HEALTH SELECT COMMISSION

Date and Time :- **Thursday 10 June 2021 at 2.00 p.m.**

Venue:- **Town Hall, Moorgate Street, Rotherham.**

Membership:- **Councillors Andrews, Atkin, Aveyard, Baker-Rogers, Barley, Baum-Dixon (Vice-Chair), Bird, A. Carter, Elliott, Griffin, Haleem Havard, Hughes, Hunter, Thompson, Wilson, Wooding and Yasseen (Chair).**

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 25 March 2021 (Pages 3 - 9)

To consider and approve the minutes of the previous meeting held on 25 March 2021 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. Update on Health and Care System Changes (Pages 10 - 21)

To receive a presentation in respect of the evolving situation regarding health and care system changes.

7. Joint Strategic Needs Assessment (JSNA) Update (Pages 22 - 38)

To receive an update presentation regarding the JSNA and Rotherham Data Hub.

8. COVID Update Briefing (Pages 39 - 55)

To receive a presentation and briefing from a Public Health perspective regarding the latest developments in Rotherham's response to COVID-19.

9. Healthwatch Update

To receive a verbal update on the recent activities of Healthwatch.

10. Initial Work Programme (Pages 56 - 62)

To discuss an initial annual work programme draft and agree scrutiny priorities for the 2021/22 municipal year.

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 meeting of the Health Select Commission will be held on 8 July 2021, commencing at 2.00 pm at Rotherham Town Hall.

Sharon Kemp.

SHARON KEMP,
Chief Executive.

HEALTH SELECT COMMISSION
Thursday 25 March 2021

Present were Councillors Albiston, Andrews (The Mayor), Bird, Clark, Cooksey, Ellis, Evans, Jarvis, Keenan (In the Chair), John Turner, Vjestica, Walsh, and Williams.

Apologies were received from Cllrs R. Elliott, Brookes, Short and Fenwick-Green.

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

139. MINUTES OF THE PREVIOUS MEETING HELD ON 04 FEBRUARY 2021

Resolved:-

That the minutes of the meeting held on 04 February 2021 be approved as a true and correct record of the proceedings.

140. DECLARATIONS OF INTEREST

There were no declarations of interest.

141. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

The Chair confirmed that no questions had been submitted.

142. EXCLUSION OF THE PRESS AND PUBLIC

The Chair confirmed that there was no reason to exclude the press or public from any of the items for consideration at this meeting.

143. INTERMEDIATE CARE AND REABLEMENT UPDATE

Consideration was given to an update presentation on the Intermediate Care and Reablement Place Project. The report provided a definition of the various services and requirements; illustrated the rationale for the recent changes; identified current aims, objectives and milestones; described the COVID-19 response; and gave detailed information about the variety of care services offered. These services are designed to keep people living at home independently for as long as they can. When appropriate, people can be discharged from hospital to continue their recovery at home with the right care in place. Several case study examples were also provided. Workforce challenges and anticipated next steps were also described.

In discussion, Members requested clarification of whether during COVID, limited numbers of community beds has limited service delivery in any way. The response noted that available funding has allowed a bed-based

discharge where appropriate. National guidance had moved assessment out of the hospital and into the community; therefore, for some people coming out of hospital, upon further assessment, an adjustment is warranted.

Members expressed interest in hearing more about the cases that were not quite as successful and the learning that has been taken forward. Quite a lot of people were very poorly coming out of hospital, some with COVID, some without, so some of these have had to go back into a 24 hour care arrangement, but it was appropriate for them. It is a balance to do the best at the time with the resources available. The service always tries to learn and improve.

Clarification was requested regarding the 1.8% increase in the rate of patients being seen, and how that translated to numbers of patients. The answer was offered after the meeting.

Further clarification was requested around the 10% of urgent KPIs for integrated rapid response that were not met, and the reasons for these not being met. It was noted in the response that the demand on the service has been greater, and staff sickness has also been greater. The data regarding staff sickness was requested to be circulated as part of the next update.

Further information was requested about how the needs of people who want to go into residential care are considered. The response from officers provided assurances that learning would be taken from an upcoming customer satisfaction survey.

Members also requested to know which services had high KPI performance. The response from officers noted these are the Therapy teams and Occupational Therapy teams which are divided into acute and long term care teams. It was noted that generalised KPIs would be implemented as part of the next steps, so that all services have some shared KPIs.

Members requested more details around the waiting time to be seen for therapy after discharge. The response from partners noted that the assessment would normally be conducted within 24 hours. Joining up staff communication in the next phase will therefore be very important. It was requested that therapy data following discharge be included in the next update.

Assurances were requested around the mitigation of the skills shortage and other service delays. In terms of skills shortages, the response noted that recruitment teams and in-house training programme would be able to support new staff coming in who need new levels of training, and it is necessary to make reablement care an attractive career of choice. In terms of delays, the need to implement the pathway across the community—not just for those leaving hospital but for all people who need

to step up their care—is still underway. And there remained the need to embed learning and changes to have easier access to reablement and care, therefore working with the Community Hub triage is still underway.

Members also requested more information about how the vaccination programme delivery affect the delivery of intermediate and reablement care. The response provided assurances that most staff have already taken up the vaccine and the key groups have been given access to the vaccine. Therefore, access to the vaccine had not yet caused any delays to the provision of intermediate or reablement care, and all staff have been supported to access the vaccine in a timely manner.

Resolved:-

1. That the next update be submitted in 12 months' time, with this update including performance data.

2. That a briefing on the data regarding discharge therapy be provided to the Commission as soon as this can be made available.

144. AUTISM STRATEGY AND PATHWAY UPDATE

Consideration was given to an update on the Autism Strategy and Pathway. The update covered progress on the implementation of the strategy, reported on the results of the on-line diagnosis pilot with Healios, highlighted action being taken to address long waiting times for assessment/diagnosis and provision of post-diagnostic support, and provided assurance that focus is on all ages. The vision, objectives, and outcomes of the strategy and pathway were also described in detail. The digitally enabled pathway redesign for children and young people and for adults were also described in detail.

In discussion, the Cabinet Member for Adult Social Care and Health clarified the role of the Joint Strategic Needs Assessment (JSNA) and noted the upcoming changes to the CCG at the national and regional level which will affect how Rotherham as a place delivers the Autism strategy and pathway in the future.

Members lauded the progress that has been made in providing training to the people who work closely with children and young people with autism, as well as in providing services to support neurodiversity ahead of official assessment and diagnosis.

Members requested further details regarding user feedback on the strategy. The response from officers illustrated the overall positive feedback with some noting desire for more information regarding mental health needs of autistic people and employment building opportunities. The Autism Partnership Board brings stakeholders together to give feedback on strategy development and ongoing implementation.

Members requested further assurances around digital inclusion. The response from officers averred that the delivery of education as a whole has become more reliant on technology, so schools have been working to provide access for children.

Members remarked on the pathway visualisation that could have been presented in a more reader-friendly way. This feedback would be passed to the publisher of this visualisation.

Clarification was requested and provided that 14 is the current number of referrals per week.

Members requested information regarding research into genetic causes of autism. Officers noted that autism is common across the whole of the country, and good practice is shared to enable services to meet the needs of children and young people with autism and enable them to be as happy and successful as they can be. Research, it was noted, was the purview of the universities, and any available research is taken on board and responded to as part of good practice.

Members requested further information regarding provision of mental health services to children and young people with autism. The response from officers noted the first line of response for children in school through the programme called With Me in Mind. The CAMHS as a while has launched an app for young people ages 11 to 18 who can go online to book an appointment and engage with a mental health professional through the app. This has been successful because it is less intimidating than accessing services in person with parents, etc. As children return to schools, it is priority to consider how best to provide training and support to the workforce to be able to better support the children and young people themselves. The priority of gathering feedback from service users was also emphasised, so that their perspectives inform the further development of the pathways.

Members asked for an update on the working through the waiting list for assessment. The response from officers averred it would take about three years to work through the waiting list. The extra capacity had been built in so that in addition to meeting current demand, the services could also chip away at the waiting list. Current capacity was keeping pace with demand, but not chipping away at the waiting list. A considered and dedicated amount of resource, accountability and attention was focused on reducing the waiting list, and HELIOS was also helping release capacity to this end.

More clarification was requested around the waiting list and how the progress would be measured and reported to scrutiny. The response from officers provided assurances that the children on the waiting list were currently receiving support, but they were not yet diagnosed. A lot of work had been done to support consistent response across schools and

strengthen their understanding of the pathway. As the pandemic eases, more focus can be given to areas of concern; however, currently the services are conscious of the need not to overload the schools as they are coping with increased pressure on staff and resources during the pandemic.

Resolved:-

1. That the next update be submitted in 12 months' time, to include a specific update on the waiting list and waiting times for assessments.

145. OUTCOMES FROM WORKING GROUP - ADULT SOCIAL CARE OUTCOMES FRAMEWORK

Consideration was given to the findings and recommendations of the recent working group which met on 25 January 2021 to examine the Adult Social Care Outcomes Framework (ASCOF) performance measures for 2019/20.

Resolved:-

1. That further information in respect of the following be ascertained and reported back to the Commission with the next annual benchmarking and performance report for 2020/21 in December 2021.
    a. Analysis of the cohort of people receiving reablement services.
    b. Analysis of the cohort of people entering residential care as a hospital discharge destination, with a view to demonstrating the effectiveness of the pathways in place which allow individuals to continue to live independently for as long as possible, and this analysis to include the proportion of new residents having previously availed social care and reablement support.
    c. Analysis of Community Hub data to explore any increase in demand for Adult Social Care referrals.
    d. A comparative account of other authorities whose ASCOF data may have been flagged with a data advisory due to challenges the pandemic has presented to data collection and authentication, and, insofar as this information may be available, a comparison of the results.
    e. A timeline for planned actions in response to the ASCOF results for 2019/20 and for 2020/21 when these become available.

2. That the following recommendations be made to the Strategic Director of Adult Care, Housing and Public Health:
    a. That the data format amended for future presentation materials with a view to clearly showing change over a period of time.
    b. That a proactive communications plan be further developed whereby the wider public can be apprised of achievements in respect of Adult Social Care work programmes and available support schemes.
    c. That policy options and frameworks be developed and system design be undertaken with a view to achieving greater parity of social care and health-based care in Rotherham, in anticipation of this provision being secured in forthcoming primary legislation.
    d. That liaison with partner organisations and community connectors such as the Rotherham libraries service be undertaken to avail all resources and infuse valuable expertise into the further development of a digital access strategy.
    e. That, toward bolstering the pathways whereby people with disabilities have gainful employment as part of full participation in the community, a strategic, place-based response be undertaken alongside partner organisations.

3. That a presentation illustrating the nuanced picture surrounding the gainful employment of people with disabilities be added to the 2020/21 work programme of the Health Select Commission.

146. HEALTHWATCH UPDATE

Consideration was given to an informal update from Lesley Cooper in respect of recent activities and studies by Healthwatch Rotherham. In particular, the update reported on the results of the recent Healthwatch survey on public opinion of the COVID-19 vaccine and the successful myth-busting session which has been held virtually, and which will continue to be hosted by Healthwatch as a series. Future work on diabetes will be undertaken in the near future.

The Chair noted her thanks for the comprehensive updates and asked how Members could assist Healthwatch in connecting with faith groups and area churches to help stop the proliferation of specific myths around the covid-19 vaccine. The response noted that Healthwatch has been reaching out to leaders of area faith groups to provide messaging ahead of the vaccine being made available to these groups of young people.

