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

Date:- Thursday, 2 March 2017 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 19th January, 2017 (Pages 1 - 17)

For Discussion

8. Update on Interim GP Strategy (Pages 18 - 111)
   Presentation by Jacqui Tuffnell, Rotherham CCG

9. Adult Care - Local Measures Performance Report - 2016/17 Quarter 3 (Pages 112 - 129)
   Scott Clayton, RMBC, to present

10. Response to Scrutiny Review - Child and Adolescent Mental Health Services (Pages 130 - 181)
    Paul Theaker, RMBC, to report

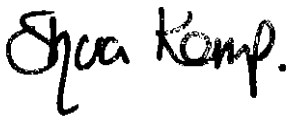
11. Progress on Rotherham Youth Cabinet Review - Improving Access to Child and Adolescent Mental Health Services (Pages 182 - 200)

12. Joint Health Overview and Scrutiny Committee for the Commissioners Working Together Programme

13. Improving Lives Select Commission Update

14. Healthwatch Rotherham - Issues

15. Date of Future Meeting
Thursday, 13th April at 9.30 a.m.



SHARON KEMP,
Chief Executive.

Membership:

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

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

HEALTH SELECT COMMISSION
19th January, 2017

Present:- Councillor Sansome (in the Chair); Councillors Albiston, Andrews, Brookes, Cusworth, Elliott, Marriott, Short and Williams, Robert Parkin and Vicky Farnsworth (Rotherham SpeakUp).

Councillor Roche, Cabinet Member for Adult Social Care and Health, was in attendance at the invitation of the Chairman.

Apologies for absence:- Apologies were received from Elliot, Ellis and John Turner.

64. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

65. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

66. COMMUNICATIONS

(1) Information Pack
The pack contained:-

- November Health and Wellbeing Board minutes
- CQC overview
- Response from Public Health to Councillor Williams' question on data from the Sustainability Transformation Plan powerpoint
- Notes from the TRFT and RDaSH Quality Account sub-groups

(2) Consultations for CWTP and Learning Disability
The Chairman urged Members to get involved in the consultations. It was imperative that Councillors complete the consultation, whether agreeing to the proposals or not, and then needed to get the facts out to constituents.

The Vice-Chairman stated that at the previous meeting assurance had been given that the consultation documents had been sent to all GP surgeries. He had recently visited 2 local surgeries and found no evidence of any documents. He was concerned that either all the documents had gone or that there had been a breakdown in communications which may be indicative of the low response that had been received so far.

Tony Clabby, Healthwatch Rotherham, confirmed that the materials had been distributed to GPs and that Healthwatch had also been involved in distributing them through their networks.

Councillor Roche, Cabinet Member for Adult Social Care and Health, reported that with regard to the Learning Disability consultation, currently there had been 193 completed online questionnaires and 180 requests for hard copies. He agreed that there was a need for as many people as possible to be involved in the consultation and he would raise the issue of leaflets in GP surgeries with the CCG.

The Chairman reported that it was the plan that all Members would be provided with a copy of the leaflet at the next Council meeting.

67. MINUTES OF THE PREVIOUS MEETINGS HELD ON 27TH OCTOBER AND 1ST DECEMBER 2016

The minutes of the previous meetings of the Health Select Commission held on 27th October and 1st December, 2016, were noted.

Arising from Minute No. 43 (Response to Scrutiny Review: Child and Adolescent Mental Health Services), it was noted that:-

- there was an agenda item providing more information on the whole School Mental Health Pilot and considering Member involvement.

- the Scrutiny Officer had had a recent positive meeting with the CCG and RDaSH to discuss presenting future progress updates following issues raised at the previous meeting and to revisit timescales where needed with some realistic revised dates.

- the latest performance report produced by RDaSH for November was now available for circulation.

Arising from Minute No. 44 (CAMHS), the RDaSH Voice and Influence template was with the Youth Cabinet for comment.

Arising from Minute No. 45 (Response to Children's Commissioner's Takeover Challenge Review), it was noted that:-

- the new Transition Board would hold its first meeting this month.
- dialogue with regard to transition was still to take place.

Arising from Minute No. 54 (South Yorkshire and Bassetlaw Sustainability and Transformation Plan), it was noted that this had been discussed at 11th January Health and Wellbeing Board.

Cabinet Roche, Cabinet Member for Adult Social Care and Health, stated that he was still very concerned with regard to the consultation on the STP which NHS England was terming "awareness raising". He was in discussion with the Chief Executive as to the most appropriate way of gaining Members' approval/endorsement of the STP. There would be a meeting on 8th February regarding governance of the Rotherham Place Plan.

Tony Clabby, Healthwatch Rotherham, reported that NHS England had asked local Healthwatch's and Voluntary Actions across South Yorkshire and Bassetlaw to deliver engagement and communication sessions. Further information was awaited from NHS England as to the timetable and the messages they wished to be included.

Arising from Minute No. 55 (Adult Social Care Performance – Yorkshire and Humber Year End Benchmarking), it was noted that the quarterly reports were to link in with other reporting cycles and that the six monthly reports were to be submitted in July and December.

Arising from Minute No. 56 (Adult Social Care Performance – Local Measures), it was noted:-

- information supplied with regard to LM01-4 for October and November, 2016. With issues arising to be fed in and discussed in March.
- the performance clinic held in July was not a formal minuted meeting. However, there was now a Practice Challenge Group.

Arising from Minute No. 36 (Learning Disability – Shaping the Future Update), it was noted that the work of the People's Parliament at Speak Up should be taken into account.

Resolved:- That the minutes be noted.

(2) That the minutes of Practice Challenge Group be submitted to this Commission.

68. OVERVIEW OF THE ADULT CARE DEVELOPMENT PROGRAMME/BETTER CARE FUND

Keely Firth, Rotherham CCG, and Nathan Atkinson, Assistant Director Strategic Commissioning, presented a progress report of the Adult Care Development Programme and the Better Care Fund (BCF) as of Quarter 3 December, 2016:-

Nathan Atkinson reported on the Adult Care Development Programme - the overarching strategy to transform Adult Care highlighting the following:-

- Community Catalysts, a not-for-profit organisation, had recently won a tender to provide expertise as to the development of community groups to deliver preventative services and supplement the wider Adult Care offer

- The Village integrated health and care locality pilot had been running since July, 2016. A Key Performance Indicator suite was being developed to enable practical comparisons to be made with other localities in terms of performance and impact.

- Training commissioned to support operational workers with understanding and delivery of a strengths based approach to assessment.

- Formal consultation on the future offer in Rotherham for people with a Learning Disability.

- All eighty-four customers attending Charnwood Day Centre had been reviewed and moved to more appropriate support.

- Current offer by the Shared Lives Team had been reviewed with a view to the development of an effective expansion plan based on national best practice.

- Community Opportunity Pathway Programme continued to work with ten customers and their families. Support for the programme ended in December, 2016.

Keely reported that the Better Care Fund was made up funding from the CCG (approximately £20M) and the Local Authority (approximately £4M). There were thirty-six schemes which had now been categorised into six key objectives of the Fund.

During 2016/17 a review had been carried out of all the services for strategic relevance, whether there were strong robust contracts in place and ways of measuring success and the outcomes.

Seven of the eight national conditions were being fully met. The remaining condition was partly met; better data sharing between Health and Social Care based on the NHS number (fully met) and better data sharing including whether Adult Care could ensure that patients/service users had clarity about how data about them used, who may have access and how they could exercise their legal rights (partly met).

What had the Fund done for the people of Rotherham:-

- Defined, improved and increased the joint working with Social Care.
- Mental Health Liaison Services introduced where Mental Health Workers from the local Mental Health Trust now worked in the front end of the Hospital allowing people accessing A&E Services to have intervention before admission and if admitted, through the Mental Health Liaison Services, they could be targeted much faster.
- Social Prescribing – excellent feedback and had given real benefits to those in receipt. It had now been extended for Mental Health Services.
- Increase in the number of community beds which enabled patients to be discharged safely from Hospital where appropriate and had meant delayed transfers of care was less of an issue.

- Increase in the number of people that accessed Personal Health budgets.
- Community Occupational Therapy Service had been subject to a rigorous review resulting in some innovative practice that had reduced waiting times and enabled people to return quicker to their own homes.

The BCF had enabled changes but had also resulted in partners working well together, especially through the difficult period of winter pressures.

Discussion ensued with the following issues raised/clarified:-

- The Community Catalysts would be working in Rotherham for two years (February 2019) and would work with the Service to create different options and look at shifting the way of thinking and current practice models, especially for people with Learning Disabilities. It would run alongside the current consultation. A diagnostic exercise of looking at what was available in the community had commenced. It was hoped to create fifteen alternatives within Rotherham communities in the first year starting with some taster sessions to give people an opportunity to go and test different activities, options and things that were available in the community. It would also include looking at community assets and buildings and working with the Community Link Workers.

- The emergency re-admissions target was a contractual Indicator and included in the Foundation Trust's contract with the Trust being incentivised not to discharge patients before it was safe to do so. However, the problem with the BCF metrics, and was a national issue for both emergency re-admissions and non-elective metrics, was that it was counted differently using different activity and patient groups. It almost became a spurious figure. Consideration was currently being given to replace it locally with an equally strong measurement with the same aims of the BCF metric.

- Continuing Health Care (CHC) was where packages of care were put into place; that was not in the BCF at the moment. The Fund had been generated through local investment as BCF was not a national pot of money but derived from partners assessing which national conditions had to be met and agreeing on the funding to pool. There had been some additional investment in Social Care but the bulk of it came from the partners. When the Fund was set initially the focus had been on the areas that felt intuitive to deliver the objectives but there was nothing to prevent the inclusion of CHC.

  Both the Council and CCG were investing more in the CHC type packages. There was no cross-subsidisation but there was an increase in investment in CHC from a different set of funds.

- Consideration should be given to CHC becoming part of the BCF. There were CHC reassessments of adults whose health were not going to improve and then that funding was lost together with residential and nursing homes then competing for funding to care for the older people.

- There had been some marked improvements in the Integrated Health Village recently. An event was to be held on 24th January to refocus activity.

- The review of Breathing Spaces had been undertaken to gain an understanding the flow of patients and there was excellent feedback from outpatients. The issue for Rotherham was that patients were frequently accessing the hospital initially as an A&E attendee, admitted for short stay assessment and then generally referred/discharged to Breathing Spaces. An audit of cases had revealed that there were those that were in clinical need and appropriate to have gone to A&E in the first instance but there were also those incidents where 999 ambulance crews had not known of Breathing Spaces' existence as an alternative. Nationally Rotherham stood out on how much it spent on people with respiratory disease but also how many people then had a good outcome from the condition. Rotherham was an outlier i.e. appeared to spend more than others but the outcomes were not showing that immediate benefit. The review was trying to ascertain what was done there, what was working well and whether things could be done differently.

  The Foundation Trust was working with the CCG to review Breathing Spaces. There was an opportunity for more "step up" arrangements and a need to review the clinical evidence base on outcomes.

- The BCF performance metric relating to permanent admissions of older people to residential and nursing care homes was a two part measure reflecting the number of younger adults and older people. Part one was younger adults and part two was older people where their long term care needs were met by residential care. It was relative to the population group and measured by how many per 100K were going into provision.

- The emergency re-admissions Indicator was performing very close to the target. It was a symptom of how seriously ill people were when they were went into hospital, the care undertaken and the discharges carried out; there would be occasions when people needed to be readmitted. From a contractually perspective with the Hospital it was not a metric that was underperforming but rather due to the way the metric was calculated.

  There was with some complexity around the metric. It would refer to those patients re-admitted with the same condition and there was some detail about other types of re-admission. The aim was right

which was to ensure when patients were treated in the acute setting and that they were supported and discharged at an appropriate point; if things were done prematurely people would be re-admitted. Scrutiny of the metric was welcomed as it was something that the Trust focussed on to ensure that as the length of stay for patients was reduced, particularly for the non-elective patients, it could be tracked as to whether it created more problems and resulted in re-admissions. The Trust was finding that as it reduced the length of stay it was still performing and above average in terms of re-admissions level - approximately in the top 1/3.

- Concern that once local Indicators were selected that the emergency re-admission indicator remain until there was a better understanding of the situation.

- All of the eighty-four customers attending Charnwood Day Care resource had moved onto alternative provision except three that were still accessing day services but from a different day service. A review would take place with those customers six months post their new service. No issues or complaints had been received.

- Information would follow regarding consultation with Light Bite users.

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

(2) That the possibility of Continuing Health Care funding being included as part of the Better Care Fund be raised at the Health and Wellbeing Board Executive Group.

(3) That feedback be submitted to this Select Commission on the 24th January Integrated Health Village event and the review of Breathing Spaces.

(4) That a briefing be provided on Community Catalysts.

(5) That the Better Care Fund be submitted to the Select Commission for comment and pre-decision scrutiny prior to sign off by the Health and Wellbeing Board.

Lite Bites

A dedicated piece of work has been undertaken to look at the operation of the café Lite Bites which is based within the complex of the Trinity Hall in Wath Town Centre.

Lite Bites is under the operation of the Oaks Day Centre and is run by staff with the support of customers from Oaks Day Centre. The work undertaken has looked at the outcomes, cost and any opportunities/threats. The work has been carried out with Oaks Day Centre in conjunction with the operation of the café within the centre itself.

A briefing note is being finalised to consider what the options are that should be considered for the cafes. This will be discussed at Senior Management Team in the coming weeks.

Health Village

The Health village event on the 24th Jan 2017 was well received and led by the team. Learning and feedback from the event have been incorporated into the action plan which is monitored on a regular basis by the project team.

There has been improvement in the staffing levels across the integrated locality pilot, specifically community nursing and the appointment of an administrator to support the team with a particular focus on co-ordination of integrated working processes. A leadership team is now in place consisting of lead officer across the services. They have undertaken a review and refresh of the action plan with the priority to support work to reduce winter pressures in secondary care and have begun to develop key procedures to support integrated working practices. Work is also underway to identify an appropriate external agency to support in the evaluation of the pilot over the summer 2017.

Breathing Spaces

The contract intentions for 2017-18 with TRFT include a review of Respiratory pathways including Breathing Space. This review will focus on quality and performance of the pathways, strategic relevance of services and value for money.

Community Catalysts

Community Catalysts are now working within Rotherham and have successfully appointed a Catalyst worker who commenced in post on the 6th February 2017. There has been an initial project group meeting which brought together key partners of the project.

The Catalyst will support and compliment the work that has already begun around collation of information and advice and building on the work that Community Link Workers and other individuals have undertaken to build community capacity. The project is focussed around the work for Learning Disabilities and will support the modernisation of the Learning Disability Offer for Rotherham.

The Community Catalysts Project forms part of the Adult Social Care Development Programme as a workstream. Therefore this has a requirement for regular updates into the internal and external board meetings to ensure progression.

69. TRANSFORMATION OF ACUTE AND COMMUNITY CARE

Louise Barnett, Chief Executive of the TRFT, and Dominic Blaydon, Associate Director of Transformation, gave the following powerpoint presentation:-

Overview of the Trust's vision for the next five years
- We will continue as a stand-alone district general hospital
- We will build a reputation for innovation and quality care
- We will achieve a CQC rating of "good" or better
- We will deliver financial sustainability
- We will have a strong emergency and urgent care function
- We will develop sub-regional specialist care centres
- We will provide a strong community health service offer
- We will integrate with health and social care partners

Community Transformation Programme
- Integrated Health and Social Care Teams
- The development of a Reablement Village
- A multi-disciplinary Integrated Rapid Response Service
- A joint approach to care home support
- An enhanced Care Co-ordination Centre

Acute Care Collaborations
- Hyper-Acute Stroke Services
- Breathing Space

Children's Transformation
- Integrated Locality Teams
- Review of Children's Assessment Unit
- Rapid access to a Community Paediatrician
- Reconfiguration of Inpatient Bed Base
- A joint approach to Workforce Development

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

- Currently if a Rotherham resident had a suspected stroke they would be taken by ambulance direct to the Stroke Unit at the District General Hospital and assessed for thrombolysis (an immediate treatment to enable to reduce the possibility of having a secondary stroke). If, due to the capacity of the Stroke Unit, a patient would be taken to A&E and receive the medical intervention or wait in A&E for a bed in the Stroke Unit. They would then spend the first seventy-two hours on a local Stroke Unit and then moved to stroke rehabilitation either at the Stroke Unit, intermediate care or rehabilitation.

- Under the new model, dependent upon where the patient lived, they would either go to the Hallamshire or Doncaster Hospitals for the first seventy-two hours. After that time they would be repatriated to Rotherham Hospital.

- Currently Rotherham residents would be taken to Rotherham Hospital to receive care unless their needs were particularly specialist/had very severe needs when they would then go to Sheffield.

- There was concern with regard to the response times, changes to the journey and what affect that would have on a patient if there was a delay in getting the right treatment. The CCG would be making the decision about what happened to Stroke Services in Rotherham and one of the key principles to making the decision was whether the quality of care to Rotherham patients was going to be better. The Governing Body would be looking very closely at if outcomes for patients would be better or worse. Travel factors would be taken into account.

- The commissioners collectively across South Yorkshire looked into whether the new care pathway would improve the quality of care. They also looked at the evidence base available which showed that where you potentially centralised the care you could provide high quality care irrespective of whether the place that a patient went to currently was providing it at the moment so there was the expectation that that would increase. It was on that basis upon which they were putting forward the proposal.

- Rotherham Trust's performance had been poorer than the Trust would have liked but had improved recently and providing much better care than previously in terms of the Sentinel Stroke National Audit Programme (SSNAP) Indicators (national metrics upon which the Trust was measured) and seeking to improve further. The case for change was there in terms of the clinical outcomes and the Trust needed to ensure through consultation that there was real input and feedback. All of the issues could be thrashed out in terms of patient experience and the lack of clarity over patients that mimicked a Stroke so that the commissioners in Rotherham and other commissioning bodies were absolutely clear on the basis on which they were making the decision and that it related to outcomes.

- There was a set of indicators that was used nationally around stroke and were gathered by SSNAP which included how quickly a patient got into a Stroke Unit, received thrombolysis and how much time they spent on a Stroke Unit when in hospital. When aggregated Rotherham performed very well even when compared to Doncaster and Sheffield. As part of the consultation process feedback had been provided that Rotherham was already a relatively high performing Stroke Unit and asked the question as to what the criteria was being used to decide who the specialist unit was. In principle the Trust did

not have a problem with centralising the resource in terms of sustainability and quality of the Service but the information submitted to the Trust and CCGs as part of the consultation process had not evidenced that. The Trust needed them to look in more detail about the impact of transporting those patients and then work through the detail of the precise plans so as to be confident that the quality of the outcomes would manifest if it happened in South Yorkshire.

- Information available regarding outcomes following a stroke such as chances of survival and maximising recovery e.g. speech, movement as well as the metrics on the stroke care pathway.

- In terms of clinical evidence around the number of individuals that the Hospital supported in terms of stroke, it was important because there was a threshold and it was helpful for clinicians to see lots of people in terms of their practice and outcomes for patients. However, since this process had begun Rotherham was slightly above the threshold that had been identified.

- Sustainability of the Trust as a standalone hospital if services were removed – Whilst the Trust would support stroke patients post-72 hours or all the way through depending upon the outcome, it needed to ensure that overall it had a breadth, depth and range of services that held together as a high performing organisation in Rotherham for patients. It was looking internally and across the place on community and making sure that integration was strong and effective but also what was needed in terms of acute. The Trust had recognised that it did not have the workforce resilience to deliver what it needed regularly, was quite vulnerable in certain teams with small numbers of clinicians and there were national shortages and so needed to work in partnership with other organisations. The aim would be to get the sustainability required with the service configuration based on population need. There was a case for specialist centres such as for spinal care, but there were still many conditions and complex needs that needed to be provided at home in the community looking at in-reach.

- The transformation of Acute and Community Care model would look at patient safety, ensuring that people were better off in terms of how the Trust did things and the need to reduce harm in terms of falls and pressure ulcers. Another area was patient and family experience and patient expectations; it was recognised that whilst medical advancements had been made, people wanted things more quickly. It was a big piece of work that the Trust needed to carry out and ensure they were able to be part of shaping what future provision would look like and do it together rather than imposing on the public. It was acknowledged that, as an organisation, it needed to get better and listen to people's opinions. The Trust had the clinical expertise but did not experience it the same as a patient and their family.

- No alternative model was being considered other than localised specialist acute model; the Trust needed to decide whether it was going forward on that particular model as part of the consultation. Should the CCG decide it did not want to proceed with the model the Trust would need to look at how it would deliver it locally. Locally there was a fully integrated Stroke pathway and there would have to be a very strong argument to fragment it and take out Hyper Acute and move to another centralised centre. There would need to be absolute assurance that the additional travel time and inconvenience for relatives and patients would achieve better outcomes and better quality service.

- The importance of easy read information and ensuring effective communication with patients and their families so everyone knew which hospital a person was being taken to following a stroke.

- It was really important that people were able to access local services that were easy to get to. There may be certain situations where it was better for the patient and family to move services further from Rotherham but the decision would not be taken lightly and every attempt made to ensure the right balance taking into account the importance of delivering services locally and the impact on patients and relatives.

- The Foundation Trust and CCG were stating that if proposals, in their view, resulted in a Stroke Care pathway that was not viable then they would not agree to it.

- Staffing and bed capacity in Sheffield and Doncaster and sharing information between services to manage additional capacity?

- Once the pathway was in place Yorkshire Ambulance Service would be fully involved and clear about where a patient was taken. The Trust had raised the point in their consultation response with regard to Doncaster and Sheffield Hospitals having the capacity and capability to be able to delivering the extended service.

- Where was the best medical team going to be?

- With regard to the proposed Children's Transformation, one area that had been rated "Inadequate" by the CQC was Safeguarding but there was no remedial action mentioned in the proposal – information to follow.

- A multi-agency project group was overseeing the Co-ordination Centre single point of access. There were three workstreams – how to incorporate the Mental Health element, how to encourage the Social Care element and also links with the Integrated Rapid Response Service. It was thought that the new extended version of

the Care Co-ordination Centre would be agreed within the next year with an implementation plan of six months.

- Under the proposal everyone who might have had a stroke would initially go to Sheffield or Doncaster not Rotherham. There was still some ambiguity about a person who presented with stroke-like symptoms. More sophistication was needed through the consultation to deal with those instances.

- Once a stroke patient had stabilised they would be repatriated to Rotherham. There had been discussion as to whether the whole of acute stroke would transfer but the consultation document just dealt with the first seventy-two hours. Rotherham Hospital would have a stroke unit to deal with everything after the first seventy-two hours.

- Concerns regarding the immediate family getting to and from Sheffield/Doncaster had been raised at the JHOSC.

- The proposed model would be advantageous to those patients that were more complex and avoid them having to be transferred to the Hallamshire Hospital for treatment.

- Governance and influence over future services if transferred from Rotherham would be through the CCG.

- It was unclear what would happen in the case of those patients who unfortunately then had secondary strokes.

- Feedback had been provided on the issue of travel times. Work had been carried out on Yorkshire Ambulance Service having the capacity to meet the travel target, however, the Service's response times were not performing well currently on their eight minute response time. The guidelines stated that a patient needed to receive thrombolytic treatment within an hour; the assessment from the consultation process stated it could be achieved by having two centralised units at Sheffield and Doncaster.

- Was the chance of having a second stroke more likely to happen within the first seventy-two hours? How did Rotherham treat patients differently in that period? An answer would be supplied.

- Transformation of Children's Services and the Locality Teams and ensuring adequate staffing given some of the recruitment and retention issues – Currently there was a lot of duplication and inefficiency in the way professionals worked with an individual coming into contact with a number of agencies, having to retell their story each time and some of the information not being joined up. If a team was brought together to support the child and family there may be less professionals but should create an ability to provide a better and more responsive support compared to the current fragmented service.

There would be still be national shortages in certain fields but there would be more attractive roles and give the opportunity to develop apprenticeship roles, Bands 2, 3 and 4, to those who had a wealth of skills and experience which would then free up others.

It was noted that Louise Barnett would seek the Trust Board's consent to supplying the Commission with a copy of its consultation response.

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

(2) That a future report on the evaluation of The Village pilot be presented to the Commission.

70. BRIEFING ON SCHOOLS MENTAL HEALTH PILOT

Further to Minute No. 43(8) Janet Spurling, Scrutiny Officer, presented a briefing on the pilot that had taken place on adopting a whole school approach to the promotion of mental health and wellbeing in Rotherham.

Six schools had been invited to take part in the scheme representing each of the Social and Emotional Mental Health school cluster areas in north, south and central Rotherham.

The whole school pilot was based on the eight principles outlined in a national guidance document produced by Public Health England and the Children and Young People's Mental Health Consortium:-

- Leadership and management
- School ethos and environment
- Curriculum teaching and learning
- Student voice
- Staff health, development and wellbeing
- Identifying need and monitoring impact
- Working with parents/carers
- Targeted support

Each of the six schools had been encouraged to benchmark themselves against all eight principles and then pick at least two to progress and written up into an action plan. The schools had until July 2017 to deliver their actions.

The report set out the six schools and their selected actions.

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

(2) That the following Members accompany officers on the one-to-one update meetings with schools:-

Rawmarsh	Vicky Farnsworth
Newman	Councillor Short
Wingfield	Councillor R. Elliott
Wales	Councillor Marriott
Oakwood	Councillor Cusworth
Maltby	Councillor Andrews

Following the meeting the changes below were agreed:-

Rawmarsh	*Councillor Marriott*
Wales	*Councillor J. Elliot*
Maltby	*Councillor Andrews and Vicky Farnsworth*

(3) That, subject to the approval of Commissioner Myers, Councillor Cusworth be nominated to represent the Select Commission on the Whole School Steering Group.

71. HEALTH SELECT COMMISSION SUB-GROUP: OLDER PEOPLE'S HOUSING

Janet Spurling, Scrutiny Officer, submitted a copy of the report to Overview and Scrutiny Management Board following the scrutiny session undertaken by a sub-group of the Select Commission regarding housing for older people in Rotherham.

The purpose of the session was to develop a clear understanding of the key issues involved in increasing the number of homes suitable for older people and to make recommendations to inform future plans for older people's housing.

The report summarised key issues identified and the ten recommendations which were as follows:-

(1) That an article be included in the tenant newsletter explaining how bungalows are allocated to different groups of people, not only older people, based on need.

(2) That discussion takes place with transport providers, including Community Transport, regarding:-

- Services for proposed sites before building commences
- Maintaining transport links to those sites in the future.

(3) That the importance of family pets for older people's health and wellbeing is considered in developing housing options.

(4) That consultation is undertaken with older people currently living in three storey buildings to capture their views on how suitable this housing is for their needs, to feed in to decisions about future models.

(5) That consultation is undertaken with older people to ascertain their views on the term extra care and how housing schemes should be branded.

(6) That the approach to branding and marketing housing options for older people should be a positive one such as promoting the third age rather than one of moving towards the end of a person's life.

(7) That new housing schemes are designed to look more generic rather than looking like they are only for older people:-

- To reduce the risk of older people being targeted
- To reflect mixed communities and reduce negative perceptions.

(8) That Shaftesbury House undergoes external renovation and is made more secure for residents.

(9) That action is taken to maintain high quality in current older people's housing to avoid the development of a "two tier" system with differences in quality and experience between current and new provision.

(10) That all multiple storey buildings for extra care housing should have lifts.

This was a good focussed piece of work and showed the role of scrutiny in policy development as opposed to its role in holding agencies and the Executive to account. It was positive to have all ten recommendations accepted with a clear response and timescales for implementation.

Resolved:- That the report be noted.

72. IMPROVING LIVES SELECT COMMISSION UPDATE

Councillor Cusworth gave the following update on the recent Improving Lives Select Commission meeting:-

- Independent Chair of Adult Safeguarding Board provided an annual review
- Domestic Abuse Service provision in Rotherham

The key link to Health was with regard to health partners responding to disclosures or signs of abuse and regional work on implementation of the Mental Capacity Act.

Should any Member require more information they should contact Councillor Cusworth directly.

Councillor Cusworth was thanked for her report.

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

Janet Spurling, Scrutiny Officer, reported that NHS England had carried out their planned mid-point review of the public consultation in late December led by the Consultation Institute. The review had found that, although the Christmas period had been taken into account regarding the length of the consultation period, it had had a greater impact than planned as the response rate was lower than expected given the approach and methodology used.

The consultation deadline had been extended until 14th February to allow for further engagement. This meant that the final decision would now be made by the Joint Committee of CCGs in April, 2017.

In light of the concerns expressed by the Select Commission regarding the proposals for Hyper Acute Stroke Services, the Chair and Vice-Chair had met with a representative of the South Yorkshire Ambulance Service to discuss their ability to deliver the service, the number of vehicles they had at their disposal currently and how many more they felt they would need to carry out the new service.

The representative had been quite clear that the Service had no problems in maintaining the service whatsoever nor were there any issues with regard to the skilling of staff. The only issue was that the Service felt it needed an additional three ambulances bearing in mind the new proposed models of working.

Members reiterated the importance of having clear data and evidence when officers and partners were presenting information to the Commission.

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

(2) That the Commission submit a collective response to the consultation.

74. HEALTHWATCH ROTHERHAM - ISSUES

Tony Clabby, Healthwatch Rotherham, reported that the Autism Strategy was to be launched by the Autism Partnership

75. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 2nd March, 2016, commencing at 9.30 a.m.

