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

**Date:-** Thursday, 22 September 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 28th July, 2016 (Pages 1 - 18)

### For Discussion

8. Rotherham's integrated Health and Social Care Place Plan (Pages 19 - 37)
   Presentation by Ian Atkinson and Lydia George, Rotherham Clinical Commissioning Group

9. Commissioners Working Together Programme (Pages 38 - 51)

10. Health Select Commission Work Programme (Pages 52 - 62)

### For Information/Discussion

11. Health and Wellbeing Board (Pages 63 - 66)
    Minutes of meeting held on 13th July, 2016

12. Quarterly Meeting with Health Partners (Pages 67 - 68)

13. Improving Lives Select Commission Update

14. Healthwatch Rotherham - Issues

15. Date of Future Meeting
Thursday, 22nd September at 9.30 a.m.

Sharon Kemp.

**SHARON KEMP,**
**Chief Executive.**

**Membership 2016/17:-**

Chairman:- Councillor Sansome
Vice-Chairman:- Councillor Short
Councillors Albiston, Andrews, Brookes, Cusworth, Elliot, R. Elliott, Ellis, Evans, Fenwick-Green, Ireland, Marles, Marriott, Roddison, John Turner, Williams and Wilson.

Co-opted Members:-
Vicky Farnsworth and Robert Parkin (Rotherham Speak Up) and Peter Scholey.

**HEALTH SELECT COMMISSION**
**28th July, 2016**

Present:- Councillor Sansome (in the Chair); Councillors Andrews, Cusworth, Elliott, Ellis, Fenwick-Green, Marles, Marriott, Short, John Turner and Williams.

Apologies for absence:- Apologies were received from Brookes, Elliot, Ireland and Roddison.

**14. DECLARATIONS OF INTEREST**

The following Declaration of Interest was made at the meeting:-

Councillor Andrews (non-pecuniary) – Mental Health Nurse working in the private sector.

**15. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS**

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

**16. COMMUNICATIONS**

Janet Spurling, Scrutiny Advisor, reported that 8 Elected Members had participated in the recent work programme prioritisation session to shortlist potential items. It was agreed that an underlying theme would be to ask questions addressing health inequalities.

Key issues were the big transformational projects some of which would follow on from last year's work:-

- Sustainability and Transformation Plan including Rotherham Place Plan
- Housing and Social Care integration
- Adult Social Care development programme
- Mental Health transformation

Within the above major projects, specific issues/services were identified including Learning Disability/Carers/Older People's Housing.

There would also be the Quality Accounts, the final monitoring of previous reviews and monitoring the Children's Commissioner's Takeover Challenge review plus the regional work on the Commissioners Working Together Programme.

A more detailed programme would be circulated in due course.

## 17. MINUTES OF THE PREVIOUS MEETING HELD ON 16TH JUNE, 2016

The minutes of the previous meeting of the Health Select Commission held on 16th June, 2016, were noted.

Arising from Minute No. 5 (Director of Public Health Annual Report), there was an outstanding question regarding Making Every Contact Count (MECC) which had been included in the first version of the Health and Wellbeing Strategy but had proved difficult to progress. The issues raised were:-

- How would we achieve the balance between the worker carrying out the core purpose of their visit or interaction with the customer (which might be a very short appointment time) and finding time to ask the wider questions?
- If someone does disclose something that needs to be acted upon, how would this be dealt with when there may be waiting lists already?

Terri Roche, Director of Public Health, reported that there had been a couple of unsuccessful attempts in Rotherham to get MECC off the ground but now seemed to be the right time due to the Health and Social Care integration and the Sustainability and Transformation Plan having a big focus on the need for prevention, self-care and early help. It was a challenge when people were incredibly busy but the important message about MECC was that you developed it with the front line staff.

It was about helping people to make healthier choices but starting where they were at and helping them to achieve small sustained long term health changes.

The organisation that was buying into it needed to consider the whole culture in which their staff worked. It was about getting senior management buy-in so they understood that their staff needed time, training and consideration to the environment in which they were working so there was more health information, posters around etc. to get the person to start thinking about healthier lifestyles before they saw a health or social care professional.

As well as the change in the individual it was important to get organisational change, including your own staff's health and wellbeing. It was easier to have these conversations with others if you were making these changes yourself.

It was not about being an expert but about having the basic information that was available to the public and being able to ask that question which checked if they were ready to change and if so to give them a small amount of information and/or signpost to specialists.

That way it was believed it would happen. There were already some positive responses from the Rotherham Foundation Trust who definitely wanted to take it forward. It was hoped that proceeding in this measured way would not overburden staff.

Arising from Minute No. 7 (Quality Account Sub-Groups), it was noted that the sub-groups had now been determined with Members having been circulated with all the relevant information for the sub-group they were involved with. Meetings would take place in November and December, dates to be notified.

**18. TRANSFORMING ROTHERHAM ADULT (18+) MENTAL HEALTH SERVICES**

Alison Lancaster and Kerri Booker, RDaSH, together with Kate Tuffnell, Rotherham Clinical Commissioning Group, presented the recommendations for the future RDaSH service based on the work that had been carried out in Phases 1 and 2.

The Clinical Commissioning Group and RDaSH were working closely with the Authority and health professionals to explore the potential for shared services such as a Rotherham Hub as an initial single point of contact and co-location of services.

A number of public engagement events had been held during 2015-16 to discuss the proposals as they had evolved and been informed by consultation and feedback. This had culminated in the recommendations for the future Service set out in the attached report.

At the Select Commission meeting on 17th December, 2015 (Minute No. 60), option 3, the needs-led community based approach, had been supported. However, since then the model had developed further (Minute No. 9 of 16th June, 2016 refers).

Positive progress from Phase 1 of the transformation was highlighted and then details of the new model were outlined, including recognising the differing needs of young adults aged 18 compared with for example adults aged 70+.

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

- How local would the services feel to the Service user? Would they be accessing the services at their GP or would there be 2 central buildings, north and south?
  The In-Patient Services would stay where they were i.e. Woodlands (for Older Persons Services) and Swallownest Court (for Adult Services). The organisation was looking at what resources building wise it had in the north as it was recognised that was a real area for requirement. A number of patients had home visits and they would

continue. Staff did have agile working but staff bases were required and whatever community assets there were would be used in order to link in with making the services as accessible as possible

- Have you considered whether whoever did the 'signposting' actually made the first contact on behalf of the client?
  Work was taking place with a couple of Council Officers who had done a huge amount of work looking at what agencies were out there, what was offered, what had changed etc. and were putting together a directory. The mapping of all the assets would also include the way the services were accessed some of which were by the client only. However, all staff were being encouraged to make the first point of contact dependent upon the patient's wishes. It was also about signposting more accurately to the appropriate service, what they were being signposted for and how it would happen

- Would there be time frameworks for the transformational change especially for CAMHS?
  There was an absolute commitment to complete the transformation with the Trust stating their intention of October for having all the management structure in place which was where most of the savings were coming from. Some of the Service users would not necessarily notice a difference to their service as they would have the same care coordinator; the difference would be for the newer patients who would go through a different progress and process. There was a lot of work taking place around the transition from CAMHS to Adult Services. It was monitored by the CCG and was with regard to identifying those people earlier than they were currently

- Preventing inpatient stays. Was there sufficient funding to employ additional community nurses and therapists if the service increased? If successful, the budget would move to the community. Was there enough trained staff to cover the needs of the staff in the community?
  The budget was what it was and, together with the resources, had to be managed accordingly. At the moment inpatient beds were full and that was not envisaged to change but it was the length of stay that had to be managed. There was a huge demand for services in the community, far more than currently could be managed and sometimes it was about helping people to access the right services and working with primary care and other organisations

  The Service regularly met with the Police, the Vulnerable Persons Unit etc. The organisation was looking at the skill mix and what was required as it moved forward; it was not necessarily about qualified staff but support workers as well and linked into how Direct Payments were used and other community assets

- Are we working with GPs with regard to depression and those patients that required counselling? The GP was usually the first point of contact if a person had never had a mental health issue

As part of the programme the Service was working with Primary Care both in Dementia and the Improving access to Psychological therapies (IAPT) Service to support GPs. Additional funding had been invested in developing a Dementia Pathway so that GPs would start to lead more in the diagnosis and support of people within their practice. There was also a Dementia Care Resilience Service which supported carers of those with Dementia

There had been some challenges for IAPT in the past year relating to waiting times. There was a whole set of national targets that the Service had relating to decreasing people's wait for IAPT services. One was that 75% of people have to receive an appointment within 6 weeks. A lot of work had taken place with the IAPT Service and there was the possibility of additional investment. Work had taken place with the national team and seen some significant decreases in the waiting times. The IAPT service was based in GP practices so there was a strong link and the organisation was currently reviewing the service as to further improvements. There was a lot of work around depression and anxiety and that aspect of the Service

- With regard to the Service configuration and framework how would you monitor the anticipated benefits to make sure that you achieved the measures laid out
  There was a performance team that monitored measures such as referral rates, complaints and compliments, PALS etc. and were reported on a quarterly basis

- Had Learning Disabilities been included within Phase 1?
  The document submitted related to Adult Services (those 18+ years). A whole host of additional transformational processes were being undertaken at the moment and Learning Disabilities were undergoing transformation and was a separate programme of work. Over the past couple of years service changes had led to an enhanced Community Service which had reduced the need for inpatient and ATU beds. The Services was also, as part of a national requirement, working with colleagues from across Doncaster, Sheffield and North Lincs CCGs and local authorities as part of the Transforming Care Partnership which was a programme of work around improving services for people with learning disabilities and linked with the Winterbourne. It was acknowledged that the CAMHS, Learning Disability and Adult transformations needed to be aligned due to the crossover between the Learning Disability and Mental Health Services and about how to make sure those transitions were smooth

  Some work had been taken place, the Green Light Agenda, where Adult Mental Health Services worked closely with Learning Disability Services. They met regularly in terms of strategic development and to identify service users that potentially would drop between the gap between Services. They also looked at what reasonable adjustments Adult Services could make and what support from Learning Disability

Services may be needed from a mental health point of view. There was a lot of support from the Learning Disability Services and they would support RDaSH in the community. Transitions between the 2 Services was much better than it had been

- How were the discussions progressing with regard to the Care Co-ordination Centre becoming the single point of access?
  Discussions were continuing including looking at the amount of work that came into the Services through their points of contact and what would be required in terms of staff training, costings and algotherims. It was not close to happening yet but the conversations were progressing

- How did you envisage a new Rotherham hub including Adult Social Care?
  From a Mental Health perspective it was about helping people navigate the services as easily as possible. There were conversations about accessing anything from anywhere via one point of contact. In terms of the actual staff on the ground there was a real will to work towards that. It was about making the journey as smooth as possible for the people that wanted it

- How did that link with the plans that were in place regarding organisational development strategy and ensuring skills because the whole package around the hub would be specialist skills and how they fitted along the pathway of care
  The representative could only really comment on the transformation that was being worked on; the other was an aspirational idea that needed a lot of work

- Page 36 of the document made reference to the challenges and risks for 2017/18 including staff reviews. To what degree had this been planned for now before the new model was implemented to try and avoid further major change?
  The plan was for several years of savings and the changes in the service regarding the client group was equally a plan for the future. It was a long term plan

- Did the plan include early diagnosis of various conditions or potential conditions such as Autism and would this decrease the waiting time? Were there any facilities planned for Rotherham?
  With regard to diagnosis of Autism in adults, there had been training within the Disability Teams so there was now the ability within Learning Disability to carry out a diagnosis. The amount of activity for adults had also been increased in Sheffield. This was the normal pathway as it was a specialist service and there was not the specialism within Rotherham. The waiting times were reducing but it was an area that required further work and discussions were taking place with the Local Authority. Discussions were also to commence

around an Autism Strategy which would really start to look at what issues there were and how we might start to work on those issues

- Do we buy diagnostic tools for Autism in the Rotherham area? Was it all in Sheffield?
  It was still in Sheffield but 4 Rotherham members of staff had recently been trained in the ADOS techniques of diagnostic. Staff had now been asked to cost the purchase of the tool. It would feed into the Autism Strategy