Officers further affirmed the positive partner working that Healthwatch has done to support the agenda of Community Champions which have also been working on myth-busting and communication of reliable information from national sources as well as those designed with the local context in mind.

Resolved:-

1. That the report be noted.

147. URGENT BUSINESS

The Chair confirmed there were no matters of urgent business to be decided at this meeting.

148. DATE AND TIME OF NEXT MEETING

The Chair announced that the next virtual meeting of the Health Select Commission would be held on 10 June 2021, commencing at 2.00 pm.

Update on the health and care system changes

Health Select Commission
10 June 2021

What’s going to be covered

- Health and care bill 2021
- Integrated care systems (ICS)
- Place based partnerships
- Public health
- Timeline and key next steps

Integrating Care: Proposed Changes

7 key changes arising from the White Paper/ Bill. These are:

1. ICS as a statutory body
2. ICS Health & Care Partnership & Strategic Plan
3. Unified National & Accountable Leadership of the NHS
4. NHS Provider Collaboration
5. Reform of Adult Social Care
6. Re-design of Public Health
7. Reform of Professional and Statutory Regulation.

Change 1 – ICS: Establishing a Statutory Body

Role & Function

- **Strategic Plan** - Develop a plan to meet the health needs of the population within their defined geography.
- **Capital Plan** - Develop a Capital Plan for the NHS providers within their health geography.
- **Commissioning** - Securing the provision of health services to meet the needs of the system population.
- **Financial Objectives** – Achieve System Wide financial objectives set by NHS England.

Included in ICS Body

Statutory ICS Body will incorporate functions of:

- Current ICS's
- Clinical Commissioning Groups (CCGs)
- NHSE – Specialised Regional Commissioning
- NHS Trusts Capital Spend.

ICS Body will also have the ability to:

- Create pooled budgets of LA, CCG, NHSE, ICS to undertake joint commissioning.
- Develop integrated workforce plans with Health Education England.

Change 2 – ICS: Establishing Health & Care Partnership & Strategic Plan

System Wide Integrated Working (South Yorkshire and Bassetlaw Leadership)

- **ICS Health & Care Strategic Partnership -** Brings together health, social care, public health (and potentially representatives from VCS, housing providers etc.) to promote integrated working.
- **ICS Health & Care Strategic Plan** - Developing a plan which addresses the health, public health & social care needs of the system. LA & NHS will require to have due regard to this plan.
- **System & Place Level Working -** Bringing together ICSs and Health and Wellbeing Boards (HWBs) as complimentary bodies at system and place level.

Change 3 - Unified National & Accountable Leadership of the NHS

Establishing one NHS England & Unified NHS Leadership

- Formally merge NHSE & NHSI.
- Abolish NHS Trust Development Authority (TDA) and Monitor and formally transfer their functions to NHS England.
- Secretary of State for Health and Social Care to formally direct NHS England in relation to relevant functions.
- Abolish annual NHS Mandates (objective setting) and instead have NHS Mandate with specific powers for BCF/ Healthwatch.
- Abolish 3 year time limit of specialist NHS Bodies to reduce bureaucracy of renewals.

Change 4 – Provider Relationships

Enabling NHS Trusts & Providers to work collaboratively & system wide

Unblocking barriers to NHS Trust / Provider collaboration by:

- Reducing bureaucracy.
- Removing competition & market law barriers.
- Giving commissioners greater flexibility in how they arrange services.
- Improving data sharing ability.
- Reviewing Tariffs for Trust commissioning.

Change 5 – Adult Social Care

Reform of Adult Social Care

- **Hospital Discharge** – Implement person-centred approaches to hospital discharge.
- **Providers Payments** - Secretary of State to make payments directly to adult social care providers.
- **Accountability** - Increase accountability in the delivery of social care through an enhanced assurance framework examining the performance of local authorities, and a new power to collect data from providers.
- **Integration at System & Place Level** - Create a more clearly defined role for social care within the structure of an Integrated Care System.
- **Better Care Fund** – Establishing a standalone legislative power to support the Better Care Fund and separate it from the mandate setting process.

Change 6 – Public Health

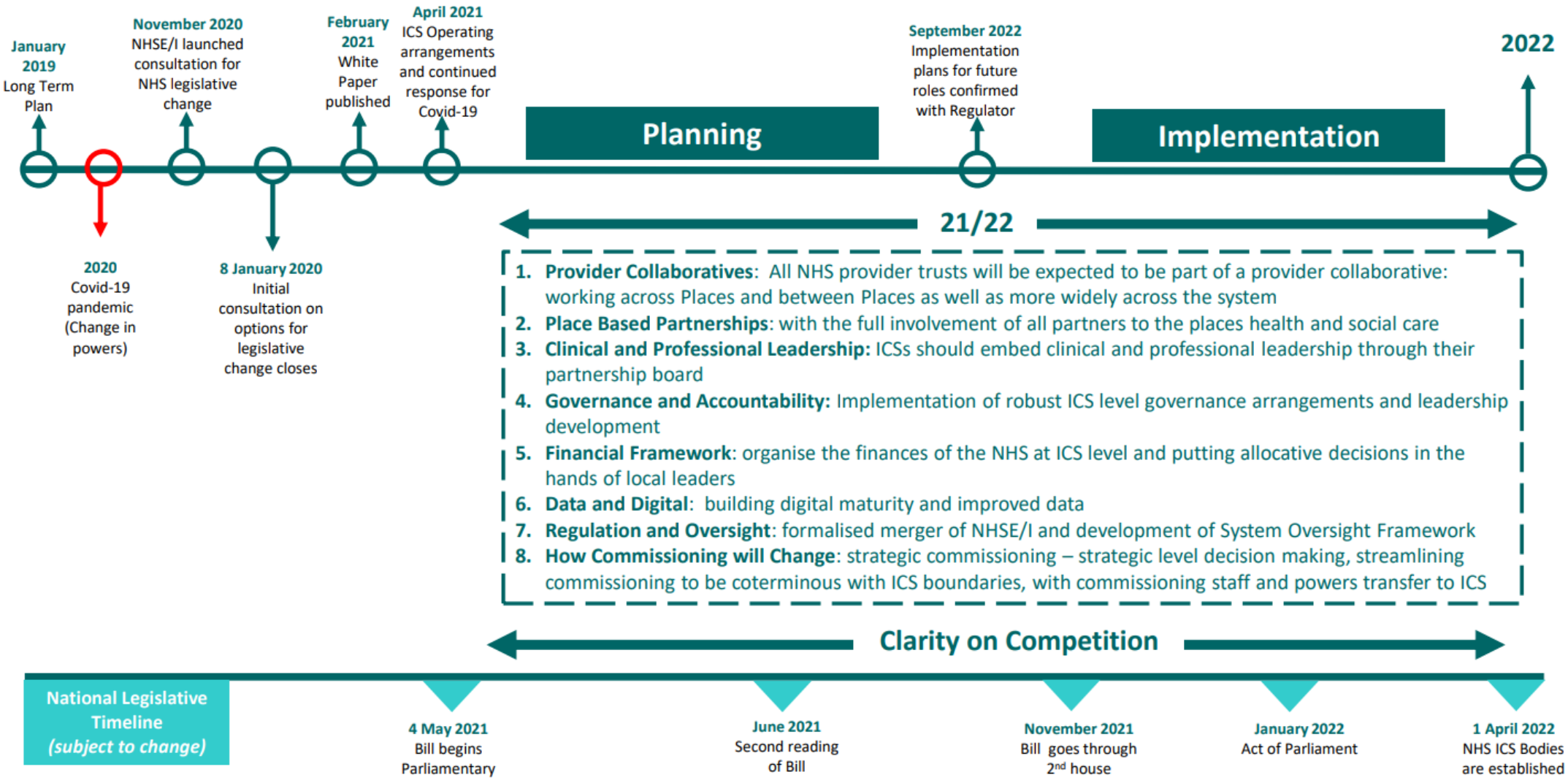
Future Design of Public Health

- Creation of the **National Health Security Agency** and the closure of Public Health England.
- Create a power for the Secretary of State for Health and Social Care to **require NHS England to discharge public health functions** delegated by the Secretary of State alongside the existing provisions.
- **Introduce primary legislation** to improve joint working on population health through ICSs, reinforce the role of local authorities as champions of health in local communities, strengthen the NHS's public health responsibilities, strengthen the role of the Department of Health and Social Care in health improvement, and drive more joint working across government on prevention.
- Review approach to **water fluoridation & obesity**.

Change 7 – Regulation

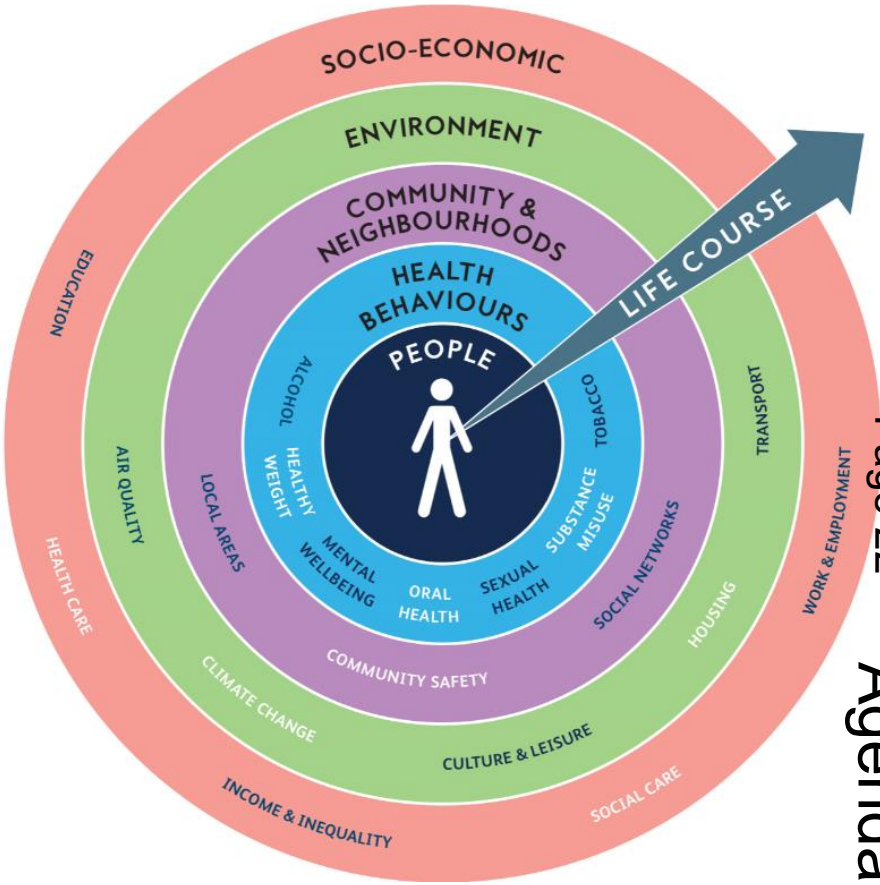
- **Independent Investigation of Incidents** - Establishment of the Health Services Safety Investigations Body (HSSIB) to investigate incidents which have or may have implications for the safety of patients in the NHS and support system learning.
- **Professional Regulation** - Enable the Secretary of State for Health and Social Care to ensure the professional regulation system delivers public protection in a modern and effective way and, that professions are regulated in the most appropriate and cost effective manner. This includes deregulation of professions and regulators.
- Care Quality Commission (CQC) will have a new role to monitor the performance of Councils (Adult Social Care).

Integrating Care: National Development Timeline



Thank you and
happy to take any questions

JSNA 2020/2021 Update



What is the JSNA?

