You are hereby summoned to a meeting of the Health Select Commission to be held on:-

Date:-	**Thursday, 22nd October, 2015**	**Venue:-**	**Town Hall, Moorgate Street, Rotherham S60 2TH**
Time:-	**3.00 p.m.**		

HEALTH SELECT COMMISSION AGENDA

1. To consider whether the press and public should be excluded from the meeting during consideration of any part of the agenda.

2. To consider any item which the Chairman is of the opinion should be considered 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 - 17)

For Discussion

8. Annual Review of NHS Rotherham Clinical Commissioning Group's Commissioning Plan (Pages 18 - 36)
   Ian Atkinson, Deputy Chief Officer Rotherham CCG and Lydia George, Planning and Assurance Manager Rotherham CCG to present

9. Interim GP Strategy (Pages 37 - 60)
   Jacqui Tuffnell, Head of Co-commissioning, Rotherham CCG, to present

10. Access to GPs Scrutiny Review - Health and Wellbeing Board Response (Pages 61 - 66)
    Michael Holmes, Policy Officer, to present

For Information/Discussion

11. Adult Social Care in Rotherham - A Vision and Strategy (Pages 67 - 72)
Graeme Betts, Interim Director Adult Services, to report

12. Healthwatch Rotherham - Issues

13. Date of Future Meetings

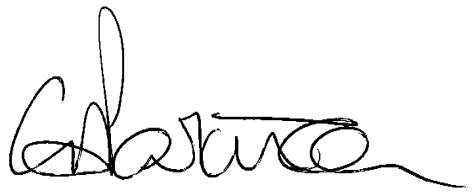
Thursday,	22nd October	3.00 p.m.
	3rd December	9.30 a.m.
	17th December	9.30 a.m.
	21st January, 2016	3.00 p.m.
	17th March	9.30 a.m.
	14th April	9.30 a.m.

Membership:

Councillors Sansome (Chair), Mallinder (Vice-Chair), Ahmed, Alam, Burton, Elliot, Evans, Fleming, Godfrey, Hunter, Khan, Parker, Price, Reeder, Rose, Rushforth, Smith and M. Vines.

Co-opted Members:

Vicky Farnsworth and Robert Parkin (Rotherham Speak Up), Peter Scholey and Russell Wells.



CATHERINE A. PARKINSON,
Interim Director of Legal and Democratic Services.

HEALTH SELECT COMMISSION
24th September, 2015

Present:- Councillor Sansome (in the Chair); Councillors Elliot, Fleming, Godfrey, Mallinder, Parker, John Turner and M. Vines, Vicky Farnsworth and Robert Parkin (Rotherham Speakup)

Apologies for absence were received from Councillors Ahmed, Alam, Burton, Hunter, Khan, Price, Rose and Rushforth.

26. DECLARATIONS OF INTEREST

Councillor Fleming made a Declaration of Interest in that he was an employee of Sheffield Hospital Trust. As the Declaration was of a personal (and not prejudicial) nature, Councillor Fleming remained in the meeting and spoke and voted on the items.

27. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no members of the press and public present.

28. COMMUNICATIONS

(1) Yellow Cards
The Chairman reminded Members that they should raise the yellow card if they required clarification on any issue/terminology used.

(2) Joint Health and Overview Scrutiny Committee
It was expected that a meeting would be held in October, 2015, on the issue of Congenital Heart Disease Services

(3) Treeton GP Practice
The Rotherham Clinical Commissioning Group had met with NHS Property Services at the beginning of August and, in conjunction with NHS England, an options appraisal for the Treeton/Waverley site had been submitted to the Primary Care Sub-Committee on 23rd September. Jacqui Tuffnell was to attend the next meeting of the Select Commission and would update on the outcome of the meeting.

(3) RDaSH
The Trust was to hold its third workshop on 25th September at the Unity Centre from 1.30 p.m.-3.30 p.m. to involve local people and partners in plans to transform Adult Mental Health Services across the Borough. RDaSH was particularly interested in hearing from those with direct experience of their Services including family members and carers.

(4) Terri Roche, Director of Public Health
Terri introduced herself to the Select Commission. She had been in post since 29th June, 2015.

Public Health had a statutory responsibility to protect the health of the public and improve the public's health. The Department was organised into 3 domains:-

Health Care Public Health – work to ensure the Health Services worked with health providers to ensure they were the best they could be and ensured they reached the right people in the right ways to address inequalities;
Health Protect – emergency planning – not to deliver the services but to hold other organisations to account and ensure things happened e.g. working with NHSE to make sure Rotherham residents were taking advantage of preventative measures to make sure they lived a long and healthy life
Health Promotion/Education – work in partnership to ensure Rotherham residents had all the information they needed to make healthy choices

29. MINUTES OF MEETING HELD ON 9TH JULY, 2015

Resolved:- That the minutes of the previous meeting of the Health Select Commission held on 9th July, 2015, be agreed as a correct record.

Arising from Minute No. 15(5) (Access to GPs and RDaSH CAMHS Reviews), it was noted that the CAMHS response would be submitted to Commissioner Newsam's 13th October meeting.

Arising from Minute No. 17 (Health and Wellbeing Board – Scrutiny Review of Access to GPs), it was noted that the outstanding part of the response in relation to the recommendations specific for the Health and Wellbeing Board had been discussed and an update would be submitted to the next meeting. Jacqui Tuffnell would be presenting the final Interim GP Strategy to the October Select Commission meeting which would address many of the points raised in the Scrutiny Review particularly GPs and practice workforce issues given the national media coverage regarding the shortage of GPs.

Arising from Minute No. 19 (Hospital Discharges), it was noted that the Quarters 1 and 2 data would be available shortly. Councillor Fleming also raised that he had asked for information relating to pressure ulcers.

Arising from Minute No. 21 (Health and Wellbeing Strategy), it was noted that the Commission had had the opportunity to comment on the draft Strategy. The final version would be submitted to the October Select Commission. It was evident that there was greater emphasis on mental health.

Arising from Minute No. (Provisional Sub-Groups for Quality Accounts), it was noted that the final sub-group memberships had now been confirmed.

30. BETTER CARE FUND

Lynda Bowen, Dominic Blaydon, Kathryn Rawlings and Sarah Whittle gave the following presentations on the Better Care Fund and potential developments from the recent Service review.

Lynda Bowen gave the following overview presentation of the Better Care Fund:-

Better Care Fund Overview
- Plan agreed by NHS England in January, 2015
- Formalised in a Section 75 Partnership Framework Agreement in April, 2015
- Strengthened governance

What does the BCF Plan aim to achieve?
- Better patient/customer experience
- Integrated service provision – seamless services
- More effective provision
- Fewer admissions to permanent care and unplanned emergency hospital admissions
- Shorter lengths of stay in hospital
- Effective reablement

BCF Metrics
- Reduction in non-elective admissions
- Permanent admissions of older people to care homes
- Delayed transfer of care from hospital
- Number of older people at home 91 days after discharge from hospital into rehabilitation

Governance
- Health and Wellbeing Board
- Strategic Vision
- Strategic Executive
- Operational Executive

Current BCF
- Complex Plan
- 72 lines of funding
- 16 workstreams
- 2 pooled funds
- Mixture of new and existing services
- Fragmented data collection
- Fragmented reporting lines
- Potential overlap/gaps in provision

Review of Workstream 13
First review of this workstream showed:-
- Lack of clarity
- Historic grants/funding lines
- Segments of Services funded from other budgets
- Diverse reporting and governance
- Overlap with separate funding areas

Service Review Methodology:-
72 funding streams each reviewed to identify:-
- Strategic relevance
- Areas for merging funding
- Areas for reallocating funding
- Services receiving funding from outside BCF
- Services that required detailed review

Outcomes from the Service Review
- Directory of Services
- Simplified structure for BCF
- Clear measures for metrics
- Revised governance for BCF services
- Recommendations for integrating BCF governance
- Recommendations for future integration and joint commissioning

Key drivers for the new BCF Plan
- Improving services for people of Rotherham
- Complementing transformational change underway in Social Care and with secondary and community health providers
- Integration with Children's Services
- Framed by:-
  Role and requirements of NHS England and Better Care Fund Team
  Ability to impact on metrics and meet performance targets

Discussion ensued on this part of the presentation with the following issues raised and clarified:-

- The 72 lines of funding was a narrative which stated where the Fund would make a difference to the Services that would be funded but there was no project plan as such for each of them. They were aggregated up to a project view for each of the workstreams. It was acknowledged that it was far too complicated but it had served a purpose. The BCF had had to be put together very quickly in the beginning so a pragmatic approach had been taken of what there was, what met the criteria and transferred into a plan

- The way that the metrics were measured was not entirely consistent with the preferred reporting that the CCG used and with CQUINS

- In response to the recent Government announcement in relation to domiciliary care and that providers needed to spend a minimum of at least 30 minutes with service users in their own home, Rotherham's providers did not make 15 minutes calls

- The Strategic Vision Group consisted of Commissioner Manzie, Julie Kitlowski, Chris Edwards, Graeme Betts, Sam Newton, Dominic Blaydon and Linda Bowden. The Group had had its first meeting and discussed ideas which involved the customer perspective and working with providers was an absolute part of the future work. There had been the realisation that the potential in Rotherham was enormous and there was the desire to roll it out. Providers themselves were having discussions about future transformation and had their own ideas about the future. There would be opportunities for other providers to join in that thinking

- There was an awareness that the current BCF did not reflect the whole change agenda and that it had been a pragmatic approach adopted at the time to meet the deadline. Although there was some fantastic work taking place, BCF was not the only change agenda and that was where the Vision Group came in so there was 1 Rotherham vision. There had been a fantastic approach from the voluntary sector who were keen to work with the smaller groups to help them through the change agenda as well as the bigger groups

- There had been no indication of what would happen to the Fund in 2016. It had been the pattern that any information was received at very short notice. Current funding was until the end of 2015 with no guidance on what would happen beyond that date. The services would not stop because there were other ways that could be considered for funding. The Comprehensive Spending Review for the next 3 years was due soon and had previously influenced how the BCF was structured

- Improvement outcomes were measured differently due to the different types of reablement. There was a keenness not to see customers receive reablement early on as a service until they were really in need of it. This was to ascertain how effective the service was at giving the customer confidence, independence and motivation. An ultimate measure was if reablement had kept people at home rather than going back into hospital or into permanent care

- The % of re-admissions to hospital following discharge would be supplied after the meeting
  (TRFT supplied the following data at the end of the meeting:

  - *July – 11.88% patients admitted as an emergency within 28 days of discharge following an emergency admission.*

- *July – 4.6% patients admitted as an emergency within 28 days of discharge following a planned admission)*

- It was not known if the Sheffield City Region would potentially have an effect on BCF. There were some services that overlapped into Sheffield for example the shared Advocacy Services. Discussions did take place with other regions within Yorkshire and the Humber and Sheffield about what they were doing and how they were combining services. What was missing currently were any links to any of the other employment/opportunities that the Sheffield City Region was offering

- Reporting was fragmented due to some projects/services already being in existence prior to BCF; they had their own way of assessing success which did not necessarily correlate with the way the Government BCF outcomes were to be reported as well as some using different reporting routes. Some reported to the Health-led groups e.g. System Resilience Groups, some to the BCF Operations Group and other to the Adults Development Board. It needed to be simple and clear. It was the intention to make a better service for the people in Rotherham and it was known that the patient journey was not always as smooth as it could be. Good work was also taking place outside the BCF

- Children's Services was another area considering moving to an ageless service and it did feel the transition from Children's to Adults was not as smooth as it should be, especially for Mental Health. The integration would be looked at very carefully

- Those Services that had integrated had done so with some success due to working in a slightly different way, talking about where one service stopped and another service started and whether they could be done differently. There were a number of learning points the biggest one of which was talking to Service users, voluntary and community agencies and not one Service trying to do things on their own in silos

- Primary Care was part of the BCF and the Chair of the CCG was herself a GP so there was a very direct link with Primary Care and engagement with the BCF. This was very helpful when looking at the delivery of the Services within the BCF at Primary Care level, talking to GPs, getting Social Workers into GP surgeries, risk strategies in GPs etc.