- How would you build safeguards into the initial screening and prioritisation of staff at the point of contact to ensure patient safety and appropriate next steps?
  As part of a generic assessment, there were questions around Safeguarding and all the staff undertook mandatory training. There was supervision around Safeguarding so staff could access Lead Nurses and linked into the Local Authority. On top of the full Needs Assessment, each patient had a risk assessment which included Safeguarding

- When doing the appraisals there would be a percentage of people that were misdiagnosed and they could be channelled into a certain channel which was the wrong place. Would you guess at a percentage of misdiagnosis?
  The diagnostics were carried out by psychiatrists and not nurses. Unless done by a diagnostic person such as a psychologist, generally mental health diagnoses were delivered and determined by a psychiatrist. There were staff trained in Mental Health and Mental ill health and a recognition of the symptoms of that. In the last 10/15 years staff had been trained in more psychological approaches so it moved away from purely a medical model which was about treating symptoms with medication which did not always work because they were often based in social/historical/trauma issues. As the awareness of psychology and the psychological application to mental ill health was wider, more staff were aware and this informed treatment. Cognitive Behavioural therapists had a 2 year degree course to complete. The staff that were doing CBT informed therapy undertook a 5 day training course supervised by a CBT therapist to do anything more complex

  There was a way of working with an individual called “developing a formulation”. This was about understanding all the components of a person and that was psychologically informed but also informed by everyone around them such as the patient themselves and the carer. Staff were being trained to use that more and about mapping out the whole story

  Diagnostics came from psychiatrists and they did not always get it right because a person’s personality develops over time and how a person presented may not be the same when they were young as

when they were older. Some symptoms could be masked by other presentations e.g. quite depressed but in fact have Dementia

- Cognitive Psychology was a new approach to appraising people. Some staff were being trained in 5 days because of the shortage of psychiatrists/psychologists and the pressure on them
  The Service did train staff up to deliver Cognitive Behavioural Therapy (CBT) and had also trained psychologists in the Service. It was about developing the skill base of the staff and would look to develop the skill set because psychologists were very expensive and there were very few of them

- How was the ease of access to clinicians for advice for the administrative staff at the initial single point of access?
  This worked now and would carry on working in the CCG and would be the same for Older People Mental Health Services. The administrative staff tended to take the basic information and then passed it to a clinician to make a decision as to what happened next

The Chairman thanked the Alison, Kerri and Kate for their attendance.

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

(2) That any comments to inform the final model would be submitted to the RDaSH Trust Board for approval.

(3) That the phased implementation by April, 2017 be noted.

(4) That a report be submitted in September, 2017.

## 19. ADULT SOCIAL CARE PROVISIONAL YEAR END PERFORMANCE REPORT 2015/16 - FOLLOW-UP RESPONSE

In accordance with Minute No. 6 of 16th June, 2016, Nathan Atkinson, Assistant Director, Strategic Commissioning, submitted the additional information requested by the Select Commission.

Scott Clayton, Interim Performance and Quality Team Manager, and Stuart Purcell, Performance Officer, were in attendance to answer any issues raised.

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

- Reassurance was needed that the improvement in data was leading to changes/changes of approach
  There was a challenge with the benchmarking of Yorkshire and Humber data due to the availability of data to benchmark as it tended to be on an annual basis. There were other mechanisms available via the real time data from the Authority's Social Care records and day-to-day activity

The mechanisms by which the Mental Health Employment Indicator were calculated had changed very recently in terms of their platform for informing the Authority how they had calculated and therefore produced the current rate of performance. The performance for the year end as per their publication was close to 6% whereas it had dropped in the first cycle of the new published figure nearer to 2%. There was no current 2016/17 handbook of definitions but it would be unpicked when released later in the year and followed up with RDaSH regarding their performance if this had deteriorated once there was clarity on the measure. Supporting people into employment was a priority and required co-ordination with partners and a more corporate approach to employment and skills as at present there were a number of initiatives

- Given that it was about how the data trends actually improved the service, who do we ask about that to make sure they actually were doing something with the data that you collected?
  You can only run an effective organisation by using your data wisely to inform whether you were on the right track. The data was used and aligned to the budgetary position as well. It was the key to good performance

  The data was fed into the Senior Management and Directorate Leadership Teams and into the Corporate reporting mechanisms. Issues would also be discussed with Service Managers to see if the performance data reflected how they felt about what was actually happening within their Services.

  An update was submitted to Cabinet but there was no reason why progress reports could not be submitted to the Select Commission

- What was the decision making process for accepting an expression of dissatisfaction as an actual complaint
  Customers filled in a complaints form or contacted the Complaints Team through a number of channels. There was no decision making process as such - if a customer had filled in a complaint form it was a complaint. In the majority of cases if someone wanted to make a complaint there was no barrier

- There had been 75 complaints which were a slight increase to last year. Did that relate to those forms filled in or complaints accepted at Stage 1?
  These were formal complaints where someone had taken the time to write or contact the Complaints Team to say they wanted to make a formal complaint

- What was the decision making process on whether it was escalated through to Stage 2 and Stage 3 and who made those decisions?
  It was a customer driven process. If a customer made a request to go

to Stage 2 it would proceed to Stage 2. There may be individual circumstances based on the complaint where it may be suggested that it would be better to go straight to the Local Government Ombudsman. There were a certain amount of decision making processes within the Complaints Team through experience but if a request been made we escalate the complaint

- Complaints about the quality of service had increased by over 50%. What action would be taken in context of the wider service changes?
  Given the amount of changes that have taken place affecting customers and family members a greater increase in complaints would have been expected. However, it was credit to the staff/team managers on the ground who had been able to deal with customers' dissatisfaction/concerns before it turned into formal complaints.

  The learning from complaints and management oversight of complaints had strengthened over the last 12-18 months. If a complaint was upheld or partially upheld Managers were requested to specifically identify what they had done about it, what their learning had been and reported to the Departmental Management Team. It was an opportunity to share good practice across the whole Directorate, therefore, giving the Management Team good oversight. Where learning was identified by a manager it was shared

- How large was the sample of people each year in the annual user survey? Was there other means of obtaining service user feedback?
  1,400 surveys were issued which equated to a 40% response rate. It was very prescriptive in the way it had to be operated in terms of identifying who the cohort was and based on the sample of your Service users told you how many surveys you had to post out and put people into that sample

  There were a number of different ways for specific teams and services who had their own satisfaction type customer surveys which were analysed to ascertain the satisfaction rate. They were submitted on a regular basis to the Directorate Management Teams

- Transformation – were there plans to extend Social Prescribing further and increase the budget?
  Social prescribing was funded by the Clinical Commissioning Group (CCG) and included in the Sustainability and Transformation Plan bid. There was an ask for further investment in Social Prescribing. There was an evaluation report which the CCG were compiling about how effective the Mental Health Social Prescribing had been. Certainly the intention from the Council was to invest and to look at how it could support organisations in the communities that could supplement and add value to the CCG funded Social Prescribing

- Across the range of indicators different local authorities head the rankings but it was noticeable that East Riding were first on 7 including 1b (with control over daily life) and 1f (Mental health users in employment). Have we looked at some of their practices and was there something we could learn to improve our performance?
  This was something that routinely happened and tapped into the regionally Yorkshire and Humber sector-led Improvement Agenda where the 15 authorities regularly came together to look at what the data was saying across the piste and gave the opportunity to "buddy up" and learn from each other. Experience had shown that once the performance had been interrogated, authorities counted different things which influenced their performance rating

- When would see the benefits from applying the learning from where others were doing well?
  The Authority was a lot more involved in ADASS where a lot of best practice was shared and also bodies such as the Local Government Association

  In the setting of the targets on a yearly basis, management teams were made aware of where they were currently or at year end, where that pitched the Authority in accordance with benchmark data, the difference made and allowed the opportunity to say what the stretch target was going to be, if that was possible or the priority for that service. You should be seeing through the tracking what was being done differently whether those specific actions were having the impact they set out to achieve. Performance clinics were held to get underneath the data

- Appendix C - was there a link between decreasing ongoing low level support and increasing universal signposting to other services especially for people 65 and over?
  The SALT table was a new way of recording this. There had been an increase and the particular areas where the biggest changes and volume in terms of numbers identified in the appendix. What was not known yet was if it was due to the change in the model of service delivery and signposting people to universal services designed to meet their needs without them coming into services long term. There was insufficient data to give an answer to that as yet

Resolved:- (1) That a further report be submitted to the meeting on 1st December, 2016, showing final 2015-16 submitted results and benchmark comparisons against regional and national data.

(2) That the responses to the outstanding issues raised at the June meeting be noted.

## 20. ADULT SOCIAL CARE - LOCAL MEASURES PERFORMANCE

Further to Minute No. 6(3) of the meeting held on 16th June, 2016, Nathan Atkinson, Assistant Director for Strategic Commissioning, presented a report on the local measures that had been priorities to ensure that they reflected areas of Adult Social Care Service activity. They also linked to the Council's overarching strategic policies and strategies.

The Directorate Management Teams received regular updates of the current performance of the Local measures alongside the National ASCOF measures reporting. Local measure in-year performance would be included in future Cabinet Member reporting arrangements. This would align and run parallel to the agreed Corporate Plan and Improvement Plan reporting schedules.

It should also be noted that, in addition to the Local measures, a range of other measures of activity were also performance managed and reported via alternative reporting streams. Service level management information measures were also regularly reported internally to Senior Management Teams.

The report set out the current performance challenges as at 31st May, 2016, which included:-

LM01 – Reviews
LM02 – Support plans % issued
LM03 – Waiting times assessments
LM04 – Waiting times care packages
LM05-07 – commissioning KLOE's

Discussion ensued with the following issues raised/highlighted:-

- Was commissioning a problem for the Directorate or across the whole of the Authority? Who decided if it was across the board and so who should look at commissioning or whether it was just in this particular Directorate and the Select Commission would look at it?
  The Directorate had self-assessed itself as red in most of the category areas. The way that Rotherham approached commissioning was a little behind its peers especially in relation to Adult Services. In terms of the development plan commitments were around co-production for outcomes that we should be doing. There was evidence of recent activity starting to move in that direction and engagement and involvement of officers working with communities and members of the voluntary sector was helping that. The Directorate was very much at the start of the journey and a lot of work to do. The staffing structures had to be considered and the skills within the existing team which was doing very effective work but very much focussed on contract monitoring especially for care homes/statutory services, and the strategic side had been somewhat lacking. There was much work to

be done with Autism an absolute area that needed to be prioritised together with Mental Health and Learning Disabilities

Nathan had been asked by the Chief Executive to oversee the Corporate Commissioning Review which was part of the Improvement Plan and a fundamental part of the Authority's journey to regain powers and within that would be looking at Children and Young People's Services, Public Health and perhaps other areas where there was some commissioning. That work was in its infancy but had a deadline of January, 2017 to conclude the review and publish the outcome. Within that there were a number of gateways which were specified within the Improvement Plan

- Where was the appropriate place for the scrutiny of commissioning? Was it the Overview and Scrutiny Management Board or the Audit Committee?
  This would be raised at the Board meeting the following day

- At what stage would a review by ADASS be triggered or would it?
  It was a Peer Review. As commissioning on a Corporate level had to be reviewed in the first instance, support may be sought from ADASS to look at the Adult element or the Local Government Association to look at commissioning across the board but that was to be determined. Peer challenge was to be welcomed as that was how you learnt and progressed. At some point within the next 6 months it was hoped to have a Peer Review after the internal work had been carried out. The real test would be when the Authority perceived itself to be on the improvement journey and the reviews would establish whether it truly was

- When the Corporate Review was complete it would be an appropriate time to have the Peer Review to give comfort that someone had looked at the plan going forward
  Absolutely agree

