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

Date:-	**Thursday, 14th April, 2016**	**Venue:-**	**Town Hall, Moorgate Street, Rotherham S60 2TH**
Time:-	**9.30 a.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 held on 17th March, 2016 (Pages 1 - 21)

For Discussion

8. Access to GPs Scrutiny Review (Pages 22 - 44)
   Terri Roche, Director of Public Health, and Jacqui Tuffnell, Head of Co-Commissioning, Rotherham Clinical Commissioning Group

9. Urinary Incontinence Scrutiny Review Update (Pages 45 - 57)
   Rebecca Atchinson, Public Health

10. Draft Carers Strategy (Pages 58 - 75)
    Sarah Farragher, Adult Social Care, and Jayne Price, Carers Forum

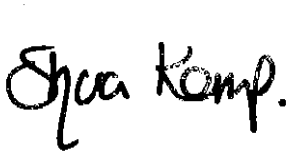
11. Response to Scrutiny Review: Child and Adolescent Mental Health Services - Monitoring of Progress (Pages 76 - 88)

For Information/Discussion

12. Quarterly Briefing with Health Partners (Pages 89 - 90)

13. Healthwatch Rotherham - Issues

14. Date of Future Meeting
Thursday, 16th June, 2016 at 9.30 a.m.



SHARON KEMP,
Chief Executive.

Membership:

Councillors Sansome (Chair), Mallinder (Vice-Chair), Ahmed, Burton, Elliot, Evans, Fleming, Godfrey, Hunter, Khan, McNeely, Parker, Price, Rose, Rushforth, John Turner, Smith and M. Vines.
Co-opted Members:
Vicky Farnsworth and Robert Parkin (Rotherham Speak Up) and Peter Scholey.

HEALTH SELECT COMMISSION
17th March, 2016

Present:- Councillor Sansome (in the Chair); Councillors Ahmed, Burton, Elliot, Fleming, Godfrey, Hunter, Khan, McNeely and John Turner.

Apologies for absence were received from Councillors Mallinder, Parker, Rose, M. Vines, Victoria Farnsworth (Speak-up) and Robert Parkin (Speak-up).

78. DECLARATIONS OF INTEREST

Councillor Fleming declared a personal interest as he was an employee of the Sheffield Teaching Hospital Foundation Trust.

79. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

80. COMMUNICATIONS

A. Information Pack
Health and Social Care Integration
The discussion paper was important in context of the Select Commission's brief.

BCF Q3 Return
The cover report contained key information. The return template to the NHS England could be found at

(http://moderngov.rotherham.gov.uk/documents/s104800/BCF%20Appendix%20A%20%20BCF%20Quarterly%20Data%20Collection%20Template%20Q3%2015-16%20FINAL.pdf)

Care Quality Commission Guidance Documents
Any comments to be forwarded to Janet Spurling, Scrutiny Officer.

B. General Practice
Contracts
Further to Minute No. 41 of the meeting held on 22nd October, 2015 (Interim GP Strategy), it was noted that the Gateway procurement had concluded. The Gateway CIC had retained the contract so there would be no changes.

Chantry Bridge patients had been dispersed to other practices. Only one patient had raised an issue with the Clinical Commissioning Group who had then worked with the patient to get them into a practice they were happy with. There were still some patients who had not yet registered with another practice but the CCG were confident that this was primarily because they had left the area.

Treeton GP Practice
The Clinical Commissioning Group had met with the developers regarding a new medical centre on the Waverley site. They were keen to explore options for the community in that area but were mindful that Treeton was at capacity and work should progress as soon as possible. The developers were meeting regularly with the Planning Service and, subject to planning permission, the CCG were looking to an opening at the end of 2017.

YAS Quality Account Feedback
Members were thanked for submitting their comments with a reminder to those who had not done so yet of the 18th March deadline.

Rotherham Clinical Commissioning Plan
The deadline for comments was Friday, 18th March.

Adult and Older People Mental Health Transformation
It was hoped that an update would be submitted to the April Select Commission meeting.

Joint Health and Overview Scrutiny Committee Meeting held on 26th February, 2016
The powerpoints were available from the meeting which provided good background information for the national picture. The information contained therein included:-

- NHS England Specialised Commissioning and National Service Reviews
- Regional Strategic Overview including delivering the Five Year Forward View and Sustainability and Transformation Plans
- Care Quality Commission – their approach to inspection and regulation and how they work with Overview and Scrutiny Committees
- Further work around delayed transfers of care (DTOC) could be included in the work programme for the Joint Committee

81. MINUTES OF THE PREVIOUS MEETING

Resolved:- That, subject to the following clerical corrections, the minutes of the previous meeting of the Health Select Commission held on 21st January, 2016, be agreed as a correct record:-

Minute No. 72 (Overview of Public Health/Spend the Public Health Grant in Rotherham)

Health Challenges in Rotherham – should read “Rotherham women 81.4 years”

and Value of the Ringfenced Grant – should read “2014/15 - £14.175M”.

Arising from Minute No. 72 (Overview of Public Health/Spend the Public Health Grant in Rotherham), attention was drawn to the fact that the figures did not add up to 100%.

82. ROTHERHAM FOUNDATION TRUST QUALITY ACCOUNT

Tracey McErlain-Burns, Chief Nurse, gave the following powerpoint presentation:-

Quality Ambitions 2014-16

- SAFE Mortality – Reduction in HSMR (Hospital Standardised Mortality Ratio) year on year
- SAFE Achieve 96% Harm Free Care (HFC) with zero avoidable grade 2-4 pressure ulcers and zero avoidable falls with harm
- CARING & RELIABLE Achieve improvements in all Friends and Family responses
- RELIABLE Achieve all national waiting times targets i.e. 18 weeks, cancer and A&E

Quality Improvements 2015/16

- 100% of unpredicted deaths will be subject to review
- From a baseline of 120 we will reduce the number of patients with a LOS>14/7 (length of stay greater than 14 days)
- Improved reporting of the deteriorating patients
- Reduce noise at night
- Increase the number of colleagues trained in Dementia care and reduce complaints
- Improve complaints response times
- Meet stroke targets

So how have we done?
Mortality

- Rolling 12 months HSMR
  December 2014 = 99.28
  November 2015 = 108.06
  (March 2015 – 112.48)
- SHMI (Standardised Hospital Mortality Index) July 2014 to June 2015 111.64

Harm Free Care

- Achieve minimum 96% Harm Free Care with the following percentage reduction on the 2014/15 baseline (No. Trending at 94.85%; a 0.5% improvement on the previous year):-
- 70% reduction in avoidable pressure ulcers grade 2-4 (yes – 74% achieved)
- 50% reduction in avoidable falls with significant harm (yes – 57% achieved)

Family and Friends Test (FFT)

- Achieve and maintain a minimum 95% positive (FFT) score – in-patients (yes – 97% achieved)
- Achieve and maintain a minimum 86% positive FFT score – A&E (yes 88% achieved)
- Achieve a 40% FFT response rate – in-patient areas (yes 41% achieved)

4 Hour Access – National Comparison

Period	TRFT Performance	TRFT Rank (of 140)	England Avg (Type 1)	No of Trusts >95% (Type 1)
April	93.3%	53	89.8%	31
May	97.3%	9	92.5%	45
June	97.1%	16	91.5%	53
Q1	95.7%	23	91.1%	44
July	93.7%	73	92.5%	55
August	88.6%	113	91.5%	44
September	93.9%	46	90.1%	34
Q2	92.1%	79	91.45	43
October	92.5%	44	88.6%	21
November	93.7%	29	87.1%	14
December	85.5%	82	86.6%	14
Q3	90.5%	58	87.4%	12

Other Improvement Priorities

- 100% of unpredicted death reviews – yes
- Reporting of the deteriorating patient – yes
- Noise at night - ?
- Dementia training – yes (61% of TRFT colleagues have had first level dementia training)
- Complaints performance – no
- Stroke targets – yes (improved proportion with AF anti-coagulated on discharge; proportion admitted directly to Stroke Unit and spending 90% of their time on the Stroke Unit; proportion scanned within an hour. Business case for allied health professional ESD team supported)

Other items to be covered in the Quality Account/Report

- Staff and patient survey results
- Listening into Action work
- Environmental improvements
- Community transformation
- Progression from the CQC action plan to a Quality Improvement Plan
- Serious incidents and Never Events
- Data quality
- Workforce

Discussion ensued with the following issues raised/clarified:-

- 4 hour access - performance had deteriorated from Q1 to Q3 and was an area of concern for the Trust

- There were a number of reasons for not meeting the A&E national target the majority of which had related to workforce matters within the Emergency Department and more recently delays in waiting for access to beds. There had been recruitment of consultants, middle grade Doctors and nursing colleagues and the use of a number of locums in the Emergency Department

- The Trust Board received an Operational Performance report and Integrated Performance report (available on the Trust's website) which provided the detail about how long patients were waiting; it did not give a number for those waiting but an indication could be provided outside of the meeting

- Those patients whose hospital stays were longer than 14 days were often elderly who were admitted during the Winter period and took longer to recover from their conditions. There was the chance that some, as it got nearer to their expected discharge date, might get a hospital acquired pneumonia due to their long length stay, or not being able to achieve a discharge plan for that patient which required multi-agency responses

- At the time of the 2015/16 Quality Account, a baseline had been set of 120 patients with a long length of stay. As of August, 2015, the Hospital had been below that baseline. An ideal target of 70 had been set which enabled the Trust to manage its bed base effectively. There had been no reduction in the number of beds across the particular time period; the figure of 70 had been calculated on the reduction of bed places previously. The reduction had been achieved with no more than 70 patients in hospital with a long length of stay and it had been planned to open beds over the winter period. That Ward remained open at the moment

- The steady increase in November had been a combination of factors. There had been pressure on A&E and work was taking place with colleagues to change the systems of working and in doing so recognised that more work was required to improve the internal systems particularly in recognising what the expected day of discharge was and how that was communicated to other agencies

- When talking about planning a patient discharge, the Hospital would often refer to the EDD (Expected Date of Discharge) which was one measure when the patient was considered, usually by the medical clinician, as being medically fit for discharge. What the Trust was trying to do currently was identify a date at which point a patient was:

(a) considered medically fit for discharge
(b) socially ready for discharge and may well include readiness of other partners to support the patient and family, and
(c) therapeutically ready for discharge particularly if Physiotherapy and Occupational Therapy colleagues might be involved

- The Trust did not have any trained psychologists; the only areas where there was some active psychological intervention was within some of the Cancer pathways. However, a number of the community-based colleagues had extensive communication skill training which took account of some psychological therapies but no training in psychological therapy techniques

- The Trust had the benefit of a Community Unit on the Hospital site should a patient require ongoing rehabilitation of a non-acute nature. There was also access to intermediate care beds through work with Social Care colleagues. If the Trust had particular pressures and had a number of patients that no longer needed to be in hospital, then work would take place with Social Care and the Clinical Commissioning Group for spot purchase where a bed was purchased for a period of time in an alternative but suitable accommodation for the patient. This would be discussed with the patient's family. If families strongly disagreed with the proposal it may lead to a slightly longer delay in that patient's transfer

- Internally the Trust's target was to have no more than 20 patients in hospital who had a long length of stay and were medically fit for discharge. The presentation showed that the Trust had been having around 30-40 patients in hospital who were medically fit for discharge with an average length of stay beyond being medically fit of about 10 days. However, in the last couple of months there had been no significant increase in those numbers

- A range of mechanisms had been used to gain the patient's opinion. Trust Governors held surgeries and had spoken to many patients, families and visitors to the Hospital. The report was submitted to the Council of Governors with a management response. Further information about the Governors surgeries would be forwarded

- Friends and Family Test – still difficult to obtain responses in the Emergency Department despite trying various means. The dip in response rates and scores in C&F services was in relation to the School Nursing Service but had improved since the survey was changed from a four point to a six point scale.

- The Trust worked with a company, Dr. Foster, and through the use of Dr. Foster data sets were able to analyse mortality by diagnosis, by weekend, by day of the week and also looked at crude mortality and compared its mortality rates with other Trusts. There was a depth of data which the Quality Alerts and Mortality Group analysed on a

monthly basis and more recently the Medical Director had presented a report to the Board which was available on the Trust's website

- The Health Care Support Workers in the community were working on pressure ulcer avoidance

- The Trust measured data outliers on a daily basis by speciality; the Executive Team knew how many the Trust had. Currently there were approximately 20 patients who had been moved from 1 area to another

- There were currently 29 consultant vacancies within the Trust, many of which were being filled by locum colleagues. 5 consultants had successfully been recruited recently. The newly recruited Head of Medical Workforce would assist with the plans to make the Trust attractive to new recruitment. In some areas there were particular national shortages and district general hospitals of Rotherham's size would always struggle to compete when there was a large teaching hospital not too far away

- There were currently approximately 30 registered nursing vacancies, 22 at Band 6, and 8 at Band 5. The overseas recruitment programme had been suspended with the Trust investing in the development of the colleagues already recruited

- Additional Health Care Support Workers had been recruited together with a further 20 apprentices. There was a workforce improvement programme taking place but inevitably the use of locum and agency colleagues did not give the sense of loyalty to the organisation as that of its own workforce

- Universities still had more potential nurses apply for places than there were training places available. It was not yet understood what the impact of the changed bursary system for potential nursing students would be

- Currently there were 140 student nurses on placement at the Trust together with 50 allied professional students. Previously placement students had reported a positive experience and Tracey actively engaged with them from the beginning to help them see the benefits of working at Rotherham Hospital

- Agency nurses were currently still used where there were vacancies and, where there was long term sickness combined in a particular area with perhaps maternity leave. The Trust was currently investing in its own workforce even if that meant the opportunity to recruit over its establishment as it gave the benefit of continuity of care for the patient, commitment from a substantive colleague and a reduction in the financial burden of using agencies

- The annual staff survey changed slightly each year. The Trust had the option to survey all colleagues or only a sample of 850. Last year it had chosen to sample all colleagues and received a mid-40% response rate. It included staff morale in a number of different ways including support for line manager, whether the individual was considering leaving the Trust, whether they had reported an incident and whether they felt they had received feedback etc.

