HEALTH SELECT COMMISSION

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

Date: **Thursday, 22nd January, 2015**

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 Meeting (Pages 1 - 13)

8. Health and Wellbeing Board (Pages 14 - 29)
   - Minutes of meeting held on 3rd December, 2014

9. Meeting of Health Select Commission and the Rotherham Foundation Trust (Pages 30 - 32)
   Minutes of meeting held on 24th November, 2014

10. The Rotherham Foundation Trust - Update on Action Plan Progress
    Louise Barnett, Chief Executive, to present

11. The Rotherham Foundation Trust- Half Year Update on Quality Account
    Tracey McErlain-Burns, Chief Nurse, to present

12. Special Schools Nursing Service (Pages 33 - 37)

Juliette Penney, Clinical Services Manager, Children & Young People Services/Foundation Trust, to present

13. Date and Time of Next Meeting
    - Thursday, 19th March, 2015 at 9.30 a.m.

HEALTH SELECT COMMISSION
Thursday, 4th December, 2014

Present:- Councillor Sansome (in the Chair); Councillors Dalton, Jepson, Kaye, Swift, Vines and Wootton.

Apologies for absence:- Apologies were received from Wyatt, Hunter and Whysall.

56. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

57. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

58. COMMUNICATIONS

Joint Health and Overview Select Committee
The Chairman reported that he had attended a meeting on 28th November, 2014. There were major concerns from the attendees, some of which had been involved from the beginning, around the failure of NHS England to consult until the standards for Coronary Heart Disease had been accepted. They had been told that until the conditions were accepted, there would be no serious debate or consultation. This was creating a great deal of frustration.

They were also conscious that they had 4 surgeons at Leeds but not the workloads. It was a balance of retaining 4 surgeons/workload against a succession plan given the speciality/experience of the surgeons.

Information Packs
It was noted that a separate pack had been produced containing items for information. Should any Member have any issues to raise on the items contained therein they should be raised under Communications.

Access to GPs Review
The Overview and Scrutiny Management Board had requested a special Health Select Commission meeting to discuss the response due to a lack of detail with how some of the recommendations would be actioned even though they had been accepted.

A special meeting had been arranged on 15th January, 2015, at 9.30 a.m. to which the Clinical Quality Commission, Clinical Commissioning Group and NHS England had been invited.

Meeting with Rotherham Foundation Trust
The last meeting had been held on 24th November the notes of which were not available as yet. At the January meeting the Trust would give an

update on both their action plan and the Quality Account. They were applying to Monitor for the enforcement regarding governance to be lifted.

Seminar
A seminar was to be held on 9th December at 9.00 a.m. on the Care Act.

It was noted that Speak-Up had produced an easy read booklet on the Act.

Care Home Pilot – Waste Medicine Management
Discussions had taken place with Shona McFarlane, Director of Health and Wellbeing.

Medication in care homes was a complex matter delivered in partnership between the resident, their GP, the pharmacist and the care home. Most care homes operated a monitored dosage system or systems determined by the operating company many of which were national organisations. In setting up a contract, the Council required the home to operate a safe system of ensuring that residents received their medication correctly but the Council could not determine which specific system was used.

The key issue when delivering medication in residential care was safety and most homes found that a monitored dosage system resulted in a reduction in errors. The safety of the systems was not matched by flexibility and should someone not take their medication, or prescription change, the pre-filled cartridges were returned to the pharmacist to be destroyed which could result in wastage.

There were times when the prescription was completed incorrectly or the pharmacist did not complete the order correctly which could also result in waste when the homes had to send back the medication.

The in-house service operated 2 different approaches. Both were monitored dosages but for the home where there was 1 GP only, they had to be able to enter into an agreement to run an electronic version which resulted in a simpler to use system which could reduce waste. The Rotherham Clinical Commissioning Group was hoping to move to a '1 care home 1 GP' system which should enable more homes to use the approach.

Minor Oral procedures
At the last meeting it was agreed that the Chairman would write to NHS England with regard to the issues raised by Members about the proposals.

1 Whether the proposals would have a significant detrimental impact on Rotherham Hospital.
NHS England had engaged with the Foundation Trust about the proposals and did not consider that there would be a significant detrimental impact on the hospital. The number of patients who would be treated by an oral

surgery specialist in the community represented a small proportion of the total number of patients treated in the Trust's Oral and Maxillofacial Department. The Foundation Trust would continue to play a major and vital role in the provision of oral surgery procedures but would have a greater proportion of complex cases to manage.

2 It is essential that the contract is awarded to a practice that is easily accessible by public transport.
Accessibility of the service was a primary consideration and this was assessed through the tender evaluation framework developed for the procurement. Bidders were required to include within their premises proposal a description of the public transport services serving the particular location.

3 It is also important that the successful practice is fully accessible for disabled people in terms of both physical access and information about their treatment.
The premises proposed by any potential provider would be assessed to ensure appropriate access for patients with disabilities. However, minor oral procedures would still be available at the hospital and this may be the most appropriate place for some patients. Some patient groups received their regular dental care from the Community Dental Service based at the Community Health Centre and they would also be likely to receive oral surgery treatment at the hospital. The patient clinical pathway took account of patients' other health conditions when deciding on provider and location for treatment.

4 If information is available about the number and location of dental practices who already offer such procedures without needing to refer patients to the hospital.
At present no dental practices in Rotherham held a contract with NHS England to provide the services.

5 What arrangements will be in place for ongoing monitoring of service quality in the new contract?
All NHS England dental providers were monitored to ensure a high quality service was provided. Qualified dentists were employed as dental advisers to the commissioning and contract management team and they had a key role in monitoring service quality, mainly through practice inspections and record card audits. Providers also had to carry out patient satisfaction surveys, annual audits and to implement systems that supported the provision of a quality service.

Resolved:- That the Commission's satisfaction with the response to the issues raised be noted and the proposals be supported.

59. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the minutes of the meeting of the Health Select Commission held on 23rd October, 2014.

Resolved:- That the minutes of the meeting held on 23rd October, 2014, be agreed as a correct record for signatures by the Chairman.

Arising from Minute No. 51 (NHS Rotherham Clinical Commissioning Group – Commissioning Plan 2015-16 – Transforming Community Services), it was noted that Joanna Saunders, Public Health, was the lead officer for the transforming of the 0-5 Child Services Partnership and would submit a report to the Select Commission.

It was also noted that the Foundation Trust would give an update on the Community Transformation programme to the January meeting.

Arising from Minute No. 54 (Health and Wellbeing Board Strategy Progress – Prevention and Early Intervention – NHS Health Checks) it was noted that Health Checks were aimed at everyone over the age of 40-74 years.

60. HEALTH AND WELLBEING BOARD

The Select Commission noted the minutes of the Health and Wellbeing Board held on 24th October and 12th November, 2014.

Councillor Doyle, Cabinet Member for Adult Social Care and Health, informed the Commission that since the last meeting of the Board the Council, Clinical Commissioning Group and South Yorkshire Police had signed up to the Mental Health Crisis Concordat.

Progress on the Health and Wellbeing Strategy and plans for refresh would be presented to the Select Commission at its meeting in March 2015.

61. ISSUES FROM HEALTHWATCH

There were no matters arising.