- Had the performance clinic for LM01 been held yet?
  The performance clinic was held on 20th July with the lead officers that were accountable for reviews. A number of actions had been identified that required further consideration including looking at a whole range of activity across the care management teams to capture activity rather than the traditional model. The Care Act allowed the Authority to open up how reviews and self-assessments were carried out so that avenue needed exploring. There were also a number of actions that were being looked at in terms of activity that the teams were doing working with the customers which fell short of a review but did not necessarily take into account the holistic approach of the current assessments. The review activity allowed the Service to know whether the current package was working/whether or not things were improving or on a steady decline that would require further intervention

- Were you confident that from the performance clinic and the suggestions that you have given that we can start to pull back on the figure and the measure of LM01?
  It was a challenge and that had been recognised within the Senior Management Team by way of holding a performance clinic. That process had started and identification of what the actions were likely to impact upon it to get assurance as to how quickly it could be recovered through the remedial actions to get to the 75% and work toward towards 100% overall

  The service was still going through the Phase 2 of the remodelling and that came on stream in September which only left 6 months to pick up those who would be identified and reviewed through the additional processes over and above what was captured in the current data

- When performance clinics had first started there had been the opportunity for a Member to sit and observe/comment. Given the number of new Councillors could that invitation be extended?
  Discussion would take place with the Cabinet Member

- If extending the assessment were you completely changing the assessment tool and have you time and motion studied how long staff will take to do it?
  Part of the remodelling of the Service was looking at different ways of working where the actual input of staff time to get to the full assessment position could be reduced. It was currently a time intensive process but it was hoped to be able to strip out some of the Council staff time which in turn would improve the throughput to help the Service achieve the numbers. In terms of the detail, paperwork and methodology, that would be changing as the current recording system would move to Liquidlogic which would go live in December

- Where were/how positive results for individuals reported that resulted from their care package and support plans?
  Through Liquidlogic and the associated recording there would be the opportunity to capture with the Service user what they actually wanted to achieve as an outcome and during that process whether they felt it had been actually delivered

- The Corporate Plan contained some additional local measures. Were these being added to this document for future reporting?
  The Service reported on the Corporate Plan with the first quarter report due in September. The additional local measures had been included in the Key Performance Indicator suite which were submitted to the Strategic and Directorate Management Teams for tracking and informing decisions that were ultimately reported back into the Corporate Plan. If the Select Commission wished to extend the scorecard it was not a problem

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

(2) That the opportunity for a Peer Review be welcomed.

(3) That the outcome of the discussion with the Cabinet Member for Adult Social Care and Health be awaited with regard to an Elected Member attending performance clinics.

(4) That a report on Local Measures be submitted to the December meeting.

(5) That it be noted that once the further report had been submitted in December the Select Commission would be in a clearer position to make recommendations as to how it went forward.

## 21. CARING TOGETHER SUPPORTING CARERS IN ROTHERHAM

Elizabeth Bent, Crossroads Care, and Jayne Price, Carers Forum, presented the updated draft Strategy which emphasised the need to identify and support all carers, including hidden carers and young carers.

The following powerpoint presentation set the context for the Carers Strategy:-

Why do we need a Carers Strategy

- Approximately 31,000 carers in Rotherham
- Last Rotherham Carers Strategy expired in 2011
- Introduction of the Care Act 2014 – new rights for Carers
- Funding cuts throughout Health and Social Care

Co-production

- Multi-agency Development Group comprising representatives from:-
  Carers Groups i.e. Forum
  RMBC Adult and Children
  Rotherham CCG
  RDaSH
  Voluntary Sector
  Rotherham Foundation Trust
  Job Centre Plus
  Carers Corner

Consultation/Community Engagement

- Crossroads AGM
- Magna Event
- Carers Forum
- Adult Services Consortium
- Carers Resilience Service
- Barnardos

Outcomes
- Carers in Rotherham are more resilient and empowers
- The caring role is manageable and sustainable
- Carers in Rotherham have their needs understood and their wellbeing promoted

Where are we today
- A step in the right direction for Carers
- Draft document
- Not complete
- Not perfect
- Open to suggestions

The Future
- Aiming to present to Health and Wellbeing Board September meeting
- Strategy shared widely
- Development group – Delivery Group
- Rollout of actions – monitored by delivery group
- Annual review and update

Discussion ensued with the following issues raised/highlighted:-

- Can you explain the Pledge? How you can influence the Pledge that carers in Rotherham were not financially disadvantaged as a result of their caring role?
  Part of that was to ensure that carers had access to benefits advice and support. The work taking place with the Carers Resilience Service was funding that support and had been successful in carers getting Carers Allowance and obtaining Attendance Allowance for the people they cared for. It was not all about money but a little bit of finance could make a big difference to carers

- There was felt to be a difference in the language used in the Pledge and in the Outcomes
  We can take that back and change it. The Pledge was picked up from the National Carers Strategy as it was at present. There were plans for a new National strategy for which the consultation finished on 31st July and was another reason why Rotherham's publication had been delayed until September to ensure it was not out of line

- There were a lot of carers in Rotherham. How do you think this will help reach more carers and support them?
  There were a lot of groups in Rotherham and the information would be cascaded as widely as possible. Once the Carers Strategy was approved it would be rolled out, promoted and shared out to as many people and in as many ways possible

- Were Directorates playing ball with the new initiative? How were they linking in with you at all?
  The development group was multi-agency and working along with the Directorates. Within the Forum, the Carers Forum was the independent voice for carers. A Carers Issue Log was to be introduced whereby anybody who felt that they were not getting the services or there was some sort of failing would enter it onto the Issue Log. It would then be taken back to the people that should be addressing it i.e. the Directorates and other agencies

- As Directorates were planning out new ways of working were you being involved?
  Over the last 18 months, there had a tremendous improvement. The very fact that there was a will to put a Carers Strategy in place in Rotherham was a great step forward. One of the things identified quite early on was the need for a strong carer's voice in Rotherham which benefitted everyone. Part of the Strategy was the development of the Carers Forum. The Officer who led the Group was very keen on commissioning some support for the Forum because it was run by carers for carers

- The delivery plan stated the intention to develop an online assessment form for carers. How accessible would that be for older people?
  One size never fitted all and was another way of ticking the box on carer's assessments. We need carers to come forward and assessments completed to ascertain their needs and support them

- Outcome 3 target for working to ensure Rotherham became carer friendly. What sort of tools were in place locally to ensure employers, public and private sector, catered to employees' needs?
  Crossroads Care (a voluntary sector organisation) had carer friendly policies in place i.e. flexible working etc. Realistically if it was not law there were some employers who would not do it. The Council did some work with their own employees to find out how many of them were carers. There were ways that carers could be supported such as flexible working but it was for us all to raise the issue and address them

Elizabeth and Jayne were thanked for their presentation.

Resolved:- (1) That the draft Strategy and delivery plan be noted.

(2) That an appropriate timescale be agreed with the Delivery Group to receive a progress update on implementation once the strategy was signed off.

## 22. HEALTH AND WELLBEING BOARD

The minutes of the Health and Wellbeing Board held on 20th April and 1st June, 2016, were noted.

## 23. IMPROVING LIVES SELECT COMMISSION UPDATE

Councillor Cusworth reported that it was still work in progress but the Improving Lives Select Commission work programme shortlist included:-

Domestic abuse
Safeguarding
CSE post-abuse support
Early Help
Special Educational Needs and Disability

The Select commission had been careful to ensure there was no duplication with the work of this Select Commission.

## 24. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR THE COMMISSIONERS WORKING TOGETHER PROGRAMME

It was noted that the next meeting would be held on 8th August, 2016.

Papers were published on the website at the link below.

http://modgovapp/ieListDocuments.aspx?CId=1045&MId=13847&Ver=4

## 25. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

## 26. DATE OF FUTURE MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 22nd September, 2016, commencing at 9.30 a.m.

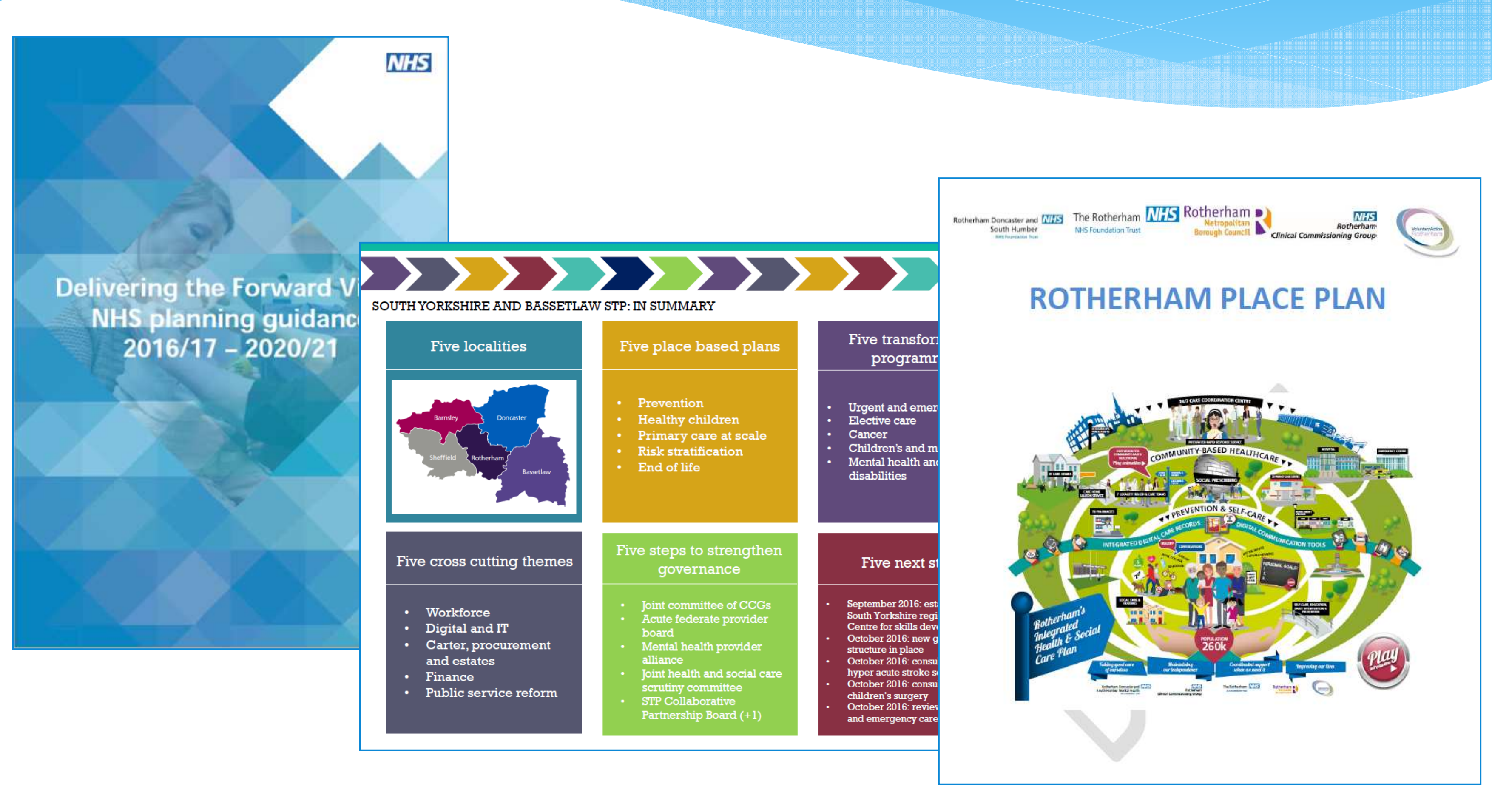
# Rotherham's Integrated Health and Social Care Place Plan

## Health Select
## 22 September 2016

# National Strategic Context

# Rotherham CCG Plan takes account of 5 Year Forward View

# Planning Guidance – STP and Place Plans



# Rotherham Integrated Health and Social Care Place Plan

Rotherham's health and social partners have joined together to look at how we can make the most of our services, with the public at the very centre of everything we do.

By changing the way we approach health and social care in Rotherham, we can improve our lives.

