HEALTH SELECT COMMISSION
Thursday 27 July 2023

Present:- Councillors Yasseen (Chair), Miro (Vice-chair), Andrews, Bird, Cooksey, Griffin, Havard, Hunter, Sansome and Thompson and co-opted member Mr. David Gill, representing Rotherham SpeakUp Self Advocacy.

Apologies for absence:- Cllrs A Carter, Foster, Hoddinott, Keenan, and Wilson, and from Mr. Robert Parkin.

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

19. MINUTES OF THE PREVIOUS MEETING HELD ON 29 JUNE 2023

Resolved:-

That the minutes of the meeting held on 29 June 2023 be approved as a true and correct record of the proceedings.

20. DECLARATIONS OF INTEREST

There were no declarations of interest.

21. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

The Chair confirmed that no questions had been submitted.

22. EXCLUSION OF THE PRESS AND PUBLIC

The Chair advised that there was no reason to exclude members of the public or press from observing the discussion of any items on the agenda.

23. ROTHERHAM ALCOHOL AND DRUG SERVICE (ROADS)

Consideration was given to a presentation by the Cabinet Member for Adult Care, Housing and Public Health; the Director of Public Health, and Operational Commissioner Public Health, joined by the Director of Implementation, We Are With You (WAWY). The presentation identified the background motivation for the recommissioning and remobilisation of the service, along with challenges associated with increasing numbers in treatment, which included:

- Recruiting suitable staff into a depleted sector
- Making services accessible to all
- Alcohol and drug service users don't always mix well
- Reaching those who are not in crisis yet so they are not so well entrenched in habits or badly impacted
- Some people enjoy using but not the consequences – need to capitalise on opportunities before it becomes a hardened addiction.

The need to improve the criminal justice pathway was described. This would prevent re-offending and support recovery and maintain any treatment gains from the relative stability of prison, etc., minimising risk of relapse and overdose when people are particularly vulnerable upon leaving prison. Currently only 1/3 of prisoners were in treatment.

Aims of the service were noted:

- A longer potential contract to offer further stability to the sector and the partnership arrangements
- Provider leads on a whole service with different pathways for different ages and needs - No wrong door approach and a single point of access
- Increased focus on alcohol following the local needs assessment
- Provider leads on the access to residential rehabilitation as the lead specialist in the field rather than the Council.

There was no wrong pathway into the Service, using a one front door approach, for services responding to all substances. Alcohol had been the most prevalent substance and with the most harmful effects overall. This area of the service was aimed at people who recognise that their drinking had become an issue, although many people were not yet ready to take this step to approach specialised services.

The mobilisation of ROADS was then described. We are With You implemented a dedicated mobilisation team, with operational and clinical expertise to successfully mobilise the service to

- Transfer patient data – 1522 patients
- TUPE staff across from the incumbent provider – 50 staff members
- Recruit to new positions
- Train and integrate the IPS (employment support) Team
- Novate Pharmacy and Primary Care contracts
- Confirm pathways and ways of working with stakeholders
- Produce and agree proposals for the utilisation of additional Supplemental Substance Misuse Treatment and Recovery Grant (SSMTRG)
- Implement a dedicated Pathfinder Team to cover the service during the first 3 weeks to allow training and induction to occur.

Milestones achieved included service base retention refreshed for the delivery of the new services and new provider. Clients had been transferred with minimal disruption; most staff and their expertise were retained under TUPE; and data had been transferred from CGL, enabling continuous provision of care.

Challenges encountered included some personnel changes during mobilisations that had set the process back; some staff left at the last minute and stayed with CGL, creating more vacancies than planned. Following the data transfer, additional resource needed to be allocated to complete new recovery plans and risk assessments for service users.

The presentation also addressed how the Service measures success, including use of the drug treatment monitoring system by community services, prison providers, inpatient detox units, residential rehabilitation facilities. The system uses data to monitor services nationally.