- There was a Performance for Payment element within BCF. If the targets were not met for non-elective/non-planned admissions it would mean a degree of the funding would be withheld and could not be used to distribute to the projects. However, this did not put projects at risk as there was a Risk Fund - it made no sense at all to plan to fail

- The Care Co-ordination Centre did not need to change as it was doing a good job. There was a separate workstream outside of the BCF which was looking at the customer journey from start to finish to ascertain the best way for those using the Service to get those Services in a simple and clear manner. Like all Services and customer journeys, the Care Co-ordination Centre role and function would be reviewed to check if it could be done in a different way/resourced differently

- Carers, the offer and strategy, and the Carers Emergency Scheme had a renewed focus. It was working well if you knew it was there and that was one of the problems – how did members of the public know they were carers and how to get the help to them. A Carer held a card and attempts were being made to flag that through to GP practices; some practices had a red flag on patient records denoting someone was a carer. There was provision for carers if they had a breakdown in care or needed to go into hospital suddenly/urgent care arrangements and the Scheme would arrange care. There was more money in the budget than was being spent. The infrastructure costs were covered so the Service had stability and as much flexibility as required to deliver the hours that could be provided for carers that had unplanned care needs, however, the message was not getting through to carers

- The Heads of Terms within the Section 75 Partnership Agreement clearly described what both partners, Health and Social Care, had signed up to with regard to mitigation and governance. In terms of mitigation, both parties planned together, delivered together and problem solved together. With regard to mitigation, in terms of future Service delivery, it was anticipated that it would only get stronger and clearer due to the commitment at the highest level and joint working which was starting to show through the specifics in terms of Service plans

At this point Dominic Blaydon, Head of Commissioning for Urgent Care, Rotherham Clinical Commissioning Group, took over the presentation:-

Directory of Services

- Category 1 Mental Health
  Mental Health Liaison Services
  - Dedicated Mental Health expertise provided to A&E 24 hours/day
  - Clinically led and operates from The Woodlands
  - Supports 16-18 year olds overnight and at weekends
  - Works alongside the Crisis Intervention Service
  - Links in with the Emergency Centre Development

- Category 2 Rehabilitation and Reablement
  - Home Improvement Agency
  - Falls and Bone Health Service

- Home Enabling Service
- Community Stroke Team
- Stroke Association – Community Integration
- Community Neuro-Rehabilitation Service
- Rotherham Equipment and Wheelchair Service
- Community Occupational Therapy
- Age UK Hospital Discharge Service
- Good Practice: Integrated Falls and Bone Health
  Targets people over 55 years with fragility fracture
  Multi-factorial Falls Assessment and therapy input
  12 week Falls and Fracture Prevention Programme
  Follow-up exercise programmes commissioned by RCCG
  Patients under 75 years undergo bone density scanning
  Establish fracture probability and prescribe bone active tablets
  Follow up patients at 3 months, 6 months and 1 year
  Check modifiable risk factors and adherence to medication

– Category 3 Intermediate Care
  - Rotherham Intermediate Care Centre
  - Integrated Therapy Team with physiotherapists and OTs
  - 3 residential units with 50 beds
  - Community Rehabilitation Service
  - Day Rehabilitation and Community Integration
  - GP contact for intermediate care
  - Intermediate Care Social Work Service
  - Specialist Mental Health OTs
  - Good Practice: Community Integration
    6 week programme led by Occupational Therapy
    Addresses social isolation and activities of daily living
    Access and utilisation of public transportation
    Development of social networks
    Leisure or recreational activities
    Educational and training activities
    Health and wellness promotion

– Category 4 Protecting Social Care
  - Hospital Social Work Services
  - Supporting Direct Payments and Personal Budgets
  - Residential respite care
  - Supporting people with learning disabilities

– Category 5 Case Management and Integrated Care Planning
  - GP Case Management
  - Integrated Rapid Response Service
  - Care Home Support Service
  - Otago Exercise Programme
  - Death in Place of Choice
  - Good Practice: Integrated Rapid Response

Merge Fast Response Advanced Nurse Practitioners and OOHs
Provides early supported discharge at home
Identifies stable hospital patients who can be supported at home
Respond to patients who are at risk of hospital admission
Co-ordinates care for up to 5 days
Supported by Home Care Enabling Service
Incorporates community rehabilitation

- Category 6 Supporting Carers

Next Steps

- Service review outcomes: options paper to be taken to BCF Executive in October
- Decisions to be taken on strategic priorities for future BCF based on review findings
- Service Integration – greater focus on joint commissioning and Service delivery
- Links with other transformational agendas especially prevention and early intervention
- Build on best practice
- Nominate lead and accountable officers

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

- Although there was no specific slide on carers, the Carers Service transcended many of the Services delivered

- Within BCF there was no funded service for supporting children who cared for adults. However, the new Carers Strategy would be more explicit in the provision for young carers as their needs were somewhat different to the needs of adult carers. There was a desire to separate them out

- There was no link between CQUINS and BCF targets. There was a cost element and they complemented each other but were both developed separately. CQUINS were agreed between the CCG and the provider but were not coterminous with the targets set by NHS England for the BCF. On the whole there was a reasonable compatibility although there was some work still to done. As both BCF and CQUIN were relatively new, it had taken some time for priorities and for the CCG to get them aligned. The Chief Executive of the CCG had been mandated to raise this with NHS England

- The issue of protective clothing in falls prevention and whether it reduced the potential for breakages was being debated as to its effectiveness. In Rotherham protective clothing such as hip protectors would be issued at times. Rotherham's Multi-Factorial Falls Assessment would assess whether protective clothing was

necessary. For those people in the residential care environment the Falls Team would carry out an assessment not just looking at possible interventions but also what types of protection they could recommend to wear. It was not always appropriate e.g. for someone with Dementia but other measures could be introduced and was part of the package they could consider

- The Bone Health Clinic not only administered medication but would identify whether there was an issue and give life choice advice and then prescribe medication. It would be dependent upon whether they felt the patient would comply. It was important that people with a learning disability receive clear information

- Patients would be followed up after 3, 6 and 12 months. It could be by way of a telephone call depending upon the level of risk. If the patient was on bone density medication there would be a follow-up process and it would be a similar process for the Falls Services to ensure the person complied with the rehabilitation programme

- The Intermediate Care Services supported those who were discharged from hospital to ensure Services got the pathway right to stop admissions in the first place

- There was a support process in place in Direct Payment as it was important that customers had control over their care packages. It was hoped to further develop health and social care integration packages which would mean that the customer would have much more control over the services going in. It was not sure how it would apply to those who were Autistic. A lot of work was required to be done within the organisations and awareness around Autism and how their needs were met

- There was an issue for those resident in Rotherham whose GPs were outside the Borough or those that had admissions to a hospital rather than Rotherham District. There was a mechanism in place but it was quite detailed and not specifically related to the BCF

- There had been substantial investment in Hospice Services over the last 3-4 years. There was now an Outreach Service and additional urgent response to enable 24/7 provision for those that were on their end of life pathway. It was essential that the Hospice worked closely with community nursing homes. Although great strides had been made it was really important to ensure that when people reached their end of life they had that choice to make

At this point Kathryn Rawling took over the presentation:-

Alzheimer's Society

What do Alzheimer's Society provide in Rotherham

- Dementia Support Workers offering emotional and practical support

- Memory Cafes
  - Held monthly at Dalton, Maltby Thurcroft and Wath upon Dearne
  - Provided an opportunity to meet regularly and talk about living with dementia in an informal social environment
  - Provided opportunities for people with dementia, families and carers to ask questions of professionals and learn from the experiences of others.
  - A dementia café will provide information about dementia and practical tips about coping with dementia

- Rotherham Unity Centre Memory Café
  - Brings together older people from the BME community including those living with dementia and their carers, from minority ethnic groups, in a relaxed atmosphere where they can meet others in a similar situation to themselves

- Social Outlets
  - Singing for the Brain – held monthly at Lord Hardy Court, Rawmarsh, and Davies Court, Dinnington

- Rotherham Carers Resilience Project
  - A new service working with Crossroads Care, Rotherham, to provide a Dementia Link Worker in all GP practices. The Society provided information and support for carers of people living with dementia in their own homes to build resilience and confidence and prevent and/or manage the risk of carer breakdown. This helped people to continue to live well with dementia in their own homes with the right support for their carers

- Rotherham Dementia Forum
  - Run by Rotherham Alzheimer's Society
  - The Forum brought together people with dementia, their carers and professionals so that they could influence the way services were provided in line with the needs of people with dementia and those who cared for them and also in the development of dementia friendly communities in Rotherham

- CrISP (Carers Information and Support Programme)
  - Aim of the programme was to improve the knowledge, skills and understanding of those caring for people with dementia
  - Programme facilitated peer support and shared learning experience led by training Society staff
  - CrISP included 2 courses:-
    CrISP1 – a 4 session programme aimed at family members and friends who supported a person with a recent diagnosis of

dementia. The modules covered included understanding dementia, legal and money matters, providing support and care and coping day-to-day and next steps
CrISP2 – a 3 session programme covering issues that arose as dementia progressed. The modules covered including understanding change as dementia progressed, live with change as more help was needed and living well as dementia progressed

- National Campaigns
  - Dementia Friends
  - Dementia Friendly Communities
  - Dementia Action Alliance

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

- Dementia was a worldwide problem with someone being diagnosed every 7 seconds. The work of Rotherham Dementia Action Alliance was invaluable by raising awareness of dementia and the Dementia Friends Programme meant that the general public were far more likely to come forward to access services and actually ask for help but it was the tip of the iceberg

- People with dementia became became socially isolated and did not reach out for help. Work done nationally and by the Alliance had the potential of increasing the needs as more people became aware. The more services that were out there prevented people going into crisis

- It was the aim of the Carers Resilience Programme to give people the support to cope and know about the Services available. GPs were being more challenged to increase the diagnosis rate. Some people were proactive and sourced help but 1 of the key symptoms for people exhibiting signs of Alzheimer's was they would not be aware that they were having problems at all and less likely to seek help

- There were approximately over 100 types of dementia which presented in different ways and it was a challenge for the families of people exhibiting and perhaps being in denial. People would go for the simple test at their GP practice and develop good ways of masking the issue. It was good for people to know about the test so they could be encouraged to go to their GP and the work of the Alliance also helped to get that information out into the public arena

- Loneliness was a big issue and if someone attended the services with their partner/family member and they then had a bereavement, the Alzheimer's Society would not prevent the surviving member from attending any more. At the Dementia Cafes attendees formed their own groups and participated in activities socially outside of the Cafes

- The Carers Resilience Alliance, funded by the CCG, was working with the Alzheimer's Society and Crossroads; the more partnership work that took place was for the greater good and could do more working together

At this point Sarah Whittle, Rotherham Clinical Commissioning Group, took over the presentation:-

Social Prescribing

- Connects people with long term conditions referred through case management teams to sources of support in their community aiming to reduce social isolation
- 5 VCS Advisors employed by VAR linked to 36 GP practices work with referred people to find a service or activity that meet their needs
- 26 VCS organisations receive funding to provide a menu of 33 different services and activities
- Provides a gateway to a wider pool of VCS services that are not directly funded through social prescribing, predominantly provided by local community centres and groups

Prescription

- Exercise/healthy lifestyles
- Self-management programmes
- Social and leisure
- Befriending
- Confidence building
- Learning/training
- Money – benefits, debs, fuel poverty
- Housing/adaptations
- Carers support
- Dementia support
- Transportation/mobility
- Advocacy

Why are we doing it?