- At the moment data quality with regard to the length of time it took before a Ward requested medication for a patient to be discharged was received was not formally reported
  Following the meeting the information below was provided for HSC
  The target was to turn the script around in under 120 minutes. The average turnaround once the prescription arrived in pharmacy was 98 minutes. This was monitored monthly and reported to the division of support services.

- There were a number of things that enabled colleagues to progress their career. There were opportunities for Health Care Support Workers to become Registered Nurses by going to university, however, the numbers were very small. There may be an opportunity for Health Care Support Workers with regard to assistant practitioner roles

- The intent, whether medical or nursing colleagues, was to recruit the Trust's own workforce and reduce agency costs. It was becoming increasingly difficult to attract some agencies as a consequence of the implementation in agency caps and therefore the reduction of the hourly rate that was paid to individuals. The Trust projected that it would continue to recruit nursing colleagues, vdrive out the use of agency combined with increasing its internal bank. Similarly for medical colleagues, the strategy was again to recruit substantively and avoid the need for agency colleagues. It could be difficult to recruit Doctors in certain areas due to national shortages and, therefore, anticipated that there would still be some reliance on agency and locum doctors. In terms of working together and savings, as a Working Together Partnership, the Trust would be looking to circa £30M savings through procurement given the amount of budget the Working Together Partnership had

- The Trust currently did not utilise self-medication in the Hospital. The majority of patients who were admitted to Hospital had their medication administered by nursing colleagues. A few patients would self-medicate whilst in hospital but it was a question as to whether there should be an increasing opportunity to self-medicate. The benefit of a patient being involved in self-medication was that when they went home they knew more about their medication. However, not many patients would be able to self-medicate when they went into hospital. Work was taking place with the new Chief Pharmacist to try and have more technical pharmacy input to help patients understand

their medications for when they returned home. There were some instances when patients were ready to go home but were waiting for their take home drugs to come back to the Ward. This could be a cause for concern

- There were some patients who had sufficient medication at home who had had no changes to their medication and would have been able leave the hospital sooner. The new Chief Pharmacist, Medical Director and Chief Nurse were currently putting together an improvement plan for medicines management. It would focus not only on medicine safety whilst in hospital but also increasing patient understanding of medication when in hospital and shortening the period they waited for medication once told they could go home. The aim would be to seek to try and achieve increased numbers of patients having an understanding of their expected date of discharge sooner in their hospital stay and, once clinicians had agreed with the patient and family the date to work towards, an obligation to prepare a prescription that could be taken to the Ward before the patient was in the position of having a long wait

Resolved:- (1) That the information presented be noted.

(2) That the draft Quality Account document be submitted to members of the Health Select Commission for their consideration.

(3) That the Select Commission provide feedback to the Foundation Trust in accordance with their timescales.

83. UPDATE ON BETTER CARE FUND

Jon Tomlinson, Interim Assistant Director Commissioning, gave the following update on the Better Care Fund:-

Background

- The Select Committee has previously received updates about progress with the Better Care Fund (BCF)
- Rotherham has successfully established robust governance and submitted returns to NHS England in a timely manner
- The BCF remains a key vehicle for integration between the NHS and local authorities
- The original BCF plan was developed around 2 years ago
- NHS England recommend that partners review their plans to ensure that progress is maintained and that funds are effectively targeting the right areas
- An initial review has been carried out on our plan and the outcomes are as follows

BCF Review

- The original BCF plan had 72 lines of funding and 15 themes
- The revised plan has 33 lines of funding with 6 broad themes
- The 6 themes cover:-
  Mental Health
  Rehab/Re-ablement and Intermediate Care
  Social Care Purchasing
  Case Management and Integrated Care Planning
  Supporting Carers
  BCF Infrastructure
- Each theme has then been rag rated in relation to strategic relevance, service specification in place, performance framework in place and are there any performance issues
- There are then recommendations about each service within the theme
- The schedule of reviews have been programmed and will take place between now and October dependent on priority
- These reviews cover 18 BCF schemes and where there are funding or performance issues or where there are concerns regarding strategic relevance

Other BCF Development

- A joint visioning event has taken place between the NHS and RMBC to further strengthen work around integration
- Our latest submission confirmed that national targets are being met
- We continue to perform well against a number of the metrics
- The BCF has increased by £1.3M from £23.2M to £24.5M
- Additional funding will be invested in Community Services
- New integration measures were introduced for the Q3 submission
- Further planning guidance has been received during February and March and officers are responding to it
- A BCF Service Directory is almost finalised

Discussion ensued with the following issues raised/clarified:-

- Currently in the Assurance period for the 2016/17 plan. Guidance had been received regarding what was required to meet assurance in terms of the plan and it was currently being written. The second stage of the Assurance process would be updated shortly with the final plan being submitted to the Health and Wellbeing Board for sign off on 20th April and NHS England on 25th April

- In order to achieve Assurance, it had to been ensured that the Plan was responding to the Key Lines of Enquiry. It was a fairly extensive process at the moment and was being reviewed through the BCF Executive by senior managers of both RCCG and RMBC to ensure the budget submitted in April responded effectively which would gain Assurance. The plan would be assessed and there would be a decision taken as to whether or not it was in full compliance and doing the right things to meet the needs of the citizens in the area. If not,

some support would be offered. In terms of reviewing and assurance of the plan, the Local Government Association, Monitor and others took part in the assurance and there was mediation across all the plans to ensure they were acceptable

- The needs of carers, whether adults or young people, needed to be responded to. It was the plan's ambition to ensure it responded to all carers and supported them

- The Health and Wellbeing Board was responsible for the governance of the plan. One of the Board's key responsibilities was to ensure it was an effective plan and whether it was an effective and integrated service. There was then a governance system with involvement of Board and senior managers as well as a strategy group, executive group and an operational group. The operational group included all the managers who were involved in delivering the projects/schemes and services. It was proposed that the strategy group develop into a programme board to ensure that the integration plans were progressing effectively. Each group had its own terms of reference

- There was multi-agency support in terms of supporting young carers as well as a multi-disciplinary response. There was a joint post in CYPS and the CCG for commissioning services

- There was much more detailed information available for the 6 BCF themes

- Generally speaking all the Indicators were performing pretty well

- All the organisations in the care system welcomed feedback to improve where partners needed to be and had to be prepared to decommission as well as commission if something was not effective

- Much of the Care Act talked about early intervention and preventative services. Every Rotherham pound had to be spent effectively consideration had to be given as to whether some of the things being delivered were effective and did they need to be changed

- It was difficult to give a timeline as to when data sharing across IT systems of health partners and social care would include Mental Health. The data sharing that was described in terms of the BCF at the moment was with regard to a particular cohort of citizens. In terms of extending it, consideration would be given as to how the work had moved forward but would look to using the NHS number as the main indicator

- The locality pilot was very much part of visioning events. The original visioning event had been held in early December at which time the locality discussions were already taking place. The visioning events were agreeing a high level set of outcomes to achieve across the system of which part of would be good locality working

- The 7 day Service was progressing well and being monitored through the BCF Executive. The Social Care Team that responded to requests for assessment was in place and had been since December.

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

(2) That the Chair liaise with Adult Social Care with regard to the scheduling of future agenda items in the 2016/17 work programme.

84. ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST QUALITY ACCOUNT

Karen Cvijetic, Head of Quality and Patient Engagement, gave the following powerpoint presentation:-

Quality Report
- Nationally mandated
- 2015/16 was the eighth quality report

Care Quality Commission (CQC) Ratings (September 2015)
- Overall rating – requires improvement
- Safe – requires improvement
- Effective – requires improvement
- Caring – good
- Responsive – good
- Well-led – good

What the CQC said we do well
- Learning Disability Services
  Solar Centre – commended by patients and carers
  88 Travis Gardens – outstanding for caring
- Adult Mental Health Services
  Mental Health Crisis Teams – rated overall by CQC as Outstanding
  Mulberry House – introduction of the 'Perfect Week'
  Doncaster Perinatal Service
  Rotherham dedicated service for deaf patients with mental health problems
- Children and Young Peoples' Mental Health Services
  Safeguarding Advisor in post and training at a high level across all services
  Out of hours duty system provides excellent coverage of emergency/crisis calls

Peer Support Workers assist with transition to Adult Mental Health Services

- Drug and Alcohol Services
  Peer Mentor Scheme developed including training packages to provide service users with the skills and knowledge to become Peer Mentors
  Peer Mentors from New Beginnings worked across the services in Doncaster and three had progressed into paid employment
- Older People's Mental Health Services
  Community-based services for Older People rated as Outstanding for Caring
  Young Onset Dementia Day Care offering carer respite and patient engagement
  Male Carers Support Group for patients with Huntingdon's Disease
  Cognitive Stimulation Programme – support patients with cognitive functioning
  Kings Fund advice and guidance to make Wards Dementia Friendly

Our Approach and Response

- September, 2015 – immediate actions were taken and action plan drafted following initial feedback from CQC
- November, 2015 – Trust Quality Improvement Plan developed following receipt of draft CQC reports
- December, 2015 – Executive Director leads identified for all quality improvement actions
- February, 2016 – Trust Quality Improvement Plan shared at Quality Summit
- March, 2016 – action plan submitted to CQC

Governance Arrangements

- Published CQC reports to the Board of Directors' meeting on 28th January, 2016
- Monthly action plan updates to Board of Directors
- Monitoring and oversight by Executive Management Team (EMT)
- Divisional action plans monitored through Trust Board of Directors' Sub-committees
- Divisional-level action plans to address local issues and share learning

Patient Safety

Quality Metric	Baseline 14/15	Aim	Q1 15/16	Q2 15/16	Q2 15/16
Patient Safety					
		Aim to Reduce Major/ Moderate Medication Errors to 0 by March 2018			
Number of Serious incidents	88		24	17	18
			2015/16 forecast: 82		
Number of Trust reported suicides/suspected suicides	21		4	5	2
			2015/16 forecast: 18		
Number of Trust reported suicides/suspected suicides expressed as a rate per 100,000 England population	0.05		0.01	0.01	0.01
			2015/16 forecast:0.01		
Number of Grade 3 pressure ulcers	29		2	0	4
			2015/16 forecast:8		
Number of Grade 4 pressure ulcers	5		0	0	0
			2015/16 forecast:0		
Number of restrictive interventions	Not reported in 14/15		417	301	345
			2015/16 forecast:1436		
Number of falls (serious incidents)	2		1	1	2
			2015/16 forecast:4		

Number of medication errors	45		8	3	Reported quarter Retro-spective
			2015/16 forecast:32		

Patient Experience

Quality Metric	Baseline 14/15	Aim	Q1 15/16	Q2 15/16	Q2 15/16
Patient Friends and Family Test					
Percentage of service users/patients who would 'be extremely likely/likely to recommend our service to friends and family if they needed similar care or treatment'	95.6% (Q4 14/15	To achieve % above national average	84.7%	87.3% (July/ Aug 2015)	88.3%
Complaints					
Number of complaints received	124	Aim to reduce by 5% (117 in 15/16)	33	24	34
			2015/16 forecast:114		
Percentage of complaints 'upheld'	17%	Reduce by 5% (16% in 15/16)	9.1%	12.5%	Reported Quarter Retro-spective
			2015/16 forecast:10.5%		
Annual Community Mental Health Survey					
Score for 'overall care received in the last 12 months' (CQC annual community mental health survey)	7.3 (about the same as other Trusts)	Aim to be 'better than other Trusts'	Annual survey results published Autumn 2015	Annual survey results published Autumn 2015	7.2
Score for 'were you involved as much as you wanted to be in agreeing what	7.9 (about the same as	Aim to be 'better than other	Annual survey results published Autumn 2015	Annual survey results published Autumn 2015	7.7

care you will receive?" (CQC annual community mental health survey)	other Trusts)	Trusts'			
Score for 'were you involved as much as you wanted to be in discussing how your care is working' (CQC annual community mental health survey)	9.1 (about the same as other Trusts)	Aim to be 'better than other Trusts'	Annual survey results published Autumn 2015	Annual survey results published Autumn 2015	7.7
Percentage of service users who responded to annual community mental health survey	26%	Aim to increase response rate above national average	Annual survey results published Autumn 2015	Annual survey results published Autumn 2015	32%

Clinical Effectiveness

Quality Metric	Baseline 14/15	Aim	Q1 15/16	Q2 15/16	Q2 15/16
CQUIN					
Percentage of CQUIN achieved in Mental Health and Learning Disability Services	96%	Aim to achieve 100%	100 %	100 %	Reported quarter retro-spective
Percentage of CQUIN achieved in Community Services	100%	Aim to achieve 100%	100 %	100 %	Reported quarter retro-spective
Percentage of CQUIN achieved in Forensic services	100%	Aim to achieve 100%	100 %	100 %	Reported quarter retro-spective
Clinical Audit					
Percentage of clinical audits rated as 'Outstanding'	To be developed in 15/16	To be developed in 15/16	22%	25%	0%

Percentage of clinical audits rated as 'Good'	To be developed in 15/16	To be developed in 15/16	33%	25%	50%

Finally

- Receive Select Commission's comments for inclusion in the Quality report – May, 2016
- Report to Board of Directors – 28th April, 2016
- Report to Council of Governors – 13th May, 2016
- Report to Monitor – 27th May, 2016
- Review by Audit Commission – April/May, 2016

Discussion ensued and the following points were raised/clarified:-

- The Learning Disability Service had received a rating of 'Inadequate'. The CQC were concerned that the staffing levels in North Lincolnshire were not safe in the community team. To mitigate that, a business case had been submitted for additional funding as the staff in that team were based on the funding received. A business case had been submitted to the North Lincolnshire CCG the outcome of which was awaited

- The issue within the Adult Mental Health Community Teams was the care record planning. Plans were in place, as could be seen through the action plan, had been rapidly escalated and hopefully resolutions put into place

- The difference between the 2 Community Health Teams – 1 was the Mental Health Services. In Doncaster Community Services were also provided e.g. End of Life Care, District Nursing, School Nursing, Health Visitors. The other was specially Mental Health Community Teams

- The Inadequate rating related to staffing issues; there had not been any comments in the CQC report that they had found clients wrongly allocated

- CQC reports do not split outcomes by locality but where it was possible, the data would be separated so as to give actions specifically for Rotherham

- As well as investigating the root causes of falls, any possible underlying cause was also investigated to ascertain if there was a medical condition. The majority of falls were by elderly people on Wards. If necessary work would take place with Acute Care colleagues to ensure medical care was taken

- The reporting of medication errors had now changed. The number of medication errors that were moderate or above where RDaSH had had involvement with the service users involved had fallen drastically. Pharmacists went onto Wards, worked across all the Community Teams, looking at how medication was prescribed, was it recorded properly etc.