62. CHANTRY BRIDGE GP REGISTERED PATIENT SERVICE

Richard Armstrong, Interim Director of Commissioning, NHSE, and Dominic Blaydon, Head of Long Term Conditions and Urgent Care, CCG, presented a report on the actions taken to date and those being considered by NHS England in order to ensure adequate, high quality future provision of GP services in the Chantry Bridge area of Rotherham.

Current services were located in the Community Health Centre on Greasbrough Road and were part of the contract with Care UK together with the Out of Hours Service and the Walk-in Centre.

Appendix A of the report provided a detailed account of the context and position regarding future provision as well as:-

- Introduction and background to the existing service
- Current position
- Demographic information
- Other Primary Care services at Chantry Bridge
- Engagement
- Procurement principles
- Risk management
- Next steps

Discussion ensued with the following issues raised/clarified:-

– The service had commenced in 2009, commissioned at that time by the Rotherham Primary Care Trust to provide both a registered practice for patients as well as walk-in patients who chose to visit during the extended opening hours and for convenience due to its central location for people working in Rotherham

– The contract had been let for 5 years with an expectation that the practice list would grow to 5,000-6,000 people

– At the time of the contract coming to an end in May, 2014, the practice had a list of approximately 1,700 and Care UK still provided a walk-in service

– During the 2013 changes to the NHS structure the responsibility for Urgent Care Services (walk-in centre and out of hours) moved to the Clinical Commissioning Group. NHS England remained responsible for commissioning GP services provided to a registered list of patients

– Notification had been received that Care UK wished to withdraw from the provision of GP services but were willing to continue with the provision of out of hours services. Negotiations had resulted in an extension of the contract until September, 2015. This was timed to coincide with the opening of the new Emergency Centre at Rotherham Hospital but site issues have meant a delay to the opening date

– Barnsley Clinical Commissioning Group were co-commissioners for the out of hours service and had agreed to end their contract with Care UK in May 2015. Rotherham CCG would be receiving a paper from Care UK on the costs of continuing alone with out of hours

– Consultation with the registered patients had commenced to ascertain their preference. Options to explore would be whether there was a possibility of commissioning another practice in the area or another GP practice willing to take on the full patient list

– Need to ensure effective engagement with patients who were new arrivals/faced language barriers and patients with learning disabilities

or autism. It was noted that not many patient participation groups included disabled people

- 15% of the 1,700 lived more than 1 mile from the practice and travelled past other practices largely due to the convenience of extended opening hours

- If patients wished to stay registered in the area efforts would be made to re-procure through advertising the practice to any other provider who wished to take on the responsibility. Due to its small size, it would be expected to become a branch surgery of another practice

- NHS England felt that there was sufficient GP capacity in the area. Given the number of patients who actually lived out of the area it was highly likely that the majority would want to register with a GP closer to home

- The Community Health Services currently located in the building would not be affected by the changes in GP services

- The practice profile showed that 70% of the registered patients were of working age so would suggest they found the extended opening hours more convenient. There was a desire to see extended hours across the Borough and work was taking place with the Clinical Commissioning Group in looking at continuing provision for some form of walk-in centre and extending GP availability into the evenings and weekends. It was an aspiration for the future to commission services for longer periods of GP availability. GP practices were encouraged to submit a bid to the Prime Minister's Challenge Fund which was available to help improve access to general practice and stimulate innovative ways of providing primary care services

- It was not known why the patient list had not expanded. It could be that even though they may not be totally satisfied with their existing practice they could not be bothered to change. Also the service provider already provided the walk-in service for a patient whether they were registered or not so there was no incentive for Care UK to register more

- It was felt that there was still sufficient footfall for the pharmacy to be a viable business. A model being considered in terms of commissioning services from practices was looking at pharmacy services to relieve the strains on GP services and the hospital

- If practices took on more patients they would receive extra income, on average £120 per patient per practice

- If practices chose to close their patient list they had to apply to the Area Team and report why they had chosen that course of action. If it was found to be with no good reason, the application could be refused

or sanctions imposed in respect of the provision. Much of the GP practices chose to be open to register patients

- It was noted that the Friends and Family test would be introduced as from December for GP practices, to be reported monthly. This would be in addition to the national GP Patient Survey.

- NHS England did not allocate patients to a particular GP practice other than in situations where the patient was unable to choose.

Consideration was also given to a report to the NHS England and Health Scrutiny Overview Committee by Healthwatch Rotherham.

Healthwatch Rotherham had been approached by NHS England to help with the engagement around the future of the medical practice. 13 comments had been received regarding the practice relating to appointments/waiting times and other. There were some patients who had been signposted to the practice because of there being a "no boundary" approach and the extended opening hours but some were still reporting problems with appointment/waiting times to see a Doctor even though there were only 1,700 registered patients. Due to the location and layout at the Community Health Centre, many patients perceived the Walk-In Centre and Chantry Bridge GP practice as being one and the same. At the time of presenting the report Healthwatch had not received a response from Care UK who had been given a copy of the report.

Members requested further information from NHS England in order to inform their response to the proposals:-

- Information that NHSE had requested from Care UK with regard to the patient demographic profile and proximity to Chantry Bridge.
- Outcomes of the engagement with registered patients and the six GP practices within one mile of Chantry Bridge.
- An equality impact assessment/equality analysis

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

(2) That a formal response be submitted to NHS England South Yorkshire and Bassetlaw subject to receiving the information above and confirmation of the timescales.

(3) That the Select Commission's thanks and best wishes were given to Mel Hall, Chief Executive, Healthwatch Rotherham, who was leaving the position shortly.

63. CHILDHOOD OBESITY SCRUTINY REVIEW UPDATE

Joanna Saunders, Public Health, presented an update on the Childhood Obesity Review recommendations which had been considered by Cabinet on 16th October, 2013 (Minute No. 95 refers).

The re-commissioning of the Healthy Weight Framework (West Management Services) had commenced in May, 2014, following Cabinet approval (Minute No. 223 of 19th March, 2014, refers). The whole Healthy Weight Framework had been subject to review due to the budgetary pressures and the procurement process suspended at the end of July with all existing services extended to 31st December, 2014. However, the procurement had now been resumed and contracts would be awarded in the New Year.

Rotherham's Healthy Weight Framework continued to attract national interest and its specifications recognised as representing good practice in published papers and guidance.