Improving Access to General Practice

Jacqui Tuffnell

Rotherham CCG

We said:

We would bid to improve telephony systems across Rotherham

We have:

- Bid unsuccessful to date so Primary Care Committee has approved utilising primary care funding to enable the upgrades and also to enable call recording to support telephone consultation
- Appendix A – details completed practice upgrades and those which will be completed before 31 March 2017

We said:

We would introduce telehealth across Rotherham

We have:

- Piloted and now rolled out telehealth to 19 practices (as at the end of January) and will complete full rollout before 31 March 2017
- Appendix B - details the benefits already being seen from implementing the telehealth system

We said:

Access would be a significant element of our Quality Contract

We have:

- Access improvement will be a requirement of all 31 practices from 1 April 2017. Practices have all confirmed that they will meet the requirements of the quality contract by this date

- Appendix C - confirms the requirements of practices by 1 April 2017

We have:

- All practices undertaking a resilience programme ‘Productive General Practice’ to support their ongoing sustainability, by end of March 2017.
- It provides essential tools for practices to support for example skill mix, front and back office functions, planning and scheduling.
- Examples
  - The Village – care navigators
  - Woodstock Bower – telephone consultation for Advanced Nurse Practitioners
  - Rationalisation of back office functions such as clinical documentation

We said:

We would work with practices to provide more flexibility in appointments

We have:

- We have audited the number of appointments in practices to understand if more or less capacity is being provided.
- Appendix D - report and papers associated with the access audit

We have:

- Commenced a pilot of Saturday routine appointment availability to complement our urgent appointment offer in January.
  - publicising appointments in practices
  - text messages regarding Saturday appointments to all patients with mobile phones
  - article in Rotherham Advertiser (Appendix F)
- Appendix E - initial report of the uptake and patient feedback regarding the Saturday service

We have:

- Patient online numbers have significantly improved over the last year. The CCG and NHS England are working with practices who are struggling with their uptake of patient online.
- Appendix G - current information regarding uptake of patient online.
- We continue to look at ways of raising the profile of the availability.

We said:

We would implement our interim strategy for general practice

We have:

- The strategy has now been superseded by ‘the Rotherham response to the GP Forward View’
- Appendix H - our response to the GP Forward View
- Appendix I - NHS England’s February assessment of our progress in relation to implementation

We said:

We would consider health implications of building schemes impacting on Rotherham

We have:

Waverley development

- We are now at the design stage with the developers and are advised that subject to planning, the build of the new health centre will commence in September 2017.
- In the interim, an improvement project for Treeton medical centre has commenced to improve capacity.

We have:

- Reviewed medical capacity for the proposed increased housing to other sites and there is capacity in the practices surrounding the area:
- Bassingthorpe Farm development – Rawmarsh, High Street, Bellows Road and Parkgate
- York Road development - York Road, Shakespeare Road and The Gate
- Forge Island development
- We are reviewing the medical capacity as urban capacity is more limited.

Any questions?

Appendix A Telephony upgrades

Summary:

1. Stag Medical – upgrade completed
2. Greaseborough – in progress
3. Brookfield – completed
4. Broom Valley – in progress
5. Blyth Road - completed
6. The Gate Surgery – in progress
7. Rose Hill – in progress
8. Canklow – completed
9. High Street – completed
10. Thorpe Hesley – in progress
11. Rawmarsh - completed
12. Parkgate – in progress
13. St Anns – in progress
14. Morthern Road – in progress
15. York Road - completed
16. Shakespeare Road - completed
17. Wickersley – in progress
18. Village – in progress
19. Greenside – in progress
20. Magna – in progress

We are now starting discussion with the practices regarding implementation of call recording and branch site linkage.

Treeton and Broom Lane sites are not 1st call and are implementing with their provider

Appendix B Telehealth Access

MJOG, a text messaging solution was rolled out to all Rotherham Practices in January 2017, by the end of January 19 of our 31 practices were actively using it. Despite the fact that roll out was taking place throughout January, almost 1,300 appointments were cancelled remotely by text message using MJOG. This cut back the number of DNA's and created capacity for patients that needed an appointment.

MJOG has been used to manage stable hypertension patients at Clifton for almost a year now. The patients take their blood pressure reading at home, text in the results and receive automatic advice based on those results. Numerous diabetic patients are to be transferred from secondary care to primary care; they will be managed in the community using MJOG, minimising the impact on General Practice.

A growing number of practices are using MJOG to ascertain patients smoking status and have reported extremely positive results around the acceptance of referrals to smoking cessation services.

Tele-health is still relatively new in Rotherham Practices, however as confidence grows we expect practices to begin managing a number of patients, with long term conditions, remotely using MJOG. There are additional features, such as pre-appointment questionnaires (delivered with MJOG), which we expect to be useful for Practices.

Appendix C

Standard 1 – Improving access to general practice

Rationale

Practices are required to open 8am – 6.30pm Monday to Friday however there are significant variations in relation to the clinician availability within these times. GP survey data, 83% of patients were able to get an appointment last time they tried compared to 85% nationally. 71% of patients described their overall experience of making appointments as good compared to 73% nationally. From review of Rotherham Walk-in centre data, approximately 30% of patients should have attended their own GP.

Delivery

Practices will be required to deliver the following:

1. Practices will be offer sufficient capacity to achieve
    a. Urgent access within 1 working day
    b. An appointment for patients within 5 days when their condition is routine.
    c. Follow-up appointments within a working week of when the clinician identified i.e. if a 1 month follow-up, the appointment offered will be no more than 1 month and 5 working days.
2. It is a requirement that there is a minimum of 75 contacts per 1000 patients per week. Contacts may be provided by a GP (or training GP) and/or Nurse Practitioner (who is qualified to diagnose) and may be face to face or by telephone (triage followed by face to face consultation will be deemed as one episode).
3. Practices are required to have reviewed their capacity and demand and to ensure they are resourcing to meet this demand. This includes:
    - provision of capacity in alternative ways e.g. virtual (telephone) and using alternative roles.
    - 10 bookable sessions (am/pm)
    - offer access to both male and female clinicians.
4. Ensure acutely ill children under 12 are assessed by a clinician on the same day
5. Accept deflections from Yorkshire Ambulance Service (YAS).
6. Provide an in hours home visiting service for those patients presenting with an urgent clinical need requiring a home visit who live within the practice boundary but are registered with a practice outside of Rotherham CCG Boundary in accordance with GP choice requirements with associated payments (currently £60 per home visit). It is not anticipated that demands for such visits will exceed one per month.
7. Improve on patient survey measures

CCG support

- The CCG will supply and review, in collaboration with the Practice, appropriate data e.g. comparative, A&E attendance, OOHs data, variation data, Patient Survey and other related outcome data

KEY PERFORMANCE INDICATORS

1. Reduce minor A&E attendances 'in hours'
    - Reduce to peer cluster average
    - Or reduce by 1%
    - Or reduce by 10% (if already more than 1% above peer cluster average)

    (Dependent on baseline data for each Practice)

2. Reduce OOH attendances
    - Reduce to peer cluster average
    - Or reduce by 1%
    - Or reduce by 10% (if already more than 1% above peer cluster average)

    (Dependent on baseline data for each Practice)

CCG CONTACT – JASON PAGE

APPPENDIX D

NHS Rotherham Clinical Commissioning Group

LMC: 23 January 2017

A & E delivery board: 1 February 2017

GP access

Lead Executive:	Chris Edwards
Lead Officer:	Jacqui Tuffnell
Lead GP:	Dr Jason Page

Purpose:

The purpose of this paper is to provide assurance in relation to the increasing capacity being provided in general practice to meet the growing demand.

Background:

A key expectation of NHS England in the GP Forward View is to improve access in general practice. A separate paper has described and approved a pilot of Saturday general practice provision and these arrangements commenced on 14 January 2017. There are now 3 'hubs' open each Saturday providing routine appointments for Rotherham population.

Like most other areas, Rotherham practices are struggling with demand for their services. All practices in Rotherham are currently undertaking a programme 'productive general practice' which looks at areas within the practice which could be amended or improved to release capacity/improve systems. Practices are also considering alternative workforce models as per the CCG workforce plan with many already employing Advanced Nurse Practitioners and a smaller number with Clinical Pharmacist roles.

Rotherham also has the highest proportion of GPs and Practice Nurses in the age bracket 55-59 with insufficient numbers of GPs and nurses coming through to fully backfill. Rotherham CCG is therefore working with NHSE on any initiatives to support recruitment and retention.

4 practices chose not to participate in the audit.

Analysis of key issues and of risks

The attached report identifies the significant increase in capacity from 2015 to 2016, over 92000 more appointments being provided in primary care. This will include a change in service in October 2015 of all phlebotomy now being provided in general practice when some inner city practices received a phlebotomy service via the community health centre.

Workforce is not increasing at the same rate as demand. Therefore if demand continues to increase at this rate, without further workforce investment, waiting times for appointments will increase and the expectation that there will be continued secondary to primary transfers will be difficult to achieve. To mitigate this, work will continue to encourage practices to diversify their workforce by ensuring their skill mix is correct and better use of unqualified nurses, clinical pharmacists, therapists and associate physicians.

Financial Implications:

N/A

Human Resource Implications:

Practices need to keep reviewing their structures and ensuring they are appropriately succession

planning.
Procurement:
N/A
Recommendations:
To note the increase in appointment capacity across Rotherham and continuing action to meet the levels of demand.

Practice Code	*Practice Name*
C87002	Dinnington
C87003	Woodstock Bower
C87004	Kiveton Park
C87005	St Ann's
C87006	Magna Group
C87007	Stag
C87008	Swallownest
C87009	Brinsworth
C87010	York Road
C87012	Broom Lane
C87013	Parkgate
C87014	Treeton
C87015	Wickersley
C87016	Morthen Road
C87017	Clifton
C87018	High Street
C87020	Greenside
C87022	Village
C87023	Brookfield
C87024	Rawmarsh
C87029	Market
C87030	Crown Street
C87031	Shrivastava
C87603	Greasbrough
C87604	Thorpe Hesley
C87606	Queen's
C87608	Shakespeare Road
C87616	Blyth Road
C87620	Manor Field
C87621	Broom Valley Road
C87622	Gateway Primary Care
TOTALS	

Practice Code	*Practice Name*
C87002	Dinnington

C87003	Woodstock Bower
C87004	Kiveton Park
C87005	St Ann's
C87006	Magna Group
C87007	Stag

C87008	Swallownest
C87009	Brinsworth
C87010	York Road
C87012	Broom Lane
C87013	Parkgate
C87014	Treeton
C87015	Wickersley
C87016	Morthen Road

C87017	Clifton
C87018	High Street
C87020	Greenside
C87022	Village
C87023	Brookfield
C87024	Rawmarsh
C87029	Market
C87030	Crown Street

C87031	Shrivastava
C87603	Greasbrough
C87604	Thorpe Hesley
C87606	Queen's
C87608	Shakespeare Road

C87616	Blyth Road
C87620	Manor Field
C87621	Broom Valley Road
C87622	Gateway Primary Care

What do you consider is the best strategy for managing demand? Please list in priority order e.g. 1 least effective and 10 most effective (aggregated sum and mean across all practice responses from most effective to least effective):	***Sum of response score***
Patient education	185
Telephone systems to direct to appropriate service	166
Telephone triage	157
Telephone consultation	157
Patient Online	143
Navigating to appropriate clinician	141
Electronic Prescribing Service	128
Walk-in service	126
Websites	117
Telehealth	110

Other strategies for managing demand:

The structure around other health providers/ social services appears to be collapsing therefo

Well organised skill mix

Main cause of problems at our surgery relates to insufficient staff

A&E waiting times increased or patients simply turned away if after suitable triage it has bee

MASS MEDIA EDUCATION - TELEPHONE SYSTEMS TO DIRECT PATIENT TO APPROPRIATE SER

	Please identify ALL your available appointments by year: (please include HCA, phlebotomy, but direct employees of the practice not other organisations staff)	
Practice List Size (October 2016 - Actual)	***1st January - 31st December 2015***	***1st January - 31st December 2016***
20,883	No response submitted	
11,296	54064	58749
11,340	70910	70495
17,838	179360	196110
10,892	No response submitted	
11,527	54355	62202
16,582	98550	97912
9,819	No response submitted	
4,618	17630	18688
13,046	62048	64502
6,163	No response submitted	
6,473	31030	38695
7,042	34,963	36,964
11,409	61130	64880
13,364	52213	60808
7,929	5987	6353
5,865	33165	36696
7,250	51,806	53,979
2,079	9435	10779
3,997	14443	16590
11,264	45393	47574
9,142	62,970	63,908
3,230	23869	24034
3,374	14548	15503
5,717	28,936	28,275
1,533	15571	15498
5,382	26176	27169
6,013	33427	38951
6,440	33,901	34,167
1,831	No response submitted	
7,173	11,300	30,071
	1,127,180	**1,219,552**

Please identify any changes you have made to improve access in your practice e.g. telephone triage/consultation, navigation, utilising new roles e.g. pharmacists, walk-in:	***Any other suggestions in relation to managing demand?***
No response submitted	

Employed another ANP , Practice Pharmacist started in October . 8.66 % more appointments	less administration - too many chiefs all sending work .
the EMIS searches are very difficult to pull off. We have emergency clinics every day of the week and never turn patients away whilst we are open.	
We have recruited a salaried GP, a partner and an ANP. We have started offering ring back slots by GPs	
No response submitted	
In April 2016 we made significant changes to our appointment system. We adjusted GP rotas to provide one GP on call all day who would tackle urgent appointments for that day. They would triage requests for urgent appointments and book any appointments that need to be seen. We also advised reception staff to offer patients the furthest available appointment to allow for sooner requests for appointments to be adhered to. We also employed a new half time GP partner in October 2016.	

During 2016 Dr Scorah retired and he has been replaced by 2 Advanced Nurse Practitioners. As these are new roles it did adversely affect the number of appointments we could offer during the summer months (although we did employ some locum time to help with the shortfall). As the ANPs' settle in to their roles the number of appointments we offer will increase.	
Telephone consultations - Advanced Nurse Practitioner sessions	
Some telephone consultations - Phlebotomist	Flexibility on session times. - longer opening hours. -
No response submitted	
Telephone consultations & triage appointment, extended clinics, extra practice nurse.	-
Telephone consultations	The only way to improve is employ more staff
Have increased proportion of on the day appointments held back for urgent access requests with the GP's. Increased provision of telephone consultation slots, reception keeps a cancellation list of any patients unable to provide and immediate appointment to and also promote the use if WIC and pharmacy	Expand provision of in house urgent access in primary care either by commissioning additional hours with existing practices or expanding capacity within the WIC/Urgent care centre when completed in 2017

recruited pharmacists, apprentice GCAs etc. - PS thought I'd already submitted this	
Telephone Triage. - Practice Nurses completing case management	
Recently increased nursing hours	
The GP's have added extra appointment to their daily sessions. Also an increase in Nursing and HCA appointments.	Patient education is vital to managing demand, patients need to be educated to access the most appropriate service for their complaint.
Employment of new HCA and New Practice Nurse 2016	
Employed a long term condition nurse on a p/t basis - Having become a training practice in August 2016 we now have extra appointments due to having a ST3 Registrar - We have 16 on the day appointments for emergencies -	
We have employed ANPs - We have redesigned our on call system - We offer a significant amount of telephone consultations.	We have employed ANPs - We have redesigned our on call system - We offer a significant amount of telephone consultations.
Since November 2016 we have reverted back to an Appointment System instead of all telephone triage to improve our access.	

full yr. effect of phleb hours - minor illness/nurse triage introduced - nb l t sickness (from Feb 16) of 1 of partners	key has to be address patients' expectations - -also fall out from pressures on social care - - unintended consequence of open registration (for protection of homeless) is that a person can step off a plane and ask to register with a practice/be seen by a clinician all of which puts pressure on primary care
Walk in, Telephone Triage	
we have droop-in appointments every morning for both the doctor and nurse practitioner at both sites as well as pre-bookable appointments for the HCA and practice nurse we also have bookable appointments every afternoon for all clinical staff.	Our drop-in surgeries are hard to manage sometimes and it is difficult to get locums to cover
Nurse triage everymonring 09.00 -11.00 - Telephone consultations after GP's morning surgery, elderly patients like this service, some have mobility problems and struggle getting to the surgery for appts so a telephone consultation works well - New HCA who will focus on Health checks, ECG's and bloods freeing up the nurses time for long term conditions /case management work - Locum who works three sessions a week	n/a
SURGERY EXTENDED OUR GP APPOINTMENT, DO MORE TRIAGE.	CAMPAIGNS TO EDUCATE DIFFERENT ETHNIC GROUPS - CCG/ NHS ENGLAND FUNDING TO BE PROVIDED EXTRA TO SUCH GP PRACTICE; AS ABOVE

Added GP Telephone Slots	
Trialled Sit and Wait Clinic system + Telephone Triage but has not improved access.	
No response submitted	
Nurse triage system implemented. - GP clinical query list added to SystemOne. - Extended clinic times to accommodate more patients. - Employed Nurse Prescriber - increased Health Care assistant hours - Increased GP sessions - Employed own Phlebotomist	

Mean response
7
6
6
6
6
5
5
5
5
4

ore placing more demand on the GP Practice .

en decided their present problem would be better managed outside A&E
VICES IN DIFFERENT LANGUAGES.

Variance between 2015 and 2016	*Average number of available appointments per patient per year*
4685	5.20
-415	6.22
16750	10.99
7847	5.40
-638	5.90
1058	4.05
2454	4.94
7665	5.98
2001	5.25
3750	5.69
8595	#REF!
366	0.80
3531	6.26
2173	7.45
1344	5.18
2147	4.15
2181	4.22
938	6.99
165	7.44
955	4.59
-661	4.95
-73	10.11
993	5.05
5524	6.48
266	5.31
18771	4.19
92372	

APPENDIX E

GP SATURDAY ACCESS

The service commenced on 14th January 2017 for patients of practices who run Systm One software due to the delay in installing the EMIS Web Hub software. EMIS practices came on line on 21st January.

Data sharing agreements for EMIS have been opened by all EMIS practices, these were not required by the Systm One practices.

APPOINTMENTS

There are two GP sessions per hub each with 15 appointments, total of 90 appointments across Rotherham.

The appointment times are sent to the practices on Monday morning. The practices send details of the booked appointments to the hubs by 12 noon on Friday. Any un-booked appointments are then sent out to the practices to book on a rota basis.

REPORT

See Appendix A for details of booked appointments.

In the first week, 14th January 2017, North and Central hubs ran with one GP and 15 appointments as there was a delay with the installation of the EMIS hub software. From 21st January a full service for all Rotherham practices was available.

There has been a slow uptake of appointments and some practice have found it difficult to fill their allocation. However, the feedback from the patients who have attended is very positive. See Appendix B. The feedback from practices is shown in Appendix C.

The South and North hubs have found it more difficult than the Central Hub to fill their GP sessions. For the weeks 28th January and 4th February the South Hub have run with one doctor. There has been a second Doctor willing to carry out a shift but there have not been sufficient booked appointments to warrant this.

Both Hub managers are finding that practices to not fax their booked appointment sheets to the hub by the cut off time and they have to then ring round the practices requesting them to send them through.

The feedback from some practices is that the patients would be more likely to attend if they could go to the Central Hub as the others are too far away.

Going Forward

It has been agreed that the split of practices will be looked into and the possibility of moving one of the doctors from the North hub to the Central Hub and providing 45 appointments on this site.

14th January 2017

Central Hub 4 patients booked of which 1 DNA'd
North Hub 2 patients booked
South Hub 15 patients booked of which 3 DNA'd

TOTAL BOOKED APPOINTMENTS	21
TOTAL DNA	4
TOTAL OF UNBOOKED APPOIINTMENTS	35

21st January 2017

Central Hub 19 patients booked of which 2 DNA'd
North Hub 4 patients booked of which 1 DNA'd
South Hub 14 patients booked of which 3 DNA'd

TOTAL BOOKED APPOINTMENTS	37
TOTAL DNA	6
TOTAL UNBOOKED APPOINTMENTS	17

28th January 2017

Central Hub 9 patients booked of which 1 DNA'd
North Hub 1 patients booked
South Hub 5 patients booked

TOTAL BOOKED APPOINTMENTS	15
TOTAL DNA	1
TOTAL UNBOOKED SLOTS	44

4th February 2017

Central Hub 16 patients booked of which 3 DNA'd
North Hub 8 patients booked
South Hub 7 patients booked of which 2 DNA'd

TOTAL BOOKED APPOINTMENTS	31
TOTAL DNA	5
TOTAL UNBOOKED SLOTS	29

11th February 2017

Central Hub 7 patients booked of which
North Hub 26 patients booked of which 1 DNA'd
South Hub 13 patients booked of which 1 DNA'd

TOTAL BOOKED APPOINTMENTS	46
TOTAL DNA	2
TOTAL UNBOOKED SLOTS	14

APPENDIX A – BOOKED APPOINTMENTS PER PRACTICE

Name	PracticeCode	Computer System	North	14.01	21.01	28.01	4.02	11.02
Greasbrough	C87603	SystmOne	1	0	0	0	1 / 1dna	0
Greenside	C87020	SystmOne	2	0	0	0	0	0
Brookfield	C87023	SystmOne	1	0	0	0	0	0
York Road	C87010	SystmOne	2	0	0	0	0	0
Magna Group	C87006	SystmOne	3	0	0	0	0	0
Shakespeare Road	C87608	SystmOne	2	0	0	0	2 / 2 dna	0
Crown Street	C87030	SystmOne	3	1	1	1	0	0
Parkgate	C87013	SystmOne	2	N/A	0	0	0	0
Rawmarsh	C87024	SystmOne	1	1	1/1dna	0	1	1
Market	C87029	EMIS Web	4	N/A	0	0	0	0
High Street	C87018	EMIS Web	3	N/A	0	0	0	0
Thorpe Hesley	C87604	EMIS Web	2	N/A	0	0	0	0
Woodstock Bower	C87003	EMIS Web	4	N/A	2	0	4	3
St Anns & Broom L								3
			30	**2**	**4**	**1**	**5**	**7**

Reporting Name	PracticeCode	Computer System	Central	14.01	21.01	28.01	4.02	11.02
Broom Lane	C87012	SystmOne	5	0	5/1 dna	2	5	5
Broom Valley Road	C87621	SystmOne	1	1/dna	0	0	0	0
Gateway	C87622	SystmOne	2	0	1	0	0	2
Stag	C87007	SystmOne	4	2	3	3/1dna	4	4
Treeton	C87014	SystmOne	2	1	1	2	2 / 2 dna	0
Clifton	C87017	EMIS Web	5	N/A	1	1	0	4 / 1dna
St Ann's	C87005	EMIS Web	6	N/A	7/1 dna	1	3 / 1dna	11
Wickersley	C87015	EMIS Web	2	N/A	1	0	2	0
Brinsworth	C87009	EMIS Web	3	N/A	0	0	0	0
			30	**4**	**19**	**9**	**16**	**26**

Reporting Name	PracticeCode	Computer System	South	14.01	21.01	28.01	4.02	11.02
Blyth Road	C87616	SystmOne	2	2/1 dna	0	1	2/ 1dna	0
Manor Field	C87620	SystmOne	2	0	0	0	0	0
Swallownest	C87008	SystmOne	6	4	0	1	0	2
Village	C87022	SystmOne	3	0	0	3	0	0
Queen's	C87606	SystmOne	1	N/R	N/R	0	0	0
Shrivastava	C87031	SystmOne	1	N/R	N/R	0	1	0
Dinnington	C87002	SystmOne	7	5/1dna	4/2 dna	0	4/ 1 dna	6
Morthen Road	C87016	EMIS Web	4	N/A	N/R	0	0	1
Kiveton Park	C87004	EMIS Web	4	4/1 dna	10/1 dna	0	0	4 / 1dna
			30	**15**	**14**	**5**	**7**	**13**

APPENDIX B – Patient Feedback

SOUTH HUB - PATIENT FEEDBACK								
Recommend to Friends and Family?								
Extremely likely	likely	neither	unlikely	Extremely Unlikely	don't know	Alternative if no Hub	Travel	Further comments
	1					Walk In	car	
	1					Lose a days work	car	
1						Time off Work or A & E	car	
	1						car	
1						Walk In no appt at GP	car	
1						Wk day -time off work	car	
1						hard to get weekday appt	car	Keep Sat AM appointments
1						a later appt	car	
1						Time off Work for Appt	car	Teacher so perfect for me
1						GP when available	car	
1						alternative appt at GP	car	
1						week day appt with GP	car	
1						wait 6 days for avail appt	car	Best drs appointment I have eer had
	1					none	car	
1						111/A & E or WIC	car	Happy a surgery is open on a Saturday
1						wait for appt or A & E	car	
1							bus	
1						WIC	car	
1							car	very handy
1						WIC	car	Excellent service
1						WIC Sheffield	car	
	1					WIC/Pharmacy	car	
	1					week day appt with GP	car	very quick Dr was great
		1				111	walked	
			1			Sat ideal for me	car	
	1					Wait for GP appt	car	3 week wait at own doctors
1						waited	car	Brilliant service
1						hospital treatment	car	
1						next avail GP appt	car	
1						WIC	car	
1						none	car	
	1					Late night or WIC	car	
	1					Different Practice	car	
1						A & E	car	Would have resorted to an A & E visit
					1	Don't Know	car	
1						Brilliant service	car	
1						Time off work	car	

Central Hub – Patient Feedback

Rotherham Saturday Gp Access

How easy did you find it to book the appointment for this Saturday Service?

Excellent	Very Easy	Ok	Not Easy	Very difficult
1	10			

Thinking about your response to this question, what is the main reason why you feel this way?

Called own GP Friday Morning offered appointment Saturday Morning
Rang yesterday for a non emergency appointment at Stag Medical and said a Saturday appointment was available at Broom Lane
Called my own GP practice and the appointments available were a whole month away, so they told me about the Pilot Scheme straight away
Referred straight away from normal GP
It was booked for me by my own Doctors
Booked the day before got an appointment first thing - very impressed
Simple and straight forward process
It was not emergency so was surprised to be offered Saturday appointment - welcome Idea

How likely are you to recommend our service to Friends and Family if they need similar treatment or care?

Extremely Likely	Likely	Neither Likely or Unlikely	unlikely	extremely unlikely
4	7			

Thinking about your response to this question, what is the main reason why you feel this way?

The service was good and as I work Monday to Friday a Saturday appointment was welcome
An extra day of the week to be seen by a Doctor in case of Emergency
If an appointment is needed quickley then this is probably the best option if its not an emergency
Not many Drs on so could be difficult to make an appointment.
Gp's should be open outside of normal working hours. Much easiet and saves strain on emergency services. Hope it continues
Got appointment when needed. Otherwise would have had to wait one month for appointment
A 7 day service would be good

North Hub – Patient Feedback

Rotherham Saturday Gp Access

How easy did you find it to book the appointment for this Saturday Service?

Excellent	Very Easy	Ok	Not Easy	Very difficult
4		1		

Thinking about your response to this question, what is the main reason why you feel this way?

I work from 7.30 am so phoning at 8.30 to get a mid week appointment is difficult. I rang after work and got a Saturday appointment straight away
Appointment Straight away
Saturday is better for people that work
Due to work commitments Monday - Friday I find this service very reasonable
Booked appointments through my usual Drs at Rawmarsh who told me the availability

How likely are you to recommend our service to Friends and Family if they need similar treatment or care?

Extremely Likely	Likely	Neither Likely or Unlikely	unlikely	extremely unlikely
3	2			

Thinking about your response to this question, what is the main reason why you feel this way?

My Friends and family work and not all employers are flexible about time off work for appointments.
Friends may need Saturday appointments
Saturday is better for people that work
It's hard to get an appointment in the week but this service is ideal
Great Appointment, Great Time, Great Doctor

APPENDIX C – Practice Feedback

The reasons for not being able to book patients have been given as follows:

General Comments

- Not my doctor
- Have to travel
- Appointment is too early

Practice Specific Comments

Gateway- Offering appointments but patients don't want to travel to another surgery and want to see own GP

Swallownest - Offering appointments but they have been refused. 9 in first 2 weeks. Patients commented that they have better things to do with their time on a Saturday. The practice has sufficient appointments to book patients in during the week, if unable to take an appt they are offering a Sat appointment.

High Street- Patients are unwilling to travel to Kimberworth and that the Walk In centre is closer. They have not filled any slots to date

Morthen- Patients unwilling to travel to Kiveton and they have not filled any slots to date.

Dr Page- Haven't used the appointments as they simply haven't needed them.

Village- Having difficulty giving the appointments away and not through lack of trying.

Market- Many of their patients do not have cars and Kimberworth Park Practice is three buses away.

APPENDIX F

rotherhamadvertiser.co.uk

THE ADVERTISER, FRIDAY, FEBRUARY 10, 2017 Page 5

90 Saturday GPs appointments now available

ANOTHER OPTION: Dr Richard Cullen

NINETY appointments a week are now available with GPs on Saturday mornings as part of a pilot project to improve access.

The extra sessions are designed to give better access to doctors for people who struggle to attend during the working week.

Rotherham Clinical Commissioning Group is funding the pilot until April and hopes to continue offering the Saturday option in the long term.

Dr Richard Cullen said: "The whole idea is offering another option for people who cannot get to their doctor during the normal working week.

"They have the options of the walk-in centre and the out-of-hours service, but those are for urgent care. This is for routine primary care of people who are generally well.

"There is always extra demand for healthcare. There are certain pressures that people feel, in terms of working and looking after other family members such as children or older relatives.

"We want to get the message out there so that people know that these appointments are available."

The pilot is based in three "hub" surgeries, which each have two doctors working from 8am to 11am.

Every practice across the borough has access to a number of the available slots, based on population.

Dr Cullen said attendance had been quite low on the first two weekends but improved last Saturday as word of the sessions spread.

He added: "The feedback we've had from our receptionists has been that people have been very complimentary and happy about being able to have an appointment on a Saturday.

"This will carry on until April and we hope to keep it going after that if people continue to show that there is the demand.

"It's all about providing the best care to the patients as locally as possible. That's the reason we have gone for this model, as we think it's sustainable.

"If we could have every practice open, we would, but that's not sustainable in terms of the number of GPs.

"It would need a reduction in access during the week. This way, we are building on what is already available."

Saturday appointments at the three hubs must be pre-booked through patients' own surgeries.