Our vision is:

**"Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery"**

# Rotherham Context

## The Case for change:

## The 3 'Gaps'

### Health and Wellbeing

- Life Expectancy in Rotherham is less than the England average by more than one year
- Life expectancy varies by eight years between different parts of Rotherham
- Increasing numbers of older people with long term conditions

### Care and Quality

- Hospital attendances, admissions and waiting times continue to rise
- There are opportunities to manage growth in emergency admissions to hospital

### Finance and Efficiency

- NHS Rotherham CCG has a £75million efficiency challenge over the next 5 years
- RMBC has a £40 million (check) financial gap to close over the next 3 years

# Our Five joint priorities within the Place Plan

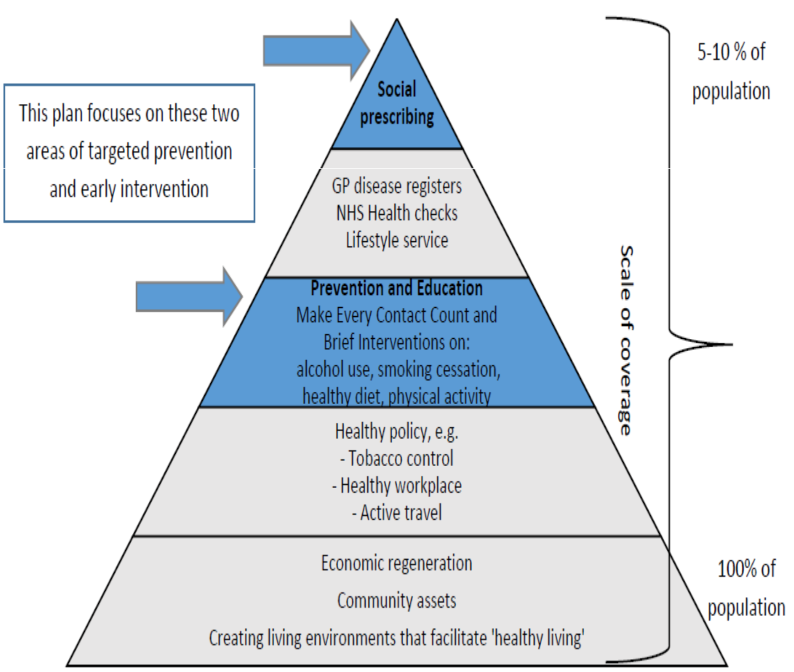
1. Prevention, self-management, education and early intervention
2. Rolling out our integrated locality model – 'the village' pilot
3. Opening an integrated Urgent and Emergency Care Centre
4. Further development of a 24/7 Care Co-ordination Centre
5. Building a Specialist Re-ablement Centre

# 1. Prevention, self-management, education and early intervention

- We will better meet the needs of local people by targeting individuals that can gain most benefit through:

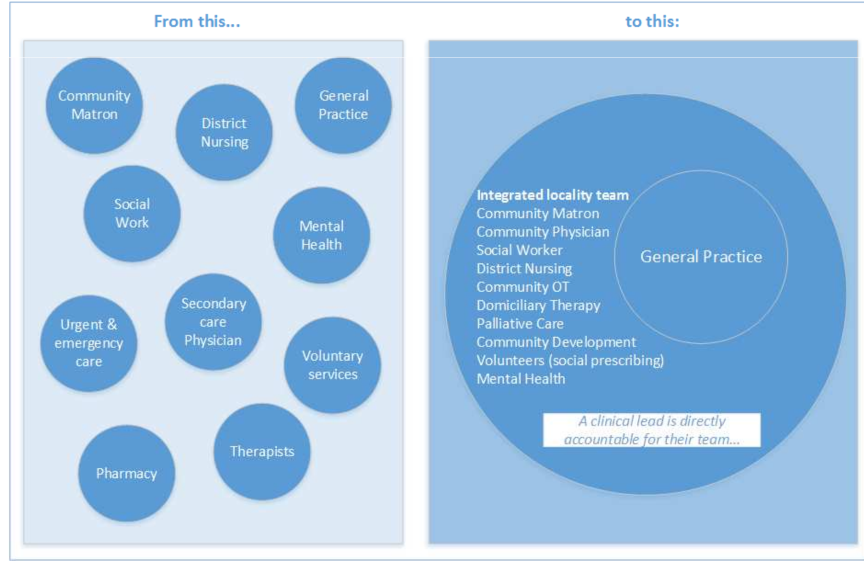
- ❑ Expanding our award-winning **Social Prescribing** service both for those at risk of hospitalisation and for mental health clients.

- ❑ Expanding systematic use of **Healthy Conversations** and advice by ensuring every statutory organisation signs up to **Making Every Contact Count** (MECC) and by training front-line staff to talk about sensitive issues such as alcohol use, healthy eating habits, increasing physical activity and quitting smoking. We will also ensure quick and easy referral to evidence based lifestyle services (e.g. smoking cessation) to support those that are ready to change and in a way that is right for them.



# 2. Roll out our integrated locality model 'The Village' pilot

* Our pilot 'the village' is in Rotherham's town centre, it was established in July 2016 and covers 31,000 patients in 1 of our 7 localities.
* It showcases joint commissioning arrangements that drive the integration of services and promote multi-disciplinary working between primary care, social care, secondary care, social care, mental health, community services and the voluntary sector, reducing the reliance on the acute sector.
* We will be rolling out the model throughout our 6 other localities.
* The aim is to provide seamless care to the designated GP practice cluster population, ensuring the client receives coordinated care from a single case management plan and lead professional



# 2. ….transformation of the care home sector

* Approximately 15% to 18% of emergency admissions into hospital are from care homes, these patients also have longer lengths of stay than average admissions.
* Partnership with the care home sector is therefore critical to reducing demand for acute services.
* We will further develop our care home liaison service, introduce 'trusted assessors' and upskill staff in care homes in assessments in practical skills to manage residents with higher medical problems.

- Our aim is that this will result in fewer admissions from care homes into hospital, more proactive management of length of stay and less people automatically placed in care homes

# 3. Urgent and Emergency Care Centre

* The Urgent and Emergency Care Centre will be complete by Spring 2017 and open by July 2017
* It will be Rotherham's 24/7 single point of access and triage for urgent cases
* It will use an innovative multi-disciplinary approach to reduce waiting times, support patient flow through the hospital and improve patient experience
* We will pioneer an innovative 'next available clinician staffing model' which integrates GPs, ED consultants and highly trained nurses.
* It will also accommodate social workers, mental health teams and care coordination teams.
* It is expected to reduce emergency admissions saving over £30m over 10 years

- The aim is for patients to be assessed and possibly treated within 20 minutes if you're an adult or 15 minutes if you're a child.

# 3. ...expanding our Adult Mental Health Liaison Service

- In April 2015, as part of our wider Mental Health services transformation plan, we launched the Rotherham Mental Health Liaison Service to provide round the clock mental health care to patients who attend Rotherham Hospital.
- We aim to expand access to this service to improve the outcomes and experience of people experiencing a mental health crisis and to improve access, reduce waiting times, admissions, re-admissions and lengths of stay, reduce use of acute beds by patients with dementia and enhance the knowledge and skills of hospital

# 4. 24/7 Care Co-ordination Centre

* The CCC has been in place for 18 months and currently takes 4000 calls a month, 24/7.
* Its aim is to act as a central point of access for health professionals and patients into community and hospital based urgent care services.
* Our aim is to expand the scope of the CCC to include mental health, voluntary and social care sector services, improving access for patients through a comprehensive directory of services, driving efficiency and cutting down waste.

* The purpose is to manage system capacity, carry out initial assessment and deploy appropriate teams to provide support, avoid potential hospital admissions and ensure people are in the most appropriate care setting.

# 5. Specialist Re-ablement Centre

* We want to develop a more integrated approach to the provision of intermediate care services for those patients who cannot be treated at home, but do not need to be treated in a hospital setting.
* Our aspiration is to locate all rehabilitation services on a single, co-located, non-acute setting to create an environment that supports integrated working.
* A fully integrated team of health and social care professionals will provide a mix of community rehabilitation services, residential intermediate care, and the current discharge to assess beds for people living in the community, and for people leaving a hospital setting.

* This model will allow Rotherham people to remain in their community longer than would otherwise be possible
* We anticipate the Re-ablement Centre will be more cost efficient through better deployment of professionals and teams and supporting an integrated multi-disciplinary way of working

# Enablers

* We will:

- Make good use of our public buildings and resources
- Make better use of technology. We're planning a major upgrade to the way we all communicate with services, healthcare professionals and patients.
- Working together and sharing information will become the norm
- Encourage everyone to use technology to care for themselves and manage their own wellbeing

# Expected Benefits and required investment

| Joint Priority | Benefit | Investment |
|---|---|---|
| **1. Prevention, self-management, education and early intervention** | • 'Making Every Contact Count' could show a return of £10 per £1 spent<br>• Expected savings for households and employers up to £28 per £1 spent<br>• Social prescribing evaluation shows improved outcomes for patients and system benefits of £1.98 for each £1 invested | • £1.8m per annum for MECC<br>• £1.1m per annum for social prescribing<br>• £45k for VAR website and £25k for VAR Health Champions |
| **2. Rolling out our integrated locality model – 'the Village' pilot** | • Improved patient outcomes and proactive management of care<br>• Reduced utilisation of secondary services<br>• Reduction in non-elective bed days by 10,000 (estimated £1.5m saving per annum)<br>• Management of high acuity patients in care home sector | • One off funding of £1.5m<br>• £1.25 per annum to trial new staffing models in primary care and to fund transformational support<br>• £0.6m for appropriate equipment and training in the Care Home Sector |
| **3. Opening an integrated Urgent and Emergency Care Centre** | • Investment to go further and faster in developing the model and to support the realisation of £30m system savings over 10 years<br>• Investment in integrated liaison service for people with dementia could show a return of investment of £4 for every £1 invested | • £0.45m for new capital guild and transformation investment |
| **4. Further development of a 24/7 Care Co-ordination Centre** | • Formal evaluation shows at least £0.86 additional system wide efficiencies<br>• Further integration of health and social care services | • £0.46m non-recurrent infrastructure costs |
| **5. Building a Specialist Re-ablement Centre** | • Transition to new staffing and skill mix models of care and enhance clinical and caring environment<br>• Transition of long stay residents from existing provision into care home provision<br>• Evidence from Plymouths' review of re-ablement services achieving financial objective of £500k savings in the first year | • £3m per annum |

# High Level Implementation Plan

| Priority Area | Key Milestone | April 2016 – March 2017 | April 2017 – March 2018 | April 2018 – March 2019 | April 2019 – March 2020 |
|---|---|---|---|---|---|
| **1. Prevention, self-management, education and early intervention** | • Evaluate Mental Health Social Prescribing<br>• Increase target from 5% to 10% of patients at risk of hospitalisation<br>• All key statutory organisations signed up to MECC and first cohort of front line staff trained | | | | |
| **2. Integrated Locality Model** | • Implement integrated locality pilot and final evaluation<br>• Roll out integrated locality model across Rotherham | | | | |
| **3. 24/7 Care Co-ordination Centre** | • Scope and plan expansion to other health and social care services<br>• Evaluate upscaled service | | | | |
| **4. Urgent and Emergency Care Centre** | • Completion of the capital build for Urgent and Emergency Care Centre<br>• Full implementation of the model of working<br>• External evaluation of the Adult Mental Health Liaison Service | | | | |
| **5. Re-ablement Centre** | • Full implementation of the Rapid Response service<br>• Full review of acute and community respiratory pathways<br>• Development of the re-ablement hub | | | | |

# Work still to do…

* Overall Governance Structure
* Finance
* Agreement through partner governance arrangements
* Alignment to wider STP Plan and workstreams
* Finalisation of illustration and infographics

# Timescales

| Date | Meeting / action |
|---|---|
| 21 September | Health and Wellbeing Board |
| 22 September | Health Scrutiny |
| 27 September | Final completion of Illustration and interactive Story Board |
| End September to Early October | • CCG GP Members Committee<br>• RMBC Senior Leadership Team<br>• TRFT Board<br>• RDaSH Board Development Session<br>• CCG Governing Body<br>• VAR Board |
| Mid October | Rotherham Integrated Place Plan finalised and signed off by partners |
| 21 October | STP Submission to NHS England |

Agenda Item 9

Public Report
Health Select Commission

**Summary Sheet**

**Council Report**
Health Select Commission - 22 September 2016

**Title**
Commissioners Working Together Programme

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

**Strategic Director Approving Submission of the Report**
Shokat Lal, Assistant Chief Executive

**Report Author(s)**
Janet Spurling, Scrutiny Officer, Assistant Chief Executive's Directorate
janet.spurling@rotherham.gov.uk 01709 254421

**Ward(s) Affected**
All

**Summary**
The Commissioners Working Together Programme focuses on collaborative work across the health service to consider how to improve the health of communities and health services across seven local authorities. There are a number of workstreams in the programme with options for substantial changes to hyper acute stroke care and non-specialised children's surgery and anaesthesia being consulted on this autumn. The report and appendices provide an overview of the work already undertaken and the development of options appraisals for both services.