Since the last update, progress had been made with work underway on a number of the recommendations:-

- Revised Healthy Weight Framework Service specifications now consistent with updated national guidance. Re-procurement would be complete and new contracts awarded across the whole Framework by January, 2015
- The new contracts would include a single point of access and web-based data management system which would ensure all patients were triaged into the correct Service and monitored effectively
- The new School Nursing specification included targets for referrals to Children's Weight Management Services
- Improvements in the relationship between Service providers and School Nursing to enhance their skills in identifying and referring young people
- The national Policy introducing free school meals to Reception and KS1 children had increased meals served per day
- The obesity performance clinic held in May, 2014, had led to enhanced collaborative working on the wider determinants of overweight and obesity with other Council services

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

- 201314 data recently published showed that Rotherham's rates had slightly gone up

- The data was always slightly skewed due to it being a different cohort measured every year

- Public Health England had started to look at trend data averaged on a three year basis to get a better picture looking at Y1-2-3, Y2-3-4 and Y3-4-5

- Over 1,000 children had achieved weight loss through the Service

- Children were very dependent upon their parents getting them to/engaging with the Service and a full family approach was best

- The height and weight measurements were carried out during the term after Christmas up to the Summer. All the results had to be uploaded onto the national system and analysed over the Summer holidays. Due to staff resources all schools were not done at the same time

- Schools were given an indication of when the programme would be coming to them and they wrote to the parents. Should a parent not wish their child to be included they had to opt out

- There were really good levels of coverage – high 90%. The measurements were taken sensitively and people were more comfortable with it taking place now it was more well established

- Currently there was no data connection between a child's height and weight and their attainment. The information could not be passed onto another provider but discussion had taken place as to the extent to which attainment could be broken down in relation to weight in the future

- MoreLife (Carnegie, Leeds) had been the provider of Rotherham's residential summer camp. Generally all the children that stayed achieved a substantial weight loss

- The Services commissioned by Rotherham were built on the model developed by the MoreLife Programme. It was a partnership arrangement between MoreLife and Places for People, Rotherham's leisure provider

- Only children in Reception (aged 4-5) and Y6 (10-11) were measured. The proportion of children who are overweight and obese increased significantly from Reception to Y6

- It was really important that physical and active lifestyles were promoted for the whole family as the children did not have the autonomy to go to playgrounds etc. without parental input and support. It was easier to influence behaviour when the child was younger

- The Carnegie camp was set in a former boarding school where a complete controlled environment could be created for a period of 5-6 weeks. The children ate normal foods with no snacking, sweets, meals ate at the table with others. The food was calorie controlled so the children learnt what was a normal healthy meal and incorporate it into family life when back home. Parents visited and were expected to engage in the education sessions and given a lot of information

about incorporating the messages into family life when the children returned home

- This year 19 young people had gone to the camp. It cost £3,500 per child who had to be agreed between 8-17 years

- In the summer holidays Rotherham also ran intensive support for obese children within the local delivery programme

- Single point of access was important. An assessment was made and a series of questions asked during the process of registration to ascertain what services would best meet their needs

- The funding had originally come from the Rotherham Primary Care Trust. It had been passported through to the Council as part of the ringfenced Public Health grant

- Free school meals had been introduced nationally for younger children and provided a good start in early years but families needed to be aware of the eligibility criteria for when children were older to encourage take up as not all families who were eligible did so

Resolved:- (1) That a further update be submitted by the Head of Health Improvement to the Select Commission in July 2015.

(2) That the Weight Management Service providers be invited to the July, 2015, meeting to talk about their services and development plans.

(3) That further information be provided regarding Recommendation 12 from the review and the points relating to schools that were considered by CYPS Departmental Leadership Team.

(4) That information about the eligibility criteria for free school meals be circulated to the Select Commission.

64. SUPPORT FOR CARERS SCRUTINY REVIEW UPDATE

Janine Moorcroft, Neighbourhoods and Adult Services presented an update on the above joint scrutiny review which had been undertaken by the Health and Improving Lives Select Commissions.

The report highlighted the joint actions agreed by the Select Commissions and incorporated actions from the Carers Charter action plan 2013-16 and the progress made on each.

The review had acknowledged the need for the recommendations to be contained within existing resources and, in the main, there were no financial implications. Now the guidance for the Care Act had been published, the working groups established had a clear direction of what they had to achieve and would be built into the action plan. There was a

further meeting arranged with lead partners in early January to look at the budgetary workstreams in relation to the Care Act.

Discussion ensued with the following issues raised/clarified:-

- Carers assessments and care plans were only done for those carers in receipt of social care. This had been acknowledged and would be fed back to the relevant workstream officer. The Care Act guidance would be considered to ascertain what changes were needed to the Carer's Needs Form and Care Plan.

- The update for recommendation 11 focussed more on public sector partners but this would be discussed at the meeting arranged for January, 2015 including all partners.

- Discussions were taking place about Carers Corner moving to the RAIN building next year on a part-time basis, as well as the introduction of a more flexible service in all communities

- It was still a challenge to monitor changes in the numbers of carers. The question was asked at over 75's healthchecks.

- Bi-monthly carers meetings were held.

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

(2) That the incorporation of the scrutiny review actions into the wider action plan be noted.

(3) That an update be submitted in 6 months.

65. ROTHERHAM RECOVERY HUB

Malc Chiddy, Drug Intervention Programme Strategic Manager, presented a report on the above.

The Council, in partnership with Lifeline (Alcohol and Drug 'Tier 2' provider service) had been successful in securing £875,000 capital funding from Public Health England to purchase and refit suitable premises as a Rotherham Recovery Hub to support recovery from drug and alcohol dependence.

The recovery services currently commissioned from RDaSH, alongside Lifeline and other services, would be relocated to the 'Hub' which was expected to be open from April, 2015.

The capital grant scheme was made available to support the recovery focus of the coalition government. Group work, housing, employment, training and lifestyle activities would be provided in a welcoming environment away from the main clinical treatment base offering some

respite for Service users and avoiding them coming into contact constantly with other active drug users.

There had been a substantial level of interest in the funding with over 200 bids submitted. Rotherham's funding allocation had been the single largest grant agreed.

The ex-Youth Offending Service building, 'Carnson House', had been purchased with the process of planning and redevelopment already underway. It was estimated that the premises would be open for use by 1st April, 2015 and fully completed by July, 2015.

Under the funding grant, the premises were owned outright by Lifeline but were to be made available for up to 20 years to Rotherham as a Recovery Hub. After that time the premises became a Lifeline asset to use or dispose of as they saw fit, however, the 20 year timescale could be reduced at any time by the Authority giving the appropriate notice.

Discussion ensued with the following issues raised/clarified:-

- RDaSH would also be in the building

- A management group had been set up and had had its first meeting

- The Hub had to be made available for Alcohol and Drug Services in Rotherham for 20 years as a grant condition

- The building had been used by the Youth Offending Service for the past 20 years so no problems were anticipated from nearby residents and there was little concern regarding the present centres at Lifeline and Clearways.

- It was a recovery hub and not a drop-in centre – it was those during their recovery stage that would be provided support. There would be a programme of work covering debt management, employment, housing, ongoing health etc. with partners brought in to support

- Both Lifeline and RDaSH worked on recovery now and had ways of measuring such. It did not have to be total abstinence but massive steps towards it and getting their life back in order. The main subjects would be housing, training/employment and relationships which were the areas that helped with recovery

- Clients would be seen by a Clinical Worker regarding medication/injections away from the Centre – it would purely be recovery workers they saw at the Hub although the 2 workers would be in contact

- Success was measured by someone not coming back into treatment for 6 months

- Clients would be offered a 12 weeks recovery programme on a rolling basis but would not be expected to stay in the Service for more than 6 months. Exact numbers were being worked up and it was expected there would be an increase to those using services at the moment

- It would not be a 9-5 service. The building would be available for other services such as Alcoholics Anonymous and Narcotics Anonymous in the evening. It was hoped to have evening and weekend sessions but it would not be 24:7 because of staff time. The focus would be on what was best for the service users

- Assurance had been received from the Planning Service that, due to the premises' previous use for more than 10 years, planning permission was not required for change of use

Councillor Doyle, Cabinet Member for Adult Social Care and Health, stated that funding had been awarded due to the excellent innovative scheme illustrating joint work across a number of different agencies. He also reported that he would request that all relevant Ward Members were kept fully informed and involved with the scheme so they could allay any fears that arose from members of the public.