Practice Name	Practice Code	Current MAIN Supplier	Registered Patients	Target No of Patients Needed >9.5%	Oct 16	Nov 16	Dec 16					PRESCRIPTIONS					512	Dec 16	TREND
					% Enabled	% Enabled	% Patients Enabled for APPTS	No of Patients Enabled for APPTS	No. Appoint's booked/ cancelled	Appoint's Booked As % of Patient Population	Shortfall (No. of Patients)	% Patients Enabled for PRESC	No of Patients Enabled for PRESC	No of Scripts Ordered	Scripts Booked As % of Patient Population	Shortfall (No. of Patients)	No. of Online Patients (Source: Strawman)	% Patients Enabled for ONLINE	No of Patients Trend
WICKERSLEY HEALTH CENTRE	C87015	EMIS	7024	667	46.4%	46.5%	46.6%	3273	258	3.7%	0	47%	3272	860	12.2%	0	3285	46.8%	4
MARKET SURGERY	C87029	EMIS	11339	1077	33.1%	33.6%	33.8%	3833	650	5.7%	0	34%	3830	1012	8.9%	0	3912	34.5%	27
STAG MEDICAL CENTRE	C87007	TPP	11540	1096	29.0%	29.1%	29.3%	3386	100	0.9%	0	29%	3375	732	6.3%	0	3396	29.4%	24
GATEWAY PRIMARY CARE	C87622	TPP	7258	690	24.2%	24.1%	24.0%	1745	101	1.4%	0	24%	1743	166	2.3%	0	1745	24.0%	4
BLYTH ROAD MEDICAL CENTRE	C87616	TPP	5993	569	23.0%	23.3%	23.5%	1410	112	1.9%	0	23%	1405	162	2.7%	0	1410	23.5%	9
TREETON MEDICAL CENTRE	C87014	TPP	6525	620	19.7%	21.0%	21.8%	1425	97	1.5%	0	22%	1431	611	9.4%	0	1434	22.0%	60
CROWN STREET SURGERY	C87030	TPP	9094	864	18.2%	19.1%	20.0%	1819	208	2.3%	0	20%	1821	705	7.8%	0	1821	20.0%	83
RAWMARSH HEALTH CENTRE	C87024	TPP	4006	381	18.4%	18.6%	18.8%	754	386	9.6%	0	19%	753	142	3.5%	0	754	18.8%	10
MORTHEN ROAD GROUP PRACTICE	C87016	EMIS	11409	1084	18.0%	18.3%	18.3%	2093	138	1.2%	0	18%	2093	397	3.5%	0	2100	18.4%	11
GREENSIDE SURGERY	C87020	TPP	5852	556	15.8%	15.9%	16.1%	944	60	1.0%	0	16%	945	184	3.1%	0	960	16.4%	14
ST ANN'S MEDICAL CENTRE	C87005	EMIS	17733	1685	14.8%	15.7%	16.1%	2861	488	2.8%	0	16%	2848	1284	7.2%	0	2865	16.2%	79
CLIFTON MEDICAL CENTRE	C87017	EMIS	13367	1270	14.8%	15.5%	15.8%	2116	90	0.7%	0	16%	2121	904	6.8%	0	2143	16.0%	44
SWALLOWNEST HEALTH CENTRE	C87008	TPP	16542	1571	14.6%	14.8%	14.9%	2460	542	3.3%	0	15%	2460	500	3.0%	0	2460	14.9%	14
MANOR FIELD SURGERY	C87620	TPP	6462	614	14.1%	14.1%	14.1%	908	79	1.2%	0	14%	933	200	3.1%	0	933	14.4%	-3
HIGH STREET SURGERY	C87018	EMIS	7930	753	12.8%	13.0%	13.1%	1035	59	0.7%	0	13%	1034	316	4.0%	0	1042	13.1%	7
BRINSWORTH MEDICAL CENTRE	C87009	EMIS	9866	937	11.7%	12.1%	12.0%	1184	109	1.1%	0	12%	1178	245	2.5%	0	1188	12.0%	-1
VILLAGE SURGERY	C87022	TPP	7328	696	10.2%	10.7%	11.2%	820	96	1.3%	0	11%	803	192	2.6%	0	830	11.3%	40
DINNINGTON GROUP PRACTICE	C87002	TPP	20835	1979	10.4%	10.8%	11.2%	2341	280	1.3%	0	11%	2343	739	3.5%	0	2344	11.3%	90
QUEEN'S MEDICAL CENTRE	C87606	TPP	1530	145	11.2%	11.1%	11.1%	170	15	1.0%	0	11%	170	36	2.4%	0	170	11.1%	0
WOODSTOCK BOWER GROUP PRACTICE	C87003	EMIS	11297	1073	8.5%	8.8%	9.0%	1020	89	0.8%	53	7%	775	421	3.7%	298	1036	9.2%	26
KIVETON PARK MEDICAL PRACTICE	C87004	EMIS	11370	1080	7.5%	7.7%	7.8%	889	160	1.4%	191	8%	890	309	2.7%	190	897	7.9%	17
BROOM VALLEY ROAD SURGERY	C87621	TPP	1802	171	2.4%	3.2%	7.9%	142	9	0.5%	29	8%	142	0	0.0%	29	142	7.9%	85
THE MAGNA GROUP PRACTICE	C87006	TPP	10976	1043	7.4%	7.5%	7.6%	829	6	0.1%	214	8%	845	200	1.8%	198	847	7.7%	10
GREASBROUGH MEDICAL CENTRE	C87603	TPP	3381	321	6.9%	7.2%	7.3%	247	3	0.1%	74	7%	247	120	3.5%	74	247	7.3%	5
BROOKFIELD SURGERY	C87023	TPP	2095	199	6.6%	7.1%	7.3%	152	4	0.2%	47	7%	152	32	1.5%	47	152	7.3%	4
BROOM LANE MEDICAL CENTRE	C87012	TPP	13035	1238	6.1%	6.2%	6.4%	832	16	0.1%	406	6%	833	253	1.9%	405	835	6.4%	19
YORK ROAD SURGERY	C87010	TPP	4637	441	5.5%	5.8%	6.4%	295	21	0.5%	146	6%	295	57	1.2%	146	296	6.4%	28
PARKGATE MEDICAL CENTRE	C87013	TPP	6186	588	4.9%	5.1%	5.2%	321	2	0.0%	267	5%	322	61	1.0%	266	322	5.2%	7
THORPE HESLEY SURGERY	C87604	EMIS	5742	545	0.5%	0.7%	2.9%	168	14	0.2%	377	3%	155	30	0.5%	390	169	2.9%	127
SHAKESPEARE ROAD SURGERY	C87608	TPP	5359	509	2.2%	2.3%	2.4%	128	74	1.4%	381	2%	127	4	0.1%	382	128	2.4%	4
DR SHRIVASTAVA'S PRACTICE	C87031	TPP	3224	306	2.1%	2.1%	2.1%	68	0	0.0%	238	2%	68	9	0.3%	238	68	2.1%	0

Practice Name	Practice Code	TREND No of Patients Trend
THORPE HESLEY SURGERY	C87604	127
DINNINGTON GROUP PRACTICE	C87002	90
BROOM VALLEY ROAD SURGERY	C87621	85
CROWN STREET SURGERY	C87030	83
ST ANN'S MEDICAL CENTRE	C87005	79
TREETON MEDICAL CENTRE	C87014	60
CLIFTON MEDICAL CENTRE	C87017	44
VILLAGE SURGERY	C87022	40
YORK ROAD SURGERY	C87010	28
MARKET SURGERY	C87029	27
WOODSTOCK BOWER GROUP PRACTICE	C87003	26
STAG MEDICAL CENTRE	C87007	24
BROOM LANE MEDICAL CENTRE	C87012	19
KIVETON PARK MEDICAL PRACTICE	C87004	17
GREENSIDE SURGERY	C87020	14
SWALLOWNEST HEALTH CENTRE	C87008	14
MORTHEN ROAD GROUP PRACTICE	C87016	11
RAWMARSH HEALTH CENTRE	C87024	10
THE MAGNA GROUP PRACTICE	C87006	10
BLYTH ROAD MEDICAL CENTRE	C87616	9
HIGH STREET SURGERY	C87018	7
PARKGATE MEDICAL CENTRE	C87013	7
GREASBROUGH MEDICAL CENTRE	C87603	5
WICKERSLEY HEALTH CENTRE	C87015	4
GATEWAY PRIMARY CARE	C87622	4
BROOKFIELD SURGERY	C87023	4
SHAKESPEARE ROAD SURGERY	C87608	4
QUEEN'S MEDICAL CENTRE	C87606	0
DR SHRIVASTAVA'S PRACTICE	C87031	0
BRINSWORTH MEDICAL CENTRE	C87009	-1
MANOR FIELD SURGERY	C87620	-3

investor in excellence

NHS
Rotherham
Clinical Commissioning Group

Rotherham response to the General Practice Forward View

Your life, Your health

1. Our vision for general practice within Rotherham

Plans and services of all commissioners and health and social service providers in Rotherham are prioritised by needs identified in our Joint Strategic Needs Assessment and the five key Rotherham Health and Wellbeing (H & WB) Strategic aims:

All children to get the best start in life
Children and young people achieve their potential and have a healthy adolescence and early adulthood
All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing
Rotherham has healthy, safe and sustainable communities and places

The CCG will work with practices to transform services over the next 3 years to achieve the following key outcomes:

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

2. Introduction

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

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

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

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

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

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

This strategy is a key component to ensure we continue to mould our journey to deliver our priorities and what we will do to make the vision a reality. The strategy aligns with the Health & Wellbeing board priorities, the CCG's commissioning plan and the General Practice Forward View (GPFV) which recognises the pressure general practice is under following years of relative under investment and sets out a national programme to invest £2.4bn by 2020/21, tackling workload, building the workforce and stimulating care

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

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

We have developed our strategy by reflecting on feedback from our patients and the wider primary healthcare teams at market place and development events held in June 2015, November 2015 and July 2016, as well as considering the challenges facing general practice. The following ten key principles have been identified to form the main elements of the general practice strategy and have been reviewed in light of the publication of the GPFV:

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

7. **Self care** – improved information including patient health portals, ability to monitor conditions at home/link to appropriate service when 'abnormal'
8. **Robust performance management** to provide assurance that safe and cost effective care is being delivered
9. Continuing our programme to **improve medicines management** with appropriate prescribing and reducing waste
10. **Engaging patients** to ensure patient pathways are optimised – to date engagement has been varied and the CCG is committed to finding alternative ways to ensure the patient voice is heard

Our interim strategy was developed in March 2015 and significant progress has been made in implementing these ten key principles. The GPFV however provides an excellent platform for implementing change at increased pace as funding streams are being identified to enable delivery of the programme. The 10 High Impact actions (actions contained within blue boxes) from the GPFV have been referenced in this document to make clear where these are incorporated.

3. Executive summary

Over the course of the next 4 years, RCCG will continue its strategy to invest in primary care as follows:

- Support the development of a Federation/LLP structure to enable practices to work at scale and ensure a sustainable general practice infrastructure - £94k has been released this financial year and will be invested in supporting this infrastructure.
- Continue to reinvest £1.94m monies released from PMS changes in the form of a quality contract for general practice and new local enhanced service schemes
- We will continue our strategy to support practices with increasing telephone consultation and delivering new methods of consultation
- We will continue to invest (current £3.4m) in local enhanced schemes, delivering care closer to home and improving the management of patients to avoid admission
- We have commenced and will facilitate the Productive General Practice Programme for all Rotherham practices by the end of March 2017
- Subject to funding, we will ensure practices are offered the opportunity to continually develop their nursing workforce and feel able to utilise new roles within

the practice e.g. pharmacists, physiotherapists, emergency care practitioners, associate physicians, mental health workers

- We will utilise resilience monies to ensure GP leaders are identified and upskilled to support their clinical colleagues in radical changes within practices
- We will ensure arrangements are in place for a 3 year programme to upskill reception and administrative staff to feel able to care navigate and deal competently with medical documentation
- The CCG will improve weekend access in 2017/18 by implementing a hub approach for routine appointments and clear standards within the quality contract specify practice requirements for availability of appointments. This will be built on as funding is released.
- We will continue our pilot of integrated working within one locality to inform the roll-out across 5-7 hubs during 2017/18
- We will implement our key IT enablers including, the local digital roadmap, telehealth, e-consultation, increasing uptake of patient online
- We will continue enhancing our social prescribing offer as this has evidenced significant improvements for patients and savings in practice time

RCCG interim general practice strategy comparison and actions following publication of the GP Forward View

	Priority Area	RCCG delivery	GPFV	NHS England deliver	Additional RCCG expected actions
1	**Quality Driven Services**	• 4 year reinvestment plan • Benchmarking • Comparing practice quality and productivity • Delegated responsibility for general practice • New models of delivery	Investing £2.4 billion per year into primary care by 2020/21 – 14% real terms increase Capital via the transformation fund Review of Carr Hill Consult re. indemnity costs by July 2016 £56m for practice resilience £246m to support redesign of services in practices Completing electronic prescribing All clinical correspondence to be electronic and coded by 2020	Anew national service for GP mental health New workforce 2020 oversight group Streamlining CQC oversight – reducing inspections Successor to QOF – review 16/17 Simplified system for how GP data and info is requested Improved payment systems Accelerating paper free Promoting best practice Review of mandatory training and the impact of Increase	Facilitating practice resilience support Facilitating redesign of practices
2	**Services as local as possible**	• New ways of managing patients: ➢ Telephone consultations, skype video consultations ➢ Utilising our wider workforce ➢ Integrating out of hours and urgent care	£900m investment for GP estate and infrastructure 18% increase in allocations to CCGs for IT and technology £45m national programme for online consultations	New rules from Sept 2016 to enable NHS England to fund up to 100% of the costs of premises development with relevant caveats	3 year bid for estate and infrastructure by end of June 2016
		Seamless services	IT actions to enable collaborative working including full interoperability across systems IT to facilitate shared care planning, telephone Enable appointments to be booked in different practices using different systems Allows healthcare professionals to inform and update a practice through the sending and management of tasks Advice & guidance platform on e-referral to allow 2-way conversations	Funding for wi-fi Ability to access data and tools to understand and analyse demand, activity and gaps in service provision National framework for cost-effective procurement of telephone and e-consultation tools	
3	**Equality of service provision**	• 'Baskets' of services • Providers working together • Focused health prevention measures ➢ Working with public health	At scale working in larger practice groupings	Roll out of access to summary care record to community pharmacy by Mar 2017	Supporting LLP/practices to work together
4	**Increasing appropriate capacity and capability**	• Workforce plan ➢ Sufficient capacity and an appropriately skilled workforce • Effective succession planning • New workforce models ➢ More effective use of different	£206m for workforce measures Targeted £20k bursaries in hard to recruit areas 250 new CCT fellowships 500 GPs attracted back to England Minimum 5000 other staff working -3000	5000 additional doctors for general practice by 2020 Recruitment campaign International recruitment campaign Improving nurse training capacity Measures to improve retention of	Supporting/facilitating transition to new models

		professions e.g clinical pharmacists, admin and clerical ➢ Engaged and empowered workforce • Recruitment strategy ➢ Improved profile of Rotherham as a place to work ➢ Improved fill rates	mental health therapists, 1500 pharmacists Pharmacy integration fund Practice nurse development strategy £45m to training current reception and clerical staff to navigate patients and free u GP time New medical assistant roles £6m in practice manager development £3.5m for MDT hubs to develop wider workforce in GP Flexible working incentives to reduce locuming £30m releasing time for patients development programme	nurses New standard contract measures to stop work shifting – access policy changes, onward referral relaxation, electronic discharges within 24 hours, outpatient letters no later than 14 days after appointment, responsibility remaining with hospital to discuss results post discharge, 7 days medication on discharge Rapid testing programme in 3 sites to review ways of better managing OPD demand New automation software from 2017/18	
5	**Primary care access arrangements**	• Review of arrangements and to pilot extended opening • Provision of wrap-around services to support GPs	£500m by 2020/21 to enable extra capacity to GP services, including routine appointments at evenings and weekends alongside effective access to OOH and urgent care Greater use of technology Primary care access hubs Implementation of 10 high impact changes	Automated appointment measuring interface to support capacity and demand modelling by 17/18 Minimum requirements –pre-bookable and same-day appointments	Await clarity of funding but hub direction of travel is the way forward. £3 per head is being identified as within CCG baselines to facilitate this in 2016/17
6	**New models of care**	• Collaborating groups of practices to deliver care in the community • New emergency centre ➢ Secondary and primary care clinicians working together	Nurses supporting LTCs Mental health support in GP practices Social workers in GP practices GPs providing services in care homes Social prescribing MCP model – single whole population budget for primary and community services Working at scale – practice groups or federations	Fit for work to reduce dependence on GPs for fit notes and advice National champion for Social prescribing Voluntary Multispecialty Community Provider contract from April 2017 to integrate general practice with community and wider healthcare MCP care model framework New blended quality & performance sceen to replace CQUIN and QOF at MCP level	Evaluate 'perfect locality' and roll-out if successful Population based budget
7	**Self care**	• Education ➢ Patients confident to manage their condition(s) • Social prescribing ➢ Signposting & support to manage their condition(s) • Technology ➢ Proactive monitoring to enable fast response	Assisting patients in managing minor self-limiting illness themselves National programme for supporting people with LTCs to self-care	National programme by Sept 2016 National enabling work to provide some functions at a national level & stimulate development of the market Digital primary care maturity index 10% of patients using one or more online services by Dec 2016 Funding to support education and support for patients to utilise digital services from Dec 2017	Implement the national programme

		• Case management ➢ Clear plans of care		Apps library to support self-care	
8	**Robust performance management**	• Performance dashboard to collate data • RAIDR to ensure consistency	•	•	•
9	**Continued improvements to medicines management**	• 6 service redesign projects to improve prescribing • Prescribing Local Incentive Scheme	•	•	•
10	**Engaging patients to ensure patient pathways are optimised**	• Effective Patient Participation Groups • Condition specific focus groups	•	•	•

Steps to Make the Vision a Reality

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

4. Context

4.1 Profile of Primary Medical Care in Rotherham

90% of all NHS contacts are with general practice.

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

Rotherham's resident population is estimated at 261,000 who are cared for by a total of 31 GP practices (as at September 2016) alongside a centrally based walk-in centre providing 14 hour/7 day access. At the present time, four GP practices in Rotherham are singlehanded compared to 27 practices with multiple GP partners or which are alternative providers.

National average list size	6287
Rotherham average list size	7182
Number of patients per WTE GP	2450

The CCG currently has 15 training practices and all Rotherham training places have been filled this year. This is important as training practices play a significant role in supporting new GPs and encouraging them to stay in the area once they are qualified.

With regard to type of contract there are:

23 Personal Medical Services (PMS) practices

7 General Medical Services (GMS) practices

1 Alternative Provider Medical Services (APMS) practices (covering 3 practices)

A Limited Liability Partnership (LLP) is in place which enables all 31 practices to work collectively and be able to respond to the demands facing general practice. The LLP currently has a GP leading on a very part-time basis and a one day per week Practice Manager supporting its administrative arrangements primarily. It is not currently equipped to support the delivery of the GPFV and work is ongoing in consulting GPs with the shape of a structure which can ensure Rotherham develops primary care to deliver.

At minimum, the LLP needs to create a community interest company or identify a host practice which would be able to hold contracts on its behalf, the LLP needs legal support to determine and agree the right vehicle for Rotherham. We anticipate that this would consist of a session with GPs (November PLT) and supporting the management team to put the legal arrangements in place.

The LLP requires a management structure which is currently lacking of at least a 1 day per week GP to provide clinical leadership, 1wte Band 8b Project Manager (to deliver the direction of travel identified by the GP lead and its members), 1wte Band 7 Development Nurse (supporting practices with identifying and responding to nurse development requirements. In the longer term, the LLP will need to fund these roles on a substantive basis.

4.2 Current General Practice

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

- GPs holding longer term contracts that build real commitment to the local Community and/or configuring under different forms e.g. multi-specialty community Providers, accountable care organisations
- Registered list that leads to continuity of relationships and care•
- GP acting as the coordinator of care between other health and social care settings
- Appetite for innovative ways of working
- Keen to learn new skills through educational programmes designed by local GPs
- Practices beginning to work together to share good practice and learning

- Secondary to primary care Local Enhanced Service agreement where practices have agreed to work together to provide services for all patients when individual practices have not got capacity
- The delivery of high quality care e.g. anticoagulation, where the increased service quality being delivered is outstanding.

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

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

4.3 Changes to Contractual Arrangements

NHS England have nationally lead changes to the payment arrangements for general practice to apply the principles of equitable funding. The aim of which is to by move to a position where all practices (whether GMS, PMS or APMS) receive the same core funding for providing the core services expected of all GP practice. The review of PMS funding, determined that any additional funding above this must be clearly linked to enhanced quality of services or the specific needs of a local population. Also that practices should have an equal opportunity to earn premium funding if they meet the necessary criteria.

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

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

- Support fairer distribution of funding at a locality level

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

The Rotherham approach to PMS reinvestment has included the development of a quality contract which consists of 14 standards:

Improving access to General Practice
Demand management
Health improvement
Screening
Health Protection
Cancer Referral
Best Care Long Term Conditions
Exception reporting
End of life care
Patient safety
Membership engagement
Mental health, learning disability and military veterans
Carers
Patient experience

The quality contract is being phased in to the timescale of the PMS disinvestment and will therefore be fully in place by April 2018.

5. Our Key Priority Areas

5.1 Quality Driven Services

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

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

Funding for all practices should be equitable for delivery of service and also demonstrate value for money. Core contract activities will be remunerated in line with national agreements. Benchmarking information using nationally available data, comparing practice quality and productivity within our area and externally, will be used to ensure value for money.

We will look to achieve best value for money, driving efficiencies in the way general practice is delivered. The quality contract also provides the platform for defining more clearly the quality requirements from practices and relevant training and support is being provided (for example diabetes specific PLT, reception team training in relation to customer care, carers and dementia) to ensure practices feel sufficiently competent. Local practices have already embraced the opportunities to be more efficient in medicines management and prescribing with £1.8m savings in 2014/15, are fully supporting a waste campaign which includes practices taking more control of what is dispensed to their patients.

The CCG already undertakes quality peer review visits to all GP practices and has developed a framework to support practices where there are quality concerns co-commissioning principles. The Care Quality Commission (CQC) are undertaking quality visits of all GP practices during 2015/16 and as at September, only 6 practices have not been visited. The majority of practices have received a 'Good' rating, 4 practices to dates have received 'requires improvement', no practices have been identified as inadequate. On a revisit to one of the four practices, the CQC have amended their rating to 'Good'. The CCG will work collaboratively with practices where any required improvements are identified.

5.2 Services as local as possible

Our main aim is for general practice to sit at the heart of a patients care. Currently, when a patient requires secondary care intervention, care is handed over to the 'specialist' and

handed back once treatment is complete or where protocols exist for care to continue in the community. Often patients could be more appropriately managed by their GP who has a holistic understanding of the patient and therefore increasing used of shared care protocols is a key aim of this strategy. This fits well with planning guidance which identifies changes to outpatient follow-up to encourage discharge back to primary care as soon as is feasible. This is difficult to achieve when there are capacity issues therefore patient management will take on a variety of forms e.g. skype and telephone consultations and utilising our upskilled nursing workforce (cross reference to workforce 5.4 page 17).

Three important local plans which will impact on general practice are the community transformation plan (which will improve and expand out of hospital care provided by teams from Rotherham NHS Foundation Trust), Rotherham Mental Health Transformation plan which will increase the locality focus of mental health services provided by RDASH and the Emergency Centre which will provide state of art facilities for those requiring urgent care but will also redirect patients to using primary care where this is deemed more appropriate.

General Practice in Rotherham is already delivering a number of services which traditionally have been provided by secondary care. These include:

DMARD monitoring
Anti-coagulation monitoring
CEA monitoring
Suturing and complex dressings following procedures in secondary care

The intention is to continue this journey with a desire that with the practices having continuing responsibility for the patient, the requirement for follow-up care within secondary care, particularly after surgical procedures will significantly diminish. This is a significant change for both primary and secondary care and links to the requirement to ensure that primary care is sufficiently resourced to manage this commitment. Section

5.4, in relation to workforce describes how the CCG is working with providers to upskilled and have sufficient numbers to ensure the service is robust.

The CCG has also committed to the provision of 'social prescribing' to support patients requiring healthcare which enables GPs and other clinicians within practices to refer patients to other appropriate services for issues which whilst not directly clinical and have impact on their health and wellbeing. These include housing, debt, loneliness. Rotherham CCG was also provided with additional funding over the winter period to increase these schemes to families and carers.

5.3 Equality of Service Provision – Enhanced Services

GPs are contracted to provide "core services" (essential and additional) to their patients. The extra services they can provide on top of these are called "enhanced services" which are voluntary but, if taken up, often add to the quality of care. The CCG is committed to maximising the uptake of enhanced services and as part of the quality contract arrangements, it will be mandatory for practices (or to have appropriate sub-contract arrangements in place) to undertake all the local enhanced services considered core quality.

Enhanced services address gaps in essential services or deliver higher than specified standards, with the aim of helping the CCG to reduce demand on secondary care and other health services. Enhanced services expand the range of services to meet local need, improve convenience and extend choice. The total investment by the CCG in 2014/15 was £3.4m. The number and variety of schemes has increased over the years as local enhanced services have been developed and the local enhanced services which will be available to the whole Rotherham population from April 2017 are:

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

- Dementia
- CEA monitoring

During 2015/16, the CCG also encouraged practices to align with care homes across Rotherham to reduce the number of GPs visiting and improve the quality of care patients receive in care homes. All care homes are now aligned and weekly clinic/ward visits take place in order to manage patients conditions proactively. Early indications are showing a reduction in non-elective admissions from care homes.

In addition to this the CCG also has Local Incentive Scheme (LIS) which ensure that practices remain up to date with current practice. Rotherham CCG spends on average £4 per head of population. Rotherham is looking to utilise the funding opportunities from GPFV to increase this spend via additional educational and support in the form of:

The Productive General Practice programme for every practice
A programme of education for reception teams which will include care navigation and enhanced medical documentation support for every practice
Releasing GP leaders to make this significant change within practices
Developing Practice Managers to lead different business models in the future
Work with the ATP programme to support practices to host and then employ Physician Associates

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

5.4 Increasing Appropriate Capacity and Capability

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

is not fully inclusive as 7 main sites are missing and 4 practices within the report are branch sites.

NHS Rotherham CCG
GP Workforce Q1 April

Overall the report identifies that whilst currently we are slightly better than the Yorkshire and Humber average in relation to numbers of GPs and qualified nurses, we have a very worrying age profile of 26% of GPs, 22% of Practice Nurses and 34% of Practice Management being aged 55 or over.

Until fairly recently, practices were almost exclusively run on a GP partner basis, with occasional use of locums to cover study, sickness or holiday absence. More recently, there has been a significant growth in locum and salaried GPs, with fewer being attracted to the partnership model. The primary care workforce is changing. An increasing number of GPs are working outside the traditional model with more sessional and locum GPs and utilisation of different professions, more typically nursing to undertake traditionally GP roles. The gender balance between male and female doctors is also changing which is also impacting on workforce availability as traditionally female GPs have chosen to work part-time. The success of the CCG will be dependent on its ability to embrace, utilise and develop potential across its whole clinical and non-clinical workforce. It will also work with provider organisations and the local authority to harness the skills of the wider primary care health and social care teams including district nursing, social work, pharmacy, podiatry, physiotherapy and others. A workforce plan is in place and incorporates the national 10 point plan – Building the workforce – new deal for GPs. This includes our plans for training administrative staff, upskilling unqualified staff and developing our Practice Managers to have the skills to lead new organisational formats. Rotherham participates in the South Yorkshire and Bassetlaw Workforce Group and is committed to the STP plan for primary care which has been co-produced by the group and Health Education England.

Workforce plan
updated September 2(

10 practices have committed to the student nurse training scheme and 8 practices now have apprenticeships. 10 practices have shown an interest in mentoring newly qualified student nurses as there is commitment to capturing the workforce early in their career instead of general practice being seen as somewhere secondary care or community nurses go later in their career. Unfortunately a bid for funding support for clinical pharmacists was rejected in 2015. Four practices have already directly employed clinical pharmacists in their new workforce models, undertaking medication reviews and long term condition management and we will support the LLP to bid for a further opportunity this year to be able to extend this workforce into more practices who are keen to adopt these new roles.

Whilst some practices have recognised the need to continually train and develop staff to enable nurses and other clinicians to feel empowered and competent to take on new roles, there are practices who have not felt able to fund and/or release time for training to the level required for the cascade of duties from GPs. All practices in Rotherham recognise that the traditional GP practice model has to change and many are already embracing the benefits of skill mix changes to fully utilise the skills of qualified and unqualified nurses. However, there are practices who require support with this both financially and physical presence as primary care does not have the benefit secondary care has of education teams co-ordinating training. It is therefore proposed to use GPFV funding for the LLP to employ a Band 7, experienced Practice Nurse to provide leadership and ensure General Practice nursing teams across Rotherham are equipped to deliver the current and future primary care agenda. This role will also provide an initial point of contact for future work developing stronger links between all nursing teams across the Borough. It is recognised that collective leadership is not present across general practice nursing teams and the value of experienced able leadership is widely recognised and well documented. The workforce report details the current risk we have of 22% of the workforce who are able to retire and have the most knowledge, it is critical that we ensure the current workforce is upskilled along with the work already taking place to attract newly qualified nurses into general practice. As detailed above, we have 10 practices providing placements for student nurses to develop the primary care workforce of the future and also intend to extend training to offer opportunities to secondary care nurses who longer term would wish to work within primary care but as they are normally specialty specific, do not meet the criteria for application. As our plan as an STP is to reduce bed bases and manage patients more within an integrated community environment, we need to start to enable

current secondary care staff to access training as in reality it takes at least 2 years for staff to be fully confident in primary care as there is such a breadth of knowledge to gain. It is proposed that the Band 7 nurse takes responsibility for this longer term plan.

