HEALTH SELECT COMMISSION

Venue: **Town Hall, Moorgate Street, Rotherham S60 2TH**

Date: **Thursday, 23rd October, 2014**

Time: **9.30 a.m.**

A G E N D A

1. To determine whether the following items should be considered under the categories suggested in accordance with Part 1 of Schedule 12A (as amended March 2006) to the Local Government Act 1972

2. To determine any item the Chairman is of the opinion should be considered later in the agenda as a matter of urgency

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of the Previous Meetings (Pages 1 - 10)

8. Health and Wellbeing Board (Pages 11 - 38)
   - Minutes of meetings held on 2nd July, 27th August and 1st October, 2014

9. Issues from Rotherham Healthwatch Ltd.

10. Rotherham Foundation Trust (Pages 39 - 40)
    Minutes of meeting held on 29th September, 2014

11. NHS Rotherham Clinical Commissioning Group - Commissioning Plan 2015-16 (Pages 41 - 71)
    Presentation by Chris Edwards, Chief Officer, and Dr. Robin Carlisle, Deputy Chief Officer

12. Update on Scrutiny Review - Hospital Discharges (Pages 72 - 75)
Michaela Cox, Service Manager, NAS, and Maxine Dennis, Director of Operations, TRFT

13. Health and Wellbeing Board - Making Every Contact Count (Pages 76 - 78)
Dr. John Radford, Director of Public Health

14. Health and Wellbeing Board Strategy Progress - Prevention and Early Intervention - NHS Health Checks (Pages 79 - 87)
John Radford, Director of Public Health

15. Date and Time of Next Meeting
    - Thursday, 4th December, 2014 at 9.30 a.m.

HEALTH SELECT COMMISSION
11th September, 2014

Present:- Councillor Steele (in the Chair); Councillors Dalton, Jepson, Swift, Vines and Wootton and Mr. P. Scholey.

Apologies for absence were received from Councillors Havenhand, Hunter, Kaye and Whysall.

31. DECLARATIONS OF INTEREST

There were 2 Declarations of Interest made at the meeting:-

Councillor Swift as a trust member of RDaSH and Chair of PPG
Councillor Dalton as a member of RDaSH

32. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

33. COMMUNICATIONS

(1) A meeting had been held on 7th August with Chris Edwards (Rotherham CCG) and the Chair and Vice to discuss establishing closer links between the Select Commission and the CCG, particularly with regard to sharing information about future plans and consultation on proposed service changes. This meeting was very useful and Councillor Steele gave thanks and appreciation to Chris.

It was agreed that a similar approach be taken with the CCG as with the Foundation Trust with quarterly briefings held with Chief Executive, Chair and Vice with notes from the meeting shared with the Select Commission.

(2) An All Members Seminar will be held on 19th December, 2014, giving an update on the Care Act (2014). Final regulations and guidance are due to be published in October.

(3) The 2014 health profiles had been published and the profile for Rotherham may be found via the following link:

http://www.apho.org.uk/resource/item.aspx?RID=142148

(4) A 2GP Cabinet response was to be considered by Cabinet on 24th September and to the Overview and Scrutiny Management Board in October.

(5) Revised guidance for the Better Care Fund had been issued with all Health and Wellbeing Boards asked to resubmit updated plans by 19th September. The plans should also include a commentary on their forecast for reductions in emergency admissions.

(6) There was to be a new task force for Mental Health Services, co-chaired by NHS England and DoH, for children which would consider how the commissioning and delivery of the Services could be improved. The task force would look into the role of the voluntary sector and how to help young people online.

(7) The Joint Health and Overview Scrutiny Commission would meet later in September to discuss the third and final report regarding the temporary closure of the children's heart surgery unit in Leeds in 2013.

NHSE consultation relating to the new Congenital Heart Disease (CHD) Review was likely to run from September-November. The JHOSC would meet with regard to this.

(8) There were to be changed to the Friends and Family test. Trusts would be required to collect free text comments from patients and demographic variables alongside test data. Also data must be collected from all inpatient services, including day cases. The data would also be published in a form that was easier to understand and would include levels of participation as well as results. From December the test would be extended to GP services, from January 2015 to Mental Health and Community Services, and from April to Dental Practices and Patient Transport Services.

The Chairman reported that Councillor Hoddinott would no longer be Vice-Chair of the Select Commission and wished her well in her new role as Deputy Leader.

34. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the minutes of the meeting of the Health Select Commission held on 11th July, 2014.

Arising from Minute No. 27 (Healthwatch – Child and Adolescent Mental Health Services), due to the volume and ages of the victims of CSE there would likely be an additional workload for CAHMS. A workshop was to be held with the Police and appropriate partners shortly to look at the pressures on services.

Resolved:- That the minutes of the meeting held on 11th July, 2014, be agreed as a correct record for signatures by the Chairman.

35. ISSUES FROM HEALTHWATCH

There were no matters arising.

36. REPRESENTATION ON PANELS AND SUB-GROUPS

The Chairman asked for volunteers to represent the Select Commission on the Environment and Climate Change Steering Group.

Resolved:- That the vacancy be no filled at the present time.

37. PROGRESS ON PLANS FOR NEW EMERGENCY CENTRE

Dr. David Clitherow, Lead GP for Unscheduled Care, RCCG, gave the following powerpoint presentation:-

Proposal
To redesign our urgent and emergency care system to ensure~:

- Patients receive the right care first time – one place to go if you have an emergency or urgent care need
- Patients receive quality care – bringing together the skills of primary care with the skills of accident and emergency in a modern facility
- Rotherham's emergency and urgent care services are sustainable for the future – more and more patients need and will need urgent care and re-investing in this area will make the whole NHS in Rotherham work better

Why do we need to change?

- Rotherham patients told us that the existing system is confusing and they do not know where to go when they have an urgent care need. Sometimes they go to more than one service
- We know that sometimes patients can wait a long time when they access urgent care, we want to improve this
- We know that demand for urgent and emergency care services continues to rise. The existing service may struggle to meet the demand in the future especially with an ageing population
- We know that patients are sometimes admitted to hospital unnecessarily creating pressure on services
- Nationally the evidence base states that 30% of A&E attendances are for conditions which could be treated by primary care
- Nationally the direction of travel is to develop emergency centres

The Vision
To have one Emergency Centre to provide a single urgent and emergency care system for the people of Rotherham, located at the hospital
This means

- Emergency Department staff and Primary Care staff working together to provide a multi-skilled workforce fully equipped to meet the patients' needs
- The GP OOH service and care co-ordination centre will be based there so all urgent care services are together in one place
- It will have better links with Mental Health Services
- It will have better links with Social Care Services
- Enhanced facilities to meet future demand

Discussion took place around the new IT system. There were different systems at present but the new system would be one system for the emergency centre to allow the sharing of information in order to provide the best care possible.

How will it work?

- Patients will book in at reception
- Patients will then be rapidly assessed by a senior clinician
- Diagnostics will be requested if appropriate (x-ray, bloods etc.)
- Patients will then be streamed to the most appropriate clinician to treat their condition. This might mean back to own GP or pharmacy if this is appropriate or direct to a speciality
- The patient will either be admitted to hospital, observed 24 hours, discharged home or alternative level of care

If patients rung the GP Out of Hours Services they would check in at reception via touch screen.

What difference will it make to the people of Rotherham?

- It will ensure patients see the right clinician first time
- Improved waiting times
- Quality, safe care
- More sustainable services for the future

Timescales

- Relevant Boards for approval – October/November, 2014
- Capital Scheme commences – October/November, 2014
- Capital Scheme complete – September, 2016
- Service model operational – October, 2016

Frequently asked Questions

Q. Will the whole of Rotherham Community Health Centre will be closing after the Walk-in-Centre leaves the building.

A. The centre currently provides health services to patients other than the Walk-in-Centre. There will still be health services provided in the building after the walk-in service leaves.

Q. *Is A&E closing, where do I go if I have an emergency?*

A. We are not closing the A&E department, we are bringing together all emergency and urgent care services under one roof to make it easier to know where to go when you have an emergency or urgent condition.

Q. What's happening about parking?

A. We recognise that parking is an concern. We know staff park in the patients car park. As part of the scheme we will be building an additional 122 spaces to move staff out of the patient car park, which will free up car parking spaces for the public.

Q. Will I have to pay for parking?

A. Yes. Patients who access A&E now pay for parking. When the emergency centre opens this will not change.

Q. *What is going into the health centre when the WIC moves out?*

A. We are currently in the process of looking at what services could be better delivered from the community health centre.

A discussion took place with the following being confirmed:

- Patients would be triaged initially by a senior clinician or an advance specialised nurse
- All staff will be under one roof working flexibly together, not two separate services and there will be better integration with out of hours services
- Common protocols would be in place for the Emergency Centre and primary care GPs regarding access to appropriate services and giving common messages to patients
- As the plan progresses groups would be invited to become involved i.e. learning disability/Age UK etc.
- Patient experience simulations prior to the centre opening
- Consideration would be given to a police presence/base within the centre
- The plan to create 122 additional parking spaces is the maximum agreed by planning consent
- Finance had been confirmed. CCG had made a commitment to deliver this project, so assurance there for TRFT. Procurement 21 framework had been used to ensure there is a ceiling on the price of the build and risk sharing with developers
- Reminder of the letter to the Chairman from the Trust regarding parking charges

Resolved:- (1) That the Select Commission receive a copy of the IT procurement proposal.

(2) That the travel plan be shared with this Select Commission.

(3) That the Select Commission receive annual updates.

(4) That the issue of parking spaces be raised with the Planning Service.

38. MINUTES OF MEETING WITH ROTHERHAM FOUNDATION TRUST

The minutes of the meeting with the Rotherham Foundation Trust held on 11th August, 2014, be noted.

39. SCRUTINY REVIEW: URINARY INCONTINENCE

Consideration was given to a report presented by Councillor Dalton which set out the findings and recommendations of the above Scrutiny Review.

The 3 main aims of the Review had been:-

- Ascertain the prevalence of urinary incontinence in the Borough and the impact it has on people's independence and quality of life
- Establish an overview of current continence services and costs and plans for future service development
- Identify any areas for improvement in promoting preventative measures and encouraging people to have healthy lifestyles

A spotlight review was carried out and evidence gathering began in May, 2014, concluding in July, 2014. It had comprised of desk top research and a round table discussion with health partners and the Council's Sport and Leisure Team.

Members recognised the good services provided by the award winning Community Continence Service (CCS) and that the Rotherham CCG had been unique in reducing expenditure on continence products in the last 5 years yet delivering improved outcomes for Service users. The CCS engaged in preventative work and plans for future Service development included greater focus on this particular area. One workstream would be to consider developing an integrated continence care pathway with a single point of access.

General awareness raising with both the public and health and care professionals was needed to emphasise the importance of good bladder and bowel health and how healthy lifestyles choices could help to prevent incontinence. Pelvic floor muscle training had been proved to relief symptoms and may reduce the risk of developing stress incontinence. More people could be encouraged to do the exercises as a preventative measures and there was scope to consider if they could be incorporated more widely within sports and fitness activities.

The review had made 6 recommendations:-

1. RMBC and partner agencies should ensure all public toilets in the Borough are clean and well equipped to meet the needs of people who have urinary incontinence, including suitable bins for the disposal of equipment and disposable products.

2. Greater links should be established between the Community Continence Service and Rotherham MBC Sport and Leisure Team to support people to participate in appropriate sport and physical activity.

3. Rotherham MBC and other sport and leisure activity providers should consider building more pelvic floor exercises into the Active Always programme and wider leisure classes.

4. There should be greater publicity by partner agencies to raise public and provider awareness of:-

   (a) The importance of maintaining good bladder and bowel health and habits at all life stages (through media such as screens in leisure centres and GP surgeries, further website development, VAR ebulletin and a campaign during World Continence Week from 22-28 June 2015)

   (b) Healthy lifestyle choices having a positive impact on general health but also helping to prevent incontinence such as diet, fluid intake and being active

   (c) The positive benefits of pelvic floor exercises as a preventative measure for urinary incontinence, including the use of phone apps for support

5. More work should take place with care homes to encourage staff to participate in the training offered by the Community Continence Service and to increase staff understanding of the impact of mobility, diet and fluid intake on continence

6. That the Health Select Commission receives a report in 2015 on the outcomes of the project considering future service development of the Community Continence Service.