- There was no trend particularly with minor medication errors. An assessment had been conducted and reported to the Clinical Governance Group. If there were any areas, the pharmacist would go to the Wards or Community Teams to address the issues

- When looking at medication errors, the organisation was trying to focus on the areas that were of higher importance; if you got the bigger areas correct it would help with the minor areas. RDaSH had focussed on the moderate severity or above where there may be harm to patients, so that improved the practice across the board including a reduced number of minor areas. Using resources more wisely to get the better impact across the organisation

- RDaSH had been involved in the Children's Looked After and Safeguarding CQC action plan and had attended monthly meetings with the CCG, Acute Care Trust and other partner organisations to implement the action plan. That action plan was hopefully being signed off shortly as being complete and RDaSH's actions as an organisation had been achieved. RDaSH was also part of the MASH where it had a member of staff sat within the team.

- RDaSH continued to hold events around CSE and awareness raising as well as Safeguarding training (adults and children), Domestic Abuse Compliance Level 1 and an e-learning package commissioned for Level 2

- There had been 2 reported suicides/suspected suicides in Quarter 3. However, it was not confirmed as yet whether they were in fact suicides as unexpected deaths were now classed as pending review until the outcome from the Coroner's Office was known

- For each serious incident, not just an unexpected death, the Trust would undertake a formal serious incident investigation and a member of staff appointed who had not had any dealings with that service user. The Trust had to report to the CCG and were monitored. The outcome was shared within the organisation and a 6 monthly learning matters bulletin available on the Trust website which included lessons learnt from a serious incident, complaints etc. by themes

- If a serious incident involved a specific clinician and the investigation identified additional training needed for that clinician that would be dealt with. There were things the Trust were going to improve e.g. care records. The Trust's Clinical Commissioning Audit Team and the

Internal Audit Service had been commissioned to undertake an audit. As a first step supervisors were to check through the 1-1s with each clinician i.e. did all the clinicians' cases have a current meaningful care record

- Delayed discharges in care were reducing. Q3 5.1% - had been 6.9% at the end of last year. Some of the reasons for the delays were due to family choice. The majority was in Older People's Mental Health Services and transferring into care homes, making sure the adaptations done at home etc. before the Service user transferred. Service users and families could choose not to accept the first place they were offered. The Trust worked closely with the Council to get the adaptations done as quickly as possible

- A number of service users and families used the Patient Advice Literacy Service (PALS). The Service talked to a person where required and linked them up with someone to help them. It was important to make sure service users and carers could access advocacy services to support them

- Each complaint received was subject to a similar process as that of serious incidents. All were investigated, all received a response from the Chief Executive and all included actions. The top themes were communication/information available so the Trust had carried out a lot of work to make sure that the information given about the service was correct. Work was needed with Service users as sometimes there were higher expectations than the Trust was able to meet and/or commissioned to deliver

- The Trust had ways of collating information including the Your Opinion Counts forms, Services worked with Service users to collect patients' stories, information was published in Learning Matters and there were regular patient stories to the Board. A number of the Services had twitter feeds so the information was collated and tailored to the needs of the population. There were Facebook pages, Services going out and collecting stories, the Health Bus and there had been a young person's event held recently in the CAMHS service

- That was a monthly publication, Trust Matters, which shared good practice both within the Trust and of the joint partnership working. That was provided to all the Trust members and available on the Trust website

Resolved: (1) That the presentation be noted.

(2) To agree a date for receiving the draft Quality Account.

(3) That the Health Select Commission submit their comments agreed by the date agreed with RDaSH

85. WORK PROGRAMME 2016/17

Janet Spurling, Scrutiny Officer, advised that consideration was required as to the 2016/17 scrutiny work programme and priorities. Cabinet, SLT and Commissioners would all have a view as well as Scrutiny Members.

The Select Commission had had a clear brief for the 2015/16 Municipal Year to scrutinise Health and Social Care Integration and work towards ensuring sustainable high quality Health and Social Care Services.

A lot had been achieved through the Better Care Fund and the Members' Working Group for Adult Health Transformation but there was still a lot of further work to take place.

Members should consider whether they wished this to continue to be a priority for the forthcoming year as the wider changes began to take place.

In 2015/16 the Select Commission had also:-

- Taken a more detailed approach with sub-groups on the Quality Accounts
- Been part of the consultation on the Clinical Commissioning Group's plan as well as the refresh of the Health and Wellbeing Strategy and Members might wish to ensure the action plans for the Strategy were being implemented next year
- Scrutinised progress on the Interim GP strategy

Mental Health had clearly been identified as a priority in the past for the Commission and ongoing transformation both for adults and older people; CAMHS could be included next year.

Sub-regional scrutiny of the NHS Commissioners Working Together initiative was also being developed

An e-mail would be sent to all the Select Commission Members with suggestions for the 2016/17 work programme and requesting further ideas.

Resolved:- That Health Select Commission Members give further consideration to the 2016/17 work programme and pass any suggestions to the Chair and Scrutiny Officer by 31st March, 2016.

86. UPDATE FROM IMPROVING LIVES SELECT COMMISSION

Councillor Ahmed reported that the Select Commission had not met since the 3rd February.

One of the areas the Commission would be focussing upon in the 2016/17 Municipal Year would be the scrutiny of CSE Services. Following the meeting in April she would give a detailed update.

87. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

88. DATE OF FUTURE MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 14th April, 2016, commencing at 9.30 a.m.

Rotherham Metropolitan Borough Council

Health Select Commission

Title
Access to GPs scrutiny review – progress on recommendations

Date
14 April 2016

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)
Kate Green, Partnership & Policy Officer
Ext. (2)2789

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.

This report provides an updated summary of the action being taken for each of the recommendations.

Recommendations
Members are asked to:

a. note the action being taken in relation to the access to GPs review

List of Appendices Included
Appendix 1, updated Cabinet response.

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 2015. An update in relation to the

specific recommendations made to the Health and Wellbeing Board was presented to Health Select Commission on 22 October 2015.

Council Approval Required
No

Exempt from the Press and Public
N/A

Access to GPs scrutiny review – progress on recommendations

1. Recommendations

1.1 Members are asked to:

a) Note the action being taken in relation to the access to GPs review.

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).

2.2 The review produced 12 recommendations, which are described, along with detail of the action being taken, in the attached appendix. Recommendations covered the following areas:

2.3 **Improving access** – ensuring patients' views on access and ways to improve are heard; maintaining access to professional interpretation services; and adopting hybrid and flexible approaches to appointment systems.

2.4 **Sharing good practice** – showcasing best practice and sharing successes on providing good access to patients.

2.5 **Improving information for patients** – maintaining up to date information about each GP practice; the importance of cancelling unneeded appointments; and accessing the right health care service and health care professional at the right time.

2.6 **Capacity to deliver primary care** – mitigating risk to primary care in Rotherham in light of future challenges; encouraging GPs to remain in Rotherham after training; and being proactive about future increases in demand.

2.7 The Health Select Commission carried out further scrutiny of the initial response from partner agencies in January 2015 and undertook a mini survey with GP Practice Managers at their Forum meeting in May last year.

3. Key Issues

3.1 The majority of the actions in response to the 12 recommendations fall to Rotherham Clinical Commissioning Group (CCG) and NHS England.

3.2 Three of the recommendations were aimed at the Health and Wellbeing Board, and although it was clear the board would not lead specifically on any campaigns, it had a role in bringing partners together to ensure consistent messages were delivered. One of the ways in which this would happen would be through a revamped website, due to be completed by end of May 2016, and a Twitter account now set up to keep the public and stakeholders updated on partners' activity and health and wellbeing initiatives.

4. Options considered and recommended proposal

4.1 A range of methods have been used to address the issues raised in the access to GPs review, the activity which has taken place is outlined in the attached appendix. The broad approach recommended was 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.

5. Consultation

5.1 This report has been informed by the activity undertaken by the CCG and NHS England.

6. Financial and Procurement Implications

6.1 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 have fallen to Rotherham CCG to deliver, but it will be important for all partners and RMBC directorates to work together to ensure consistent messages are provided. This will continue to be done through the Health and Wellbeing Board.

13. Risks and Mitigation

13.1 Risks in relation to GP access generally relate to the 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)

Terri Roche, Director of Public Health
Ext. (2)55845

Appendix 1 Updated Cabinet Response to Scrutiny Review Access to GPs

Recommendation	**Cabinet Decision** *(Accepted/ Rejected/ Deferred)*	**Cabinet Response** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)*	**Agency Responsible**	**Action by** ***(Date)***
1. Patients' experiences of accessing GPs vary from practice to practice; therefore NHS England needs to ensure that patients' views on access are reflected in the forthcoming Personal Medical Services contract re-negotiations and five year commissioning plan.	Accepted	**NHSE** - NHSE take seriously the results of the National Patient Survey and include these in monitoring all primary care contractors. In addition to enabling comparative analysis the survey provides a means of assessing overall primary care capacity within the area. - NHSE are working with RCCG to develop a coherent place based strategy for improving health care and outcomes for the population of Rotherham. As part of that there is a commitment to reinvest any funding released from one practice (following the PMS contract reviews) into primary medical care within RCCG area, ensuring that we secure real improvements in care and outcomes for patients. Consultation with public, patients and GPs is due to commence in June 2015. **CQC** - Inspections involve preparation beforehand - they send out comment cards to the practices and ask them to place them for patients to complete. CQC look at patient surveys, CCG data on the profile of patients and other data. We specifically look at patient themes of vulnerability, mental health illness, work age population, children, over 75, those with long term conditions. - The key to the inspection is to speak to all the staff in the practice and 8-10 patients on the day about their experience and use of the practice. - We want to see policies, procedures and processes on how practices capture patient feedback, how they investigate incidents, their outcomes, how they measure actions and	NHS England (NHSE) Rotherham Clinical Commissioning Group (RCCG) Care Quality Commission (CQC)	October 2014 CQC visits begin nationally, Rotherham from April 2015 September 2015 Primary Care Strategy (PCS) in place for Rotherham

		implementation so it is a robust process - corroboration and evidence. **CCG** The ability to have varying co-commissioning of services has been incorporated into the 5 year strategy, with access and improving access highlighted. Now have delegated responsibility. **March 2016** The CCG is submitting a bid to improve telephony systems within a significant number of GP practices this financial year. It is also working with practices to review how capacity can be flexed to meet high levels of demand. A number of schemes are ongoing to support freeing up practice capacity e.g. telehealth (patients taking their own BP and texting results to practices), electronic notification of blood results, telephone consultation. Along with different workforce models e.g. 5 practices have now recruited Practice Pharmacists who are able to undertake medication reviews and manage LTC patients whilst also improving prescribing (quality and waste) in practices. A quality contract for general practice is currently in progress with consistency in access a significant element with a core standard of being seen within 24 hours if urgent and within 5 working days if the issue is routine.		
2. The continuation of the Patient Participation Directed Enhanced Service in 2014-15 should be used to ensure patients are well informed and empowered through the Patient Participation Groups to challenge poor access and suggest improvements. All	Accepted	**NHSE** CQC will continue to look for evidence that access to clinicians is sufficient to meet reasonable need, and that patient survey results alongside any complaints are addressed. In December 2014 the new compulsory Friends & Family Test was introduced to all practices. All patients that attend the practice on a given day, whether to see a clinician, or pick up a prescription, will be asked two questions (the first is mandatory): a. Would you recommend this Practice to another person? b. One other question the Practice want to ask the patient	Rotherham CCG NHS England CQC	On-going monitoring of contract compliance

practices should be encouraged either to participate in the PPDES or to establish other effective mechanisms for ensuring patient engagement.		(this could be agreed with the Patient Participation Group) Following national negotiation on revised contractual arrangements, the existing PPDES ceased on 31 March 2015 as existing arrangements should be largely embedded in general practice. From 1 April 2015 it has been a contractual requirement for all practices to have a patient participation group (PPG) and to make reasonable efforts for this to be representative of the practice population. **March 2016** CCG The primary care committee has reviewed data regarding the variance in compliance with PPGs. Support has been offered to practices to develop or improve their arrangements e.g. Healthwatch has been commissioned to work with some practices. Action completed		
3. Although recognising the importance of clinical need, the expectations and preferences of patients are changing, and practices should explore more hybrid and flexible approaches to appointments. All GP practices should be encouraged to have a part of each day for sit and wait slots.	Accepted that helpful to have a flexible approach to appointments and access but not sit and wait slots.	*Context (Dr John Radford)* *All General Practices should have adequate arrangements to see urgent or same day cases. Appropriate arrangements will vary from practice to practice. These should form part of the new CQC inspections. The Commissioner (CQC) should be requested to produce a report summarising the adequacy of access on the basis of these reports to Health and Wellbeing Board in Oct 2015.* **NHSE** All practices have processes and systems in place that enable them to respond to requests that are clinically appropriate. Most GP practices operate as independent contractors and are responsible for organising the delivery of primary medical care services as they choose, subject to meeting specific contractual requirements. As such it is for each individual Practice to determine how they meet patient demand for appointments and NHSE is unable to require them to respond in specific ways.	NHS England Rotherham CCG	Report October 2015 September 2015 Primary Care Strategy