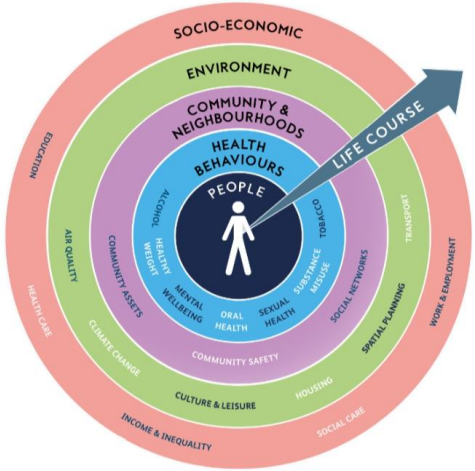
- “An assessment of current and future health and social care needs of the local community”

  - This includes specific health and social care behaviours (e.g., smoking) but also wider determinants of health such as housing and access to green spaces
- The information found from the JSNA can be used to inform strategy, policy and action by any organisation in the borough.
- All local authorities must produce a JSNA, but there is no specified format, meaning that they vary between areas
- Rotherham’s version of the JSNA is the Rotherham Data Hub: http://www.rotherham.gov.uk/data/

Statutory guidance on joint strategic needs assessments and joint health and wellbeing strategies (publishing.service.gov.uk)

ROTHERHAM DATA HUB

MENU



Welcome to the Rotherham Data Hub, the new home of the Rotherham Joint Strategic Needs Assessment (JSNA.) This website brings together data and intelligence to inform the local understanding of the current and future health needs of Rotherham people. The Rotherham Data Hub is a partnership initiative overseen by Rotherham's Health and Wellbeing Board.

We know that our health is not only influenced by health behaviours (such as smoking, alcohol, diet and exercise) and the health care we receive, but also by our social interactions with others, our sense of community, the environment we live in and our economic circumstances.

Evidence demonstrates that these 'wider determinants of health' have a significant impact across the life course and drive health inequalities between the most and least advantaged in society. The Rotherham Data Hub has been based on this model and broken into five sections, reflecting the wide range of influences on health. For more information on what is included within each section, please refer to the diagram.

- Socio-Economic
- Environment
- Community and Neighbourhoods
- Health Behaviours
- People
- Accessibility Statement

What does the Rotherham JSNA contain?

Section	Theme
People	Population including IMD domains and autism subsections
Socio-economic	Work and employment
	Income and inequality
	Health care
	Adult social care
	Children social care including special educational needs and disability (SEND)
	Education
Environment	Air quality
	Climate change
	Culture and Leisure
	Housing
	Transport
Community and Neighbourhoods	Local areas
	Community safety
	Social networks
Health Behaviours	Alcohol
	Healthy weight
	Mental wellbeing including gambling subsection
	Oral health
	Sexual health
	Substance misuse
	Tobacco

Structure of theme sections

Most theme sections are set up in a similar way:

- Initial introductory page – introducing the topic, it's overall relevance to good health and key points for Rotherham
- COVID lens – a page discussing the current impact of COVID on this topic and some potential impacts for the future
- Data for Rotherham – local authority level data or, where available, ward level or lower super output area (LSOA) level data
- Useful links – links to further reading
- List of data sources

Example ‘Introduction’ page

Healthy Weight

DATA REFRESHED: 13 APRIL 2021

Rotherham Data Hub

Obesity is associated with an increased risk of developing ill health including diabetes, circulatory disease and some types of cancer (such as colon and breast cancer). It is recognised as a major determinant of premature mortality and avoidable ill health. Obesity increases the risks of complications during pregnancy and planned care. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

Lack of physical activity may lead to ill health including circulatory problems, diabetes and some forms of cancer. Taking part in regular physical activity can improve physical and mental health and well-being. Remaining physically active into older age can improve functioning and contribute to maintaining independence.

Headlines

Rotherham residents (data relates to 2017/18 unless stated):

- Around 1 in 4 (26.6%) of children aged 4-5 years were overweight or obese (2019/20)
- Around 1 in 4 (22.4%) of children aged 10-11 years were overweight or obese (2019/20)
- Over two-thirds (75.6%) of adults (18+) were overweight or obese
- Around 30% of adults were physically inactive
- Just under half (44.6%) of adults (aged 16+) ate the recommended ‘5 a day’ portions of fruit and vegetable on a ‘usual day’

Local Picture

Data on excess weight in children at ward level shows a strong link with deprivation especially at Year 6 (children aged 10-11)

Trends

Over time, the trends for many factors involved in healthy weight such as breastfeeding initiation, overweight/obesity in reception age children, adult overweight/obesity and adult inactivity have worsened. Overweight or obesity in Year 6 children has shown slight improvement.

Example ‘Impact of COVID’ page

Healthy Weight - Impact of COVID

DATA REFRESHED: 13 APRIL 2021

Rotherham Data Hub

Recent data has shown that people who are overweight or obese are at not at higher risk of contracting COVID-19 compared to those of normal weight. People with excess weight are, however, more likely to be go to hospital, get admitted to intensive care and die from COVID-19 than those who are a healthy weight. One recent study found that compared to people who were not obese, people with a body mass index (BMI) of 35-40 were 40% more likely to die from COVID-19. People with a BMI of over 40 were 90% more likely to die than those who weren't obese.

A potential reason that overweight and obese people are at higher risk of COVID-19 complications is likely to the fact that excess fat can affect the respiratory system. In addition, excess weight can affect immune function, affecting the way in which a person's has to respond to an infection which may make them more vulnerable to the effects of infections such as COVID-19.

The key findings of a review of weight management services during the earlier stages of the Pandemic included: Individuals who were overweight and obese being concerned about the risks of Covid-19 infection, access to weight management services were reduced and adults living with obesity were using food to manage their emotions during the first lockdown, adversly impacting self report dietary and physical activity behaviours.

Behavioural changes which may have an impact on weight, such as healthy eating and exercise, have been mixed during lockdown. A recent Food Standards Agency/IPSOS Mori survey of 2000 adults suggested that more people were cooking from scratch and 'eating healthier' than they had been before lockdown. Over the same time, however, 42% of people said they were eating more cakes, biscuits, chocolate, sweets or savoury snacks than they had done previously.

It appears that people were thinking about doing exercise at home, with Google searches for words such as 'home-based exercise' increasing following the March 2020 lockdown annoucement. A Sport England survey, however, found that physical activity levels may have decreased following lockdown. From April to May 2020, a survey found that around 33% of those who responded were doing a similar amount of activity as before lockdown, 30% were doing more exercise and 37% were doing less exercise. Increased working from home may have contributed to an increase in sedentary lifestyle which also has a big impact on health. Those with a physical or mental disability or long-term illness were more likely to have done less exercise than the general population. An Age UK study looking at the impact of the pandemic on older peoples physical and mental wellbeing found that 26% reported not being able to walk as far as they used to.

Support services have had to adapt their services as a result of lockdown. The case study on the next page provides an example of what has been happening in Rotherham.

Example ‘Data’ page

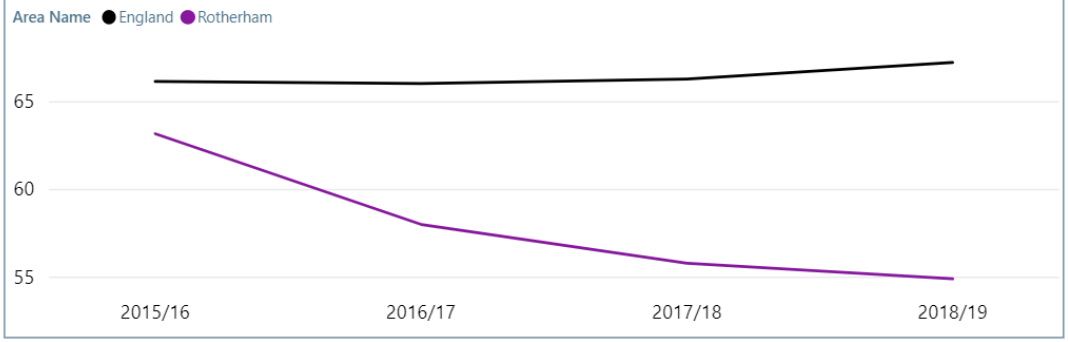
Physically active adults

DATA REFRESHED: 13 APRIL 2021

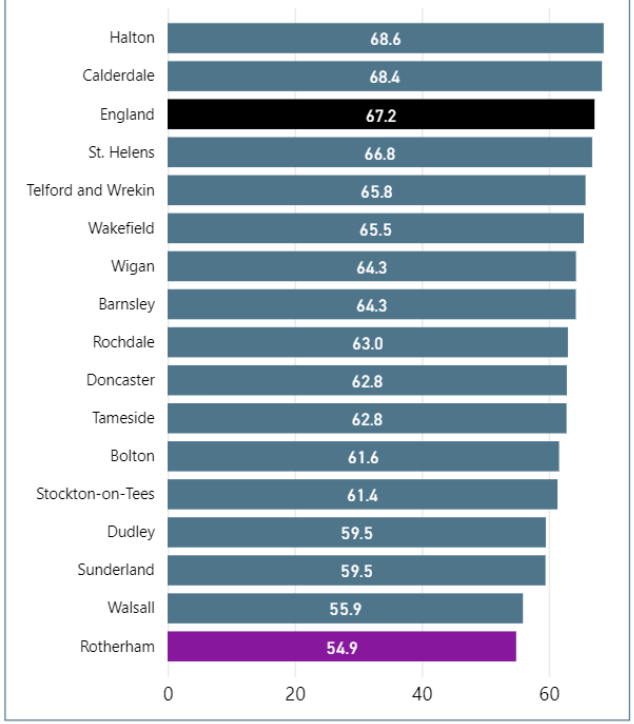
Rotherham Data Hub

Physical inactivity is the 4th leading risk factor for global mortality accounting for 6% of deaths globally. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis and colon/breast cancer and with improved mental health. In older adults physical activity is associated with increased functional capacities. The estimated direct cost of physical inactivity to the NHS across the UK is over £0.9 billion per year.

Percentage of physically active adults. Percentage 2015/16 to 2018/19. Rotherham compared to England



Percentage of physically active adults. Percentage 2018/19. Rotherham and CIPFA nearest neighbours



Example ‘Data’ page

Child Poverty (Absolute)

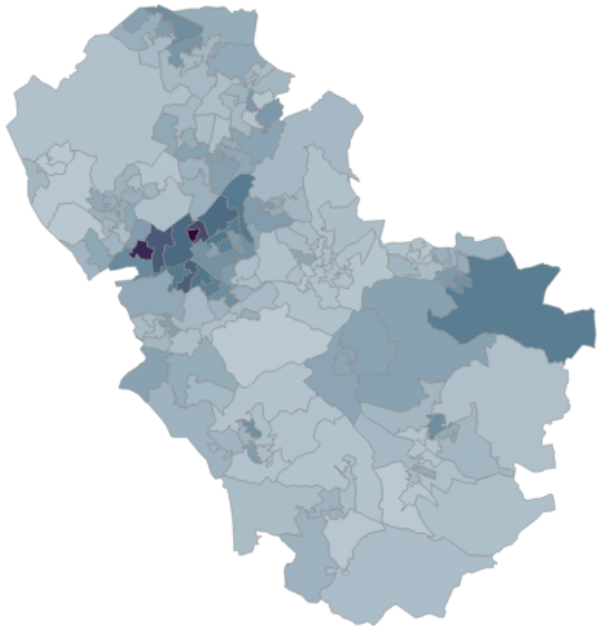
DATA REFRESHED: 13 APRIL 2021

Rotherham Data Hub

Nationally the relative poverty line is 60% of median income, which means that 14m people in the UK live in poverty. Absolute poverty is where a household's income is less than 60% of the median as it stood in 2011.
The figures below show the number of children in absolute poverty for each lower layer super output area (LSOA) in Rotherham. Please note that this a number, rather than a rate, and so may be affected by the overall age distribution of the population within that LSOA.

