free up community and intermediate care beds • Suspend elements of community to allow for resource to be focused on the Covid-19 pandemic response
2.5	In primary care four main areas of activity are undertaken in general practice: • Urgent response • Chronic disease and long-term condition management • Immunisation and vaccination • Ongoing planned care around routine follow up In the early stages the CCG and GPs were asked to work on the urgent response around Covid-19 but they also tried to continue with the second and where possible with the third area of activity, especially for new-born babies and young children.
2.6	Several initiatives put in place by necessity in response to the pandemic have worked very well and the learning from these will inform future services and ways of delivering care. A number of the changes made during the peak of Covid-19 will continue on a temporary basis and others may become permanent. However, as the local system was

	still responding to the pandemic at the time of the workshop, it was difficult to provide specific details of timescales for decisions on key changes to pathways of care.
3. Key Points Discussed	
3.1	**Local Picture** Rotherham had 1,909 confirmed Covid-19 cases (cumulative at 12 July), which is 721.3 per 100,000 population and 275 deaths. The data showed that older people and males experienced worse outcomes from the coronavirus. Rotherham had no particular hotspots but was seeing infections among the working age population, which would be monitored. There could be a future focus on communities, geographical or of interest, for example if high transmission rates were seen through the data or if any clusters emerged. Also, possibly there could be a focus on houses of multiple occupation or areas with high density population. Members asked about other data on specific groups, such as disabled people or people from Black, Asian and Minority Ethnic (BAME) communities. There was some evidence at national level that BAME people were more at risk, but this was not really coming through in Rotherham. Track and Trace data was not detailed regarding BAME communities as it recorded postcodes rather than ethnicity. As at 12 July 2020, TRFT had treated 620 Covid-19 positive inpatients, with 389 having recovered and been discharged. Sadly, there had been 194 deaths. The pandemic had created unprecedented demand for high dependency care and at its peak TRFT were treating 70 Covid-19 positive patients, this figure had reduced to less than 20 who remained in acute beds.
3.2	**GPs** **a) Triage, Appointments and Consultations** Patient management and how they access primary care had really changed with “total triage”. Patient triage had already been in place via the Rotherham Health App by utilising the symptom checker and booking a telephone slot if it had determined an appointment was required. 10% of the population had the App downloaded but for patients without access to technology, a similar process was used where a patient would be telephone triaged to determine whether advice or a telephone slot was required. All GP’s were operating telephone appointments, with many using video consultation via the Rotherham Health App, which had been especially useful. Any promotion that Members could do in this regard would be welcome. Face to face appointments had been minimised unless absolutely necessary, with relevant Personal Protective Equipment (PPE) but were starting to increase in number again. Feedback from patients had been positive, advising that where telephone or video appointments were required these had been on the same day. A new primary care consultation service for suspected Covid-19 positive patients with primary care needs went live at the former walk-in centre at Rotherham Community Health Centre on 31 March. In another example of partnership working, this involved Rotherham Hospital releasing the site and deploying outpatient services to alternative sites, to enable patients to be treated in a separate site from those without symptoms. This had been effective in managing patient flow and keeping people safe. The service moved to Whiston medical centre on 15 June as TRFT required the building again to re-set services and is planned to remain in place until March 2021, which would also assist with resilience for winter or a possible surge in the pandemic.

Extended access to GPs encompasses core hours, 6-8pm on weekdays and the weekend hubs. Virtually overnight with lockdown a massive decrease in use ensued and this funding was used for the paramedic home visiting service (see below) and seven-day per week “hot site”, thus extended hours could still be provided if needed.

b) Home Visiting
A new service commenced on 16 April with four paramedics/advanced care practitioners undertaking ‘hot’ and ‘cold’ (“hot” - possible Covid positive and “cold” - routine) visiting on behalf of all practices across Rotherham and supporting care homes. The provider is a private paramedic service with fully trained paramedics capable of providing advanced care and is being piloted to the end of March 2021, using money from the national allocation. It started with two paramedics seeing on average 20 patients per day and then four on rota up to 30. It could be flexed again in the event of a surge between Covid possible and non-Covid patients and assists with winter preparations.

This service reduces the numbers of healthcare professionals going into patients’ homes and being at risk, reduces demand on practices and creates safe pathways. It has met with positive feedback from patients.

Ongoing debate occurs at national and local level about home visits, as many could be by paramedics or Advanced Nurse Practitioners and would not always need to be a GP as there was always the ability to go through 999 if urgent or to link back to senior decision makers. Potentially this service could be expanded further as traditionally all 30 GPs undertake their own home visits, so it would be a new model to have a borough-wide approach managed through a central point, which could be more efficient and effective in how patients are supported. Learning would come through the pilot.