- Strengthening individuals, strengthening communities
  - NHS Efficiency Challenge – reduces pressure on NHS and Social Care
  - Improves outcomes for patients with long term conditions and their carers
  - Recognition that patients need support with non-medical issues – creates a wider range of options for primary care and patient
  - Shift of focus to prevention and early intervention – increases independence, resilience of individuals and communities
  - Supports integration and personalisation
  - Doing things differently – 'more of the same' is not an option

- Outcomes for Patients and Carers
  - Quantative and qualitative evidence points to a range of improvements for patients and carers
    Improved mental health
    Greater independence
    Reduced isolation and loneliness
    Increased physical activity
    Welfare benefits
  - Social Prescribing represents an important first step to engaging with community based services and wider statutory provision]without Social Prescribing many patients and carers would be unaware of or unable to access these services

- Wellbeing Improvements
  - 83% of patients made progress in at least 1 outcome area
  - 20% reduction in A&E attendances
  - 21% reduction in in-patients stays
  - 21% reduction in out-patients
  - 3,500 patients referred
  - For every £1 spent at least £3 saving
  - The CCG benefits as it addresses inappropriate admissions
  - The GPs benefit as it gives them a third option other from referral to hospital or to prescribed medication
  - The voluntary and community sector benefit as it supports their sustainability
  - The patient and carers love it as it improves quality of life, reduces social isolation and moves the patient from dependence to independence

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

- Although there were pockets of social prescribing across the country, Rotherham was the only place in the country doing it on this scale. The 3rd year operation would be coming out shortly and would be slightly different with a focus on those aged under 80 than those over age of 80 but that did not meant there would be nothing for the latter category

- It had been extended into Mental Health Services where the Mental Health provider was actually referring people into the voluntary sector and hoping to discharge a number of people, who had been under Mental Health Services for a number of years, and give them the help to become more independent and be part of the community. It was currently a pilot in its first year but there were many other areas this model, working with the voluntary sector, could be used and have a choice/need to do things differently in the future

- Quite often a number of the schemes in the voluntary sector were geared towards those who were getting older and female rather than male. The assessor would carry out an independent evaluation of the needs of the client. There were a number of clients who had the beginnings of dementia and been through social prescribing and helped in the community such as having a chat over a cup of coffee. That was for both sexes. There were a number of projects for men as well as women

Resolved:- (1) That the progress made for the Rotherham BCF including more integrated joint working between Health and Social Care and revised and strengthened governance for the BCF be noted.

(2) That the proposed timescale for future developments within the BCF plan be noted.

(3) That the existing good practice arising from the Better Care Fund services in Rotherham be noted.

31. HEALTH AND WELLBEING BOARD

The contents of the minutes of the meeting of the Health and Wellbeing Board held on 8th July, 2015, were noted.

Councillor Roche, Chair of the Health and Wellbeing Board, informed the Commission:-

- BCF – The Board was moving forward and positively commended by the Commissioners in their half yearly report to the Secretary of State.
- Health and Wellbeing Strategy - Final draft would hopefully be approved at the Board meeting on 30th September
- Dame Carol Black had visited Rotherham as part of the National Obesity Service. Even though Rotherham had a higher percentage of overweight people than the norm, Rotherham was seen as a leader for Obesity

The Chairman reported that a number of questions had been received from Select Commission Members who had not been able to attend the meeting. They would be e-mailed to Councillor Roche with the responses submitted to the next meeting.

Arising from Minute No. 5 (Care Act Progress – cap on care costs), it was noted that a number of providers nationally had contacted the Government stating more time was required for planning purposes in regards to the care cap element of the Care Act and this has now been deferred. The cap would have allowed people to have their financial contributions to care managed so that when they reached the care cap (which was set at £72,000) it would then have allowed them access to funding from the local authority.

Local authorities would have been able to start to identify self-funders to enable offers of an assessment to be made and advice/information given. The introduction of the cap in 2016 would have meant these people potentially coming forward to the local authority, so the deferment means there may be unknown potential clients with self-funded care not getting the necessary information and advice they require.

The deferred payment scheme was a loan to be paid back at some stage against their property and the amount of money they could be loaned previously was very limited. Rotherham already had a scheme in place but the new scheme now made this available to everybody.

32. QUARTERLY MEETING NOTES

The notes of the first quarterly meeting with health partners, held on 23rd July, 2015, were noted.

It was noted that the action plan in response to the CQC Children's Safeguarding inspection had been developed and was now on the website as part of the agenda pack for the 30th September Health and Wellbeing Board.

RDaSH had invited the Select Commission to submit input into their CQC submission. The Commission had submitted its CAMHS review report

33. YORKSHIRE AMBULANCE SERVICES - CQC INSPECTION

Janet Spurling, Scrutiny Officer, presented a summary of the outcomes of the CQC Quality Summit for Yorkshire Ambulance Service held on 18th August, 2015. It highlighted that, although there were areas of outstanding practice, there were a number of areas for improvement. The overall rating for the Trust was "requires improvement".

Following a CQC inspection, a Quality Summit was convened to develop an action plan and recommendations based on the findings of the inspection team. A range of stakeholders were invited to the Summit to hear the findings and respond/contribute to the action plan

It had been previously been agreed by the regional Joint Health Overview and Scrutiny Committee that Councillor Rhodes, Wakefield Metropolitan District Council, would attend the Quality Summit on behalf of Health Scrutiny as Wakefield Clinical Commissioning Group were the lead commissioner for the Service. It was proposed that Wakefield Health Overview and Scrutiny Committee would undertake any ongoing monitoring of improvement actions from the CQC inspection report with an invitation to attend such meetings extended to other Health Scrutiny Chairs from the JHOSC.

Resolved:- (1) That the Yorkshire Ambulance Service Quality Account sub-group consider the findings of the inspection and resulting action plans when they scrutinise the Quality Account.

(2) That Wakefield Metropolitan District Council lead on the follow-up work on behalf of the Joint Health Overview and Scrutiny Committee ensuring all JHOSC members are brief and invited to future monitoring meetings.

34. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

35. DATE OF NEXT MEETING

Resolved:- (1) That the planning meeting for the next commission meeting be held on Tuesday, 13th October, 2015, commencing at 3.00 p.m.

(2) That, in light of the Better Care Fund and the current review of the 72 funding streams, a special scoping meeting be arranged to give consideration to the review outcomes and issues that the Select Commission may wish to scrutinise in more depth.

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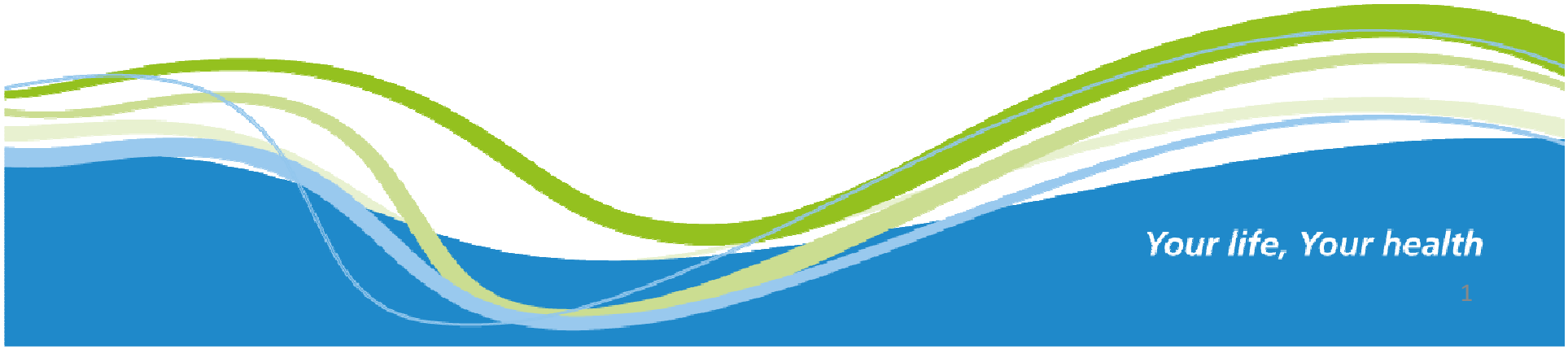
NHS
Rotherham
Clinical Commissioning Group

Annual Review of NHS Rotherham CCG's Commissioning Plan

Ian Atkinson
Deputy Chief Officer
Rotherham CCG



Presentation Overview

1) Process for reviewing the CCG's Commissioning Plan
2) Background: 2015-19 Strategic Direction
3) Background: Financial Challenge
4) Review of 2016-17 priority areas

1) Process for reviewing the plan

Purpose

- To fully engage CCG member practices and stakeholders in the CCG's 2016-17 planning process, through the review and refresh of the CCGs 2015-19 Commissioning Plan.

- It is important to note that for 2016-17 the CCG will only refresh the plan.

Process –

Locality members and stakeholders are asked to review the identified key priorities within the 2015-19 Commissioning Plan, ratify the plan and suggest any amendments for 2016/17.

Stakeholders will receive the first draft version of the plan for comment in mid-**December,** plan signed off in **February**.

2) 2015-19 Strategic Direction

Strategic Aims

Health and Wellbeing 'Strategic Aims'

The CCG Strategic Aims seek to address all six H&WB Strategic Aims across all life stages and for all communities both geographical and communities of interest. See full document for more information

Unscheduled Care (unplanned care)
Emergency Centre, GP Case Management, 7 day working, enhanced care co-ordination centre

Clinical Referrals (planned care)
Improving care pathways so patients get the right care at the right time including reducing the number of hospital follow-ups

Mental Health
Deliver Adults and CAMHS transformation plans, including Adult MH Unions and Parity of Esteem

Rotherham Partnerships
To deliver the Better Care Fund and the joint children's agenda, with RMBC

Transforming Community Services
Locality based nursing, safer discharge, admissions prevention, integrated out of hours

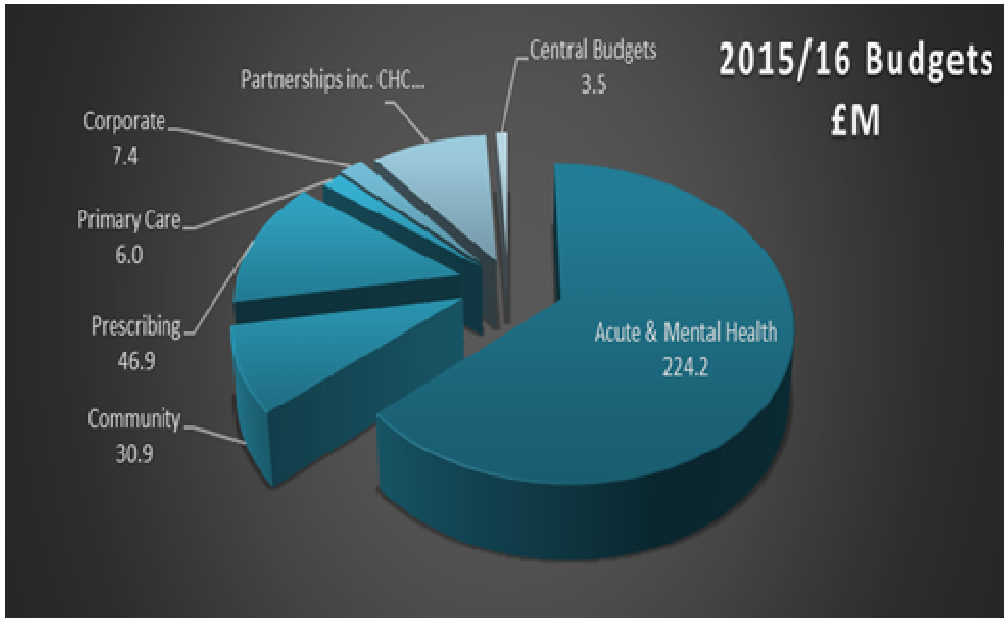
Medicines Management
Increase quality, efficiency, reduce variation & waste across 36 practices, six service redesign projects

Developing General Practice
Delegated responsibility for commissioning general practice and co-commissioning of Primary care and specialised services

Regional Partnerships
Deliver the 'Working Together Collaboration', with other CCG's across South Yorkshire

3) Financial Challenge

- Rotherham has a £75m financial efficiency challenge over the 5 year period 2014 -2019.
- In 2015/16 providers of health care will receive around 2% less for providing the same service.
- Rotherham Hospital has an Efficiency plan of £12.5m in 2015-16.
- Increased costs and activity means that health services would need an extra 6% in the budget each year, just to stay still. Budgets are increasing at around 1-2%.