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

(2) That a visit to the premises be made once the project was up and running.

66. DATE OF NEXT MEETING

Resolved:- (1) That a special meeting be held on Thursday, 15th January, 2015, commencing at 9.30 a.m.

(2) That a further meeting be held on Thursday, 22nd January, 2015, commencing at 9.30 a.m.

HEALTH AND WELLBEING BOARD
3rd December, 2014

Present:-

Councillor Doyle	Cabinet Member, Adult Social Care and Health **In the Chair**
Councillor Beaumont	Cabinet Member, Children and Education Services
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Dr. Richard Cullen	Vice-Chair of the Strategic Clinical Executive, Rotherham Clinical Commissioning Group (representing Dr. Julie Kitlowski)
Chris Edwards	Rotherham Clinical Commissioning Group
Jason Harwin	South Yorkshire Police
Councillor Hoddinott	Deputy Leader
Joanna Saunders	Public Health
Carol Stubley	NHS England
Janet Wheatley	Voluntary Action Rotherham

Also Present:-

David Hicks	Rotherham Foundation Trust (representing Louise Barnett)
Michael Holmes	Policy and Partnerships Officer, RMBC
Ian Jerrams	RDaSH (representing Chris Bain)
Sarah McCall	Observer
Nigel Parr	Neighbourhoods and Adult Services (representing Shona McFarlane)
Chrissy Wright	Strategic Commissioning Manager, RMBC

Apologies for absence were received from Chris Bain, Louise Barnett, Naveen Judah, Dr. Julie Kitlowski, Dr. Jason Page

S43. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

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

S44. MINUTES OF PREVIOUS MEETING

Consideration was given to the minutes of the meeting held on 12th November, 2014.

Concern was expressed that the last sentence of the final paragraph of Minute No. S40 (Emotional Health and Wellbeing Strategy) did not accurately reflect the discussion that had taken place. The following amendment was suggested:-

“Some partners felt it was realistic to provide outcomes as part of their strategy at this stage”.

Resolved:- That, subject to the above amendment, the minutes of the meeting held on 12th November, 2014, be approved as a correct record.

Arising from Minute S36 (Health Action Plan), Carol Stubley, NHS England reported that the Plan being produced in relation to the CSE investigation was in draft form and had been contributed to by NHS England, Clinical Commissioning Groups and other health organisations. There would be a meeting in the next couple of weeks to review and ascertain if there were any gaps in the provision by Health. The Plan and Guidance were expected to be published by 23rd December.

Arising from Minute No.S36 (Vaccinations and Immunisations), Carol Stubley, NHS England, reported that discussions had taken place with Rotherham Foundation Trust. Unfortunately, due to the training the midwives would have to undertake, the Trust had confirmed that it was not in a position to take it forward at the current time. All women requiring vaccinations would be signposted to Primary Care.

David Hicks, Rotherham Foundation Trust, expressed his disappointment that the Trust had not been able to facilitate this but it was due to capacity and resources. It was hoped, and endeavours would be made, to implement it for the next financial year. The Head of Midwifery had given a commitment to look at it for 2015/16 as it was a real opportunity missed.

The Chair asked that the Board be kept up-to-date with any developments on this issue.

S45. COMMUNICATIONS

NHS England Organisational Alignment and Capability Programme (OACP)

Carol Stubley, NHS England, presented a letter received from Eleri de Gilbert, Director NHS England (South Yorkshire and Bassetlaw) regarding the changes to the organisation's internal structure.

The aim of the reorganisation was, across England, to reduce the number of teams from the current 27 to 12 including the London configuration and to establish 4 regional teams. For South Yorkshire that would mean a move to 1 geographic team which would encompass Yorkshire and the Humber meaning the 3 existing teams (South Yorkshire and Bassetlaw, West Yorkshire and North Yorkshire) would disappear and form into 1. The changes were internal to the NHS and, therefore, there had been internal consultation with staff. The changes would be implemented as from the beginning of 2015.

Whilst moving to 1 geographic footprint, there would still be a presence in each of the localities e.g. in Oak House for South Yorkshire and Bassetlaw.

In terms of the director functions for Yorkshire and the Humber there would be a Director of Operations and Commissioning (replacing the existing area teams – an appointment made and commencing on 5th

January, 2015), a Medical Director, Finance Director and a Nursing Director. There would be a further 3 Directors, each 1 would be locality based i.e. 1 within South Yorkshire and Bassetlaw, 1 for West Yorkshire and 1 for North Yorkshire. The structure for this area had been developed specifically taking into account the large geographic area and the fact that each of the areas had unique issues.

There may be a change in attendance at the Health and Wellbeing Board but there would be more information once the team had been established.

The Chairman stated that he personally felt that the role of a NHS England representative on the Board was invaluable.

Better Care Fund
Chris Edwards, Rotherham Clinical Commissioning Group, reported that a meeting had been held with Nick Clarke, Better Care Adviser. The submission was being revised and would be communicated to the next Board meeting.

Health and Wellbeing Website
Michael Holmes, Policy and Partnership officer, reported that the website was up and running but at some point the Board should consider developing a wider communication plan including the use of social media. There had been no feedback from partners with regard to any additions required.

The website would link to the NHS Constitution.

Crisis Care Concordat
It was noted that the Council had signed up to the Concordat as had the Clinical Commissioning Group, South Yorkshire Police and RDaSH.

RDaSH
It was reported that Chris Bain was to leave her position as Chief Executive of RDaSH.

Resolved:- That the Board's best wishes be conveyed to Chris and appreciation for her work in supporting the Board.

Child and Adolescent Mental Health Services
Scrutiny Reviews that had implications for the Board and/or partners would be circulated at the scoping stage so there was the opportunity for the Board to discuss and possibly have an input.

S46. NHS 5 YEAR FORWARD VIEW

Carol Stubley, NHS England, presented the NHS 5 Year Forward View:-

The NHS have achieved a lot
- Currently #1 healthcare system in the world
- More than 2/3 UK public believe the NHS “works well”
- Cancer survival is at its highest ever
- Operation waiting lists are down – many from 18 months to 18 weeks
- Early deaths from heart disease are down over 40%
- 160,000 more nurses, doctors and other clinicians
- Single sex wards implemented

We are delivering more care – compared with 2009 the NHS is delivering more care
- 4,000 more people are being seen in A&E each day
- 3,000 more people are being admitted to hospital each day
- 22,000 more people have outpatient appointments each day
- 10,000 more tests are performed each day
- 17,000 more people are seeing a dentist each day
- 3,000 more people are having their eyes tested each day

Demand for care is rapidly growing
- We are facing a rising burden of avoidable illness across England from unhealthy lifestyles:
  1 in 5 adults still smoke
  1/3 of people drink too much alcohol
  More than 6/10 men and 5/10 women are overweight or obese
- Furthermore:
  70% of the NHS budget is now spent on long term conditions
  People’s expectations are also changing

There are also new opportunities
- New technologies and treatments
  Improving our ability to predict, diagnose and treat disease
  Keeping people alive longer
  But resulting in more people living with long term conditions
- New ways to deliver care
  Dissolving traditional boundaries in how care is delivered
  Improving the co-ordination of care around patients
  Improving outcomes and quality
- The financial challenge remains with the gap in 2020/21 previously at £30bn by NHS England, Monitor and Independent think-tanks