Local SOA Name	2014/15	2015/16	2016/17	2017/18	2018/19
Anston Greenlands	34	24	34	18	23
Anston Park	29	21	25	33	21
Aston East	22	13	19	12	25
Aston Lodge	85	81	83	94	109
Aston North	28	38	44	49	31
Aston North West	112	141	128	118	139
Aston South	31	19	21	22	35
Aughton North & Ulley	51	29	28	28	22
Blackburn	73	80	76	45	55
Bow Broom	38	40	19	53	42
Bradgate	136	124	93	97	108
Bramley Grange	29	35	27	23	29
Bramley North	32	23	23	20	37
Bramley South East	37	35	30	43	30
Bramley South West	43	23	32	28	33
Bramley West	43	55	41	31	31
Brampton North	103	96	111	98	100
Brampton South	70	48	66	69	67
Brecks	31	14	35	32	28

Number of Children Living in Absolute Poverty by LSOA, 2018/19



Example ‘Further Reading’

Further Reading

DATA REFRESHED: 13 APRIL 2021

Rotherham Data Hub

NHS guidance on healthy eating: https://www.nhs.uk/live-well/eat-well/
Further NHS guidance on eating well: https://www.nhs.uk/live-well/eat-well/the-eatwell-guide/

NHS guidance on exercise for children: https://www.nhs.uk/live-well/exercise/
NHS guidance on exercise for children: https://www.nhs.uk/live-well/exercise/physical-activity-guidelines-children-and-young-people/
Sport England tips on exercise at home: https://www.sportengland.org/jointhemovement
BBC Sport Get Inspired (list of sports clubs in the UK): https://www.bbc.co.uk/sport/get-inspired/45353880

BMI calculator: https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/

PHE guidance for obesity/diet is available at: https://www.gov.uk/health-and-social-care/obesity
PHE guidance for physical activity is available at: https://www.gov.uk/government/publications/health-matters-physical-activity

Example ‘Data sources’

Data sources

DATA REFRESHED: 13 APRIL 2021

Rotherham Data Hub

Contextual information is from online Fingertips Profiles data published by Public Health England (PHE)

Most data and context from PHE Public Health Outcomes Profile (PHOF) at :
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0/gid/1000042/pat/6/par/E12000003/ati/102/are/E08000018/iid/93088/age/168/sex/4
Prevalence of obesity and context from:
https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/1/gid/1938132859/pat/6/par/E12000003/ati/102/are/E08000018/iid/92588/age/168/sex/4
Public Health England. Public Health Profiles. [last accessed 2 March 2021] https://fingertips.phe.org.uk © Crown copyright [2021]

Source data:
Breastfeeding initiation: NHS England.
Childhood excess weight data: NHS Digital, National Child Measurement Programme.
Adults classified as overweight or obese: Public Health England (based on Active Lives survey, Sport England)
Prevalence of obesity: Quality and Outcomes Framework (QOF), NHS Digital

Adults classified as overweight or obese.
Proportion of the population meeting the recommended '5 a day' on a'usual day'.
Percentage of physically active/inactive adults
All above: Public Health England (based on Active Lives survey, Sport England)

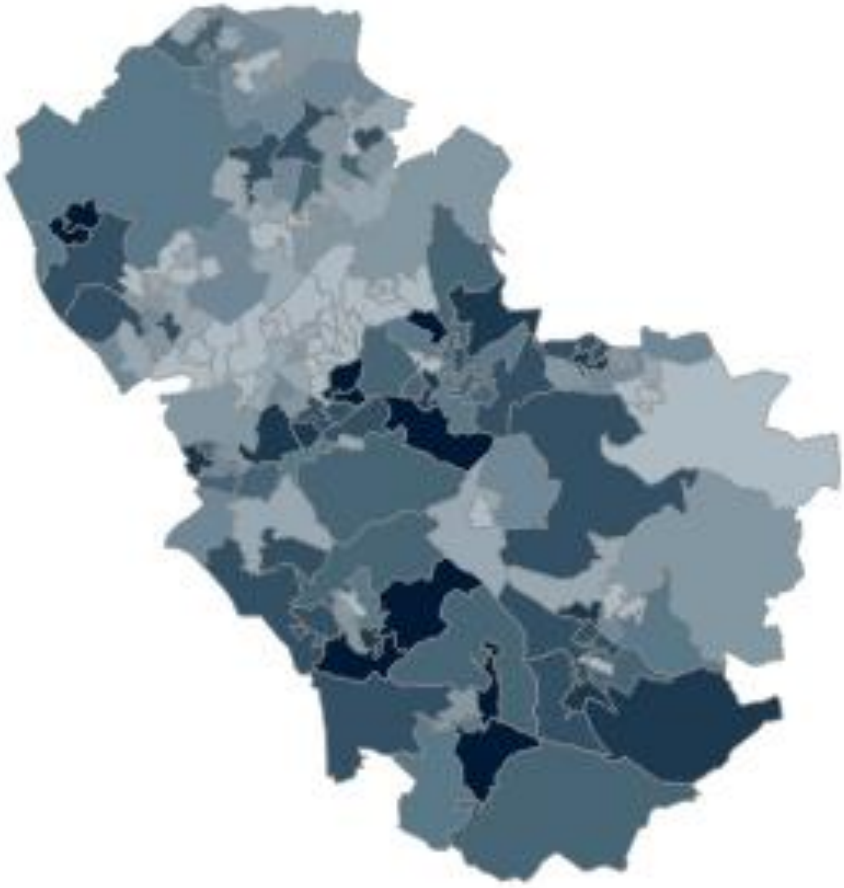
COVID Lens data:
Public Health England. Excess weight and COVID-19: insights from new evidence [2020].
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907966/PHE_insight_Excess_weight_and_COVID-19__FINAL.pdf
Sport England. Activity habits in early weeks of lockdown revealed [2020]. https://www.sportengland.org/news/activity-habits-early-weeks-lockdown-revealed
Ding D et al. Is the COVID-19 lockdown nudging people to be more active: a big data analysis [2020]. http://dx.doi.org/10.1136/bjsports-2020-102575

Impact of covid

- The long-term impacts of COVID are yet to be fully determined, but they are likely to be worse in more deprived areas and to worsen any pre-existing inequalities in all areas

- Deprivation in Rotherham is high compared to England as a whole – a third of Rotherham residents live within the top 20% most deprived areas in the country and overall deprivation increased between 2015 and 2019 according to the Index of Multiple Deprivation (IMD)

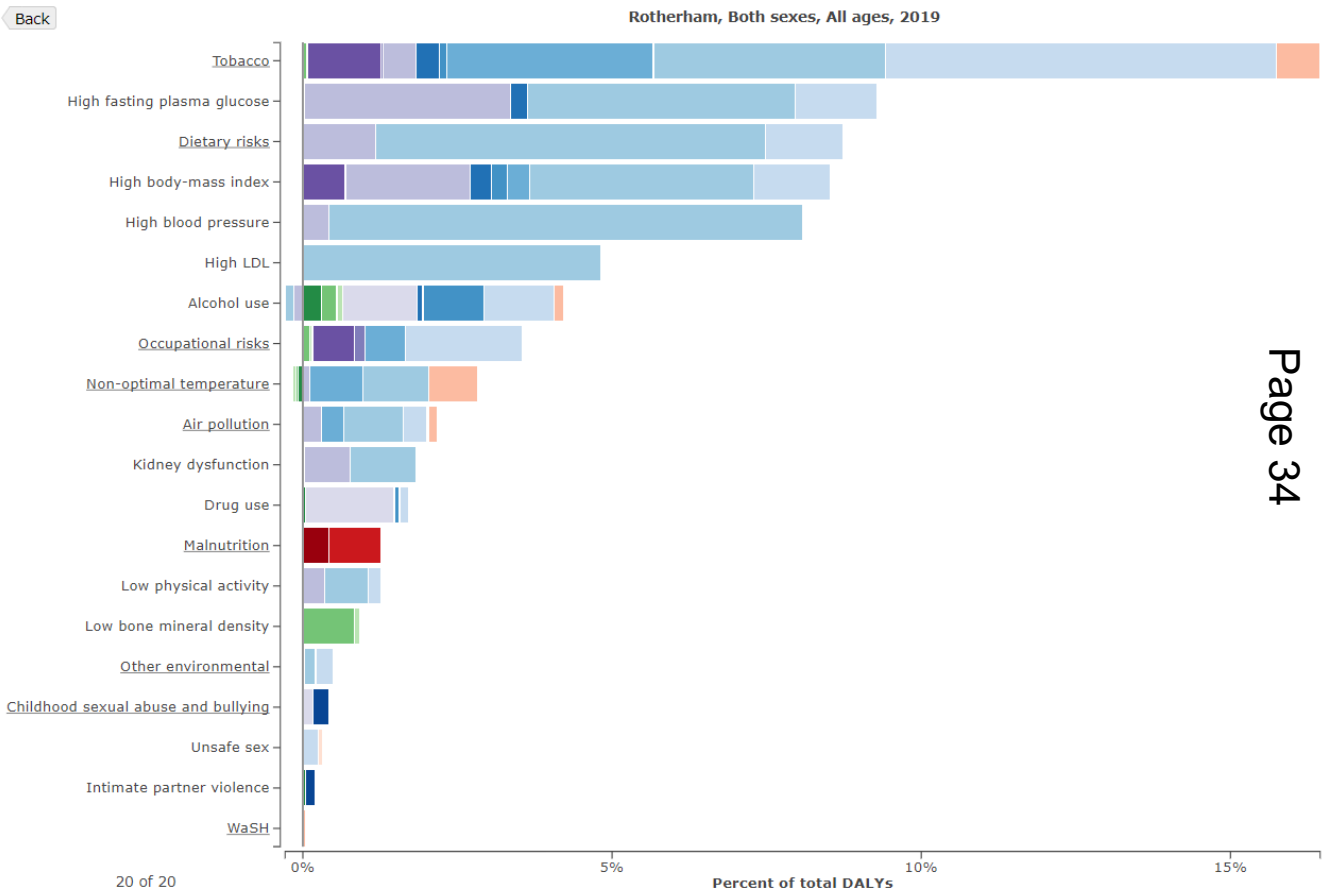
2019 IMD Decile by LSOA



Lighter colour = more deprived
Rank 1 equates to the top 10% most deprived LSOAs in England