In terms of Service effectiveness, success was defined from six months having elapsed since leaving treatment. National data would later become available, and Key Service Outcomes were also noted to show what was considered successful treatment outcomes. Baseline improvement had been shown from the previous year. Some data points had been affected by the pandemic which prevented people from being passed through to recovery. These clients were retained in the Service to keep them safe. Service capacity had also been increased following the SSMTR Grant. There was an ambition to increase the capacity and improve on outcomes in 2024/25.

The WAWY Director of Implementation described the service model. Expanding community delivery locations would enable people to access one all age service from where they are, including dedicated specialist teams and partnership working. Community prescribing was described, to illustrate the awareness and sensitivity of the Service to how distances and travel to treatment affects clients.

The Director of Implementation explained the aim of the Service to interrupt generational cycles of substance misuse. This involves understanding the specific vulnerabilities and has led to development of a specific pathway for young people. Dedicated roles for YOS Young person work, Transitional Worker, and Family Worker within the team were noted, and there was work to upskill the local community and wider workforce. The next training was being delivered in August. The Service worked with Criminal Justice to do prison in-reach and include criminal justice administrators within the team. Working with women in a women-only space was also expected to help address the underrepresentation of women in recovery services.

Importance of individual placement and support were also emphasised, along with targets to support clients back into work. There were underserved communities with whom the service was working differently, such as through targeted outreach and harm reduction with the Roma community, meeting with community elders e.g., local Imams, and being visible to local residents at events such as Rotherham Show. This work sought to reduce stigma and publicise the impact of drug and alcohol use. This also showed that not just specialist treatment was provided; WAWY support people at every part of their journey.

In discussion, clarification was sought regarding the duration of funding. The response from the Director of Public Health noted that three years of funding had been confirmed. As this was the second year of a ten-year drug strategy, continuation of funding was expected.

Members sought additional context surrounding the roughly three percent completing treatment for opiates, and the roughly one third of clients who are in the sixth year or more of treatment. The response from the Director of Implementation noted that different strategies had a different focus; a former focus on maintenance compared to the current focus toward recovery. The former focus had operated from the view that being in treatment is safer than not being in treatment. The benefits of being in treatment were noted, such as annual checks for bloodborne virus risk which led to earlier detection. The Service did encourage people to be able to move on with their lives rather than to be perpetually in treatment or going to the pharmacy on a frequent, sometimes daily, basis. There were other options, and the Service worked with people who have been through the treatments. The Director of Public Health noted that some people will function well for many years with a methadone prescription, which will help them to reintegrate into their family and other aspects of life. Therefore, starting the pathway earlier could make a big difference. It was acknowledged that some of the reasons some people come to the service, including trauma, mean that they will always self-medicate in some way.

When people are entering the service, further information was requested about whether people entering the Service from previous treatment had received the right support and whether this was being carried on by the Service. The response from the Director of Implementation confirmed that each prison team had an arm that specialised in drug and alcohol, many people were open to the Service before leaving, and had received support in prison. Assessments were done before they leave, and there was data continuity to continue the same treatment episode. This meant that the team had access to forwarding address, prescriptions, and risk factors to ensure they could be captured by the Service when they were released.

Members requested assurance that the Service is prepared to pick up where the prison Services leave off. The response from the Director of Implementation confirmed that clients experience a hard stop in support from the prisons when they leave unless they are under license or probation. Therefore, there were multiple professionals looking after a person when they leave.

Members sought additional information regarding support available on weekends and holidays. The response from the Director of Implementation noted that release from prisons took place always on a Friday afternoon. There was a piece of work to stop prisons from releasing on Friday afternoons. The clients coming from prison were known to the Service, which worked with them to get them into the Service in time. Schemes such as GROW allowed all the necessary consultations to happen in one place, including prescriptions, housing, etc. Having all the professionals the clients need to speak to in one room was important. Saturday hours were available. This ensured the client could take the prescription to a nominated pharmacy, as they were released with their Friday dose only.

Clarification was sought around support for people with a learning disability. The response from the Director of Implementation indicated that the teams work to provide interventions that were accessible to everybody, and at the point of assessment the teams talk about how best the client can receive support and what would be best for them. This could mean sitting across from them at a table, or going for a walk, or going to an allotment to do a project together. Team members were trained to identify and support people with different needs and to pose these questions in a way that was non-threatening.