The future NHS – the Forward View identifies three ‘gaps’ that must be addressed:-
- Health and Wellbeing
  Radical upgrade in prevention
  Back national action on major health risks
  Targeted prevention initiatives e.g. diabetes
  Much greater patient control
  Harnessing the ‘renewable energy’ of communities

- Care and Quality
  New models of care
  Neither 'one size fits all' nor 'thousand flowers'
  A menu of care models for local areas to consider
  Investment and flexibilities to support implementation of new care models
- Funding
  Implementation of these care models and other actions could deliver significant efficiency gains
  However, there remains an additional funding requirement for the next Government
  Need for upfront pump-priming investment

Getting serious about Prevention

- Focusing on Prevention
  Incentivise healthier individual behaviours
  Strengthen powers for local authorities
  Targeted prevention programmes starting with diabetes
  Additional support people to get and stay in employment
  Create healthier workplaces – starting with the NHS
- Empowering Patients
  Improve information: personal access to integrated records
  Investment in self-management
  Support patient choice
  Increase patient control including through Integrated Personal Commissioning (IPC)
- Engaging Communities
  Support England's 5.5m carers – particularly the vulnerable
  Supporting the development of new volunteering programmes
  Finding new ways to engage and commission the voluntary sector
  NHS reflecting local diversity as an employer

Developing new Care Models

- We need to take decisive steps to transition towards better care models
- There is wide consensus that new care models need to:-
  Manage systems (networks of care) not just organisations
  Deliver more care out of hospital
  Integrate services around the patient
  Learn faster from the best examples around the world
  Evaluate success of new models to ensure value for money
- There are already examples of where the NHS is doing elements of this
- However, cases are too few and too isolated
- The answer is not 'one size fits all' nor is it 'a thousand flowers bloom'
- We will work with local health economies to consider new options that provide a viable way forward for them and their communities

New deal for Primary Care

- Funding
  Stabilise core funding for two years and increase investment in the sector over the next Parliament
  New funding for schemes such as the Challenge Fund
  New infrastructure investment
- Commissioning
  Increase CCG influence over commission of primary care and specialised services
  New incentives to tackle inequalities
- Workforce
  Increase the number of GPs in training
  Train more community nurses and other primary care staff
  Invest in new roles, return and retention
- Public Engagement
  Building the public's understanding of pharmacies and on-line resources to reduce demand

Multi-Speciality Community Providers

- What they are
  Greater scale and scope of services that dissolve traditional boundaries between primary and secondary care
  Targeted services for registered patients with complex ongoing needs (e.g. the frail elderly or those with chronic conditions)
  Expanded primary care leadership and new ways of offering care
  Making the most of digital technologies, new skills and roles
  Greater convenience for patients
- How they could work
  Larger GP practices could bring in a wider range of skills – including hospital consultants, nurses and therapists, employed or as partners
  Shifting outpatient consultations and ambulatory care out of hospital
  Potential to own or run local community hospitals
  Delegated capitated budgets – including for Health and Social Care
  By addressing the barriers to change, enabling access to funding and maximising use of technology

Primary and Acute Care Systems

- What they are
  A new way of 'vertically' integrating services
  Single organisations providing NHS list-based GP and hospital services, together with Mental Health and Community Care Services
  In certain circumstances, an opportunity for hospitals to open their own GP surgeries with registered lists
  Could be combined with 'horizontal' integration of social and care
- How they could work
  Increased flexibility for Foundation Trusts to utilise their surpluses and investment to kick-start the expansion of Primary Care
  Contractual changes to enable hospitals to provide Primary Care Services in some circumstances

At their most radical they could take accountability for all health needs for a register list – similar to Accountable Care Organisations

Other New Care Models

- Urgent and Emergency Care Networks
  Simpler and better organised systems achieved by
  - Developing networks of linked hospitals to ensure access to specialist care
  - Ensuring 7 day access to care where it makes a clinical difference to outcomes
  - Proper funding and integration of Mental Health Crisis Services
  - Strengthening clinical triage and advice
- Specialised Care
  Consolidating services where there is good evidence that greater patient volumes lead to greater quality
  Working with a smaller group of lead providers willing to take responsibility for developing geographical networks of specialised and non-specialised care
  Moving towards specialised centres of excellence for rare diseases
- Viable Smaller Hospitals
  Help sustain local hospital services where:
  - They are the best clinical solutions
  - They are affordable
  - They have commissioner support
  - They have local community support
  - Consider adjustments to payment mechanisms
  - Explore new staffing models
  - New organisation model including sharing management across sites, satellite provision on smaller sites and Primary and Acute Care systems
- Modern Maternity Services
  Explore how to improve our current services and increase choice by:
  - Commissioning a review of future maternity units for Summer 2015
  - Ensure funding supports choice
  - Make it easier for midwives to set up services
- Enhanced Health in Care Homes
  Developing new models of in-reach support and services by:
  - Working in partnership with Social Services and care homes
  - Building on existing success

Implementing new Care Models

- To deliver new care models we need a new type of partnership between national bodies and local leaders
- Working with local communities and leaders, NHS national bodies will jointly develop:
  Detailed prototyping of new care models
  A shared methodology for assessing the characteristics of health economies

National and regional expertise and support for implementation at pace
National flexibilities in current regulatory, funding and pricing regimes
A new investment model to help 'pump prime' and fast track the new care models

Delivering Innovation and Change
To deliver the scale and pace of change required we will also take steps to

- Align NHS Leadership
- Develop a modern workforce
- Exploit the Information Revolution
- Accelerate innovation

Efficiency and Funding

- It has previously been calculated that the NHS faces a gap between expected demand and funding of -£30bn by 2020/21
- To address this gap we will need to take action on 3 fronts: demand, efficiency and funding. Less impact on any 1 of these will require compensating action on the other 2
- Delivery of the more active demand and prevention activities outlined in the Forward View would deliver in the short (e.g. prevention of alcohol harm) and medium term (e.g. action on diabetes)
- The long run efficiency performance of the NHS has been -0.8% annually. We have achieved nearer 2% more recently although this has been based on some actions that are not indefinitely repeatable e.g. pay restraint
- However, with upfront investment and implementation of new care models, we believe that we could achieve 2% rising to 3% over the next Parliament
- Combined with an increase in funding equivalent to flat-real per person (e.g. adjusted for population growth and age) - about £8bn more – would close the gap

Next Steps

- NHS England is now embarking on work with other NHS national bodies and wider stakeholders to implement the commitments in the Forward View

Discussion ensued with the following issues raised/clarified:-

- People were living longer but an increasing number of people with long term conditions
- Ever increasing number of people that needed access to services because of lifestyle factors e.g. alcohol, obesity, lack of exercise
- Culture of change required and for people to take more responsibility for their personal health and lifestyle choice
- Need to be more innovative and creative in terms of creating care models locally reflecting the needs of the local population

- Still expectation that will deliver 3% savings every year for the next 5 years whilst recognising need for upfront investment and double running costs to be incurred
- £8Bn expected funding gap identified
- 2015/16 was the first year of the Plan – guidance would be published by NHS England on 23rd December
- Difference in opinion as to whether the changes to the funding formula was thought to have a negative effect for Rotherham
- Funding and framework was required to allow patients to be empowered to make their own choices and self-management as well as the vulnerable members of society requiring advocates to access the services
- Although the document was welcomed, the CCG was concerned about the risk to Rotherham with regard to the new formula

Resolved:- That the report be noted.