The Review Group and Scrutiny Officer were thanked for their work on this issue.

Resolved:- (1) That the findings and recommendations of the report be endorsed.

(2) That the report be forwarded to the Overview and Scrutiny Management Board and Cabinet.

40. MENTAL HEALTH SCRUTINY REVIEWS

Janet Spurling, Scrutiny Officer, presented a brief overview of local Mental Health Services to inform the 2014-15 work programme as well as highlighting potential issues to consider for the scope of the Child and Adolescent Mental Health Services review.

Given the wide range of Mental Health and Wellbeing Services available to support and treat children and young people, Members may wish to limit the review to specific Services within the wider CAMHS provision, whether delivered by RMBC, RDaSH and/or other providers.

Potential areas to consider included:-

- Numbers and demographic profile of Service users
- Referral mechanisms and pathways
- Waiting times once referred
- 7 day access to Services
- Getting support in a crisis
- Service quality
- Experience of service users/patients
- Experience of families and carers
- Complaints and results of satisfaction surveys
- Outcomes for Service users
- Financial resources and budget allocation
- Targets and performance
- Access to wider counselling and support
- Awareness raising and breaking down barriers
- Information about Services and how to access them

The Chairman asked for volunteers for a sub-group.

Resolved:- (1) That a sub-group meeting would take place on 19th September, 2014, at 12.00 Noon.

(2) That the review group consist of the Chairman and Councillors Dalton and Vines, Mr. P. Scholey plus 2 representatives to be invited from the Improving Lives Select Commission.

(3) That an invitation to join the review group be forwarded to those Health Select Commission members not in attendance.

41. HEALTH SCRUTINY GUIDANCE

Janet Spurling, Policy Officer, presented a briefing presenting an overview of the recent guidance for health scrutiny issued by the Department of Health in June 2014.

The guidance emphasised the holistic, wide ranging role that health scrutiny had beyond focussing on specific health services and holding commissioners and providers to account:-

- The primary aim of health scrutiny was to strengthen the voice of local people ensuring that their needs and experiences were considered as an integral part of the commissioning and delivery of health services and that those services were effective and safe
- Health scrutiny should be outcome focussed, looking at cross-cutting issues, including general health improvement, wellbeing and how well health inequalities were being addressed, as well as specific treatment services
- Health scrutiny also had a strategic role in taking an overview of how well integration of health, Public Health and social care was working

The briefing also drew attention to:-

- Health and Social Care Act 2012
- Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013
- Powers and duties
  Local Authority powers

  Local Authority requirements

  Reporting and making recommendations

  Powers and duties for the NHS

  Wider range of “responsible persons” as service providers

  Providing information

  Local Healthwatch

- Consultation and involvement on Service reconfiguration
  Duty to consult

  Responding to consultation

  Referrals to the Secretary of State

Resolved:- That the content of the briefing be noted.

42. DRAFT LOCAL HEALTH PROTOCOLS

Janet Spurling, Policy Officer, submitted the draft joint protocol between the Health and Wellbeing Board, Health Select Commission and Healthwatch Rotherham. It detailed the distinctive roles of each body and presented examples of working together and reporting arrangements.

All 3 bodies recognised that they had a role to play in the way that local services were planned and delivered and that how they interacted with each other would directly influence and add value to outcomes for local people and communities.

Two minor changes had been tabled since the papers were published, with the first two bullet points under action 3 worded as follows:

Chair of HWB invited to attend HSC and share minutes of meetings
Open invitation for scrutiny members to attend HWB as observers

Resolved:- That the protocols, as updated, be agreed from the perspective of Health Select Commission.

43. DATE OF NEXT MEETING

Resolved:- That a further meeting be held on Thursday, 23rd October, 2014, commencing at 9.30 a.m.

HEALTH AND WELLBEING BOARD
2nd July, 2014

Present:-
Members

Councillor John Doyle	Cabinet Member for Adult Social Care **(in the Chair)**
Chris Edwards	Chief Operating Officer, Rotherham CCG
Naveen Judah	Rotherham Healthwatch
Dr. Julie Kitlowski	Clinical Chair, Rotherham CCG
Councillor Paul Lakin	Deputy Leader
Chief Supt Paul McCurry	South Yorkshire Police
Shona McFarlane	Director of Health and Wellbeing, RMBC
Dr. John Radford	Director of Public Health
Carol Stubley	Director of Finance, NHS England
Joyce Thacker	Strategic Director of Children, Young People and Families Services

Also in Attendance:

Tracy Clark	RDaSH
Dr. David Hicks	Rotherham Foundation Trust (representing Louise Barnett)
Sharon Schofield	CAMHS
Janet Wheatley	Rotherham Voluntary Action Rotherham

Apologies for absence were submitted by Tom Cray, Councillor Amy Rushforth, Chris Bain, Louise Barnett, Kate Green, Jason Harwin and Martin Kimber.

S1. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no questions from the press and public,

S2. MINUTES OF PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 4th June, 2014, be approved as a correct record.

S3. COMMUNICATIONS

(a) Carers Review

Janet Wheatley asked if the voluntary sector and multi-agency working group had been set up and, if so, who was the contact.

Shona McFarlane reported that the Service Manager would be Janine Moorcroft. The Steering Group for Carers at present had no 3rd sector representative but it was being refreshed. There would be an invitation extended to VAR and others to take part in that process.

Councillor Jenny Andrews was the Champion for Carers.

(b) Dalton and Treeton Health Centres

Prior to the PCT reorganisation last year, 2 capital projects had been agreed in Rotherham (replacement of 2 ageing health centres in Dalton and Treeton). However, no progress had been made.

In the reorganisation it had been passed to Propgo and it was believed there was still the intention to proceed with the development.

Resolved:- That Carol Stubley, NHS England, submit a progress report to the next Board meeting.

S4. PERFORMANCE MANAGEMENT OUTCOMES FRAMEWORK

Dr. John Radford, Director of Public Health, gave the following powerpoint presentation on Performance Management:-

Performance Management

- Clear accountability for each performance measure – 1 accountable lead
- Targets, action plans and milestones track progress and direction of travel
- Performance monitoring – current performance, RAG status and direction of travel
- Governance arrangements play a fundamental role managing performance/risk
- Concerns and outliers are identified to prompt necessary action including clinics
- Trigger points for a performance clinic:
  - If performance is below target/is predicted to not meet the year end target
  - On target but due to a known event/issue is predicted to n ot meet the year end target
- The clinic will develop and agree a remedial action plan with the accountable lead
- Service improvement work takes place immediately upon agreement of the plan
- Progress monitored and reported to provide assurances that issue is under control necessary improvements in performance are delivered
- Latest available Public Health data used as a ‘can opener’ to prompt where performance clinics could take place

Public Health Outcome Framework Scorecard Summary – 110 National Public Health Outcome Framework Measures

- National Benchmark RAG Status
  - 32 Indicates rated Red
  - 27 Indicators rated Amber
  - 35 Indicators rated Green
- Regional Benchmark RAG Status
  - 23 Indicators rated Red

- 46 Indicators rated Amber
- 24 Indicators rated Green

Green Measures

- Wider determinants of health
  1.02i/ii School Readiness
  1.06i LD Settle Accommodation
  1.06II MH Settled Accommodation
  1.06ii LD/MH Employment (Gap)
  1.10 Killed and Seriously injured casualties on England's roads
  1.15i/ii Statutory Homelessness – Acceptances/Households in temporary accommodation
  1.17 Fuel Poverty
  1.18i Social Isolation

- Health improvement
  2.07ii Rate of Emergency Admissions caused by unintentional and deliberate injuries in young people aged 15-24 years
  2.20i/ii Cancer Screening Coverage (Breast/Cervical)
  2.22i/ii NHS Health Checks – Take up/Offered
  2.24i/ii/iii Injuries due to falls in people aged 65 and over

- Health protection
  3.02i/ii chlamydia Diagnoses (15-24 year olds)
  3.03iii/iv/v/vivii/x/xii/xiii/xiv/xv Vaccination Coverage
  3.05ii Incidence of TB

- Healthcare and premature mortality
  4.1 Suicide Rate

Amber Measures

- Wider determinants of health
  1.09i Sickness Absence – the % of employees who had at least 1 day off in the previous week
  1.18ii Loneliness and Isolation Carers

- Health improvement
  2.04 Teenage Conceptions
  2.06i Excess Weight in 45 year olds
  2.07i Rate of Emergency Admissions caused by unintentional and deliberate injuries in children aged 0-14 years
  2.12 Excess Weight in Adults
  2.13i % of physical active and inactive adults – active adults
  2.15ii Successful completion of Drug Treatment – non-opiate users
  2.18 Alcohol-related Hospital Admissions
  2.23i/ii/iii/iv Wellbeing response from Integrated Household Survey

- Health protection
  3.03viii/ix MMR Vaccination Coverage
  3.04 People presenting with HIV at a late stage of infection

- Healthcare and premature mortality
  4.01 Infant Mortality
  4.06i/ii U-75 Mortality Rate from Liver Disease/considered preventable
  4.07ii U-75 Mortality Rate from Respiratory Diseased considered preventable
  4.14i/ii/iii Hip Fractures in People aged 65 and over
  4.15i/ii/iii/iv Excess Winter Deaths Index

Red Measures

- Overarching Indicators
  0.1i/ii Health Life Expectancy at Birth
  0.2i/ii Life Expectancy at Birth
  0.2 vi Gap in Live Expectancy at Birth between each Local Authority and England as a whole

- Wider Determinants of Health
  1.01ii % of all dependent children under 20 in relative poverty
  1.02ii School Readiness (Y1 pupils)
  1.09ii Sickness absence - % of working days lost to sickness absence
  1.12i Violent crime (including sexual violence) – hospital admissions for violence
  1.14 % of the population affected by noise
  1.16 Utilisation of outdoor space for exercise/health reasons

- Health Improvement
  2.01 % of all live births at term with low birth weight
  2.02i/ii Breastfeeding initiation/prevalence
  2.03 Rate of smoking at time of delivery per 100 maternities
  2.06ii Excess weight in 10-11 year olds
  2.13ii % of physically active and inactive adults – inactive adults
  2.14 Smoking prevalence (adults) over 18
  2.15i Successful completion of drug treatment – opiate users
  2.17 Recorded diabetes
  2.21 vii Access to non-cancer screening programmes – diabetic retinopathy

- Healthcare and Premature Mortality
- 4.02 Tooth decay in children aged 5
- 4.03 Mortality rate from causes considered preventable
- 4.04i/ii U-75 mortality rate from all cardiovascular disease/considered preventable
- 4.05i/ii U-75 mortality rate from cancer/considered preventable
- 4.07i U-75 mortality rate from respiratory disease
- 4.08 mortality from communicable diseases
- 4.11 Emergency readmissions within 30 days of discharge

Health and Wellbeing Board Priorities – Red Measures

Smoking

- % smoking at delivery
  2012-13 outturn (19.2%)
  Last update Q3 2013/14 (21.1%) against a target of 18.2%

Alcohol

- Number of FPN waivers which result in attendance at binge drinking course
  2012-13 outturn (86)
  Last update Q3 2013/14 (17)
  Lower than last year

Fuel Poverty

- The number of properties receiving energy efficiency measures through Community Energy Saving Programme (CESP)
  A3 2014-14 (16) against a target of 236
- The number of properties receiving energy efficiency measures through Department of Energy and Climate Change (DECC)
  Q2 2013-14 (68) against a target of 320

