HEALTH SELECT COMMISSION
Thursday, 13th June, 2019

Present:- Councillor Keenan (in the Chair); Councillors Bird, Brookes, R. Elliott, Ellis, Jarvis, Walsh, Williams and Wilson.

Councillor Roche, Cabinet Member, for Adult Social Care and Health was also in attendance at the invitation of the Chair.

Apologies for absence were received from The Mayor (Councillor Jenny Andrews),Councillors Cooksey, Short and Vjestica.

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

1. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

3. MINUTES OF THE PREVIOUS MEETING HELD ON 11TH APRIL, 2019

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 11th April, 2019.

Further to Minute No. 83 (Intermediate Care and Re-ablement Project) it was hoped that the basic principles of the business case would be available by September, 2019 as this had to take into account new requirements regarding Primary Care Networks.

With regards to Minute No. 84 (My Front Door) a seminar was in the process of being arranged in July when the evaluation was complete. It was also noted that only five people remained at Oaks Day Centre and this this would have reduced to nil by the end of the month.

Further to Minute No. 85 (Implementation of Health and Wellbeing Strategy) it was noted that the Autism Strategy was likely to be on the November meeting agenda and A date for the Carers' Strategy was yet to be confirmed.

Reference was made to Minute No. 87 (Work Programme) where it was suggested that the Commission revisit the transition from CAMHS and check on its progress.

The Scrutiny Officer would also liaise with officers and partners on the full draft work programme for agreement in July. Any further suggestions were welcome.

In regards to the JSNA – Public Health working with I.T., this had moved from October to be listed in either November or December.

It was also noted that Ward Plans helping with prevent work and JSNA profile modernisation should be available in the near future.

With regards to Minute No. 88 (Healthwatch Update) no feedback had yet been received on maternity complaints.

In addition, the database regarding access to GPs issues had been checked and showed comments regarding access to GP appointments that same day with a named GP of choice. If patients wanted an appointment with a specific GP that usually had to be booked in advance. Most G.P. surgeries offered a same day appointment with an ANP (Advanced Nurse Practitioner) who could prescribe, or offer a telephone appointment with a G.P.

Further to Minute No. 91 (date and time of the next meeting) the 17th October, 2019 meeting had since moved to the 10th October, 2019.

Resolved:- That the minutes of the previous meeting held on 11th April, 2019, be approved as a correct record.

4. COMMUNICATIONS

(a) The Chair advised the Commission that an issue had been raised in connection with Yorkshire Ambulance Service. This would be followed up and brought back to a future meeting.

(b) Councillor Jarvis provided an update following the last meeting of the Improving Lives Select Commission where it was noted the meeting had considered key challenges for education in Rotherham via John Edwards, Regional Schools Commissioner (East Midlands and the Humber Region). Officers took on board his comments for consideration.

The agenda also included Rotherham Education Strategic Partnership Update where an overview and update of progress was provided in respect of the key areas for action identified within the RESP strategic plan. Four meetings had so far taken place and feedback on what was working well, what was not and any issues needing development. Further detail was provided on the seven issues including SEND, Gypsy, Roma and Traveller students, Early Years, Primary, Secondary, Post-16 and Social Emotional and Mental Health (SEMH).

A report on the Children and Young People's Services 2018/2019 Year End Performance provided a summary of performance under key themes and headlines.

(c) The Scrutiny Officer provided an update on the membership for the three quality account sub-groups TRFT, RDaSH and Yorks Ambulance, plus the performance sub-group.

It was, therefore, proposed to keep the same membership as last year unless any Member wished to change if they had particular commitments or if any new Members had a particular preference. Discussion had already taken place with some Members, but as a reminder the membership would be re-circulated.

5. SEXUAL HEALTH STRATEGY FOR ROTHERHAM (REFRESH 2019-2021)

Consideration was given to the report introduced by Councillor Roche, Cabinet Member, which detailed how the Strategy, previously approved by the Health and Wellbeing Board, had since been refreshed and an action plan agreed ready for consultation.