S47. CARE ACT 2014

Nigel Parr, Professional Standards and Development Service Manager, gave the following powerpoint presentation:-

Care Act 2014

- Received Royal Assent on 14th May, 2014
- The Act was in 3 parts – Care and Support, Care Standards and Health
- Part 1 of the Act consolidated and modernised the framework of care and support law with new duties for local authorities and new rights for Service users and carers
- It replaced many previous laws e.g. Chronically Sick and Disabled Person Act 1970, Community Care (Direct Payments) Act 1996

What is the Act trying to achieve?

- That care and support
  Is clearer and fairer
  Promotes people's wellbeing
  Enables people to prevent and delay the need for care and support and carers to maintain their caring role
  Puts people in control of their lives so they can pursue opportunities to realise their potential

An integrated Act

- Different sections of the Act are designed to work together
- Local authority wide
- Overlap with Children and Families including transitions
- Partnerships and integration
- Leadership

Framework of the Act and its Statutory Guidance

- Underpinning principle
  Wellbeing
- General responsibilities and key duties
  Prevention
  Integration, partnerships and transitions
  Information, advice and advocacy
  Diversity of provision and market oversight
  Safeguarding
- Key processes
  Assessment eligibility
  Charging and financial assessment
  Care and support planning
  Personal budgets and direct payments
  Review

The Wellbeing Principle

- Wellbeing broadly defined 9 areas in particular
- Local authorities should also have regard to other key principles when carrying out their activities such as beginning with the assumption that the individual is best-placed to judge their wellbeing

New Responsibilities of Local Authorities towards all Local People

- Arranging services or taking other steps to prevent, reduce or delay peoples' needs for care and support
- Provision of information and advice including independent financial advice
- Promoting diversity and quality in the market of care providers so that there are services/supports for people to choose from

New Duties – Integration and Market Oversight

- A statutory requirement to collaborate and co-operate with other public authorities including duty to promote integration with NHS and other services
- Duty for local authorities to step in to ensure that no-one is left without the care they need if their service closes because of business failure
- Care Quality Commission oversight of financial health of providers most difficult to replace were they fo fail and to provide assistance to local authorities if providers do fail

New duties – Advocacy, Safeguarding and Transitions

- A duty to arrange independent advocacy if a person would otherwise be unable to participate in or understand the care and support system
- New statutory framework for protecting adults from neglect and abuse. Duty on local authorities to investigate suspected abuse or neglect, past or present, experienced by adults still living and deceased

- Duty to assess young people and their carers in advance of transition from Children's to Adult Services where likely to need care and support as an adult

What might this mean for People needing Care and Support?

- Better access to information and advice, preventative services and assessment of need
- An entitlement to care and support
- A cap on care expenditure which an individual is liable for comes into effect from April, 2016
- A common system across the country:
  Continuity of care
  Fair Access to Care Services replaced by a national eligibility threshold

How will people experience the new system in 2016/17?

- If you have care and support needs you could be supported by
  Assessment of the care and support you need and eligibility for state support
  Information and advice on local services and how much they cost
  Reablement, rehabilitation and other free services
  Support from family networks community
- How much you might pay for your care and support depends on your financial situation
  You have a financial assessment to see what you have to pay
- Costs are capped
  There is a cap on expenditure on eligible care from April, 2016
- Every year the local authority
  Reviews your care needs and financial situation
  Keeps a record from April, 2016, a care account, how much eligible care you have needed in total

What does this mean for Carers?

- The Care Act strengthens the rights and recognition of carers:
  Improved access to information and advocacy should make it easier for carers to access support and plan for their future needs
  The emphasis on prevention will mean that carers should receive support early on and before reaching crisis point
  Adults and carers have the same rights to an assessment on the appearance of needs
  A local authority must meet eligible needs of carers and prepare a support plan
  A carer should be kept informed of the care and support plan of the person they care for
- Children and Families Act 2014

What might this mean for Local Authorities?

- New duties and responsibilities
- Changes to local systems and processes

- More assessments and support plans
- Responsibilities towards all local people
- Better understanding of self-funders and the care market needed
- Training and development of the workforce
- Costs of reforms
- Preparation or reforms needed

What might this mean for Local Authority Partners and Care Organisations?

- NHS, Housing and Children's Services share the duty to integrate
- Partners and providers will find:
  They may need to respond to the wellbeing principle
  Greater local authority focus on promoting diversity and quality in the market and market intelligence about self-funders needed
  Greater local authority involvement in services focussed on prevention and delay
  National, not local, eligibility criteria
  New statutory Safeguarding arrangements

Summary

- A significant piece of legislation that modernises the framework of care and support law bringing in new duties for local authorities and for Service users and carers
- It aims to make care and support clearer and fairer and to put people's wellbeing at the centre of decisions and embed and extend personalisation
- Local authorities have new responsibilities towards all local people including self-funders
- There are significant changes to the way that people will access the care and support system

Discussion ensued with the following issues raised/highlighted:-

- The Act came into force as from 1st April, 2015
- National eligibility criteria as from April, 2016
- Anticipated additional 5,357 requests for a care assessment in Rotherham as the eligibility criteria was reduced
- Local Authority would have to look on a case-by-case basis to ascertain eligibility
- Engagement with local resources/voluntary and community sector to work in partnership to support the needs of the community at a far greater level than present
- Belief that self-funders that will present themselves/eligible for support would be in the region of 667
- In 2015/16 Rotherham would see an increase in costs of £727,000 in terms of assessments and financial support
- Routine workforce meetings as well as the Association of Directors of Adult Social Services looking at the implementation of the Act to ensure continuity across the region

- A large amount of the Act was desperately needed but there were also great concerns regarding the equity of resources
- A lot of people would be caught by the changing of the cap to £100,000 given the average house price in Rotherham
- The rationale was set against a background of year-on-year budget cuts and greater increase in the population
- Consultation would commence shortly with the voluntary and community sector, however, the eligibility criteria had only recently been released and officers were working through what the implications would be
- Discussions had started with the Police regarding vulnerable persons and the processes required
- Innovative means of communicating the information to the public were being worked up
- Training would involve legal advisors and be accessible to partners and the voluntary and community sector
- It was anticipated that the forthcoming grant would not be sufficient to meet the additional burden

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

(2) That a schedule of the training events be submitted to the next meeting.

S48. COMMISSIONING FRAMEWORK

Chrissy Wright, Strategic Commissioning Manager, submitted a Commissioning Framework for the Board's consideration.

In order to continuously improve the quality of commissioning across the Council, the document had been developed to provide a framework for commissioning to ensure a consistent high quality commissioning activity in line with national good practice, outcome focussed and met the needs of the citizens and the Council.

The Framework set out a definition of commissioning, the commissioning principles and the legal requirements. It was hoped that the Framework would be agreed by the appropriate bodies including the Board and the Leader of the Council as a public document.

The Framework set out the required commissioning approach particularly with respect to the Council's Standing Orders, Financial Regulations, legislation and equality and diversity.

It was noted that the Framework corresponded with the Health and Wellbeing Strategy and Joint Strategic Needs Assessment.