4) 2016-17 Refresh of the Plan

CCG Governing Body, Strategic Clinical Executive Members and RMCB representatives have already reviewed the current plan (2nd September) and have identified the following key elements for specific discussion and feedback:

1) Approach to joint commissioning with RMBC including Better Care Fund

2) Commissioning of Children's Services

3) Response to Child Sexual Exploitation (CSE)

4) Hospital & Community Services

5) Mental Health Services (including Learning Disability)

6) Primary Care

*there are many other areas of the plan for which the CCG would welcome feedback. The final slide provides further details.

1) Joint Commissioning with RMBC inc BCF

Current Plan states:

- In 2015/16 we will Consolidate the Better Care Fund plan

2016/17 propose to include:

- Review of the current Better Care Fund initiatives

- Explore opportunity for future joint commissioning in the following areas:
  - Children
  - Learning disabilities
  - Continuing Health Care
  - Mental Health
  - Social Care

2) Commissioning of Children's Services

Current Plan states:

- Focus on Integration of The Rotherham Foundation Trust (TRFT) Acute and Community Children's Services
- Collaboration between South Yorkshire hospitals children's services (Working Together)

2016/17 propose to include:

The development of a Children's Joint Commissioning Strategy:

- Children and Adolescent Mental Health Services (CAMHS)
- 0 – 5 year olds
- Special Educational Needs and Disability
- CSE post support
- Looked After Children
- Early help (Children's Centres)

- Delivery of Care Quality Commission (CQC) action plans affecting children (TRFT and Rotherham Looked After Children and Safeguarding)

- Focus on Efficiency with the Hospital (number of beds, assessment beds & rapid assessments)

- Explore potential for locality working

3) Response to Child Sexual Exploitation (CSE)

Current Plan states:

- We will work with partners to address all issues that arise from the Jay and Casey Reports into CSE

2016/17 propose to include:

Delivery of Child Sexual Exploitation Strategy (Evolve)

- Prevent
- Pursue
- Victim Support

4) Hospital & Community Care

Current Plan states:

Unscheduled Care - Commission New Emergency Centre (Spring 2017)

Elective Care - Focus on pathway work to manage demand

Commission 7 day hospital services working

Quality

- Care Quality Commission (CQC) action plan
- Stroke action plan
- Commissioning for Quality and Innovation (CQUIN)/local outcome framework

QIPP

- 3.5% year on year efficiency
- Non elective activity to flat line
- Follow ups reduce by 8%

2016/17 propose to include:

- Focus on the Development of Information Technology (IT) interoperability
- Working together (including implementing regular ward rounds and including RMBC)
- Sustainability review and consider Integrated models spanning organisational Boundaries / Acute Care Collaboration with Federation board

4) Hospital & Community Care …contd

Current Plan states:

Community Transformation Phase 1

- Community nursing – invest, reconfigure and distribute according to need
- Care Co-ordination Centre
- Community unit
- Falls & Bone health
- Neuro-rehabilitation

2016/17 propose to include:

Community Transformation Phase 2

- Realign Intermediate Care
- Integrated rapid response
- Reduce delayed transfers of care
- Further develop care co-ordination centre
- Joint protocols with social care & Rotherham Doncaster and South Humber NHS Trust (RDASH)
- Review of respiratory pathway

5) Primary Care

Quality driven services

- 4 year investment plan – needed to stabilise practices
- Benchmarking e.g. staffing
- New models of delivery – primary/community led services
- Quality and Outcomes Framework (QOF) – concentrate on Personal Medical Services (PMS_ reinvestment in the first instance but there is a consistent view that QOF not fit for purpose

Services as local as possible

- Telephone consultations, skype
- Wider use of workforce
- Integrating Out of Hours and urgent care
- Estates review – Rotherham CCG strategy

Equality of service provision

- Explore opportunity to develop a Basket of Enhanced services
- Review opportunity for Primary Care to work jointly to deliver borough wide coverage of provision.

5) Primary Care …contd

Increasing appropriate capacity & capability

- Develop Workforce plan
- Explore New workforce models given difficulty in recruitment,
- Recruitment strategy

Access

- Weekend/bank holiday pilot
- Provision of wrap-around services to support pilot

New models of care

- Collaborating practices to deliver care in the community

Self care

- Social prescribing – extension
- Technology assisted
- Case management
- Improved Patient education – this was felt to be fundamental – where to go, who to see, how we handle 'dissatisfaction'

5) Primary Care …contd

Robust performance management

- Performance dashboard to support consistency
- Use of RAIDR (Reporting Analysis & Intelligence Delivering Results)

Continued improvements to medicines management

- Waste scheme
- Prescribing Local Incentive Scheme
- Minor ailments - out of practice and into pharmacy

Engaging patients to optimise patient pathways

- Reinvigoration of Practice Participation Groups
- Condition specific focus groups

6) Mental Health, CAMHS & Learning Disabilities

Current Plan states:

- Parity of Esteem/Crisis Care Concordat
- Quality Innovation Productivity and Prevention (QIPP) – 3.5% year on year efficiency for RDASH but re-invested in mental health e.g. voluntary sector or primary care mental health
- Quality agenda (NB CCG and RDaSH CQC reports)
- Support to historical victims of child abuse and ensure safeguarding arrangements are fit for purpose
- Reducing delayed transfers of care

2016/17 proposal:

- National waiting time targets – Improving Access to Psychological Therapies (IAPT) & Early Intervention in Psychosis
- CAMHS Transformation Plan – 5 year plan
- National programmes to improve perinatal mental health and eating disorders
- Winterbourne & new commissioning models for Learning Disability

6) Mental Health, CAMHS & Learning Disabilities …contd

Adult & Older Peoples Mental Health Transformation Plan	
Adult Mental Health Liaison (Better Care Fund)	Better reporting on outcomes
Improving Access to Psychological Therapies (IAPT)	Single point of access , reduce Did Not Attend (DNA) rates, reduce waiting times and improve recovery
Dementia Carer Resilience and Mental Health Social Prescribing pathways	Provide GP link workers in practices, support locality working and improve recovery
Dementia (including GP Local Enhanced Services)	Emphasis on prevention, reduce waiting times, recovery & locality focus

6) Mental Health, CAMHS & Learning Disabilities …contd

Learning Disabilities

- New community investment
- Assessment & Treatment Unit future plan
- Moves toward joint commissioning with RMBC

CAMHS Transformation plan

- Universal services
- Review Efficiency of existing service
- Getting best value for CCG **20%** additional investment
- Review Pressures on the system Tier 3/4 interface & impact on Adult wards

Other sections in the Plan

The following list are areas not covered in the presentation but are very important to the CCG, feedback is welcome:

- Health & Well Being Strategy
- Joint Strategic Needs Assessment
- Medicines Management
- Continuing Care & Funded Nursing Care
- End of Life Care
- Ambulance & Patient Transport Services
- Specialised Commissioning
- Public Involvement & Promotion of Choice
- Health Inequalities
- Statutory Responsibilities
- Efficiency
- Finance
- Information Management & Technology
- Communication
- Performance & Assurance
- Risk
- The prevention of Child Sexual Exploitation will remain a priority in 2016-17

Feedback from Stakeholders

The CCG welcomes all feedback and any comments can be sent via the CCG email address Rotherhamccg@rotherham.nhs.uk

The current 2015/16 Commissioning Plan is available at http://www.rotherhamccg.nhs.uk/our-plan.htm

The first draft version of the 2016/17 Commissioning Plan will be circulated to stakeholders for comment mid-December.

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

Rotherham Metropolitan Borough Council

Public Report
Council/or Other Formal Meeting

Summary Sheet

Council Report

Health Select Commission meeting Thursday 22 October 2015

Title

Interim GP Strategy – Rotherham Clinical Commissioning Group

Is this a Key Decision and has it been included on the Forward Plan? N/A

Strategic Director Approving Submission of the Report N/A

Report Author(s) Jacqui Tuffnell, Head of Co-commissioning, Rotherham CCG

Ward(s) Affected All

Executive Summary
This report provides the Commission with a copy of the Interim GP strategy which sets out how the CCG will work with practices to transform services over the next five years to achieve six key outcomes for Rotherham. An update on the re-procurement of the Chantry Bridge and Gateway contracts is included in Appendix 2.

Recommendations

- That the Interim GP strategy be noted.
- That the approach to re-procurement of the contracts be noted.

List of Appendices Included

Appendix 1 Interim GP Strategy
Appendix 2 Briefing paper – The Gateway and Chantry Bridge

Background Papers
NHS England Five Year Forward View

Consideration by any other Council Committee, Scrutiny or Advisory Panel No

Council Approval Required N/A

Exempt from the Press and Public No

Title Interim GP Strategy – Rotherham Clinical Commissioning Group (CCG)

1. Recommendations

- That the Interim GP strategy be noted.
- That the approach to re-procurement of the contracts be noted.

2. Background

2.1 Rotherham CCG took on delegation for general practice in April 2015 and the first key task has been to work on the key strategic aims to give the organisation priority areas. This will be under regular review and incorporated into the CCG full commissioning plan.

2.2 The CCG are also required to manage issues in relation to specific contracting issues.

3. Key Issues

3.1 The ten key strategic aims identify the key issues for general practice and how it is proposed these are addressed to meet the key outcomes set out on page 2 of the strategy.

3.2 The briefing paper identifies the issues with the contracts for the Chantry and Gateway practices and how these are being addressed.

4. Options considered and recommended proposal

4.1 The 10 key strategic aims are identified along with actions to address them, summarised in the General Practice Plan on a Page 2015-19 (p6).

4.2 Appendix 2 identifies the issues with the Chantry and Gateway practices and how these are being addressed.

5. Consultation

5.1 Engagement and consultation has taken place with GPs, patients and carers via events and the draft key strategic aims and proposals for addressing these were discussed with the Health Select Commission prior to finalising.

6. Timetable and Accountability for Implementing this Decision

6.1 The strategy has now been approved by the primary care sub-committee and is being implemented.

7. Financial and Procurement Implications

7.1 None for RMBC.

8. Legal Implications

8.1 None for RMBC

9. Human Resources Implications

9.1 None for RMBC

10. Implications for Children and Young People and Vulnerable Adults

10.1 Improvements to access and capacity within general practice

11 Equalities and Human Rights Implications

11.1 Improvements to equity of provision

12. Implications for Partners and Other Directorates

12.1 Not applicable

13. Risks and Mitigation

13.1 Not applicable

14. Accountable Officer(s)

Approvals Obtained from:-

Strategic Director of Finance and Corporate Services:- Named officer

Director of Legal Services:- Named officer

Head of Procurement (if appropriate):-

Name and Job Title.

This report is published on the Council's website or can be found at:-

http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories=

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NHS
Rotherham
Clinical Commissioning Group

Our Interim Strategy for General Practice within Rotherham

Your life, Your health

1. Our vision for general practice within Rotherham

Plans and services of all commissioners and health and social service providers in Rotherham are prioritised by needs identified in our Joint Strategic Needs Assessment and the six Rotherham Health and Wellbeing (H & WB) Strategic outcomes(due to be reviewed in September 2015:

Prevention and early intervention
Expectations and aspiration
Dependence to independence
Healthy lifestyle
Managing long term conditions
Reducing poverty

The CCG will work with practices to transform services over the next 5 years to achieve the following key outcomes:

- Improved consistency in access to general practice – aspiring to within 24 hours for an urgent appointment and within 5 days for routine appointments
- A combined, collaborative workforce across primary, secondary and community care providing a seamless pathway for patients with GPs as the linchpin for care
- Patients able to self manage their conditions from home utilising technology to connect with healthcare professionals
- 200 additional years of life
- All patients will be able to access equivalent services
- We will increase the wider workforce within general practice to improve consistency in patient experience

2. Introduction

Rotherham Clinical Commissioning Group (CCG) is responsible for commissioning the majority of health services for Rotherham patients, its overall strategy is available on the following link: CCG Commissioning Plan 2014-19

Primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing ongoing mental and physical health conditions and helping recovery

from episodes of ill health and injury (Ref: NHS mandate 2013). General practice plays a significant part in primary care and Rotherham CCG is committed to adhering to the principles of the NHS and how these are applied locally to best meet the needs of our population.