Gill Harrison, Public Health Specialist, was welcomed to the meeting who presented the 2019-2021 refresh of the Sexual Health Strategy for Rotherham.

The Strategy set out the priorities for the next three years for improving sexual health outcomes for the local population. It provided a framework for planning and delivering commissioned services and interventions (within existing resources) aimed at improving sexual health outcomes across the life course.

It aimed to address the sexual health needs reflected by the Public Health England sexual and Reproductive Health Epidemiology report 2017 which highlighted areas of concern. The following were identified as concerns to identify actions for 2019-2021:-

- Sexually Transmitted Infection diagnosis in young people.
- Sexual health within vulnerable groups.
- Under 18 conception rate.
- Pelvic Inflammatory Disease admission rate.
- Abortions under 10 weeks.

The refreshed Strategy also reflected concerns expressed in the Rotherham Voice of the Child Lifestyle Survey 2018 which showed increased numbers who said that they did not use any contraception and a significant increase in those reporting that they had had sex after drinking alcohol and/or taking drugs.

Sexual Health had since moved on and it was timely to look at new changes and new priorities.

A PowerPoint presentation highlighted:-

- Definition – sexual health.
- Strategic Ambitions.
- Improving sexual health.
- Rates of gonorrhoea (2013-2017) – success stories – public awareness and good contact tracing and working with partners.
- Priorities STI.
- Improving Reproductive Health – downward trend reduced the rate of under 18 conceptions by 60% between 2008 and 2017 higher, but started off a lot higher. A range of factors contributed – access to clinics, contraception, good reputation good relationship and sex education – range of other interventions self- esteem and aspirations.
- Priorities – under 18 conception rate, access to contraception and timely access to abortion services.
- Focusing on vulnerable groups – showing young people affected.
- Priorities – diagnosis of new STIs, prevention, treatment and care.
- Building on successful service planning and commissioning.
- Priorities – provision of integrated services and building on success.
- Key indicators for success.
- Implementation and monitoring – action plan.

Discussion ensued with the following issues explored:-

- What had been successful in the 2015-19 Strategy, what had not been delivered on and why was the focus on repeat abortions?

  It was not just repeat abortions but it was important to focus on problems with ongoing care and with relationships. The Pause Programme dealt with repeated pregnancies, identified problems and how issues could be dealt with.

  The refresh of the Strategy looked further as it had not previously had a fully integrated service delivery model which was viewed as a priority and was now in place.

- The statistics appeared to be incorrect, especially in relation to Chlamydia.

  The populations were different as the figures for Chlamydia focused on 15-24 year olds so they were correct.

- How did the national graph or local graph compare with other areas and were specific areas of concern targeted.

Public Health England had a fingertip tool that showed the national figures and individual areas and allowed an individual to manipulate and compare across the country. The Services were keeping an eye on trends around the country and would target specific areas if there appeared to be an issue. If there was a specific issue or an increase of STI's in Rotherham then Public Health England would be in touch.

- It would appear that one of the diseases was identified as borderline untreatable.

  Certain strains were resistant which required a combination of antibiotics to treat. So far the Service had not found one that was not treatable. However, a watching brief would continue and any particular issues were plotted for the area. There were, however, a couple of highly resistant strains in the country that had hit the national news, but this was being closely monitored.

- There had been a marked improvement in Gonorrhoea so what intervention had been effective.

  There had been no specific interventions put in place, but awareness raising in populations with increased contact tracing ha probably had an impact.

- What was the cost of this awareness raising and could the Service pick the next worse one and do the same thing.

  Awareness raising had all been within existing resources so there had been no extra funding. Some partner organisations would have had extra workloads that had the cost of staff time. Commissioned services worked within a financial envelope and some infections would require more work than others and national campaigns would be used.

- There had been a reported rise in men who have sex with men contracting STI's, but were there any indications this was happening in Rotherham.