Members sought additional clarification around how the Service linked with the hospital. The response from the Operational Commissioner noted that, in terms of the service model, an alcohol liaison officer is located within the hospital. Sexual health and maternity had forged links as well. The hospitals were connected with these systems, and the GP shared care practices were all linked together to this information as well.

Further detail was sought regarding how the Service works to increase the awareness and sensitivity of employers of people who may be in recovery. The Director of Public Health noted in response that employers have the responsibility to ensure they have the right occupational health policies and practices in place to respond to employees who may be seeking treatment or in recovery. Through health checks and programmes like Drinkcoach, the Service presented opportunities for people to identify their issues. It helped that the Services had a single point of access. To achieve the desired treatment numbers, it was important for all areas of the community to be on board with making referrals. The Director of Implementation noted that workers engage with employers to encourage employment and advocate for recovering people as assets to the workforce.

Further clarification was also requested regarding the availability of local service data to enable successful completion exits and drop out exits to be understood locally. The response from the Director of Public Health noted there was a conversation going on nationally about successful treatment data. The Services had been releasing some people that began treatment during the pandemic. Some discussions considered how data reflected different approaches had been taken at different times. The Director of Implementation also noted that Rotherham-specific measures relating to the local need were part of the contract. Re-admissions were also tracked. Hospitals track and measure differently, but the Service did know of some people who were regular attendees to A&E. The map was used to decide where Services needed to be and how to use existing sites. For example, near probation or the hospital, there were easy places to be able to access due to mutual benefit to providers, and it was also necessary to drill down using local data to consider public transport to inform the community delivery plan.

Clarification was requested around how the service addressed root causes. The response from the Director of Implementation noted that front line staff were trained in Cognitive Behavioural Therapy solution focussed therapies and work with clients to develop SMART Goals. This was not provision of trauma therapy, but a trauma-informed Service, down to the physical atmosphere of spaces and curation of client experience of the Service attempted to ensure a nice and safe experience. The Service were building more pathways to channel people into specialist services.

Members requested additional clarification around whether there were any prison referrals outstanding, who did not take up the offer. The response from the Director of Implementation noted that everyone who was released was given the option and is referred to the service. They are all referred to the community provider. Some people have been in prison for some time and may feel ok or be at a more stable position. Strengths based assessments, relapse prevention, or specialist treatment were all part of the offer to everyone who was being released.

Members sought further reassurances regarding oversight of the long-term use of methadone by some clients. The response from the Director of Implementation noted that clinical guidelines specified an optimal dose range. For those with complex needs, the focus was stabilising the person, which might require a high dose. The dose must be high enough that the person did not crave the use of heroine anymore. Once they were at a point of stabilisation, going to the pharmacy more than once a day could put a strain on people. There were emerging options, for example, injections that are required only once a month. These were among the other options to methadone.

Members requested further reassurances that prison services were working on their side to reduce overreliance on methadone. The response from the Director of Implementation indicated that the prison teams could do this on a risk basis. A reduction in dosage whilst in prison and in the community sometimes happened. Sometimes being in prison was still very risky, however. Therefore, a very much person-centred approach had to be taken in each case.

The Healthwatch Manager noted that feedback among people who use English as an Additional Language and required translation services had found it difficult to access the Service in Rotherham. Therefore, further information was sought as to how the Service addressed this. The response from the Director of Implementation described that translation service via phone or a physical interpreter was available within the sessions. All literature was available in a variety of languages, and people could change the language on the website to their language of choice.

Members also sought additional information regarding the attrition rates among young people. The response from the Director of Implementation acknowledged that the low rates reflected the young people in structured treatment which involved regular weekly contact. Unstructured

interventions in schools, including one-off sessions and information in assemblies were not captured. The NDTMS only captured structured treatments which were part of caseloads but did not capture the unstructured work that was reported to the Council.