		- An increasing numbers of practices are offering more flexible opening times and new innovative ways of contact with patients e.g. electronic prescriptions, text reminders, emails, better use of telephone triage and there is further scope for e-consultations etc. We will be working with CCGs to encourage those practices that have not yet done so, to embrace new technologies and new approaches to improving patient access. - A new national agreement has been reached to enable direct data sharing between all GP IT systems such as EMIS and SYSTM1 which will enable access to patient records and support new says of working collaboratively between practices. - NHSE has worked with the Royal College of General Practitioners and other organisations such as NHS IQ to support practices to operate more efficiently and effectively to respond to their patients' needs. - RCCG and NHSE will continue to work with practices to achieve our shared aim for a more varied and flexible approach, to improve patient satisfaction with their access to GP services. A review of the extended hours DES will consider what delivers best access for patients. - The vast majority of patient s would prefer to be able to make a specific appointment and such arrangements also provide a more manageable way for practices to manage their workload. NHSE cannot find evidence that having periods where patients "sit and wait" will improve patient satisfaction with either the quality of, or access to, the consultation they seek. Indeed, they believe such systems may only increase the demand and pressure on the provision of GP appointments by those who can wait rather than improve overall care for the whole population served. NHSE propose the following potential actions: - Looking to extend the availability of General Practice • Expanding PM Challenge Fund pilots: models for 7-day		Doctor First pilot from

		access to general practice • 'Doctor First' – this is now being used by some practices. This enables same day telephone triage, with around two thirds of patients being dealt with by phone. - Ambition of 'Patient Online' – providing the ability to book appointments, prescriptions and view medical records online **CCG** The primary care strategy consultation will be looking at this issue. **March 2016** CCG Sit and wait was not highlighted as an overall patient preference when consultation took place on the strategy. Overall patients preferred to be given an appointment time and to be seen as close to this time as possible. As detailed above, the CCG is working with practices to ensure there is sufficient capacity across all practices and deliver a standard of being seen within 24 hours if urgent and within 5 working days if it is a routine issue. Feedback from patients is that it is the routine appointments are the appointments they are struggling to obtain. **Practice Managers Forum meeting** Following from the issues raised at OSMB HSC surveyed the practice managers to capture their recent experiences, if any, of having open surgery sessions. 26 responses were obtained (out of 35 practices) and only 5 currently have such sessions, 3 had previously had them but had stopped and 17 hadn't had them within the last five years. Of these only 3 practices said they would perhaps consider having open sessions. A number of reasons were cited for not having them – present system works, no need to have them, staffing issues, managing demand, possible detrimental knock on effect on undertaking home visits, have a book on the day appointment system, on-call doctor for urgent cases supplements booked appointments, triage – either		April 2015, evaluation Autumn 2015.

		full GP-led or nurse-led when all appointments have gone, lack of room, patient frustration with waiting, GP workload/stress. Of the practices that do have open surgeries patients like them/the idea but there are issues over increasing demand leading to increased waiting time, especially with patients not realising that they are supposed to be for acute not routine problems. Waiting can be an issue for some, including working patients. Also some patients have a preferred GP which is difficult on open surgeries.		
4. NHS England should maintain access to interpretation services for GPs, with an emphasis on professional services, supported by training for GPs and practice staff to increase confidence in using telephone services where appropriate.	Accepted	NHSE have agreed a national service specification (early 2015) and asked the main players to procure a framework contract for the NHS people to use a group of providers who can meet that service specification to secure consistent and reliable access for patients across England. We will continue to work closely with Rotherham CCG, Rotherham MBC Public Health, and the Health and Wellbeing Board, and where appropriate, other stakeholders, to consider how by working together we can ensure people are able to access care services appropriate to their needs and are able to easily navigate such services. **March 2016** NHSE A specification has not been released for use nationally, and existing local arrangements are still in place. CCG We are still awaiting	NHS England	Immediate

5. NHS England should review their current interpretation provision to see if economies could be achieved through signing up to Rotherham MBC's framework agreement, which is open to partner agencies.	Rejected as need to comply with national specification and framework.	NHSE welcomes the opportunity to look at ways to jointly commission interpreting services with RMBC, so as to provide a more coherent and effective service for the population of Rotherham within the level of expenditure each party currently spends. It should be noted that interpreting services are currently commissioned from a variety of different providers separately by NHS England and the 5 CCGs within the South Yorkshire & Bassetlaw area. RCCG and NHSE are committed to get better interpretation services because we are wasting money between us in buying the different services. **March 2016** NHSE As referred to in item 4 above, local arrangements are still in place, and services are commissioned from SCAIS, Big Word, and Language Line.	NHS England	
6. GP practices should regularly showcase best practice and share successes on providing good access to patients through existing means such as the practice manager forum and Protected Learning Time events. (Please see pages19-22 of review report)	Accepted	**NHSE** New national programmes to support General Practice to improve patient access to primary care provision have been established, including the Prime Minister's Challenge Fund. We will fully support Rotherham practices to take the opportunity to innovate themselves or to learn from existing PM Challenge Fund pilots. (Note: no practices from SY&B took part in the first tranche and no Rotherham practices have submitted applications for the second funding round in 2015.) Sheffield has a 3 hub model for evenings and Saturdays in which all practices participate. NHS IQ operated a programme to improve the efficiency and effectiveness of GP practices, which practices were encouraged to participate in. NHSE are considering whether an e-based learning platform could be developed to further support practices to share and learn from each other. NHSE regionally will continue to hold events that will support GP practices and CCGs to learn from new innovative approaches that	NHS England Rotherham CCG	NHSE Immediate RCCG Actioned

		will support delivery of better and more accessible care to patients. A number were planned across the north of England for February and March 2015 to try and showcase what practices are doing and learn from each other but they can only ever reach 100 GPs at a time so are more reliant on what the CCG are doing. **CCG** RCCG is building relationships with NHSE so that quality in GP practice can be developed. The bi-monthly practice managers' forum already has designated time for NHS England. Best practice is a standing item on that agenda. There is a regular programme of events and although we schedule things in, we leave space for topical issues. Sharing of best practice will also become a topic for consideration when planning future Protected Learning Time (PLT) events which happen bi-monthly and cover a wide range of topics aimed at improving care and outcomes for patients. Sharing of best practice is also considered when GP Peer review visits are undertaken. We also encourage practices to have their own in-house events and we monitor what topics are looked at. March 2016 Action completed		
7. Patient information and education is important, both generic information about local services and specific information about how their surgery works.	Accepted bar 7b which was deferred	*Since the initial response was received the Health and Wellbeing Board has launched a new health website which may provide an opportunity for promotional health campaigns*. Links to new Primary Care Strategy **See sub-recommendations a-e below**.	NHS England Rotherham CCG	September 2015 Primary Care Strategy
a. GP practices should ensure their practice leaflets and websites are kept up to date about	Accepted	**NHSE** It is a contractual requirement for each Practice to maintain a practice leaflet and website, containing up-to-date information for patients with specific information, although the format is not	NHS England	Immediate

opening times, closure dates for training and how the out of hours service works.		specified. NHSE monitor practice compliance on a regular basis. We have been increasingly encouraging practices to use the internet to facilitate more access and make more information available on the practice website - being able to book appointments, order repeat prescriptions - and do more on electronic communication. Not all patients want to do that and information is available through NHS Choices and various helplines. We can still do more to improve communications - ourselves to practices and practices to patients - and we will continue to work on that to improve efficiency and effectiveness. **CQC** We do look at the information provided to patients and if we do not see it we give practices feedback. **March 2016** CCG It is a contractual requirement to keep websites up to date with this information. The CCG now annually review the websites and advise practices of required changes. Action completed		
b. NHS England should explore developing an App with practice information that people with smartphones and tablets can download.	Deferred	NHS E will explore this option further, recognising the importance of harnessing new technology, in use by many age groups. The GPC and NHSE will jointly promote the use of new technology, especially where it would bring benefits to both GP practices and patients. The new Primary Care Strategy will be considering ICT. **March 2016** NHSE GP practices will receive guidance on signposting the availability of apps to patients to allow them to book online appointments, order repeat prescriptions and access their GP record. Apps will be	NHS England	September 2015 Primary Care Strategy

		clinically and technically validated through the GPSoC programme during 2016/17 before being made available to patients. Technical support for patients in using the Apps will be provided by the App suppliers. Action completed		
c. Health and Wellbeing Board should consider developing a borough wide publicity campaign to raise awareness about the impact of not cancelling unneeded appointments.	Accepted	RCCG and NHSE would welcome the opportunity to engage with the Health & Wellbeing Board on this matter. NHSE do not collect data on missed appointments in a consistent manner and where there has been such an exercise it showed that the rate had not increased or changed. It is a bugbear for GPs that patients do not attend but also for many the 10-15 minutes without a patient means they can catch up time. RCCG are looking to publish more information in practices on the number of clinical hours lost through DNAs. At the Practice Managers Forum meeting on 12/05/2015 participants were asked via a show of hands if DNAs were a problem for their practice – with the majority indicating that they were. October 2015 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. 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	RCCG	Completed

		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. 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. 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*. **March 2016** CCG CCG has developed an A3 poster with a wipe clean space for practices to insert the number of appointments missed per month/cost so this can be displayed in practices. The CCG also publicises the cost of DNA along with cost of procedures at CCG events. Action completed		
d. GP practices should work with their reception staff, patients and Patient Participation Groups to encourage patients to provide more information to staff when contacting the practice, enabling them to see the right person in the practice team.	Accepted	NHSE agree that patients should be encouraged to provide sufficient information to aid their signposting to the most appropriate service/professional. Patients must also have a right to expect that personal information about their health and care is treated confidentiality to give confidence to them to share. One reason patients are less satisfied is because of longer waiting times. NHSE think the solution is to improve the access and convenience, increase capacity and get more people who walk in general practices to make better use of practice nurses, doctors from hospitals, physiotherapists and other health professionals, which is also a big culture change for many. The	NHS England RCCG	

		Prime Minister's Challenge Fund was starting to demonstrate that the whole new skill mix placed in and around the GP can relieve some of the pressure on GP practices and ensure patients are still seeing a clinician. That is what we need to build on. **March 2016** CCG As outlined in 1, the CCG is submitting a bid for a telephony system to support practices with streaming patients. There are systems which allow patients to provide information to enable a call back from a relevant clinician. A local campaign is also taking place this year to provide information to the general public regarding the different roles within practices and to reduce perception that they are not being managed appropriately if they are supported by anyone other than a GP. Action completed		
e. 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.	Accepted	NHSE propose the following potential actions: • Right Care: clearer to patients and the population how best to access the right care to meet their needs • Using 111 can direct people to get the right care – which can include self-care • Encouraging use of pharmacy as an alternative to GP: - Feeling Under the Weather is a national campaign focusing on the management of winter illnesses. - Treat Yourself Better is a national campaign focusing on management of illness without expectation of antibiotics. - Pharmacy First is a national 'brand' used by many CCGs which encourages patients with some minor ailments to use the pharmacy. Patients who are exempt from prescription charges receive free medicines. Choose Well campaign is featured on TRFT website; RCCG website has Right Care, First Time on its website. Local publicity for Pharmacy First has been distributed.	TBC	To add

		October 2015 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*. 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. **March 2106** Action completed		
8. In light of the future challenges for Rotherham outlined in the 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.	Accepted	In the light of co-commissioning of primary care between NHS England and RCCG the Board has agreed to receive a report on GP access for patients and will expect the CCG Commissioning plan to reflect a proactive approach to ensuring Rotherham is an attractive place to undertake General Practice. Commissioning Plan published. October 2015 Regarding 7c and 7e 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. 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.	Health and Wellbeing Board	September 2015

		March 2016 CCG An interim strategy for General Practice has been developed and is being implemented of which there is now a workforce plan for general practice. Good progress is being made in relation to new roles to sustain capacity e.g. pharmacists and healthcare assistants however attention is drawn to the committee that there is no contractual requirement to adhere to the workforce plan and is reliant on practices thinking differently about their workforce. Action completed		
9. NHS England should consider incentives to attract GPs to start their career in Rotherham following training in the area, to help address the demographic issues of our current GPs.	Accepted non financial	NHSE and RCCG are working with Health Education England (HEE) to explore how to minimise recruitment and retention difficulties so as to attract as many more GPs and nurses as possible. We are looking at examples where non-traditional GP professionals (Physiotherapists, Pharmacists, etc.) have joined practices and the impact this has had on reducing GP workload. We will continue to work with HEE to promote practices becoming involved in the Advanced Training Practices scheme which aims to generate increasing numbers of qualified practice nurses. But it is not just about the practice workforce, we will support CCGs to explore further the scope for attaching community and current hospital based clinical staff to work closer with general practice so as to be able to offer a wider range of care and services close to the patient and enabling general practice to increasingly act as a care co-ordinator to patients with a number of chronic conditions. NHSE nationally propose the following potential actions to increase the overall supply of clinicians in primary care, including: • increase the number of training places for GPs; • increasing number of doctors qualifying that wish to enter general practice; • changes to the induction and returner scheme to enable GPs	NHS England	On-going

		to return more swiftly to the GP performers list; • new models of care which meet demand differently, including through widening skill mix; (e.g. minor ailments services, direct physio access, and e-consultations) **CCG** Rotherham has some very challenging communities which are difficult to attract GPs to and Sheffield attracts more. One big advantage in Rotherham is that we have a training scheme with 14 registrar GPs training. Rotherham is the only place that is fully staffed and our training scheme is perceived to be the best in Yorkshire and Humber. We have tried to get the 14 GPs to stay, embrace Rotherham and feel a sense of ownership. We have looked at everything from payments and financial incentives but cannot attract extra funding for that. It is still tough and primary care staffing levels are not where we would want them to be. New physician associate course in Sheffield from 2016 with training places in Rotherham will help put the borough on the map. **March 2106** CCG We are still attracting good numbers to train in Rotherham which is one of the main factors for recruiting. CCG is reinvesting monies released from a review of PMS contracting arrangements into a quality contract for practices to help stabilise practices to continue to recruit. Action completed		