Obesity

- Percentage of overweight and obese children in Reception
  2011-12 outturn (16.1%)
  Last update 2012-13 (22.2%)
  2013-14 not available but deterioration in direction of travel between 2011-12 and 2012-13
- Percentage of overweight and obese children in Year 6
  2011-12 outturn (33.0%)
  Last update 2012-13 (35.2%)
  2013-14 not available but deterioration in direction of travel between 2011-12 and 2012-13
- Healthy eating prevalence (Integrated Household Survey/Active People Survey)
  2011-12 outturn 21.3% against a target of 28.7%

Future Performance Clinics

- The following Indicators have been identified as requiring focus/action – either Red or Amber with deterioration and/or in the bottom quartile regionally:-
  Obesity
  Low birth weight babies
  Breastfeeding
  Drug treatment
  School readiness
  Emergency readmissions
  Sickness absence
  Smoking
  Mortality
  Access to non-cancer screening programmes

Children in poverty
Violent crime
Noise
Tooth decay
Alcohol (binge drinking course)
Energy Efficiency

- 3 areas identified as priority areas for first performance clinics – Obesity, Drug Treatment and Breast Feeding
- Obesity and Drug Treatment had taken place during May, 2014 and Breastfeeding to be held shortly

Discussion ensued on the presentation with the following issues raised/clarified:-

- Importance of joint working to develop strategies
- Need to work with the voluntary sector to ascertain what was available in the community in order to maximise resources
- Possible use of local businesses/supermarkets
- The need to think differently/interventions that would hopefully reduce the need for urgent health care
- Engagement with Parish Councils and inclusion in Parish Plans
- Need for performance clinics to be radical – "what would the effect be if stop doing what we are doing?"
- Hold current structures to account – there were a whole host of disparate processes across the Local Authority and partners. Engaging Scrutiny would be extremely positive as they gave a fresh view on issues
- Performance clinic to be held on Maternity Health

Chris Edwards reported that NHS England had requested the CCG to set up a System Resilience Group on which all partners were represented. The membership was clearly defined.

Resolved:- (1) That the report be noted.

(2) That the results of performance clinics, the procedures followed and the work undertaken be reported to future Board meetings.

(3) That a report be submitted to the next Board meeting on the System Resilience Group.

(4) That NHS England submit a report to the next Board meeting on Diabetic Retinopathy screening.

S5. BETTER CARE FUND

Chris Edwards reported that the final submission had been due to be made to NHS England. However, NHS England had requested that the 10 exemplar areas test out the system which would then be rolled out to the remaining 200.

Rotherham had been selected as of the exemplar areas as its plan was judged to be 1 of the most developed plans and fit for purpose.

The new submission date for the return was now 9th July, 2014.

Discussions had taken place and it was felt the deadline would be achievable with the return being submitted to the August Board meeting.

A telephone conference call to the 10 areas was taking place that morning.

Rotherham had no option but to conform to this request.

Naveen Judah reported that from a national point of view, it seemed that a number of plans submitted were not considered realistic or achievable.

It was noted that the requirement for further work would place a burden on the resources of Adult Social Care who were currently working on the significant changes brought about by the Care Act and the Local Authority's budget process.

Chris Edwards stated that no additional work was required and the return would have to have been made but was now to a different timescale and on a different template.

The Chairman stated that no decision would be made until the results of the telephone conference was reported to the next Board meeting.

S6. CAMHS

Naveen Judah, Chair of Healthwatch Rotherham, presented the report produced in partnership with a group of local parents into the work of the Children and Adolescent Mental Health Services

Nationally, health and social care provision was being evaluated in light of the Francis report as well as a national review of CAMHS as part of the Children's Plan.

In Rotherham stakeholders had come together to produce and deliver the Rotherham Emotional Wellbeing and Mental Health Strategy for children and young people. The Strategy would inform service planning and commissioning for the next 5 years. The aims of the investigation were to:-

- Seek views on how local people believed the culture of CAMHS was affecting Service delivery
- Obtain views and ideas as to how things could be done better
- To share the views of local people with the provider and commissioners of CAMHS
- Ensure local people in Rotherham knew about the activity

To enable Healthwatch to achieve the above, 3 methodologies were used:-

- A purpose designed survey
- A public 2 day event gathering views on themed topics
- A review of the Healthwatch Rotherham Database

From all the statements made it could be concluded:-

- that there was a high level of dissatisfaction with the Service provided
- parents/carers did not feel listened to
- felt blamed for the problems they and their child were experiencing
- did not feel included or able to participate
- no clarity on what to expect from CAMHS and what services they provided
- difficult to make a complaint
- complaints were not handled consistently or in a timely manner
- waiting times to be seen were too long leaving families feeling unsupported
- when children were discharged from the service it did not always include families and they were unaware they had been discharged
- no crisis planning leaving families feeling unsupported and not sure what to do

When the concerns had first been raised, Healthwatch had looked at the work being done so as to avoid any duplication and to tackle the area of how Services users were feeling/being treat as opposed to diagnosis and pathways.

It was very important that CAMHS communicate and set out the correct expectations from the community. Services users often thought that CAMHS would be there throughout the process when in actual fact they may only be involved at the referral stage and then someone else took over resulting in CAMHS being wrongfully blamed for everything that subsequently went wrong.

Sharon Schofield, CAMHS, apologised that the carers and children had not received the service they felt they should have received from the Service. It was a small number given the numbers that used the Service nevertheless it was important that the best possible care was given to everybody.

A lot of work had taken place, supported by CCG commissioners, to improve both the processes in terms of looking at how appointments were made in a timely way and working within the issues of capacity and demands. In some cases the professionals that would have been there to support CAMHS in the past unfortunately, due to budget cuts etc., were no longer there. Sharon had also stated the Service's intention to meet with all the parents who were unhappy on an individual basis to understand what their issues were in an attempt to resolve them.

Julie Kitlowski reported that the GPs had been extremely concerned and had carried out a lot of work together with RDaSH. A survey monkey had been sent to GPs to ascertain what their concerns were. CAMHS had developed an action log which they monitored which would hopefully include additional input in terms of the consultants they had and also to reduce the confusion as to who prioritised what as some of the Services expected of them were not actually delivered by them. A second survey of GPs had reported significant improvement. The situation would be monitored but satisfied they had a robust action log which would significantly improve the Service.

Chrissy Wright stated that RDaSH had been served with a Default Notice with regard to issues relating to the CAMHS Service. There had been a review by Attain commissioned by the CCG which had been helpful and the agreed Strategy was to be considered by the Health Select Commission on 11th July. There was now a partnership agreement with the CCG on behalf of the Council on how to work in localities.

Healthwatch Rotherham had agreed to revisit CAMHS in a year's time.

Resolved:- That the report be noted.

S7. RFT PATIENT RECORD SYSTEM

Chris Edwards reported that from the commissioner's point of view, they were receiving reports from GPs that the Patient Record system was working in an acceptable manner and had no current concerns.

David Hicks stated that the Trust had requested Monitor to lift the Enforcement in this area. The response had been quite encouraging when they had last visited and expected to hear formally very shortly as to whether the request had been acceded to.

Resolved:- That the report be noted.

S8. VACCINATIONS AND IMMUNISATIONS

Fiona Jordan, Consultant in Public Health and Vaccinations and Immunisations, presented a report on Rotherham's performance against the Public Health Outcomes Framework in terms of vaccinations and immunisations.

She drew attention to the following areas:-

- Men C – the red Indicator was due to a problem with data and not performance. The schedule had changed from 2 dose to 1 dose but the IT system still counted dose 2 as a missed appointment. This was expected to be rectified for Quarter 1
- Neonal Hep B – the new local service specification from April, 2014, included data collection. Intensive work was taking place to ensure that every baby involved received the correct dosage etc. and on time
- Pertussis vaccination in pregnant women – there was currently a 50% standard against this indicator due to it being relatively new. Locally this was being pushed with GPs, however, there was a problem in that the IT systems between Maternity and GPs did not always link up in specific time for the practice to pick up that a vaccination was required. Work was taking place with Maternity Services and GP practices to try and ensure a more rigorous call and recall programme. Discussions had taken place with the Foundation Trust that the Midwives would be best placed to administer the injection

Resolved:- That the report be noted.

S9. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 27th August, 2014, commencing at 1.00 p.m. in the Rotherham Town Hall.

HEALTH AND WELLBEING BOARD
27th August, 2014

Present:-

Members

Councillor John Doyle	Cabinet Member for Adult Social Care **(in the Chair)**
CI Richard Butterworth	South Yorkshire Police (representing South Yorkshire Police)
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Chris Edwards	Chief Officer, Rotherham CCG
Melanie Hall	Rotherham Healthwatch (representing Naveen Judah)
Dr. Julie Kitlowski	Clinical Chair, Rotherham CCG
Councillor Paul Lakin	Deputy Leader
Carol Stubley	NHS England
Joyce Thacker	Strategic Director, Children Young People and Families Services

Also in attendance:

Tracy Clark	RDaSH (representing Chris Bain)
Miles Crompton	Policy and Partnerships
Kate Green	Policy Officer
Martin Havenhand	Rotherham Foundation Trust (representing Louise Barnett)
Michael Holmes	Policy and Partnerships
Shafiq Hussain	Voluntary Action Rotherham (representing Janet Wheatley)
Satvinder Rana	Local Government Association
Jasmine Swallow	Performance Officer
Sue Wilson	Performance and Quality Manager
Chrissy Wright	Strategic Commissioner, RMBC

Apologies for absence were received from Councillor Amy Rushforth, Chris Bain, Louise Barnett, Jason Harwin, Naveen Judah, Martin Kimber, Dr. John Radford and Janet Wheatley.

S10. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no questions from the press and public,

S11. MINUTES OF PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 2nd July, 2014, be approved as a correct record subject to the inclusion of the following addition:-

S5 (Better Care Fund) “Rotherham had no option but to conform to this request according to current information”.

Arising from Minute No. S3 (Dalton and Treeton Health Centres), Carol Stubley gave the following update:-

The former NHS Rotherham Board had approved, in principle, the development of new medical centres at Dalton and Treeton with tender processes to commence subject to funding being available and re-confirmation by the Board.

With regard to the Dalton Health Centre, all the legal and lease agreements had been signed on 19th August and contractors would be on site to commence the build at the end of September, 2014 with an estimated build time of 9 months.

The timescale with regard to the Treeton Health Centre was less clear at the present time. The next stage was to start work on a detailed project plan and time frame. An update would be given to a future meeting.

Arising from Minute No. S8 (Vaccinations and Immunisations), Dr. Kitlowski reported that a meeting had taken place with all the partners with regard to vaccinations and immunisations in pregnant women for influenza and whooping cough. The plan was to hopefully to implement it from 2015. An action plan would be submitted to the next Board meeting.

S12. INDEPENDENT INQUIRY INTO CHILD SEXUAL EXPLOITATION IN ROTHERHAM

The Chairman referred to the recent publication of the above Inquiry report which had yet to be considered by the Council and partners.

He felt that the Board needed to be satisfied that the systems in place were as robust as possible and fit for purpose. Accordingly he proposed that all partners consider the report and report back to the Board.

Although it was the ultimate responsibility of the Rotherham Local Safeguarding Children Board there was the governance relationship between the 2 Boards. It was noted that the Safeguarding Board was to convene a special meeting to consider the report.

Resolved:- That the Chairman of the Rotherham Local Safeguarding Children Board be invited to a future meeting of this Board.

S13. COMMUNICATIONS

Better Care Fund

The Board considered 2 letters that had been received from the Departments of Health and Communities and Local Government and the BCF Programme Director, both dated 11th July, 2014, which gave a general update with regard to the funding and the new BCF Programme Team.

A further letter had since been received which gave much more detail and included the new updated guidance and deadlines for resubmitting plans.

S14. BETTER CARE FUND

The Chairman reported that the latest letter received from NHS England dated 25th July set out the changes to the Fund.

The most important change was that in relation to the previous £1bn Payment for Performance Framework which had now been revised so that the proportion linked to performance was dependent solely upon an area's scale of ambition in setting a planned level of reduction in total emergency admissions i.e. general and acute non-elective activity.