Resolved:-

1. That the report be noted.

2. That the service consider how best to mitigate the barriers that prevent people from accessing the service.

3. That the Service where possible monitor local data on a regular basis to augment the national data snapshot which is only available annually.

4. That a fully joined up approach be sought with other Council and community services which can help address core needs of service users, especially those living with trauma.

5. That the next update be received in 12 months' time, including local data and pathway information.

24. PLACE PLAN PRIORITIES CLOSE DOWN REPORT - MAY 2023

Consideration was given to a presentation from the Deputy Place Director on the Rotherham Place Plan Close Down Report from May 2023 which summarised the objectives achieved and carried over to 2023-25. Approximately 50% of the actions were complete and that the remaining 50% will be picked up in the refreshed Place Plan as they are ongoing priorities. The development of Rotherham Place Partnership 2023-25 was described.

Inputs into the development of Rotherham Place Partnership 2023-25 Place Plan included:

- Interactive development sessions with both the contract and service improvement leads and Place Board and senior managers focussing on priorities
- Alignment with the South Yorkshire Integrated Care Strategy and the Joint Forward Plan
- Annual Operational Planning Guidance
- Continued alignment with the Rotherham Health and Wellbeing Strategy
- Outputs from the Update of Priorities: Close Down Report
- Inputs and comments from all place partners

Key outputs from the development session discussions confirmed:

1. The following chapters were within the previous Plan and remain in the refreshed version:

- Best Start in Life (maternity / children & young people)
- Improving mental health and wellbeing
- Support people with learning disabilities & autism
- Urgent, emergency and community care

2. The following are new chapters:
- Live Well for Longer (prevention, self-care & long-term conditions)
- Palliative and End of Life Care

Ongoing Performance was also described. As with previous Place Plans, a performance report covering both KPIs, and milestones would be produced and regularly reported to Place Board. This would enable issues, risks and blockages to be identified and addressed.

In discussion, Members requested additional details around how monitoring of targets was done, for example pertaining to mental health. It was noted that SMI health checks were now above target where they were previously amber. The transformation group worked collectively to deliver any objectives that were off target. A tender process to commission the peer support service had been undertaken but had not found a provider.

Clarification was requested around the targets which were being carried over. The response from the Cabinet Member noted that some of the points had not been completed this year because they were intended to be ongoing. The page count of next years' document had been reduced by half, and an easy-read version had been requested. This document had been discussed at the Place Board in Rotherham and was reported to the Health and Wellbeing Board for added transparency. This then feeds into the South Yorkshire Integrated Care System and the Integrated Care Partnership.

The co-opted member from Speakup noted that easy read has its place, but a Plain English version, which adopts a straightforward and direct tone was welcome. The response from the Cabinet Member that this suggestion would be taken back to the Place Board for consideration.

Clarification was requested regarding training around working with people with autism and learning disabilities. The response from the Cabinet Member noted that the South Yorkshire Police are a key partner to the health and wellbeing board, and training is a good idea. An offer to extend this training to Members was in discussion as well, as SYP do this training.

Resolved:-

1. That the report be noted.

2. That consideration be given to creating a Plain English version of future Place Priorities Plans.

3. That narrative be provided around the amber targets.

4. That the support of Members for a continued focus on improving equality of access and experience of services be noted.

25. WORK PROGRAMME

Consideration was given to a revised outline schedule of scrutiny work for the 2023/24 municipal year. The Chair highlighted specific areas of upcoming scrutiny and emphasised the various formats of effective scrutiny work.

In discussion, members expressed interest in giving consideration to the limitations of benchmarking as an indicator of quality and the importance of organisational culture.

Resolved:-

1. That the updated work programme be noted.

2. That the Governance Advisor be authorised to make changes to the work programme in consultation with the Chair/Vice Chair, with any changed reported to the next meeting for endorsement.

26. URGENT BUSINESS

The Chair advised that there were no urgent items of business requiring a decision at the meeting.

27. DATE AND TIME OF NEXT MEETING

Resolved:-

The next meeting of Health Select Commission will take place on 28 September commencing at 5pm in Rotherham Town Hall.