The document would be refreshed to take account of the Jay report, Corporate Governance and Ofsted recommendations.

Chris Edwards, Rotherham Clinical Commissioning Group, stated that Health carried out Quality Impact Assessments of their strategies and would be willing to share their working practices.

It was noted that comments had been received from the voluntary and community sector which would be collated and forwarded to Chrissy.

Resolved:- (1) That the Commissioning Framework be noted.

(2) That the final document be submitted to future Board meetings.

S49. HEALTH AND WELLBEING STRATEGY REFRESH

Michael Holmes, Policy and Partnerships Officer, submitted a proposed reporting timetable that would enable the Board to review progress to date against its 6 strategic outcomes and locally determined priorities as part of the Health and Wellbeing Strategy refresh and discuss priority areas for the updated Strategy.

It was proposed that reports be submitted on 3 priority areas at the next 4 Board meetings (January to June) with members considering:-

- What progress had been made and what factors had prevented further progress?
- Could tangible achievements be identified?
- Was this still a priority and why?

At the end of this process a workshop, either at the June meeting or separately arranged, could focus on the refresh considering outcomes from the Board sessions as well as other relevant issues and potential priority areas.

The Health and Wellbeing Steering Group would support priority leads helping them to prepare for the Board sessions. From May, 2015, it was proposed that a task and finish group be established to work on the refresh.

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

- Work of the workstreams had been delayed due to recent pressures on time and resources
- The refresh would miss the current Clinical Commissioning Group round but would be considered in September/October
- The aim would be to have 1 plan for Rotherham including all partners' strategies but would need clarity on governance and accountability
- Needed to take account of the Jay report, Ofsted and Corporate Governance Inspection
- Need to ensure that the actions of the Improvement Board and Children's Improvement Board were clear and no duplication of work

Resolved:- That the proposed approach and timetable for the refresh of the Health and Wellbeing Strategy be noted.

S50. ANY OTHER BUSINESS

A&E

There had been recent media attention surrounding the capacity of A&E. A&E had been pressured together with staff shortages at key levels in the organisation.

The methodology used in the past had been the Intensive Support Team which had been really positive and used as a beacon at national conference. However, that now had to become normal practice which the impending Winter Plans did state.

Rotherham's A&E had performed at 95% in the last 2 quarters; the latest performance was just under that figure. The next few months were very dependent upon the weather and issues that the Trust could not control. The Resilience Board regularly discussed this issue.

The long term solution would be the proposed Emergency Care Centre.

South Yorkshire Ambulance Service

There had also been issues recently with regard to ambulance response times and instances when the Police had been called upon to transport members of the public to the hospital.

The Service was currently operating at reasonable levels. Doncaster was operating at 93% patients seen within 4 hours, Sheffield at 94.6%, Rotherham at 94.8% and Barnsley 98%. Rotherham was only 0.2% below what was considered to be good performance nationally. The pressure on emergency services was at a critical level.

Nevertheless, performance levels experienced currently were not acceptable and Rotherham and Barnsley particularly disadvantaged for Model A Response Target (response within 8 minutes). Last month Rotherham had operated at 65% of patients against a target of 75%.

There was very little scope as it was a legal requirement to contract with South Yorkshire Ambulance Service so it could not be market tested. The Good Governance Institute had conducted a review which had only given a partial reassurance and an action plan had been drawn up.

Walk-in Centre

Anecdotal evidence suggested that the Centre was frequently being closed on an evening to patients unless they were children or had life threatening conditions; members of the public were being sent to the A&E.

Resolved:- That Chris Edwards submit an update on all the above issues to the next meeting.

S51. DATE OF NEXT MEETING

Resolved:- That a meeting of the Health and Wellbeing Board be held on Wednesday, 21st January, 2015, commencing at 11.00 a.m. in the Rotherham Town Hall.

Notes from meeting 24 November 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 Ken Wyatt, Chair and Cllr Stuart Sansome, Vice Chair

Notes: Janet Spurling, Scrutiny 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. Notes from the previous meetings formed the basis for this discussion and update on progress to date.

Discussion points

Management - changed roles are in place for the executive team and the CX now receives more line reports (to improve financial information). There are four statutory roles and recruitment is underway to fill the last of these – permanent Medical Director (Dr David Hicks is acting). Simon Sheppard is the new Finance Director, Chris Holt Chief Operating Officer and Lynne Waters HR Director. Joe Barnes is Non-Executive lead of Audit.

Monitor/Finance – Hospital trusts have to apply to have enforcements lifted and the application is ready to go to Monitor to have the enforcement on governance lifted. TRFT received good feedback at a meeting with Monitor last week and is on target to deliver the plan. Although the CIP will be a challenge they expect to deliver the targets and surplus.

CQC Risk/Intelligent Monitoring rating – The latest CQC report is due on 3 December and the rating is expected to improve and hopefully to return from 2 to 4 (lower risk) by the year end when some of the issues around historical data are no longer a factor.

CQC inspection – acute and community services will be inspected by CQC in February.

Winter plans – funding in place

Care and Safety issues – 17 cases of c.dificile to date this year, all unavoidable and no lapses in care.

Targets - 4-hour A&E performance is just below the national 95% target at 94.7%. TRFT has seen a large increase in numbers in the last few weeks, an increase in acuity and more pressure on other non-elective admissions. TRFT remain confident they can improve and meet the target again. Daily average is approx. 220 patients in A&E. The small triage room is also a constraint. Some longer waits can be due to waiting to be admitted to a ward.

Emergency Centre – TRFT board has approved this but there are some extra processes to go through with Monitor because of the breach and Board certification will be approved next month.

There is a delay to the original timescale as there is a gas pipe to be moved on site (which will be funded by the CCG) and TRFT is in discussion with the National Grid about this. The matter is further complicated by the fact that services will still be delivered from the site whilst the building work takes place. TRFT are also looking at what services might move to the current Walk In Centre when the new centre opens.

Working Together – as TRFT chose option 1 the intention is to maintain as many services as possible with patients receiving the services they would expect, but also collaborating with other trusts as in present arrangements with Barnsley and Doncaster.

Specialty reviews – proceeding to schedule to be completed by the end of December. An extra stage has been added to the process following the initial pilot. The review outcomes will feed in to the next two- and five-year plans.

Minor oral surgery – HSC had responded to the consultation by NHSE and asked about the impact on the hospital.

Finance Director is co-ordinating possible tenders and the TRFT position.

Staffing – still nursing vacancies so will go ahead with overseas recruitment. Some roles have been restructured to a higher band with greater responsibility. Staff turnover has reduced further. It is positive to have the new HR Director in post but still early days.

Sickness absence management – sickness absence is high and is a priority as it increases costs through use of bank and agency staff. A campaign is under way and managers are encouraged to take ownership in their teams and to manage the issue in a supportive manner. Aim is to reduce to 3% as elsewhere in the country. TRFT had been commended for their approach to the industrial action that has taken place earlier that day.

Various measures would show if absence was impacting on care quality – Friends and Family test, no. of serious incidents, complaints, patient experience, clinical effectiveness.

Child sexual exploitation – it was noted that the Jay Report had made little direct reference to health services. Intelligence from health partners was raised as being important to tackle this issue.