Whilst the CCG provides regular learning events and release time, it is considered that this will not be sufficient for the upskilling described above. Whilst the CCG would like nursing staff to aim for diploma level it is acknowledged that this may not always be feasible and therefore the Band 7 would work with each practice's Lead Nurse to ensure there was a skills matrix for their team which includes succession planning. The role would support closer working between practices to share resources and other initiatives and support practices nurses through nurse revalidation together with nurse development. Additionally the role would be expected to contribute to the short, mid and long term planning for the development of primary care. The CCG requires funding for 1 WTE B7 nurse plus course and release time.

We already have a significant number of high quality, committed and dedicated administrative staff who support and care for our patients. But we recognise that their roles could be enhanced to provide more support whilst also enabling this workforce to be more empowered and therefore more likely to be retained. We will utilise GPFV monies to facilitate training sessions in relation to care navigation and medical documentation along with customer care, dementia and carer awareness. After exploring different options, we are working with colleagues across the STP footprint to deliver this training at scale to provide the most benefits.

The CCG has considered piloting the use of Emergency Care Practitioners within its model but this would presently mean ceasing one scheme to commence another and there is no agreement to ceasing any of the current schemes which are working hard to reduce admission to hospital (social prescribing, care co-ordination centre, rapid response service). The Emergency Care Practitioner model provides a home visiting service on behalf GPs/ANPs to release capacity in practice and also

undertake visiting much earlier in the day to ensure patients requiring admission are admitted timely as currently most home visits take place at the end of morning surgery therefore there is a pressure point in the system for ED and the ambulance service in transporting patients. There are successful pilots running locally and Rotherham would wish to participate in a pilot for the Emergency Care Practitioner model. It is anticipated that the cost of such a pilot will be in the region of £100k.

The CCG is also keen to pilot 'Physio First' to release GP capacity. There is already an established MSK service within Rotherham who could quickly mobilise a 12 month pilot which is estimated would free up 105 GP/ANP appointments per week in a locality. Patients would be redirected by reception teams to the in-house MSK clinic which will assess, treat (joint injections and physiotherapy if patient requires only 1 appointment), refer where appropriate. It is considered that this could make a significant difference to working arrangements within practices, making workload significantly more manageable. There is scope to mobilise this pilot by December 2016 if approval to go ahead can be achieved by the end of October. The cost of the pilot will be in the region of £90k to mobilise 'immediately' £75k to mobilise by the new financial year.

The CCG has met with local universities regarding physician associate training and promoted this with practices. Key concerns remain in relation to the roles being paid at the same or even higher level than Advanced Nurse Practitioners who it is currently considered require less direction and are able to prescribe and order x-rays. The CCG undertook a workforce development session in 2015 with practices and an externally facilitated session with all GPs took place in September 2016. The CCG is also an active member of the Primary Care Workforce Group (South Yorkshire and Bassetlaw) and the STP plans for workforce. It is proposed that the CCG will work with the ATP regarding opportunities to support practices with training and recruiting to these new roles.

At the moment, health and wellbeing support within general practice is provided on an informal basis and needs to improve. The CCG is keen to implement the resources identified in GPFV to support GPs in relation to their health and wellbeing. The CCG will work with the LMC/LLP to understand the need for this support within Rotherham and actively pursue funding as it becomes available.

The CCG has training leads and spends time with new trainees identifying and promoting the different opportunities for work within Rotherham. These include portfolio careers enabling new GPs to have more varied roles by also working in secondary care or having a particular specialised interest developed.

Rotherham commenced a whole-scale programme of Productive General Practice in September 2016 via 3 cohorts of 10/11 practices receiving intensive support to release 'Time to Care'

Cohort 1	Thursday	Thursday
Week	22/09/2016	29/09/2016
Input	Group based learning session	Group based learning session

Then there is a 12 week delivery model.* (extra week for half-term/Christmas / new year)

Week	1 w/c Mon 03/10/2016	3 w/c Mon 17/10/2016	5 w/c Mon 31/10/2016	6 Thursday 10/11/2016	7 w/c Mon 14/11/2016	9 w/c Mon 05/12/2016	11 w/c Mon 09/01/2017	12 w/c Mon 31/01/2017
Input	Practice hands on session 1	Practice hands on session 2	Practice hands on session 3	Group based learning session	Practice hands on session 4	Practice hands on session 5	Practice hands on session 6	Group based learning session

Cohort 2	Thursday	Thursday
Week	13/10/16, 6 weeks in advance	(17/11/16) 2 weeks in advance
Input	Group based learning session	Group based learning session

Then there is a 12 week delivery model.* (extra week for half-term/Christmas / new year)

Week	*1 Friday 28/10/2016	3 w/c Mon 12/12/2016	5 w/c Mon 02/01/2017	6 Tuesday 17/01/2017	7* w/c Mon 30/01/2017	9 w/c Mon 13/02/2017	11 Thursday 09/03/2017	12 Thursday 23/03/2017
Input	Practice hands on session 1	Practice hands on session 2	Practice hands on session 3	Group based learning session	Practice hands on session 4	Practice hands on session 5	Practice hands on session 6	Group based learning session

Cohort 3	Tuesday	Thursday
Week	1/11/16, 6 weeks in advance	24/11/16, 2 weeks in advance
Input	Group based learning session	Group based learning session

Then there is a 12 week delivery model.* (extra week for half-term/Christmas / new year)

Week	1 w/c Mon 05/12/2016	3 w/c Mon 09/01/2017	5 w/c Mon 30/01/2017	6 Tuesday 07/02/2017	7 w/c Mon 20/02/2017	9 w/c Mon 06/03/2017	11 w/c Mon 20/03/2017	12 Thursday 30/03/2017
Input	Practice hands on session 1	Practice hands on session 2	Practice hands on session 3	Group based learning session	Practice hands on session 4	Practice hands on session 5	Practice hands on session 6	Group based learning session

From previous programmes, this releases on average 10% of practice time as well as

supporting individuals to consider their individual practices to ensure they are as efficient as feasible.

Practice size and sustainability is an important consideration. Rotherham has historically benefitted from having high quality services provided by practices of different sizes. In May 2015 the CCG Governing Body took the view that as opportunities arise the CCG will work to encourage small practices to work closer together in order to provide more sustainable services. Since January 2015 to number of practices has reduced from 36 to 31 and work continues with the LLP to support practices unable to deliver certain services because of their scale. As detailed in section 4.1, the LLP requires more development and possibly to change its organisational form in particular to be able to contract on behalf of practices when a scheme is required across providers.

5.5 Primary Care Access Arrangements

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

All practices are able to text remind patients of their appointments and RCCG is currently trialling increased functionality with MJOG for patients to report blood pressure readings which has also enabled access for patients to text cancellations direct to the clinical system which is having significant success in the practices which are piloting this arrangement. A significant number of practices are achieving the target for online services.

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

	Access / Satisfaction										ED 3	ED 2	ED1 Clinical									
	Easy to get thru by phone	Usually see or speak to pref GP	Able to get speak / see s'one last time tried	Last app was conv-enient	Recep-tionists helpful	Exp of making an app as good	Usually wait 15mins or less after their apt to be seen	Satisfied with surgery's opening hours	Would rec'mend this surgery	Don't normally have to wait too long to be seen	Exp of making an app as good	Describe overall exp of surgery as good	Last GP saw/spoke to gave enough time		Last GP saw /spoke to was good at listening to them		Last GP saw /spoke to was good at exp' tests / t'tment		Last GP saw/spoke was good at in'ving them in decisions about their care		Last GP saw/ spoke to treat them with care / concern	
													GP	Nurse	GP	Nurse	GP	Nurse	GP	Nurse	GP	Nurse
National Avg	73	59	92	92	87	73	65	76	78	58	73	85	87	92	89	91	86	90	82	85	85	91
CCG Avg	70	59	92	92	87	70	70	76	77	63	70	85	88	92	90	91	88	89	84	85	87	90

As can be seen above, Rotherham are in line with the national average for ED1 and 2 but continuing to have difficulty with ED3, experience of making an appointment. We have focused on improving this area and access is a key standard in the new quality contract and from April 2017 all practices have committed to the following:

1. Practices will offer sufficient capacity to achieve
    a. Urgent access within 1 working day
    b. An appointment for patients within 5 days when their condition is routine.
    c. Follow-up appointments within a two day window of when the clinician identified i.e. if a 1 month follow-up, the appointment offered will be no more than 1 month and 5 working days.
2. It is a requirement that there is a minimum of 75 contacts per 1000 patients per week. Contacts may be provided by a GP (or training GP) and/or Nurse Practitioner (who is qualified to diagnose) and may be face to face or by telephone (triage followed by face to face consultation will be deemed as one episode).
3. Practices are required to have reviewed their capacity and demand and to ensure they are resourcing to meet this demand. This includes:
    - provision of capacity in alternative ways e.g. virtual (telephone) and using alternative roles.
    - 10 bookable sessions (am/pm)
    - offer access to both male and female clinicians.
4. Offer pre-bookable appointments 1 month in advance at main sites where clinically required.
5. Ensure acutely ill children under 12 are assessed by a clinician on the same day
6. Accept deflections from Yorkshire Ambulance Service (YAS).
7. Provide an in hours home visiting service for those patients presenting with an urgent clinical need requiring a home visit who live within the practice boundary but are registered with a practice outside of Rotherham CCG Boundary in accordance with GP choice requirements with associated payments (currently £60 per home visit). It is not anticipated that demands for such visits will exceed one per month.
8. Improve on patient survey measures

Mobilisation meetings took place individually with practices in June and July to ensure they will be able to meet these requirements in the required timescale. This standard will enable us to have the platform for using the Apollo tool in future to ensure capacity is increased

beyond the requirements detailed in the quality contract to ultimately deliver 30 minutes additional general practice availability per 1000 population.

Integration with GP out-of-hours providers and other urgent care services will help to reduce duplication and confusion about how best to access urgent care. Rotherham CCG has committed to capital funding to build a new emergency centre on the Rotherham Hospital Foundation Trust site. Building work has commenced with a completion date in July 2017, along with significant pathway work between primary and secondary care clinicians to ensure pathways are as seamless and effective as possible. Currently, Rotherham has 7 day access to general practice via the Walk-in Centre. This arrangement will be continued for patients requiring urgent primary care within the new Emergency Centre arrangements however it is acknowledged that there is a gap of provision of routine access at weekends presently and in the future Emergency Care model. As part of this, work is ongoing in relation to the creation of three hubs (North, South and Central) to enable patients with commitments within the week, to access general practice at the weekend in addition to the current arrangements of extended access (morning and evening weekday**). It is proposed to have this arrangement in place in time for Winter 2016 utilising the £3 per head funding identified within baseline and enhancing the directed enhanced service which is currently 21 practices provide 91.3 additional hours outside of core working. The proposal for additional working at weekends will provide an additional 21 hours per week.**

Work is also continuing to improve the escalation arrangements across Rotherham and ensure there is clarity of the required actions which can be taken in primary care to support e.g. supporting escalated discharge, ensuring all alternatives to admission are explored.

5.6 New Models of Care

In October 2014, an alliance of NHS organisations published the Five Year Forward View (5YFV). A significant element of this strategy is to review the local healthcare system to consider different models of delivering healthcare. Different variations of the models are now being piloted. Greater Manchester health and social care budgets are now devolved to the region's councils and health groups enabling local control over how budgets are allocated and with a main purpose to pool resources to improve out of hospital care. In March? 2016 NHS England announced that as part of the 5YFV a sustainability and

transformation plan on a wider than place footprint to understand the major local challenges, how these are expected to evolve in the next 5 years and emerging hypotheses for what is driving the gaps and action required. Rotherham is included within the South Yorkshire and Bassetlaw footprint for this plan. Primary care is clearly fundamental within the plan.

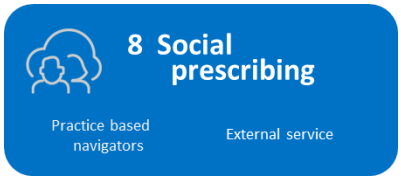
As outlined in 5.5, the CCG has already committed to a new emergency centre which is based on a partnership between urgent care providers in Rotherham and best utilising the different skills of clinicians with primary and secondary care training. The CCG has also committed to transforming community services and already seen significant improvement to out of hospital care, focus is currently on the following:

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

We have commenced a pragmatic pilot in July 2016 of integrating community, mental health, social care, palliative care and social prescribing teams further and also includes the availability of secondary care specialists in primary care settings. This enhanced care will be provided in the home setting regardless of place of residence meaning those people who live in care homes will be able to access enhanced community and home based care. An effective case management Local Enhanced Service is already in place providing effective management of more than 12,000 patients who are at highest risk of hospital admission. Rotherham has also aligned care homes in Rotherham with general practices to strengthen relationships and improve continuity of care. Almost all care homes are aligned with 1 practice although the bigger homes have more than 1 as it would not be feasible for 1 practice to manage on their own. Practices are required to provide additional input to the care home to ensure there is a proactive instead of reactive management of patients which in the early stages is starting to show reduced admissions to hospital. Those practices with access to clinical pharmacists are also using these new roles to review medicines with the care homes and support the management of long term conditions.

5.7 Self Care

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



The CCG is also piloting the use of technology to assist patients to manage their conditions for example blood pressure monitoring at home with results reported directly into the GP to take action where results are abnormal. The results of the pilot are currently being evaluated and it is hoped to roll-out self-monitoring by the end of the financial year.

Education will be a key component to self care, to empower patients and their carers to manage their conditions and to take a more active role in consultations and decisions about their care. Practices are able to access Health Trainers but we know that to date, success in improving patient attendance and adherence has been patchy e.g. uptake for cardiac rehabilitation and we must work harder to devise innovative ways of reaching our population. This area is also now being considered as part of the wider work of the STP as detailed in section 6.3.

Rotherham is keen to implement e-consultation and bid for funds in the ETTF however since bidding it has been announced that an alternative funding scheme will be released in the near future. This scheme will be prioritised to this timescale.

As detailed in Appendix 1, Rotherham has bid for funds to enable remote consultations with patients and enable patients to gain confidence in managing their conditions.

Rotherham is also always horizon scanning and exploring smart inhaler concepts which has current positive evidence of reducing eacerbations and 50% improvement in inhaler useage.

5.8 Robust Performance Management

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

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

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

As each practice has been quality visited by the CQC during 2015/16, the programme of quality visits normally undertaken was suspended in 2016. Instead, as part of the quality contract work, mobilisation meetings have taken place with each practice to understand practice readiness for implementing the standards. The standard of mobilisation plans received has been very good. The baseline data for the standards is being added to the performance dashboard as it becomes available (ie as each standard is signed off). There are clear key performance indicators for the quality standards and an action plan within the mobilisation plan for addressing any shortfalls.

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

5.9 Continued Improvements to Medicines Management

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

The CCG also has a minor ailment scheme in place which will be reviewed again this year and provides the ability for patients to be redirected to pharmacies for medicines not requiring prescription. It is also the intention to invest in technician support for practices to release GP time and ensuring patients medications are regularly reviewed to prevent wastagel

5.10 Engaging Patients to Ensure Patient Pathways are Optimised

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

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

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

However, PPGs are only one mechanism for patient and public engagement and experience. The CCG also aims to extend engagement, and work with a variety of organisations to improve the patient voice for specific communities, both geographical

and communities of interest, for example people with specific long term conditions. If the CCG is to develop new ways of working; it will be vital to ensure that patient experience actively and meaningfully informs new systems and processes. This cannot be done in one way, and may involve any of the following:

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

6. Enablers to Delivering our Strategy

6.1 Development of the primary care model(Federation/LLP)

As identified in section 4.1, Rotherham currently has a Limited Liability Partnership (LLP) in place which enables all 31 practices to work collectively and be able to respond to the demands facing general practice. The LLP currently has a GP leading on a very part-time basis and a one day per week Practice Manager supporting its administrative arrangements primarily. It is not currently equipped to support the delivery of the GPFV and work is ongoing in consulting GPs with the shape of a structure which can ensure Rotherham develops primary care to deliver.

At minimum, the LLP needs to create a community interest company or identify a host practice which would be able to hold contracts on its behalf, the LLP needs legal support to determine and agree the right vehicle for Rotherham. We anticipate that this would consist of a session with GPs (November PLT) and supporting the management team to put the legal arrangements in place.

The LLP requires a management structure which is currently lacking of at least a 1 day per week GP to provide clinical leadership, 1wte Band 8a Project Manager (to deliver the direction of travel identified by the GP lead and its members), 1wte Band 7 Development Nurse (supporting practices with identifying and responding to nurse development requirements. In the longer term, the LLP will need to fund these roles on a substantive

basis. It is hoped that once the benefits of federation working are realised that this will be extended to ensure general practice across Rotherham continues to develop by having central access to skills and resources to support practices.

6.2 Primary Care Estates and Premises

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

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

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

Rotherham Metropolitan Borough Council are currently reviewing all ‘government’ estate to ensure it is fit for purpose and utilised appropriately across all services. Whilst this is welcomed by the CCG, many general practices are privately owned by partners in the practice and will not therefore be captured under this review. NHS England have recently procured site surveys of all GP practices to provide CCGs with an assessment of the current estate suitability for primary care. Whilst some estate issues have been identified, the estate is in fairly good order and other than a planned development there are no identified requirements for new healthcare premises. A strategic plan for Rotherham estates has been developed:

Rotherham Strategic Estates Plan - revised

The strategic direction is towards larger practices and configurations of practices, able to provide a range of general medical services, enhanced services and community based healthcare and on this basis the CCG has bid for funding to create seven neighbourhood/community hubs to enable fully integrated working arrangements. The outcome of this bid should be known in November 2016. The CCG has also bid for a number of other schemes detailed in Appendix 1 which will support the delivery of GPFV if successful.

6.3 Information Management and Technology

Technology emerging through our flag ship Sheffield City Region Testbed programme will drive innovation and act as a primary delivery vehicle for identifying, implementing and evaluating new technologies which meet local need. Other leading initiatives across South Yorkshire and Bassetlaw have included the significant collaboration between our local provider organisations, developing innovation in the way they work together across key clinical areas. The following planning assumptions and objectives have been defined by the technology workstream:

Planning Assumptions	Objectives
1. New Models of Care (NMC) will increase care delivered across provider networks/chains	1. Implement an integrated digital health record, paper free at the point of care where information is captured only once only and widely available.
2. Patients will experience care in more locations out of hospital, including home	
3. Current paper based information will significantly limit implementation of NMC	
4. Use of wearable tech to manage personal health and wellbeing will grow significantly over the next 5 years.	2. Support citizens to use digital technologies to manage their own health and wellbeing and develop capability to connect information sharing with the primary care team
5. The SCR Testbed and other leading technology pilots in SY&B will drive a significant increase in the number of people using digital technology to manage their own care	3. Develop a culture with providers of working with innovators to embed technology as a key enabler to independence and reduce the risks of avoidable admissions, particularly for citizens with multiple LTC's
6. As a consequence of all of the above, considerably more data will be generated than at present.	4. Establish an advanced data analytics capability to support improvements in population health planning, risk stratification, at risk patient management and provide real-time analysis and decision support.
7. Investment will use the outputs of the Digital Roadmaps and digital maturity assessment to inform investment needs that will have a net positive ROI and reduce/avoid costs	5. Improve system wide operational efficiency, safety, patient experience and reduce duplication and waste by improving digital maturity to a level that supports care delivery as part of a more distributed healthcare system

Rotherham is leading the way with a Clinical Portal (the Rotherham Health Record) supporting primary, acute and secondary care clinical information to be accessible from any web connected device and integrated into clinical systems. This requires further development time to ensure it is fit for purpose across the system and extend the portal to have to functionality which includes live updates of patient in secondary and urgent care settings, integration with the primary care systems, patient alerts to enable quicker response by primary care, supporting transfer of care, improving safeguarding arrangements, sharing case management plans. To undertake this additional work an investment of £136k will be required.

This enables community teams to support early discharge, locality management of patients, and GPs to have a detailed view of hospital information about their patients. Rotherham's Clinical lead for IT will also help drive forward the following STP wide projects:

- Synthesised health and wellbeing data could provide early warning alerts to patients and their GP's to allow early intervention avoiding hospital attendance and more costly treatment.
- Interoperability and data sharing between providers will improve the effectiveness of primary care with a full medical record and test results available at every consultation.
- Better integration of care provided across the patient pathway but with particular benefits in community care.
- Access to shared care records will revolutionise in and out of hours care, supporting access to relevant intelligence about patients when needed not when services are 'open for business'.
- Self care and better coordinated care, particularly for people with chronic disease and long term conditions, will mean more people will be managed in their homes or in the community without the need to attend hospital for admission or in outpatients.
- Digital health supporting new forms of consultation including phone, text message, e-consultation, video consultation and in some cases group consultations that could include other relevant health professionals and experienced patients for LTC management. This includes the development of accessibility to more senior/expert decision makers for support and advice as and when needed in order to maintain patient care outside a hospital environment.

- Greater integration for all the primary care team through coordinated administration systems, real time information exchange and single integrated healthcare record.
- Further support for sharing of sensitive information and speeding up referrals between public sector and voluntary, charitable and other community based agencies to meet the needs of individuals including police, fire, and employment agencies for example.
- Promotion of mobility of our workforce through increased deployment of mobile devices as well as supporting software in combination with Wi-Fi to support truly agile working within the patient's home as well as across health and care settings (e.g. comprehensive access to NHS Roam across all health and care sites within the SYB footprint).
- Active signposting of available services including on-line, telephone, video, better reception navigation and one to one consultation through on-line portals.
- Reducing DNA's through easy access to GP booking systems, reminders, patient self-recording.
- A reduction in paper work and other non-digital data transport will mean gains in operational efficiency.
- There are benefits from improved access to services for patients and citizens. This ranges from access to community services (e.g. via e-booking, telephone consultations, skype consultations, patient online) to access to secondary care via e-referrals.
- Better access to patients of expert decision support systems and help to navigate to lower cost health advice and delivery channels could reduce demand for primary care services.
- Supporting working across emerging GP federations through the integrated digital care record, shared practice administration systems etc. supporting greater efficiencies in the management as well as delivery of community based services.
- Greater integration of care means that it is more likely A&E or hospital admission will be avoided as deteriorating patients are picked up earlier with an appropriate intervention at that time.
- Remote monitoring linked to intelligent alerts means that patients, their carers as well as community based teams can focus on priorities knowing that they will be alerted if a patient starts to deteriorate. Alerts will enable specialist outreach teams (e.g. cardio, oncology, vascular) to be auto alerted on their patient events, such as

hospital admission, or deterioration. Local community/locality/hospice teams can be alerted if patients attend unscheduled care etc. which can support care planning, especially in relation to End of Life care pathways.

- Better tracking and scheduling of staff resource through geographical tracking technology used extensively by distributed service providers.

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

Practices should be able to access electronic information relating to their patients when they are treated in other parts of the health system. This particularly includes discharge and out patient summaries, pathology, diagnostics and care delivered in community settings. The Local Digital roadmap for Rotherham was submitted to NHS England on 30 June 2016, this sets out the five year vision and plans to achieve the ambition of 'paper free at the point of care' by 2020.

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

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

an excellent incentive for the EPaCCS to be fully implemented and for patients to get real benefits from a co-ordinated and well informed approach to their care

The CCG is committed to ensuring that all patients have equal access to internet based services, in particular the ability to book appointments online and order repeat prescriptions which are then automatically forward to pharmacies for collection. 68% of practices are now live with EPS Release 2 functionality and 82% of pharmacies. Many general practices in Rotherham already offer the facility to online book but it is not well publicised and websites are not easy to navigate therefore the CCG has bid for funding to optimise websites and also enable provision of e-consultation.

Rotherham CCG had commenced roll-out of a primary care system (RAIDR) which supported risk stratification and also enabled practices to better understand their patient flows and compare their activity with their peers. The tool had a range of Dashboard covering areas such as emergency admissions, patients who regularly attend hospital, risk stratification, linkages between prescribing and activity data. There are also screens that will help practices with tasks such as flu vaccination, dementia diagnosis and data quality. Over time it will be possible to develop screens that will make reporting for Locally Enhanced Services to become less onerous. Unfortunately with provider changes at CSU level, Rotherham will no longer be able to access RAIDR after 2016 however work is ongoing with the new provider (EMBED) to utilise Dr Foster tools to deliver these requirements as a minimum and preferably an enhanced system.

During 2016, access to SystmOne from Care homes has been piloted with one GP practice and one care home to support the work which has been undertaken to align the practices with homes.

All GPs have been provided with laptops to support remote working.

GP to community e-referrals are currently being piloted and it is anticipated that roll-out will commence in Winter 2016.

We are working to achieve paper-light status with all practices by December 2016

We are working with practices to increase referrals via the E-referral service. System and capacity issues had meant that GPs within Rotherham had become frustrated with the

system and resorted to paper based referral. This has been addressed via mobilisation discussions and training and support offered.

15 practices are currently achieving the target of 10% of registered patients registered for 1 or more of the patient online services. NHS England representatives have been supporting practices and CCG representatives to increase use.

6.4 Access to GPFV funding

Rotherham is keen to increase the pace of delivering its interim strategy along with the commitments identified in the GPFV and recognises that funding is now being released to support delivery. As Rotherham had already embarked on setting up the Productive General Practice programme with the lead delivery partner for the North, this placed us in an excellent position to extend this across all Rotherham practices. We are also well positioned, from the work taking place in relation to the quality contract to quickly operationalise training for receptionists and prepare for 7 day working. Appendix 2 details clearly, Rotherham CCG requirements to be able to deliver this at pace.

6.5 Wider primary care contribution

The CCG is working with NHS England to ensure services both compliment and collaborate with each other. 7 day dental services are in operation via NHS 111, a number of emergency care attendances relate to dental care therefore these services are essential. The CCG will work with NHS England to develop Enhanced eye care services such as Ocular Hypertension monitoring, Low vision services, Minor Eye care Conditions (MECS/PEARS) Schemes in primary care providing care closer to home. We will also liaise with the LEHN on developing better services for patients with short waiting times and reducing cost.

As detailed in section 5.9, the CCG already works in collaboration with local pharmacies and the minor ailment scheme is currently under review to ensure it is as effective as feasible. A number of pharmacies also support the flu campaign across Rotherham.

7. Governance arrangements

The primary care committee is responsible for ensuring delivery of this strategy. The primary care committee programme of work has been updated to reflect the timescales and commitments detailed in this strategy. The programme of work is timetabled for quarterly review at the committee to ensure timescales are being achieved and also

support where there are any difficulties being encountered. The programme of work is included at Appendix 3.