  The proportion of reported new STIs from men having sex with men was a relatively small number, but there had been seen a significant increase within that small population. Specific work had been undertaken and they had identified as one of the vulnerable groups to work with.

- Was there a profile of groups most likely to present with PID?

  There were no profile as such. One of the things planned as a group was to unpick this by looking at the data with partner organisations such as the Foundation Trust to find more about it, see if there was a profile and identify what partners should be doing.

- Often a different story was heard around this including changes in sexual practices of young people and young women's confidence and esteem Information earlier said this was more than about infection control which was what we seemed to measure success by. Was there any evidence to document this?

  From work that was taking place with various people there were models of good practice in relation to young people and attitudes to sexual health. The latest voice and influence survey raised a few concerns around risk taking behaviour in relation to alcohol, drug use and anti-barrier contraception, which appeared to be at odds with other surveys when risk taking tended to be lower than it used to be. This needed to be unpicked. Traditional interventions needed to change and move on. Whilst some concerns were shared, from experience there was some good practice taking place.

- There were lots of different experiences targeting vulnerable groups and issues. Around healthy relationships and education in schools, what percentage of schools were taking this up and what was happening in primary and secondary schools including how many schools were not doing it? It was disappointing in that there was more information on infection control and a focus on this in the measures rather than on consent, sexual abuse, reduction of CSE, reduction of rape and sexual assault healthy relationships.

  All information had come from the Sexual Health Strategy Group. An annual update from the Schools' Effectiveness Services highlighted what information was provided to primary and secondary schools in relation to sex and relationship education. Overall a good number of schools were providing good sex and relationship education. There were some pockets where this was not happening, but this would happen more widely when it became a statutory duty to do so. The Strategy Group would look at this as to how partners could assist schools to maintain that level of education.

- The numbers of participating schools and information from schools needed to be shared on how this would be delivered and whether this had an impact on young people if the data was sophisticated enough to show that.

  This would be taken back to the Strategy Group to discuss, but it was noted that the data was provided by schools and questions about education should be addressed to Children and Young People's Services. Data about Child Sexual Exploitation fell under the remit of the Safer Rotherham Partnership.

- Was the Strategy made up a variety of partners and multi-agency?

  The Strategy was signed up to by range of partners originally from the Health and Wellbeing Board as a Sub-Group and was multi-agency.

- With regards to the media coverage of a faith school talking about gay relationships, did this have a knock-on effect with regard to about healthy sexual relationships?

  Rotherham had laid out its policy on sexual health and PSE and all schools should adopt it.

- Teenagers socialised more in a virtual world so to what extent did this have an influence?

  There was no research available.

- Data access to contraception was concerning as it had been good up to 2017, but then contracts were terminated for LARC (long-acting reversible contraception) to be supplied through GP services. The Strategy did not seem to recognise or mitigate for that. There appeared to be a bottleneck for LARC for non-contraceptive services which had been effective and very safe for debilitating conditions such as fibroids or endometriosis. Recent information from the Pause Project indicated that people were having trouble accessing appointments for LARC so what could be done to resolve this to give patients better access?

  Contracts with GP's were terminated, but not completely as the Integrated Sexual Health Service sub-contracted these after the first year. There had been issues with regard to clinical governance and maintaining GP competency, but it was important to have a main provider and training. Performance meetings had taken place with services and information provided on the GPs who provided the range of different LARC services to all ages.

  In terms of endometritis the LARC IUCD (COIL) tended not to be used for young women other than for regulating menstrual difficulties or gynaecology issues rather than contraception. Long waiting lists had not been reported so this information would be taken back to the partnerships within the Strategy Group.

- Gynaecological issues were intertwined as these conditions affected fertility.

  There had to be a cut-off point for the Sexual Health Strategy. The Group had had discussions on a whole range of issues, but was it universal and, if so, why had the Service chosen to go down that path?

- Young people had a particular vulnerability, especially those who were Looked After. Had there been any targeting of resources or reversal as to why the Service had chosen to go down that path.