TRFT response to the report includes working with partners and looking internally to ensure staff come forward with any information, issues or concerns (acute and community). The Chief Nurse is the lead and works with the Safeguarding Board. “Stop the Shift” training to ensure staff report any concerns. Comparisons were drawn with concerns and evidence regarding domestic abuse.

Benchmarking – the benchmarking exercise to review overall costs at TRFT and compare them with peer organisations is going well, carried out by a company called Channel 3. Their final report will include assessing opportunities for cost efficiencies. There are no surprises with regard to the findings e.g. cancelled appointments, analysis of beds taken up when people are fit for discharge (c/f scrutiny review).

Partnership working post Monitor intervention – taking it forward with genuine buy-in to maintain it. Collaboration with partners takes place both within the NHS and outside. There are links between both staff satisfaction and patient experience and between staff satisfaction and finances.

Five strategic objectives – very clear that patients are first.

Effective performance management in such a large organisation – on a journey with several levels of performance reporting from board level (balanced score card, quadrant and process indicators) and monthly performance meetings in the four directorates (dashboards). Diagnostics meet each department and go through issues/indicators ahead of the other meetings.

TRFT felt it needed to be simpler and better coordinated allowing for innovation within a structured framework, such as less time wasted, new procedures or using new technologies, either medical or IT.

Staff suggestions (opportunities for ideas/rewards) – TRFT do get ideas in from staff but this could be more structured. They could perhaps explore a "Dragon's Den" approach where services bid for funding to pump prime an initiative to further invigorate spend to save and innovate where appropriate. Bulletins with positive stories with regard to the CIP are in their infancy.

Staff appraisals – 86% completion to date.

Relations with GPs – varies as some practices are better at working with them than others. Community transformation programme underway (HSC agenda item in January).

Agreed actions:

1 TRFT to send latest information on progress of specialty reviews to the HSC Chair and Vice Chair:

2 For the next meeting HSC Chair and Vice Chair to identify key information they would like TRFT to present at the HSC meeting on 22 January.

Date and time of next meeting:

Wednesday 14 January 2:00pm at TRFT

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**22 January 2015**
3.	**Title:**	**Special Schools Nursing Service**
4.	**Directorate:**	**The Rotherham NHS Foundation Trust**

5. Summary

The report provides Members with an overview of the Special Schools Nursing Service in Rotherham which provides holistic nursing care for children and young people with additional health needs, enabling them to access education.

6. Recommendation

That Members:

- **Note the contents of the report and the services provided for children and young people with specific health needs.**

7. Proposals and Details

The Health Select Commission identified information on the Special Schools Nursing Service as part of its work programme for 2014-15. This follows up a presentation about the revised specification for the mainstream School Nursing Service. Appendix 1 provides an overview of the current service in Rotherham and illustrates the differences and commonalities with the mainstream service. The report covers the following areas:

- Team composition and location
- Role of the Special School Nurse
- Training
- Safeguarding
- Education and health care plans

8. Finance

No direct financial implications from this report.

9. Risks and Uncertainties

The caseload of the team and the health needs of the children and young people accessing the service will vary over time as different cohorts enter and leave education.

10. Policy and Performance Agenda Implications

Individual education and health care plans aim to maximize the child's educational experience and to provide adequate preparation for responses to urgent situations.

11. Background Papers and Consultation

None

Contact Name:

Juliette Penney, Clinical Services Manager, Children & Young People Services
The Rotherham NHS Foundation Trust
Juliette.Penney@rothgen.nhs.uk

Appendix 1

Report for Health Select Commission

Special School Nursing Service

The special school nursing service is jointly commissioned by Public Health which is now part of RMBC. The health education element is commissioned separately and funded by schools. Special school nurses provide holistic and focused nursing care for children and young people, with additional health needs, in order that they may access education in school or early years setting.

Team Composition

Band 6 = 1.6WTE
Band 5 = 1.9

The team consists of a mixture of children's trained and learning disability trained nurses. This variety is essential in order to meet the needs of the children and young people with additional health needs.

The team currently service 6 schools:

- Abbey
- Hilltop
- Kelford
- Milton
- Newman
- Willows

In addition to these schools the team work with all other RMBC schools where children attend who have additional health needs requiring care plans. At present there are 50 of these which are active.

Role

The school nurse has a unique role in the provision of school health services for children with special health needs, including children with chronic illnesses and disabilities of various degrees of severity. These children are included in the regular school classroom setting. The school nurse will assess the student's health status, identify health problems that may create a barrier to educational progress, and develop a health care plan for management of the problems in the school setting. The school nurse ensures that the child's individual health care plan is developed and implemented with the participation of school and the main carers, to ensure the child's needs are met. The school nurse's participation in the health care plan development heightens the potential for achieving the goals of the plan, which are to maximize the

child's educational experience and to provide adequate preparation for responses to urgent situations.

Dialogue with subspecialists, and other staff, can add important information. The school nurse will provide safe and effective services or facilitate the performance of special health care procedures, such as tracheostomy care, suctioning, Epipen training and nasogastric tube feeding etc.

The team works with social care and contributes to effective planning for those children requiring a safeguarding or child in need plan. Health assessments and attendance at meetings are also completed for those children who are 'Looked After'. The team works collaboratively with other agencies and health professionals and will offer sign posting for parents to ensure the child's needs are met.

Service Provision differs from mainstream school nursing service and includes

- Completion of and updating care plans
- Contributing to medical assessments
- Home Visits to meet parents and child prior to attending school
- Contribute to complex health assessments
- Work collaboratively with parents and other health professionals
- Liaison with SEN panel to identify children with additional health needs earlier in order to provide early support.
- Contribute to safeguarding, child in need and looked after children plans.
- Attend open days and highlight the service.
- Advice and support schools in ensuring the child's needs are met safely whilst accessing the education setting

The team also provides services that mainstream school nursing provide including immunisations, drop in clinics, health assessments and assessment of growth.

Training delivered

- Monthly Epipen training for new staff, as well as yearly updates
- Gastrostomy training
- Suction training
- Tracheostomy care
- Adrenal insufficiency training
- Medication training

Once the training has been delivered the staffs are required to assess and sign off the named individual ensuring they are competent to deliver the task they have been trained for. Training is delivered to staff for the benefit of the child in the educational setting they attend. This could be in an early years setting, primary or secondary school.

Safeguarding Role

The team members must ensure they maintain their skills in managing safeguarding cases and are required to ensure their training is up to date. Individual supervision is given by a specialist nurse from the safeguarding team to support practitioners. Collaborative working with schools and colleagues in children services is the main route for identification of those children who are deemed to be vulnerable and need social care intervention and support. If a member of the special school nursing team identifies a vulnerable child who is deemed to be at risk, they will follow The Rotherham NHS Foundation Trust safeguarding procedures.

If a child is identified as being sexually exploited again The Rotherham NHS Foundation Trust safeguarding procedures would be followed as well as making contact with the children's advocate and appropriate agencies.

Future

With the advent of Education and Health Care Plans this team of nurses will be well placed to contribute and become involved with the formation of Rotherham's EHC plans. They will be able to contribute and support parents in ensuring the plan meets the needs of the child and family.

The AAP recommends and supports the continued strong partnership among school nurses, other school health personnel, and pediatricians. These partners should work together closely to promote the health of children and youth by facilitating the development of a comprehensive school health program, ensuring a medical home for each child,[8] and integrating health, education, and social services for children at the community level.

Committee on School Health, 2001–2002