Appendix 1

	Name of Bid	Date of Bid	What it is about	£	Source of Funds	Outcome?
1	**Local Digital Roadmap (LDR) - *Various delivery bids (names and schemes to be confirmed)***	Expect to make bids in Autumn 2016.	*To support delivery of the Local Digital Roadmap (LDR) . Partners to the LDR are RCCG, TRFT, RDaSH, RMBC, Rotherham Hospice and Rotherham GP Practices. The LDR sets out a 5 yr. vision and plans to support the Rotherham health and care community in achieving the ambition of working "paper free at the point of care" by 2020. The bids put forward in Autumn 2016 will be for agreed programmes of work to support delivery of the LDR (subject to it being approved by NHSE) . The LDR was submitted to NHSE 30-6-16. Prioritisation and development of the delivery bids will be managed by the Interoperability Group.*	Not known at this stage. There is £1.4bn over 5 years nationally. [RCCG indicative 'fair share' would be c £6.3m/5yrs = £1.26m pa]	Driving Digital Maturity Investment Fund	Not known at this stage
2	**Connection of GP Practices to the CCG Network**	Jul-16	*To implement network connectivity to the remaining GP practices that are without a connection to the CCG network was approved in July. These practices will be connected up using the Public Sector Network. We will also replace existing GP practice network connections with the same technology, which will decrease the overall cost of our current network provision.*	£100k	NHSE GP IT Capital	Bid was approved August 2016
3	**Local Area Network Replacement Scheme**	Jul-16	*The aim of this project is to replace local area network equipment (cabinets and data switches) in 20 general practice sites where the equipment is 'end of life', has run out of support and presents a risk to operation of IT Services in the GP Practice*	£211k over 2 years	NHSE GP IT Capital	Bid was approved August 2016
4	**PC Replacement Scheme**	Jul-16	*The aim of this project is to replace the PCs which will run out of warranty during 2016/17 and that are approaching the end of their useful life. The replacement PCs (100 units) cover 15% of the PCs currently deployed in General Practice in Rotherham.*	£509k over 5 years	NHSE GP IT Capital	Bid was approved August 2016
5	**E-consultations**	Jun-16	*Ability to provide sign-posting and electronic consultations*	£163k recurrent	NHSE Estates & Transformation Technology Fund (ETTF) although it has also been announced that there will be a separate fund for this so likely to be excluded from this bid	Late November 2016 - then will have 12 months from decision date to commit funds unclear of decision dates re. new e-consultation funds
6	**Remote Consultations**	"	*Ability to use video consultations with patients*	£35k Year 1 and then £24k recurrent	NHSE Estates and Transformation Technology Fund (ETTF)	Late November 2016 - then will have 12 months from decision date to commit funds
7	**Tele health**	"	*Supporting remote consultations within care homes*	£178k recurrent	"	"
8	**Web optimisation**	"	*Updating websites to help sign-post patients*	£30k	"	"
9	**Improved telephony**	"	*Improving telephone systems to improve access for patients and enable practices to stream calls more efficiently*	£107k	"	"
10	**Integrated hubs**	"	*Enabling works and IT requirements to create 7 integrated hubs across Rotherham*	£700k	"	"
11	**Clinical portal**	"	*Penetration testing, web security, stress testing and hardware to support clinical portal development.*	£30k	"	"
12	**Targeted investment scheme**	"	*Each CCG was allowed to put forward the practice which has been attempting to recruit GPs for the longest period - we put forward Woodstock Bower*	£14k plus recruitment support	NHSE GP Forward View	Approved 8 August 2016
13	**Sustainable practice funding**	"	*12 practices identified interest in sustainable interest funding and the CCG bid for funding to undertake productive general practice*	£120k	"	Unofficially approved in July awaiting formal approval
14	**General practice development funding**	Aug-16	*NHSE have approached RCCG to bid for early funding to enable all practices in Rotherham to receive productive general practice support during this financial year*	£133k	"	Imminent as the programme is expected to commence in September 2016

Appendix 2 - GPFV bids/funding requirements

	Name of bid/funding requirement	Date of bid	What is it for and how does it help deliver the STP	Outcome	£
1	Clinical Pharmacists	Anticipated December	To support practices to recruit and train pharmacists to undertake traditionally GP roles. Without the support monies it is difficult for practices to train the pharmacists as they require significant support (at least 6 months) to start to make an impact in the practice.	Without funding, it is difficult to get practices to commit to new models of workforce and they will continue to try for traditional GP roles	
2	Mental health staff		To support practices to recruit mental health expertise to be able to redirect patients. Without the support monies, patients with mental health needs will continue to be seen by GPs.	Without funding, it is difficult to get practices to commit to new models of workforce and they will continue to try for traditional GP roles	
3	Associate Physicians		To support practices to recruit and train associate physicians to undertake traditionally GP roles. Without the support monies, it is difficult for practices to commit to these roles as they require significant support (at least 1 year) to start making an impact in the practice.	Without funding, it is difficult to get practices to commit to new models of workforce and they will continue to try for traditional GP roles	
4	Receptionist training	Sent to baseline in September	To support practices to upskill reception teams to care navigate and/or manage medical correspondence on behalf of the clinical team	Awaiting further information in relation to delivery partners and will then set up a programme of events across Rotherham	£23k in budget

5	Practice manager development	STP	To support practices to ensure Practice Manager are receiving appropriate development to manage practices in the longer term. Without these monies, it will be increasingly difficult and challenging for Practice Managers as the environment is changing so quickly.	Without funding, it is difficult to engage with practices to see the benefits of upskilling their workforce	**Monies for the programme**
6	GP development	Individuals apply	To provide leadership development to GPs	GPs are feeling overloaded and unable to engage in developments in the system	
7	GP 'stress' support		Stress management support to improve retention and reduce absenteeism. At present, as independent contractors it is difficult for GPs to invest in such schemes and therefore their own health needs are not properly considered	It is understood that this will be received via NHSE performers route	
8	7 day services	STP	Easier and more convenient access to GP services, with the option to book after 6.30pm weekdays and weekends. As GPs are not used to working weekends, it has been difficult to negotiate to date. Using learning from PM challenge fund schemes, it is hoped that additional funds will support engagement.	CCG commits to using £3ph for the remainder of the financial year to commence transition on the basis of £6ph from 2017/18 £7ph from 2018/19, £9ph from 2019/20	**£6ph 2017** **£7ph 2018** **£9ph 2019**
9	Resilience/development funding	STP	Federation development /new models of care including staffing, legal requirements and supporting delivery of GPFV GP leadership, enhanced Productive general	Without funding Rotherham is unlikely to have a functioning 'collective' of GPs	**£100k/2 years required** £120k

			practice package including release time to ensure delivery. There is already acknowledgement that the CCG needs a provider(s) to work on schemes to deliver these new arrangements. Support for embedding federation arrangements will be key to the delivery of the strategy.		approved
9	General practice development funding	Aug 16	A programme of embedding skills within practices to use 'lean' techniques to increase time for care and enable sustainable practices Pilot of the Emergency Care Practitioner to understand the impact on time released from practices to concentrate on long term conditions Extending and improving the clinical portal Physio First pilot to release GP/ANP capacity within practices	Agreed – programme commences September 2016	£214k approved **£100k required** **£136k required** **£90k/75k dependent on mobilisation timeframe**
10	Nurse development strategy	National team	Upskilling practice nurses to manage long term conditions and undertake roles traditionally undertaken by GPs Without this support, the current divide between developing nurses and business as usual requirements is likely to increase.	Without funding and with practices stretched, it is unlikely that nurse development will be given the priority required to ensure we have a fit for purpose workforce.	

Key lead/s	Objective	Workstream and current RAG rating	2015/16				2016/17				2017/18				2018/19				2019/20			
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Dawn Anderson	Quality driven services	CQC reviews - action plans, peer reviews																				
		Continue PLT support																				
		Benchmarking																				
		Safeguarding actions																				
		Devise and implement a local quality contract																				
		Mobilisation meetings with practices																				
		Support following CQC inspections																				
Jacqui Tuffnell & Rachel Garrison	Services as local as possible	Introduction of new LESs i.e. Phlebotomy, Minor Surgery, Joint Injections, Ring Pessary, CEA Monitoring, Dementia																				
		Continued movement from secondary to primary care; Denosumab, Testosterone																				
		Diabetes care; increased primary care involvement																				
		Pilot of integrated working at locality level																				
Rachel Garrison	Contracting	Contracting of LESs for General Practice and Optometry																				
		Review and update of LES service																				

		specifications																						
		Contract Variations																						
Jacqui Tuffnell, Dawn Anderson & Rachel Garrison	Equality of service provision	Basket review and implementation																						
		Care home alignment																						
		Productive General Practice Programme																						
Jason Page, Jacqui Tuffnell & Dawn Anderson	Increasing appropriate capacity & capability	Workforce plan																						
		Pharmacists																						
		Associate Physicians; encouraging practices to provide training places																						
		Technology																						
		Supporting practice sustainability																						
		Student nurses; encouraging practices to provide training places																						
		Newly qualified nurses; encouraging practices to provide posts																						
		Supporting the LLP to bid for 2nd round funding for clinical Pharmacists																						
		Organising receptionist training for care																						

		navigator and medical documentation roles																					
		Supporting Practice Manager development																					
Jason Page & Jacqui Tuffnell	Primary care access arrangements	Weekend / Bank Holiday pilot																					
		New full access arrangements; pilot ahead of EC opening																					
Jason Page & Jacqui Tuffnell	New models of care	Collaborating practices																					
		LLP / Federation Structure																					
		LLP development																					
		Community transformation programme																					
		Social prescribing extension																					
Jason Page & Chris Barnes	Self-care	Pilot of anticoagulation, Diabetes, BP COPD, self-management																					
		Review of case management arrangements to incorporate care home patients																					
		Patient education																					
		Roll-out of Telehealth																					
		Web optimisation																					

		Local digital roadmap submitted																					
		Implementation of local digital roadmap																					
		Use of EPaCCs																					
		Use of online services																					
		EPS implementation																					
		Increasing the use of e-referral																					
		Ability of use e-referral for community services																					
		Connecting care homes to SystmOne																					
		E-consultations																					
Jacqui Tuffnell, Dawn Anderson, Rachel Garrison & Chris Barnes	Robust performance management	Performance dashboard development roll out																					
		Procedure in place for managing commissioning / quality issues																					
		Performance management arrangements being reviewed as part of the quality contract work																					
Stuart Lakin	Continued improvements - medicines management	Waste campaign																					
		Supporting practices with clinical Pharmacist development																					

Helen Wyatt	Engaging patient-optimised pathways	PPG development; LIS audit and recommendation																					
		Co-production of pathways																					
		Carers support																					
Jacqui Tuffnell, Chris Barnes, NHS England & NHS Property Services	Estates	Approve Waverley build																					
		Waverley build (January 2017 to January 2018)																					
		Procurement of provider required during 2017																					
		Estates strategy produced																					
		Approve Canklow move																					
		Canklow move (actual)																					
		GP main practice surveys																					
		Management of required actions from practice surveys																					
Andy Clayton & Wendy Lawrence	IT	All GPs have a laptop to enable remote working																					
		All practices have Wi-Fi enabled																					
		Remote consultation implementation																					
		STP schemes																					

		All care homes have Wi-Fi enabled																					
Garry Charlesworth, John Heney, Dawn Roberts	NHS England	Collaborating with community pharmacies																					
		Optometry support to practices - direct cataract referral																					
		7 day dental arrangements																					
		Optometry secondary to primary transfer																					

Glossary

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

Assurance template - Rotherham **Appendix I**

legend

good	
average	
poor	
blank	

	1. Investment in Primary Care					2. Incr
Name of CCG	**1.1. Planned local investment in Primary Medical Care (£)**	**1.2. Planned spend to train care navigators and medical assistants (£)**	**1.3. Planned spend on improving GP Access (£)**	**1.4. Planned spend on increasing Primary Care workforce (£)**	**1.5. CCG non-recurrent funding to support Primary Medical Care transformation (£)**	**2.1. Articulated plans to increase Doctors working in Primary Care (numbers and supply identified)**
Rotherham	Green	Green	Green	Amber	Green	Amber

easing Primary Care workforce			3. Reducing workload in General Practice				4. Supp
2.2. Articulated plans to increase other Clinicians working in Primary Care (numbers and supply identified)	2.3. Plan to roll-out Clinical Pharmacy	2.4. Plan to roll out Mental Health therapists in Primary care	3.1. Plan to roll out online consultation systems	3.2. Plan to develop Care Navigators and Medical Assistants	3.3. Support to Practice to implement 10 High Impact actions and Time for Care programme	3.4. Plans to strengthen Practices (Resilience programme)	4.1. Clear local Estates strategy and digital roadmap
Green	Amber	Amber	Amber	Green	Green	Green	Amber

›orting Premises Infrastructure and			5. Care Redesign			
4.2. Plan to maximise utilisation of available estate	**4.3. Articulated plan for use of digital technology to support primary care provision**	**4.4. Planned rollout of wifi in general practice**	**5.1. Delivery of GP Extended Access (that meets minimum core national specification)**	**5.2. Plans to develop wider integrated enhanced (prevention, diagnostics and treatment in) primary care provision**	**5.3. Development of 'at scale' Primary Care organisation**	**5.4. Plans to support self-care**
Amber	Green	Blank	Green	Green	Green	Green

	6. Improving Quality and engagement				Overall Assurance
5.5. View on (estimated impact) hospital based provision	**6.1. Identification of opportunities to improve quality and address variation in performance**	**6.2. Measures to address inequalities in population health (including case management of highest at risk patients)**	**6.3. Has CCG involved Practices and wider profession in developing implementation plan**	**6.4. Plans to engage public (population and patients)**	**DCO assessment**
Blank	Green	Green	Green	Green	Green

Rotherham Metropolitan Borough Council

Public Report
Health Select Commission Meeting

Summary Sheet

Council Report
Health Select Commission 2 March 2017

Title
Adult Care – Local Measures Performance Report – 2016/17 Quarter 3

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

Strategic Director Approving Submission of the Report
Anne Marie Lubanski, Strategic Director of Adult Care and Housing

Report Author(s)
Scott Clayton, Interim Performance & Quality Team Manager

Ward(s) Affected
All

Executive Summary

The first Local Measures Performance report was requested to be submitted to the Health Select Commission (HSC) following the consideration of the provisional year end 2015/16 performance report, on 16th June 2016 and was presented at the HSC 28th July 2016 meeting.

A further reported was requested to be submitted for the 1 December 2016 meeting, plus four existing corporate plan measures were requested to be included in future reports and these have been included in this refreshed report. This is part of a quarterly cycle of performance reporting. This report covers the Quarter 3 period – October – December 2016.

Recommendations

That members of Health Select Commission:

Note the contents of the report.

List of Appendices Included

Appendix A - Adult Care Local Measures Performance Scorecard
Appendix B - Briefing note on the Practice Challenge Group
Appendix C – Health Select Commission Briefing Paper

Background Papers

Agenda and minutes of HSC meeting held 1 December 2016 provide additional information that has informed this report.

Consideration by any other Council Committee, Scrutiny or Advisory Panel

None

Council Approval Required

No

Exempt from the Press and Public

No

Title: Adult Care – Local Measures Performance Report – 2016/17 Quarter 3

1. Recommendations

That members of Health Select Commission:

1.1. Note the contents of the report.

2. Background

2.1 As part of the continued performance management framework and to support the business needs of the Adult Care Directorate Leadership Team, a number of key local measures have been developed. These measures contain performance targets for 2016/17 and are designed to complement the statutory national ASCOF measures referenced in the Adult Care & Housing – Final published Year End Performance Report for 2015/16 presented at the 1 December 2016 Health Select Commission. The specific measures are referenced in the Local Measures Scorecard (attached as Appendix A),which now also includes four measures that are reported in the Council's Corporate Plan; that were requested by Health Select Commission members to be included in future quarterly reports of local measures.

2.2 The local measures have been prioritised to ensure that they reflect areas of Adult Care service activity and that they link back to the Council's overarching strategic policies and strategies e.g. Improvement Plan, Corporate Plan plus delivery flows from the key work streams of the Adult Social Care Development Programme. A number of the Local Measures were formerly national measures which are no longer reported, but they retain local value in providing assurance on service responsiveness and outcomes for customers.

2.3 In addition to the Local Measures included in the scorecard, it should also be noted that a range of other measures of activity are also performance managed and reported via alternative reporting streams, for example Safeguarding Adults Board performance measures. Service level management information measures are also regularly reported internally to Senior Management Teams.

2.4 The reporting arrangements on the range of Local Measures included in the scorecard and compilation of the data from within existing Adult Care reporting systems also enable any necessary and agreed, new in-year prioritised local measures to be incorporated and performance monitored readily.

3. Key Issues

3.1 The targets for 2016/17 reflect the progress and expectation of the Adult Care and Housing Directorates Development Programme actions and key delivery milestones. The measures provide an assurance opportunity to gauge the pace, impact and effectiveness of changes being implemented. This is particularly important as more traditional service offers are re-modelled,

alternatives to traditional service delivery are developed and personalisation is further rolled out. These provide insight into the customer journey experience.

3.1.1 Service focused cohort analysis reporting – The Adult Care Development Programme embeds the key changes required to service delivery models as the Directorate moves away from traditional service support packages to more personalised packages. Progress will be tracked using live data evidencing impact from the identified cohorts of service users. This is reported and subject to governance arrangements of the Adult Care Improvement Board.

3.1.2 The Performance and Quality Team, have developed new reporting capability to extract from the Liquid Logic and ContrOCC finance systems; that enables the service to 'in real-time' identify changes in types of support packages being delivered, their cost and budget impact projections. A short demonstration of the features of the 'live' on-line dashboard is available to Members. This dashboard will allow the Adult Development Work Programmes to further identify key milestone and local measures, which can be added to this suite of reporting.

3.1.3 These changes dovetail and complement the work of the Practice Challenge Group (PCG). This has been established during Quarter 3 to enable the service to gain insight of how changes are being delivered by front line workers and teams whilst at the same time getting used to new recording and strength based approaches to assessing and reviewing customer needs. Attached as Appendix B is a briefing note that summarises the work to date of the PCG.

3.2 **Current Performance as at 31st December 2016 - Quater 3** data is reflected, where available or as at **30th November 'shut down'** of SWIFT/AIS data.

3.2.1 The Health Select Commission briefing paper update (Appendix C) of 17 January 2017, provided the latest available Quarter 3 performance update for the four specifically requested measures, LM01-LM04. A number of follow up responses were requested and these are provided below by Sam Newton, Assistant Director Independent Living and Support, Adult Social Care

1. Given that the improvement in performance is moving very slowly upwards, in your professional opinion are the 3 targets ever likely to be achieved?

   The targets set for 2016/17 are not going to be achieved with one month of the financial year remaining. Unfortunately the targets were set without consideration of the impact of the restructure across Adult Social Care and the delay in implementing and the final implementation of Liquid Logic – these issues emerged during the financial year.

2. What is an achievable target?

The target setting exercise will be finalised alongside the Directorate Plan for Adult Care & Housing and the Corporate Plan throughout March 2017. We will need to consider in this setting process both the overall Adult Care Development Plan, the agreed savings targets and the resources available and therefore we will then be in a better position to set and agree realistic final targets for 2017/18.

The three measures are all local measures and may not be the most appropriate measures to take forward in our 2017/18 plans as the Adult Care Development Plan activity has matured with the Project Initiation Documents identifying a wider focus.

3. Can you give more information as to what are the pressures in the service on a performance basis, you have identified training and the installation of Liquid Logic?

The overall pressures were exacerbated by the implementation of the Adult Care Development Plan and the savings targets set within 2016/17 which meant resources needed to be targeted to specific areas of work which may not have directly impacted positively on performance targets set. The restructure was a significant change which had an impact on all staff across Adult Care and took time to embed. The implementation of Liquid Logic in slowing down performance cannot be underestimated. All service users required a full re-assessment to be undertaken and inputted into the new system. Pressure at the Rotherham Foundation Trust hospital site in relation to hospital discharges and delayed transfers of care have also impacted as resources in the community have had to be diverted to support the hospital activity as a priority. The Directorate have also had to remove most of the support given from agency Social Workers due to cost.

4. What other training issues are there, is there any capability/competency issues within the service that are preventing performance levels increasing?

We accept that there are training issues to address with staff. Some of this may be a capability/competency issue and we have to work through these. We have introduced a Practice Challenge Group that will start to identify this and address where applicable. We are looking at individual performance through staff supervision. We have invested in Wellbeing and Strength based approach to Social Work training which is currently taking place and introduced mandatory Care Act E-Learning training for all

staff. We are also introducing action learning sets including peer coaching and peer mentoring.

3.2.2 **LM05-07 – Commissioning KLOE's**

In response to the Council's Improvement Plan – action D.20 Strategic Commissioning , the Local Government Association (LGA) were invited to review the 'as is' commissioning for People services across, Children & Young People's Services, Adult Care & Housing and Public Health. The independent review took place from 7-10 February and the methodology of the review was based on the Commissioning for Better Outcomes peer challenge process. The findings from the peer challenge therefore provide some evidence to the self-assessment status for measures LM05 Person Centred and Outcome Focused, LM06 Well Led and LM07 – Promotes a Sustainable and Diverse Market Place. The review found that Adult Care & Housing commissioning:

- had a strategic and grounded DASS leadership
- a grip on what needs to be done and how best to do it
- quickly established internal and external relationships based on mutual respect
- had a common sense approach to BCF and Place Plan

However, there was a need to:

- inject greater pace into market shaping
- make personalisation the default operating model
- translate good relationships with partners into tangible delivery

The peer challenge feedback demonstrated a reasonable degree of accuracy regarding the Quarter 2 self-assessment, but the LM05 measure has been revised down from green to amber to reflect the LGA comments. There is evidence emerging of recent commissioning activity being outcome focused and person centred, hence the previous green rating. However, the LGA peers, though recognising positive examples, demonstrated that this approach is not embedded yet in all commissioned services or in a defined operating model. An action plan has been devised to address the two amber areas and to take forward the wider suite of LGA recommendations.

3.2.3 **LM08 –** CP2.B3 No. of people provided with information and advice first point of contact (to prevent service need)

This Corporate Plan measure tracks the numbers of Adult Care service users who following contact with the service were able to have their needs met through effective provision of good information and advice at the first point of contact.

Current Quarter 3 (NB. 2 months activity recorded in AIS up to November 2016) activity demonstrates 2130 people (587 more since Quarter 2) were able to be supported in this way. This shows a continued upward trend and the rate increase contributes to the demand management of increased demographic pressures presenting at the 'front door' and prevention of higher long term services being required.

3.2.4 **LM09 –** CP2.B5 No. of carers assessments (only adult carers and not including young carers)

This Corporate Plan measure tracks the number of Adult care carer assessments.

Current Quarter 3 (NB. 2 months activity recorded in AIS up to November 2016) activity demonstrates a further 164 Carers (totalling 935 as at end of November) received an assessment this year. We identified that post introduction of the Care Act that previous practice of recording 'joint service user and carer assessments' is no longer valid.

This change in practice results in Carers being offered an assessment in their own right, but many choose to decline the offer.

This means the historically based target is 'flawed' and future target setting needs to take account of 2016/17 learning. Changes in the assessment processes in Liquid Logic, improve the recording of carer's assessment outcomes. Mental Health carer's assessments have been affected by high levels of sickness absence and actions to reduce the impact are being progressed to improve performance in Quarter 4.

3.2.5 **LM10 –** CP2.B7 No. of admissions to residential rehabilitation beds (intermediate care)

This Corporate Plan measure tracks the number of admissions into intermediate care beds.

Current Quarter 3 accumulative score of 498 an increase of 186 since Quarter 2 continues to show a positive upward trend and remains on track to exceed target.

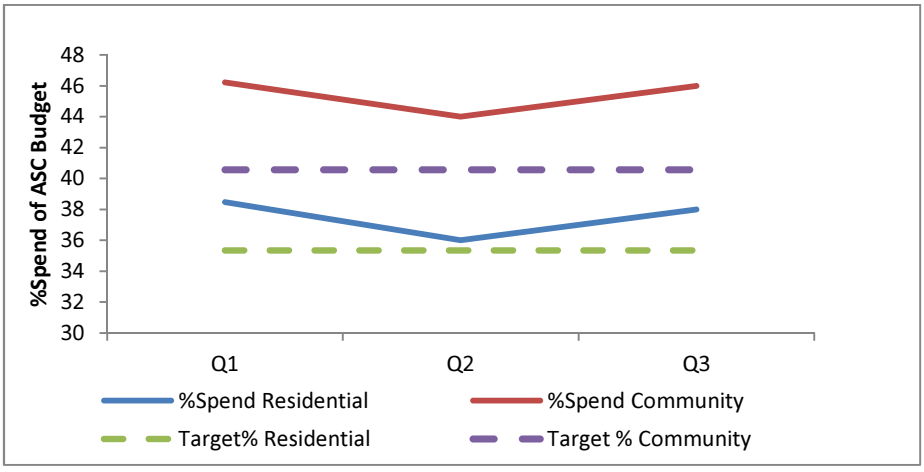
3.2.6 **LM11 –** CP2.B9c % spend on residential and community placements new measure 2016/17

This Corporate Plan measure tracks the Council current actual percentage spend on residential and community placements, compared to the percentage budget allocation. This helps demonstrate the progress being made to focus spend on the prioritised areas through switches being made in the support packages for service users enabling them to remain for longer in the community, achieving better outcomes, rather than more traditional 24 hour care residential models.

Current Quarter 3 activity demonstrates that the gap between actual spend and budget for both residential spend has reversed the previous Quarter 2 positive trend towards target (see graph illustration below) and as a result has now been RAG rated as red from amber. The expected pace of positive impact of service re-modelling has not been realised as at Quarter 3. Finance report this is due to increased in-year demographic pressures and also additional costs to current provision.

There are pressures on the residential and nursing care budgets as a result of an increase in the average cost of placements and lower than forecast 'Continuing Health Care' income contributions against the approved budget. There are currently 916 placements within the independent sector plus 120 placements in the two in-house residential care establishments including intermediate care provision. Residential Care has seen an increase in number of placements in respect of clients under 65 over the last 12 months including some loss of CHC funding. Over 65 placements are reducing but the average cost of care packages increasing. Community budgets are being impacted by continued increase in demand for services including Domiciliary Care (+11%), full year effect of a 29% increase in Direct Payments in 2015/16 plus a further 4.3% increase in numbers so far in 2016/17. Also, impact on cost of service provision in respect of the increase in National Living Wage which increased fees paid to independent providers by nearly 6%.

The introduction in Quarter 3 of the Practice Challenge Group (see briefing paper Appendix B) provides additional analysis and insight as well as service 'learning' that can inform future decisions as to what further remedial actions are required.



4. Options considered and recommended proposal

4.1 None

5. Consultation

5.1 None

6. Timetable and Accountability for Implementing this Decision

6.1 None

7. Financial and Procurement Implications

7.1 Commissioning activity in line with the recommendations of *Commissioning for Better Outcomes* should inform procurement approaches and ensure best value is attained.

8. Legal Implications

8.1 Compliance with statutory requirements under the Care Act 2014.

9. Human Resources Implications

9.1 None

10. Implications for Children and Young People and Vulnerable Adults

10.1 Adult Care primarily provides services to vulnerable adults and therefore the attainment of local measures demonstrates a higher quality of service being offered to customers.

11. Equalities and Human Rights Implications

11.1 The *Commissioning for Better Outcomes* standards ensure compliance with the Human Rights Act (2004) and duties under the Equality Act (2010).

12. Implications for Partners and Other Directorates

12.1 Improved Adult Care services have positive benefits for health partners and young people transitioning into Adult Care from Children's Services.

13. Risks and Mitigation

13.1 Non-compliance with the Care Act requirements, mitigated by implementing the Adult Care Development Programme.

13.2 In year budget pressures are being addressed by a range of management actions, but if these do not contain the increased costs then further mitigations and 2017/18 actions will be required.

14. Accountable Officer(s)

Approvals Obtained from:-

Anne Marie Lubanski, Strategic Director of Adult Care and Housing

Nathan Atkinson, Assistant Director, Strategic Commissioning

Scott Clayton, Interim Performance and Quality Team Manager

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

http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories= [Please update link reference]

Adult Care Local Performance Measures 2016/17 (Appendix A HSC 2 march 2017)

Direction of Travel Key symbol shows indicator has	⇧	improved	⇔	no change	⇩	deteriorated

Indicator Ref		Indicator Title	RAG	Freq.	2015/16 Performance	16/17 Target	DOT (15/16 - 16/17)	16/17 Performance as 30/11/16 (2 months of Q3)	Head of Service	Accountable Officer	Comments / Remedial Actions
LM01	SALT 1	Proportion of Adults on service over 12 months as at 31st March who received a review in year	High	Monthly	49.23%	75% min 100% max	⇩	21.87% RED	Sam Newton	Elaine Hudless	Q2 20.95% RED
LM02	NAS 18 (PAF D39)	Percentage of people issued a support plan	High	Monthly	79.33%	90.00%	⇩	74.78% RED	Sam Newton	Elaine Hudless	Q2 75.02% RED
LM03	NI 132	New - Social Care assessments only (excludes OT/Sensory activity) completed within 28 days from first contact.	High	Monthly	76.13%	90.00%	⇩	68.06% RED	Sam Newton	Elaine Hudless	Q2 77.66% RED
LM04	NI 133	New - Social Care packages of care only (excludes OT activity) in place within 28 days of assessment (Adults)	High	Monthly	84.00%	95.00%	⇩	79.03% new proxy from SALT RED	Sam Newton	Elaine Hudless	Q2 73.1% Final Ex-RAP RED
Commissioning KLOE - Self Assessment Ratings * 3											
LM05	C_Kloe1	Person-centred and outcomes-focused	RAG	Quarterly	Not Applicable	RED Qtr 1	GREEN Qtr 2	AMBER Qtr 3 - as @ Feb	Nathan Atkinson	Nathan Atkinson	Revised Q3 RAG rating in light of LGA peer review feedback - see main narrative in report.
LM06	C_Kloe2	Well led	RAG	Quarterly	Not Applicable	RED Qtr 1	GREEN Qtr 2	GREEN Qtr 3 - as @ Feb	Nathan Atkinson	Nathan Atkinson	
LM07	C_Kloe3	Promotes a sustainable and diverse market place	RAG	Quarterly	Not Applicable	RED Qtr 1	AMBER Qtr 2	AMBER Qtr 3 - as @ Feb	Nathan Atkinson	Nathan Atkinson	
LM08	CP2B3	Number of people provided with information and advice at first point of contact (to prevent service need)	High	Quarterly	945	Baseline year	⇧	2130 AIS as @ 30th Nov 16 data GREEN	Sam Newton	Debbie Beaumont	2015/16 new data collection commenced and represents activity Nov-Mar = 189 per month and annual estimate 2268 Q2 1543 = GREEN Q3 shows increase of 587 in 2 months activity recorded in AIS before inputting ceased prior to Liquid logic migration.
LM09	CP2B5	Number of Carer's Assessments Completed	High	Quarterly	2420	2500	⇩	935 AIS as @ 30th Nov 16 data RED	Sam Newton	Debbie Beaumont	Q2 771 RED Q3 shows increase of 164 in 2 months activity recorded in AIS before inputting ceased prior to Liquid logic migration.
LM10	CP2B7	Number of admissions to residential rehabilitation beds (intermediate care)	High	Quarterly	613	600	⇧	498 Q3 data GREEN	Sam Newton	Darren Rickett	Q2 312 (adjusted from 322) GREEN Q3 shows increase of 186 in Qtr 3 **on track** to exceed target.
LM11	CP2B9c	% spend on residential and community placements	Low (Res) High (Com)	Quarterly	Not available - not previously required	Residential 35.35% Community 40.56%	⇩	Q3 RED Residential 38% - Gap from target 2.65% Community 46% - Gap from target 5.44%	Sam Newton	Mark Scarrott Service lead - TBC	Q2 AMBER Residential 36% - Gap from target 0.65% Community 44% - Gap from target 3.44%

Appendix B

Practice Challenge Group – Health Select Commission 2/3/2017

Background

The Practice Challenge Group (PCG) was introduced to further develop and support social work practice and support a strengths based approach to social work and to reinforce and support practice as defined by the Care Act 2014. This in turn will ensure a holistic approach with customers and carers. Furthermore prevention and wellbeing will be the cornerstone of practice within RMBC

.

The group provides an opportunity to discuss cases, support the development of practice and decision making to ensure an asset, individualised solution is provided. The process ensures those with eligible adult care needs presented to the group are provided with proportionate support and services to promote and maximise independence in a person centred, strengths based approach.

The PCG meetings provide an opportunity to support practitioners to fully explore community based assets, to provide an opportunity to be creative in meeting needs and doing something different alongside gaining intelligence to help understand and support the business.

The development of the group supported data being produced and a tracker was developed to understand activity support to the workforce including training and development. Rather than taking minutes, data is recorded on to the tracker (a spreadsheet) and outcomes of the meetings are captured on the Adult Care system to enable timely sharing with the allocated worker for action.

Data on the tracker is analysed on a monthly basis and fed in to the Housing and Adult Care Directorate Leadership Team. Part of the process affords opportunities to promote good practice and use good examples to support developing a learning environment, sharing best practice throughout the service.