Risk factors affecting DALYs

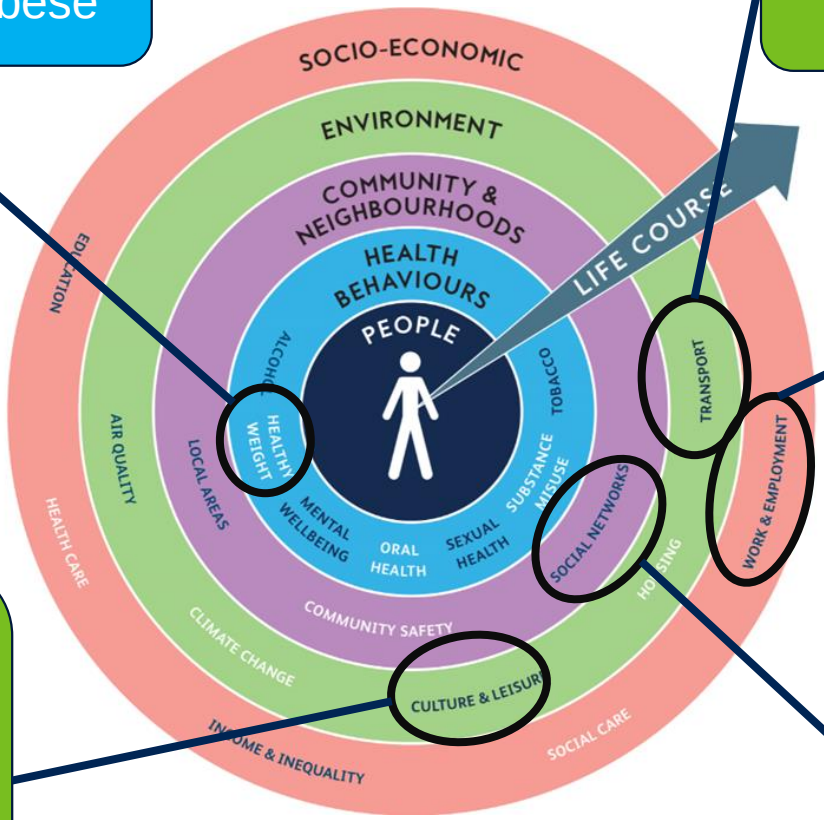
- The top 10 risk factors contributing DALYs in Rotherham are:
  - Smoking
  - High blood glucose
  - Diet
  - High BMI
  - High blood pressure
  - High cholesterol
  - Alcohol use
  - Occupational Risk
  - Cold homes
  - Air Quality



Headline data examples

75.6% of adults classified as overweight or obese

0.5% of workers cycle to work



25% of 16-64 years olds not economically active

14% of residents utilise outdoor space for health or exercise purposes

Gismo search for ‘weight’ -> RUCST weight loss programme

Links to the JSNA

- http://rotherham.gov.uk/data/

- http://rotherham.gov.uk/data/socio-economic
- http://rotherham.gov.uk/data/environment
- http://rotherham.gov.uk/data/community-neighbourhoods
- http://rotherham.gov.uk/data/health-behaviours
- http://rotherham.gov.uk/data/people

Future Actions

- Greater focus on **prevention and inequalities**

- Greater input across **place** – CCG, Healthwatch Rotherham and VAR all contributed data this year
  - TRFT and RDASH keen to contribute some data during this calendar year (e.g. smoking, IAPT (Improving Access to Psychological Therapies)

- As part of input across place, greater inclusion of information about **long-term conditions** such as cancer and cardiovascular disease
  - Links to work around Population Health Management

Future Actions cont.

- Incorporating an interactive **‘ward profile’** element within the JSNA, collating all data at ward level into one place rather than having to go through each section individually
  - Acknowledging delays to data available at new ward level
  - Changes to ward boundaries this year may reduce the degree of comparable data available for the next few years

- Incorporating a **‘lifecourse’** element, where data relevant to each life stage (child, young adult, adult, elderly) across all themes is brought together

Rotherham COVID-19 Surveillance Briefing for Health Select

10th June 2021

Rotherham Metropolitan Borough Council

The four tests

Test 1

The vaccine deployment programme continues successfully.

Test 2

Evidence shows vaccines are sufficiently effective in reducing hospitalisations and deaths in those vaccinated.

Test 3

Infection rates do not risk a surge in hospitalisations which would put unsustainable pressure on the NHS.

Test 4

Our assessment of the risks is not fundamentally changed by new Variants of Concern.

Only when the Government is sure that it is safe to move from one step to the next will the final decision be made.

Decisions will be based on four tests.

Test 1 – Vaccine rollout

Total number of 1st vaccines given by cohort (CCG data) (as at 27 May 2021)
(also 2nd doses shown in brackets)

Total = 158,045 (2nd doses = 103,202)
Equates to 59.54% of resident population (2nd doses = 38.88%)
74.98% of eligible adult population* (2nd doses = 48.96%)

	1st doses (2nd doses)
% Coverage in those aged 70+:	**96.85%** (95.42%)
% Coverage in those aged 50-69:	**92.04%** (66.49%)
% Coverage in those aged 40-49 :	**81.80%** (28.98%)
% Coverage in those aged 30-39 :	**61.79%** (20.70%)
% Coverage in those aged 18-29 :	**28.11%** (14.21%)

% in the Clinically Extremely Vulnerable: **93.34%** (86.66%)
% in Moderate-risk adults aged under 65: **84.77%** (62.65%)

(all above based on “eligible population”)

*Eligible population has been expanded to include those aged between 18 and 49 (Cohorts10-12), thus reducing the total percentage achieved.

Cohorts

1	Care Home Residents and Staff (Local data)
2a	Frontline Health and Social Care workers (Local data)
2b	All those 80 years of age and over
3	All those 75 years of age and over (75-79)
4a	All those 70 years of age and over (70-74)
4b	Clinically extremely vulnerable individuals
5	All those 65 years of age and over (65-69)
6	Moderate-risk adults under 65 years of age
7	All those 60 years of age and over (60-64)
8	All those 55 years of age and over (55-59)
9	All those 50 years of age and over (50-54)
10	All those 40 years of age and over (40-49)
11	All those 30 years of age and over (30-39)
12	All those 18 years of age and over (18-29)

Note – provisional data, includes local data and may be incomplete.
Local Data - Includes patients who work in Rotherham but are not Rotherham registered patients.
Source: INTERNAL - CCG Planning Summary.

Test 2 – Evidence of vaccines reducing hospitalisations and deaths

An effect against hospitalisation continues to be seen when linking pillar 2 testing data linked to emergency admissions. Among those who develop symptomatic infection, risk of hospitalisation is reduced by 35 to 45% after one dose of either vaccine. Combined with the reduced risk of becoming a case, this is consistent with a vaccine effectiveness against hospitalisation which is similar to previously reported value of 80%. (Public Health England vaccine effectiveness report, March 2021)

Public Health England (PHE) has submitted a pre-print of a real-world study that shows that both the Pfizer and Oxford-AstraZeneca vaccines are highly effective in reducing COVID-19 infections among older people aged 70 years and over.

Since January, protection against symptomatic COVID, 4 weeks after the first dose, ranged between 57 and 61% for one dose of Pfizer and between 60 and 73% for the Oxford-AstraZeneca vaccine.

In the over 80s, data suggest that a single dose of either vaccine is more than 80% effective at preventing hospitalisation, around 3 to 4 weeks after the jab.

There is also evidence for the Pfizer vaccine, which suggests it leads to an 83% reduction in deaths from COVID-19.” (too early for data on the Oxford-AstraZeneca vaccine)

The study also demonstrates a clear effect of vaccines against the UK (B.1.1.7/Kent) variant of concern as data in the study based on cases from a period when this variant formed the mass majority.
Source: https://www.gov.uk/government/news/new-data-show-vaccines-reduce-severe-covid-19-in-older-adults (1 March 2021)

Data from Public Health England’s real-world study shows that both the Pfizer and Oxford/AstraZeneca vaccines are highly effective in reducing COVID-19 among older people aged 60 years and over. There has already been a significant impact of the vaccination programme on reducing hospitalisations and deaths, with more than 10,000 lives saved by vaccinations between December and March.
Source: COVID-19 vaccines have prevented 10,400 deaths in older adults - GOV.UK (www.gov.uk) (13 April 2021)

Test 2 – Evidence of vaccines reducing hospitalisations and deaths

Data continue to show encouraging effects from a single dose of the Pfizer vaccination on risk of mortality in symptomatic cases over 80 who have been vaccinated, where the risk of death is reduced by 54%. Combined with the reduced risk of becoming a case, this is consistent with a vaccine effectiveness against mortality which is similar to previously reported value of 85%. (Public Health England vaccine effectiveness report, March 2021)

Everybody in cohorts 1 to 9 – those aged 50 and over, the clinically vulnerable and health and social care workers – has been offered a vaccine, meeting the government's 15 April target ahead of time.
This group accounts for 99% of all COVID-19 deaths during the pandemic, so by offering them the vaccine, we are helping ensure the most vulnerable are protected from the virus.
Source: UK moves into next phase of vaccine roll-out as government target hit early - GOV.UK (www.gov.uk) (13 April 2021)

A new study by Public Health England (PHE) has shown that one dose of the COVID-19 vaccine reduces household transmission by up to half. Those who did become infected 3 weeks after receiving one dose of the Pfizer-BioNTech or AstraZeneca vaccine were between 38% and 49% less likely to pass the virus on to their household contacts than those who were unvaccinated. Protection was seen from around 14 days after vaccination, with similar levels of protection regardless of age of cases or contacts. This protection is on top of the reduced risk of a vaccinated person developing symptomatic infection in the first place, which is around 60 to 65% – 4 weeks after one dose of either vaccine. Source: Impact of vaccination on household transmission of SARS-COV-2 in England.

Dr Mary Ramsay, Head of Immunisation at PHE, said:
Vaccines are vital in helping us return to a normal way of life. Not only do vaccines reduce the severity of illness and prevent hundreds of deaths every day, we now see they also have an additional impact on reducing the chance of passing COVID-19 on to others.
Source: One dose of COVID-19 vaccine can cut household transmission by up to half - GOV.UK (www.gov.uk) (28 April 2021)

Effectiveness of COVID-19 vaccines against VOC-21APR-02 (B.1.617.2)

PHE has undertaken analysis of vaccine effectiveness against symptomatic disease with VOC21-APR-02 (B.1.617.2), using the national genomic and immunisation datasets. These findings suggest that while there is a reduction in vaccine effectiveness against VOC-21APR-02 (B.1.617.2) after one dose, any reduction in vaccine effectiveness after 2 doses of vaccine is likely to be small (Table below). These data combine all vaccines, and a breakdown by vaccine is provided in the full analysis.