10. Rotherham CCG should collect and analyse monitoring information to ensure services are resourced to meet peaks in demand during protected learning time at the new Emergency Care Centre from 2015.	Accepted	NHS 111, who now provide the call handling information and Care UK (who provide the Out of Hours) have been asked to provide regular activity information. This will feed into the planning process for the Emergency Centre. RCCG regularly speak to the Walk-in Centre to see if demand has been catered for. The System Resilience Group set up by the NHS in all areas of the Country to ensure proper access to emergency care will also consider this matter. **March 2106** CCG The emergency centre is due to open in 2017 and building work is progressing well. Capacity and demand has been scoped utilising historical attendance at A&E and the Walk-in centre and therefore PLT days have been scoped in. The CCG has a business intelligence tool for regularly reviewing whether there is any pattern of increased attendance at A & E when a PLT is taking place, to date there is no impact. The WIC have also scoped a 6 month period to understand impact and the requirements are incorporated into the rosters for the new emergency centre. Action completed	Rotherham CCG	Emergency Centre opens in 2017
11. NHS England needs to be more proactive in managing increases in GP demand due to new housing developments, rather than waiting for existing services to reach capacity.	Accepted	NHSE have established formative links with some Local Authority planning departments across South Yorkshire & Bassetlaw and welcome the recommendation that health partners are invited by the Planning Department to be part of a multi-disciplinary approach to proposed new developments in Rotherham. - Funding for practices is done on a weighted capitation basis, with core contract income adjusted on a quarterly basis to reflect any changes in practice list size. Therefore, as practices increase their list size so funding increases, enabling employment of more staff to deliver services to the registered list.	NHS England	Immediate

		-Where a significant new housing development is planned, NHS England and the relevant CCG will work ahead of that development to consider available primary care capacity in that locality to take on additional patients and where that is assessed to be less than desirable, to undertake a new procurement for contractors to meet that population's needs. New national infrastructure fund that practices can bid into - £1bn over 4 years in addition to the existing capital fund. PCS will include an estate strategy and there will be a review/audit of all practices as some have void space which could be utilised. In a multi-agency approach all publically owned premises will be audited. **March 2016** CCG NHS England, have, released funding for a 6 facet survey of all GP surgeries across England to be completed to inform the CCG estates strategies. This will enable us to future proof existing housing development and there are now processes in place for informing the CCG of planning applications to ensure there is sufficient capacity for the area Action completed		

12. Rotherham MBC, when considering its response to the scrutiny review of supporting the local economy, should ensure health partners are invited by the Planning Department to be part of the multi-disciplinary approach to proposed new developments.	Accepted	Planning are aware of the request for GP's to be better informed on planning applications – particularly in relation to residential development and care homes as this may impact on their service. - Planning have requested a central contact in the NHS who can feed into the process from a strategic perspective around provision of service and who can also provide information on capacity of local surgeries and collate GP's comments as necessary on individual applications. A meeting is planned with CCG Deputy Chief Officer to discuss this in early 2015. - In relation to future housing sites in the local plan we have liaised with public health colleagues to allow them to comment on proposed sites but also to provide them with general information about areas of future development which may come forward during the next 15 years to assist them with their longer term financial planning. **March 2016** CCG The Head of Co-commissioning is now contacted in relation to planning applications although this is sometimes very late in process but allows the opportunity to identify whether there is sufficient health capacity in the area. Action completed	Rotherham MBC	Immediate

Rotherham Metropolitan Borough Council

Public/Private Report
Council/or Other Formal Meeting

Summary Sheet

Council Report

Title Urinary Incontinence Scrutiny Review Update

Is this a Key Decision and has it been included on the Forward Plan?
No

Strategic Director Approving Submission of the Report
Teresa Roche, Director of Public Health

Report Author(s)
Rebecca Atchinson, Public Health Principal, Healthcare Public Health

Ward(s) Affected
All wards

Executive Summary
Rotherham's Health Select Committee completed a scrutiny review of urinary incontinence services in May – June 2014. This review identified a series of recommendations which cut across the Council's directorates. This report provides the Health Select Commission with an update of the progress to date. This has been coordinated by Public Health.

Recommendations

The Health Select Committee are asked to consider;
- The recommendations and responses to the urinary incontinence review
- The progress to date.

List of Appendices Included

Cabinet's Response to Scrutiny Review Urinary Incontinence – update April 2016

Background Papers

- Scrutiny review: Urinary Incontinence: Review of the Health Select Commission May – July 2014
- SLT paper – 9.12.14
- Cabinet paper – 14.1.15
- Annual update to Health Select Commission - 9.7.15

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

Council Approval Required
No further approvals

Exempt from the Press and Public
No exemptions required

Title Urinary incontinence scrutiny review update

1. Recommendations

1.1 The Health Select Committee are asked to consider;
- The recommendations and responses to the urinary incontinence review
- The progress to date.

2. Background

2.1 There were three main aims of the urinary incontinence review which were:
- To ascertain the prevalence of urinary incontinence in the borough and the impact it has on people's independence and quality of life.
- To establish an overview of current continence services and costs, and plans for future service development.
- To identify any areas for improvement in promoting preventive measures and encouraging people to have healthy lifestyles.

2.2 The review focused primarily on prevention rather than the costs of current service provision, but recognised that preventative work contributes towards achieving savings for services, for example by reducing admissions to hospital or residential care. Centralisation of continence prescribing has improved outcomes for service users and future service development with greater emphasis on prevention should also produce both further savings and better outcomes. Awareness raising of the importance of having a healthy bladder and bowel and being physically active, including doing pelvic floor exercises as a preventive measure is essential. It is recognised that this could lead to fewer people having their quality of life diminished through urinary incontinence and result in lower future demand for services.

2.3 The spotlight review formulated the following six recommendations;

1 RMBC Streetpride and partner agencies such as South Yorkshire Passenger Transport Executive (SYPTE) should ensure all public toilets in the borough are clean and well equipped to meet the needs of people who have urinary incontinence, including suitable bins for the disposal of equipment and disposable products.

2 RMBC Sport and Leisure team should establish greater links with the Community Continence Service in order to support people to participate in appropriate sport and physical activity.

3 RMBC Sport and Leisure team should liaise with other sport and leisure activity providers to consider building more pelvic floor exercises into the Active Always programme and wider leisure classes

4 There should be greater publicity by partner agencies, coordinated through the Health and Wellbeing Board, to reduce stigma associated with incontinence and to raise public and provider awareness of:

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

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

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

d) the need to include the impact of incontinence due to medication, such as diuretics, within a patient's care

5 RMBC Neighbourhoods and Adult Services should work with care homes to encourage more staff to participate in the training offered by the Community Continence Service and to increase staff understanding of the impact of mobility, diet and fluid intake on continence.

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

3. Key Issues

3.1 Progress has been challenging due to the changes in staffing within Rotherham Council over the last six months. These changes were further challenged by technical problems with uploading information to the Public Health TV systems since September 2015. There are now plans in place to move the activity forwards, particularly in the area of prevention and early support agenda.

3.2 Public health met with the Continence Service in August 2015 to explore opportunities to deliver the recommendations in partnership with the Continence Service. Awareness raising training and practical skills is to be offered to all physical activity providers in the Summer 2016 to improve their awareness of bladder conditions and help target exercises to maintain a healthy bladder. Rotherham Public Health is working closely with Active Rotherham to ensure that our physical activity provision is sensitive to the needs of patients with urinary incontinence.

3.3 The challenge of addressing urinary incontinence in isolation from wider health and wellbeing issues may have resulted in it not receiving the profile it needs to fully implement the recommendations formulated by the

Review. There may also be a need to identify at risk groups for the physical activity recommendations e.g. mothers, older people, as it is recognised that their needs may be different. It may be advisable to review the recommendations and to consider the similar conditions/issues to help to raise the profile of the issue further.

4. Options considered and recommended proposal

4.1 The Health Select Commission are asked to consider the progress against the recommendations and the appropriate next steps.

5. Consultation

5.1 There is further consultation required with activity instructors to ensure that their requirements are being fully met.

6. Timetable and Accountability for Implementing this Decision

6.1 Timetable to be agreed with the Health Select Commission.

7. Financial and Procurement Implications

7.1 The responses which require additional resources are either low or no cost. The integration of the recommendations into ongoing activities will ensure that financial commitments are minimal and activities are joined up to maximise impact.

8. Legal Implications

8.1 There are no legal implications.

9. Human Resources Implications

9.1 There are minimal human resource implications to deliver the proposals. The majority of the activity sits within public health and EDS (Active Rotherham) working in partnership with the NHS Community Continence Service at The Rotherham NHS Foundation Hospital Trust. The most significant human resource is the delivery and attendance at the training session.

10. Implications for Children and Young People and Vulnerable Adults

10.1 The paper will support vulnerable adults with continence problems and provide preventative approaches improving the bladder wellbeing.

11 Equalities and Human Rights Implications

11.1 There are no additional equality or human rights implications.

12. Implications for Partners and Other Directorates

12.1 The majority of the activity sits within public health and EDS (Active Rotherham) working in partnership with the Continence Service at The Rotherham NHS Foundation Hospital Trust. There is additional interest from the CCG particularly prescribing as they are the commissioners of the consumables.

13. Risks and Mitigation

13.1 There are a number of risks and uncertainties are related to the changes in the funding available for facilities and activities which may be challenges as part of the Council budget reductions.

14. Accountable Officer(s)

Teresa Roche, Director of Public Health

Approvals Obtained from:-

Strategic Director of Finance and Corporate Services:- n/a

Director of Legal Services:- n/a

Head of Procurement (if appropriate):- n/a

Rebecca Atchinson, Public Health Principal, Healthcare Public Health

Cabinet's Response to Scrutiny Review Urinary Incontinence – update April 2016

Recommendation	**Cabinet Decision** *(Accepted/ Rejected/ Deferred)*	**Cabinet Response** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)*	**Officer Responsible**	**Action by** ***(Date)***
1. RMBC Streetpride and partner agencies such as South Yorkshire Passenger Transport Executive (SYPTE) should ensure all public toilets in the borough are clean and well equipped to meet the needs of people who have urinary incontinence, including suitable bins for the disposal of equipment and disposable products.		Response - SYPTE have confirmed that the toilet facilities provided by SYPTE at its Interchanges meet the requirements recommended in Urinary Incontinence Scrutiny review. All SYPTEs toilet facilities are appropriately maintained, regularly cleaned and re provisioned with consumable products throughout the day including weekends to ensure a pleasant customer experience. July 2015 No further information Response – Asset Management Facilities Team have confirmed that toilet facilities in Rotherham have suitable waste disposal systems are cleaned regularly to meet the needs of people with urinary incontinence. July 2015 No further information *April 2016 – Action completed*	Dave Whittle SYPTE Centre Manager – Interchanges and Retail Kim Phillips	January 2015

2. RMBC Sport and Leisure team should establish greater links with the Community Continence Service in order to support people to participate in appropriate sport and physical activity.		Response – Active Rotherham agree to work more closely with the Community Continence Service and take further guidance on how to improve the pathways to physical activity from the service. Suggestions include literature for patients and information on suitable exercises for pelvic floor to be added the new Get Active Rotherham website which is currently under development. July 2015 Active Rotherham had attempted to encourage pelvic floor exercises in the Active Always programme and make links with the Continence Nurses at Rotherham hospital. Outstanding action – website is still under development. *April 2016* *Outstanding action – website is still under development but should be completed in the Summer 2016* *http://www.rotherhamgetactive.co.uk/activeforhealth* *Bladder health training planned for the summer will cement the links between the Active Rotherham team and NHS Community Continence Service.*	Steve Hallsworth	January 2015
3. RMBC Sport and Leisure team should liaise with other sport and leisure activity providers to consider building more pelvic floor exercises into the Active Always programme and wider leisure classes		Response – Active Rotherham will include pelvic floor exercises into their existing "active always" provision. Public Health will also raise the importance of pelvic floor exercises at the next Rotherham Active Partnership meeting and long term conditions subgroup which covers most activity providers across the Borough. If there are any training requirements identified, these will be considered and delivered to the Rotherham Active Partnership members to ensure the exercises are embedded in all services.	Steve Hallsworth	January 2015