**Recommendations**

That Members:

1.1 Note the work undertaken to date by the Joint Health Overview and Scrutiny Committee.

1.2 Consider and discuss the proposals that will be going forward for public consultation in October.

**List of Appendices Included:**
Appendix 1 - Hyper Acute Stroke Services Options Appraisal – Summary for the OSC
Appendix 2 - Children's Surgery Options Appraisal – Summary for the OSC

**Background Papers**
Letter from NHS England and NHS Rotherham CCG to Chief Executives
Agenda papers and Terms of reference for the Joint Health OSC

**Consideration by any other Council Committee, Scrutiny or Advisory Panel**
None

**Council Approval Required**
No

**Exempt from the Press and Public**
No

**Title**

Commissioners Working Together Programme

## 1. Recommendations

That Members:

1.1 Note the work undertaken to date by the Joint Health Overview and Scrutiny Committee.

1.2 Consider and discuss the proposals that will be going forward for public consultation in October.

## 2. Background

2.1 On 12th October, 2015 an initial meeting was held with representatives from Health Overview and Scrutiny Committees and NHS partners to discuss the formation of a joint health overview and scrutiny committee. Its purpose would be to consider the proposals for health service change being developed by the Commissioner Working Together Programme in South and Mid Yorkshire, Nottinghamshire and Derbyshire (WTP).

2.2 The Health Select Commission (HSC) discussed the potential new joint health overview and scrutiny committee at its meeting on 17 December 2015. Members agreed it was important to be represented in order to ensure Rotherham had a voice in the future of health services and to ensure that the needs and concerns of local people would be reflected in decisions about service developments.

2.3 HSC recommended that the proposal to establish the new joint committee was supported and that the Chair be nominated as RMBC's representative. These recommendations were approved by Lead Commissioner Sir Derek Myers.

2.4 The new Joint Health OSC is now in place with agreed terms of reference.

## 3. Key Issues

3.1 The WTP focuses on collaborative work across the health service to consider how to improve the health of communities and health services across a geographical footprint wider than the eight individual clinical commissioning groups (CCGs). The programme is covering a strategic review of health and social care across the region with a number of specific workstreams that are likely to impact on future services for the borough.

3.2 Substantial changes to hyper acute stroke care (the first 72 hours after a stroke) and non-specialised children's surgery and anaesthesia are being consulted on this year.

3.3 The Joint Health OSC met in May and August 2016 and considered the following papers in relation to these services (all available via the Council website):

May

- Pre-consultation Reports for Children's Surgery and Anaesthesia and Hyper Acute Stroke Services
- Communications and engagement strategy and plans for public consultation for Children's Surgery and Anaesthesia and Hyper Acute Stroke Services

August

- Commissioners Working Together Hyper Acute Stroke Unit, Stage 3 - Detailed Option Appraisal
- Joint Commissioners and Provider Working Together Programmes Non-Specialised Children's Surgery and Anaesthesia - Options Appraisal
- Draft Consultation Documents:
  - Providing hyper acute stroke services in South Yorkshire, Bassetlaw and North Derbyshire
  - Providing Children's Surgery and Anaesthesia Services in South and Mid Yorkshire, Bassetlaw and North Derbyshire.

3.4 Appendices 1 and 2 provide an overview of the work undertaken already by the WTP and the development of options appraisals for both services.

3.5 Following a recommendation from the Joint Health OSC, the draft consultation materials for each service have been circulated to the individual health scrutiny committees for comment and feedback, drawing on their local knowledge of how best to engage with their own communities.

**4. Options considered and recommended proposal**

4.1 The focus of the options appraisal process has been to develop sustainable options that provide the best outcomes for patients, in line with national standards. Preferred options have been identified for both services (see appendices 1 and 2) after reviewing services against a number of criteria such as activity levels, cross-boundary impact, workforce issues, impact on visitors/carers, and taking account of the key themes that emerged from the pre-consultation.

**5. Consultation**

5.1 Consultation on the proposals will run from October 2016 to January 2017, based on the Communications and Engagement Strategy and Plans referred to above and the draft consultation materials previously circulated to HSC for discussion and feedback.

**6. Timetable and Accountability for Implementing this Decision**

6.1 Final decisions for both services will be taken following the public consultation and assurance by NHS England.

**7. Financial and Procurement Implications**

7.1 There are no direct implications arising from this report but financial analyses and full business case development will be completed by officers in the WTP.

**8. Legal Implications**

8.1 Where proposed changes to health services are substantial and affect more than one local authority area local authorities are required to form a joint overview and scrutiny committee [Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013].

**9. Human Resources Implications**

9.1 There are no direct implications arising from this report but a national shortage of skilled and experienced staff for these specialties is a key factor in developing options for sustainable services.

**10. Implications for Children and Young People and Vulnerable Adults**

10.1 As mentioned above one of the workstreams is non-specialised children's surgery and anaesthesia.

**11 Equalities and Human Rights Implications**

11.1 Proposals for service changes need to take account of equality protected characteristics, the Public Sector Equality Duty and the Human Rights Act.

11.2 Major health service reconfiguration is subject to formal consultation and the methods used and materials need to be inclusive and accessible to all communities.

11.3 The Joint Health OSC will give due consideration to these issues in its programme of work.

**12. Implications for Partners and Other Directorates**

12.1 Health partners initiated the WTP and will work with and consult local authorities and other agencies.

**13. Risks and Mitigation**

13.1 There are no specific risks associated with commencing public consultation.

**14. Accountable Officer(s)**

James McLaughlin, Democratic Services Manager

Approvals Obtained from:-

Strategic Director of Finance and Corporate Services:- N/A

Director of Legal Services:- N/A

Head of Procurement:- N/A

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

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

Appendix 1

# Hyper Acute Stroke Services Options Appraisal

## Summary for the OSC

### 1. Purpose

The purpose of this paper is to:

- Summarise the work undertaken to date, by our CCGs, in reviewing hyper acute stroke (HAS) services across South Yorkshire and Bassetlaw and North Derbyshire.
- Inform the OSC on the progress around the ongoing work and motion towards public consultation on the options for the reconfiguration for the hyper acute stroke services (HASUs).

This change is confined to the hyper acute part of the stroke pathway which is the first 72 hours of care.

### 2. Background and Context

Over the past eighteen months the region's CCGs have undertaken a review of hyper acute stroke services across South Yorkshire, Bassetlaw and North Derbyshire as *Commissioners Working Together.* The current model of delivery for hyper acute stroke (HAS) services is delivered from 5 units in Barnsley, Chesterfield, Doncaster, Rotherham and Sheffield.

The main drivers for considering change are outlined below and these remain. In particular, a sustainable workforce to deliver hype acute stroke services remains a significant challenge.

Key messages from the review:

- 3 out of 5 HASU centers admit less than the best practice minimum of 600 per unit
- There is a shortage of medical, nursing and therapy staffing
- Door to needle time of over 1 hour in most places

- Low thrombolysis rates across all providers
- Not achieving 1 hour scanning time
- Unsustainable medical rotas
- Gaps in early supported discharge
- Education and training required for delegated staff
- Delays in endarterectomy

Our review was shared with the Yorkshire and the Humber Senate who supported our findings. The senate also recommended that our review was considered in context of the full regional picture with any potential impact taken into account.

In June 2015, CCGs supported the case for change with a clear mandate to develop options for future service delivery and the Yorkshire and the Humber Strategic Clinical Network (SCN) took forward the development of a 'Blueprint' for HAS across Yorkshire and the Humber.

The principle of the Blueprint was to provide a high level overview of what would provide clinically safe and sustainable HAS services and ensure the best equity of access for all our local populations.

Summary of key themes from 'HAS Blueprint':

Reconfiguration in South Yorkshire and Bassetlaw should include:

- A plan to reduce the number of HAS within the South Yorkshire and Bassetlaw and move to a minimum of 2 units
- Consider the cross-boundary impact and East Midland review for Chesterfield unit
- Transformation should include a review of patients flows
- No center should exceed the maximum stroke numbers of 1500
- Best practice travel time of 45 minutes and clinical viability
- Steps to improve clinical outcomes and provide sustainable stroke services.
- Reconfigure total number of HAS (services should deliver more than 900 interventions per year) to support clinical outcomes and improve performance seen in the SSNAP reports

The SCN presented the 'Blueprint' in April 2016 and subsequently the Senate reviewed the findings.

The final June recommendations in the SCN Blueprint for hyper acute stroke now recommends that for South Yorkshire and Bassetlaw, HAS services should include consideration of the viability of reducing the number of HAS services to a minimum of 2.

## 3. Stakeholder engagement and pre-consultation

Commissioners Working Together have facilitated significant stakeholder engagement throughout the review process engaging in particular with providers and commissioners and other key partners via a series of workshops, engagement events and the stroke steering group between January 2015 and May 2016.

Between January and April 2016, Commissioners Working Together held an open pre-

consultation for the review of hyper acute stroke services across South Yorkshire and Bassetlaw and North Derbyshire. The question, 'what matters to you when accessing urgent stroke services' was asked with conversations held face to face and across social and digital media. Thousands of people accessed the website to read about the case for change, several hundred were involved in face to face discussions and over two hundred responses were received.

The key themes emerging were: being seen quickly when get to hospital, being seen and treated by knowledgeable staff, safety and quality of service, fast ambulance response/travel times and good access to rehabilitation services locally.

A communication and engagement strategy for consultation has been developed for the next phase of this work and to enable us to progress to consultation with the public about proposed changes to HAS in the autumn.

## 4. Developing options

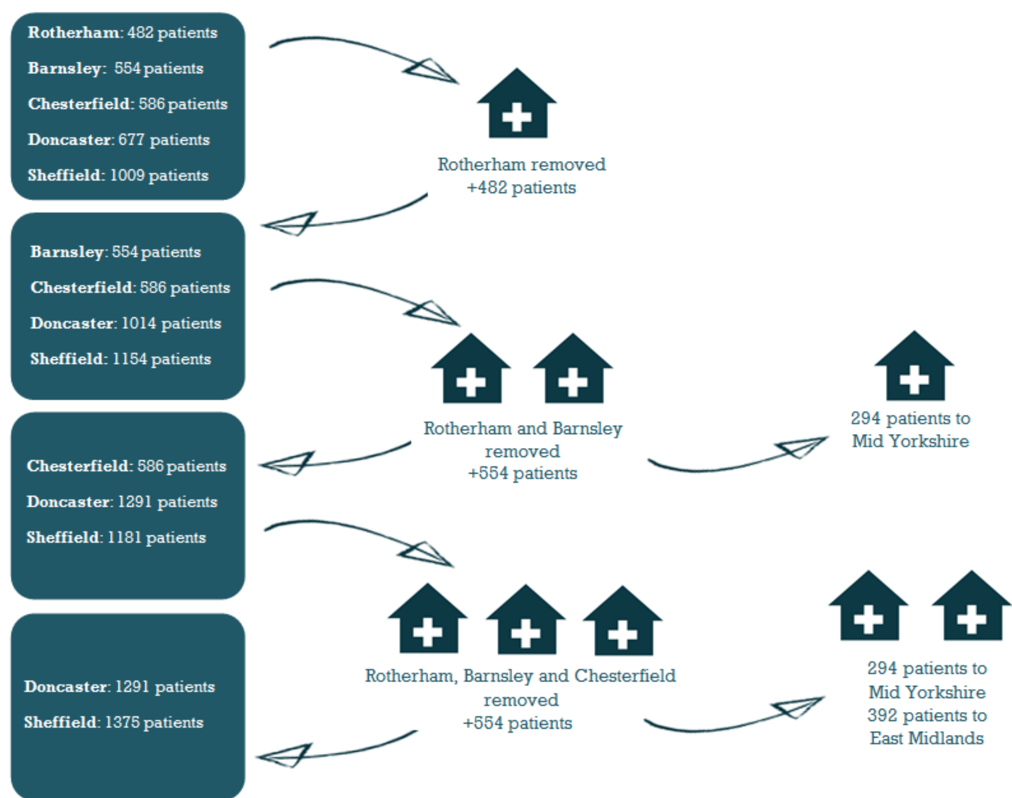
The development of the options appraisal framework to support improvements to the delivery of HASU has been undertaken working with the stroke steering group, comprising of commissioners and providers from across our Working Together partners. The steering group has also been established to support and oversee this work. The focus has been on ensuring that the appropriate outcome measures and weighting were allocated to the options appraisal matrix this was then used to review the various options and those that are most likely to impact on overall improvements to outcomes and sustainability of services.