The CCG has an overall vision of working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities. Primary care, defined for this purpose as care that can be provided out of hospital by GPs and the teams they employ, is at the heart of the NHS and will play a central role in achieving this aim by ensuring a co-ordinated service for patients, centred on the needs of the people that we serve and not silo organisations.

We have fantastic examples of care in Rotherham but as our population increases and ages, it is critical that we respond by providing services in different ways to ensure we continue to sustain and improve during challenging times. Our key challenges within GP services include our own ageing workforce. Over 33% of GPs in Rotherham are due to retire in the next 5 years with limited availability of trainees to fill vacancies. In addition there are significant changes to funding arrangements for GP practices potentially destabilising investment and pressure to improve access.

Rotherham CCG believe a significant step forward in this journey included bringing back, the commissioning of primary care (GP services) to Rotherham, this was achieved in April 2015. We are already seeing the benefits of being able to respond to local issues with local knowledge as often it is difficult to understand and respond to our population from afar but with our dedicated resources we are able to ensure this is achieved. To ensure good governance is maintained, the CCG has created an additional committee, Primary Care Sub-Committee which is chaired by a Lay member of the CCG and meets monthly in public to discuss all issues affecting general practice. Healthwatch, NHSE and a representative from the Health and Wellbeing Board are all committee members. The CCG will continue to work with NHSE who commission other primary care services i.e. pharmacy, optometry and dental to ensure these services complement each other however this strategy is focused on GP services.

This strategy is a key component to ensure we continue to mould our journey to deliver our priorities and what we will do to make the vision a reality. The strategy aligns with the Health & Wellbeing board priorities and the CCG's commissioning plan which has a specific strategic aim of developing general practice. The strategy should also be

considered as an enabler for, and read in conjunction with the RCCG Better Care Fund (BCF) plan which is a pooled budget of £23 million for health and social care.

There are some considerable challenges to be overcome as we move towards delivery of our vision. 56.8% of our population live with health-related problems. More people are living longer with more chronic diseases and medical treatments are getting more complex and expensive. We have to deliver healthcare differently as funds are not growing to deliver in its current format which could increase inequity in funding if it is not managed effectively.

We have developed our strategy by reflecting on feedback from our patients and the wider primary healthcare teams at market place and development events held in June 2015, as well as considering the challenges facing general practice. The following ten key principles have been identified to form the main elements of the general practice strategy:

1. **Quality driven services** – providing high quality, cost effective, responsive and safe services
2. **Services as local as possible** - teams working in community in conjunction with GPs, in-reaching into secondary care where possible
3. **Equality of uniform service provision** - addressing inequalities in Rotherham's life expectancy – we will focus on health prevention and education to support these areas along with 'baskets' of services to ensure equality across Rotherham
4. **Increasing appropriate capacity & capability** – as well as continuing to recruit to our workforce, we will develop new roles to support the GP and nursing workforces to ensure patients are well managed along with innovative models to manage patients conditions e.g. telephone support and extended use of pharmacists. We will also educate the public to feel confident in using different health professionals for their care.
5. **Primary care access arrangements** – ensuring our access to general practices meets the needs of our population
6. **Maximised use of integrated / aligned care pathways** – new models of care, taking a lead from the new Vanguard models and other good practice across the NHS
7. **Self care** – improved information including patient health portals, ability to monitor conditions at home/link to appropriate service when 'abnormal'
8. **Robust performance management** to provide assurance that safe and cost effective care is being delivered

9. Continuing our programme to **improve medicines management** with appropriate prescribing and reducing waste
10. **Engaging patients** to ensure patient pathways are optimised – to date engagement has been varied and the CCG is committed to finding alternative ways to ensure the patient voice is heard

We have now developed our strategy for general practice, its journey for approval will be as follows:

Draft strategy for discussion	May Primary Care Sub-Committee
Draft strategy for discussion	June AGM/Commissioning events for engagement
Draft strategy	July Operational Executive (endorsement) Strategic Clinical Executive (feedback) GP members committee(feedback) Local Medical Negotiating Committee(feedback)
Final strategy approval	August Primary Care Sub-Committee
For information	September governing body

Engagement with local professional, patients and the public will continue as we develop more detailed operational plans. There will be continued opportunities for people to influence how we make our vision a reality. This strategy will be incorporated during 15/16 into the CCG overall commissioning plan to ensure that delivery and review remain high priority.

3. General Practice Plan on a Page 2015-19

Vision				
	Priority Area	Challenges	Solutions	Outcome
1	Quality Driven Services	Financial Uncertainty	• 4 year reinvestment plan • Benchmarking • Comparing practice quality and productivity • Delegated responsibility for general practice • New models of delivery	• Improved patient experience – ED1-3 • Improved efficiency
2	**Services as local as possible**	Capacity to deliver	• New ways of managing patients: ➢ Telephone consultations, skype video consultations ➢ Utilising our wider workforce ➢ Integrating out of hours and urgent care	• % reduction in patient attendances at GPs
		Care closer to home	Seamless services	• Improved efficiency • Improved patient experience
3	**Equality of service provision**	Inequalities in life expectancy equity of services	• 'Baskets' of services • Providers working together • Focused health prevention measures ➢ Working with public health	• 200 years of life per year • All patients able to access equivalent services
4	**Increasing appropriate capacity and capability**	Recruitment and retention	• Workforce plan ➢ Sufficient capacity and an appropriately skilled workforce • Effective succession planning • New workforce models ➢ More effective use of different professions ➢ Engaged and empowered workforce • Recruitment strategy ➢ Improved profile of Rotherham as a place to work ➢ Improved fill rates	• Improved workforce numbers • Improved workforce retention • Improved patient experience
5	**Primary care access arrangements**	Public expectation GP facilities Contract arrangements	• Review of arrangements and to pilot extended opening • Provision of wrap-around services to support GPs	• % reduction in patient attendances at A & E • Improved patient experience
6	**New models of care**	Contractual complexity	• Collaborating groups of practices to deliver care in the community • New emergency centre ➢ Secondary and primary care clinicians working together	• Improved efficiency • Improved patient experience
7	**Self care**	Increasing demand	• Education ➢ Patients confident to manage their condition(s) • Social prescribing ➢ Signposting & support to manage their condition(s) • Technology ➢ Proactive monitoring to enable fast response • Case management ➢ Clear plans of care	• % reduction in attendances – all services
8	**Robust performance management**	Different systems in place	• Performance dashboard to collate data • RAIDR to ensure consistency	• Ability to define & manage performance issues • Improved performance ED1-3
9	**Continued improvements to medicines management**	Reducing medicines waste	• 6 service redesign projects to improve prescribing • Prescribing Local Incentive Scheme	• Improved efficiency - QUILT • Safer medicines management
10	**Engaging patients to ensure patient pathways are optimised**	Improving patient involvement	• Effective Patient Participation Groups • Condition specific focus groups	• Services which meet the needs of the population

Steps to Make the Vision a Reality

There are the key enabling strands of work that underpin the strategy. These tackle the main issues and challenges facing general practice and will allow the CCG to turn the vision into reality. More detailed consideration of them is required in the short term to translate them into an implementation plan.

4. Context

4.1 Profile of Primary Medical Care in Rotherham

90% of all NHS contacts are with general practice.

There are around 1.5M GP consultations every year in Rotherham with each patient seeing their general practice 6 times per year on average.

Rotherham's resident population is estimated at 259,800 who are cared for by a total of 36 GP practices (as at April 2015) alongside a centrally based walk-in centre providing 24/7 access. At the present time, five GP practices in Rotherham are singlehanded compared to 31 practices with multiple GP partners or which are alternative providers.

National average list size	6287
Rotherham average list size	7182

The CCG currently has 15 training practices. This is important as training practices play a significant role in supporting new GPs and encouraging them to stay in the area once they are qualified.

With regard to type of contract there are:

24	Personal Medical Services (PMS) practices
8	General Medical Services (GMS) practices
2	Alternative Provider Medical Services (APMS) practices (covering 4 practices)

A Limited Liability Partnership (LLP) is currently being formed by an appointed GP lead to enable practices to work collectively and be able to respond to the demands facing general practice. These demands are identified more extensively within this strategy.

4.2 Current General Practice

Whilst media attention is often focused on the challenges facing the heath service , it must be acknowledged that there is excellent work taking place in general practice, day in, day out to ensure patients receive high quality care. As a principle, it was agreed that these should be protected and preserved when thinking about any future model of care. They included:-

- GPs holding longer term contracts that build real commitment to the local community
- Registered list that leads to continuity of relationships and care•
- GP acting as the coordinator of care between other health and social care settings
- Appetite for innovative ways of working
- Keen to learn new skills through educational programmes designed by local GPs
- Practices beginning to work together to share good practice and learning
- Secondary to primary care Local Enhanced Service agreement where practices have agreed to work together to provide services for all patients when individual practices have not got capacity
- The delivery of high quality care e.g. anticoagulation, where the increased service quality being delivered is outstanding.

General practice incorporates the essential values of personal care, continuity of care, generalist skills and a holistic approach to patients. Prevention and the treatment of ill health both have equal priority.

It is also important to acknowledge the teams that support the clinical professionals such as practice managers, reception staff and apprentices without whom our services would not be fully functional.

4.3 Changes to Contractual Arrangements

NHS England are nationally leading changes to the payment arrangements for general practice to apply the principles of equitable funding. The aim of which is to by move to a position where all practices (whether GMS, PMS or APMS) receive the same core funding

for providing the core services expected of all GP practice. The review of PMS funding, determined that any additional funding above this must be clearly linked to enhanced quality of services or the specific needs of a local population. Also that practices should have an equal opportunity to earn premium funding if they meet the necessary criteria. NHSE have determined that over the next four years commencing 2015/16 financial year, the current PMS premium paid to PMS practices will be reduced by ¼ each year and reinvested across Rotherham GP practices to enhance the quality of services. All practices will have equal access to the payment as detailed above. A decision regarding the phasing out of MPIG for GMS had already been determined with correction factor payments reduced by 1/7th over 7 years commencing 2014/15.

On a positive note, the funding released from the PMS review will remain within Rotherham and will be reinvested back into Rotherham primary care over the 4 year period described to achieve the following:

- Reflect joint area team/CCG strategic plans for primary care – supporting an integrated approach to delivering community based services
- Secure services or outcomes that go beyond what is expected of core general practice – ensuring premium funding is tangibly linked to providing a wider range of services or providing services to higher quality standards
- Help reduce health inequalities
- Give equality of opportunity to all GP practices
- Support fairer distribution of funding at a locality level

The GMS monies released from MPIG removal will not remain within Rotherham and it is understood that they will be reinvested into the 'global sum' for general practice (equitable funding level).

5. Our Key Priority Areas

5.1 Quality Driven Services

A high-quality service can only be delivered if there is a focus on three key quality dimensions: clinical effectiveness, safety and patient experience. It is crucial that the economic challenge does not change this focus. We will, therefore continue to support

innovation in clinical practice and develop pathways that improve effectiveness and that enhance the patient experience as well as providing value for money. The CCG already supports protected learning time every 2 months, for all GP practices and sufficient time for localities to ensure they are clinically and professionally updated. There are four core components to this focus: quality, innovation, prevention and productivity. The CCG will continue to review benchmarking and learning from peers to support this agenda.