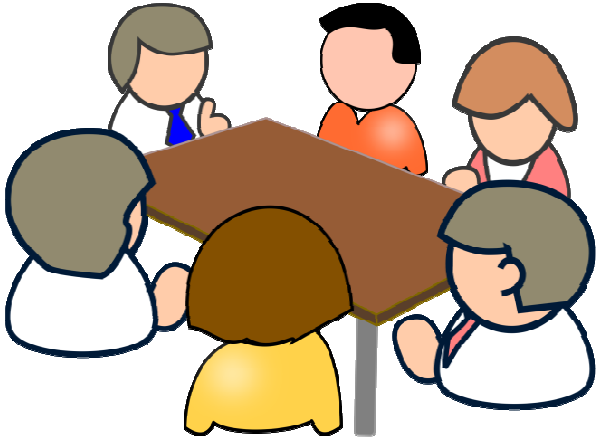
		July 2015 Active Rotherham had attempted to encourage pelvic floor exercises in the Active Always programme and make links with the Continence Nurses at Rotherham hospital. It had been slow progress, however, the aim was to deliver training to all instructors on the exercise programmes (including leisure centres) to help with providing examples of how people could incorporate suitable exercise into everyday activities and not just when they attended a class. Another aim was to ensure there was evidence to show the measures described had taken place. Active Rotherham was working with colleagues in Public Health on the programme and aimed also to roll it out in the new Sport England Active for Health project. Recently Public Health has received £500K of funding from Sport England to develop a Long Term Condition physical activity programmes which will include pelvic floor exercises, where it is deemed appropriate. *April 2016* *Developing a strong core and pelvic floor exercises are included in most exercise sessions, particularly those targeting older age groups. Public Health are arranging for bladder health training (delivered by the Community Continence Service) to be offered to all physical activity instructors in Rotherham to ensure all opportunities to improve bladder health is maximised.*		
4. There should be greater publicity by partner agencies, coordinated through the Health and Wellbeing Board, to reduce stigma associated with incontinence and to raise		Responses – SYPTE offered the opportunity to use Rotherham Interchange to promote health issues in either road show or poster display format. Public Health offer the opportunity for key messages to be	Rebecca	January

public and provider awareness of: a) the importance of maintaining good bladder and bowel health and habits at all life stages (through media such as screens in leisure centres and GP surgeries, further website development, VAR ebulletin and a campaign during World Continence Week from 22-28 July 2015) b) healthy lifestyle choices having a positive impact on general health but also helping to prevent incontinence, such as diet, fluid intake and being active c) the positive benefits of pelvic floor exercises as a preventive measure for urinary incontinence, including the use of phone apps for support d) the need to include the impact of incontinence due to medication, such as diuretics, within a patient's care		included on our Public Health TV screens as well as encouraging Pharmacies to consider prioritising incontinence as one of their Public Health Campaigns for 2015. Information will also be included on the Get Active Rotherham website to raise awareness and confidence of patients with urinary incontinence. It is recognised that the wide distribution of this review should also result in an increase in awareness of the needs of those experiencing urinary incontinence. July 2015 Public health to contact incontinence service for a short strapline for PHTV. Physical activity website still under development. *April 2016* *Public health have suggested the inclusion of the following information on the PHTV screens:* Do you have bladder problems? If so, doing pelvic floor exercises everyday could help? Why not try and include them into your daily routine to maintain a healthy bladder. Look on the NHS Choices website for more information. World Continence Week in June 2016 will be promoted to all attendees at the Active for Health sessions as part of promoting bladder and bowel health.	Atchinson	2015

5. RMBC Neighbourhoods and Adult Services should work with care homes to encourage more staff to participate in the training offered by the Community Continence Service and to increase staff understanding of the impact of mobility, diet and fluid intake on continence		Response – NAS Neighbourhood and Adult services have previously offered incontinence training to care home staff but this was not taken up and as a consequence the training was cancelled. It is unclear if there was a need for training or if this is already being met by the Community Continence service support to Care Homes. Further information is being sought and NAS Learning and Development Team are happy to provide further training if necessary. July 2015 2 short training sessions were delivered in March 2015 at Queens Care Centre Maltby to promote continence products by a representative of the LA's current provider. This was widely advertised but only moderately attended. Care Homes however did request the need for repeated training but for this to be delivered on site with each provider. All requests were forwarded directly on to Stephen Skelton in the Continence Service to determine if the Service has the capacity to deliver on site. *April 2106* *No further action required*	Rebecca Atchinson/ Nigel Mitchell	January 2015
6. That the Health Select Commission receives a report from Rotherham Clinical Commissioning Group in 2015 on the outcomes of the project considering future service development of the Community Continence Service.		Response – The CCG have been forwarded the Health Select Commission report and will be invited directly to attend the Commission and report back their findings. July 2015 The CCG from money released from the continence contract has funded two nurses (not full time posts) to undertake audit/research in the following areas o Catheter related infections		January 2015

		o Referral pathways for continence issues o A\E attendances for continence issues This work is now complete and will be presented to the CCG shortly, the CCG will consider the outcomes and recommendations that arise from this work stream and this will inform future commissioning decisions/intentions. April 2106 RCCG • Catheter related infections The project team developed a catheter care booklet which is now given to all patients who are discharged from hospital with an indwelling catheter. The booklet: - contains essential clinical information which will reduce the patients risk of developing a symptomatic catheter associated urinary tract infection (UTI). - offers advice on how and when to seek medical advice if the patient experiences problems with their catheter. The team also developed a set of catheter alert safety stickers which are used in the in-patient settings. The stickers remind health care professionals to review the patients on-going clinical needs and to remove the catheter as soon as clinically indicated. • Referral pathways Baseline data generated as a result of a retrospective audit of referrals into RFT services identified level 1 continence assessment is often not undertaken in primary care. This may result in inappropriate referrals to secondary care services. Further work is required in the future to decide what appropriate and effective referral pathways will look like. • A&E attendances for continence issues		

		The project team identified a high number of patients attend A&E with symptoms of UTI. Further work is required in the future to understand why patients present at A&E rather than their GP or a Walk in Centre.		



CARING TOGETHER SUPPORTING CARERS' IN ROTHERHAM

Update on Carers' Strategy and Carers Forum

Sarah Farragher & Jayne Price

April 2016

The Carers Strategy

Our pledge…….

- ***That every carer in Rotherham is recognised and supported to maintain their health, wellbeing and personal outcomes***
- ***That carers in Rotherham are not financially disadvantaged as a result of their caring role***
- ***That carers in Rotherham are recognised and respected as partners in care***
- ***That carers can enjoy a life outside caring***

The strategy is being co-produced

There are now members of the carers forum on the group alongside officers from RMBC, Health and the voluntary sector

The Carers Strategy

- The strategy is progressing well and is on track for sign of at Health and Wellbeing Board in June
- Plan is to launch during Carers week
- Carers strategy group will become delivery group
- Carers information booklet to be produced

Carers Forum

Re- Launched in January 2016 and operating independently of the Council

Briefing paper for Health Select Commission 14 April 2016

Caring Together Supporting Carers in Rotherham

Introduction

At its meeting on 3 December 2015 the Health Select Commission received a presentation covering the development of a new Carers Strategy for Rotherham. This has been a partnership approach through a multi-agency group comprising RMBC officers, members of the Carers Forum and health and voluntary sector partners.

Draft Strategy

Attached is the draft strategy which focuses on three outcomes for carers:

- Outcome One: Carers in Rotherham are more resilient and empowered.
- Outcome Two: The caring role is manageable and sustainable.
- Outcome Three: Carers in Rotherham have their needs understood and their well-being promoted.

The paper also includes:

- An introduction that defines who a carer is and includes a four-point pledge
- Statistics about informal care
- Carers rights
- Support for carers from partners
- Feedback from carers, including young carers
- Actions under each of the three outcomes

A detailed implementation plan is also being developed that will form part of the strategy document once completed.

Recommendation

Members of Health Select Commission are asked to:

- Consider and comment on the draft strategy.
- Consider whether monitoring implementation of the action plan should be included in the draft work programme of the commission.

Briefing note: Janet Spurling, Scrutiny Officer janet.spurling@rotherham.gov.uk

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2016 – 2018

CARING TOGETHER SUPPORTING CARERS' IN ROTHERHAM

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| PARTNER LOGOS?

CONTENTS

The Care Act has a strong focus on carers, recognising the caring role as fundamental to the whole adult social care system. Carers have increased rights and status within the Act with enhanced rights to promotion of well-being, earlier support and personalised support.

Image

IMAGE

1. Introduction

Who is a Carer?

A Carer is anyone who provides unpaid support to a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support

In Rotherham we recognise that informal carers are the backbone of the health and social care economy and that enabling them to continue this role is vital.

Our pledge.....

- ***That every carer in Rotherham is recognised and supported to maintain their health, wellbeing and personal outcomes***
- ***That carers in Rotherham are not financially disadvantaged as a result of their caring role***
- ***That carers in Rotherham are recognised and respected as partners in care***
- ***That carers can enjoy a life outside caring***

To achieve this pledge we need to build stronger collaboration between carers, the Council and other partners and recognise the importance of the whole family relationships.

We want to lay the foundations for achieving these partnerships and set the intention for future working arrangements

We want to do something that makes a difference now…whilst setting up the right co-produced options for the future.

2016 marks the start of a renewed partnership to support carers in the borough. This document sets out our commitment to working together so that collectively over the next two years we can work towards the following agreed outcomes:

- ***Outcome One:*** *- Carers in Rotherham are more resilient and empowered*
- ***Outcome Two****:- The caring role is manageable and sustainable*
- ***Outcome Three****:- Carers in Rotherham have their needs understood and their well-being promoted*

2. What do we know about Carers?

Young carers undertake full range of care tasks on a regular and sustained basis[1] which can seriously impact on mental well-being (Abraham & Aldridge 2010).

Nationally

5.8million people nationally are providing informal care, with 24% of these people providing in excess of 50 hours per week[1].

The estimated financial value of this care annually is £119billion and that this has risen by 37% since 2007 (Buckner & Yeadle, 2011).

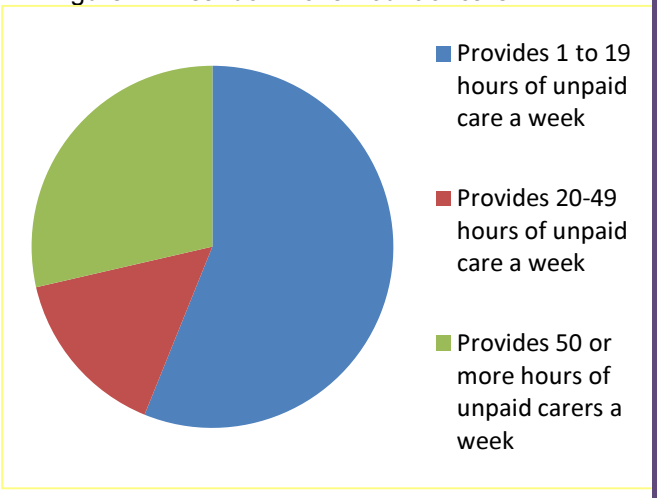
35% rise in the number of older carers between 2001 and 2011 and evidence that many of these carers providing over 60 hours a week of care.

Mutual caring is a way of life for many older couples but also in families where there is a family member who has a disability. It is estimated that one in four people with a learning disability live with a parent over the age of 70 and the mutual caring remains hidden until the family experiences a crisis[1].

In Rotherham

In Rotherham there are an estimated 31,000 people providing care. This equates to 12% of the population, compared to the national average of 10.3%. Of these carers 28% are providing more than 50 hours per week, again this is slightly higher than the national average. A breakdown of carers in Rotherham can be seen in figure one

Figure 1: Breakdown of amount of care provided by carers in Rotherham



In 2013 / 2014 2375 assessments of carers needs undertaken were undertaken with 72% of these taking place jointly as part of the cared for persons assessments. 105 carers assessments are recorded as refused during this period. Estimates for 2015/2016 are for 2378 carers assessments to be completed with a further 2404 carers offered information advice and signposting[1]

Carers in Rotherham receive similar levels of benefits[1], assessments[1] and reviews to other local areas

3. Carers Rights

Changes in policy and law over the last few years have meant that carers have more rights than they did in the past

The Care Act (2014)

- A strong focus on carers with carers entitled to the same recognition, respect and parity of esteem as the person they are caring for

Children and Family Act (2014)

- stipulates the duty to assess young carers

The introduction of the "family test" (DOH, 2014)

- brings a need to consider the impact on family life when making policy decisions.

Practical guidance on planning with families in holistic way focuses on the natural support networks in place and the outcomes that the family want to achieve rather than the traditional split between "carers" and cared for people.

Equality Duty

Four key priorities for supporting carers:

- ✓ identification & recognition,
- ✓ realising & releasing potential,
- ✓ A life alongside caring,
- ✓ Supporting carers to stay healthy

National Carers Strategy (DOH, 2014)

- ✓ Changes in employment law mean that since 2007 carers have the right to request flexible working

4. Partnership Contributions to Supporting Carers in Rotherham

The NHS does not have dedicated carers budget but supports a range of dedicated carers services such as social prescribing, and carer respite. Carers are also entitled to free flu jabs and health checks

Carers resilience work is now taking place in 17 GP practice across the Borough

Rotherham Metropolitan Borough Council spends over seven million pounds a year on carers' related services, however most of this money is spent on services to the cared for person.

The biggest area of spend (£5.07 million) is day services and whilst day care may provide carers with a break, it is also used by customers for other purposes.

Formal respite services account for 1.78 million of this spend and approximately £320k is spent on carers specific teams and service provision.

The Carers forum has recently re-launched. As a carers led organisation which is completely independent of statutory services it aims to provide a single voice for Carers in Rotherham

The partners in Rotherham all contribute to supporting carers, however this support is fragmented and many carers are not aware of what is available and how to access this

Crossroads have just been awarded lottery funding to implement a befriending scheme for carers

The Rotherham, Doncaster and South Humberside NHS Trust (RDASH) was one of six pilot sites to sign up for the Triangle of Care

The Rotherham Hospice offers 24 advice line for carers and well as targeted carers support and wellbeing support

5. What Carers have told us?

to be Involved

Financial Help

Information and Advice

A break

Valued

Consistent support

Time for Me

A voice

Quality Care

Understanding

learning and about the illness the person I care for has so I can understand

someone to talk to

Time out

being able to socialise with other Young Carers

meeting other Young Carers

As part of developing this plan we asked carers to tell us what things would make a positive difference to their caring role.

some of these where extremely personal examples however most of this feedback can be grouped into a number of themes

We also had responses from a group of young Carers, and the feedback from

Barnardos is that these responses are reflective of other young carers.

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6. The Outcomes

Outcome One: Carer's in Rotherham are more resilient and empowered

Carers need to be enabled to continue in their caring role. At times carers may need support to build, maintain or regain their resilience in relation to the caring role.

BUT….some carers are worried.