Table Vaccination status and vaccine effectiveness for VOC-20DEC-01 (B.1.1.7), VOC21-APR-02 (B.1.617.2)

Vaccination status	Vaccine Effectiveness	
	VOC-20DEC-01 (B.1.1.7)	VOC21-APR-02 (B.1.617.2)
Dose 1	51.1% (47.3 to 54.7)	33.5% (20.6 to 44.3)
Dose 2	86.8% (83.1 to 89.6)	80.9% (70.7 to 87.6)

Taken from Public Health England, 'SARS-CoV-2 variants of concern and variants under investigation in England - Technical briefing 12' Published 22 May 2021

Test 3 – Infection rates do not risk surge in hospitalisations (1)

Measure	As of 20th May	As of 27th May	% change on prev week
Daily Numbers			
Confirmed Covid patients*	5	3	-40%
On Mechanical Ventilation	0	0	0%
7-day rate (per 100,000)	**Previous 7 days to 13th May**	**Previous 7 days to 21st May**	**% change on prev week**
Case rate (persons aged 60+)	5.9	5.9	0%
Case rate (all ages)	28.6	23	-24%
7 Day asymptomatic rate **	**Previous 7 days to 13th May**	**Previous 7 days to 21st May**	**% change on prev week**
Case rate (persons aged 60+)	1.5	1.5	0%
Case rate (all ages)	12.8	9.4	-27%

*Total occupied beds

**Asymptomatic positive cases .

Source: Hospitalisations : INTERNAL – TRFT (Data from TRFT up to 27/05/21)
Case rates: PUBLIC – Coronavirus dashboard – last updated 26/05/21, (Asymptomatic INTERNAL ONLY – last updated 26/05/21)
https://coronavirus-staging.data.gov.uk/details/cases?areaType=ltla&areaName=Rotherham

Test 3 – Infection rates do not risk surge in hospitalisations (2)

Heat Map showing 7-day case rate by age group:

(rate for 7-day period up to date in column heading reported)

Age Band	10/5/21	11/5/21	12/5/21	13/5/21	14/5/21	15/5/21	16/5/21	17/5/21	18/5/21	19/5/21	20/5/21	21/5/21	22/5/21	23/5/21	24/5/21
0 - 4 Pre School	25.7	12.9	12.9	6.4	19.3	19.3	19.3	12.9	12.9	12.9	12.9	0.0	0.0	6.4	6.4
05 - 11 Primary Age	42.3	21.2	12.7	12.7	21.2	25.4	25.4	12.7	21.2	25.4	42.3	42.3	38.1	46.6	50.8
12-17 Secondary Age	109.0	92.7	60.0	54.5	60.0	49.1	49.1	38.2	38.2	49.1	54.5	38.2	38.2	32.7	38.2
18-29	71.6	52.3	49.5	46.8	38.5	38.5	44.0	38.5	44.0	33.0	30.3	38.5	41.3	30.3	24.8
30-39	56.9	56.9	53.9	56.9	44.9	44.9	35.9	27.0	29.9	27.0	24.0	27.0	29.9	29.9	38.9
40-49	49.5	43.3	46.4	49.5	43.3	46.4	37.1	40.2	40.2	30.9	24.7	27.8	18.5	18.5	15.5
50-54	20.8	20.8	20.8	15.6	20.8	26.0	20.8	26.0	31.2	36.4	36.4	31.2	31.2	36.4	20.8
55-59	10.9	10.9	16.3	16.3	16.3	16.3	21.8	16.3	10.9	5.4	10.9	10.9	10.9	10.9	16.3
60-64	12.5	12.5	12.5	12.5	12.5	12.5	12.5	0.0	0.0	0.0	0.0	0.0	0.0	6.3	12.5
65-69	14.1	14.1	14.1	7.0	7.0	7.0	0.0	7.0	14.1	14.1	14.1	14.1	14.1	21.1	14.1
70-74	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.0	13.9	13.9	13.9
75-79	9.9	0.0	0.0	0.0	9.9	9.9	9.9	9.9	9.9	9.9	9.9	0.0	0.0	0.0	0.0
80+	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	0.0	0.0

The most recent rates (for the 7 days to 24 May) are highest in the 05-11 age group then those aged 30-39.
Lowest rates are in those aged 50 and over.
Rates have decreased recently in those aged 50-54.

Source: INTERNAL – PHE Covid-19 Situational Awareness Explorer (last updated 26/05/21)

Test 4 – Variants of Concern (VOC) and Variants under investigation (VUI)

National (UK) data (at 20 May)

Variant	Other names by which this variant may be known*	Lineage	Country in which first detected	Total confirmed cases^	New cases since last update (data up to 12 May)
VOC-20DEC-01	VOC-202012/01	B.1.1.7	England, UK	249,637	7,066
VOC-20DEC-02	VOC-202012/02	501Y.V2	South Africa	904	41
		B.1.351			
VUI-21JAN-01	VUI-202101/01	P.2	Brazil	60	0
VOC-21JAN-02	VOC-202101/02	P.1	Japan ex Manaus, Brazil	143	30
VUI-21FEB-01	VUI-202102/01	A.23.1 with E484K	England, UK	79	0
VOC-21FEB-02	VOC-202102/02	B.1.1.7 with E484K	England, UK	43	0
VUI-21FEB-03	VUI-202102/03	B.1.525 (previously designated UK1188)	England, UK	461	20
VUI-21FEB-04	VUI-202102/04	B.1.1.318	England, UK	226	22
VUI-21MAR-02	N/A	P.3	Philippines	6	0
VUI-21APR-01	N/A	B.1.617	India	418	50
VOC-21APR-02	N/A	B.1.617.2	India	3,424	2,111
VUI-21APR-03	N/A	B.1.617.3	India	13	2
VUI-21MAY-01	N/A	AV.1	TBC	49	Initial

* Currently, there is no agreed international naming system for variants.
^ Confirmed and probable genomic confidence categories assigned to each case have been unified into a single confirmed category. This is being done as a probable genomic confidence indicates a high confidence in variant assignment and the public health significance is the same.

‘No fundamental change in risk assessment due to circulating Variants of Concern or Variants under Investigation’.

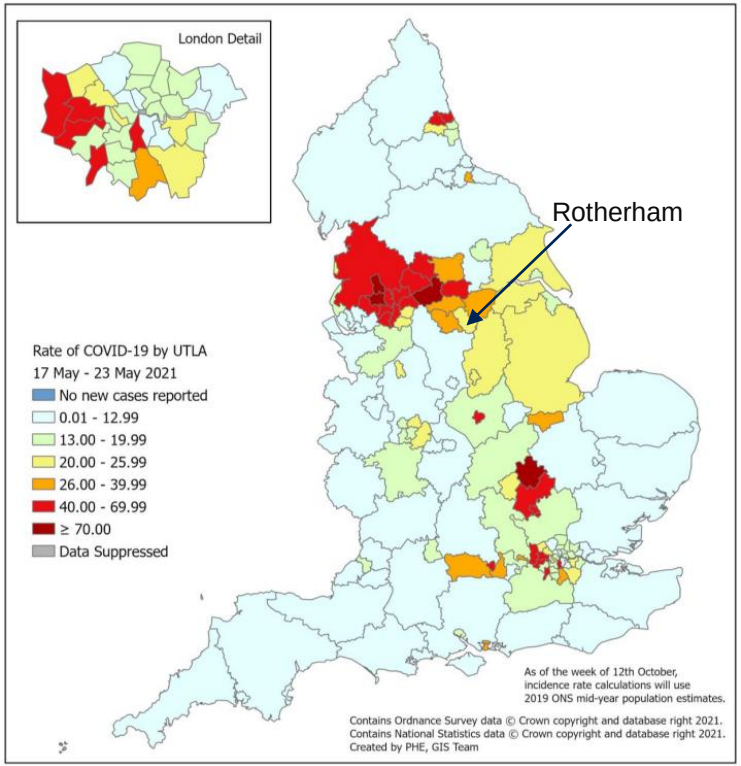
PUBLIC – GOV.UK Coronavirus data: https://www.gov.uk/government/publications/covid-19-variants-genomically-confirmed-case-numbers/variants-distribution-of-cases-data (last updated 27/05/21)

Infection rate headline summary

- Rotherham 7-day infection rate (to 22nd May) is 22.6 per 100,000. (England 23.6). For the second day running the rate is lower than the national average which is slightly rising.
- Rotherham currently ranks 66th highest in England (out of 314 Lower Tier Local Authorities, 7-day data to 21st May), and the lowest rate in South Yorkshire. Rest of SY local authorities are in the top 51 LTLAs.
- The 7-day infection rate for persons aged 60 (to 21st May) is currently 5.9 per 100,000 (England 6.1).
- The 7-day rate of positivity is 1.5% for Rotherham (Y&H Region 1.6%, England 0.7%) Test sites continue to have plenty of capacity. Although reduced uptake of LFDs since March, testing overall for Rotherham remains high comparative to other areas.
- Rates are highest in those aged 20-24 (49.3 for 7-day rolling rate to 22nd May).
- Postcode data suggests cases are spread out across the community.

England comparisons

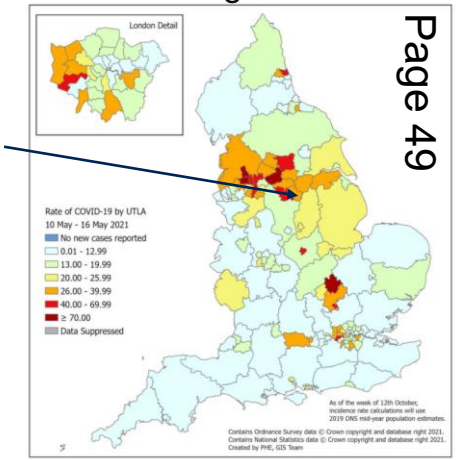
Figure 9: Weekly rate of COVID-19 cases per 100,000 population tested under Pillar 1 and Pillar 2 by upper-tier local authority, England (box shows enlarged map of London areas)



This map from the official national PHE Weekly Flu/COVID-19 Surveillance Report shows the latest weekly rate of positive cases per 100,000 population based on Week 20 data (17-23rd May)

Rotherham's rate in the map is 40.3 per 100,000 (yellow). This may differ to rates stated elsewhere due to differences in timing.

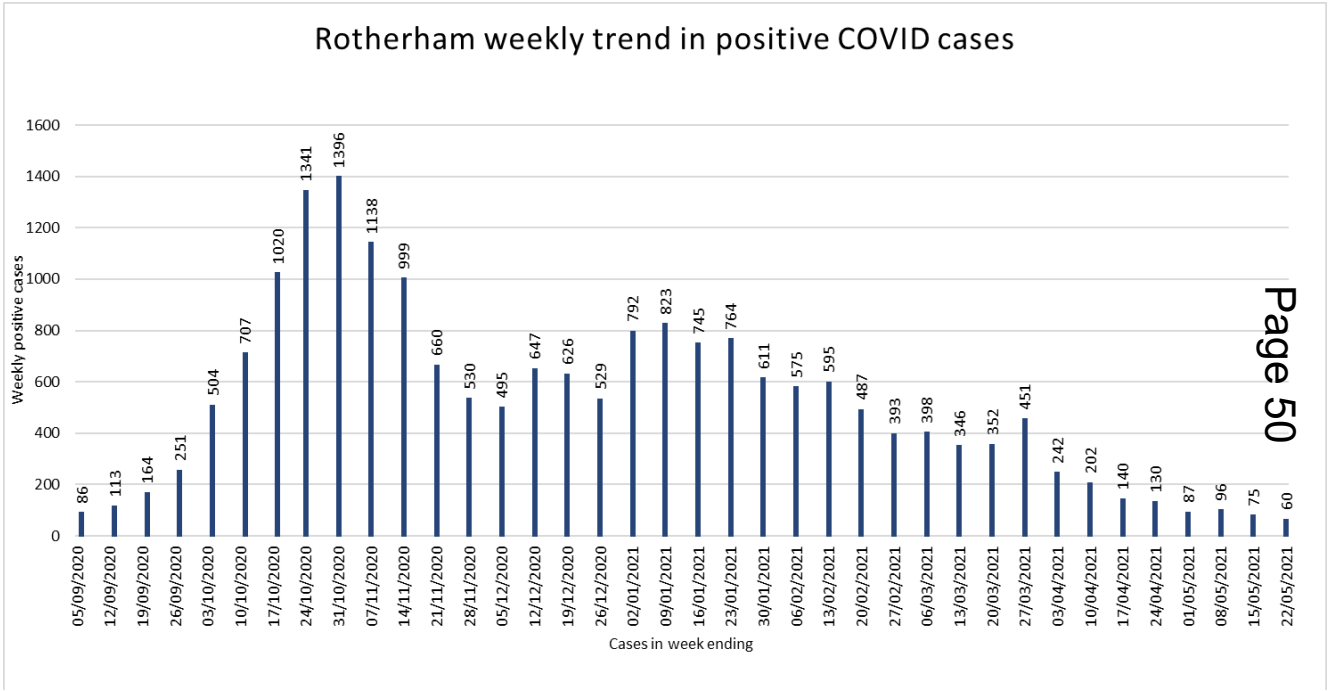
Inset map shows the previous week's data for 10-16 May (Rotherham 26.8, orange)