The matrix reviewed:

- Access meets 45 mins (provided by YAS)
- HASU activity levels (and the impact from reducing a HASU)
- Cross boundary impact (recognising Mid Yorkshire and East Midlands)
- 7 day working
- Workforce
- Impact on visitors (information obtained from pre –consultation)
- Finance

This approach provided a comprehensive review and evaluation to support recommendations to improve clinical outcomes and sustainability. A full business case with detailed financial analysis is currently being developed based on the outcome of the options appraisal and will be completed in the next 2 months. The working hypothesis is that positive impact on outcomes can be achieved at null cost. This is based on change that has taken place in other parts of the country with a similar approach. We are also working with our partners in West Yorkshire and Derbyshire on the potential cross-boundary impact.

## 5. Summary of the outcome of the optional appraisal matrix




The outcome of the options appraisal identifies a preferred option and it is proposed that we consult the public on this preferred option from October 2016. A consultation strategy has been developed to support this process with engagement from all local communications and engagement teams.

The preferred option is that we will move from a 5 hyper acute stroke unit's model to a 3 unit model in the first stage.

The preferred option is that hyper acute stroke will be provided at Sheffield, Doncaster and Chesterfield.

Chesterfield is currently being considered as part of the East Midlands review and therefore any potential changes to the hyper acute stroke unit in Chesterfield will need to be considered in light of this review and therefore in stage 2.

The benefits of this change are that we will move to a more sustainable model of Stroke care provision for all parts of the clinical pathway and impact on the original divers for change outline in the case for change and specifically:

- Hyper acute – first 72 hours
- Acute stroke service – delivered in all 5 local sites

- Rehabilitation - delivered in all 5 local sites

Further work is required on the "do-ability" aspect which will support the operationalizing of the recommendations in the future. This is being taken forward with the stroke steering group. This work is currently taking place and will support the pre consultation business case which will be shared with NHSE to gain Level 2 assurance.

**6. Assurance**

Preparation work is currently being undertaken in order to submit the evidence to support Level 2 Assurance with NHSE.
This has included seeking guidance from the Clinical Senate, undertaking an Equality Impact Assessment and reviewing the viability of the current and proposed financial modeling.

**7. Summary next steps**

- Stage 2 Assurance for NHS England 17th August
- Financial analysis and full business case development September
- Formal consolation on preferred option 1st October for 14 weeks

**8. Recommendation**

OSC is asked to:

- Note progress of the work and the implications for moving forward through NHSE Level 2 Assurance and towards public consultation for the options in October.

**Paper prepared by Mandy Philbin 28th July on behalf of Professor Graham Venables Clinical Director, Yorkshire and the Humber Clinical Networks.**
**To be read in conjunction with the full Options Appraisal**

Appendix 2

# Children's Surgery Options Appraisal

## Summary for the OSC

### 1. Purpose

The purpose of this paper is to:

- Summarise the work undertaken to date, by our CCGs and Providers, in reviewing children's non specialised surgery across South and Mid Yorkshire, Bassetlaw and North Derbyshire.

- Inform the OSC of the progress around the ongoing work and recommendation to go to public consultation on the options for the reconfiguration of children's non specialised surgery

### 2. Background and Context

2.1 As Commissioners Working Together, CCGs have undertaken a review of Children's non-specialised surgery. he first phase of work was agreed in June 2015 and following this, the case for change was agreed by CCGs and trust boards in the Working Together footprint in autumn 2015. The programme then progressed work as part of the review which included:

- A fully developed project plan
- A provider self-assessment against national standards of care
- Benefits analysis and outcomes
- Assessment of need and demand for provision
- The specified model of care including the standards to enable designation of providers of surgical care
- Undertaking procurement advice and market analysis
- Considering best practice nationally and internationally.
- Development of options to re-configure services to provide sustainable care.
- An appraisal of options for configuration to provide sustainable care

Progress reports have been considered by the Working Together Programme Team which has representatives for all CCGs and acute provider trusts, this has continued throughout the review of children's surgery. The work was phased and updates in between were taken to trust boards and CCG governing bodies. The phases included:

2.2 Phase one development January 2015 – September 2015 – included the development of the case for change including:

- Engaging with key stakeholders
- Establishment of a clinical task and finish group with representation from all trusts
- Undertaking a baseline assessment of current services
- Forming consensus of the issues
- Identifying best practice models
- Specifying the pathways that should be in place to meet standards
- Exploring strengths and benefits of potential models
- Considering our populations needs for the future
- Seeking external clinical scrutiny of the work to date (through the clinical Senate)

2.3 Phase Two October 2015 – September 2016

The development of a specification, options on a model and drafting full outline business case including:

- Implementation of communication and engagement strategy - Pre –engagement with patients and the public, key stakeholders (Health Overview and Scrutiny Committees) and staff
- Enacting procurement advice, including a provider engagement event and Prior Information Notice of Service changes
- Development of a service specification meeting national standards and gap analysis against existing provision
- Expert assessment panel advice and guidance
- Exploring demand and need, including flows in provision.
- Development of options on a service model and assessment and appraisal of options
- Consideration of the implementation plan and mechanisms to mobilise and operationalise change
- Development of full business case including activity and financial impact
- Planning for formal consultation
- Consideration of options to implement change and the impact

**3. Stakeholder engagement and pre-consultation**

Commissioners Working Together have facilitated significant stakeholder engagement throughout the review process engaging in particular with providers and commissioners and other key partners via a series of workshops, engagement events and the clinical task and finish group.
Between January and April 2016, Commissioners Working Together, held an open pre-consultation to inform the review of children's surgery services across South and Mid Yorkshire, Bassetlaw and North Derbyshire. Asking 'what matters to you when accessing children's surgery' the conversations were held face to face and across social media. Thousands of people accessed the website to read about the case for change, several hundreds were involved in face to face discussions and over two hundred responses were received.

The key themes emerging were: being seen and treated by knowledgeable staff, safety and quality of service, is the most important thing and that families were happy to travel for the right care services locally. It was also important to people that professionals had information on about their child and that the professionals talked to each other about the needs of the child and family.

A communication and engagement strategy for consultation has been developed for the next phase of this work and to enable us to progress to consultation with the public about proposed changes to children's surgery this autumn.

**4. Developing options**

The development of the options appraisal to support improvements to the delivery of children's surgery was discussed at the task and finish group, the core leaders group, and with key clinicians through a clinical reference group.
The focus has been on assessing the options and looking to the most sustainable option that provides the best outcomes in line with national standards.

It is proposed that provision is developed through a network of providers across the geography and that elective day case provision not requiring overnight care is provided at as many local sites as possible. This will be planned through a Managed Clinical Network of Providers that will work across organisational boundaries.

It is then proposed that non elective urgent care out of hours surgery is managed in fewer sites.

**5. Summary of the outcome of the optional appraisal to date**

The outcome of the options appraisal identifies a preferred option and it is proposed that we consult the public on this preferred option in October 2016. A consultation strategy has been developed to support this process with engagement from all local communications and engagement teams.

The preferred option is that we will move to a network of planned provision across all providers who meet the new service specification.

It is then proposed that for non-elective out of hour's surgery that provision is consolidated over fewer sites to provide 3 hubs and entry points out of hours.

The preferred option is that for these small numbers for some areas of non-specialised out of hours provision will be provided in Doncaster, Sheffield and Wakefield.

Chesterfield currently has a network in place with Nottingham so may take a view on developing these arrangements for out of hours provision.

The benefits of this change are that we will move to a more sustainable model of networked provision for all parts of the clinical pathway.

Further work is required on the detail around sub specialty areas that can be treated at local level where skills are available or maintained. Aspects of the operationalizing of the provision for the future will need development through the Managed Clinical Network. This work is currently taking place and the Managed Clinical Network is in the process of

developing a draft business case based upon these changes which will be shared with NHSE to support Level 2 assurance.

## 6. Assurance

Preparation work is currently being undertaken in order to submit the evidence to support Level 2 Assurance with NHSE.
This has included seeking guidance from the Clinical Senate, undertaking an Equality Impact Assessment and reviewing the viability of the current and proposed financial modeling.

## 7. Summary next steps

- Stage 2 Assurance for NHS England - 17 August
- Financial analysis and full business case development September
- Formal consultation on preferred option - 2 October for 14 weeks

## 8. Recommendation

Joint HOSC is asked to:

- Note progress of the work and the implications for moving forward through NHSE Level 2 Assurance and towards public consultation on the options in October.

**Paper prepared by**

**Kate Laurance Head of Commissioning on behalf of Dr Tim Moorhead Commissioners Working Together Clinical Lead for the Working Together Programme**
**To be read in conjunction with the full Options Appraisal**

Public Report
Health Select Commission

**Summary Sheet**

**Council Report**
Health Select Commission 22 September 2016

**Title**
Health Select Commission Work Programme 2016-17

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

**Strategic Director Approving Submission of the Report**
Shokat Lal, Assistant Chief Executive

**Report Author(s)**
Janet Spurling, Scrutiny Officer, Assistant Chief Executive's Directorate
janet.spurling@rotherham.gov.uk 01709 254421

**Ward(s) Affected**
All

**Executive Summary**

This report presents the final draft of the work programme for 2016-17 for Health Select Commission members to consider and agree following the discussion at the planning and prioritisation meeting on 19 July 2016.

**Recommendations**

That the Health Select Commission:

1. Receives and approves the draft work programme for 2016-17.

2. Notes that if any urgent items emerge during the year this may necessitate a review and re-prioritisation of the work programme.

**List of Appendices Included**
Appendix 1 – Work Programme 2016-17
Appendix 2 – Terms of Reference

**Background Papers**
Council Constitution
Minutes of HSC meetings during 2015-16

**Consideration by any other Council Committee, Scrutiny or Advisory Panel**
Overall scrutiny work programme at Overview and Scrutiny Management Board,

16 September 2016.

**Council Approval Required**
No

**Exempt from the Press and Public**
No

**Health Select Commission Work Programme 2016-17**

## 1. Recommendations

That the Health Select Commission:

1.1 Receives and approves the draft work programme for 2016-17.

1.2 Notes that if any urgent items emerge during the year this may necessitate a review and re-prioritisation of the work programme.

## 2. Background

2.1 At its planning and prioritisation meeting in July 2016, the Select Commission agreed to focus much of its work around the transformation of health and social care, building on the work undertaken in 2015-16. A work programme (attached as Appendix 1) has been drawn up focusing on this area but also including other issues prioritised for inclusion by scrutiny members from a long list of potential items.