Changes to service models in particular day service and respite is causing lots of anxieties, this can reduce carer resilience and add extra pressures to the caring role

What we plan to do to support this outcome:

We (the partners) need to develop a culture and reality of collaboration and co–production to deliver:

- Co-produced and delivered training package for agencies on carers' issues.
- Integration of current carers support services
- Partnership support for developing fundraising and match funding opportunities to build carers resilience within Rotherham

We Will:

- ✓ Raise the profile of carers within the wider health and social care economy
- ✓ Offer opportunities for support and a voice within the Council for Carers and self-advocacy groups
- ✓ Involve carers in the planning of services.
- ✓ Develop a family assessment that focuses on whole family approaches that can be used interchangeably with individual assessments as appropriate
- ✓ Enable carers assessments to be undertaken in more flexible ways, e.g. online or through carers support services
- ✓ promote carers right to have an assessment
- ✓ Create and maintain strong links between children's and adult services and ensure that there are systems in place to identify young carers.
- ✓ Strive to ensure carers can access proportionate advice, in the right way at the right time.

YOUNG CARERS

Outcome Two – The caring role is manageable and sustainable

Carers need to be enabled to manage their current caring role. If we achieve the first outcome and carers are more resilient then this will help, but carers may also need breaks from the caring role. Carers need access to a level of support for their cared for person that makes the caring role sustainable, the amount and intensity of this support will vary and this support needs to work both for the carer and the person requiring support.

Carers need to be assured that there are good plans in place to continue the caring role if they are unable to do so. This could be an emergency plan or a longer term plan.

Image

We will:

- ✓ treat carers as equal partners with professionals when supporting the cared for person
- ✓ develop "shared care" models for people with the most complex needs as an alternative to traditional care models
- ✓ Increase the amount of community based, local support and networking opportunities for provision of support
- ✓ Improve the information, advice and guidance offer for carers and link this up to immediate support during periods of crisis.
- ✓ review the carers emergency scheme to make sure that it works for carers of all people with support needs in Rotherham
- ✓ develop a supporting families planning project that enables early planning to take place in families where an adult with support needs is living with older family carers
- ✓ develop a carers pathway

Something about planning support for young carers around key times, e.g exams

Outcome Three – Carers in Rotherham have their needs understood and their well-being promoted.

The steps identified to achieving the first two outcomes will support with making the caring role more manageable but in addition to this carers in Rotherham need to be recognised outside of their caring role.

There needs to be a recognition that:

- For some carers do not recognise or accept this label and see the caring relationship as part of family life.
- not all carers want to be carers
- Trust needs to be fostered between carers and statutory services

Image

we will

- ✓ Develop a well-being budget and resource allocation system that supports carers independently of the support for the cared for person
- ✓ Develop carers assessments and devolved carers budgets to voluntary sector support services
- ✓ encourage the development of a range of circles of support around carers within their community including hard to reach communities (support people where they live)
- ✓ work proactively with the carers of young people with care and support needs transitioning to adulthood.
- ✓ ensure information and advice is available in appropriate formats and venues and is sensitive to the diverse range of needs in Rotherham
- ✓ ensure Carers are supported to maximise their financial resources by:
  - ✓ working with partners to encourage Rotherham employers to become carer friendly
  - ✓ ensuring benefit advice is available to support carers
- ✓ strive to work closely with parent carers

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Rotherham Metropolitan Borough Council

Public Report

Council Report

Health Select Commission – Thursday 14th April 2016

Title

Response to Scrutiny Review: Child and Adolescent Mental Health Services – monitoring of progress

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

Ian Thomas, Strategic Director, Children & Young People's Services

Report Author(s)

Paul Theaker, Operational Commissioner, Children & Young People's Services

Ward(s) Affected

All wards

Executive Summary

The Overview and Scrutiny Management Board at its meeting in December 2015 noted the main findings and recommendations of the scrutiny review of Rotherham, Doncaster and South Humber NHS Trust Child and Adolescent Mental Health Services and the response to these recommendations from the Council and partner agencies. It was agreed at the meeting, that the response to the Scrutiny Review be delegated to the Health Select Commission for the ongoing monitoring of progress.

This report outlines current progress against the response template, which is attached as Appendix 1.

Recommendations

- That the monitoring of progress against the responses to the Scrutiny review of Child and Adolescent Mental Health Services be noted and discussed.

List of Appendices Included

Appendix 1 – Response template to the Scrutiny review – progress monitoring

Background Papers

Scrutiny Review report and appendices.

Future in Mind: Promoting, Protecting and Improving our Children & Young's Mental Health and Wellbeing – NHS England 2015.

Consideration by any other Council Committee, Scrutiny or Advisory Panel

The Overview and Scrutiny Management Board at its meeting on 11th December 2015 delegated the ongoing monitoring of the Scrutiny Review to the Health Select Commission.

Council Approval Required

No

Exempt from the Press and Public

No

Title: Response to Scrutiny review: Child and Adolescent Mental Health Services – monitoring of progress

1. Recommendations

1.1 That the monitoring of progress against the responses to the Scrutiny review of Child and Adolescent Mental be noted and discussed.

2. Background

2.1 At its meeting in April 2014, the Health Select Commission (HSC) decided to focus its work around the theme of mental health and wellbeing during 2014-15. It was agreed in July 2014 that a review of Rotherham, Doncaster and South Humber NHS Trust (RDaSH) Child and Adolescent Mental Health Services (CAMHS) be included in the work programme, following local concerns and a report from Healthwatch.

2.2 The key focus of Members' attention was to identify any issues or barriers which impact on children and young people in Rotherham accessing timely and appropriate RDaSH CAMHS services at Tiers 2 and 3.

2.3 A full scrutiny review was carried out by a sub-group of the Health Select Commission and the Improving Lives Select Commission. Evidence gathering began in September 2014, concluding in March 2015. This comprised presentations, round table discussion and written evidence from health partners, RMBC officers, Rotherham Youth Cabinet and desktop research.

2.4 The Scrutiny review formulated 12 recommendations and the Council and its partners developed a response to those recommendations. The response was presented to the Overview and Scrutiny Management Board on 11th December 2015, where it was agreed that the response to the Scrutiny Review be delegated to the Health Select Commission for the ongoing monitoring of progress.

3. Key Issues

3.1 The NHS England Future in Mind Report was published in May 2015 and sets out a clear national ambition to transform the design and delivery of a local offer of services for children and young people with mental health needs.

3.2 The Rotherham CAMHS Transformation Plan was developed in response to the Future in Mind report and encompasses all local Emotional Wellbeing & Mental Health transformational developments. The response to the Scrutiny review was therefore aligned to the local CAMHS Transformation Plan and the response to the Scrutiny review is monitored through the CAMHS Partnership Group as part of the overall plan.

3.3 RDASH has been undertaking a whole CAMHS service reconfiguration, which was originally due to be completed by December 2015. The reconfiguration includes the establishment of clear treatment pathways, a Single Point of Access (SPA) and locality workers linked with locality based Early Help and Social Care teams as well as schools and GPs. The reconfiguration has taken longer than anticipated, due to the requirement for extensive staff consultation and recruitment to a whole new structure.

3.4 The RDASH CAMHS service reconfiguration will be complete by June 2016, when all of the posts within the new structure will have people in post. This has had an impact on the delivery of a number of the actions within the response to the Scrutiny review and these are detailed within Appendix 1.

4. Options considered and recommended proposal

4.1 The Scrutiny review formulated 12 recommendations, which were as follows:

4.1.1 Once the national refresh of prevalence rates of mental disorder is published, RMBC and RCCG should review the local *Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People* and the mental health services commissioned and provided in Rotherham across Tiers 1-3.

4.1.2 Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data collection and information sharing on their service users and patients:

- to help maintain a detailed local data profile of C&YP's mental health over time
- to strengthen the C&YP's section of the Joint Strategic Needs Assessment
- to inform the development of local outcome measures for C&YP individually and with regard to reducing health inequalities in Rotherham.

4.1.3 RDaSH training and awareness raising with partner agencies and schools should include a focus on improving the quality of information provided in referrals to RDaSH CAMHS Duty Team to reduce delays in making an assessment.

4.1.4 In its leadership role with schools, RMBC should ensure schools link in with partner agencies to discharge their wider duties and responsibilities towards C&YP's emotional wellbeing and mental health.

4.1.5 CAMHS Strategy & Partnership Group is asked to consider if there is a need to develop a protocol for transition/step up/step down between providers in Tier 3 and providers in Tier 2 to supplement the planned pathways and protocols.

4.1.6 Following the work to build links between RDaSH CAMHS and GPs locality work should now be rolled out by RDaSH into schools, youth centres and other community settings as a priority.

4.1.7 *"Investigate the options to provide more robust services at an early stage, both in lower tiers and at an early age, to ensure that patients are prevented from moving into higher (and more expensive) tiers."*

Prevention and early intervention is a clear commitment in plans at strategic level so the CAMHS Strategy & Partnership Group should clarify how this will be delivered through clear resources and outcome focused actions that are closely monitored.

4.1.8 The target waiting time from referral for routine assessments by RDaSH CAMHS should remain at three weeks for 2015-16 and then be reviewed in the light of the impact of the recent positive changes introduced by the service and the delivery of the EWS.

4.1.9 RDaSH should review and evaluate the recent changes made to the CAMHS Duty Team to identify successes and any areas for further improvement by September 2015.

4.1.10 CAMHS Strategy & Partnership Group should ensure the new mental health and wellbeing website meets accessibility standards and incorporates a user feedback mechanism and measurement of the number of "web hits" received.

4.1.11 RDaSH should continue to work in partnership with Rotherham Youth Cabinet on service improvements and are asked to submit a progress report on the changes as a result of this work to the Health Select Commission in September 2015.

4.1.12 RDaSH and RCCG should continue to work together in 2015 on developing a clearer breakdown of costs and on the definitions of treatment to inform future outcome measures.

4.2 The response to the Scrutiny review is attached at Appendix 1 and contains an action plan against the key recommendations and progress made as at the end of March 2016.

5. Consultation

5.1 Evidence gathering as part of the Scrutiny review comprised of presentations, round table discussion and written evidence from health partners, RMBC officers, Rotherham Youth Cabinet and desktop research.

6. Timetable and Accountability for Implementing this Decision

6.1 It is anticipated that once the report has been noted and discussed by the Health Select Commission, the recommendations will continue to be taken

forward within the timescales outlined and further progress updates will be made to the Health Select Commission.

7. Financial and Procurement Implications

7.1 The financial implications of implementing the Scrutiny review recommendations have been met through monies made available by NHS England to implement the CAMHS Transformation Plan and through the re-allocation of existing resources by RDASH as part of their service reconfiguration.

8. Legal Implications

8.1 There are no identified legal implications.

9. Human Resources Implications

9.1 There are no identified human resource implications.

10. Implications for Children and Young People and Vulnerable Adults

10.1 The Scrutiny review recommendations aim to impact positively on children and young people, through enhancing current mental health service provision.

11 Equalities and Human Rights Implications

11.1 There are no negative impacts identified as a consequence of taking forward the recommendations identified within this report. The recommendations will bring about a positive contribution to promoting equality through improving access into mental health provision from disadvantaged and vulnerable groups.

12. Implications for Partners and Other Directorates

12.1 The recommendations arising from the Scrutiny Review have implications for RMBC, Rotherham Clinical Commissioning Group and RDASH CAMHS. These responsibilities are outlined within the action plan that is attached at Appendix 1.

13. Risks and Mitigation

13.1 Accessible and high quality mental health care is essential for children and young people in all parts of the borough to achieve improved health outcomes and reduced health inequalities for our community. Higher levels of deprivation in Rotherham mean the prevalence of mental health disorders is estimated to be 14% above the UK average. The Joint Strategic Needs Assessment and local consultation identified high levels of emotional, behavioural and attention deficit disorders at 4-19 years and high levels of depression from 20+.

13.2 It is difficult to maintain an accurate overall picture of children and young people's mental health and the prevalence of mental health conditions across the borough, including comparisons over time. This is due to the complexity of multiple providers, different IT systems, variations in data recording, and young people moving between, or in and out of, services as their level of need changes, or potentially not accessing support.

13.3 Prevalence rates of mental health conditions in the population are estimated on the basis of national studies, taking account of the impact of socio-economic and demographic factors. However the current national prevalence rates were published by the Office of National Statistics in 2004 and are likely to be out of date.