Funding for all practices should be equitable for delivery of service and also demonstrate value for money. Core contract activities will be remunerated in line with national agreements. Benchmarking information, comparing practice quality and productivity within our area and externally, will be used to ensure value for money.
We will look to achieve best value for money, driving efficiencies in the way general practice is delivered. Local practices have already embraced the opportunities to be more efficient in medicines management and prescribing with £1.8m savings in 2014/15.

The CCG already undertakes quality peer review visits to all GP practices and has developed a framework to support practices where there are quality concerns co-commissioning principles. The Care Quality Commission (CQC) have advised the CCG that they will be undertaking quality visits of all GP practices during 2015/16 commencing with 8 practices in June 2015. The CCG will work collaboratively with practices where any required improvements are identified.

5.2 Services as Local as possible

Our main aim is for general practice to sit at the heart of a patients care. Currently, when a patient requires secondary care intervention, care is handed over to the 'specialist' and handed back once treatment is complete or where protocols exist for care to continue in the community. Often patients could be more appropriately managed by their GP who has a holistic understanding of the patient and therefore increasing used of shared care protocols is a key aim of this strategy. This is difficult to achieve when there are capacity issues therefore patient management will take on a variety of forms e.g. skype and telephone consultations and utilising our upskilled nursing workforce.

Three important local plans which will impact on general practice are the community transformation plan (which will improve and expand out of hospital care provided by teams

from Rotherham NHS Foundation Trust), Rotherham Mental Health Transformation plan which will increase the locality focus of mental health services provided by RDASH and the Emergency Centre.

Integration with GP out-of-hours providers and other urgent care services will help to reduce duplication and confusion about how best to access urgent care. Rotherham CCG has committed to capital funding to build a new emergency centre on the Rotherham Hospital Foundation Trust site. Building work has commenced with a completion date in 2017, along with significant pathway work between primary and secondary care clinicians to ensure pathways are as seamless and effective as possible.

The CCG has also committed to the provision of 'social prescribing' to support patients requiring healthcare

5.3 Equality of Service Provision – Enhanced Services

GPs are contracted to provide "core services" (essential and additional) to their patients. The extra services they can provide on top of these are called „enhanced services" which are voluntary but, if taken up, often add to the quality of care. The CCG is committed to maximizing the uptake of enhanced services and will look to practices to collaborate with each other to ensure that patients have equitable access.

There are three types of enhanced service:

1. National enhanced services (NES) - services to meet local needs, commissioned to national specifications and benchmark pricing. The CCG is unable to influence these.
2. Directed enhanced services (DES) – must be commissioned by NHS England (optional for GPs to provide). The CCG will work with NHS England to ensure these arrangements are congruent with CCG aspirations.
3. Local enhanced services (LES) – locally developed and commissioned services designed to meet local health needs. These are now commissioned by the Local Authority and CCG.

Enhanced services address gaps in essential services or deliver higher than specified standards, with the aim of helping the CCG to reduce demand on secondary care and

other health services. Enhanced services expand the range of services to meet local need, improve convenience and extend choice. The total investment by the CCG in 2014/15 was £3.4m. The number and variety of schemes has increased over the years as local enhanced services have been developed and the local enhanced services are currently:

- Case management
- Anticoagulation
- Aural care
- DMARDs (Rheumatology monitoring)
- PSA
- Suture removal
- Acupuncture

In addition to this the CCG also has Local Incentive Scheme (LIS) which ensure that practices remain up to date with current practice. Rotherham CCG spends on average £4 per head of population, which is at the lower end of the national range

The CCG is responsible for providing services for all Rotherham patients so developing the capacity to help all eligible patients will be an important consideration when planning future expansions of general practice services.

5.4 Increasing Appropriate Capacity and Capability

Fewer trainees are choosing general practice when they qualify and more GPs are choosing to retire earlier than normal retirement age. Rotherham has a good track record of attracting trainees, predominantly due to a good reputation for education but also the proximity to Sheffield.

Until fairly recently, practices were almost exclusively run on a GP partner basis, with occasional use of locums to cover study, sickness or holiday absence. More recently, there has been a significant growth in locum and salaried GPs, with fewer being attracted to the partnership model. The primary care workforce is changing. An increasing number of GPs are working outside the traditional model with more sessional and locum GPs and utilisation of different professions, more typically nursing to undertake traditionally GP roles. The gender balance between male and female doctors is also changing which is also impacting on workforce availability as traditionally female GPs have chosen to work

part-time. The success of the CCG will be dependent on its ability to embrace, utilise and develop potential across its whole clinical and non-clinical workforce. It will also work with provider organisations and the local authority to harness the skills of the wider primary care health and social care teams including district nursing, social work, pharmacy, podiatry, physiotherapy and others. A workforce plan is under development and will also incorporate the national 10 point plan – Building the workforce – new deal for GPs.

Practice size and sustainability is an important consideration. Rotherham has historically benefitted from having high quality services provided by practices of different sizes. In May 2015 the CCG Governing Body took the view that as opportunities arise the CCG will work to encourage small practices to work closer together in order to provide more sustainable services.

5.5 Primary Care Access Arrangements

Primary care access arrangements are set out in the GMS contract. This defines core hours as the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday, except Bank holidays. The contractor must provide essential services at such times within core hours, as are appropriate to meet the reasonable needs of its patients. Practices offer a variety of systems for walk in access, telephone triage, same day and pre-booked appointments. Some practices close for one afternoon a month in order to have protected learning time however many increase their capacity during that week to ensure the same number of appointments are offered. Where practices are closed, arrangements are in place for patients to access the out of hour's service during this period.

It is acknowledged that access is one of the most significant concerns for the general public. As detailed below, the area requiring most focus is patient experience of making an appointment. From triangulating this data, we have commenced work with practices about their capacity for patients contacting their surgeries along with the service received once their call has been answered.

	ED 1										ED 2	ED3			
	Last GP/N they saw /spoke to was good at giving them enough time		Last GP/N they saw/spoke to was good at listening to them		Last GP/N they saw /spoke to was good at exp' tests / treatment		Last GP/N they saw/ spoke to was good at involving them in decisions about their care		Last GP/N was good at treating them with care & concern		Describe overall exp of surgery as good	Exp of making an appt as good			
	GP	Nurse	GP	Nurse	GP	Nurse	GP	Nurse	GP	Nurse			ED 1	ED 2	ED 3
Roth	87	83	88	82	83	79	76	69	83	80	86	74	81	86	74
Eng Av	86	81	88	79	82	75	74	67	82	78	86	77	79.2	86	77

The CCG will also work with practices to examine the options for extended hours to support access and redesigned service provision. At present, no GPs open on Saturdays with the known increase in impact on secondary care which is no longer sustainable. We will therefore review this evidence and pilot extended working arrangements to meet Rotherham population needs. This ambition will also support the new urgent care pathways which culminate with a new Emergency Centre opening in 2017.

5.6 New Models of Care

In October 2014, an alliance of NHS organisations published the Five Year Forward view. A significant element of this strategy is to review the local healthcare system to consider different models of delivering healthcare. Different variations of the models are emerging and NHSE announced in March the first wave of 29 Vanguard sites which will lead the way for piloting new operating models. It was also recently announced that Greater Manchester health and social care budgets will be devolved to the region's councils and health groups by April 2016 enabling local control over how budgets are allocated and with a main purpose to pool resources to improve out of hospital care.

As outlined in 4.2, the CCG has already committed to a new emergency centre which is based on a partnership between urgent care providers in Rotherham and best utilising the different skills of clinicians with primary and secondary care training. The CCG has also committed to transforming community services and already seen significant improvement to out of hospital care, focus is currently on the following:

- Better quality community nursing services
- Supported discharge and admission prevention
- Enhancing the Care Co-ordination Centre
- An integrated out of hours service

We will consider facilitating the availability of specialists and community teams in primary care settings. Consultants may work with federated groups of practices to provide integrated care, defaulting to primary and community settings rather than hospitals. This enhanced care will be provided in the home setting regardless of place of residence meaning those people who live in care homes will be able to access enhanced community and home based care. An effective case management Local Enhanced Service is already in place providing effective management of more than 12,000 patients who are at highest risk of hospital admission.

5.7 Self Care

The aim of self care is to prevent patient's conditions from deteriorating to facilitate them being able to remain at home, in familiar surroundings but with the knowledge that their condition is well managed. As well as the changes outlined above, which facilitate the most effective arrangements for long term care, patients and carers will be supported to take control of their long-term conditions through a variety of different ways. Case management and social prescribing are already in place to support patients. Community transformation projects will also refocus community nursing and social work time to input into patient reviews so all the patients needs are considered.

The CCG will also be considering the use of technology to assist patients to manage their conditions for example blood pressure monitoring at home with results reported directly into the GP to take action where results are abnormal.

Education will be a key component to self care, to empower patients and their carers to manage their conditions and to take a more active role in consultations and decisions about their care. . We know that to date, success in improving patient attendance and adherence has been patchy e.g. uptake for cardiac rehabilitation and we must work harder to devise innovative ways of reaching our population.

5.8 Robust Performance Management

As a CCG with delegated responsibility for GP commissioning, we have agreed trajectories for patient survey results with NHS England for the following three outcomes:

1. ED1 Satisfaction with quality of consultation at the GP practices
2. ED2 Satisfaction with the overall care received at the surgery
3. ED3 Satisfaction with accessing primary care

2014/15 performance is included within the primary care access arrangements section of this strategy. In addition to this, the CCG has developed a performance dashboard that provides the primary care sub-committee with an effective tool for high level monitoring of general practice key performance indicators. Data alone is not an indication of poor service provision however this enables the primary care sub-committee to focus attention on practices that are outlying to ensure that the primary care team are triangulating with other local intelligence to take the necessary steps and provide the committee with an appropriate level of assurance.

This also supports the published commissioning and quality principles for primary care. These identify the processes which will be followed in circumstances where the key performance indicators are not being achieved.

5.9 Continued Improvements to Medicines Management

The CCG is responsible for all GP prescriptions issued by its member practices. In 2014/15, the CCG spent £45.2 million on prescriptions and on commissioned services (nutrition and continence). The CCG is focused on ensuring all patients are receiving the right medications, at the right time, to date efficiency savings of over £1.8m have been achieved. A Prescribing Local Incentive Scheme commenced in 2014/15 and is reviewed regularly to ensure more effective practice is achieved. More info required from Stuart

5.10 Engaging Patients to Ensure Patient Pathways are Optimised

Rotherham CCG is committed to active and meaningful engagement with all its patients and potential patients Link to engagement and communications plan.

Patient Participation Groups have been in existence for several years; the changes to primary care commissioning will mean that the CCG can more effectively:

- Work with practices to ensure that wherever possible, practices have an active PPG, operating to acknowledged good practice (Link to NAPP website)
- That PPGs are supported through the PPG Network with information, shared good practice, and the opportunity to consider wider, cross Rotherham issues

However, PPGs are only one mechanism for patient and public engagement and experience. The CCG also aims to extend engagement, and work with a variety of organisations to improve the patient voice for specific communities, both geographical and communities of interest, for example people with specific long term conditions. If the CCG is to develop new ways of working; it will be vital to ensure that patient experience actively and meaningfully informs new systems and processes. This cannot be done in one way, and may involve any of the following:

- Condition specific focus groups
- Patient interviews and/or diaries
- Patient experience – from survey work, consultations, and other feedback (ie social media, complaints and issues raised with other bodies such as Healthwatch)

6. Enablers to Delivering our Strategy

6.1 Primary Care Estates and Premises

The CQC has a mandate for ensuring that essential standards of quality and safety are met.

However, the CCG undertakes quality visits which encourage practices to offer premises that:

- Deliver care in the right place with the right access
- Provide the patient with an environment that is fit for purpose
- Ensures easy access with clear sign posting
- Meets all statutory and mandatory requirements including compliance with all relevant disability, fire, health and safety legislation

Rotherham Metropolitan Borough Council are currently reviewing all 'government' estate to ensure it is fit for purpose and utilised appropriately across all services. Whilst this is welcomed by the CCG, many general practices are privately owned by partners in the practice and will not therefore be captured under this review. The CCG will therefore undertake an assessment of the current estate suitability for primary care in Rotherham. The strategic direction is towards larger practices, able to provide a range of general medical services, enhanced services and community based healthcare.