2.2 The overall performance of health partners is scrutinised through their quality accounts, with three sub-groups formed for this purpose. Their work will be supplemented by the quarterly meetings of the Chair and Vice Chair with the Rotherham NHS Foundation Trust; Rotherham, Doncaster and South Humber NHS Foundation Trust; and Rotherham Clinical Commissioning Group, which have been in place since 2014/2015.

2.3 Another facet of the work programme will be to receive progress reports on recommendations and work resulting from previous reviews or meetings, to ensure these are being taken forward and leading to service improvements and/or better outcomes.

2.4 The final element is scrutiny of the Commissioners Working Together Programme, undertaken by the Joint Health Overview and Scrutiny Committee, in accordance with the terms of reference for HSC in Appendix 2.

2.5 Agenda items from June and July are included so HSC members have the full programme in one document.

## 3. Key Issues

3.1 The proposed work programme helps to achieve corporate priorities by addressing key policy and performance agendas, aligned to the priorities in the Corporate Plan, with a clear focus on adding value.

3.2 It was agreed at the planning and prioritisation meeting in July 2016 that an underlying theme would be to ask questions regarding addressing health inequalities. A further consideration is the importance of meaningful public consultation and involvement of service users, customers, patients and families/carers in service transformation.

3.3 Priorities will be the major transformational projects, which are interlinked:

- Sustainability and Transformation Plan including the Rotherham Place Plan
- Health and social care integration (continuing from 2015-16)
- Adult Social Care development programme
- Mental health transformation (all ages)

3.4 Within these major projects specific issues/services were identified, including:

- Learning disability
- Carers
- Older people's housing

3.5 For some workstreams it will be a case of seeing and commenting on proposals at an early stage this year and then revisiting issues or services in 2017 and/or 2018 to scrutinise the success of changes made and the differences in outcomes for people in Rotherham.

3.6 The intention is that the Health Select Commission will conduct the majority of the scrutiny work through its full membership during scheduled agendas. Witnesses will be required to submit information two weeks prior to the meetings, in order to allow time for full preparation in advance.

## 4. Options considered and recommended proposal

4.1 This report presents the final draft of the Health Select Commission work programme for 2016-17 for members to consider and approve following the OSMB work planning meeting on 8 July 2016 and discussions at the HSC planning and prioritisation meeting on 19 July 2016.

## 5. Consultation

5.1 Not applicable.

## 6. Timetable and Accountability for Implementing this Decision

6.1 Scheduling of agenda items is detailed in Appendix 1.

## 7. Financial and Procurement Implications

7.1 None arising from this report.

## 8. Legal Implications

8.1 There are no direct legal implications from this report, although the work programme of the Overview and Scrutiny Management Board (OSMB) and the Select Commissions encompasses statutory duties of the Council.

## 9. Human Resources Implications

9.1 None arising directly from this report.

## 10. Implications for Children and Young People and Vulnerable Adults

10.1 The work of the Health Select Commission includes services and support for children, young people and adults, with a specific focus on mental health service transformation and the adult social care development programme.

10.2 Five members of the HSC are also members of the Improving Lives Select Commission, which facilitates information sharing and feedback on relevant issues for children and young people between the two commissions.

10.3 Non-specialised children's surgery and anaesthesia is a workstream of the Joint Health Overview and Scrutiny Committee.

## 11. Equalities and Human Rights Implications

11.1 Scrutiny focuses on promoting equality through improving access to services and support for all and ensuring the needs of groups sharing an equality protected characteristic are taken into account.

## 12. Implications for Partners and Other Directorates

12.1 The work programme primarily focuses on the Adult Social Care & Housing and Public Health directorates and partner agencies across the local health economy, including Rotherham Clinical Commissioning Group, The Rotherham NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust.

## 13. Risks and Mitigation

13.1 The development of a clear work programme maximises the potential for Scrutiny to have an impact and mitigates against the risk of using resources with little impact or outcome.

13.2 The programme does need to maintain flexibility to accommodate additional or urgent items that may emerge during the year, for example resulting from pre-decision scrutiny by OSMB. If items are added, this may necessitate a review and re-prioritisation of the work programme by the Commission.

## 14. Accountable Officer(s)

James McLaughlin, Democratic Services Manager

Approvals Obtained from:

Strategic Director of Finance and Corporate Services: N/A
Director of Legal Services: N/A
Head of Procurement: N/A

This report is published on the Council's website or can be found at:-
http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories=

**Appendix 1** **Health Select Commission work programme 2016-17**

| Meeting Date | Time | Activity and expectations from the meeting |
|---|---|---|
| 16 June 2016 | 9:30 – 12:00 | **Public Health annual report**<br>- Clear understanding of the key issues, inequalities and challenges regarding C&YP's health in Rotherham.<br>- Members support for the 8 far-reaching recommendations.<br>- Follow up action: HSC will receive further info in July and annual report 2017.<br><br>**Adult Social Care (ASC) provisional performance report on ASC Outcome Framework (ASCOF) measures**<br>- Overview of performance on the national measures, where improvements are being made and ones which remain a challenge.<br>- Follow up action: HSC to receive further info in July. |
| 28 July | 9:30 – 12:00 | **ASC performance on local measures and complaints - as requested in June**<br>- Overview of performance on the local measures and targets for 2016-17 plus summary of complaints regarding ASC.<br>- Understanding current performance on key measures in order to scrutinise the impact of the ASC development programme over time.<br>- Follow up action: HSC to receive a final report in autumn with 2015-16 benchmarking data and will be able to make recommendations.<br><br>**Carers Strategy and action plan**<br>- Latest draft of strategy and first draft of action plan for consideration and comment.<br>- Follow up action: HSC to monitor implementation once final version signed off.<br><br>**RDaSH adults and older people's mental health transformation**<br>- Latest recommendations for new model for consideration and feedback.<br>- Follow up action: HSC to receive a progress report on implementing the model once it has time to embed – provisionally September 2017.<br><br>**Confirmation of sub groups for quality accounts**<br>- Membership and relevant documents/links circulated.<br>- Follow up action: half year progress meetings November/December and year end presentations March/April. |

| Meeting Date | Time | Activity and expectations from the meeting |
|---|---|---|
| *12 September* | *12:30 - 13:30* | ***Commissioners Working Together Programme (CWTP)***<br>*– hyper acute stroke services*<br>*– non-specialised children's surgery and anaesthesia*<br>- Workshop session to discuss the draft consultation materials and communication and engagement plans.<br>- Follow up action: Feedback from HSC to NHS England by 14 September |
| 22 September | 9:30 – 12:00 | **Sustainability and Transformation – Rotherham Place Plan**<br>- Understanding of transformation taking place across the NHS, including closer integration between health and social care.<br>- Local priorities for Rotherham and how the Place Plan links in with the wider SY&B plan.<br>- Opportunity to feed back on the presentation pack for the public (tbc).<br>- Follow up action: HSC to determine.<br><br>**Commissioners Working Together Programme (CWTP)**<br>- Overview of the work to date and outcomes of options appraisals for both services that will be going forward for public consultation, for consideration and comment.<br>- Follow up action: Chair to feedback from HSC to the JHOSC and CWTP<br><br>**Work programme**<br>- Detailed work programme for the year to be agreed by HSC. |
| 27 October | 3:00 – 5:30 | **Scrutiny review update - Child and Adolescent Mental Health Services (CAMHS)**<br>- Scrutiny of progress in implementing the recommendations from past joint scrutiny review with ILSC.<br>- HSC to determine if they require a further progress report (links with items below) and to identify any other actions required.<br><br>**Response to Rotherham Youth Cabinet Children's Commissioner's Takeover Challenge review "*Improving Access to CAMHS*"**<br>- Initial response from RMBC and partner agencies to the recommendations from the spotlight review<br>- Q&A with partner agencies to look at in depth<br>- Follow up action: HSC to determine date for a progress report.<br><br>**Voice and Influence review report**<br>- Key findings from the review presented and discussion/questions on taking forward the recommendation.<br>- Follow up action: HSC to determine. |

| Meeting Date | Time | Activity and expectations from the meeting |
|---|---|---|
| *November tbc* | | ***Older People's Housing Delivery Plan***<br>- Workshop session to discuss and inform the draft plan and actions to deliver the key objectives.<br>- Exploring links between housing, health and social care to support older people and help them to maintain their independence for longer.<br>- Follow up action: HSC to determine. |
| | | ***Sub-group sessions for half year progress on NHS Quality Accounts***<br>*(planning meetings beforehand tbc)*<br><br>- *Overview of performance in quarters 1 and 2 on national measures and the local priorities for 2016-17.*<br>- *Opportunity to explore any areas of concern.*<br>- *Follow up action: HSC to receive final draft accounts for consideration and comment, including on the local quality priorities for 2017-18, in March/April.* |
| *30 November* | *10:00 - 11:30* | ***The Rotherham NHS Foundation Trust (TRFT)*** |
| *30 November* | *13:30 - 3:00* | ***Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)*** |
| *tbc* | *tbc* | ***Yorkshire Ambulance Service (YAS)*** |
| 1 December | 9:30 – 12:00 | **ASC performance 2015-16** (benchmarking and half year to date)<br>- Report including 2015-16 benchmarking data on the ASCOF measures with the other Y&H local authorities and nationally.<br>- Year to date performance on local measures.<br>- HSC to make recommendations regarding any issues emerging from the data.<br>- Follow up action: further reports to maintain an overview of ASC performance and the impact of implementing the ASC development programme (dates tbc).<br><br>**SY&B Sustainability and Transformation Plan**<br>- Details tbc |

| Meeting Date | Time | Activity and expectations from the meeting |
|---|---|---|
| | | **Learning Disability and Autism Strategy update**<br>- Overview of the work to date for information and discussion.<br>- Follow up action: HSC to determine.<br><br>**Commissioners Working Together Programme (CWTP)**<br>- Feedback from JHOSC with mid-point update on how the consultation is progressing (timescale tbc).<br>- Follow up action: Chair to feedback from HSC to the JHOSC and CWTP. |
| 19 January 2017 | 9:30 – 12:00 | **Overview of Adult Social Care Development Programme/Better Care Fund (BCF)**<br>- Overview of the work to date under the development programme/BCF and next steps.<br>- Opportunity to inform BCF plans for 2017-18.<br>- Follow up action: HSC to determine.<br><br>**TRFT – progress on community and acute transformation and integration**<br>- Overview of the work to date and how it contributes to closer integration between health and social care.<br>- Follow up action: HSC to determine.<br><br>**Social prescribing evaluation – mental health pilot**<br>- Information on the impact of the pilot and future plans as social prescribing is a key workstream.<br>- Follow up action: HSC to determine. |
| 2 March | 9:30 – 12:00 | **Interim GP strategy progress update**<br>- Overview of implementation of the strategy and progress on key outcomes to improve access and equality, deliver new models of care and ensure a sustainable GP workforce (links to previous HSC scrutiny review).<br>- Follow up action: HSC to determine.<br><br>**Reablement hub and intermediate care (BCF action)**<br>- Progress on developing the new model to maximise multi-disciplinary working and support a wider range of people, whilst also achieving efficiencies.<br>- Follow up action: HSC to determine.<br><br>**CAMHS reviews update?** |
| 13 April | 9:30 – 12:00 | **Quality accounts** TRFT/RDaSH/YAS – full meeting or in sub-groups tbc?<br>- Overview of performance for 2016-17 and the local priorities for 2016-17.<br>- Follow up action: HSC to submit statements for inclusion in the published accounts and to have a half year |

| Meeting Date | Time | Activity and expectations from the meeting |
|---|---|---|
| | | progress update in November 2017.<br><br>**Carers Strategy Progress – action plan and outcome of support service mapping**<br>- Update on progress in implementing the action plan supporting the strategy.<br>- Focus on actions linked to previous scrutiny review recommendations such as development of carers' pathway.<br>- Follow up action: HSC to determine. |
| 15 June | 9:30 – 12:00 | **Public Health annual report**<br>- Progress on the eight broad recommendations for C&YP<br>- Clear understanding of the key issues, inequalities and challenges regarding health in Rotherham in the next phase of the life course.<br>- Follow up action: HSC to determine.<br><br>**Locality Pilot – integrated health and social care teams (BCF action)**<br>- Opportunity to scrutinise how the new model has operated so far – successes, challenges and impact on service users/patients.<br>- Follow up action: HSC to determine linked to evaluation of the pilot.<br><br>**ASC performance update?** |
| **Core themes** | | ❖ Health inequalities<br><br>❖ Community consultation and involvement |

**Appendix 2**

## Terms of Reference

As outlined in the Council's Constitution (Appendix 2 - Overview and Scrutiny Procedure Rules - February 2016), the Health Select Commission is tasked with carrying out in-depth overview and scrutiny as directed by the OSMB, including –

- performing the role of the Council's designated scrutiny body for any issue relating to health and the public health agenda including those functions contained within the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013;

- scrutinising the health services commissioned for the people of Rotherham (under the powers of health scrutiny as outlined in the Health and Social Care Act 2001);

- scrutinising partnerships and commissioning arrangements in relation to health and well-being and their governance arrangements and the integration of health and social care services and budgets

- scrutinising measures for achieving health improvements and the promotion of wellbeing for Rotherham's adults and children;

- scrutinising measures designed to address health inequalities;

- scrutinising public health arrangements;

- scrutinising food standards and environmental health; and

- scrutinising issues referred to the select commission by the Healthwatch Rotherham (or any successor body).