Arrangements had also been agreed with the community team to reduce interactions in patient homes e.g. checking with the Care Co-ordination Centre at TRFT to establish if anyone else was due to visit the patient.

c) Care Homes
Almost 80% of care home patients in Rotherham already had an aligned GP providing regular ‘ward rounds’ enabling proactive care. This was extended in June to 100% of care home patients (registered with the CQC) having equal access to these arrangements in line with the national direction. This enables multi-disciplinary team and digital interaction with the care home around patient care and patient management.

d) Practice Capacity
Daily situation reporting (SitRep) from practices was working well. In addition to enabling system support, it informed the Directory of Service at 111 so if a practice had staffing issues and was struggling with capacity it would show on the national system. All GPs vary in size and number of staff, with more fragility and risk for some smaller practices and a possible impact on 2000 patients if one had to close. All practices had remained open but for some it had proved difficult to manage flow through, due to estate constraints, therefore remote triage was better. There has been no need to shift the patient list from one practice to another on a short-term basis but a process was there. Learning from this will be applied for winter.

e) Recovery and Re-set
The focus was on the primary care re-set now with new national guidance to comply with and getting all primary care services back on where possible. The next six weeks would focus on robust flu planning and ensuring patients who are high risk, vulnerable, over 65

and children would be vaccinated in a timely way in the next few weeks. (See 3.9 for more on vaccination under winter planning).

3.3

Rotherham Hospital

a) Access to the Hospital
TRFT closed visiting (in line with national guidance) from early March but put measures in place to ensure inpatients could remain in contact with family and carers e.g. ipads in critical care and communication advisors going around the trust. Few complaints had been received.

b) Critical Care
For TRFT a major learning point had been in respect of critical care as the hospital had moved from a small, eight-bed unit to a larger space with 50 beds to meet the demand within the system and staff deployed accordingly to support the additional need within critical care. In order to enhance capacity, intense work had taken place to introduce new supplies of oxygen into the hospital and additional ventilators obtained, which had been sufficient for the peak. The thinking was now to move away from the larger critical care unit and patients had returned to the pre-existing smaller unit, freeing up beds that were needed as admissions increased again.

c) Urgent and Emergency Care
Access to the Urgent and Emergency Care Centre (UECC) had changed significantly with patients being triaged at the front door to screen for possible Covid-19. At the height of the pandemic low numbers of patients were attending the Urgent Care centre, falling from often 300 patients per day to 120/130 but confidence was returning and numbers increasing again.

Concerns had been raised with Members by residents about other family members not being able to stay with the patient, even if the patient did not speak English, which had led to some reluctance to go to the UECC or to stay in hospital. At present it was still preferable for family members not to attend with the patient at UECC unless they were critically ill, a minor or had dementia. The hospital appreciated the difficulties but had access to phone interpretation services.

d) Community and Outpatient Activity
Both services had changed the way in which they worked to meet the demands of Covid-19 and this would be likely to continue. Many community services had moved to remote ways of working, only accessing individual homes where necessary. As with general practice, for people needing outpatient care more video and telephone support were made available.

e) Staffing – Capacity and Support
TRFT staff were praised for their commitment and bravery in responding to the pandemic and caring for patients, whilst working within some challenging environments. The number of staff self-isolating or shielding was tracked and monitored daily and the overall sickness absence (excluding Covid-related) was down, which was positive.

After the tremendous efforts by staff, they needed some downtime and were being encouraged to take leave for their own wellbeing. A contact centre was set up and available for staff to talk about any conditions and could also offer support. Some of the funds from charitable donations had been invested in resilience training, which could be cascaded across the organisation. Support and occupational health were also available. Regular walks round the hospital from the executive team took place providing a visible presence. Morale was good and staff positive.

f) Recovery and Re-set

Whilst still responding to Covid-19, TRFT were focusing on re-establishing services, aspiring to 90% for March, with particular attention on ensuring cancer patients received timely care. Private sector use had helped for trauma and orthopaedics, urology, general surgery and accommodation. MRI and CT scans had been carried out in the private sector but the Trust was enhancing their internal capacity and a mobile MRI unit and CT scan in a box had been procured to help catch up. Further analysis would be necessary to understand the position on waiting lists for planned care.

Anecdotally Members had heard concerns from residents regarding cancer diagnosis and asked how the Trust was working to get cancer treatment and testing back up again. They asked if there were concerns over the cancer diagnosis rate in Rotherham. Scan results were pretty much business as usual and the Trust were unaware of any issues but if there were specific cases these could be discussed after the meeting. Members were asked to be mindful in their communities as one of the key challenges was late presentation of patients accessing health care services because of being fearful of Covid-19. People needed to be encouraged to go early so they were not presenting late in the pathways, at primary care in the first instance. Member support with messages would be extremely helpful.

3.4

Embedding New Ways

In starting to think about the re-set, Members inquired whether the lessons learned and new techniques might influence long-term ways of working and potentially be more robust, efficient and effective in both primary and secondary care. For the hospital there was learning from the use of technology for communication with patients where possible, and work with partners. Endoscopy and gastro-intestinal bleeds for on call patients had been handled by Sheffield in the evenings which seemed to work well and there was an arrangement with Barnsley. Private sector use had been invaluable and would continue to help TRFT get back on track.