6.2 Information Management and Technology

The CCG has developed its IT strategy through consultation with GPs, RMBC and providers and the following identified the key areas where IT development will support the general practice agenda

Practices should be able to access electronic information relating to their patients when they are treated in other parts of the health system. This particularly includes discharge and out patient summaries, pathology, diagnostics and care delivered in community settings.

The CCG is supporting the roll-out of SystmOne to practices as the system of choice. At present 8 practices use a different system, EMIS web which to date has caused a barrier to linking practices. EMIS web and SystmOne have now agreed to facilitate interoperability between the 2 systems which will significantly support the CCG's strategy to facilitate the exchange of information between practices and other local providers, dissemination of guidelines, audit etc. whilst ensuring patient confidentiality is maintained, there are appropriate levels of data protection and access will be undertaken only on a need to know basis.

The CCG is also supporting practices to utilise the Electronic Palliative Care Co-ordination Systems (EPaCCS) which enables the recording and sharing of patient's preferences and key details about their care with those delivering their care. The systems support co-ordination of care and the delivery of the right care, in the right place, by the right person, at the right time. EPaCCS is the most effective way of providing an EOLC register for patients in Rotherham, enabling information to be seen and shared by all parties involved in a patient's care. A template has been developed and IT solutions put in place to enable

the sharing of this information across primary care. GPs have a key part in the roll-out of an electronic EOLC register in Rotherham and linking this to the PMS premium will provide an excellent incentive for the EPaCCS to be fully implemented and for patients to get real benefits from a co-ordinated and well informed approach to their care

The CCG is committed to ensuring that all patients have equal access to internet based services, in particular the ability to book appointments online and order repeat prescriptions which are then automatically forward to pharmacies for collection. 33% of practices are now live with EPS Release 2 functionality and 82% of pharmacies. Many general practices in Rotherham already offer the facility to online book but it is not well publicised and websites are not easy to navigate so a key aim will be

- The CCG is also committed to exploring best practice in relation to IT solutions for self care, it will therefore commission and IT workstream to review the following:
- Monitor and review telehealth solutions that can be used to support the elective referral programme
- Monitor and review telehealth solutions that can be used as part of Long Term Conditions management
- Observe the work ongoing in other health communities and the whole system demonstrator programme to identify opportunities for local telehealth implementations in particular, there is strong support across the NHS for Flohealth with positive feedback from where it has been implemented to date

Implementing (RAIDR) Reporting Analysis & Intelligence Delivering Results. The CCG is required to provider member practices with high quality information on patient activity and costs. In summer, 15/16 the CCG will pilot RAIDR which is a GP developed tool initially from the North East of England. It is expected that this tool will help practices better understand their patient flows and compare their activity with their peers. The tool has a range of Dashboard covering areas such as emergency admissions, patients who regularly attend hospital, risk stratification, linkages between prescribing and activity data. There are also screens that will help practices with tasks such as flu vaccination, dementia diagnosis and data quality. Over time it will be possible to develop screens that will make reporting for Locally Enhanced Services to become less onerous. If the tool pilots well the CCG will procure RAIDR for all practice in autumn 15/16.

Glossary

A&E	Accident & Emergency
APMS	Alternative provider of medical services
BCF	Better Care Fund
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DES	Directed Enhanced Service
FyFV	Five year forward view
GMS	General Medical Services
GPs	General Practices
LES	Local Enhanced Service
LIS	Local Incentive Scheme
MPIG	Minimum practice income guarantee
NES	National Enhanced Service
NHS	National Health Services
NHSE	NHS England
PMS	Personal Medical Services
QIPP	Quality, innovation, productivity and prevention programme
RMBC	Rotherham Metropolitan Borough Council

NHS
Rotherham
Clinical Commissioning Group

THE GATEWAY REPROCUREMENT & CHANTRY BRIDGE DISPERSAL

Background

Rotherham Clinical Commissioning Group received delegated authority to commission GP services in Rotherham from 1 April 2015. Health Scrutiny committee has been kept updated in relation to the drafting of the interim GP strategy however there were a number of operational contracting issues handed over to RCCG as part of delegation. This included the requirement to re-procure the Chantry and Gateway contracts as Chantry was due to expire in September 2015 and the Gateway is due to cease on 31 March 2016.

Committee members will be aware that The Gateway is a social enterprise consisting of 3 practices; The Gate, Canklow and Rosehill. RCCG is working closely with the Gateway in relation to this requirement and will be briefing patients in early October. The services provided from the Gateway will not be subject to any change.

Chantry Bridge is currently provided by Care UK and operates from Rotherham Community Health Centre.

Process

Chantry

The CCG's delegated committee for primary care approved a full re-procurement for retaining services at Rotherham Community Health Centre. Following this competitive process, unfortunately there was no compliant provider to retain GP services at the centre. Therefore, the CCG is managing the transfer of around 1,700 patients to other GP practices across Rotherham.

The walk-in centre and all other health services currently provided at Rotherham Community Health Centre will remain open to all Rotherham patients and is not affected by the changes to Chantry Bridge GP practice.

Gateway

RCCG is re-procuring the services for the Gateway practice in their current format and therefore, subject to re-procurement being successful, patients will not see any change to the services delivered from these practices. We are legally required, because of the length and size of the contract to tender these services openly. The Gateway practice understand this requirement. If the current provider is unsuccessful, TUPE regulations are applicable and therefore staff currently employed within the practices will be transferred.

RCCG will be in the practices during October to explain the re-procurement process to patients and to answer any questions they ma y have. The timeline for the process is as follows:

15 October	Invitation to tender published
26 November	Deadline for responses
w.c 4 January	Notification to providers
1 April	Contract mobilised

As this is for a larger population and the existing provider is keen to continue, a similar situation to that which occurred at the Chantry is not expected.

RCCG will advise Health Scrutiny Committee of the successful provider once the procurement process has concluded.

Jacqui Tuffnell - Head of Co-commissioning

Rotherham Metropolitan Borough Council

Health Select Commission

Title
Access to GPs scrutiny review – Health and Wellbeing Board response

Date
22nd October 2015

Is this a Key Decision and has it been included on the Forward Plan?
This is not a key decision.

Strategic Director Approving Submission of the Report
Terri Roche, Director of Public Health
Ext. (2)55845

Report Author(s)
Michael Holmes, Partnership & Policy Officer
Ext. (2)54417

Ward(s) Affected
All

Executive Summary
The Health Select Commission's access to GPs scrutiny review, carried out between September 2013 and March 2014, produced a number of recommendations grouped in four broad areas: improving access, sharing good practice, improving information for parents and capacity to deliver primary care.

Three recommendations were directed to the Health and Wellbeing Board:

Improving information for patients
- The Health and Wellbeing Board should consider developing a borough wide publicity campaign to raise awareness about the impact of not cancelling unneeded appointments.
- The Health and Wellbeing Board should consider revisiting the "Choose Well" campaign to raise awareness of how to access local services and which is the most appropriate service in a range of situations.

Capacity to deliver primary care
- In light of the future challenges for Rotherham outlined in the (review) report, the review recommends that a proactive approach is taken by the Health and Wellbeing Board to mitigate risk to the delivery of primary care.

This report provides a brief summary of the action being taken.

Recommendations
Members are asked to:

a. note the action being taken in relation to the access to GPs review's specific recommendations directed to the Health and Wellbeing Board.

List of Appendices Included
None

Background Papers
Scrutiny review: access to GPs – final report

Consideration by any other Council Committee, Scrutiny or Advisory Panel
The Health and Wellbeing Board considered the access to GPs scrutiny review recommendations at its meeting on 8th July.

Council Approval Required
No

Exempt from the Press and Public
N/A

Access to GPs scrutiny review – Health and Wellbeing Board response

1. Recommendations

1.1 Members are asked to:

a. note the action being taken in relation to the access to GPs review's specific recommendations directed to the Health and Wellbeing Board.

2. Background

2.1 The Health Select Commission undertook a review of access to GPs between September 2013 and March 2014. The aims of the review were to:

a) establish the respective roles and responsibilities of NHS England and GP practices with regard to access to GPs
b) ascertain how NHS England oversees and monitors access to GPs
c) identify national and local pressures that impact on access to GPs – current and future
d) determine how GP practices manage appointments and promote access for all patients
e) identify how NHS England will be responding to changes nationally
f) consider patient satisfaction data on a practice by practice basis and to compare Rotherham with the national picture
g) identify areas for improvement in current access to GPs (locally and nationally).

The review produced 12 recommendations, three of which were directed to the Health and Wellbeing Board:

Improving information for patients

- The Health and Wellbeing Board should consider developing a borough wide publicity campaign to raise awareness about the impact of not cancelling unneeded appointments.
- The Health and Wellbeing Board should consider revisiting the "Choose Well" campaign to raise awareness of how to access local services and which is the most appropriate service in a range of situations.

Capacity to deliver primary care

- In light of the future challenges for Rotherham outlined in the (review) report, the review recommends that a proactive approach is taken by the Health and Wellbeing Board to mitigate risk to the delivery of primary care.

3. Key Issues

3.1 The majority of the actions in response to the above recommendations would fall to Rotherham Clinical Commissioning Group (CCG) given their role in commissioning GP services.

Publicity campaign on cancelling unneeded appointments

3.2 The CCG provides a text messaging reminder service for patients, though this does rely on patients signing up. It should also be noted that a significant number of appointments made on the day are also missed, so forgetting appointments is clearly not the sole issue.

3.3 Screens and posters in GP practices will promote messages asking patients to cancel unneeded appointments with the intention that practices may also maintain and publicise a running total of appointments missed and hours lost. The CCG and other partners will include similar messages in staff bulletins, emphasising the fact that the NHS is busy and missed appointments cost money and prevent the slot being used for other patients who need help. This could include Rotherham Chamber pushing messages out through their member employers.

3.4 Within the council, we can raise awareness amongst staff via the managing director's briefing, Friday Factfile (the weekly corporate bulletin) and Take 5 staff newsletter. The message will include a request to spread the word through friends and family.

3.5 Finally, missed appointments/cancelling unneeded appointments will be picked up with the public at a 19th November CCG event on *the changing face of GP services*.

Revisit the "choose well" campaign to raise awareness of how to access the most appropriate service

3.6 Locally, *choose well* has been superseded by *right care, first time*, which has a similar focus on changing behaviour and encouraging people – in the appropriate circumstances – to use options such as Pharmacy First or self-care rather than a GP, or to call NHS 111 before attending A&E. The CCG have produced leaflets and other literature to support this initiative, which will tie-in with national campaigns, such as *stay well this winter*.

3.7 The CCG have now produced a winter communications action plan, linked to right care, first time. Again, this will focus on four key steps: self-care, Pharmacy First, NHS 111 and GP or walk-in centre. There will be a multi-agency campaign utilising banner stands in practices, adverts and interviews in the local media, social media messages, websites and internal publications.

The Health and Wellbeing Board takes a proactive approach to mitigate risk to the delivery of primary care

3.8 In all of the actions above, the board will have a role in bringing partners together to ensure consistent messages are delivered, though the board would not lead on any campaigns. Beyond that, the board will take a wider perspective – working with the new Rotherham Together Partnership – in promoting Rotherham as a destination and highlighting local health and wellbeing initiatives.

3.9 The board will use a revamped website, a Twitter account and a new quarterly newsletter to raise awareness of partners' activity and disseminate important messages.

4. Options considered and recommended proposal

4.1 As outlined above, a range of methods will be used to address the issues raised in the access to GPs review. The broad approach recommended is for the CCG to lead on specific activity, but with the Health and Wellbeing Board having an overview and channelling efforts from a range of partners. An alternative would be for the board to take a lead role, but given that it has no budget and relatively low public awareness, this is not considered to be the best option.