Nationally the assumption was that this would be in the region of a 3.5% reduction against the baseline detailed in the technical guidance. If this was achieved, it would equate to a national payment for performance pool of around £300M. The remaining £700M would be available upfront in 2015/16 to be invested in NHS commissioned out-of-hospital services. The detail would be subject to local agreement.

Although Rotherham had been selected as 1 of the fasttracked 15, it had been decided not to proceed due to the unknown/unquantified burden and the changes that were being made almost on a daily basis. The present scheme was significantly changed from what had originally been proposed.

The Fund had caused tensions between the Local Authority and CCG and it was important that lessons were learnt as a result. Locally there had been groundbreaking work around integration which the Fund had diverted the partners from and it was crucial that the partnership and direction of travel was not lost.

The submission now had to be submitted by 19th September which was before the next scheduled Board meeting.

The CCG had reduced its non-elective admissions by 10% during the last 2 years; its ambition was to maintain the non-emergency admissions at the 2008/09 levels. This was part of the 5 year plan which they had widely consulted upon. NHS England would be looking for a 5.8% reduction but the CCG would strongly argue that they had already achieved the reduction and making the case of maintaining that reduction.

It was proposed that the Task Group be delegated authority to complete and submit the application by the September deadline.

Resolved:- That, subject to no significant changes being made, the Task Group be delegated the authority to complete the submission and submit to NHS England by the 17th September, 2014, deadline.

S15. HWB PEER CHALLENGE

Satvinder Rana from the Local Government Association, reported that the Peer Challenge team would be on site from 9th-12th September.

Background work had been undertaken with the questionnaires previously supplied to members analysed. Statistics had been collated and documentation reviewed by the team.

Once on site, discussions would be held with Board members/stakeholders in the health and wellbeing system to ascertain how things were going. There was a suite of core questions in addition to the direction supplied on the type of things the Board wanted the team to focus upon.

It must be remembered it was not an inspection. The team consisted of practitioners i.e. someone from health and wellbeing, a Chief Executive from a Council, Director of Public Health etc. each bringing their experiences and feeding back on what they saw.

After the 4 days the findings would be fed back. There would be a presentation on the Friday morning followed by a report in 2 weeks later. The Board would have the opportunity to comment upon the report and, once signed off, would be published.

The Chairman encouraged members to be open about their experiences within the Board. It was hoped the Peer Challenge would be a constructive and positive process and provide recommendations to continued development.

All Board members would be invited to the presentation on the 12th September and requested that responses be provided to the invitation.

Resolved:- That the report be noted.

S16. JOINT STRATEGIC NEEDS ASSESSMENT

Chrissy Wright, Strategic Commissioner, submitted a report on the progress made in updating the Joint Strategic Needs Assessment (JSNA).

The JSNA was reviewed and revised at the end of 2011, however, a further refresh was required to meet Government guidance and a new online version developed and agreed in February, 2014. The JSNA process was a co-ordinated and consistent approach to data and information that had been validated and was evidence based.

All those who had contributed to the 2013 JSNA refresh were asked to provide any changes or additions to the information previously provided. In most cases the changes so far had been minor and the key issues emerging remain as previously reported.

Revised population projections now suggested that Rotherham would have 2,500 (1%) fewer residents by 2021 than previously projected. The reduction mainly affected people of working age whilst the expected numbers of older people aged 65+ and 75+ were slightly higher than previously projected. This illustrated the value of being able to update the JSNA so that new information could quickly be made available online.

A new requirement was for an Asset Register for the Borough such as physical community resources, leisure facilities and individual community resources. Compiling the Register had been a substantial piece of work but the information could be interrogated as required by the user to identify the resource sought. It was proposed that the Asset Register be used alongside the events and organisations information database on Connect to Support. The Register was in the process of being uploaded to the JSNA website.

Discussion ensued with the following comments made:-

- The document would become increasingly important particularly for commissioners as well as the move to more community-based services and integrated working

- Similarly the Asset Register for interested parties/communities linking into case management plans and single patient records so every locality knew exactly what resources each had in their community

- It was particularly important to understand what the voluntary sector had in place so it was essential it was refreshed on a regular basis. There were champions in each organisation whose responsibility it was to feed updated information through which would then feed into the Board 6 monthly updates

- VAR had a directory of 600 organisations which spelt out which provided what services in each area

- The JSNA featured in RDaSH's 5 year strategic plan of services

- A meeting had been arranged to discuss how Healthwatch and the public could feed into the process

- RFT had found it extremely valuable when producing their 5 year strategy

Resolved:- (1) That the progress made in relation to the updating of the Joint Strategic Needs Assessment and the establishment of the Asset Register be noted.

(2) That further updates be submitted twice a year (September and March) and by exception if so required.

S17. COMMISSIONING PLANNING CYCLE

Discussion ensued on the partners' commissioning cycles and the commitment made previously to share plans as soon as possible.

However, it was noted that all of the organisation's commissioning cycles were different. The CCG was about to start consultation with their GP members shortly with a view to getting draft plans out to stakeholders in November and formally to their Board in February, 2015.

It was suggested that by January, 2015, all organisations should have a draft commissioning plan.

Resolved:- That commissioning plans be submitted to the Board in January, 2015.

S18. OPERATIONAL RESILIENCE IN 2014/15

In accordance with Minute No. S4, Chris Edwards presented a report on Operational Resilience in 2014/15.

Following direction from NHS England, Rotherham CCG had set up a System Resilience Group which would build on the successful work in 2013/14 through the Urgent Care Working Group. The membership of the former Group had been widened to include a mental health provider (RDaSH).

The role of the Group was to inform and advise NHS England how it managed allocations on NHS waiting lists and System Resilience monies for Winter. It reported to NHS England and it was proposed that the minutes of the Group be circulated to the Board.

Discussion ensued on the Group with the following issues raised:-

- It was not just a change of name but change of tenure for the Group
- Need to ensure the representatives present had the delegated authority and, if unable to attend, the appropriate deputy attended
- Due to the short timescales that were normally associated with funding i.e. Winter pressures, decisions were needed within a few days not allowing representatives to take it back through their own governance structures
- Unrealistic tight timescales for important decision to be made for Winter Resilience Monies

Resolved:- That the minutes of the Group be circulated to enable Board members to gain an understanding of what was discussed at the meeting and, if required, a meeting be convened to discuss the matter further.

S19. CUSTOMER CHARTER (EXPECTATIONS AND ASPIRATIONS WORKSTREAM)

Sue Wilson (Performance and Quality Manager) and Jasmine Swallow (Performance Officer) presented a report setting out an overview of the consultation process undertaken to develop the customer standards, suggestions for monitoring performance and future plans for launching and embedding with employees and customers.

Initial consultation to identify the top priorities had narrowed the 36 Service standards to 15 priorities which had been further consulted on at the 2013 Rotherham Show. This had identified the top 5 promises which were the most important to customers/potential customers when accessing services across the Partnership. These were:-

'Our Promises to you' Customer Charter:

- We will make it easy for you to find out what services are available
- We will aim to be flexible if you need to meet with us
- We will actively listen to you and treat you with dignity and respect
- We will be honest about what we can do to help you
- We will ensure the services we provide are timely

It had also been suggested that a strapline within individual organisations' version of the Customer Charter be included.

The concept of the design of the Charter was that the jigsaw pieces fitted together to provide a partnership commitment to promising and delivering against standards for customer service. There was a clear indication of who the Health and Wellbeing partners were which was reflected in the prominence of the logo, use of colours and each organisation's logo within one jigsaw piece.

It was proposed that monitoring performance through annual satisfaction surveys be conducted at the Rotherham Show. It was anticipated that the baseline performance would be gained at the 2014 Show as part of a 'You told us…We have…' campaign. Monitoring activity would be co-ordinated through Performance and Quality at the Expectations and Aspirations Workstream Group with results reported to the Health and Wellbeing Board and communicated to the public.

A Communications and Marketing Plan was being developed to ensure the customer standards reached a wide audience, informing customers about the standards they should expect and demand when accessing services and providing consistent standards for employees to work to assuring the best customer service possible.

It was hoped that a formal launch would be held at the New York Stadium which would see the 'jigsaw' brought to life recreating the logo as an enlarged puzzle for the photo call.

There was also a further Priority 2 action within the work plan to develop generic customer care training. This would be a further opportunity to work in partnership to provide a co-ordinated approach to embed the single set of customer standards into working practices.

Each partner gave a brief report on their involvement in the workstream:-

- VAR – involved in the development of the Charter as well as its member organisations in the development of the Standards. There was nothing contained within it they would not be able to aspire to. The VAR Board and a number of VCS networks had supported and endorsed it

- SYP – consulted/contributed as part of the process and very supportive in relation to the Standards. Unfortunately, it was a county-wide organisation of which Rotherham was an element but would initiate work with officers and staff in terms of the Standards. Feedback was already being received from Your Voice Counts but the Charter would be used as a template to get more feedback and engagement from the public on the services delivered and to what standard they were delivered to

- RFT – meeting held with Chief Executive and Communications and Marketing Manager. There had been issues with regard to the NHS Constitution but since then it had been agreed and understood that the Standards were very much complimentary and supplementary

- RDaSH – meeting held with representative of organisation and further work carried out during August. The Charter and Standards were similar to the organisation's set of values. It had not been through their governance process as yet

- CCG – some of the wording had been subtly changed to meet NHS guidance and would be used as a complimentary document

- CYPS – the Directorate had signed up to the Charter

- Healthwatch – had been part of the process and provided support at the Rotherham Show

Sue and Jasmine were thanked for their work in producing a fit for purpose and meaningful document.

Resolved:- (1) That the single set of customer Standards 'Our Promises to you' (Customer Charter) be approved and endorsed.

(2) That the partnership approach for monitoring performance, as set out in the report, be approved.

(3) That information be submitted regarding additional monitoring activities which single organisations could adopted.

S20. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 1st October, 2014, commencing at 9.00 a.m. in the Rotherham Town Hall.

HEALTH AND WELLBEING BOARD
1st October, 2014

Present:-

Councillor Doyle	Cabinet Member for Adult Social Care and Health **(in the Chair)**
Councillor Beaumont	Cabinet Member for Children and Education Services
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Chris Edwards	Chief Officer, Rotherham CCG
Jason Harwin	South Yorkshire Police
Fiona Jordan	NHS England (representing Carol Stubley)
Martin Kimber	Chief Executive
Dr. Julie Kitlowski	Clinical Chair, Rotherham CCG
Jason Page	Executive Lead, Referrals and Pathways, Rotherham CCG
Dr. John Radford	Director of Public Health
Dorothy Smith	Director of Schools and Lifelong Learning, RMBC

Also in Attendance:-

Richard Butterworth	South Yorkshire Police
David Hicks	Rotherham Foundation Trust (representing Louise Barnett)
Michael Holmes	Policy Officer, RMBC
Ian Jerrams	RDaSH
Shona McFarlane	Director of Health and Wellbeing, RMBC
Donald Rae	Special Education Needs and Disability Strategic Lead
Mark Scarrott	Finance Manager, RMBC
Janet Wheatley	Voluntary Action Rotherham
Chrissy Wright	Strategic Commissioner, RMBC

Apologies for absence were received from Councillor Emma Hoddinott, Chris Bain, Tracy Holmes, Naveen Judah and Carol Stubley.

S21. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no questions from the member of the public present at the meeting.

S22. MINUTES OF PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 27th August, 2014, be approved as a correct record.

Arising from Minute No. S15 (Peer Challenge), it was noted that the Peer Challenge had been deferred in light of the corporate governance inspection taking place. It would be arranged at some point in the future.

S23. COMMUNICATIONS

Peer Challenge
See Minute No. 22 above.

Pharmaceutical Needs Assessment (PNA)
Dr. John Radford, Director of Public Health, reported that a draft PNA had been produced in line with the statutory requirement for the Board to produce such a document before April, 2015.