  Younger people were likely to be more disadvantaged by STI's and Looked After Children were a vulnerable group. One of the things the Group was looking at was how to target and get information out to young people and tease this out. An action plan was being re-introduced with targets to see how this could be done better.

- Could data be drilled down further as part of an EIA?

  This was recognised and more details would be provided on the EIA as part of the Strategy.

- Did we know what the origins of the gender imbalance were as it appeared to affect more females than males at an early age?

  It was not apparent, but this would be looked into further about what was happening in other areas and to be able to see the difference.

- Some of the priorities in the action plan were contracted to other people; how was this monitored, were there any issues and if there were was there consideration to bring this back in-house to give some reassurance how the contract was managed?

  There were some direct contracts in relation to the Integrated Sexual Health Service at the hospital. There were regular performance monitoring meetings to discuss and monitor the Service specification. Actions in the action plan were assigned to specific partners.

- Delivering awareness - quality was important with young and vulnerable people so how did the Service ensure the quality was good?

  Yorkshire Mesmac were contracted to provide this service and were successful following a tender process. Evaluation had taken place to drill down using nationally accredited information and techniques with quality assurance built in.

- What measures were being taken to make access to Sexual Health Services more accessible in circumstances where vulnerable teenagers lived with prudish parents who were against pre-marital sex?

  Information was easily accessible. The Voice and Influence survey asked where did teenagers go for sexual health information and the vast majority identified peers, but this information needed to be culturally acceptable with the young people themselves to ensure the right messages and information were passed on. A presentation had

been made on ten week abortions at one of the Strategy Group meetings by two providers and consideration given as to how this information was easily accessible to people and who young people could talk to.

- Some of the indicators were a bit woolly and it would be better to have smarter targets and indicators so that hard information could be interpreted in measuring the impact for good sexual health. If social issues around consent and safe, healthy relationships were not going to be measures within the Strategy should they be left out?

This would be taken on board.

Resolved:- (1) That the refreshed Sexual Health Strategy and the associated action plan be noted.

(2) That school data questions be sent to Children and Young People's Services for a response to be scheduled into the work programme for future discussion.

(3) That the EIA be submitted to Health Select Commission for this Strategy and for any new or refreshed strategies.

(4) That consideration be given by the Sexual Intervention Group to developing a broader and SMART range of performance indicators to measure success.

6. RESPONSE TO THE SCRUTINY WORKSHOP - ADULT RESIDENTIAL AND NURSING CARE HOMES

Further to Minute No. 135 of the Cabinet Meeting held on 15th April, 2019, Nathan Atkinson, Assistant Director, Adult Care, Housing and Public Health, supported by Councillor Roche, Cabinet Member, gave an update on the recommendations and corresponding actions arising from the Scrutiny Review of Residential and Nursing Care Homes for Adults aged over 65.

The purpose of the review was to consider progress in bringing about improvements to safety, quality and effectiveness in the sector as well an opportunity to explore the impact of the Care Homes Support Service as the care home sector was one of the transformation initiatives under the Rotherham Integrated Health and Social Care Place Plan.

The Commission was advised that the Service had not closed any care homes, but three private care homes had closed so in two of these cases people placed by the Council had been withdrawn. One home was re-opening shortly under a new provider but people would not be placed there unless it complied with the Council's standards.

The Council's powers with private care homes were very limited. However, they were monitored under contract compliance and residents removed if there were issues about their care especially with regard to safeguarding. There were also close links with CQC and G.P.'s as every care home had a G.P. linked to them. Wherever possible, good relationships with private care homes were maintained.

In comparison to the rest of Yorkshire, Rotherham did not have a single failing care home, which was an improvement. Work was still taking place to improve the direction of travel towards outstanding and it was pleasing to report that the Cabinet agreed to the recommendations which endorsed current and planned work in this area. Scrutiny were thanked for their work on this review.