The information recorded captures key intelligence of the business and builds a weekly picture of activity in relation to;

- To support embedding the Care Act principles
- Personalised and creative options
- To support community solutions and appropriate use of residential care if needed
- Number of cases at each PCG meeting
- Number of new cases
- Number of existing cases and what services/support a person is currently receiving and the cost of current care package
- What services are being proposed and the cost of this care package
- Whether the case is agreed, deferred or rejected
- If a case is agreed, what the actual package of care is and the actual cost and the date the package of care becomes effective.

The key benefits of tracking this information and having all the information in one place ensures the directorate is able to –

1. Identify areas of good practice and learning points which are fed back to managers to pick up on celebrating good practice, highlight themes and trends and ascertain any training and development opportunities and see a reduction in the number of re-submissions to the PCG
2. Identify whether the Indicative Budget is in line with the actual cost of the package of care
3. Quantify the amount the budget will fluctuate per individual and overall
4. Explain movement in the budget; what is the story behind why spend increases or decreases and map which cohort fluctuations are attached to
5. Track the customer journey in relation to the difference in what a customer is receiving currently, what is being proposed and what is agreed relating to both type of service and cost
6. Capture demand and identify any gaps in provision or capacity issues of providers to deliver support and services; this information will be fed to commissioning to inform and shape the market
7. Over time, identify a movement away from traditional packages of care towards alternative, community based solutions.

Example Analysis: **PCG meeting 18th January 2017**

Number of cases: 14 (4 new, 10 existing)

Re-submissions: 2/14

Outcome: 8 agreed, 6 deferred, 0 rejected

Of the 8 agreed: 4 were increases to the existing package of care which met identified need and 4 were new cases and therefore increases.

Total increase: £1,034.29 p/w

On all occasions the 'proposed' package of care was agreed / became actuals.

Of the 6 deferred: all were existing cases with no identified urgent need

3 were proposing an increase, 1 no change (extend residential care), 1 no costs available, 1 proposing a decrease (clarification required on eligibility).

Reasons for cases being deferred:

- Client views should be articulated in the assessment
- Further information required and clarity on the options in the package of care; more descriptive text needed to explain these options
- Resource Allocation System (RAS) incorrect, Social Prescribing could be considered, input from Dual Sensory Team could be considered

- Unclear pathway; querying Social Worker involvement as case is open to Mental Health Services
- Clarification required on Care Act Eligibility
- Timeliness of the Decision Support Tool for Continuing Health Care, this should have been carried out sooner.

BRIEFING PAPER FOR HEALTH SELECT COMMISSION 2/3/2017 – Appendix C

1.	**Date of meeting:**	**19th January 2017**
2.	**Title:**	**Local Measures Performance Report – 2016/17 Quarter 2 - update as at 30/11/2016**
3.	**Directorate:**	**Adult Care and Housing**
4.	**Report from:**	**Scott Clayton – Performance and Quality Manager** **Nathan Atkinson – Assistant Director, Strategic Commissioning**

Background

On 1st December, the above referenced Quarter 2 report was presented and a briefing update on progress made as at the 30th November 2016 in respect of Local Measures LM01-04 was requested to be provided for the HSC January meeting.

Current Performance as at 30th November 2016 - Qtr 3 (2 months Swift/AIS data)

LM01 - Reviews

Indicator Ref	Indicator Title	Performance 15/16	16/17 Target	DoT (15/16-16/17)	Qtr 2	30th Nov 2016
LM01	**Reviews**	49.23% DoT	75% min 100% max	⇩	20.95% RED	21.87% RED

This measure accumulatively counts the percentage of service users in receipt of long term services (over 12 months), who have had a review of their care packages and are currently receiving on-going support in the financial year.

Update: Performance has remained almost static, with a 1% rise since Qtr 2 up to the end of November 2017. This was anticipated by the service as the focus has been on implementing phase 2 of the restructure effectively during Qtr 3, ensuring that staff have undertaken

Care Act Training and been prepared for the transition to working with the new Liquid Logic care management system rather than Swift/AIS.

The introduction of the Practice Challenge Group **(PCG)** provides an opportunity for the service to ensure that new ways of working are being embedded and that both new assessments and reviews are being completed in ways that are customer focussed and personalised. A range of proportionate options on the future types of reviews to be undertaken by staff have also been considered following identification in the 'clinic' and are being phased in from Qtr 4 activity.

The service expects that the pace of reviews by year end will be increased and that Qtr 4 performance will inform future target setting for a full year activity in 2017/18.

LM02 - Support plans % Issued

Indicator Ref	**Indicator Title**	**Performance 15/16**	**16/17 Target**	**DoT (15/16-16/17)**	**Qtr 2**	**30th Nov 2016**
LM02	**Support plans % Issued**	79.33%	90%	⇩	75.02% RED	74.78% RED

This measure tracks that customers support plans are updated in line with their assessment, so that they are informed of the outcome and aware of the level of care/support required to meet their needs.

Update: Performance has remained constant and reflects a very small % decline from the position reported at Qtr 2.

However, the current performance of approx 75%, does **not** include a further 409 support plans which are "work-in-progress". These had not passed through two of the remaining authorisation and issuing processes as at the end of November reporting period, thus not being able to be counted in the score. The service will resolve these cases and issue the support plans during Qtr 4. When these are issued it will effectively lift the performance to almost 83%.

Following the transfer in December to Liquid Logic, this measure's Qtr 4 activity will require a new performance report to be developed. This will track progress through to year end; which captures the new Liquid Logic recording and issuing processes. The new recording processes require additional timely authorisation by staff of plans; in order to progress through the system.

LM03 – Waiting times assessments % Issued

Indicator Ref	Indicator Title	Performance 15/16	16/17 Target	DoT (15/16-16/17)	Qtr 2	30th Nov 2016
LM03	**Waiting times assessments**	76.13%	90%	⇩	77.66% RED	68.06% RED

This measure tracks the time to complete new customer's assessment so that they are undertaken in a timely manner. The service aims to complete within 28 days from date of first contact.

Update: Performance has seen a significant 9% decline from the position reported at Qtr 2. This has been impacted by the preparatory training of staff in readiness for switching to Liquid Logic, plus activity completed in the period not being back loaded onto the 'old' Swift/AIS system. Thus 68% is not truly reflective of all activity in the period.

In Qtr 4 performance will require a new report to be developed to track progress through to year end and to evidence if the anticipated impact following service re-modelling is positively influencing by year end. This will inform decisions as to if any further remedial actions are required.

LM04 – Waiting times care packages

Indicator Ref	Indicator Title	Performance 15/16	16/17 Target	DoT (15/16-16/17)	Qtr 2	30th Nov 2016
LM04	**Waiting times care packages**	84%	95%	⇩	73.1% From final RAP report RED	79.03% From SALT report RED

This measure tracks the time to put in place a customer's support plan services. The measure tracks the time from the date the assessment is completed until all services have been set up. The service aims to complete within 28 days from the date of the completed assessment.

Update: It has been necessary to re-configure the reporting of this measure as the data was extracted as per previous business processes (requirements for the “RAP” annual return). However, we have seen a gradual degradation of data captured by the reports quarter on quarter from 30th November. This meant that the reliability of the calculation was compromised beyond acceptable tolerances. As a consequence we have applied a proxy measure using the new ‘SALT’ annual return. This measure reflects that activity over April to November has performed at 79%.

Whilst this is below last year’s outturn and target, it is also likely that some of the activity ‘gap’ has also been created, as final Swift/AIS back loading of November activity has not been undertaken. In Qtr 4 performance will require a new Liquid Logic based report to be developed to track progress through to year end.

Rotherham Doncaster and South Humber NHS Foundation Trust

Rotherham Children and Young People's Mental Health Services- Progress report

RDaSH leading the way with care

Barbara Murray- Deputy Assistant Director

22nd February 2016

Rotherham Doncaster and South Humber NHS Foundation Trust

Contents

- Service Model
- Pathways overview

RDaSH leading the way with care

Service Model

- Incorporating local and national priorities and agendas
  - Future in Mind, local transformation plans, including eating disorder pathways
  - Building early intervention and prevention
  - Community focussed engagement

Rotherham Doncaster and South Humber NHS Foundation Trust

Service model

OPERATIONAL MANAGER - GAVIN PORTIER - 1.00

LEARNING DISABILITIES		
Nurse Consultant	**B8b**	**0.60**
Tracey Wileman		
Principal Psychologist	**B8a**	**0.50**
Abigail Oldfield		
Specialist Child MH Practitioner	**B7**	**0.60**
Mike Waite		
LD Nurse	**B6**	**0.60**
Victoria Mullins		
LD Nurse	**B5**	**0.80**
Gemma Hobson		
Assistant Psychologist	**B4**	**1.00**
Laura Dunk		
Support Worker	**B2**	**1.00**
Shakeela Kelly		
TOTAL WTE - 5.10		

SPA		
SPA Lead	**B7**	**0.80**
Paula Crisp (Mat Leave)		
CAMHS Practitioner	**B6**	**1.80**
Sarah Burton		
Sharan Quixall		
Rebecca Snape (FT 3 Months)		
TOTAL WTE - 2.60		

SPEAK UP CONTRACT - LD		
Peer Support Worker - SpK Up	**B2**	**0.80**
James Gosling		
TOTAL WTE - 0.80		

INTENSIVE COMMUNITY SUPPORT		
Intensive Community Support Lead	**B7**	**1.00**
Jackie Loughran		
Principal Psychologist	**B8a**	**0.50**
Abigail Oldfield		
Paediatric Nurse Liaison	**B7**	**1.00**
Katey Bickerstaffe		
Senior CAMHS Practitioner	**B6**	**3.50**
Kelly Harrison		
Becky Collins		
Hannah Li Wan Po (LTS)		
Emmy Moffett (Mat Leave)		
TOTAL WTE - 6.00		

LOCALITY		
Locality Lead	**B7**	**1.00**
Michelle Robinson		
CAMHS Practitioner - North	**B6**	**1.00**
Laura Airey		
CAMHS Practitioner - South	**B6**	**1.00**
Chris Stoker		
CAMHS Practitioner - Central	**B6**	**2.00**
Diane Spencer		
Jo French		
CAMHS Practitioner - Core	**B6**	**1.00**
Jayne Trezise		
Peer Support Worker	**B2**	**1.64**
Nanette Mallinder		
Tony Hudson		
TOTAL WTE - 7.64		

LOCALITY - Additional Funding - UASC		
CAMHS Practitioner	**B6**	**2.60**
Kelly Sanderson - South		
Emma Lewis-Gibb		
Clare Cotton - North		
TOTAL WTE - 2.60		

LOCALITY - Additional Funding - Corporate		
CAMHS Practitioner	**B6**	**2.00**
Helen Besley		
Wendy Shaw		
TOTAL WTE - 2.00		

PSYCHOLOGY AGENCY		
Clinical Psychologist	**8a**	**1.00**
Name TBC		
TOTAL WTE - 1.00		

CSE		
Pathway Lead	**B8a**	**1.00**
Janine Cherry-Swaine		
CAMHS Practitioner	**B6**	**0.91**
Natasha Koraichi		
CAMHS Practitioner - Evolve DoH	**B6**	**1.00**
Sally Deakin		
TOTAL WTE - 2.91		

DEVELOPMENTAL DISORDER		
Pathway Lead / Principal Psychologist	**B8b**	**0.5**
Jenny Nicholson		
ASD/ADHD Clinical Psychologist	**B7**	**1.00**
Hannah McCormack		
ADHD Nurse Prescriber	**B7**	**1.00**
Mandy Sutton		
ASD Clinical Specialist	**B7**	**0.80**
Allen Walton		
ASD/ADHD Practitioner	**B5**	**1.00**
Kirsty Russell		
Assistant Psychologist	**B4**	**2.00**
J Lomas		
Nicola Wilson		
TOTAL WTE - 6.30		

EATING DISORDER SPOKE		
Consultant Psychiatrist	**B9**	**0.30**
Dr M Thomas		
CAMHS Nurse	**B6**	**1.00**
Kelly Thompson		
Family Therapist	**B7**	**0.20**
Provided by Psychological Therapies		
CBT Therapist	**B7**	**0.30**
Provided by Psychological Therapies		
TOTAL WTE - 1.80		

PSYCHOLOGICAL THERAPIES		
Clinical Psychologist	**B8b**	**0.50**
Jenny Nicholson		
Clinical Psychologist	**8a**	**1.00**
Vacant - Advert due out		
CBT Therapist	**B7**	**1.80**
Bernadette Whitehead		
Joanne Harvey		
Family Therapist	**B7**	**1.00**
Karl Phillips		
TOTAL WTE - 4.30		

RDaSH leading the way with care

Rotherham Doncaster and South Humber NHS Foundation Trust

Pathway overviews

- Learning Disability
  - Specifically working with young people with a mental health problem and 'moderate to severe learning disability
- Single Point of Access
  - Receiving all referrals and triaging for urgency on the same day
  - Available as a point of contact for anyone to ring with any concerns
  - Working towards working jointly and some co-location with Early Help and MASH ('First Response')

RDaSH leading the way with care

Rotherham Doncaster and South Humber NHS Foundation Trust

Pathways cont.

- Crisis/ intensive community support
  - Urgent assessments
  - Short term additional support during crisis, supporting people into and out of hospital
  - Longer term interventions where there are high levels of risk
- Locality teams
  - Assessments and brief interventions (6-8 sessions)
  - Liaison with other services- GPs, schools, early help

RDaSH leading the way with care

Rotherham Doncaster and South Humber NHS Foundation Trust

Pathways cont.

- Psychological Therapies
  - Time limited specialist therapy alongside other workers and consultation to colleagues
  - Longer term work with young people/ families
- CSE
  - Works alongside other colleagues
  - Provides support, advice and consultation to different services
- Developmental Disorders (ASD and ADHD)
  - Diagnostic assessment for ASD and ADHD
  - Post diagnosis support for ADHD

RDaSH leading the way with care

Rotherham Doncaster and South Humber NHS Foundation Trust

Any questions?

RDaSH leading the way with care

Rotherham Metropolitan Borough Council

Public Report

Council Report

Health Select Commission – Thursday 2nd March 2017

Title

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

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

This is not a key decision

Strategic Director Approving Submission of the Report

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

Report Author(s)

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

Ward(s) Affected

All wards

Executive Summary

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

The Health Select Commission considered progress against the response to the Scrutiny Review at its meeting in October 2016 and requested that a further update against progress be given at its meeting in March 2017.

There has been significant progress made against the Scrutiny Review recommendations since the last progress update was given in October 2016. The refresh of the Emotional Wellbeing and Mental Health Needs Analysis is complete and a common performance framework that provides improved and standardised

data collection across the whole mental health system has been developed and is being tested with service providers.

The timescales for outstanding actions within the response template have been revisited due to the impact of delays in the CAMHS service reconfiguration and are now achievable and realistic. There is robust monitoring of these actions taking place through the CAMHS Contract Monitoring Group and CAMHS Partnership Group, to ensure that they are completed by the due dates.

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

Recommendations

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

List of Appendices Included

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

Background Papers

Scrutiny Review report and appendices.

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

Consideration by any other Council Committee, Scrutiny or Advisory Panel

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

Council Approval Required

No

Exempt from the Press and Public

No

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

1. Recommendations

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

2. Background

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

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

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

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

2.5 The Health Select Commission considered the progress made against the response to the scrutiny review at its meeting in April 2016 and October 2016 and requested that a further update against progress be given at its meeting in March 2017.

3. Key Issues

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

3.2 The Rotherham CAMHS Transformation Plan was developed in response to the Future in Mind report and encompasses all local Emotional Wellbeing & Mental Health transformational developments. The response

to the Scrutiny review was therefore aligned to the local CAMHS Transformation Plan and the response to the Scrutiny review is monitored through the CAMHS Partnership Group as part of the overall plan. The Rotherham CAMHS Transformation Plan has been refreshed and was published at the end of October 2016.

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

3.4 The RDASH CAMHS service reconfiguration was not fully completed until September 2016, due to a difficulty in recruiting appropriate staff to a number of posts. This had an impact on the delivery of a number of the actions within the response to the Scrutiny review and following agreement at the Health Select Commission meeting in October 2016, these outstanding actions have been revisited and are now achievable and realistic.

There is robust monitoring of these actions taking place through the CAMHS Contract Monitoring Group and CAMHS Partnership Group, to ensure that they are completed by the due dates.

4. Options considered and recommended proposal

4.1 The Scrutiny review formulated 12 recommendations and the progress made against those recommendations is outlined below:

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

The annual refresh of the Emotional Wellbeing and Mental Health Needs Analysis has been undertaken and the recommendations from the refresh are informing the RDASH CAMHS Service Specification for 2017/18 and the CAMHS Transformation Plan refresh.

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

The common performance framework across all mental health provision has been developed and is currently being tested with service providers, which will inform any enhancements to the framework.

This important development will, for the first time, enable a deeper understanding of the support and specific interventions that children and young people are accessing in schools, the community and within the CAMHS treatment service. This will drive the enhancement of service quality across the whole mental health system and help to ensure that children and young people are accessing the most appropriate advice, support and treatment.

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

The RDaSH CAMHS service continues to hold regular meetings within localities to provide support and advice to schools, Early Help, Social Care and other services, which has improved the quality of referrals into the service. In addition, RDASH CAMHS has provided a number of training sessions to services such as School Nurses, Early Help and SENCO leads, which has raised awareness of the service pathways and how to access CAMHS treatment.

There is an Emotional Wellbeing and Mental Health workforce competencies framework currently being developed. This will clearly identify the levels of training required for different staff groups. The Rotherham Framework will incorporate the NHS England Yorkshire and Humberside Schools Competency Framework and will be produced by September 2017.

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

The CAMHS whole school approach pilot is an exciting piece of work that is being undertaken by five secondary and one special school in Rotherham. Each of the pilot schools undertook a mini needs analysis to identify the key emotional wellbeing and mental health priorities for their particular school and they are now taking forward their priorities in this academic year based on a clear action plan.

The priorities being taken forward include developing peer mentoring mechanisms, 'RAG' rating the emotional wellbeing and mental health needs of pupils and providing appropriate support and staff support. There is termly monitoring of the school pilot schemes and a full evaluation will be undertaken in July 2017.

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

There is currently a review of all CAMHS pathways, which will be completed by April 2017. The pathways are being updated to take into account the RDaSH CAMHS service reconfiguration and the development of a Single Point of Access and the pathway diagrams are being re-designed to be in a more user-friendly format.

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

The implementation of the RDaSH CAMHS locality worker model has brought about much closer working between CAMHS and Early Help and has reduced the number of referrals being inappropriately signposted between the services. There are currently robust KPIs being developed for the CAMHS locality service, which will be in place by May 2017.

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

The Family Support Service, which is led by Rotherham Parent/Carer Forum, is providing support to families who have children and young people with mental health issues, with the aim of preventing children and young people moving into higher tiers of service.

The Family Support Service is being exceptionally well received, with 95% of families who access the service now feeling empowered to independently access services.

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

The waiting times for assessment and treatment continue to improve and are monitored on a weekly basis by commissioners of service. The length of time awaiting ASD and ADHD assessment has significantly reduced. At the beginning of February 2017 there were no people waiting for more than 10 weeks for initial assessment.

The service has consistently achieved 100% against a target of 100% of appropriate urgent referrals assessed within 24 hours (KPI 3). There are currently 31% triaged referrals assessed within the CCG stretch target of 3 weeks, which is a 4.3% increase from the previous months position of 26.7%. When reported against the national 6 weeks target, 60.3% were assessed within 6 weeks. The average waiting time is 49.6 days.

The current CCG stretch target will remain in 2017/18 however performance against the national 6 week target continues to be monitored and RDASH are undertaking work to benchmark Rotherham CAMHS against other areas in relation to the 6 week target.

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

The CAMHS SPA/Early Help Triage teams will be fully aligned by May 2017 and the evaluation of effectiveness will take place in September 2017. The CAMHS SPA team are currently spending two days per week within the Early Help Triage team and this has already resulted in a reduction in inappropriate referrals and signposting between the two services. This will be enhanced further through full alignment.

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

The ‘My Mind Matters’ website continues to be very well received by children and young people, parents/carers and practitioners. There has recently been a full refresh of the website with input from members of the Youth Cabinet and the changes are currently being uploaded.

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

RDaSH continues to work with the Youth Cabinet and has recently shared the transitions policy and a participation self-assessment audit with the Youth Cabinet for feedback.

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

There is currently national work being undertaken on developing a CAMHS payment system, which is at a small pilot and data gathering stage.

4.2 The full response to the Scrutiny review is attached at Appendix 1 and contains an action plan against the key recommendations and progress made as at March 2017.

5. Consultation

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

6. Timetable and Accountability for Implementing this Decision

6.1 It is anticipated that once the report has been noted and discussed by the Health Select Commission, the recommendations will continue to be taken forward within the timescales outlined and further progress updates will be made to the Health Select Commission.

7. Financial and Procurement Implications

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

8. Legal Implications

8.1 There are no identified legal implications.

9. Human Resources Implications

9.1 There are no identified human resource implications.

10. Implications for Children and Young People and Vulnerable Adults

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

11 Equalities and Human Rights Implications

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

12. Implications for Partners and Other Directorates

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

13. Risks and Mitigation

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

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

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

13.4 There has been a whole service reconfiguration of CAMHS, which has resulted in a number of the actions within the response to the scrutiny review being significantly delayed, due to there being changes to pathways, component CAMHS services, such as the CAMHS SPA, and locality working. The whole service reconfiguration is now complete and the actions are being acted upon as outlined in the attached Response Template to the Scrutiny Review. To mitigate these risks, the timescales within the Response template have been revisited.

14. Accountable Officer(s)

Linda Harper, Interim Assistant Director of Children and Young People's Services

Approvals Obtained from:-

Strategic Director of Finance and Corporate Services - not applicable

Director of Legal Services - not applicable

Head of Procurement - not applicable

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

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

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

Recommendation	**Response** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)*	**Officer Responsible**	**Action by** ***(Date)***	**Progress**
1. Once the national refresh of prevalence rates of mental disorder is published, RMBC and RCCG should review the local *Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People* and the mental health services commissioned and provided in Rotherham across Tiers 1-3.	The national refresh of prevalence rates of mental health will be considered when available.	Paul Theaker	TBC	The national prevalence rates have not been released as yet by the Government
	Undertake the annual refresh of the local *Analysis of Need: Emotional Wellbeing & Mental Health for Children & Young People.*		October 2016	The annual refresh of local need is currently being undertaken and the draft Needs Analysis will be produced by the end of October 2016. **March 2017** The annual refresh of local need has been completed and the revised Needs Analysis has been produced.
	Recommendations from the Needs Analysis refresh to inform the RDASH CAMHS Service Specification for 2016/17 and the CAMHS Transformation Plan refresh.		March 2016 March 2017	The annual refresh of need was, in part, delayed due to the need to be in-synch with the Local Transformation Plan refresh and the 2017/18 CAMHS commissioning round. **March 2017** The recommendations from the Needs Analysis refresh are informing the RDASH CAMHS Service Specification for 2017/18 and the CAMHS Transformation Plan refresh.
2. Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data collection and information sharing on their service users and patients: a) to help maintain a detailed local data profile of C&YP's mental health over time	Scope out performance information that is currently available across the mental health system.	Paul Theaker Nigel Parkes	December 2015	Performance information across the mental health system has been scoped out with assistance from the RMBC CYPS Performance Team and service providers.
	Work with stakeholders to develop a common performance framework. Standardised data collection will provide a detailed local data profile and provide more robust information for the Joint Strategic Needs Analysis..		March 2016	A draft common performance framework has been developed. However, this has not been implemented, as the development of a joint CAMHS/Early Help Single Point of Access (SPA) will change current pathways and information requirements – the changes and new performance information requirements are currently being developed. Regular updates are provided for the Joint Strategic Needs Analysis. This will be strengthened by more robust whole mental health system information.

b) to strengthen the C&YP's section of the Joint Strategic Needs Assessment				Revised date February 2017	*Additional information 27/10/2016* *The performance framework will be for the full mental health system, so not only RDaSH but also other services including counselling in schools and Early Help counselling, formerly Youthstart. It was also being adapted and refined to meet national reporting requirements* *For RDaSH CAMHS there was detailed information about young people who are in treatment. Good high level information but a need to unpick and get consistency in what was provided from partners.* **March 2017** Regular updates continue to be provided for the Joint Strategic Needs Analysis and information from the recent local Needs Analysis refresh is being incorporated. This will also be strengthened by more robust whole mental health system information from March 2017 onwards. A common performance framework has been developed for the full mental health system as described above. It has been adapted and refined to meet national reporting requirements.
	Implement a common performance framework.			December 2016 Revised date February 2017 March – July 2017	Working towards implementing a common performance framework by December 2016 *Additional information 27/10/2016* *It would be tested fully in the new year.* **March 2017** The common performance framework was finalised in February 2017 and standardised data is being gathered. It is currently being tested with mental health service providers, which will inform any further enhancements to the framework.
2 Continued Through the CAMHS Strategy & Partnership Group service commissioners and providers should work towards improved and standardised data	CAMHS patient outcome reporting is currently being incentivised through an NHS Commissioning, Quality and Innovation (CQUIN) measure. RDASH to continue to develop CAMHS outcomes reporting through the 2015/16 CQUIN.	Nigel Parkes Barbara Murray (RDASH)		March 2016	RDASH are meeting the CQUIN target of over 92% (currently 94%) of patients having recorded goals. The CQUIN has been developed further in 2016/17 and robust outcome reporting is in place and being captured. Work is currently being undertaken to interpret improvement in outcomes and a format for presenting the outcome information.

collection and information sharing on their service users and patients: c) to inform the development of local outcome measures for C&YP individually and with regard to reducing health inequalities in Rotherham.				**March 2017** RDASH are meeting the CQUIN target of 95% of patients having recorded goals (consistently performing over 95%). See Appendix 4 for more detail.
3. RDaSH training and awareness raising with partner agencies and schools should include a focus on improving the quality of information provided in referrals to RDaSH CAMHS Duty Team to reduce delays in making an assessment.	RDASH, through their Duty Team, are providing feedback to referrers on the quality of information provided and there is a focus on reducing inappropriate referrals.	Ruth Fletcher-Brown Barbara Murray (RDASH)	Ongoing	RDASH are continuing to provide feedback to referrers. The RDASH referral information and letters to patients and referrers has been revamped to provide more detailed information. *Additional information 27/10/2016* *CAMHS pathways have changed since the development of the SPA, enabling smoother access. RDaSH workers were alongside Early Help triage.* *Schools/other workers can refer young people to the SPA, where they have a more holistic assessment of their needs. Locality Workers see children at an earlier stage and children are going in to RDaSH CAMHS who meet their criteria, with others getting earlier support through Early Help, as before children might have waited for a few weeks but then not met RDaSH criteria once assessed.*
	RDASH to undertake awareness raising sessions with referring agencies.		March 2016	RDASH continue to provide awareness raising sessions. In early October 2016, information packs were distributed to schools, detailing referral information and the support that they would receive from their respective locality workers. These information packs will be rolled-out to other partners within Rotherham. *Additional information 27/10/2016* • *Meetings with schools to consider how they could work together better* • *Refreshing the "top tips" documents – criteria and where to refer* • *Information packs distributed to all secondary and primary schools* • *Working with South Yorkshire Eating Disorder*

				Association, asking what training people want rather than assuming what they want. **March 2017** The CAMHS Top Tips (see Appendix 2) have been reviewed and changed as necessary. There have been regular meetings held within localities with schools, early help etc. and invitations for GPs to have meetings with locality staff. There have been a number of training sessions run by RDaSH CAMHS, including to school nurses, Early Help, SENCO meetings to present the current service and pathways, how to access etc. There have also been individual consultation sessions arranged within localities.
	Develop a CAMHS workforce development strategy that identifies and acts upon training needs for the wider workforce in Rotherham.		March 2016 Revised date September 2017	A draft workforce development plan has been developed and presented to the CAMHS Partnership Group. Work is currently being undertaken to develop a framework of training providers that will deliver the graduated training requirements as outlined within the workforce development plan. *Additional information 27/10/2016* *Although the draft plan had been produced to the timescale it had not yet been signed off. It considered training needs at each level across the wider workforce e.g. from a playground supervisor needing basic awareness through to a mental health practitioner, looking at where services' plans sit in the framework and then directing people to the training packages.* **March 2017** A framework for workforce development was shared with the CAMHS Partnership Group. At the same time NHS England, North (Yorkshire & the Humber) started leading on a Schools Competency Framework for mental health and emotional wellbeing. It is envisaged that the competency framework will have three tiers of skills; a core/universal level followed by a more intermediate level and a third level enhanced level. These levels would apply to staff in early years settings, schools and colleges. The timescale is to produce a framework for launching

				with schools by the beginning of the Autumn term. Staff from Rotherham are inputting into this framework. The Rotherham framework will incorporate this Y&H framework extending it to cover the wider CAMHS workforce.
4. In its leadership role with schools, RMBC should ensure schools link in with partner agencies to discharge their wider duties and responsibilities towards C&YP's emotional wellbeing and mental health.	Implement a pilot for a whole school/college approach in Rotherham. This will specifically include developing and implementing a clear Emotional Wellbeing and Mental Health Plan tailored to each individual school.	Paul Theaker Ruth Fletcher-Brown	March 2016 September 2016 – July 2017	Five secondary schools and one special school have signed up to the pilot project and have developed their own individual plans. The pilot schools started acting on the priorities that they have identified at the beginning of the 2016/17 academic year. *Additional information 27/10/2016* *Each pilot school undertook a mini needs analysis which led to them identifying their 2 or 3 priorities for this academic year, for example peer mentoring with young people or staff wellbeing. Each school has identified a mental health champion (usually SEN or Safeguarding lead) who leads on rolling the work out. Not all schools have training as one of their priority actions, but this links back to the action above on workforce development and who could provide training at the different levels.* *Schools and academies cannot be directed regarding what training they undertake but could be made aware of what was available through the workforce plan.* *There is a school counselling service which could be provided by Rotherham and Barnsley MIND, MAST or by people directly employed by schools.* *The role of CAMHS Locality Workers is to provide support, not just for schools but also for GPs, Early Help teams etc. so that is about supporting schools about techniques and enabling smoother referrals into CAMHS*. **March 2017** All six schools are progressing with their actions (for their priorities see HSC briefing paper January 2017). The strategy group last met in December 2016. One to

				one meetings are being planned with all six schools for February/March. Elected Members who have volunteered to attend are being invited to these one to one meetings. The lead for the project in each school is either the SENCO, Safeguarding Lead and or Assistant Head. Whilst this was not a requisite of the whole school project in relation to Youth Mental Health First Aid (MHFA) Training: Wingfield Academy- lead is Youth Mental Health First Aid trained Maltby Academy- lead is a qualified counsellor and several other members of staff have attended the Youth MHFA Wales High School - The leads are not Youth MHFA trained but other staff members are. The leads however have been on other mental health training Rawmarsh Community School- lead has attended Youth MHFA training Oakwood High School- lead has not attended this training but other staff members have Newman School- has not attended Youth MHFA but has attended other mental health courses run by Rotherham Multi Agency Support Team
	Evaluate the effectiveness of the whole school/college approach and roll-out.		July 2017 and September 2017	There is termly monitoring in place, with the next monitoring visits in December 2016. There will be a full evaluation in July 2017. **March 2017** There is termly monitoring in place, with the next monitoring visits taking place in February and March 2017. There will be a full evaluation in July 2017 and it is intended that the pilot schools will encourage other schools to adopt the approach through a "teach meet" approach from September 2017.
5. CAMHS Strategy & Partnership Group is asked to consider if there is a need to develop a protocol for transition/step up/step down between providers in Tier 3 and providers in Tier 2 to supplement the	Review the CAMHS pathways that were developed in March 2015.	Paul Theaker Ruth- Fletcher Brown	January 2016	The review of current CAMHS pathways was paused due to the RDASH service reconfiguration, as the development of new pathways within CAMHS, a Single Point of Access (SPA), CAMHS locality working and clarification of CAMHS thresholds has changed the current pathways.