A PNA was a tool required by NHS England to allow new pharmacies or changes in pharmacies across the Borough. It was a legal framework for pharmacies to enter the market place. This would be of particular importance in the town centre when the new emergency and urgent care centre at the Hospital opened and the maintenance of a pharmacy over that period.

The document would be circulated to Board Members as part of the 2 months consultation period with comments submitted to the Board. Once finalised and published there will be a process to update whenever required.

CAMHS Strategy
This item would now be discussed at the November Board meeting together with the Emotional Health and Wellbeing Strategy.

Alex Jay Independent Inquiry
A special Board meeting was to be held on 24th October at 1.00 p.m. to discuss the report.

S24. BETTER CARE FUND

Chris Edwards, CCG, reported that the Task Group had communicated via e-mail due to there being no significant changes to be made to the submission. A joint tele-conference had taken place with NHS England to provide external assurances.

No significant feedback had been received as yet but a report would be received as to whether NHSE's requirements had been met.

Resolved:- That the report be noted.

S25. SOCIAL CARE SUPPORT GRANT 2014-15

Shona McFarlane, Director of Health and Wellbeing, presented a report on the transfer to the Local Authority of the above Grant, details of the local allocations and the recommendations on how it could be spent for the 2014/15 financial year. NHS England would transfer £6.166M to the Council which included an increase of £1.351M from 2013/14.

Payment of the Social Care Support Grant was to be made via an Agreement under Section 256 of the 2006 NHS Act. The Agreement would be administered by the NHS England Area Team and would only pass over to local authorities once the Section 256 Agreement had been signed by both parties.

The Grant must be used to support Adult Social Care Services that delivered a health benefit. However, beyond that broad definition, NHS England wanted to provide flexibility for local areas to determine how the investment in Social Care Services was best used.

Guidance required NHS England to ensure that the local authority agreed with its local health partners on how the funding was best used. Health and Wellbeing Boards would be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent. NHS England would make it a condition of the transfer that RMBC and RCCG had regard to the Joint Strategic Needs Assessment for their local population. It would also be a condition that RMBC demonstrated how the funding transfer would make a positive difference to Service users.

The Fund would be overseen by a robust joint governance framework which supported achievement of the following:-

- Reduction in emergency admissions
- Reduction in delayed transfers of care from hospital
- Proportion of older people still at home 91 days after hospital discharge into rehabilitation
- Number of re-admissions to hospital within 30 days of discharge

It was proposed that the Grant be used to support existing Services and Transformation Programmes where such services or programmes were of benefit to the wider health and care system:-

- Additional short term residential care places or respite and intermediate care
- Increased capacity for home care support, investment in equipment, adaptations and telecare
- Investment in crisis response teams and preventative services to avoid hospital admission
- Further investment in reablement services to help people regain their independence

The appendix to the report submitted set out the proposed spending programme.

Discussion ensued on the proposed spending programme with the following issues raised:-

- Would consideration be given to the individuals entering the criminal justice system as part of the Mental Health Service?
- Was there sufficient funding for the development of community based Dementia Care
- RDaSH would be evaluating their triage project which had been running in conjunction with the Police

Resolved:- (1) That the programme of expenditure set out in the report be approved.

(2) That the development of a light-touch performance framework for the Grant be approved.

(3) That as part of the Board review, the processes and sub-groups be reviewed together with the appropriateness of the memberships.

S26. PERFORMANCE MANAGEMENT FRAMEWORK

Dr. John Radford, Director of Public Health, presented the current position on the reporting framework for 6 Priorities of the Health and Wellbeing Strategy drawing attention to:-

- Reducing hospital admissions due to alcohol related illness – activity had worsened. Although it reflected an increase in hospital admissions it was not an accurate figure. The CCG were carrying out work to understand the issues and had a pilot in place to reduce alcohol related hospital admissions

- Discussions were taking place with South Yorkshire Police regarding the number of FPN waivers which resulted in attendance at binge drinking courses – it was believed that the number was higher than reported

- The trend in terms of healthy life expectancy in Rotherham was improving. There were issues in relation to childhood obesity and very high levels of inactivity in Rotherham than elsewhere in the country

Discussion ensued with the following issue raised/clarified:-

- There was poor dental health in children of 2-5 years. Public Health England had been asked to submit a report setting out the trends. It again raised the issue of fluoridation and persuading parents to give their children water/milk rather than sugary drinks

Resolved:- (1) That the report be noted.

(2) That a report be submitted to a future Board meeting in relation to the trends associated with Priority 2 particularly relating to reduced hospital admissions due to alcohol related illness, the number of FPN waivers and children's dental health.

(3) That future performance management reports highlight any indicators off target together with the reasons for such performance.

S27. HEALTHWATCH ROTHERHAM

Further to Minute No. 88 of 26th March, 2014, Chrissy Wright, Strategic Commissioning Manager, reported that the contract for Healthwatch Rotherham had terminated with Parkwood Healthcare Ltd. on 31st August, 2014, and the contract commenced with the social enterprise Rotherham Healthwatch Ltd. on 1st September.

Rotherham Healthwatch would continue to deliver the service under the same terms and conditions as the previous provider using the original specification for the service and the existing staffing arrangements. All existing staff had been transferred to Rotherham Healthwatch Ltd. under TUPE regulations.

The report also set out performance for the first half of the year as well as future work for the remainder of the year.

As of yet it was not known whether there would be Government funding post-March, 2015. If funding was forthcoming it was the intention to recommission the social enterprise.

Discussion ensued with the following issues raised/clarified:-

- The contract was currently until April, 2015
- Healthwatch had also work on the Mental Health Review and the SEND Review
- The social enterprise had been fully aware of the risk of the possibility of no further funding when the contract had been signed
- The decrease in the number of volunteer hours and volunteers used during July

Resolved:- (1) That the setting up of the social enterprise Rotherham Healthwatch Ltd. be noted.

(2) That the termination of the contract with Parkwood Healthcare Ltd. and the transfer of the rights and obligations of the Healthwatch Rotherham Service to Rotherham Healthwatch Ltd. be noted.

(3) That the progress achieved be noted.

(4) That further updates be submitted in due course.

(5) That the reduction in the number of volunteer hours and volunteers used be referred to the Chief Executive of Rotherham Healthwatch Ltd. for comment.

(6) That the Board's congratulations be conveyed to those concerned in achieving social enterprise status and wished well for the future.

S28. VACCINATIONS AND IMMUNISATIONS FOR PREGNANT WOMEN

Further to Minute No. S11. Dr. Julie Kitlowski, CCG, reported that agreement had now been reached and that midwives would be trained to give vaccinations but not until next year.

David Hicks, TRFT, stated that there were issues around training, resources and the timing of when vaccinations were due, however, it was the Trust's intention to implement the programme next year.

An action plan would be drawn up. It was imperative that any barriers to implementation were raised so agencies could work together and agree a way forward.

Fiona Jordan, Screening Officer, NHS, reported that a lot of work was carried out with GP practices and the hospital emphasising the need to increase the uptake of the Pertussis. There was a need to ensure that all pregnant women were offered the vaccination by their GP or midwife and that the statistics were captured of those who refused the offer. Weekly e-mails were sent to practices to reiterate the message.

Resolved:- That an update be submitted to the next Board meeting.

S29. DIABETIC RETINOPATHY SCREENING

Jacky Mason, NHS England, reported that the NHS Diabetic Eye Screening Programme had been introduced to reduce the risk of vision loss in people with Diabetes. Everyone with Diabetes who was 12 years of age or over should have their eyes screened once per year to check for signs of Diabetic Retinopathy.

The joint Barnsley and Rotherham Programme was commissioned in 2007 and provided by Barnsley Hospital Foundation Trust. In line with the national trend, the diabetic population in Barnsley and Rotherham was increasing year on year. It currently had 27.707 registered patients 25,906 of which were eligible for screening. Those not eligible were managed in line with the national programme guidance and reviewed and validated every 3 months to ensure they still met the exclusion/suspension criteria.

The programme was currently commissioned on behalf of Public Health England via NHS England South Yorkshire and Bassetlaw Area Team to the national service specification for Diabetic Eye Screening.

Programme performance was reported nationally on a quarterly basis and also into the quarterly Programme Board. Any performance issues were escalated to the SYB Screening and Immunisation Advisory Group NHS England Public Health Commissioning Local Delivery Group and South Yorkshire Commissioners Group.

The programme in Rotherham was currently underperforming in some areas. These were being monitored by an action plan with a monthly update submitted to the SYB Screening and Immunisation Team.

The combined programme update was currently above the Public Health Outcomes Framework standard of 70% but below the stretch achievable target of 80%. Each individual programme showed a similar picture. In attempting to address, patients who had DNA had been surveyed and some of the findings acted upon including offering clinics at evenings and weekends.

All cancer and non-cancer screening programmes were subject to an external quality assurance review. The Barnsley and Rotherham review was planned for October, 2014 and would be the first programme in SYB to be quality assured in this manner.

Resolved:- That the report be noted.

S30. SPECIAL EDUCATIONAL NEEDS AND DISABILITY TRANSFORMATION

Further to Minute No. 107 of 4th June, 2014, Donald Rae, Special Education Needs and Disability Strategic Lead, presented an update on the implementation of the Reforms to support children and young people with special educational needs and a disability.

The 'In It Together' event held on 4th July, 2014, had attracted over 500 parents and young people who were able to gather information from education, health and care providers and attend workshops to discuss how best to introduce a more personalised approach/how the new assessment model was developing. It is expected that it will become an annual event not lease to ascertain the views of children, young people and parents about Rotherham's SEND Local Offer website.

The 2 key tasks required to be in place by 1st September had been met i.e.:-

- Rotherham's SEND Local Offer Website (www.rotherhamsendlocaloffer.org). The site aimed to provide as much information as possible within the site and not a link to other sites

- New assessment system for those with special educational needs and disability bringing together separate systems for early years, schools and colleges. SEN Statements and Learning Difficulty Assessments had been replaced by Education Health and Care Plans and a timetable had been published showing how the Statements would transfer to the new EHC Plan

The report also set out a range of actions that had been agreed by the Special Educational Needs and Disability Transformation Commissioning Group. Whist some of the actions would be delivered quickly others were more long term reflecting that the transformation of services would take up to 3 years.

Discussion ensued on the report with the following issues raised/clarified:-

- The new working practice was much more focussed on what was best for the parent and the young person particularly those aged 16-25 years.
- A further major change was how the plans the plans were reviewed, how schools were involved, care professionals working in a different way and how the plan was progressing particularly as a young child became a young person
- The new model had to have the parent and young person at the heart and deliver what they wanted
- There had been implications for the training and supporting of staff
- The new care plans included input from all professionals that represented the needs of the individual
- The CCG was fully engaged with the new way of working
- There was an issue that health data tended to be 4-5 years out of date but work was taking place on how to gather information through the health system much earlier so that babies with complex needs and the implications thereof were known throughout the system
- The Joint Strategic Needs Assessment had a particular section containing all the SEND details and was monitored as part of the regular scheduled updates
- Rotherham's SEND Local Offer website was continually updated with any links to organisations of interest some of which were suggestions from parents. There was a danger of putting too many onto the website but if it came from a recommendation it was included
- The website had been built on the same platform as Connect to Support
- The new system allowed a much more open assessment with regard to how resources would be allocated and how much was available

Resolved:- (1) That the progress made be noted.

(2) That an update be submitted in 12 months.

S31. DATE OF NEXT MEETING

Resolved:- (1) That a special meeting be held on Friday, 24th October at 1.00 p.m.

(2) That a meeting of the Health and Wellbeing Board be held on Wednesday, 12th November, 2014, commencing at 1.00 p.m. in the Rotherham Town Hall.