All the recommendations were now in place and in recent weeks emails had been circulated to relevant Ward Members to update them on Care Quality Commission (CQC) ratings for homes in their Wards. Detailed briefings were also provided if there were any concerns or if the CQC had been in.

Discussion ensued with the following issues being raised and clarified:-

- Training for staff - how was this being monitored, were there any issues and how was it implemented?

  Of the two care homes that were run by the Council, training was provided and monitored. However, in terms of private homes, it was made clear what the requirements were and what steps would be taken if they were not compliant. However, in terms of training, the Council could only suggest, cajole and recommend.

  The Council had maintained the training offer for the independent sector. It also had its own services and needed to make sure these were of requisite standard with staff access to training and refreshers. Much was also open to the independent sector but the onus was on organisations to take up that offer. Part of the contract monitoring was to look at where staff were in regard to annual refresher training and any areas for additional training were welcomed or if there were issues identified.

  Contract compliance required registered providers to carry out an annual self-assessment that related to the Council's contract, including policies and procedures, staffing and training. Validation work examined the annual training matrix and this was cross referenced against staff records. The Council found that when training had been booked staff had not attended and this was addressed to ensure the non-attenders were charged.

There was regular communication between Contract Compliance Officers and the training team who were available to be contacted for advice, guidance and support. Any issues were addressed to the home manager and a six week period improvement plan put in place to address issues.

The Service annually produced a training programme in consultation with care providers and commissioned on need. There was always an element of flexibility in the programme as not all staff could attend on the dates organised and the trainers did reschedule to get value for money if numbers were low. Attendance at training was booked through Directions internally and all information was made available to providers direct. Training provided externally to the Council had to be ratified and identified through Skills for Care.

Work with the Care Homes Support Service had gone well and the Clinical Quality Advisor undertook a range of audits and the Service then targeted any additional training around the themes where issues have been found. It was confirmed that contractually providers were obliged to pay staff to attend training. Training and Development colleagues would be able to answer questions with regard to the use of Directions.

- Had there been any progress to increase the number of nursing beds within the local provision?

  The closure of some nursing homes had seen the reduction in nursing beds, but Greasbrough nursing home would be re-opening shortly with some provision. This was a challenge nationally for the sector in securing nursing staff when competing for agency nurses and driving costs up. There were also challenges around standards as nursing homes tended to have lower CQC ratings than residential. It was the aim with all new providers to steer towards nursing care as there was still substantial over capacity on the residential side.

  Pay remained an issue in care homes and some providers had gone bankrupt due to rising costs.

- Training pathways for young people in partnership with local college had been discussed previously.

  The Council was involved in work taking place with the Health Education England Skills for Care to develop these. The trainee Nurse Associate course was attracting more people to make a career in nursing. Other work would take place with regard to the new Home Care Service to make careers in the Service a more attractive proposition for younger people.

- Under-provision of nursing care had been mentioned. Were there waiting lists given that there was an excess of residential care?

  There were no waiting lists per se but capacity in the system was limited and, for example, as part of the Winter Plan, block buying of nursing beds was often done by Health colleagues. There had never been a situation that did not have a solution within the Borough but there was more provision of residential than nursing beds but much depended upon location. Choice was part of the assessment.

  The first choice was always to return a person home, but there could be delays if adaptations were required. There was a redefined pathway for intermediate care and enablement under the principles of Home First to get people back home independently and for them to continue to live in their community.

- What were the current vacancy rates?

  There were 1,686 beds across the Borough with a 31.6% vacancy factor, which equated to 84 residential, 92 residential EMI beds, 36 nursing beds and 18 EMI beds.

- With vulnerable children and adults there was the environment for potential abuse and neglect especially when people were not properly trained or paid enough. Was the Council sufficiently confident to spot neglect and abuse at an early stage for families in residential care to ensure issues were picked up quickly.