planned pathways and protocols.			Revised date June 2017	**March 2017** The review of all pathways is taking place, based on a workshop held with key stakeholders. The refreshed pathways will be published in June 2017.
	If necessary, develop a protocol for transition/step up/step down between providers in Tiers 2 and 3.		February 2016	*Additional information 27/10/2016* *The RDASH CAMHS Service reconfiguration was completed at the end of June, 2016 with a new single point of access and locality workers in place.* **March 2017** There has been positive feedback from partners on the changes made and this development has alleviated the need for a specific step-up/step-down protocol.
6. Following the work to build links between RDaSH CAMHS and GPs locality work should now be rolled out by RDaSH into schools, youth centres and other community settings as a priority.	RDaSH to implement the Locality Worker model and create working links with all GP localities, schools/colleges and key services in each area. This to include both telephone and face to face links and delivery of community services as appropriate.	RMBC RCCG RDASH	December 2015	The locality worker model has been implemented and there are named locality workers for each Early Help, Social Care and GP locality, as well as schools and colleges within those localities. The number of locality workers has recently been increased to reflect need. *Additional information 27/10/2016* *For RDASH locality workers, closer working with the local authority means it will be easier to know if other workers are already involved with a family, with the Locality Workers then supporting those other workers, so services are more streamlined.* March 2017 The closer working between CAMHS and Early Help services has reduced the number of referrals being inappropriately signposted between the services.
	KPIs developed to ensure that locality working is fully operational by the due date.		November 2015 Revised date May 2017	March 2017 Robust KPIs for locality working are being developed and will be further informed by the evaluation of the Locality Worker Model in May 2017.
	Evaluate the 'Locality Worker Model'.		June 2016 Revised date May 2017	The Locality Worker Model is being monitored through RDASH contract monitoring meetings and progress will be further evaluated through consultation with locality based services

7. *"Investigate the options to provide more robust services at an early stage, both in lower tiers and at an early age, to ensure that patients are prevented from moving into higher (and more expensive) tiers." (Action 4.5 in EWS)* Prevention and early intervention is a clear commitment in plans at strategic level so the CAMHS Strategy & Partnership Group should clarify how this will be delivered through clear resources and outcome focused actions that are closely monitored.	Develop a Family Support Service to specifically support families who have children and young people with mental health issues, so as to prevent patients moving into higher tiers.	Paul Theaker Nigel Parkes Ruth Fletcher-brown	March 2016	The Family Support Service, which is led by the Rotherham Parent/Carer Forum became operational in February 2016 and there continues to be a high take up of service. There are examples of cases where the service has prevented patients moving into higher tiers. *Additional information 27/10/2016* *By quarter 2 38 families had been supported and 50+ children, mainly aged 5-11, and a significant number with issues around ASD. Support was not just around CAMHS but also with Education, Health and Care plans and school and home as well. The CCG was proposing to increase funding for 2017-18 by £15k. Contact was available via phone, email, facebook or face-to-face.* **March 2017** There are 95% of families who access the service who now feel empowered to independently access services. By quarter 3, 57 families had been supported and 50+ children, mainly aged 5-11, and a significant number with issues around ASD. The CCG will increase funding for 2017-18 by £15k.
	Evaluate the new Family Support Service and refine as required.		March 2017	To be evaluated by the due date. **March 2017** The evaluation of the Family Support Service is underway and will be complete by the due date.
	Undertake various Community Approach work streams, including ;- • Community led approach to building resilience with parents and carers. • Peer support for parents and carers. • Community led approaches to building resilience with young people. • Peer support for young people • Enhance links to Early Help provision in localities. • Develop further self-help		April 2016	The Whole School Approach pilots have built in community led approaches to building resilience with young people and parents/carers. These pilot schools have also included peer support as part of their approach. The RDASH locality workers are continuing to develop links with Early Help provision in the localities and links are also being strengthened at strategic level. Self-help approaches are included on the My Mind Matters website. The Youth Cabinet Mental Health Conference on 21 March 2015 included workshops on self-help and the outcomes from the conference are being taken forward.

	approaches • Undertake Suicide prevention and self-harm work			Rotherham self-harm prevention guidance was distributed widely in January and February 2016. There has been advanced and wider workforce suicide prevention training and it is now an element of Mental Health First Aid Training and the training undertaken by MAST. See Appendix 3 for the Suicide Prevention Action Plan
8. The target waiting time from referral for routine assessments by RDaSH CAMHS should remain at three weeks for 2015-16 and then be reviewed in the light of the impact of the recent positive changes introduced by the service.	The waiting time for routine assessments has improved significantly in the first and second quarters of 2015/16.	Paul Theaker Nigel Parkes	February 2016	There have been significant improvements in the waiting time for routine assessments in the second quarter of 2016/17. As part of remedial action, there are currently bi-weekly meetings with the Assistant Director of RDASH until recovery of performance is achieved.
	The waiting time target will be reviewed as part of the development of the 2016/17 RDASH Service Specification.			*Additional information 27/10/2016* *In the past there was a problem with long waits for assessment but that has improved. In May 2016 240 children were on the waiting list for an assessment appointment but that was now down to 50. The most that children were waiting now for an appointment date was four weeks and the average was 8 weeks to be seen for assessment, against the 3 week target, although this is expected to reduce significantly now staff are in place. The three week target is a challenging one. Regarding C&YP starting treatment, target is 8 weeks but the national target is 18 weeks.* *Once a referral was made RDaSH were gathering information in advance of the appointment e.g. from schools. A lot of people Do Not Attend (DNA) for their first appointment because people have not filled in the form. There were problems on information sharing between partners to be sorted out. Because of the long waiting lists RDaSH had two teams, one working on the three week waiting list and the other bigger team bringing down the waiting list.* **March 2017** The waiting times for assessment and treatment continue to improve and are monitored on a weekly basis by commissioners of service. The length of time awaiting ASD and ADHD assessment has significantly reduced. At the beginning of February 2017 there were no people waiting for more than 10 weeks for initial assessment.

				Current waiting time position: KPI 3 - The service has consistently achieved 100% against a target of 100% of appropriate urgent referrals assessed within 24 hours KPI 5 – 31% of triaged referrals were assessed within the CCG stretch target of 3 weeks in January 2017. This is a 4.3% increase from the previous month's position of 26.7%. When reported against the national 6 weeks target, 60.3% were assessed within 6 weeks in January 2017. The average waiting time is 49.6 days. The current CCG stretch target will remain in 207/18 however there is an acknowledgement of performance against the national 6 week target.
9. RDaSH should review and evaluate the recent changes made to the CAMHS Duty Team to identify successes and any areas for further improvement by September 2015.	Develop the RDaSH CAMHS Duty Team into a true Single Point of Access (SPA) which will also provide advice on, and signposting to, other services which RDaSH don't provide such as those provided by RMBC and other organisations.	Christina Harrison (RDASH)	December 2015 Revised date May 2017	The development of a SPA was delayed due to RDASH service reconfiguration work. The SPA model has been developed and the CAMHS SPA team will be aligned to the RMBC Early Help Triage team. The CAMHS SPA Team will move to Riverside House in early November 2016 to work alongside Early Help Triage. **March 2017** The CAMHS SPA Team are currently spending two days a week within the Early Help Team at Riverside House and full integration will take place by May 2017
	Ensure that the SPA makes it easier for Children, Young People and parents to navigate and access services, including the option of self-referral into the SPA.	Christina Harrison (RDASH)	March 2016 Revised date May 2017	These requirements have been built into the SPA model of service – see above. *Additional information 27/10/2016* *The aim is for one phone number for Rotherham for all to use into Early Help and from there it would be decided who is the best person to meet needs.* *Top tips documents for GPs and for universal service (Appendix 2), plus a directory of services, set out the criteria and where to refer e.g. low level anxiety to school nurse.* *Self referral by young people is still in place but marketing is an area to work on, tied in with access*

				through the Early Help hub once fully co-located.
	Evaluate the effectiveness of the SPA.	Christina Harrison (RDASH)	December 2016 Revised Date September 2017	Due to the CAMHS SPA/Early Help Triage teams not being fully aligned until November 2016, the evaluation of effectiveness will not take place until March 2017. **March 2017** Due to the CAMHS SPA/Early Help Triage teams not being fully aligned until May 2017, the evaluation of effectiveness will not take place until September 2017.
10. CAMHS Strategy & Partnership Group should ensure the new mental health and wellbeing website meets accessibility standards and incorporates a user feedback mechanism and measurement of the number of "web hits" received.	A user feedback mechanism and measurement of the number of "web hits" has been incorporated into the website.	Ruth Fletcher Brown	December 2015 and 6 monthly	A user feedback mechanism and measurement of the number of "web hits" has been incorporated into the website.
	Continue to develop and update the website as appropriate, liaising with all partners/stakeholders. Emphasis of the December update will be on the self-help elements of the website.			The My Mind Matters website is continually being updated, with themes included at key times of the year e.g. how to cope with exam stress. The website is currently being fully refreshed, which includes input from members of the Youth Cabinet as to how the website can be enhanced. The website continues to be widely promoted at staff team meetings and to young people through schools and at the various events, such as the Rotherham Show. *Additional information 27/10/2016* *My Mind Matters web hits – over the last 6 months average of 341 hits per month, 57 of whom were new users, so some repeat visitors. 57% hits from YP, 25% from carers and 18% from practitioners.* **March 2017** The website has been fully refreshed and the changes will be uploaded by March 2017.
11. RDaSH should continue to work in partnership with Rotherham Youth Cabinet on service improvements and are asked to submit a progress report on the changes as a result of this work to the Health Select	RDASH has continued to work in partnership with the Youth Cabinet. Progress report deferred until the reconfiguration and recruitment to the new service happens in November and December 2015.	Christina Harrison	January 2016	RDASH has continued to work with the Youth Cabinet. As part of CAMHS Transformation, Rotherham CCG commissioned an independent review of voice and influence within RDASH and the recommendations from findings are currently being implemented by the service. In September 2016, RDASH met with the Youth Cabinet

Commission in September 2015.				to give feedback on the development of a Mental Health Transitions Policy. The Overview and Scrutiny Management Board worked with the Youth Cabinet on the children's commissioner takeover challenge. **March 2017** Transition policy and participation information and self-assessment have been shared with the Youth Council. The services are keen to continue to work with the Youth Council around aspects of service development
12. RDaSH and RCCG should continue to work together in 2015 on developing a clearer breakdown of costs and on the definitions of treatment to inform future outcome measures.	Treatment definitions have been agreed and the referral to treatment target is now measured against young people actually starting treatment rather than the second appointment.	Nigel Parkes Christina Harrison	November 2015	Completed - see column 2
	Rotherham CCG to co-ordinate further work to understand child and adolescent mental health funding flows.		March 2017	The RDASH reconfiguration has given a clearer understanding of costs and definitions of treatment. This work is continuing. *Additional information 27/10/2016* *National work will affect how services are paid for by commissioners. At present it was a block contract, but for a few years now work has been done looking at a cluster model, based on level of need, for example "getting help for ADHD" or "getting more help for eating disorders". This would be a way of monitoring activity and understanding where patients were going.* *Some of the work with the new pathways will be to see what each pathway is costing.* **March 2017** National work on the CAMHS payments system is on-going, but this remains at a small pilot and data gathering stage; there is no timescale for development further.

Appendix 2 Guidance for Universal Workers and targeted workers on Referral of Children & Young People with Emotional Wellbeing Issues

Referrals to **Universal Services** and **Routine CAMHS** and **Urgent CAMHS** referrals.

Issue	Symptoms/presenting problems	Refer to:-
Behavioural Difficulties	• Poor behaviour at Home only	**Evidence Based Parenting Programme. For under 5s please contact Health Visiting Team in the first instance**
	• Poor behaviour at School only	**School (Learning mentor, SENCO) Early Help Service**
	• Severe behaviour in both home & School Note – The CDC will accept referrals for behaviour difficulties where they are associated with additional development concerns, e.g. social communication differences, speech and language delay, gross or fine motor problems.	**Discuss with Health Visitor first. Child Development Centre (CDC) for under 5 years, CAMHS (Routine) for over 5 years.**
Eating Disorders	• Eating Issues (Low Level) – Will only eat certain foods	**Health Visitor if under 5 or GP if over 5**
	**Note: A young person may be at normal weight, but still have an eating disorder. • Anorexia: evidence of self-induced weight loss and/or fear of fatness • Rapid and sustained weight loss • Bulimia: Persistent binge & purge behaviour • Binge eating disorder is when someone may feel like they have to eat more than they normally would do all in one go. Emotionally the person may feel sad, not be able to concentrate at work or school and feel hopeless and lonely	**Ring RDaSH Community Eating Disorder Service (CEDS) on 01709 304808 GP (for physical assessment) South Yorkshire Eating Disorders Association. (SYEDA) deliver education and awareness raising sessions for young people, their parents and professionals. Ring SYEDA on 0114 2728822**
Anxiety Disorders	• Worrying about specific situations	**School Nurse, School (learning mentor etc.), Early Help, MIND, MAST**
	• Severe, persistent anxiety. • Panic attacks. • Attachment disorders • Severe and disabling phobia where it is impacting on a young person day to day life and ability to functions (Social and specific phobias).	**CAMHS (Routine)**
Mood Disorder or Depression (Refer if symptoms present for at least 2 weeks)	• Low mood, not impacting on daily life and no risk evident (no suicidal thoughts or self harm)	**School (learning mentor pastoral support), Early Help, MIND, School Nurse, MAST**
	• Persistent low mood. • Physical symptoms – poor sleep (or early wakening) or loss of appetite and weight • Cognitive symptoms inc. pervasive negative thoughts • Loss of interest/Social isolation/withdrawal seen at home and school. • Suicidal thoughts without planned intent (discuss urgency of referral with team)	**CAMHS (Routine)**
	• Suicidal thoughts with planned intent **REFER URGENTLY**. • Suicidal thoughts without planned intent (discuss urgency of referral with team) • Previous attempts to end life	**CAMHS (Urgent)**
Post Traumatic Stress Disorder – Symptoms Following an	• Avoidance of reminders of the traumatic event. • Persistent anxiety. • Repeated enactment of reminders of the traumatic event. • Intrusive thoughts and memories – e.g. nightmares.	**CAMHS (Routine)**

event very traumatic to the individual	• Sleep disturbance. • Hypervigilance. • Symptoms continuing longer than three months following event.	
Self-Harm	Always discuss case with duty team to help guide urgency • Presenting with maladaptive coping strategies but less severe/frequent/recent.	**CAMHS (Routine), Early Help, MIND and MAST**
	• Presenting with maladaptive coping strategies (e.g. self-cutting and **where recent occurrence**).	**CAMHS (Urgent)**
Obsessive Compulsive Disorder (OCD)	• Repetitive, intrusive thoughts, images or behaviour affecting daily life & activity. • Obsessions/compulsions causing functional impairment.	**CAMHS (Routine)**
Relationship Difficulties	• General relationship difficulties	**Early Help, School (Learning Mentors, pastoral support), School Nurse, Family Recovery Programme, Grow (15-19 years), MIND, MAST**
	• Persistent patterns of abnormal functioning in interpersonal relationships. • Where family dynamics are fractured and conflicts unresolved.	**CAMHS, Intense Family Support**
Suspected Autism Spectrum Disorder/ Condition (ASD/ASC)	• Persistent and severe problems with communication & social & emotional understanding in 2 or more settings – e.g. Home, School. Consider whether referral would be better made by school and/or Educational Psychologist.	**Child Development Centre (CDC) for under 5 years, CAMHS (Routine) for over 5 years.**
Suspected Attention Deficit Hyperactivity Disorder (ADHD)	For Children aged 6 years & above only. Initially refer to parent training. Refer if symptoms persist after parenting work. • Poor concentration • Over-activity • Distractibility • Impulsivity All the above onset before 12 years old and persistent and evident in at least 2 settings, e.g. home, school.	**CAMHS (Routine)**
Psychosis or suspected psychosis	Criteria for Routine / Urgent referrals – Always discuss with duty team to assist decision making re urgency. If child over 16 refer to early intervention in psychosis team • Active symptoms inc.; Paranoia, delusional beliefs & abnormal perceptions, (hearing voices & other hallucinations). Fixed, unusual ideas. • Negative symptoms inc.; deterioration in self-care & social & family functioning.	**CAMHS (Routine)** **CAMHS (Urgent)**
Conduct Disorder	• Very severe and persistent behavioural problems, at home, school and in the community, and unresponsive to parent training. • If school related – preferable for school/ Educational Psychologist to make referral with relevant background information.	**CAMHS (Routine)**
Gender Identity Disorder	• Initial exploration of issues	**LGBT Youth Worker, LGBT Youth Group & Early Help,**
	• Strong, persistent cross-gender identification. • Persistent discomfort in gender role. • Above causing impairment in social, family and school functioning.	**CAMHS (Routine)**
Chronic Fatigue/Somatisation Disorder (When physical symptoms are caused by mental or emotional factors it is called	Criteria for Routine referrals – refer to GP in first instance. • Excessive fatigue. • Unexplained medical symptoms.	**CAMHS (Routine)**

somatisation)		

A Directory of Services – '**Emotional Wellbeing Services for Children & Young People Living in Rotherham**' has been produced which gives further information on the **Universal Services** referred to above.

Process to be followed for CAMHS referral:-

1. In order to effectively triage a referral, please provide the contact telephone number for the child/young person and parent/carer
2. **Referrals** will be **acknowledged within 5 working days**, with the aim to have an **initial appointment within 15 working days** of receipt of referral. **Urgent referrals are seen within 24 hours**. If available, a copy of the Common Assessment Framework (CAF) should also be provided and parent/carer/child/young person permission demonstrated.
3. Following **Initial Assessment** – Needs are identified & where appropriate a management plan communicated to the referrer.

Where appropriate, referrals may be **signposted to other services** but only where child/young person and parent/carer contact details and consent is provided with the referral.

CAMHS Referrals should be sent with the child/young persons and/or family's consent and using the agreed **referral form** to:- **The Duty Team, Child & Adolescent Mental Health Service, Kimberworth Place, Kimberworth Road, Rotherham, S61 1HE**. Tel. 01709 304808. Fax. 01709 302547.

DO NOT REFER	**Do not refer** if not included in the above list. **If in doubt please discuss with the CAMHS Duty Team**

Date Approved: January 2017	**Review Date: January 2018**

Appendix 3

SUICIDE PREVENTION AND SELF-HARM ACTION PLAN 2016/18

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS

Suicide is not inevitable. It is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity.

In 2012 the Government produced “Preventing suicide in England A cross-government outcomes strategy to save lives”:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

The strategy outlined six areas for action:

1. Reduce the risk of suicide in key high risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

This action plan outlines the actions agencies across Rotherham are taking to prevent suicides.

Rotherham takes suicide prevention seriously and the Director of Public Health Chairs the Suicide Prevention Group who are tasked to implement this plan. The Health and Wellbeing Board will receive a minimum of annual updates against the plan.

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
1. Increase local level of understanding suicide and establish reporting mechanisms to strategic partners: - **Health & Well-Being Board** - **Elected members** - **Clinical Commissioning Group** - **Safe Guarding Adults Board** - **Safeguarding Children Board** - **Rotherham Health Protection Committee**	Rotherham Suicide Prevention and Self Harm Group chaired by Consultant in Public Health to meet bi monthly Local Suicide Prevention and Self Harm Group reports to the Rotherham Health Protection Committee. Annual reporting to the Health and Well Being Board. Annually review membership of the Rotherham Suicide Prevention and Self Harm Group, ensuring voluntary sector membership.	Public Health Specialist (Mental Health) Chair of Rotherham Suicide Prevention and Self Harm Group	Terms of Reference reviewed annually Update reports produced Membership reviewed annually	Terms of reference agreed including reporting mechanisms agreed and reviewed annually. Rotherham Suicide Prevention and Self Harm Group's membership reflects the partnership approach to suicide prevention.	Terms of reference to be signed off at February2017 mtg
	Annual update on the epidemiology of suicides and actions taken against suicide prevention is provided to the Rotherham Health and Well Being Board.	Rotherham Suicide Audit Group	June 2017 & June 2018	Partner activity of suicide prevention reflects local need	Not due

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
2. Reduce risk in high risk groups (non-specific)	Suicide Audit Group to alert frontline workers to emerging risk factors, for example in briefing articles for GPs.	Suicide Audit Group and Public Health Specialist Partners of the SP & SH Group to ensure risk factors are disseminated and cascaded within their respective organisations	Suicide Audit Group meets bimonthly and reports trends to SP & SH Group.	Frontline workers are alerted to risk factors, identifying people who may be at risk and providing appropriate support	Information included in GP Top Tips for suicide prevention Other briefing opportunities to be explored
2. Reduce risk in high risk groups (non-specific)	Update the GP Top Tips on suicide prevention	RCCG CAMHS Commissioner Public Health Specialist	November 2016	GPs make appropriate referrals	Updated and agreed and will be included in Top Tips bite size update (Feb 2017)
2. Reduce risk in high risk groups (non-specific)	Explore options to promote Samaritans Drop -in sessions	Rotherham Samarians working with Public Health Specialist and Comms Leads in Statutory partner organisations	From September 2016	Drop-in sessions promoted via partner communications	
2. Reduce risk in high risk groups- Children and young people	Rotherham Suicide and Self-harm Community Response Plan(2015) for children and young people to be revised to include the following : • Circles of vulnerability • Out of hours support and information • Management of severe self-harm behaviour • Critical response plan for schools.	Public Health Specialist (Mental Health)	Plan to be revised by Jan 2017 Partner organisations to be notified of the revised plan.	Revised Rotherham Suicide and Self-Harm Community Response Plan to be loaded on the Rotherham Local Safeguarding Children Board Manual Contents (Tri-x procedures)	Plan is being revised (due now April 2017) and responsibility for activating the plan and coordinating the meetings will move to Early Help All schools have been sent the Critical Incident Prompt Sheet

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	• Emerging national guidance				
	Rotherham Suicide and Self-harm Community Response Plan to be actioned within 24-48 hours of any event	Led by LSCB/Public Health Supported by all agencies involved in Rapid Appraisal Process	In the event of a suspected death by suicide of a young person or an adult within the school community	Rapid Response process will ensure this happens. Rotherham is continuing the Real Time suicide Surveillance work. Rotherham Suicide Audit Group reviews all suicides.	See earlier comment
	Ensure every school and college is aware of the Critical Incident prompt sheet	Educational Psychology Public Health Specialist (Mental Health)	October 2106	Schools and colleges using the recommended best practice	All schools have a copy of this prompt sheet and evidence that schools have been using it
2. Reduce risk in high risk groups- Children and young people	To review the My Mind Matters website. To continue to promote the My Mind Matters website	CAMHS Commissioners RMBC and RCCG to lead	Review of website to be completed by December 2016		Website is being reviewed and will be complete March 2017
	Support schools and colleges in identifying mental health problems in pupils through collaborative working between education and health professionals: - Promotion of the CAMHS Top Tips –	Public Health Specialist (Mental Health) working with CAMHS commissioners from Rotherham CCG, RMBC and CAMHS providers.	Top Tips and Directory of Services to be reviewed December 2017	Schools and colleges using CAMHS Top Tips and Directory of Services.	Top Tips for Universal workers has been updated. Next update due in Jan 2018 GP Top Tips has also been reviewed.

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Guidance on the referral of children and young people with emotional wellbeing issues into universal, targeted and RDaSH CAMHS services - Directory of Services – Information on services that provide emotional wellbeing support.				
	Review of the Rotherham Self-Harm Practice Guidance (2015)	Public Health Specialist (Mental Health)	Annual Review due by April 2017	Safe, timely and effective response to children and young people who harm themselves or are at risk of harming themselves.	Not yet due
2. Reduce risk in high risk groups- Children and young people	Development of a local awareness campaign to target young people (15-21) Campaigns to look at non health organisations and sites which could promote these messages Campaigns will include social media marketing techniques relevant to young people	RMBC Comms working with Public Health Specialist, Rotherham Suicide Prevention and Self Harm Group (SP &SH Group), Rotherham Youth Cabinet	Schedule plan to be shared by Comms at the August 2016 SP & SH meeting. Consultation with young people to begin in September 2016. Drafts of the materials to be ready by December 2016 Launch of the campaign January 2017		Progress has started with consultation events with young people's groups on the message of the campaign and design work. There has been a delay now until the new financial year

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
2. Reduce risk in high risk groups: Men in particular middle aged men	Promotion of local awareness campaign targeting males particularly middle aged men Campaigns will include social media marketing techniques. Sources will include Public Health Channel, Qmatic Screens, social networking, PH website and non-health sites to promote messages. Campaigns to look at non health organisations and sites which could promote these messages throughout the year.	RMBC Comms working with Public Health Specialist and Rotherham Suicide Prevention and Self Harm Group (SP&SH Group),	Campaign launched July 2016 12 month marketing plan to be brought to the SP & SH Group meeting in August 2016 which will show how campaign will promoted throughout the year. Further promotion organised for September 2016 (World Suicide Prevention Day)	Campaign materials displayed through key venues in Rotherham. Partners all aware of the campaign Men and families and friends able to recall seeing campaign materials Increase in number of people accessing help.	Campaign was launched July 2016 and has been promoted a various opportunities since: Home Matters magazine Dec 2016 Adverts in local papers Dec 2016
2. Reduce risk in high risk groups : People experiencing domestic abuse	Continue to promote awareness of this group amongst GPs – Annual update of GP Guidance / Referral pathway for people experiencing domestic abuse. Ongoing promotion of this resource and	RCCG Safeguarding Lead	Ongoing promotion of the flowchart and annual review July 2017	GPs better equipped to identify and support patients experiencing domestic abuse.	

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	annual review				
2. Reduce risk in high risk groups: women	Rotherham Suicide Audit Group to identify trends of increased suicide in women and report findings to SP & SH Group. SP & SH Group to agree on actions to address this	Rotherham Suicide Audit Group SP & SH Group	Report to SP & SH Group in October/November 2016 Action to address suicides in women agreed October/November 2016		Suicide Audit Group monitoring trends reflected in presentation to GPs at PLT event September 2016
2. Reduce risk in high risk groups: Rotherham residents affected by the changes to welfare reform	Continue roll out of training for frontline customer services using the CARE about suicide resource	PH Specialist (Mental Health), HR (RMBC working with Team Managers within RMBC to deliver training sessions for frontline customer service staff within RMBC	200 Plus staff trained to date. Ongoing training provided.	Staff feeling better equipped to support people who may be in distress and/or expressing thoughts of suicide	RMBC Revs & benefits staff attended training along with Housing Officers
2. Reduce risk in high risk groups: witnesses of suicide	Publication of leaflet for people witnessing suicide. Vulnerable Persons Unit (VPU) to distribute	RMBC Comms, Public Health Specialist working with SP & SH Group. VPU	Leaflet produced January 2017 Leaflet launched and used by frontline services inc VPU from	People who witness suicides receiving timely and supportive information.	A4 paper version distributed by SYP Officers.