Notes from the meeting held on Monday 29th September, 2014
Health Select Commission and The Rotherham NHS Foundation Trust

Present:

TRFT – Louise Barnett, Chief Executive and Anna Milanec, Director of Corporate Affairs/Company Secretary

HSC – Cllr Brian Steele, Chair and Cllr Stuart Sansome, Vice Chair

Notes: Sharon Crook, Scrutiny Support Officer, RMBC

Purpose of the meeting
As agreed at HSC on 25th June 2014 the first of a series of monthly meetings took place on 11th August, 2014 to discuss progress on Rotherham Foundation Trust's Five Year Strategic Plan. The notes from the meeting formed the basis for this discussion and update on progress to date.

Monitor and the five year plan
The Performance Review meeting was very good with Monitor requiring further information on two areas for the plan (for reassurance).

a. Benchmarking exercise (comparable with a similar size trust)
   - How efficient
   - Level of risk

This should be completed and available by the end of October

b. Clinical speciality review

This should be completed and available by the end of December

Financial position
– on track

CQC/Intelligent Monitoring Banding – The risk status is 2
Complaints – information from the last financial year will be used which should be much better but uncertain if the improvement made will alter the banding in the next report due to the reporting period for the data sets. .

Pneumonia – this has been met (a care bundle is now in place)

Lots of positive action has been taken. The Head of CQC, John Croft had been invited to a meeting which had been positive and very productive.

Nurses recruitment
Lynne Waters is the new Executive Director of HR on the Board. The focus is on recruitment and retention

Recruitment
- Newly qualified nurses have been recruited
- 18 apprentices (Healthcare Assistants)
- Still many gaps, filling the vacancies is a priority

- Improvements being made to the recruitment process and time to recruit
- More work to do locally

Retention
Work is being done to retain staff through exit interviews and looking at the reasons why staff are leaving with some positive results.

National check survey with staff
The survey is being carried out by an external provider. It has been sent out to the whole workforce and closes in December. The results will give a national picture and a comparison to last year. The results may improve as there has been significant progress in a number of areas including:-

- A permanent chief executive and chairman, Some enforcements have been lifted (i.e. Board Governance)
- Lots of progress made with staff engagement and morale including roadshows for staff

However, it is difficult to anticipate the outcome given the level of change over the past year.

Response from SYPTE
The response from SYPTE confirmed that the bus routes to hospital leaflets do still exist but due to budget cuts and cost saving exercised the number of outlets where the leaflets used to be displayed have been reduced and, therefore, they are no longer available from within the hospital. However, leaflets can still be found within bus interchanges, travel information centres and online.

Copies of the following documents were given at the meeting:-

1. Copy of 5 year plan
2. Annual report and quality report 2013/14
   - Including staff survey results from last year
3. Clinical services review timetable
   - A & E has been looked at first re New Emergency Centre
   - December target has to be hit
4. Plan on a page for staff (given at the meeting)
   - Strategic objectives

Agreed Actions:
1. Further information be provided in relation to charging for damaged hearing aids:
   - How is accidental damage assessed
   - How is the decision made regarding who has to pay

NB: The date of the TRFT Board meetings have changed to the last Tuesday of the month at 9.30am in the Board room. The next meeting is 28th October, 2014.

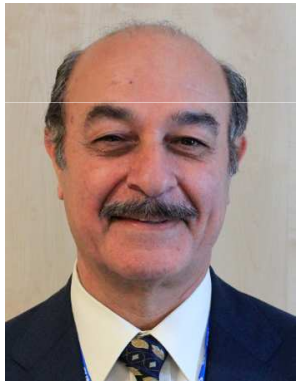
Date and time of the next meeting
27th October, 2014 at 3pm
Venue: Town Hall

investor in excellence

NHS
Rotherham
Clinical Commissioning Group

NHS Rotherham CCG Commissioning Plan 2015/16

Chris Edwards & Leonard Jacob



Your life, Your health

Introduction to Presentation (1)

The 2014/15 Commissioning plan is available on the intranet

http://www.rotherhamccg.nhs.uk/our-plan.htm

For 2015/16 we will refresh the plan rather than do a complete re-write

The following presentation concentrates on key priorities in last years plan

- Unscheduled care
- Mental health
- Clinical Referrals
- Medicines management
- Transforming community Services
- Maximising partnerships including GP Co-commissioning, partnerships between acute hospitals and the Better Care Fund with RMBC

CCG transformation capacity is finite so it is important that if new initiatives are prioritised some exiting initiatives are stopped

Introduction to Presentation (2)

The presentation has background information on the priority areas, followed by suggestions for changes, slides in this colour on pages 7,8,11,15,18,24 & 30

Feedback from localities will go back to the SCE GP responsible for the different areas to produce the draft refreshed plan for GP members Ctte on 17 December

As well as the areas disused in the presentation there are many other areas covered in the full plan, these include commissioning areas such as Children, EOLC and patient transport, CCG responsibilities such as quality & safeguarding and support functions such as finance and IT.

As well as feedback through localities please send any additional feedback back on the ccg email address

Rotherhamccg@rotherham.nhs.uk

Strategic Clinical Executive

Dr Julie Kitlowski
RCCG Chair

Dr Richard Cullen
RCCG Vice Chair
Finance, Governance & IT

Dr Russell Brynes
Mental Health

Dr Phil Birks
Acute Contracting

Dr Jason Page
Primary Care

Dr Avanthi Gunasekera
Medicine Management

Dr David Clitherow
Children & Young People

Dr Anand Barmade
Clinical Referrals

Clinical Referrals, Medicine Management & Mental Health

Clinical Referrals

7. Improving care pathways
8. Efficient follow-ups

Medicines Management

9. Increase quality, efficiency and reduce variations across 36 practices
10. Six service redesign projects

Mental Health

4. Parity of Esteem
5. Fundamental review of investment outcomes and role of providers
6. Improve Dementia services

2014/15 Progress and Issues

Clinical Referrals

- Early 2014/15 data show referrals & electives rising after 2 flat years
- Audit programme & feedback via PLT working well, TRFT starting medical directorate 'PLT'
- Follow up audits failing to identify many opportunities to reduce follow ups

Medicines Management

- Cost growth currently on track
- 33 out of 36 practice plans agreed
- Service redesign projects performing well but some risks re TRFT re-organisation
- Waste!

2015/16 Proposals

Clinical Referrals

Similar priorities – improve quality of pathways while keeping within affordable trajectories

- Develop a “Plan B” for the increase in referrals
- Monitor and address issues with “other referrals”
- Closer involvement of CCG in the development of RFT medical pathways
- Improve access to neurology and develop appropriate pathways
- Bench Marking for GPs to improve quality and consistency
- Development of pathways to provide advice on access to blood tests and imaging.
- Explore opportunities for self care and non face to face consultations
- Explore the market for primary care based Dermatology and Diabetes services.
- Develop the prevention agenda with Public Health England

2015/16 Proposals

Medicines Management

Same priorities plus realising the benefits of electronic prescribing (decreased waste)

Address the high admission rate for respiratory conditions and prescribing rates

Consider local and national risk of reducing waste

Address waste in term of general waste and in particular nursing home waste

Plan for the risk to special projects due to TRFT restucturing

2014/15 Progress and Issues

Mental Health & LD

- 3 reviews carried out (Adults, CAMHS and LD)
- LD – following consultation will implement the decision taken at 3 Sept Governing Body
- Action plan for RDASH services due to be agreed in Sept/October, common messages agreed, includes being minding to ct with RDASH as main provider but investing QIPP in voluntary sector or general practice
- Adult & Older peoples mental health liaison service most urgent issue
- Issues with partnership working

2015/16 Proposals Mental Health

Adults & Older People

Implement action plan including; Improved data & pathways, Adult mental health liaison, primary care focussed model, improved IAPT, improved dementia services

- Increase the number of mental health patients on the case management programme.
- Develop a dementia pathway with more focus on Primary Care and “one stop shops”
- Involve the voluntary sector on the dementia pathway
- Improve RDASH communication with stake holders and providers
- Support RDASH management of change
- Obtain patient experience of instances of poor service in respect of long waiting times and poor communication.
- Parity of Esteem and 7/7 working
- Long term impact of child sexual exploitation
- Learn from CRMC referral pathway work
- Address the acute management of the physical health of mental health patients
- Address the variations in mental health care (IAPT/Dementia)
- Extend Community Transformation to include IAPT and Dementia
- Measurable outcomes

2015/16 Proposals Mental Health CAMHS & LD

CAMHS

Ensure that 2014/15 improvements are maintained and that the extra consultant improves capacity

Impact of Child sexual exploitation

Learning disability

Evaluate the impact of GB approved ATU/community investment decision

Unscheduled Care & Transforming Community Services

1. Urgent Care redesign
3. Care Coordination Centre
11. Transforming Community Services – Locality Based Nursing
13. Increased Use of Alternative Levels of Care to Hospital

Transforming Community Services

Priority 1:	A better quality community nursing service
Priority 2:	Integration across health and social care
Priority 3:	An enhanced Care Coordination Centre
Priority 4:	Utilisation of alternative levels of care
Priority 5:	A Better governance framework

2014/15 Progress and Issues

- New service model agreed for community nursing
- Locality nursing teams serving GP practice populations
- Extend Care Coordination Centre hours to 24/7
- Development of the supported discharge care pathway
- Reconfiguration of the Community Unit to support frail elderly
- Discharge to assess (D2A) care pathway for CHC patients
- Commissioning of specialised nursing home beds for D2A and winter
- New governance framework in place for community health services

2015/16 Proposals

- Development of locality based health and social care teams
- Development of an Integrated Rapid Response Service
- Integration of the Care Coordination Centre with Rothercare
- Introduction of integrated telehealth and telecare packages
- Extend use of Care Coordination Centre to support case management
- Clarify arrangements for medical cover in alternative levels of care
- Primary care engagement in performance management framework

2014/15 Progress and Issues Emergency Centre

2014/15 – The plan

- Set up a project management structure
- Work up capital scheme options, undertake options appraisal and work up scheme – capital development to be completed by July 2015
- Design and agree service model and workforce – understand training implications
- Finance due diligence work, running and capital costs
- Work up business case for approval
- Service model to go live July 2015

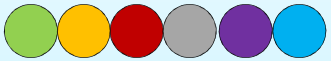
2014/15 Progress Emergency Centre

- Governance structure for project management in place
- Service model designed and work underway to establish patient flow pathways
- Capital development designed and planning permission approved. Capital scheme proposed includes adaptions to the existing A&E department and a cost of £12m
- External review from the emergency care intensive support team
    - Service model is innovative, safe, provides a quality service to Rotherham residents and makes the best use of resources
    - Review of workforce to staff the service model undertaken for each of the scenarios which may prevail
- Finance and Contracting discussions on-going.
- Draft IT service spec being firmed up
- Business Case for Approval
    - TRFT board - 31st October 14
    - CCG Governing Body - 5th November 14

2015/16 Proposals/Next Steps

1. Agree finance and contracting arrangements
2. Commence with Capital development
3. Continue service model development – testing out pathways at simulation events and ratifying via CRMC and MH QUIPP group
4. Develop pathway back to GP practices and implement
5. Procure, develop and implement IT system
6. Implement workforce development strategy to move away from reliance on locum cover
7. Develop clear transition arrangements and monitor progress
8. Robust strategy on culture change to be developed and implemented
9. Establish regular clinician to clinician meetings
10. Implement communications strategy a) public campaign b) internal coms across organisations

Maximise Partnerships & Primary Care



14. Better Care Fund

-incorporating GP Case Management and additional investment in care outside hospital (2 and 12)

15. To effectively align secondary and primary care plans, with NHS England *(co-commissioning of primary care and specialised services)*

16. To deliver 'working together' in collaboration with other CCGs

Better Care Fund

2014/15 Progress

- No new money
- £23m total fund (£13.5m health/£9.5m LA) to a single pooled budget for health and social care services to work more closely together supporting adult social care services
- 15 agreed schemes within the plan (see list, the schemes include GP Case Management)
- BCF plan contributes to 4 of the strategic outcomes of the H&WBS
- Rotherham recognised as one of the top 15 plans nationally
- On track for the resubmission of plans by 19 September
- BCF now incorporates the schemes from the investment in care outside hospital

Better Care Fund

2014/15 Issues

- Nationally expected to see a 3.5% decrease in non elective admissions within the plan, Rotherham's ambition is 0% as a result of the significant reduction (10%) over the last few years
- Nationally expect 'benefits' to be attributable to BCF – but BCF is one part of the overall commissioning plan and we need to ensure the picture is not 'skewed'
- Capacity to deliver on the 15 agreed schemes and to meet ongoing reporting requirements
- The 2nd evaluation event for the additional investment in care outside hospital is arranged for 22 October. As part of BCF, continuation of funding is a joint decision, the main criteria for evaluation is to demonstrate impact on hospital admissions

Better Care Fund

2015/16 Proposals

- Implement the revised plan agreed and submitted on 19 September
- Continue to work in partnership with RMBC
- Agree realistic timescales for the 15 schemes and ensure capacity to deliver

GP Case Management

2014/15 Progress

- Currently 6687 active care plans
- 35 out of 36 practices are signed up
- Inclusion of 75 and over health check- 1410 completed

2014/15 Issues

- Range of uptake across Rotherham from 0.1% to 5%
- Capacity of practices to deliver this
- 35 different methods of delivery- wide disparity in uptake of supporting services
- Complexity of IT systems to support

2015/16 GP Case Management

- Continued funding of the service for at least 5 years with possible amendments to how it is delivered
- Annual evaluation

Better Care Fund

The following is feedback from the SCE/GP session on 3 September:

General Comments

- It has been a difficult Journey – but the pain has gone and the outcome is good.