5. Consultation

5.1 This report is informed by discussions with the CCG and incorporates wider partner input from discussions at the Health and Wellbeing Board.

6. Timetable

6.1 The CCG's winter communications action plan timetable has activity running from October through to February 2016. The Health and Wellbeing Board aims to have a Twitter account up and running for its next meeting on 25th November, with the new-look website running to a similar timetable and the first newsletter due no later than February 2016.

7. Financial and Procurement Implications

7.1 There are no direct financial or procurement implications for the council arising from this report.

8. Legal Implications

8.1 There are no direct legal implications.

9. Human Resources Implications

9.1 There are no direct human resources implications.

10. Implications for Children and Young People and Vulnerable Adults

10.1 Blocking up the system by not cancelling unneeded appointments or using the "wrong" service, leads to increased pressure on primary care services and can make it more difficult for vulnerable people – adults or children – to get help when they need it. This can create a vicious circle where parents or carers, unable to get a timely GP appointment, attend A&E instead, putting further pressure on the system.

11 Equalities and Human Rights Implications

11.1 It is vital to ensure that Rotherham can attract sufficient numbers of GPs and provide an effective service, given that levels of deprivation are likely to correlate with relatively high demand for GP services in the borough.

11.2 Communications should consider language barriers, people with autism or learning disability, and people with a sensory impairment, as well as specific barriers faced by other disadvantaged groups.

12. Implications for Partners and Other Directorates

12.1 As noted in the report, the majority of actions will fall to Rotherham CCG, but all partners and RMBC directorates will need to work together, through the Health and Wellbeing Board, to provide consistent messages.

13. Risks and Mitigation

13.1 Risks in relation to GP access generally relate to the twin pressures of reduced funding combined with rising demand, exacerbated by workforce / recruitment issues.

13.2 Local partners need to work effectively together, through the Health and Wellbeing Board, to maximise resources, provide good quality information to enable people to access the right service at the right time, and ultimately work towards improving health and reducing health inequalities to minimise future demand.

14. Accountable Officer(s)

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Adult Social Care in Rotherham

A Vision and Strategy

Introduction

Nationally, the provision of social care for adults has undergone enormous change over the past generation. While the direction of travel has been reasonably consistent, the pace of change has accelerated over the past few years as the demand for more personalised services continues to grow, traditional models of care are seen to be outdated and not delivering independence, choice and control and pressure on the system grows from more demand and less resources.

It is well-recognised that the state – national and local – has often created and maintained dependency rather than supporting independence. There is a recognition of the importance of building resilience at an individual, family and community level as this is better for people and offers a more sustainable model for the future.

Linked to this, the approach in Adult Social Care is increasingly based on an assets model – identifying with the person what they can do, what they do have, who they know and which community groups they are linked into, what their family and friends can do as carers and what the wider communities can offer.

Further, the focus in ASC is on outcomes – both for individuals and their carers and families but also for the wider community and residents. Improving the help and support for individuals who need it at any specific time benefits the whole community as they are likely to be family and friends of people requiring support or who may come to need it.

These changes have now been reinforced with the introduction of the Care Act – assessing on the basis of outcomes – health and wellbeing, quality of life, engagement in the community and so on. Equal rights for carers and the cared for which builds on years of legislation and enshrines the rights of carers.

For many years, care was based on an institutional model and as this began to change with the recognition of the scale of abuse that was taking place, more care began to be provided in the community. However, the replacement of large institutions outside of town with smaller ones based in towns was never a sustainable model as users and carers increasingly demanded “a life” not “a service”.

Therefore, there has been an increasing development of care based on a personalised model with people enabled to live in their own homes and to access services, facilities and buildings as part of the wider community. Consequently, the role of ASC has changed – rather than being focused on delivering a range of services, it has had to develop a strong partnership and influencing role. Within the

Council, it has led on the development of the recognition about making all services accessible to all sections of the local population. Further, it has led on developing the recognition that all members of the community, no matter how disabled or elderly all should be valued members of the community.

Beyond the Council, ASC has become a key partner with health services and this partnership has been enshrined in different ways – eg through the Health and Wellbeing Boards and the Better Care Fund. Increasingly, integrated services are seen as the way forward in delivering more personalised and holistic care.

In considering what integrated services look like, it is essential to ensure that mental health services are seen as a key element of the integrated care and health services. It is essential to put in practice the slogan “no health without mental health”. The evidence is very clear that physical health and mental health are inextricably linked and that it is essential to treat them equally in addressing people’s care and health needs. Many studies have demonstrated the benefits in terms of improved outcomes for users through the integration of services. Integration should include the commissioning and delivery of care services and physical and mental health services.

Further, as there has been a move to maintaining people in the community there has come the recognition that there needs to be a wide range of accessible community services, facilities, buildings, activities and community engagement. ASC has been central to the development of these community assets to which older people and people with disabilities should have access. Consequently, ASC has developed strong partnerships with third sector organisations, community groups, faith groups and individuals who are delivering a wide range of activities and services in local communities.

Over time, the nature of the needs that ASC must address has changed. Improvements in health and care services have meant that people with disabilities are living longer which has brought new challenges eg caring for people with learning disabilities who have dementia. The growth in the number of very elderly people has meant that there are more older people with more complex needs. While this has meant that these people require higher levels of service, there is also a recognition that more can be done to avoid them requiring intensive services and consequently, the aim is to divert people from the formal care system and to develop preventive services and rehabilitation services to enable people to regain and maintain levels of independence.

The importance of prevention and early intervention is well-recognised and this cuts across social care, physical and mental health. Further, the principle should be employed in whatever situation people live. It is essential that the person is seen in the whole – that their health and wellbeing are addressed – and that this is done in at every stage of people’s journey through life – whether they are outside of the formal

care system or whether they are receiving high levels of formal care and health services. It is essential that the opportunity is taken at all times to maximise people's independence and ability to make choices and take control of their lives.

Another major change over the recent past is the development of safeguarding for adults. While initially focused on protection and reacting to instances of abuse, the approach to safeguarding has developed to recognise that it is an integral part of the personalisation agenda helping to ensure personalisation is possible and deliverable. The recognition that safeguarding adults is everybody's business is well-established and the growing intolerance of hate crimes helps to ensure that older people and adults with disabilities can access wider community assets.

Another significant change is the funding available for ASC. This has grown significantly over many years but has been clawed back dramatically in the face of the economic recession. The national picture is that social care for adults is underfunded and resources have been transferred from NHS budgets to underpin adult social care budgets. Demographic pressures, rising standards and expectations have added to the challenge facing adult social care budgets and there has been enormous pressure to ensure that the available resources are used effectively and deliver best value. Consequently, new ways of delivering care have emerged – personal assistants, micro-enterprises, CICs etc.

Given these changes at a national policy level and given the groundswell of demand for change from users and carers it is essential that the vision and strategy for Adult Social Care take these changes on board and reflect them.

Vision for Adult Social Care in Rotherham

The ambition in Rotherham is that adults with disabilities and older people and their carers are supported to be independent and resilient. The outcomes that are desired for these groups are that they should live good quality lives and their health and wellbeing is maximised.

For most people, this will entail remaining in the community with friends and family. However, for some to achieve these goals, alternatives such as Shared Lives, Supported Living , Extracare Schemes etc will be necessary and for a small minority a residential placement may be necessary. The focus should be on maintaining people in the community and this requires long term support eg homecare as well as a wide range of prevention and rehabilitation services and a wide network of resources, services, groups and activities in the community.

It is essential to recognise that during the course of people's lives, there may be times when they need support and care and health services need to be prepared to intervene on those occasions. However, the aim should be to intervene appropriately with the aim of providing minimal support to enable people to maintain their

independence. There is always a risk that by providing too much support people will have their independence eroded.

In order to achieve this vision, it is fundamental that a network of support is created which includes Council services, health services, private and third sector services and voluntary, community and faith groups – as well as friends, family and neighbours. Further, it needs to be recognised that as people grow older or live with a disability, it is ever more important that local facilities and services are well-developed as these are the ones they will look to first and foremost. Therefore, what is required is a partnership across Rotherham.

The strategy to deliver this vision

The development of a wide range of community resources in Rotherham's communities underpins the strategy. This network of community assets provides the support for people to live fulfilling lives engaged with their family, friends and community. This prevents their physical and mental health deteriorating and is the basic building block for the strategy and without it the pressure on the formal care and health system will overwhelm it.

Therefore, the strategy must recognise that this network of community resources needs to be developed and invested in and that it is best delivered through a partnership with the third sector. The Council and the health services, along with other partners such as the police, must work in partnership with each other and with the third sector to build the community assets which ensure people thrive and not just survive in the community.

At any point, people may feel they need advice or support for themselves of for a family member or friend. Therefore, the strategy needs to ensure that there is a front door which listens to what people are asking for and addresses these requests in a way which supports them to take control of the situation for themselves and this could mean the provision of information or advice or it could include requesting simple equipment or undertaking a self -assessment. In this way, people are supported through simple, one-off interventions which allows them to maintain in control and to maintain their independence. The aim is that a minimum of 75% of these requests are dealt with successfully at the front door.

However, for some people it may be that their needs are greater or the initial response hasn't resolved the position. In these situations people will need to be assessed. However, again the aim is to assess for the desired outcomes and to support the person to develop a solution which maximises them taking control and minimises interventions from the formal care sector. This is where preventive services such as telecare and services such as rehabilitation and enablement become critical. But even here, it may be that the intervention that is required is support to re-engage with the local community which might be achieved through a volunteer offering support. The strategy focuses on building prevention, rehabilitation

and enablement throughout the system as well as one-off interventions such as telecare which give people back control and independence.

Even when people have begun to engage with the formal care sector, it is still essential to ensure that they are engaged with the community assets. Being supported to dress and look after oneself is a means to an end of social engagement and it is essential that this is seen as important as meeting the needs of daily living.

Particularly for people with physical and mental disabilities and mental ill-health, it is essential that the focus is on enabling people to live normal lives – employment, volunteering, education, leisure activities, social activities etc etc. Part of this is taking risks and being supported to make good choices that enhance people's lives. The strategy needs to focus on developing opportunities to participate in normal activities in the community – not separated off into separate activities.

For some people as a result of disability, it will be necessary to provide more support but the aim of the strategy is to develop alternatives to traditional services. So, the strategy promotes services such as Shared Lives, supported living, extracare schemes, homes suitable for older people, key ring schemes etc. The strategy seeks to minimise the use of residential and nursing care while recognising that there is a place for it in a care and health economy. Similarly, the strategy promotes personalised services as alternatives to day services and for some this will include employment while for others this will not be possible but people can lead fulfilling lives outside of day centres.

As well as working in partnership with the third sector, care and health services need to work in partnership with each other. The strategy promotes the development of integrated commissioning and integrated delivery of services such as intermediate care. It is inconceivable that care services can be delivered outside of an effective partnership which promotes integration at every opportunity.

It is essential to recognise that in Rotherham, the CCG, the mental health trust and the hospital trust are committed to developing their services in a similar way. There is a commitment to locality working and to utilising community assets effectively. Indeed, the CCG has developed a nationally recognised scheme on social prescription. Further, the emphasis on integrated services, prevention and early intervention are all key themes in the transformation programmes the Trusts are developing.

The underpinning thrust of the strategy is the personalisation of services and this carries over into safeguarding. There is a need for a shift in culture not just in the way social workers assess for outcomes rather than services but also in regard to safeguarding. Establishing desired outcomes, putting people at the heart of safeguarding rather than processes, allowing people to take risks with support if necessary and appropriate are essential elements of the strategy.

Delivering the strategy

In order to deliver the strategy a series of interrelated commissioning strategies need to be developed. These strategies will involve Council services – especially adults, children, housing but also community development and community safety - and health services and other organisations where appropriate such as the police.

The strategy should be owned by the Health and Wellbeing Board and the Adult Safeguarding Board and it will be delivered through a range of Boards and groups. Ultimately, the DASS as the Statutory Office has responsibility for developing the strategy and ensuring it is being delivered.

Graeme Betts

30th July 2015