  In terms of older people, there were thirty-four homes in the Borough, of which two were Council-owned. There was regular monitoring from the Local Authority, which was very frequent, along with health professionals who were also going into the care homes, so the eyes and ears were good. Rotherham did not have any inadequate homes as the sector had been proactive in dealing with issues. The number one priority was to work with providers to address some of the concerns and raise standards and there were excellent working relationships with the CQC with joint working and sharing of intelligence to ensure joint visits were effective.

  There were often concerns about the potential for abuse in people's own homes and some of the smaller establishments for people under 65 were monitored closely. There were 111 smaller establishments in the Borough and all were monitored.

  The CQC did a recent league table relating to quality ratings and Rotherham was third out of fifteen in the Yorkshire and Humber. Everyone was doing their best and, whilst there would still be challenges, the aim was to be a proactive Borough and remain passionate about quality.

- Was anyone talking to residents?

  Performance colleagues were resourced to carry out this work and ensure the Service user was heard. There was also free independent advocacy for people which they were encouraged to use and the Service worked closely with Healthwatch Rotherham but did want to get more Service user voice.

- Were there any plans to have a "trip adviser" type review for care homes?

  An older people care home guide identified homes available in Rotherham and another explained what a family or resident should be looking for in a care home in order to make the best choice.

- Recognising that work was being developed on Service user voice, could the Select Commission contact Healthwatch Rotherham to ascertain how they captured the Service user voice?

- How was the work of the Quality Board progressing, including the Quality Matters initiative and the Leadership Academy?

  Work on the Quality Board was in progress. Plans were in place to expand membership to wider health partners. Quality matters and principles of good contract monitoring were in the Service Plan working on a quality strategy. It was recognised there were real challenges, but progress was on an upward trend and the workforce, availability of quality and adoption of the key principles remained a priority.

- The issue of choice and whether to go back into the home required lots of professionals to work together and evidence showed that was being successful.

Resolved:- (1) That the response to the recommendations of the Scrutiny Review of Residential and Nursing Care Homes for Adults aged over 65 be noted.

(2) That consideration be given to inviting Healthwatch Rotherham to submit a response to the meeting should they be unable to attend.

7. 2018 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Councillor Roche, Cabinet Member, introduced the 2018 independent annual report. For the previous three years, the annual reports had focused on the life course; the 2018 report took a new approach and sought to champion the strengths of Rotherham's local communities and share experiences of what kept its residents healthy, happy and well.

The general public had been asked to submit photographs which showed what kept them healthy, happy and well where they lived. These were then grouped by theme and found that they fell into two main themes – community and the environment – as well as capturing all five of the 'five ways to wellbeing'.

The 2018 annual report was broken down into chapters on:-

- What does keeping healthy, happy and well in Rotherham mean to you
- Our communities
- Five ways to wellbeing
- What can we do to support health and wellbeing
- Recommendations
- What we will do together
- Progress on last year's recommendations

The key recommendations in the report were:-

- Consider 'health and wellbeing' in the wider context of being influenced by everything around us
- Seek first to understand what is 'strong' in our communities and what assets we can build on together to support the health and wellbeing of our residents.

Terri Roche, Director of Public Health, gave a presentation via PowerPoint which highlighted:-

- What does it mean to be healthy in Rotherham?
- Health influencing factors.
- Recommendations – consider health and wellbeing in the wider context, what is strong and what assets can build on together.
- What can be done together?

A discussion and a question and answer session ensued and the following issues were raised/clarified:-

- How was Wickersley chosen to host the loneliness project, when it was thought other areas may have benefitted from the research more?

  Multi-agency groups in Wickersley, Dinnington and Maltby explored projects to work on together. The group in Wickersley were aware of issues around loneliness for all services and chose to run with it. Comments on the choice of area and disjointedness would be taken back but loneliness did not demonstrate barriers and it was a factor for all age groups.

- The asset/strengths based approach was positive, as was the five steps to welling being simple and evidence based. This process seemed increasingly disconnected and disjointed when much more impact could be achieved if there was joined up work with adults, community learning and some of the work with older people, neighbourhood working etc. Of concern was the growing level of inequalities in health with the need for discussion on this and how the resources could be targeted at communities who needed them most.