Risks identified

- The outcome of the non recurrent event on 22 November
- Ability to demonstrate reductions in non electives
- Relationships
- Ensuring reductions in social care are not picked up by health

Suggestions

- Enhance joint commissioning arrangements to increase capacity i.e. officers not schemes
- Consider further areas for joint work, e.g. continuing healthcare, as the work matures.

Align secondary & primary care plans, with NHS England

(co-commissioning of primary care and specialised services)

2014/15 Progress

- NHS England have asked CCGs to express interest in co-commissioning primary care
- It is also expected that CCGs will be asked to take a greater role for the commissioning of some specialised services

2014/15 Issues

- Should we move towards being a 'one' place commissioner
- Finances will need to be delegated to CCGs from NHS England
- CCG will need to review staffing structures and governance arrangements if it wishes to proceed with co-commissioning

2015/16 Proposals

- The CCG proposes to co-commission primary care from 1 April 2015
- Further information regarding specialised co-commissioning is expected from NHS England in October 2014

Align secondary and primary care plans, with NHS England

(co-commissioning of primary care and specialised services)

The following is feedback from the SCE/GP session on 3 September:

General comments

- Strong support for commissioning GPs, optometrists and pharmacies but further consideration would be needed in relation to dentists
- Prefer early engagement where there is more opportunity to influence
- Important to have local input as the Area Teams get fewer
- Protect against impact on CCG reputation by making sure other CCG priorities are not affected – challenge is not to break a good CCG
- Integrate primary care with other CCG priorities
- Agree an SCE GP lead
- Learn/buddy with other CCGs such as Hull, North Derbyshire and Scotland
- Primary care contract issues must be dealt with by officers and lay members (not GPs)
- Set out the benefits to patients within our plan
- Makes sense once all issues are addressed – right direction of travel

Align secondary and primary care plans, with NHS England

(co-commissioning of primary care and specialised services)

The following is feedback from the SCE/GP session on 3 September:

Risks

- Conflict of interest
- Financial resources
- Capacity issues
- Governance issues

Benefits

- Rotherham has a good track record of investment in primary care
- Optometrist and pharmacist input to CRMC would be valuable
- Better value from local enhanced services
- 'One Place' commissioner
- No duplication
- Yorkshire & Humber area team would not be accessible for GPs
- Protect Primary Care funding in Rotherham

Deliver ‘working together’ in collaboration with other CCGs

2014/15 Progress

- 8 CCGs and the Area Team as commissioners of Primary care and Specialised Services have initiated a programme of work to collaborate on key priorities (smaller specialities, paediatrics, stroke)
- SYCOM agree a PID in February 2014 and programme director recruited in April 2014 to work with each commissioning partners
- Project Initiation Documents have been agreed for three of the four clinical priorities
- Good progress made to date with three of the four work-streams
- Following agreement to take forward the Children’s Work-stream jointly with provider colleagues a joint document has been produced which will be shared and discussed at the joint meeting on 5 September

Deliver 'working together' in collaboration with other CCGs

2014/15 Issues

- Identify shared resources to deliver projects between CCGs
- The Out of Hospital work-stream has been placed on hold pending further details of phase two of the National Urgent Care Review

2015/16 Proposals

Over the next 12 months, to continue to deliver the four agreed key priorities:

- Acute Children Services
- Acute Cardiology & Stroke Services
- Smaller Specialties (Specialty Collaborative)
- Out of Hospital (currently on hold)

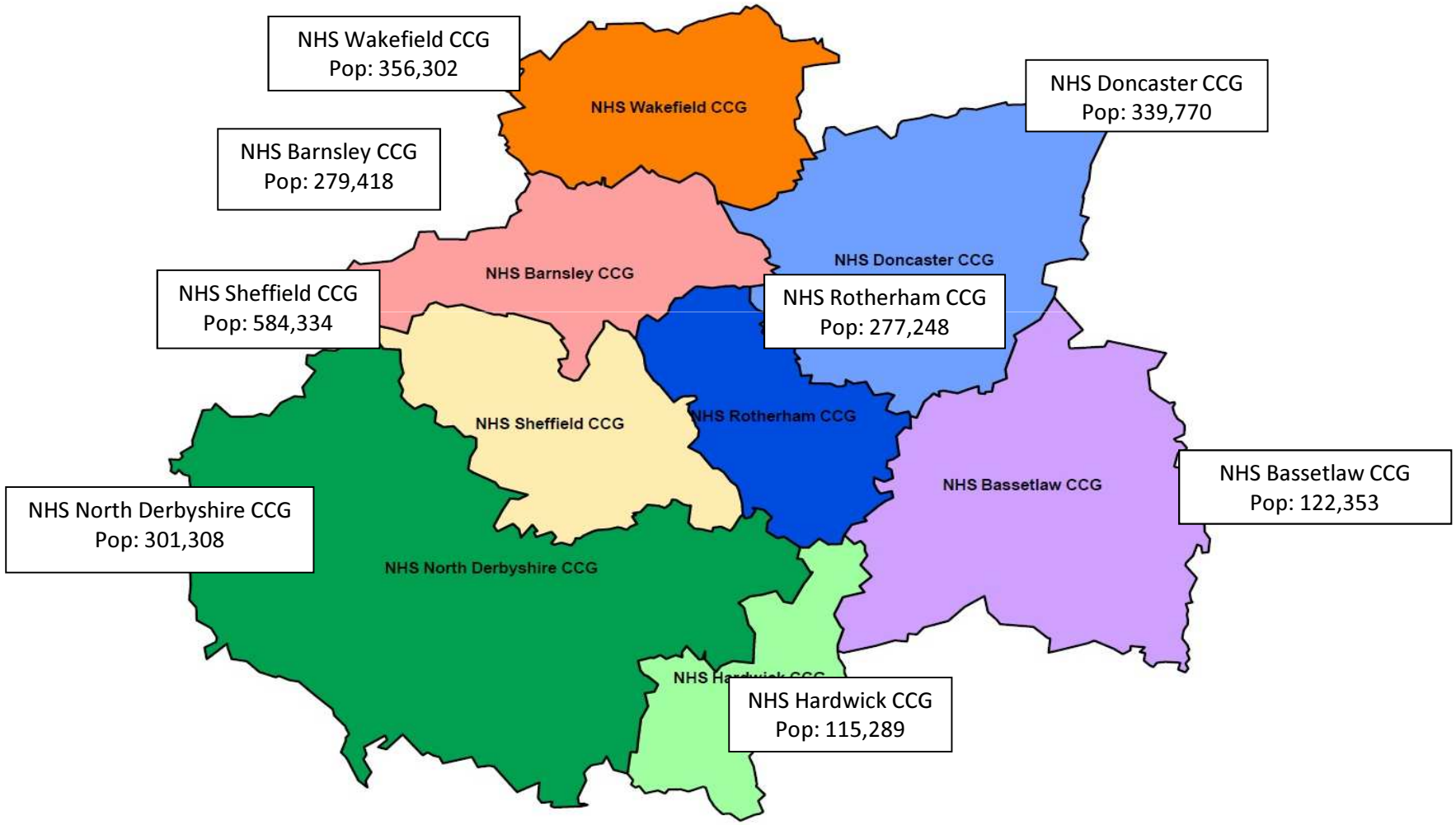
Deliver 'working together' in collaboration with other CCGs

The following is feedback from the SCE/GP session on 3 September:

General Comments

- People will be supportive if the work is presented in the right way
- Need to ensure early, appropriate public consultation and engagement is addressed
- Is the children's project moving at sufficient pace
- Could CAMHS be looked at on a wider footprint?
- Make sure all services are not centred in Sheffield

‘Working Together’: Collaborative Footprint



ROTHERHAM BOROUGH COUNCIL – HEALTH SELECT COMMISSION

1	**Meeting:**	**Health Select Commission**
2	**Date:**	**23 October 2014**
3	**Title:**	**Review of Hospital Discharges**
4	**Directorate:**	**Neighbourhoods and Adult Services**

5 **Summary**

Rotherham as a health and social care community admits more patients into hospital with long-term conditions at any one time, above the national average. Patients are admitted into acute hospital beds that do not necessarily require that acute level of care.

The number of emergency admissions continues to rise year on year, and this year there is to date a 7.6% increase in emergency admissions compared to last year. There is a significant increase in the number of frail elderly people being admitted to hospital.

Following concerns based on anecdotal evidence, that there was a problem with out of hours discharges (late at night or weekend) and patients being discharged without adequate support arrangements in place. Elected Members requested a spotlight review to be undertaken to look into these concerns.

A spotlight review took place between May and August 2013, and a report with a number of recommendations was presented to the Health Select Commission. This report provides an update on the action plan in response to those recommendations.

6 **Recommendations**

- **That the Health Select Commission receives and notes the report.**

7 Proposals and Details

7.1 The recommendations of the Spotlight review have been welcomed, and have been addressed through effective joint work between NHS Rotherham and RMBC. Good progress has been made in addressing the recommendations, as can be seen from the attached plan, which has been agreed by the Clinical Commissioning Group, and the Rotherham Foundation Trust.

7.2 The potential for unsafe discharges has reduced, the Care Co-ordination Centre and the hospital have done a lot of work on managing how it plans and co-ordinates discharge, this includes talking, having written communication to both patients and carers about predicted date of discharge.

8 Finance

The recommendations have been implemented without any additional resources being required.

9 Risks and Uncertainties

The recommendations in this report have been taken forward by strategic leads within NHS/RMBC to minimise risk and improve outcomes for patients.

Communication – effective communication is the key to ensure proposed recommendations are implemented and to avoid unnecessary misconceptions about discharges.