One clear benefit of telephone and video consultation was the elimination of sitting and waiting for an appointment in a surgery waiting room, potentially exposed to illnesses from other patients, plus the time to travel there and back. Although this had arisen out of necessity Members wondered to what extent it would become the norm. Utilisation of digital means was on the national agenda for primary care due to the demands on the workforce but had been exacerbated by Covid-19 in both primary and secondary care, so a return to the previous model was unlikely. Engagement through the CCG with the Patient Participation Groups and individual patients showed it did represent a culture change but feedback had been positive from patients with co-morbidity or managing long term conditions. Further dialogue was needed and it was important to get the right balance and the right people being seen face-to-face.

3.5

Personal Protective Equipment (PPE)

This had been more of a concern in the early days but all partners gave assurances that current stocks were adequate and work continued to ensure this, including for the winter and in the event of a second wave. It would become a national level issue depending on the timing, size and scale of any second wave. TRFT were part of a joint procurement cell for the longer term. The CCG had also commissioned additional PPE and an order had been approved for the winter on 15 July 2020. Joint work and sharing PPE across the system assisted where necessary. PPE availability for vaccinations would also be

3.6 included within this and would depend on the delivery models used.

Communications

Public Health were working closely with the Communications Team and the Director of Public Health and community leaders were helping with the communication of key messages around the pandemic. Members emphasised the importance of clear,

accurate communication with residents as there seemed to have been cases of conflicting information.

Acknowledging the likelihood that increasing the number of tests would result in an increase in the number of people testing positive, Members explored how this would be communicated as media coverage seemed to be based on a "league table" type approach to reporting numbers of cases in different locations. It was important that people were informed that we had more cases because of carrying out the extra testing, to provide some reassurance. Residents were also asking if Rotherham would be likely to have a local lockdown.

South Yorkshire along with Bradford and Kirklees would be in a similar position. The communications and how data was used would both be key as the data was confusing and the point in time would be changed to a seven-day week data collection period rather than one day. A watching brief would be maintained.

3.7

Track and Trace Programme

The Government was working to refine the programme to speed up reaching contacts to minimise onward transmission. Feedback had been given about the need for speedier test results. Granular detail was not received, only overall data but now postcodes of cases were available this could be mapped. The Army run the centres and do the swabs which were then sent to Public Health England laboratories.

3.8

Testing

It was confirmed that home tests were available for residents without symptoms, either through ringing NHS 119 or ordering one on-line (best option if people had access to the internet) because of the special dispensation for enhanced testing. As people were being told they needed to have symptoms this would be escalated to the Local Resilience Forum as a South Yorkshire wide issue.

Under the national testing programme, private sector nursing homes would test staff weekly and residents monthly. Tests were carried out at the hospital for staff and had been from early on, including the antibody tests. It had been the case throughout that people testing negative had returned to work swiftly.

3.9

Winter Planning and Flu Vaccination

NHS partners and social care were preparing for winter pressures, taking account of Covid-19 and seasonal influenza. Emergency planning scenarios had formed part of the planning, learning from what had been done in past winters and the first wave of the pandemic. The intention was to ensure a vaccination plan that could deliver at scale and ensure the highest level of population coverage.

Members sought assurances about the availability of sufficient flu vaccine and plans to roll out vaccination early. Under the traditional model, over 65s were vaccinated through their GP with 3000-4000 patients seen quickly over six weeks, usually on Saturdays and Sundays, possibly some evenings. This model would not be possible this year, therefore new models of delivery at scale for primary care were being explored to have an accessible service. Pharmacists also do vaccinations and could potentially vaccinate over 65s but dialogue would be needed with them on the practicalities of delivery bearing in mind throughput of patients and the one in, one out scenario at pharmacies.

NHS England notification via Public Health England regarding targets for flu was expected w/e 17 July 2020. Irrespective of the targets Rotherham aspired to higher levels of coverage as the right thing to do for Rotherham residents. The timing of vaccinations will be key and is usually September or October with the same risks for

3.10	Rotherham as elsewhere. Availability of the vaccine is crucial, especially if the plan is for higher numbers to be vaccinated over and above what has already been ordered. **Preparedness for Second Wave** Actions outlined above contribute to being ready to deal with a second wave, in the autumn/winter – close data monitoring, enhanced testing, winter planning, vaccination plans and embedding new models and ways of working. However, across the entire health and care system limiting factors are always present in terms of the winter and then early recovery of the services - the ability to work with the physical estate to manage patient flows and keep staff and patients safe; availability of staff at work; and availability of PPE.
4. Recommendations from the Workshop	
4.1	The Health Select Commission are asked to endorse the recommendations below that emerged from the workshop and to consider any additional ones they wish to make. • That the gratitude and thanks of the Health Select Commission to colleagues working at Rotherham Hospital and in primary care be formally recorded and fed back, commending them on their commitment and bravery in responding to the pandemic and caring for patients. • That the gratitude and thanks of health partners to colleagues working in care homes be formally recorded and fed back, in recognition of their hard work and care for residents during the pandemic. • That members of the Health Select Commission support the Council and partners through their communication with residents to help people understand the measures being taken and to reiterate the key messages and to encourage people with health needs to go to primary care in the first instance to ensure early presentation for diagnosis. • That members of the Health Select Commission encourage residents to download the Rotherham Health App if they are able to use the technology.