- Those elements of this scrutiny function relating to NHS England's new review of Congenital Heart Disease services are delegated to the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber)

The Health Select Commission will also act as a consultee in respect of those matters of "substantial variation" on which NHS bodies must consult with the Council in relation to its health scrutiny function.

The Health Select Commission will lead on the overview and scrutiny of any regional and specialist health service health matters affecting residents of two or more local authorities within Yorkshire and the Humber, and will conduct such overview and scrutiny reviews in accordance with the Protocol for the Yorkshire and the Humber Council's Joint Health Scrutiny Select Commission.

**HEALTH AND WELLBEING BOARD**
**13th July, 2016**

**Present:-**

**Members:-**

| | |
|---|---|
| Councillor David Roche | Cabinet Member for Adult Social Care and Health **(in the Chair)** |
| Graeme Betts | Interim Strategic Director, Adult Social Care and Health |
| Tony Clabby | Healthwatch Rotherham |
| Richard Cullen | Governance Lead, Rotherham CCG |
| Chris Edwards | Chief Officer, Rotherham CCG |
| Sharon Kemp | Chief Executive, RMBC |
| Julie Kitlowski | Clinical Chair, Rotherham CCG |
| Councillor Janette Mallinder | Chair, Improving Lives Select Commission |
| Mel Megs | CYPS, RMBC |
| Terri Roche | Director of Public Health, RMBC |
| Janet Wheatley | Voluntary Action Rotherham |

**Report Presenter:-**

| | |
|---|---|
| Andrew Clayton | Rotherham CCG |

**Officers:-**

| | |
|---|---|
| Kate Green | Policy Officer, RMBC |
| Dawn Mitchell | Democratic Services, RMBC |

**Observers:-**

| | |
|---|---|
| John Deffenbaugh | |
| Gordon Laidlaw | Rotherham CCG |
| Councillor Sansome | Chair, Health Select Commission |
| Janet Spurley | Scrutiny Officer, RMBC |
| Councillor John Turner | |

**Apologies:-**
Robert Odell (South Yorkshire Police), Kathryn Singh (RDaSH), Ian Thomas (RMBC)

**13. DECLARATIONS OF INTEREST**

There were no Declarations of Interest made at the meeting.

**14. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS**

There were no members of the press and public present.

**15. PROFESSOR GRAEME BETTS**

The Chair reported that this would be the last Health and Wellbeing Board before Graeme left Rotherham next month.

Board members thanked Graeme for all his help in getting the Board to its much improved position and wished him well for the future.

## 16. MINUTES OF THE PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 1st June, 2016, be approved as a correct record.

## 17. ROTHERHAM LOCAL DIGITAL ROADMAP

Andrew Clayton, Head of Health Informatics, presented the draft Local Digital Roadmap (LDR) for the Rotherham Health and Care Community for the Board's endorsement.

The roadmap had been agreed by the Rotherham Interoperability Group, the multi-agency Rotherham IT Strategy Group and Rotherham CCG Operational Executive before submission to NHS England on 30th June, 2016. It had been supported by information provided by the Foundation Trust, RDaSH, Rotherham Hospice and the Council, along with knowledge of the local health and care agenda. The LDR narrative had been developed to present a vision for the future of digitally supported health and care services in Rotherham and plan for delivery of the services for the next 4 years.

LDRs would be assessed in July, 2016, within the broarder context of the assessment of Sustainable and Transformation Plans (STPs). Whilst a signed-off STP would be a condition of accessing the Sustainability and Transformation Fund in the future, a signed off LDR would be a condition for accessing the £1.8bn Driving Digital Maturity Investment Fund. Draft guidelines for the LDR assessment indicated that those LDRs assessed as "Investment Ready" would be eligible to apply for 2017/18 funding in the autumn of 2016; LDRs which were not assessed as "Investment Ready" would be given feedback and support to revise their plans and would be expected to make a further LDR submission in November, 2016.

Discussion ensued with the following issues raised/highlighted:-

- Liquid Logic that the Council would be implementing was seen as a move in the right direction

- Work was to take place on GP Practice websites to ensure they gave a consistent message to patients on how they were expected to access healthcare as well as prevention

- Linked into the Social Prescribing network but a need to also include Connect2Support, E-Market and Gismo

- Acknowledgement of the excellent engagement of partners in the process

- Healthwatch Rotherham had invested in a new CSM system which had trebled the number of comments being received which could be linked in to improve services

- Communications with Elected Members and the wider public and ensuring there was consistency and reassurance

Resolved:- That the Local Digital Roadmap be endorsed.

**18. SOUTH YORKSHIRE AND BASSETLAW SUSTAINABILITY AND TRANSFORMATION PLAN**

Chris Edwards gave an update on the South Yorkshire and Bassetlaw Sustainability and Transformation Plan process.

The NHS Shared Planning Guidance had asked every local health and care system in England to come together to create its own ambitious local plan for accelerating implementation of the Five Year Forward View. The blueprints, called Sustainability and Transformation Plans (STPs) would be place-based, multi-year plans built around the needs of local populations.

To deliver STPs, local health and care systems had come together to form 44 footprints which collectively covered the whole of England. The geographic footprints were of a scale which should enable transformative change and the implementation of the Five Year Forward View vision of better health and wellbeing, improved quality of care and stronger NHS finance and efficiency by 2020/21.

Rotherham sat within the South Yorkshire and Bassetlaw footprint. The Rotherham place based plan was currently being developed and summarised local ambitions for the STP. It was jointly produced by the Rotherham CCG, Council, Rotherham Foundation Trust, RDaSH and Voluntary Action Rotherham.

Discussion ensued with the following issues raised/highlighted:-

- The final first submission was estimated to be around September

- There was to be an All Member seminar and consideration by the Health Select Commission in October

- The important role the Board had to play

- Feeling that inclusion was required of sections on Primary Care as a provider and also on children and young people

- A user friendly version was required to communicate to the general public

- There needed to be a clear message to public on what was sustainable and transformative about the Plan

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

(2) That responsibility be delegated to individual organisations to sign off the September STP submission.

(3) That the September submission be submitted to a future meeting of the Health and Wellbeing Board for information.

## 19. ANY OTHER BUSINESS

Tony Clabby reported that there was to be an Older People's Summit at the New York Stadium on 7th October, 2016.

## 20. DATE, TIME AND VENUE OF THE NEXT MEETING

Resolved:- That a further meeting be held on Wednesday, 21st September, 2016, commencing at 9.00 a.m. venue to be confirmed.

Agenda Item 12

**Notes from Health Select Commission and Health partners meeting 12 July 2016**

Present: Chris Edwards, Rotherham Clinical Commissioning Group (RCCG), Cllr Sansome, Kathryn Singh, Rotherham Doncaster and South Humber NHS Trust (RDaSH)
Apologies: Louise Barnett, The Rotherham Foundation Trust (TRFT)
Notes: Janet Spurling, Scrutiny Officer

**Purpose of the meeting**
This was the first meeting in 2016-17 to discuss the current and future work of health partners, including when/how HSC would be involved.

**Summary of main discussion points**:

Sustainability and Transformation Plan (STP)
- £105m funding available across South Yorkshire and Bassetlaw – likely to fund hospital overspends (£85m) and growth in GP practices.
- Some money may be provided for transformation, but this may only be equivalent to the reductions made to CCGs funding under annual efficiency savings.
- Future sustainability depends on greater collaboration between hospitals.
- TRFT is engaged in this work looking at 12 specialties, with A&E and maternity being the two highest profile.
- The new Emergency Care centre at TRFT opens in July 2017 and will improve both patient care and the long term sustainability of the trust. (Tours will be available.)
- Maternity services – the number of births in the unit will inform workforce planning in line with national standards. Consultation is taking place with the Chairs of the Y&H maternity network and there will be joint work on communicating key messages.
- For the other specialties patients will not expect to see noticeable differences in services at this stage.
- STP Board (with all four chief executives/chief officers involved) meets on Wednesdays working towards the submission of the plan in early October
- Governance of the STP - 17+1, based on the Manchester model involving LAs, CCGs, Mental Health Trusts, Acute Trusts

Rotherham Place Plan
- Has been to the Health and Wellbeing Board (HWBB) and developed through true partnership working.
- By September there will be the place plan for Rotherham, supported by a set of slides for officers/managers, a set of slides for the public and probably an animation.
- STP/Place Plan - to the HSC meeting in September/October.

HSC and Pre-scrutiny
- New HSC Vice Chair is Cllr Peter Short who will be invited to future meetings
- The Council's new pre-decision scrutiny arrangements were discussed, with HSC considering this with regard to the forward plan for HWBB papers.
- Pre-decision scrutiny had commenced last year with HSC having the opportunity to scrutinise the Health and Wellbeing Strategy prior to sign off by the board.

Waverley
Dialogue is taking place between the CCG and LA regarding a GP practice as part of the wider infrastructure but funding has not yet been released. A new build will be the right option.

*After the meeting it was clarified that the CCG are awaiting proposed plans from the developers to be able to progress planning in the autumn, working to a timescale of opening early 2018.*

## Autism Strategy
It was confirmed that this will be a LA responsibility not RCCG. RDaSH carry out diagnosis but not follow up support post-diagnosis.

## RDaSH

CAMHS
- The plans for the new model and achieving the three week waiting time target are fine but have taken a while due to the extensive recruitment.
- At one point nearly 50% of staff were interim, agency or bank but recruitment is nearly complete with only two posts outstanding.
- Improvements in quality and delivery are being seen and the expectation is that traction will start to be seen in waiting times from July/August.
- Two very experienced clinical leads have been appointed and this will help with triage and the list.
- Looked After Children remain a priority for CAMHS.
- Update on CAMHS scrutiny review and response to Children's Commissioner's Takeover Challenge (CCTOC) review by Rotherham Youth Cabinet to come to HSC October meeting.

New IT system
- A preferred provider for the whole trust has been identified.
- New system will have inter-operability with partners
- Local Digital Roadmap is progressing (see HWBB papers)

CQC visit
- A thematic visit on "Well-led" was due to start on 10th October but there had been no details as yet from the CQC although they will revisit all the improvement areas.
- HSC Chair had attended a recent CQC engagement event where stakeholders raised questions regarding their processes.

## A&E performance
- Performance is averaging around 92% on the four hour target.
- There has been a good response from adult social care to support the hospital on intermediate care and hospital discharge.

**Agreed actions**:
1. Janet to schedule STP/Rotherham Place Plan for September HSC and send meeting requests.
2. Janet to schedule CAMHS review update and CCTOC response for October HSC and send meeting requests.
3. Chris to check timescales for a GP practice in Waverley.

**Date and time of next meeting:**
Thurs 6 October 12 noon at Riverside House