Data source: PUBLIC – PHE Weekly Covid19 Surveillance report
https://www.gov.uk/government/statistics/national-flu-and-covid-19-surveillance-reports

Current infection rate

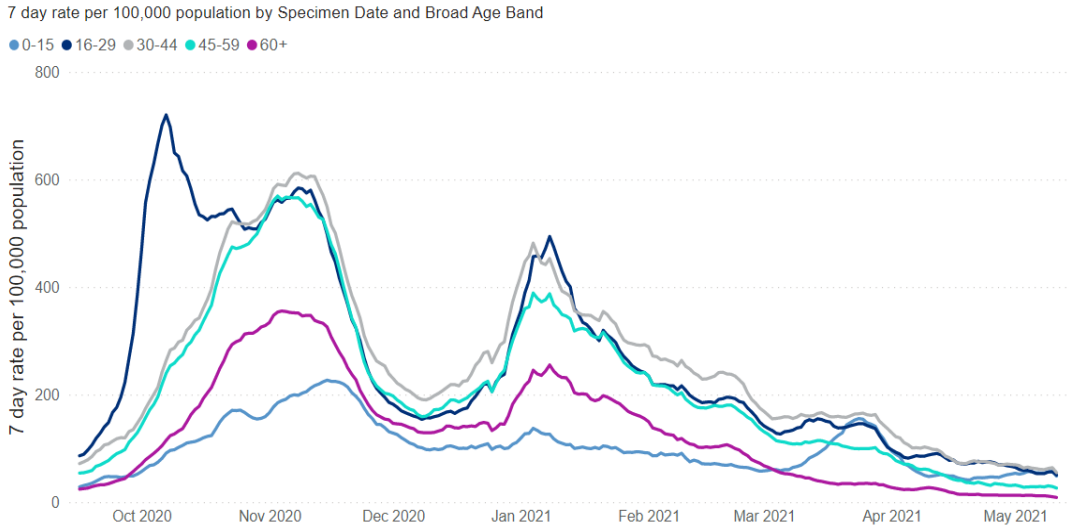
- The 7-day infection rate is 22.6 per 100,000 (for the 7 days to 22nd May).
- This is from 60 positive cases in those 7 days.
- Data has fluctuated but generally decreased since early January.



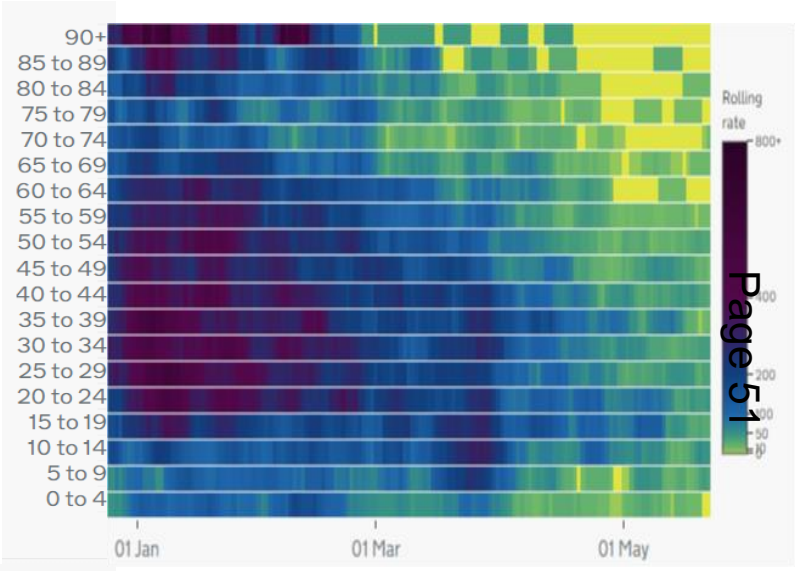
Data source: PUBLIC – Coronavirus dashboard – last updated 27/05/21

Age trends

Positive samples – Rates per 100,000 (rolling 7 day averages) (broad age groups)
Data 16 September 2020 to 22 May 2021 (provisional)



Age-specific case rates per 100,000 by 5-year age groups 15 December to 22 May 2021



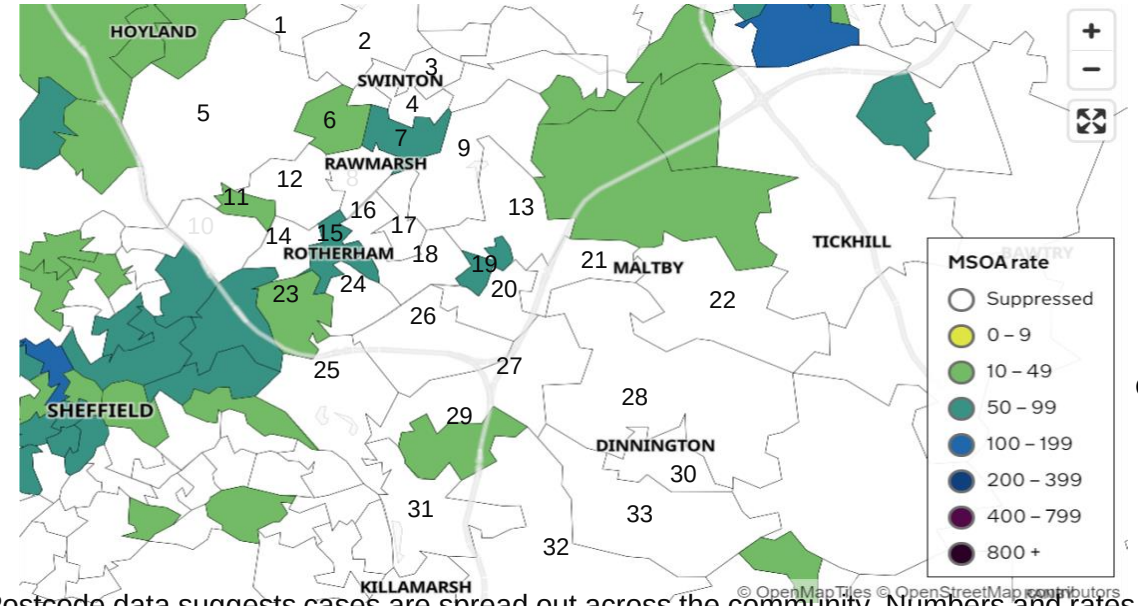
After increasing recently, Rotherham's rates have levelled out. (see line chart) This appears due to an increase in the 0-15 age group offsetting decreases in all other age groups. The highest rates are currently in those aged 10-14. The lowest are in those aged 50 and over (see heat map chart)

Data source: INTERNAL – Situational Awareness Explorer (PHE) 26/05/21 (left chart)
PUBLIC – Heat map via Coronavirus dashboard https://coronavirus.data.gov.uk/; - last updated 27/05/21 (right chart)

Weekly Rates and Cases by Local Area

7 days 2-8 May: Rotherham Number of cases by MSOA
The MSOAs in Rotherham with higher numbers (3 or more) are:
(1) Brampton & West Melton: 5
(2) Wath upon Dearne: 4
(3) Swinton North (<3)
(4) Swinton South (<3)
(5) Thorpe Hesley (<3)
(6) Rawmarsh N West: 7
(7) Rawmarsh N East: 3
(8) Rawmarsh South 7
(9) Thrybergh & Hooton Roberts (<3)
(10) Kimberworth 10
(11) Kimberworth Park (<3)
(12) Greasbrough (<3)
(13) Ravenfield & Bramley North: (<3)
(14) Masbrough & Bradgate: 3
(15) Rotherham Central - Canklow, Wellgate, and St Ann's: 3
(16) Eastwood & East Dene: (<3)
(17) East Herringthorpe: 3
(18) Herringthorpe: (<3)
(19) Wickersley North (<3)
(20) Wickersley South & Bramley South: (<3)
(21) Maltby West & Hellaby (<3)
(22) Maltby East 6
(23) Brinsworth 7
(24) Rotherham South - Moorgate/Broom: 3
(25) Catcliffe, Treeton & Waverley 4
(26) Whiston (<3)
(27) Thurcroft (<3)
(28) Laughton & Throapham (<3)
(29) Aston 7
(30) Dinnington (<3)
(31) Swallownest & Wales: 5
(32) Kiveton, Todwick & Harthill 3
(33) Anston & Woodsetts (<3)

Coronavirus (COVID-19) positive cases by MSOA – Rotherham (rate per 100,000)

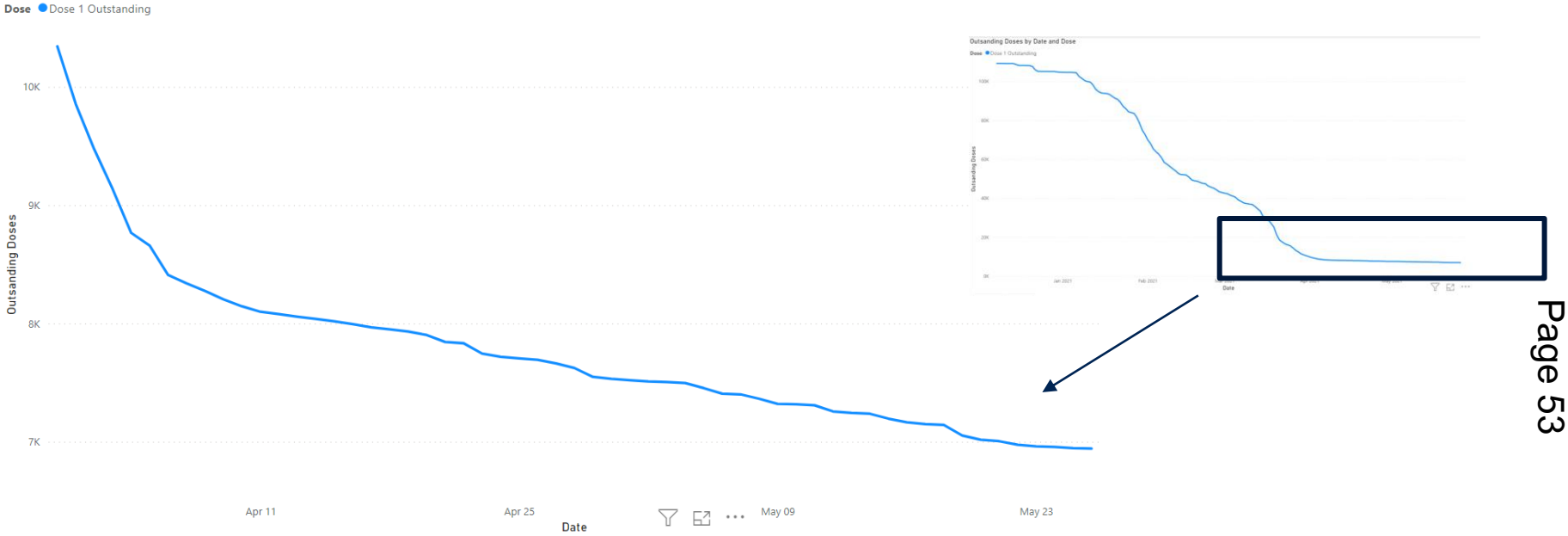


Postcode data suggests cases are spread out across the community. Numbers and rates have decreased for the 7 days to 22nd May. None of Rotherham's 33 MSOAs have a rate over 100 per 100,000 resident population. The highest rate was in Rotherham Central with 71.9 per 100,000. Rawmarsh North West has the lowest at 38.8 (of 6 MSOAs with 3 or more cases) However, positions can change daily due to the small numbers involved.