14. Accountable Officer(s)

Nicole Chavaudra, Assistant Director, Commissioning, Performance & Quality

Approvals Obtained from:-

Strategic Director of Finance and Corporate Services - not applicable

Director of Legal Services - not applicable

Head of Procurement - not applicable

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

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

Response to Scrutiny Review: Rotherham, Doncaster and South Humber NHS Trust Child and Adolescent Mental Health Services (RDaSH CAMHS)

Recommendation	**Response** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)*	**Officer Responsible**	**Action by *(Date)***	**Progress**	**RAG**
1. Once the national refresh of prevalence rates of mental disorder is published, RMBC and RCCG should review the local *Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People* and the mental health services commissioned and provided in Rotherham across Tiers 1-3.	The national refresh of prevalence rates of mental health will be considered when available. Undertake the annual refresh of the local *Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People.* Recommendations from the Needs Analysis refresh to inform the RDASH CAMHS Service Specification for 2016/17 and the CAMHS Transformation Plan refresh.	Paul Theaker	 February 2016 March 2016	The national prevalence rates have not been released as yet. The annual refresh of need will follow the release of this data. It is anticipated that the refresh will commence in May 2016 and will be complete by July 2016.	
2. Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data collection and information sharing on their service users and patients:	Scope out performance information that is currently available across the mental health system. Work with stakeholders to develop a common performance framework. Implement a common performance framework.	Paul Theaker Nigel Parkes	December 2015 March 2016 September 2016	Performance information across the mental health system is currently being scoped out with assistance from the RMBC CYPS Performance Team and service providers. Framework to be developed by end of July 2016. Working towards implementing a common framework by the due date of September 2016.	
a. to help maintain a detailed local data profile of C&YP's mental health over time	Standardised data collection from September 2016 onwards will provide a detailed local data profile.	Paul Theaker Nigel Parkes	September 2016	Working towards the September 2016 deadline – see above.	

b. to strengthen the C&YP's section of the Joint Strategic Needs Assessment	Standardised data collection from September 2016 onwards will provide more robust information for the Joint Strategic Needs Analysis.	Paul Theaker	September 2016	Regular updates are provided for the Joint Strategic Needs Analysis. Working towards standardised data collection and more robust information from September 2016.	
c. to inform the development of local outcome measures for C&YP individually and with regard to reducing health inequalities in Rotherham.	CAMHS patient outcome reporting is currently being incentivised through an NHS Commissioning, Quality and Innovation (CQUIN) measure. RDASH to continue to develop CAMHS outcomes reporting through the 2015/16 CQUIN.	Nigel Parkes Gaynor Connor (RDASH)	 March 2016	RDASH are meeting the CQUIN target of over 92% of patients having recorded goals. The CQUIN is being developed further in 2016/17 to include robust outcome reporting.	
3. RDaSH training and awareness raising with partner agencies and schools should include a focus on improving the quality of information provided in referrals to RDaSH CAMHS Duty Team to reduce delays in making an assessment.	RDASH, through their Duty Team, are providing feedback to referrers on the quality of information provided and there is a focus on reducing inappropriate referrals. RDASH to undertake awareness raising sessions with referring agencies. Develop a CAMHS workforce development strategy that identifies and acts upon training needs for the wider workforce in Rotherham.	Ruth Fletcher-Brown Gaynor Connor (RDASH)	Ongoing March 2016 March 2016	RDASH are continuing to provide feedback to referrers. The RDASH referral information and letters to patients and referrers has been revamped to provide more detailed information. RDASH has undertaken awareness raising sessions. However, these have not taken place in February and March due to service reconfiguration. Expected to re-commence in April 2016. The draft workforce development strategy has been developed and details the different training requirements for staff working at universal level through to complex. The strategy will be implemented by September 2016.	
4. In its leadership role with schools, RMBC should ensure schools link in with partner agencies to discharge their wider duties and responsibilities towards C&YP's emotional wellbeing and mental health.	Implement a pilot for a whole school/college approach in Rotherham. This will specifically include developing and implementing a clear Emotional Wellbeing and Mental Health Plan tailored to each individual school. Evaluate the effectiveness of the whole school/college approach and	Paul Theaker Ruth Fletcher-Brown	March 2016 September 2016	Five secondary schools and one special school have signed up to the pilot project and have developed their own individual plans. It has been agreed that the pilot schools will act on the priorities that they have identified in the	

	roll-out.			2016/17 academic year and therefore full evaluation will be available in July 2017. There will be a schools conference in September 2016 to share initial learning and to encourage other schools to take a whole school approach to Emotional Wellbeing and Mental Health.	
5. CAMHS Strategy & Partnership Group is asked to consider if there is a need to develop a protocol for transition/step up/step down between providers in Tier 3 and providers in Tier 2 to supplement the planned pathways and protocols.	Review the CAMHS pathways that were developed in March 2015. If necessary, develop a protocol for transition/step up/step down between providers in Tiers 2 and 3.	Paul Theaker Ruth- Fletcher Brown	January 2016 February 2016	The review of current CAMHS pathways was paused due to the RDASH service reconfiguration, as the development of new pathways within CAMHS, a Single Point of Access (SPA) and locality working will change the current pathways. The review of pathways has now commenced with assistance from the CYPS Performance Team and refreshed and more user pathways will be developed by July 2016.	
6. Following the work to build links between RDaSH CAMHS and GPs locality work should now be rolled out by RDaSH into schools, youth centres and other community settings as a priority.	RDaSH to implement the Locality Worker model and create working links with all GP localities, schools/colleges and key services in each area. This to include both telephone and face to face links and delivery of community services as appropriate. KPIs developed to ensure that locality working is fully operational by the due date. Evaluate the 'Locality Worker Model'.	RMBC RCCG RDASH	December 2015 November 2015 June 2016	The locality worker model was developed by December 2015. However, due to longer than anticipated staff consultation and recruitment, the model was not operational until 4 April 2016. There are now named locality workers for each Early Help, Social Care and GP locality, as well as schools and colleges within those localities. The Locality Worker Model will be monitored through RDASH contract monitoring meetings and progress will be evaluated in June 2016, through consultation with locality based services.	

7. *"Investigate the options to provide more robust services at an early stage, both in lower tiers and at an early age, to ensure that patients are prevented from moving into higher (and more expensive) tiers." (Action 4.5 in EWS)* Prevention and early intervention is a clear commitment in plans at strategic level so the CAMHS Strategy & Partnership Group should clarify how this will be delivered through clear resources and outcome focused actions that are closely monitored.	Develop a Family Support Service to specifically support families who have children and young people with mental health issues, so as to prevent patients moving into higher tiers. Evaluate the new Family Support Service and refine as required. Undertake various Community Approach work streams, including ;- • Community led approach to building resilience with parents and carers. • Peer support for parents and carers. • Community led approaches to building resilience with young people. • Peer support for young people • Enhance links to Early Help provision in localities. • Develop further self-help approaches • Undertake Suicide prevention and self-harm work	Paul Theaker Nigel Parkes Ruth Fletcher-brown	March 2016 March 2017 April 2016	The Family Support Service, which is led by the Rotherham Parent/Carer Forum became operational in February 2016 and there is a high take up of service. To be evaluated by the due date. The Whole School Approach pilots have built in community led approaches to building resilience with young people and parents/carers. These pilot schools have also included peer support as part of their approach. The RDASH locality workers are developing links with Early Help provision in the localities and links are also being strengthened at strategic level. Self-help approaches are included on the My Mind Matters website. The Youth Cabinet Mental Health Conference on 21 March 2015 included workshops on self-help and the outcomes from the conference will be taken forward. Rotherham self-harm prevention guidance was distributed widely in January and February 2016. There has been advanced and wider workforce suicide prevention training in March 2016.	
8. The target waiting time from referral for routine assessments by RDaSH CAMHS should remain at three weeks for 2015-16 and then be reviewed in the light of the impact of the recent positive changes introduced by the service and the delivery of the EWS.	The waiting time for routine assessments has improved significantly in the first and second quarters of 2015/16. The waiting time target will be reviewed as part of the development of the 2016/17 RDASH Service Specification.	Paul Theaker Nigel Parkes	February 2016	There has been deterioration in the waiting time for routine assessments in the fourth quarter of 2015/16. As part of remedial action, there are currently weekly meetings with the Assistant Director of RDASH until staffing issues are resolved and recovery of performance is achieved.	

9. RDaSH should review and evaluate the recent changes made to the CAMHS Duty Team to identify successes and any areas for further improvement by September 2015.	Develop the RDaSH CAMHS Duty Team into a true Single Point of Access (SPA) which will also provide advice on, and signposting to, other services which RDaSH don't provide such as those provided by RMBC and other organisations.	Christina Harrison (RDASH)	December 2015	The development of a SPA was delayed due to initial RDASH service reconfiguration work. The SPA model is now being developed and will be aligned to the RMBC Early Help triage team. It is anticipated that this wourk will be complete by the end of July 2016.	
	Ensure that the SPA makes it easier for Children, Young People and parents to navigate and access services, including the option of self-referral into the SPA.	Christina Harrison (RDASH)	March 2016	These requirements are being built into the SPA model of service – see above.	
	Evaluate the effectiveness of the SPA.	Christina Harrison (RDASH)	December 2016	To be undertaken by the due date.	
10. CAMHS Strategy & Partnership Group should ensure the new mental health and wellbeing website meets accessibility standards and incorporates a user feedback mechanism and measurement of the number of "web hits" received.	A user feedback mechanism and measurement of the number of "web hits" has been incorporated into the website. Continue to develop and update the website as appropriate, liaising with all partners/stakeholders. Emphasis of the December update will be on the self-help elements of the website.	Ruth Fletcher Brown	December 2015 and 6 monthly	The My Mind Matters website is continually being updated, with themes included at key times of the year e.g. how to cope with exam stress. The website has been widely promoted at staff team meetings and to young people through schools and at the recent Youth Mental Health Conference.	
11. RDaSH should continue to work in partnership with Rotherham Youth Cabinet on service improvements and are asked to submit a progress report on the changes as a result of this work to the Health Select Commission in September 2015.	RDASH has continued to work in partnership with the Youth Cabinet. Progress report deferred until the reconfiguration and recruitment to the new service happens in November and December 2015.	Christina Harrison	January 2016	RDASH has continued to work with the Youth Cabinet. The progress report has been deferred until the RDASH reconfiguration is complete. As part of CAMHS Transformation, Rotherham CCG has commissioned an independent review of voice and influence within RDASH and the findings are due in early April 2016. The Overview and Scrutiny Management Board has been working with the Youth Cabinet on the children's commissioner takeover challenge and a report will be going to the Oversight and Scrutiny Management Board in May/June 2016.	

12. RDaSH and RCCG should continue to work together in 2015 on developing a clearer breakdown of costs and on the definitions of treatment to inform future outcome measures.	Treatment definitions have been agreed and the referral to treatment target is now measured against young people actually starting treatment rather than the second appointment. Rotherham CCG to co-ordinate further work to understand child and adolescent mental health funding flows.	Nigel Parkes Christina Harrison	November 2015 March 2017	The RDASH reconfiguration has given a clearer understanding of costs and definitions of treatment. This work is continuing.	

Notes from Health Select Commission and Health partners meeting 25 February 2016

Present: Louise Barnett (TRFT), Chris Edwards (RCCG), Cllr Sansome
Apologies: Cllr Mallinder, Kathryn Singh (RDaSH)
Notes: Janet Spurling, Scrutiny Officer

Purpose of the meeting
This was the third meeting in 2015-16 to discuss the current and future work of health partners and when/how HSC would be involved.

Summary of main discussion points:

RDaSH CQC inspection

The CQC quality summit had taken place and the overall rating was requires improvement. Kathryn had delivered a presentation on the key findings at HWBB on 24 Feb. The need for improvement in Rotherham CAMHS had already been recognised and recruitment is under way for the new model, expected to be completed by March. Delivery of the transformation plan was essential and the trust hopes to meet the three week wait for assessment performance indicator soon.

New CAMHS model

- The final model has taken account of staff feedback and has been approved by commissioners.
- The time and motion work by Meridian means RDaSH will be able to start working towards par with national averages.
- Recruitment shortages persist for some CAMHS professionals, but now they have moved to a therapist model recent recruitment events have been more successful.

School Nursing Service

Provider savings for 2016-17 imposed under RMBC all service review process. TRFT have carried out a benchmarking exercise regarding numbers of Health Visitors, School nurses and community nurses. The work programme of the SNS links in with CAMHS Tier 1 services.

Commissioners Working Together Programme (CWTP)

- The children's surgery and hyper-acute stroke services are now at the pre-consultation stage prior to formal consultation on the proposals for reconfiguration, although the number of stroke patients affected is very small.
- Discussions are still taking place within and between the seven local authorities in the sub-region about the establishment and resourcing of the mandatory joint health overview and scrutiny committee.
- TRFT management committee will shortly be discussing a paper regarding a new early supported discharge team who will work with stroke patients.
- An additional workstream is cancer survival following a £5m grant from Macmillan.
- Paediatric surgery – proposals need to consider both urgent and emergency care and elective care and the critical mass and skills needed for patient care.

Sustainability and Transformation Plan (STP)

- This is a new place based plan for South Yorkshire and Bassetlaw ("Bigger Place Plan"), with funding attached to delivery.
- The focus of the CWTP is better outcomes but the service reconfiguration will not generate any savings so this will be looked at again in the STP.
- Financial balance across the NHS is a key national policy aim and some tough decisions will be needed on allocations and contracts in order to meet the local funding gap, which is currently being quantified.

TRFT

- Performance on SSNAP PIs (Sentinel Stroke National Audit Programme) has improved and been maintained even with winter pressures.
- Agency staff costs and projections will be reported to HSC in March.
- The financial deficit will significantly exceed the forecast figure, with the cost of agency staff being a major factor in the variance, mainly for medical staff rather than nursing.
- Coding for records has impacted on the deficit with £1.6m income lost this year.
- Monitor are aware of the variance from plan and are in regular dialogue. The breach is expected to remain in place but the trust may explore having some of the conditions lifted.
- £15m loan reported in the press is for the capital programme and refurbishment.
- CIP of 12.9m is progressing well, currently at £12.3m

Providers Working Together Partnership (WTP)

- In September 2015 the WTP was selected as one of the 13 acute care collaboration vanguards linking local hospitals to improve their clinical and financial viability.
- Good governance is in place and TRFT is keen to drive the work forward at pace.
- Core clinical strategy, finances and sustainability are key issues.
- Grouping some specialties will lead to better outcomes for patients.

Action following TRFT CQC inspection

- Services for C&YP have been improved since the inspection – physical environment, staff skills set, especially for mental health
- RDaSH have trained paediatric ward staff on mental health, triggers and escalation
- Bed base has been reorganised with an assessment tool for acuity and dependency so the hospital is more sensitive to demand
- CQC are satisfied with the changes made
- More work is still needed at Kimberworth Place to embed and sustain actions
- The lack of senior staff in children's acute and community services has been addressed through appointing a Matron for Children's services

A&E performance

- Performance fluctuates on the four hour target with Q4 performance to date averaging 87.91% although some days have seen the target exceeded – 24 Feb 97.31%. For the year to date the figure is 91.86%.
- Breaches have occurred due to issues within the department rather than solely due to bed pressures, with medical staffing a factor.
- A 100 point action plan is in place for A&E improvement with weekly meetings.

Sickness absence

- This remains a major concern for the trust although in December the figure was 4.89% compared to 6% the previous year.
- The target is 3% and the Listening into Action initiative is trying to help reduce sickness absence by asking colleagues: "what do you need to help you?"

Agreed actions:

1. RCCG to send final version of transformation plan to HSC Chair.
2. HSC to include monitoring delivery of the transformation plan on its draft work programme for 2016-17.

Date and time of next meeting:
Schedule to be agreed for 2016-17