10 Background Papers and Consultation

- Scrutiny Review of Hospital Discharges (September 2013)
- Community Care Delayed Discharge Act 2003

Contact Name: Michaela Cox, Service Manager
Telephone: Ext 55982
E-mail: michaela.cox@rotherham.gov.uk

Cabinet's Response to Scrutiny Review of Hospital Discharges

Recommendation	**Cabinet Decision** (Accepted/ Rejected/ Deferred)	**Cabinet Response /Update (in red)** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)*	**Officer Responsible**	**Action by (Date)**
1. That ways should be considered as to how to involve community services more effectively with complex cases and their discharge arrangements.	Accepted	A Business Process Review is underway. It is looking at how Community Services can be better engaged with admission & discharge processes. Update: Business Process Review was completed and the findings rolled into Community Transformation Programme. Report will be presented to Urgent Care Management Committee.	Michaela Cox	Completed
2. The perception of problems relating to discharge is not supported by factual information therefore; feeding this back to elected Members should be a priority. Methods to achieve this should be explored. Any individual issues raised with an Elected Member need to be fed in by the most appropriate route.	Accepted	Factual information in relation to complaints, concerns raised relating to discharges needs to be checked and validated by managers prior to feeding back to Members to ensure accuracy. **Update:** No further concerns received specific to complaints in relation to discharge from hospital The Scrutiny Report contains information which should reassure Elected Members. To consider Healthwatch taking this issue up. A formal request to Healthwatch to undertake a review and keep a watching brief on issues.	Michaela Cox Maxine Dennis Complete	Ongoing Complete
3. Communications are key within the discharge process and scope to improve this should be explored. Literature in plain language and making the process understandable for vulnerable patients should be considered.	Accepted	A leaflet and information on website to be developed. Learning from customer's forum to review. Review the scope to improve communications with staff, consultants and patients regarding discharge processes. **Update:** The hospital has done a lot of work on managing how it plans and co-ordinates discharge through the SAFER care bundle. This includes talking to patients about their predicted date of discharge and having written communication with patients and relatives	Maxine Dennis Maxine Dennis	Revisited date of 30.11.14, due to changes outline on the plan.

4.	The Care Co-ordination Centre and its discharge support service are supported by members and they request that a progress report on this is brought to the Health Select Commission in 6-12 months.	Accepted	Progress report to be provided on Care Co-ordination Centre in 6-12 months. **Update:** A briefing report on the Care Co-ordination Centre supported discharge service will be discussed at the meeting.	Maxine Dennis	Completed
5.	Members welcomed the re-activation of the Operational Discharges Group and requested a progress report on their work in 6-12 months. This should also go to the Health Select Commission.	Accepted	Progress report to be provided on the Operational Discharges Group in 6-12 months. **Update:** There is now a forum whereby hospital and social service colleagues meet three times a week to review delayed discharges and operational issues. Continuing Health Care colleagues join this forum once a week. This multi-agency forum is currently developing some joint work on a Discharge to Assess model which will support earlier discharge, whilst ensuring a robust assessment process	Maxine Dennis	Completed
6.	Members endorse the implementation of the business process re-engineering as a result of this review and request that the outcomes are monitored by the Health Selection Commission.	Accepted	Outcomes of business process re-engineering will be presented to the Health Select Commission in a report by January 2014. Update: Superseded by work on Community Transformation Project.	Michaela Cox	Completed
7.	The policy on speeding up delayed discharges due to patient choice should be looked at as part of the business re-engineering process.	Accepted	The policy on delayed discharges due to patient choice will be reviewed and completed. **Update:** This has been reviewed as part of the Discharge to Assess model – the assessment timeframe (no more than 28 days) and the process will drive the patient choice to take place within this timeframe	Maxine Dennis	Revised due to changes outlined on plan
8.	Cabinet should consider whether social care services should be provided at a greater level out of hours to move towards a 7 day week service, however, members noted the potential resource implication of this.	Accepted	Current 7 day operation is considered to be adequate under the present operation, however if procedures change we may need to review this. Requirements in future grant conditions will result in a service review.	Michaela Cox	Complete

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**23th October 2014**
3.	**Title:**	**Making Every Contact Count (MECC)**
4.	**Directorate:**	**Public Health**

5. Summary

The report provides an overview of the Making Every Contact Count (MECC) initiative. The development and implementation of MECC has been supported by the Health & Wellbeing Strategy.

6. Recommendations

6.1 That HSC receives and accepts the report.

7. Proposals and Details

The opportunity to garner a wider public health workforce brings with it the need for robust, inclusive systems that ensure everyone understands how to influence and communicate behaviour change messages effectively and make every contact count.

The Prevention and Lifestyle Behaviour Change Competence Framework provides a mechanism to ensure systematic, measurable and evidenced development of workforces to meet the challenge.

The framework is informed by NICE guidance, the KSF (Knowledge and Skills Framework), staff reviews, National Workforce Competences (NWC) and National Occupational Standards (NOS).

Whilst these clearly define the need and the competencies, the framework also acknowledges the complexity and the challenging factors effecting health and wellbeing behaviour and therefore operates from the premise of 'starting from where the person is' and considers behaviour change in the context of the wider and social determinants of heath.

The framework provides the architecture to facilitate workforce strategies that deliver the public health agenda and embed behaviour change into strategies and relative Outcomes Frameworks designed to improve the health and wellbeing of individuals and populations.

As well as the clear benefits for commissioning, service provision and improving the capacity of the workforce, the Framework also provides a barometer for organisations' investment in staff health and wellbeing and associated improvements in productivity.

Making Every Contact Count has been discussed at the Rotherham Health and Wellbeing Board. Though Partners agree in principle with the concept, actual engagement with and tangible implementation of MECC has been disappointing.

We are currently reviewing the approach to MECC and looking at alternative strategies to engage partnership organisations.

8. Finance

There is no dedicated funding for the development and implementation of MECC. There are costs incurred by the delivery of training and resources to support the signposting of the public to behaviour change services. There is limited dedicated officer time within the Public Health team to support partner organisations in developing and implementing their MECC proposals.

9. Risks and Uncertainties

Partner organisations have indicated that a "one size fits all" approach is not what they would wish to see. Individual organisations are being encouraged to propose

their preferred approach, and this will lead to variation in the focus and impact of the programme.

10. Policy and Performance Agenda Implications

Resulting numbers of referrals to behaviour change services can be monitored, though the actual impact of the MECC programme may be difficult to measure unless it is embraced in the context of staff performance and development.

11. Background Papers and Consultation

Contact Name :
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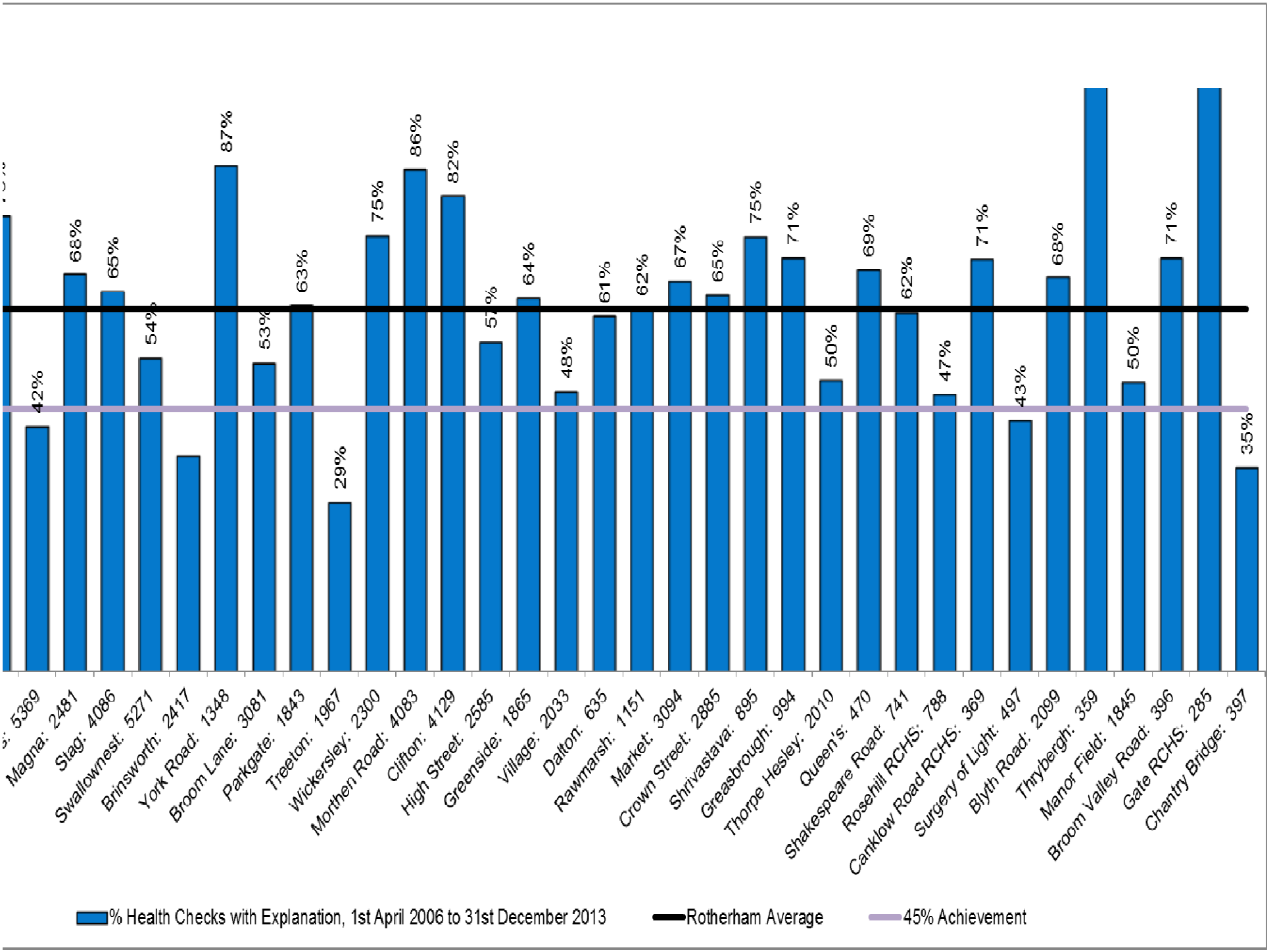
Rotherham Metropolitan Borough Council
Where Everyone Matters

NHS Health Check

Dr John Radford
Director of Public Health

NHS Health Check

- Risk Assessment
  - CVD
  - **T2DM**
- Risk Communication
- Risk Management
  - Lifestyle advice
  - **Referral for behaviour modification**
  - Prescribing


42%
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Magna: 2481
Stag: 4086
Swallownest: 5271
Brinsworth: 2417
York Road: 1348
Broom Lane: 3081
Parkgate: 1843
Treeton: 1967
Wickersley: 2300
Morthen Road: 4083
Clifton: 4129
High Street: 2585
Greenside: 1865
Village: 2033
Dalton: 635
Rawmarsh: 1151
Market: 3094
Crown Street: 2885
Shrivastava: 895
Greasbrough: 994
Thorpe Hesley: 2010
Queen's: 470
Shakespeare Road: 741
Rosehill RCHS: 788
Canklow Road RCHS: 369
Surgery of Light: 497
Blyth Road: 2099
Thrybergh: 359
Manor Field: 1845
Broom Valley Road: 396
Gate RCHS: 285
Chantry Bridge: 397
% Health Checks with Explanation, 1st April 2006 to 31st December 2013
Rotherham Average
45% Achievement

Our Objective

- Screen 18% of eligible 20% of population annually
- Challenge to deliver this in the most deprived communities

Lipid Modification NICE 2014

Rotherham Metropolitan Borough Council
Where Everyone Matters

- Systematic approach 40-74
- QRISK2
- Ethnicity,BMI,family history
- High intensity statin for risk conditions with 10% risk
- High intensity 20 mg atorvastatin for primary prevention

Diet

- Reduce saturated fats
- Replace saturated fats with olive oil rapeseed oil
- Reduce refined sugar and fructose
- Fruit and vegetables whole grains
- 2 portions of fish
- Sign post to NHS Choices

Exercise

- High Risk CVD 30 minutes of at least moderate activity daily
- If unable to do this offer exercise to maximum capacity
- Recommended physical activity can be built into daily living
- Additive 10 mins or more accumulated as effective as longer sessions

Q Risk 2

- Age
- Gender
- Smoker
- Premature family CVD
- Hypertension treatment
- Social deprivation
- Total HDL cholesterol
- Ethnicity
- Rheumatoid
- CKD
- AF

Risk Communication

- Individual risk and benefit
- Numerical presentation
- Signpost to appropriate information
- Feelings and beliefs
- Readiness to change lifestyle
- Shared management plan
- Check what has been discussed