Data source: PUBLIC – Coronavirus dashboard – last updated 27/05/21
https://coronavirus-staging.data.gov.uk/details/interactive-map

•Contains MSOA names © Open Parliament copyright and database right 2020
•Contains Ordnance Survey data © Crown copyright and database right 2020
•Contains Royal Mail data © Royal Mail copyright and database right 2020
•Contains Public Health England data © Crown copyright and database right 2020
•Office for National Statistics licensed under the Open Government Licence v.3.0

Over 50’s outstanding dose 1



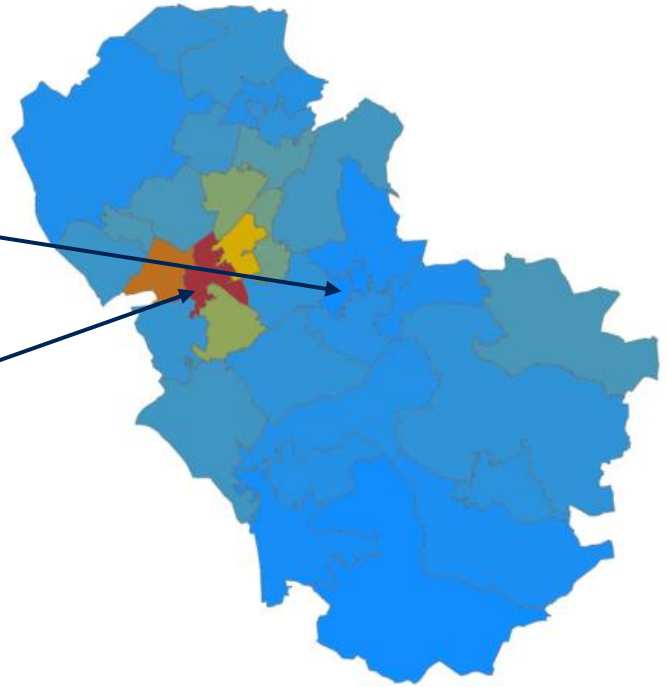
- By the end of March, a significant majority of 50+ year olds had received first dose of vaccine. Rate of uptake is reducing (3,400 completed since 1st April, 10,343 remaining) and now to be subject to additional catch-up focus.

Source: INTERNAL – PHE Covid-19 Situational Awareness Explorer (last updated 26/05/21)

Coverage over 50's of 1st vaccine

Wickersley North has the highest coverage of 1st vaccine – 96.4% have had their first dose

Rotherham Central has the lowest coverage of 1st vaccine – 75.7% have had their first dose



Source: INTERNAL – PHE Covid-19 Situational Awareness Explorer (last updated 26/05/21)

Vaccination Access Work with the CCG

- 71 at Ferham Primary (12th May)
  - 23 of these being teachers
  - 48 parents/relatives of the children.
- 73 at Hellaby Businesses (16th May)
- 214 at Rotherham Businesses (19th & 20th May)
- 50 (minimum) vaccines allocated for a walk in Eastwood village (22nd May) – exact figures not known at the time of writing

Rotherham Metropolitan Borough Council

Public Report
Health Select Commission

Committee Name and Date of Committee Meeting
Health Select Commission – 10 June 2021

Report Title
Initial Work Programme

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

Strategic Director Approving Submission of the Report
Jo Brown, Assistant Chief Executive

Report Author(s)
Katherine Harclerode, Governance Advisor
01709 254532 or katherine.harclerode@rotherham.gov.uk

Ward(s) Affected
Borough-Wide

Report Summary
To outline an initial work programme for Health Select Commission.

Recommendations

1. That Health Select Commission give consideration to an outline work programme using the draft set out in Appendix 1 as a basis for the discussion and to agree priorities for the 2021/22 municipal year.

2. That the Chair and Governance Advisor meet with the relevant Cabinet member, representatives of partner organisations, and officers to receive feedback on these proposed areas of work.

3. A further report proposing the formal work programme for 2021-22 will be submitted to the Health Select Commission meeting in July of 2021 in order for Members to agree a clear set of priorities for this municipal year.

List of Appendices Included
Appendix 1 Work Programme – Health Select Commission

Background Papers
Agendas of Health Select Commission during the 2020/21 Municipal Year
Minutes of Health Select Commission during 2020/21 Municipal Year

Consideration by any other Council Committee, Scrutiny or Advisory Panel
Not applicable

Council Approval Required
No

Exempt from the Press and Public
No

Initial Initial Work Programme

1. Background

1.1 Overall performance of health partners is scrutinised through their quality reports, incorporating a range of national measures together with a number of locally agreed quality priorities. Adult Care and Public Health both have outcome frameworks of performance measures which enable progress to be gauged year on year and also benchmarked nationally and regionally.

1.2 Addressing health inequalities that exist in the borough, through health and social care strategies and plans, and through looking at the wider determinants of health should be an overarching principle.

1.3 The Health and social care services continue to undergo transformation and move towards more integrated working through joint commissioning, joint posts, locality working, greater co-location and multi-disciplinary teams. This work has been an important long-term programme that the Health Select Commission (HSC) has kept under scrutiny since 2015-16 and is still evolving. The recent publication of the Government's White Paper will bring changes in health care systems that will remain a focus and which will have evolving implications for how health scrutiny is conducted in the future.

1.4 Another continuing piece of work is scrutiny of any major changes to NHS services across South Yorkshire, Derbyshire and Nottinghamshire, undertaken by the Joint Health Overview and Scrutiny Committee, in accordance with the terms of reference for the HSC in the Council Constitution.

1.5 The way in which the Commission discharges its scrutiny activity is a matter for itself, having regard to the provisions of the Constitution and any direction from the Overview and Scrutiny Management Board. The IPSC has chosen to scrutinise a range of issues through a combination of pre-decision scrutiny items, policy development, performance monitoring, information updates and follow up to previous scrutiny work.

1.6 Health Select Commission has eight scheduled meetings over the course of 2021/22, representing a maximum of 16 hours of scrutiny per year – assuming 2 hours per meeting. Members therefore have to be selective in their choice of items for the work programme. The following key principles of effective scrutiny should be considered in determining the work programme:

- Selection – There is a need to prioritise so that high priority issues are scrutinised given the limited number of scheduled meetings and time available. Members should consider what can realistically and properly be reviewed at each meeting, taking into account the time needed to scrutinise each item and what the session is intended to achieve.

- Value-added – Items had to have the potential to 'add value' to the work of the council and its partners.

- Ambition – the Programme does not shy away from scrutinising issues that are of greatest concern, whether or not they are the primary responsibility of the council. The Local Government Act 2000 gave local authorities the power to do anything to promote economic, social and environmental wellbeing of local communities. Subsequent Acts have conferred specific powers to scrutinise health services, crime and disorder issues and to hold partner organisations to account.

- Flexibility – The Work Programme maintains a degree of flexibility as required to respond to unforeseen issues/items for consideration during the year and to accommodate any further work that falls within the remit of this Commission.

- Timing – The Programme has been designed to ensure that the scrutiny activity is timely and that, where appropriate, its findings and recommendations inform wider corporate developments or policy development cycles at a time when they can have most impact. The Work Programme also helps safeguard against duplication of work undertaken elsewhere.

2. Key Issues

2.1 Members are required to review their work programme at each meeting during the 2021/22 municipal year to give focus and structure to scrutiny activity to ensure that it effectively and efficiently supports and challenges the decision-making processes of the Council, and partner organisations, for the benefit of the people of the borough.

2.2 Following the discussion at Health Select Commission, a revised draft work programme for 2021/22 will be developed and presented at a future meeting for endorsement.

3. Options considered and recommended proposal

3.1 Members are recommended to agree priorities for the 2021-22 municipal year and contribute suggestions for the work programme.

4. Consultation on proposal

4.1 The work programme is subject to consultation with the Chair and Members of the Health Select Commission. Regular discussions take place with Cabinet Member, partner organisations, and officers in respect of the content and timeliness of items set out on the work programme.

5. Timetable and Accountability for Implementing this Decision

5.1 The decision to develop and endorse a work programme is a matter reserved to the Commission and will be effective immediately after consideration of this report.

5.2 The Statutory Scrutiny Officer (Head of Democratic Services) is accountable for the implementation of any decision in respect of the Commission's work programme. The Governance Advisor supporting the Commission is responsible on a day-to-day basis for the Commission's work programme. Members are recommended to delegate authority to the Governance Advisor to make amendments to the programme between meetings.

6. Financial and Procurement Advice and Implications

6.1 There are no direct financial or procurement implications arising from this report.

7. Legal Advice and Implications

7.1 There are no direct legal implications arising from this report.

7.2 The authority of the Select Commission to determine its work programme is detailed within the Overview and Scrutiny Procedure Rules and Responsibility for Functions parts of the Constitution. The proposal to review the work programme is consistent with those provisions.

8. Human Resources Advice and Implications

8.1 There are no direct human resources implications arising from this report.

9. Implications for Children and Young People and Vulnerable Adults

9.1 There are no implications for children and young people or vulnerable adults arising from this report.

10. Equalities and Human Rights Advice and Implications

10.1 Whilst there are no specific equalities implications arising from this report, equalities and diversity are key considerations when developing and reviewing scrutiny work programmes. One of the key principles of scrutiny is to provide a voice for communities, and the work programme for this Commission has been prepared following feedback from Members representing those communities.

11. Implications for CO2 Emissions and Climate Change

11.1 There are no implications for CO2 emissions or climate change arising from this report.

12. Implications for Partners

12.1 The Commission has a co-opted Member from Rotherham Speak Up who contributes to the development and review of the work programme. Where other matters are being considered for inclusion on the work programme, relevant partners or external organisations are consulted on the proposed activity and its timeliness.

13. Risks and Mitigation

13.1 There are no risks arising from this report.

14. Accountable Officer(s)

Craig Tyler, Head of Democratic Services and Statutory Scrutiny Officer

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This report is published on the Council's website.

Appendix 1 - Work Programme

Meeting Date	Agenda Items
10 June 2021	Update on Health and Care System Changes
	Joint Strategic Needs Assessment (JSNA) Update
	COVID Briefing
	Initial Work Programme 2021/22
8 July 2021	Carer's Strategy Update
	Health and Wellbeing Board Annual Report
	Revised Work Programme 2021/22
August 2021 Workshop	Yorkshire Ambulance Service (YAS)
2 September 2021	Community Hub
	The Rotherham NHS Foundation Trust (TRFT) Annual Report
	Findings and Recommendations from YAS Workshop
September 2021 Training	All Member Mental Health First Aid and Suicide Prevention Training
7 October 2021	Prevention-led Strategy Systems
	Drug and Alcohol Treatment and Recovery Service Update
25 November 2021	Quality Accounts: TRFT, Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH), YAS
	Local Authority Declaration on Healthy Weight Update
	Room for Items Referred from Overview and Scrutiny Management Board (OSMB)
December 2021 Working Group	Adult Social Care Outcomes Framework (ASCOF) Performance Measures
13 January 2022	Director of Public Health Annual Report 2021
	Findings and Recommendations from ASCOF Working Group
24 February 2022	CAMHS Service Update
	Sexual Health Strategy
March 2022 Working Group	Medication Policy Development
7 April 2022	Quality Accounts Half-Year Reports: TRFT, RDaSH and YAS
	Autism Strategy and Pathway Update
	Intermediate Care and Reablement Update