  In looking at universal proportionalism and how inequalities could be addressed resources were getting tighter. However, it was time to make a real difference through our good partnership model, with a good Housing Strategy incorporating homelessness, neighbourhood ways of working and robustness in Equality Impact Assessments were building blocks bringing the work together. This was about engaging with communities and using that intelligence in a different way.

- There were inequalities of health and it was appreciated that there was a universal approach, but how could this be driven to encourage others to be connected and for this to link some important areas of work in the community and adult learning. The five ways to wellbeing could be used to target some of the energy and resources in the most deprived areas suffering inequalities.

- The issues were bigger than Public Health and it was more about how a real difference could be made to the community to ensure the most deprived areas were supported.

  There were strengths and a weakness in neighbourhood working as it was reliant upon relationships and personalities and there were opportunities and risks. It was about working better together; this was working in some areas, but it could always be better. Some of the work in Paul Walsh's team was more globally working well. In time there was more to scrutinise and to challenge ourselves on health equality in all policies. In the political arena there were opportunities for working differently, for good practice to be shared with a systematic way of working more widely.

- How many volunteers were there as some actions were channelled through areas that had Parish Councils. More broadly, it was about keeping volunteers going including how well the VAR volunteer scheme matched up people and opportunities. It was also about contract monitoring to ensure quality. So how could there be scrutiny of the work being undertaken and how it was being delivered to be equal.

  It was not possible to comment on how VAR could be scrutinised, but they were part of the solution. Volunteers did not have to be outside their home to be able to offer valuable support. With the free flow of volunteers it was difficult to control, but different ways of working and

different models sometimes stifled the flow. Some of the MESMAC activity was positive on how they reached people.

When the contract was up for renewal there might be an opportunity for more input around the volunteering scheme and this would be followed up.

- Consideration needed to be given to the best forum for volunteers and the offer and whether there was a role for Scrutiny.

- Wellness schemes only worked if people engaged. Wellness goes to the root, but did require individual citizens to change their own lives. In more deprived neighbourhoods this might be more difficult and somehow citizens had to be motivated and engaged. To what extent would Social Prescribing help to achieve this?

  Behavioural changes were challenging in addressing some of the inequalities. There was some reliance on individual experiences, but self-prescribing could work for some people. It was more about societal changes within the environment people lived, worked and played to make them more healthy.

- In terms of the Members' Cycling and Walking Group, what initiatives encouraged people to engage in cycling and walking as a means of getting active and was there a link with cycling with travel and transport planning.

  There were many initiatives that encouraged walking with the health walks, the cycling hub located regularly outside Riverside House on a Thursday and staff could also try out the electric bike. There was also a link to active travel and Regeneration and Environment were looking to link the Members' Cycling and Walking Group to the Rotherham Active Partnership.

- The report referred to 13.4% people in Rotherham suffering with depression. How did this compare with other areas or nationally and was it increasing or decreasing over time.

  Accurate figures would be provided.

Resolved: - (1) That this Commission's concerns about health inequalities be raised with the Health and Wellbeing Board and the Rotherham Partnership.

(2) That the actions below be supported:-

- Continuing to raise awareness of the 'Five ways to wellbeing' and working together to tackle loneliness and social isolation
- Supporting the continued development and expansion of Social Prescribing as laid out in the NHS Long Term Plan

- Continuing to support healthy work, through initiatives such as the 'working win' trial and promoting uptake of the BeWell@Work workplace award.

8. HEALTHWATCH ROTHERHAM

No issues had been raised.

It was suggested, however, that any written comments be provided when representatives were unable to attend.

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

There were no matters to feedback from the Committee as it had not met since March, 2019.

A further meeting would be scheduled shortly. Options were being developed around the hospital services programme.

10. URGENT BUSINESS

There was no urgent business to report.

11. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission take place on Thursday, 11th July, 2019, commencing at 10.00 a.m.