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	leaflet to witnesses.		October January 2017		
2. Reduce risk in high risk groups: Carers	Training for carers going into the home about the risk that carers experience	RCCG Commissioning Lead for Mental Health Public Health Specialist Crossroads	To be discussed at the Dementia Carers Resilience steering group. September 2016	Workers supporting carers able to spot the signs someone may be vulnerable to suicide.	Discussed at Dementia Carers Resilience steering group. Training due to be delivered by April 2017
3. Tailor approaches to improve mental health in specific groups	Promotion of whole school pilot programme	Public Health Specialist RMBC CAMHS Commissioner 6 Rotherham schools	Action plans developed. Work commencing September 2016- July 2017 Learning shared within School Learning community from September 2017 onwards	Wholes embedding mental health and emotional well-being within school community	Schools began implementing their action plans in September 2016.
	Training to schools on staff wellbeing and resilience / improving own coping mechanisms.	Educational Psychology (RMBC)	?	Children, young people and adults with improved emotional resilience.	
	Promotion of the Workplace well-being scheme to local employers	Public Health (RMBC)	No. of companies signed up to the scheme	Workplaces which support the mental health and emotional well-being of employees.	
4. Reduce access to means	Suicide Audit Group bimonthly meetings to identify any hotspots using reports from the police and mental health	Attendees include: PH, RCCG, SYP & RDaSH. Meetings chaired by PH PH Specialist to work with	Hotspot work initiated as and when areas are identified. Actions recorded and reported to the wider Suicide	Action taken at hotspots which could include: -installation of	RFB and NK (SYP-VPU) met with SYPTE in January 2017. Actions from this meeting being

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	services. Minutes and actions are recorded. Actions are initiated. Actions incorporated in Suicide Prevention and Self-Harm Action Plan	other agencies as and when required (Local Coroner's Office, Highways Agency, Samaritans, colleagues within RMBC, local media)	Prevention and Self-Harm Group.	physical barriers and or moving ligature points -encouraging help seeking behaviours -increasing the likelihood of a third party intervention through surveillance and staff training -responsible media reporting	implemented which includes training for staff and distribution of CARE about suicide cards to staff.
	Local partners to share actions and learning to reduce suicide particularly after a serious incident (SI) with Suicide Audit Group and the Rotherham Suicide Prevention and Self-Harm Group.	Provider Services for example: RDaSH, SYP TRFT	SIs discussed at each Suicide Audit meeting	Suicide prevention practice is shared across organisations	
4. Reduce access to means	Training frontline staff to identify access to means, e.g. carers going into the home, Housing staff	Public Health Specialist SP & SH Group members Crossroads RMBC Housing	Housing staff given suicide prevention training 2015/16. Training to rolled out to carers organisations from October 2016	Staff vigilant to access to means and appropriate action taken	Shared at suicide prevention training
4. Reduce access to means	Investigate potential work with Trading Standards re sales of	Public Health Specialist Trading Standards	December 2016	Retailers adhering to legal requirement of Paracetamol sales.	

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Paracetamol				
4. Reduce access to means	Reminders to general public re safe storage of medication incl prescribed and over the counter, using Public Health Channel, Qmatic screens and internal communications.	Public Health Specialist Comms Leads (RCCG, RMBC) Local Pharmaceutical Committee?	January 2017	Safe storage of medication both prescribed and over the counter within the home.	
4. Reduce access to means	Explore opportunities to work with Planning Department re access to means at new builds	Public Health Specialist working with RMBC Planning	January 2017		
4. Reduce access to means	Training frontline staff to identify access to means, e.g. carers going into the home, Housing staff	Public Health Specialist SP & SH Group members Crossroads RMBC Housing	Housing staff given suicide prevention training 2015/16. Training to rolled out to carers organisations from October 2016		Training for carer organisations by April 2017
5. Better information and support to those bereaved by suicide	Bereaved families to receive a visit from VPU within 48 hours of notification of death. Families to receive Help is at Hand and other local contact details	SYP VPU	Ongoing	Improved post bereavement support for adults	Families visited within 48-72 hours of the suspected suicide. Each family offered the Help is at Hand resource. Families asked if they would like to be referred to the bereavement support provided by Rotherham Samaritans. SPY VPU make the referral

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Every GP Practice in Rotherham to have copy (copies) of the Help is at Hand resource	Public Health Specialist RCCG- incl RCCG Comms Lead	Resource to be promoted at PLT in September 2016.	Supportive information available for people who are bereaved.	All GP Practices issued with this guidance in September 2016
	Using a variety of Comms channels to promote messages of support to those bereaved by suicide	RMBC Comms to lead working with Comms Leads from TRFT, RDaSH, SYP, RCCG Input from Public Health Specialist	Comms Lead to be vigilant to when this may be required. Particular action to be taken on dates like World Suicide Prevention Day (10th September 2016)	Supportive information available for people who are bereaved.	During 2016 promotion of suicide prevention messages via Twitter, Qmatic screens, PH Channel, RMBC Staff briefing and local newspapers
	To continue to promote the LSCB Bereavement pathway for children and young people bereaved as a result of suicide or sudden death. 6 month review of pathway	Public Health Specialist working with Rotherham LSCB and the Rotherham Suicide Prevention and Self Harm Group	First launched in January 2015 Reviewed in May and updated version sent out in July 2016 January 2017	Children and young people received timely and appropriate support when bereaved by suicide or sudden death.	Pathway reviewed in May 2016. Need to promote again with SYP Officers

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Rotherham Samaritans to offer 2 booked phone calls with individuals and families who have been bereaved by suicide. Offer will be made to families via VPU when visiting bereaved families. Support to be reviewed after 6 months	Rotherham Samaritans Rotherham VPU	Starting September 2016 Review Feb/March 2017	Bereaved families offered support from an independent source.	Bereavement support launched January 2017. Rotherham Samaritans to collate numbers
6. Support media in delivering sensitive approaches to suicide and suicidal behaviour	Develop a marketing plan which indicates how the men's and young people's campaigns are to be promoted throughout the year	RMBC Communications & Media Manager working with Communication leads from RDaSH, TRFT, SYP and RCCG.	12 month marketing plan to be brought to the SP & SH Group meeting in August 2016 which will show how both campaigns will promoted throughout the year. Further promotion organised for men's campaign in September 2016 (World Suicide Prevention Day)	Campaign materials displayed through key venues in Rotherham. Partners all aware of the campaign Men, young people, families and friends able to recall seeing campaign materials Increase in number of people accessing help.	See earlier comments

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Continue to promote the Rotherham CARE about suicide resource. CARE about suicide resource to be on every statutory partners' website	RMBC Communications & Media Manager working with Communication leads from RDaSH, TRFT, SYP and RCCG. Support given from Public Health Specialist (Mental Health)	CARE resource to be on all statutory partners' websites by October 2016	Increase in confidence of universal workers and the general public to ask about suicide and take appropriate action	
7. Data collection and monitoring	Continuation of Real Time Suicide Surveillance. South Yorkshire Police to share real time data around recorded incidents of attempt suicide, to inform and enable the group to identify trends, at risk groups, locations, to better inform and deliver services in preventing future suicide episodes in Rotherham. Data is reviewed at the Rotherham Suicide Audit meetings. Findings may lead to work with geographical communities and communities of interest	RMBC Public Health SYP VPU RCCG Suicide Audit Group Suicide Audit Group working with partners like Area Assemblies, Early Help, GP Practices.	Ongoing with Suicide Audit Group meeting bimonthly Targeted work either with geographical communities or communities of interest.	General themes and trends reported back to Suicide Prevention and Self Harm group and actions to reduce risk reflected in action plan. Real time public health interventions for suicide prevention. Identifying at risk groups will inform commissioning cycle.	Still awaiting decision on SY real time surveillance. Rotherham VPU goes through all police records and alerts partners; RDaSH and Housing to suspected suicides.
	Suicide audit group	Attendees include: PH,	Suicide audit group to	General themes and	Suicide Audit Group

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	bimonthly meetings to identify any hotspots using reports from the police and mental health services. Minutes and actions are recorded. Actions are initiated. RDaSH to share SIs with the Suicide Audit Group to enable public health prevention actions to be identified.(Serious Incident Reports). Suicide Audit group agrees actions. Actions are reviewed at next meeting. Generic actions are reported back to the wider Suicide Prevention and Self Harm Group.	RCCG, SYP & RDaSH. Meetings chaired by PH PH Specialist to work with other agencies as and when required (Local Coroner's Office, Highways Agency, Samaritans, colleagues within RMBC, local media)	meet every bimonthly and review each death by suicide and agree follow-up actions.	trends reported back to Suicide Prevention group and actions to reduce risk reflected in action plan. Real time public health interventions for suicide prevention. Identifying at risk groups will inform commissioning cycle.	meets bimonthly. Action points are taken and updated at next meeting
	Develop closer working relationships with the Coroners Officer to assist with real time surveillance and with any learning post	Rotherham Coroner's Office Public Health SYP VPU	October 2016	Suicide prevention measures put in place.	

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	inquest				
8. Workforce Development	Provision of 4 Adult MHFA Training during 2016/17	RCCG, RMBC PH and RDaSH	Commencing April 2016- March 2017	Improved awareness of mental health, reduced stigma and awareness of local services	3 courses July 2016, January 2017 and February 2017 An additional MHFA course will be running in WV Area Assembly
	Provision of 4 Youth MHFA Training during 2016/17	PH RMBC and L&D Leads	Commencing April 2015	Improved awareness of mental health, reduced stigma and awareness of local services	2 courses August 2016 & October 2016 An additional Youth MHFA course will be running in WV Area Assembly
	To roll out further ASIST courses and other suicide prevention and self-harm courses to frontline workers	PH RMBC and L&D Leads	ASIST courses commence September 2016	Improved response to people in emotional distress	WV Area Assembly is funding suicide prevention work in the Maltby Hellaby and Wickersley wards which includes ASIST and Safe Talk
	To explore opportunities for other training for non-health workforce e.g Faith Leaders, Town Pastors, Carers and befrienders	Public Health Specialist SP & SH Group members L & D (RMBC)	January 2017	Improved awareness of mental health, reduced stigma and awareness of local services	See above comment In addition Public Health Specialist ran training session run for SY Town pastors in July 2016
	Delivery of a GP Projected Learning Time Event on mental health crisis	RCCG	2015/16	Increase awareness of the Mental Health Crisis Care Pathway	PLT presentation in September 2016

Suicide Prevention and Self-Harm Action Plan 2016/18

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS

Glossary

ASIST	Applied Suicide Intervention Skills Training
DPH	Director of Public Health
MHFA	Mental Health First Aid training
PH	Public Health
PHE	Public Health England
PHS	Public Health Specialist
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham, Doncaster and South Humber NHS Foundation Heath Trust
TRFT	The Rotherham Foundation Hospital Trust

Appendix 4

CAMHS Outcome CQUIN

Progress Report

1. **Goal Recording**

	Q1			Q2			Q3			Q4		
Rotherham	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Actual	**96%**	**95%**	**95%**	**99%**	**99%**	**98%**	**98%**	**98%**	**96%**			
Variance	1	0	0	4	4	3	**3**	**3**	**1**			
Patients with a goal				599	590	595	**576**	**583**	**584**			
Patients without a goal				7	8	14	**8**	**13**	**22**			

Rotherham CAMHS have achieved the 95% goal recording target for each month in Q3.

Achievement Summary

Achieved

2. **Improve frequency of goal scoring at clinically appropriate review in line with the target agreed in Q1.**

During Q2, a meeting took place between Rotherham CAMHS Service Manager, Rotherham CCG and CQUIN to discuss the frequency of goal scoring at clinically appropriate times.

The CAMHS Service Manager proposed that for this element of the CQUIN, should focus on the 'Locality' and 'Intensive Home Treatment' teams with a view to achieving 95% goal scoring by end of March 2017. Goal scoring will be undertaken by the clinicians within these teams at clinically appropriate times and will be closely monitored by the Service Manager.

It was also agreed that any diagnostic pathways (for example Autistic Spectrum Disorder) should not be included in the goal scoring figures as RDASH undertakes the assessment only and does not provide the post diagnostic service.

Quarter 3 – 2016/17

The information in the following table has been extracted from the Children's Improving Access to Psychological Therapies (CIAPT) 018 CAMHS Goal Score at Discharge and Positive Outcomes report and then analysed to provide the numbers below.

		2016-Oct	2016-Nov	2016-Dec	Q3
1.	**Number of Patients Discharged**	**9**	**13**	**4**	**26**
1a.	Intensive Home Treatment	2	2	0	4
1b.	Locality	7	11	4	22
2.	**Number of Positive Outcomes**	**7 (78%)**	**9 (69%)**	**3 (75%)**	**19 (73%)**
2a.	Intensive Home Treatment	1	1	0	2
2b.	Locality	6	8	3	17
3	**Number of Non-Positive Outcomes**	**2 (22%)**	**3 (23%)**	**1 (25%)**	**6 (23%)**
3a.	Scored deteriorated	0	0	0	0
3b.	No Goals Recorded	1	0	1	2
3c.	No Score at Discharge	1	3	0	4
4.	**Exception Report**	**0**	**1 (8%)**	**0**	**1 (4%)**
4a.	Patient Dropped Out	0	1	0	1

Headlines

- 73% patients scored their treatment suggesting they had received a positive outcome from working with CAMHS.
- 23% of patients fall into the Non-Positive Outcome category, the most prevalent are those did not have a score at discharge (n = 4).
- 1 patient dropped out and has therefore been removed from Non-Positive Outcome figures. This accounts for the remaining 4%.

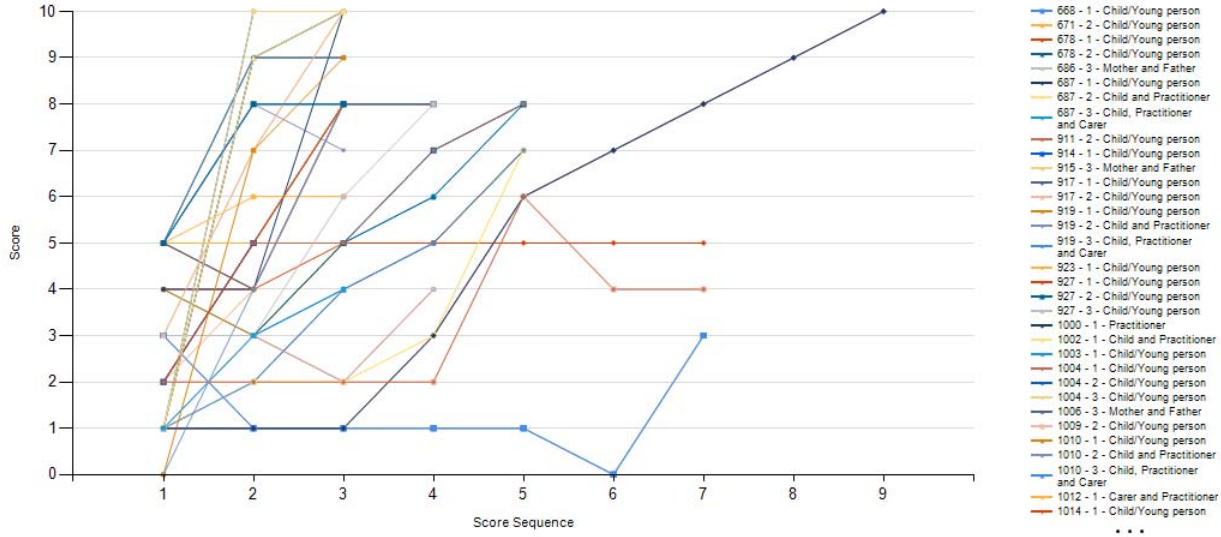
- The work undertaken throughout Q3 has shown an increase in the ability to evidence positive outcomes for patients (approximately 60% in Q2 to 73% in Q3).

3. **Present report evidencing goal scoring and review data for all patients which provides an on-going picture of each patient's situation in respect of goals met (i.e. outcomes).**

During Q1, the CQUIN Programme Office, along with CAMHS and Health Informatics Department came up with a specification for presenting goal recording & scoring for all CAMHs patients.

The feedback received from Rotherham CCG was to provide a summary and not include the full report.

The Q3 graph below displays a random selection of patients, the goals recorded against those patients and the scores recorded against those goals by hierarchy.



The patient goal scoring data for this graph can be seen in Appendix CAM1.

In summary, the Q3 data relates to 50 patients where all goals have been scored by the same person(s).

33 Patients had 1 goal, 5 patients had 2 goals and 7 patients had 3 goals, giving a total of 69 goals.

Of the 50 patients, 45 patients showed an improvement between their first scored goal and their most recently scored goal. This relates to 64 goals.

The remaining 5 patients (who all had 1 goal) showed maintenance between their first scored goal and their most recently scored goal.

Therefore, 100% of these patients show maintenance or improvement.

Rotherham Metropolitan Borough Council

Public Report
Health Select Commission

Summary Sheet

Council Report
Health Select Commission 2 March 2017

Title
Progress on Rotherham Youth Cabinet review - Improving Access to Child and Adolescent Mental Health Services

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

Under the auspices of the Children's Commissioner's Takeover Challenge Rotherham Youth Cabinet undertook a spotlight review of Child and Adolescent Mental Health Services. This report presents an update on the actions agreed by partner agencies in response to the review recommendations.

Recommendations

That the Health Select Commission:

1 Receive and consider the progress updates for the review undertaken by Rotherham Youth Cabinet.

2 Determine the arrangements for any further progress monitoring.

List of Appendices Included
Appendix 1 – Response template - Improving Access to Child and Adolescent Mental Health Services
Appendix 2 – The Collaborative Network
Appendix 3 – Voice and Influence Review template

Background Papers

- Minutes from Health Select Commission 27/10/2016
- Improving Access to Child and Adolescent Mental Health Services Review - Report to OSMB May 2016
- *Mind the Gap - A Rotherham Youth Parliament Report about Mental Health*, September 2015
- *Future in mind Promoting, protecting and improving our children and young people's mental health and wellbeing*, Department of Health and NHS England March 2015

Consideration by any other Council Committee, Scrutiny or Advisory Panel
OSMB delegated monitoring of the review response to the Health Select Commission.

Council Approval Required
No

Exempt from the Press and Public
No

Progress on Rotherham Youth Cabinet review - Improving Access to Child and Adolescent Mental Health Services

1. Recommendations

That the Health Select Commission:

1.1 Receive and consider the progress updates for the review undertaken by Rotherham Youth Cabinet.

1.2 Determine the arrangements for any further progress monitoring.

2. Background

2.1 The review was part of the ongoing work by Rotherham Youth Cabinet (RYC) to improve access to mental health services and support for young people in Rotherham, following their work on self harm in 2014.

2.2 The key focus of the young people's attention was on services provided by Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH), following a major reconfiguration that resulted in a new service model for Child and Adolescent Mental Health Services (CAMHS).

2.3 RYC were also keen to scrutinise wider working and links between partner agencies, especially through the School Nursing Service, as previous work by RYC had shown inconsistency in access to school nurses and a need to raise their profile in schools.

3. Key Issues

3.1 Progress is being made in transforming wider CAMHS through the CAMHS Strategy and Partnership Group. Integrated multi-agency working, both strategically and in localities is central to this transformation and the new service model linking RDaSH CAMHS with Early Help Services through a single point of access is now being rolled out.

3.2 Young people's involvement to inform service development is essential, as is their feedback on the effectiveness of the changes to services and support in the new service model.

4. Options considered and recommended proposal

4.1 RYC made 11 recommendations, all of which were accepted, and these are set out in Appendix 1, together with the latest progress updates on the actions agreed by partner agencies. Supplementary information provided to the HSC meeting on 27 October 2016 has also been included to provide a fuller picture of progress.

4.2 In summary the recommendations address the following issues:

- Involvement of young people - to inform practice and service development

- Reporting progress - on implementation of the new models/services
- Improving information - promoting and maintaining websites and addressing stigma
- Closer multi agency working - in localities and with schools
- School nursing service - higher profile and accessibility
- Enabling informed choices by young people - regarding their treatment

5. Consultation

5.1 Several of the recommendations from the review aim to enhance consultation and involvement with children and young people in service development and monitoring.

5.2 These also link in with the outcomes of the RDaSH Voice and Influence review commissioned by Rotherham Clinical Commissioning Group. This independent review identified a number of priorities for developing engagement with children and young people – in direct practice, service management and organisational leadership. (See Appendix 3 for mapping and planning template to progress this work).

6. Timetable and Accountability for Implementing this Decision

6.1 Timescales for agreed actions are incorporated within Appendix 1.

7. Financial and Procurement Implications

7.1 CAMHS commissioners and providers will need to take account of any financial consequences from implementing the recommendations in their annual planning arrangements.

8. Legal Implications

8.1 There are no direct legal implications arising from this report.

9. Human Resources Implications

9.1 There are no direct human resources implications.

10. Implications for Children and Young People and Vulnerable Adults

10.1 The purpose of the review was to enhance access to mental health services and support and to the School Nursing Service for children and young people.

11. Equalities and Human Rights Implications

11.1 The recommendations will bring about a positive contribution to promoting equality through improving access to services and support and ensuring stigma around mental health is addressed.

12. Implications for Partners and Other Directorates

12.1 The majority of actions are for RDaSH and for The Rotherham Foundation Trust as providers of the School Nursing Service, but all partners and RMBC continue to

work together through the CAMHS Strategy and Partnership Group to implement the new service models and transformation plan.

13. Risks and Mitigation

13.1 Failure to implement planned service changes will impact on access to services and support for children and young people and their families/carers.

13.2 Contract performance management is in place for service providers and the CAMHS Strategy and Partnership Group oversees delivery of the local transformation plan.

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 ***Response to Scrutiny Review by Rotherham Youth Cabinet - Improving Access to CAMHS***

	Recommendation	**Decision** *(Accepted / Rejected/ Deferred)*	**Response** *(detailing proposed action if accepted, rationale for rejection, and why and when issue will be reconsidered if deferred)*	**Officer Responsible**	**Action by** ***(Date)***
1	That RDaSH consult with young people who are their service users and Rotherham Youth Cabinet (RYC) on opening hours for the Single Point of Access pathway, by July 2016.	Accepted	RDaSH Reference LTP 7.1a & 20.3a Patient survey in place for 4 week period commencing 15.06.2016. Consulting with CYP&F on communications, service times, locations, awareness of care coordinator and general feedback on the service and what improvements could be made. Additional information 26/9/2016 Questionnaires out to all service users who came to CAMHS during a set period. RDaSH are working with RMBC Early Help in forming a joint SPA where CAMHS staff will support Early Help and triage CAMHS referrals that come into the SPA.	Joint RDaSH CAMHS and RMBC Early Help	July 2016 October 2016
			Additional information provided at HSC meeting 27/10/16 • *RDaSH want to move to an 8am to 8pm service so that it does not affect young people's school time and so they can be seen after school.* • *Appointments will not always be in schools as this is not always acceptable to young people and it is important to talk to young people about where they want to be seen. Families did say they wanted to be seen on weekends and between 4-6pm.* • *Views on preferred locations for appointments differed but in general Rotherham town centre was seen as better than Kimberworth Place or people wanted an appointment in a locality base, but not always in a school. Some were happy to be seen in the home and others not.* • *Out of hours will be through working with the Adult Mental Health out of hours service on call to cover 8pm-8am. Work and training with adult services would ensure safe transfer.*		**Action completed**

2	That the Public Health Team in RMBC involves RYC in the commissioning process for the new 0-19 health services contract regarding the School Nursing Service.	Accepted	RYC worked with Public Health to develop a question to include in the Invitation to Tender: "How will you raise the profile, increase the awareness and accessibility, and ensure effective two-way communication between young people and the school nursing service?" (question no. 2.4.8.2) They then scored the responses to this question from the prospective providers in a workshop session with Public Health, following an explanation about the tendering and moderation process. The decision will be presented to Cabinet in September 2016 and Public Health will feed back to RYC about the outcome. The young people were positive about the experience and learned how services are commissioned.	Giles Ratcliffe Sarah Bellamy	July 2016 **Action completed**
3	That RDaSH update the CAMHS pages on their website and include a Rotherham-specific page by date tbc, with input from RYC and service users.	Accepted	The service has developed a proposal for a new CAMHS Microsite. Approved in principle by RDASH ICT Board – timescales unclear due to organisational priorities. We would expect to engage with C&YP re content development and could do some pre-engagement work with them whilst we are confirming timescales. See proposal below: 26/9/2016 Initial options are just underway within RDaSH CAMHS about the CAMHS website. Forming a focus group in Rotherham CAMHS, who attend youth councils to meet with young people to get their thoughts on the design, proposed content and features. Given the volume of change and transformation in Rotherham CAMHS at present expected date of completion tbc but work is happening.	Gavin Portier CAMHS Microsite Proposal.doc	Date tbc
			Additional information 27/10/16 *Consultation is taking place with young people on the draft principles for the new RDaSH CAMHS website and a functioning website for young people will be in place in February, 2017. Much of the information on the current website will move across. The delay was due to the reconfiguration into place based care groups and all children's coming together.*		Feb 2017
			Update for 2/3/17 At present on the website there are young people's pages, a link to the My Mind Matters website and a link to a Rotherham specific leaflet.		

4	That by date tbc RDaSH CAMHS develop a clear policy and demonstrate a consistent approach to ensuring young people's voice and influence, including: a. consulting young people on service development and design b. collecting data and feedback from young people using their services regarding times and ease of access as the new model develops c. ensuring feedback from young people using their services is collated and used to inform practice and service development	Accepted	The organisation is undergoing a large scale policy review and transformation; we don't have any policies specifically detailing this yet. As CAMHS is also undergoing large scale remodelling of service delivery and configuration, we will assess and review policies once everything has been put in place to get the policy right first time rather than write something that is not fit for purpose. Update for 2/3/17 Attached at Appendix 3 is the mapping/action planning template that resulted from the Voice and Influence review to increase young people's involvement This was shared with RYC for comment. An action to develop a mission statement by June 2017 to reflect the involvement of young people in service development is included. a) and c) Implement collaborative network - refer to appendix 2. *Additional information 27/10/16* *The first meeting of the new collaborative network will be arranged for March 2017 and then quarterly.* Update for 2/3/17 See Appendix 3 b) CAMHS working with schools, Rotherham Parent Carer Forum, RYC via monthly/bimonthly meetings. Working jointly to ensure that feedback comment cards and questionnaires are available and completed. 26/9/2016 Operational Manager is attending meetings with the Rotherham Parent Carer Forum and clinicians attend these meetings for advice and consultation when available.	Gavin Portier	From June 2016 ongoing work with families and service users From March 2017 network
5	That annually, commencing in November 2016, the CAMHS Strategy and Partnership Group report back to a RYC meeting on progress in implementing the new service models for RDaSH CAMHS, Early Help	Accepted Accepted	**RMBC** There will be a progress update given at the Rotherham Youth Cabinet meeting on 17th November 2016. These updates will then be given annually or more frequently if requested by the Youth Cabinet. **TRFT** The clinical lead is a member of the CAMHS strategy and partnership group and attends the meetings. The next scheduled meeting is 12th	Paul Theaker Juliette Penney	November 2016 and ongoing October 2016

	and Locality Working, focusing on: a) effectiveness and demonstrating how the new services are making a difference for young people b) how feedback from young people is informing future service development		October. The clinical lead will share this information at the meeting. In discussion with the Youth cabinet member in this group, a collective discussion can be held on how we can evidence and demonstrate progress on the two focus areas described. **RDaSH** a and b delivered through collaborative network. Appendix 2		
			Update for 2/3/17 Verbal report given to RYC meeting in November 2016 and potential for a fuller update in November 2017 when new models are more embedded.		
6	That RDaSH and the School Nursing Service continue to work more closely throughout 2016 in the roll out of locality working to develop links with other partners and demonstrate improved support and access for young people.	Accepted	**TRFT** TRFT and CAMHS hold a monthly meeting, chaired by the Assistant Chief Nurse (Vulnerabilities), and an action log is maintained. A number of actions have progressed via this group including Emergency Department and CAMHS pathways when a young person needs admission. The focus currently is to improve processes with CAMHS and School Nursing / Health Visiting and working across the new localities. - CAMHS locality workers to be invited to meet locality health visitors and school nurses (0-19) - New CAMHS operational manager to be invited to attend 0-19 operational meetings - Joint communication pathway to be developed and delivered between CAMHS and 0-19 service **RDaSH** Actions are within the Promoting Resilience section of the LTP. Identified the need to develop a pathway and this will be developed now the locality workers are in post and their offer is established. Joint workshops to be planned for Sept/Oct to facilitate professional networking and relationship building. Dates to be confirmed through the monthly meeting.	Juliette Penney	October 2016
			Additional information provided at HSC meeting 27/10/16 *The monthly provider to provider meetings have taken place for several months and are well attended by TRFT and RDaSH colleagues and led to some of improvements seen, particularly the*		

			A&E response by RDaSH and the children's ward response by RDaSH. *Now the 0-19 contract has been awarded there is some work to do in rolling out locality working and there is the willingness and commitment to do that. Meeting dates have been set and a joint communications pathway will be developed between RDaSH/SNS.* *The School Nursing Service was already locality based and RDaSH has been reconfigured around the same localities so that will enable joint working from there. Although there were some anomalies in the number of localities used by different agencies, for example with Early Help based on nine, there is an overlap so areas are covered.*		
			Update for 2/3/17 TRFT held a 0-19 development day on 25.1.2017 which was attended by the CAMHS Operational Manager who provided an update and presentation on the CAMHS service and the locality workers. RDaSH circulated training needs audit forms for TRFT staff to complete by 6 March 2107. The forms have also been sent to C&YP for social care and Early Help Teams. Once an analysis of the forms has been completed RDaSH hope to deliver training based on the identified needs in conjunction with early help and social care teams, to promote collaborative working in line with futures in minds. Locality workers are beginning to make links with schools and school nursing practitioners. An invitation has been extended by the SNS to the new CAMHS locality pathway lead to meet and push forward locality working across all areas of Rotherham. Meetings have not yet taken place between SNS and RDaSH CAMHS locality lead to formulate the communication pathway.		31 July 2017
7	That the School Nursing Service and schools develop initiatives to raise the profile and accessibility of the	Accepted	Clinical lead is attending secondary head teachers forum and is to be invited to attend school lead safeguarding officers meeting. School nurses to allocate a named practitioner with contact details for	Juliette Penney	From November 2016

	service, involving young people in developing new approaches, by 1st April 2017.		each school and to develop a standardised notice board, with pictures, names and details of availability for drop in sessions in secondary schools. *Additional information provided at HSC meeting 27/10/16* *Clinical lead attends the secondary headteachers meetings and will be leading on raising the profile of the SNS in schools and involving headteachers in how to market the SNS.* *Part of the work on marketing the SNS will also be going out to young people to encourage them to work with the service and contact has been made with a RYC member for their input.* Update for 2/3/17 TRFT are in the mobilisation phase preparing for the new contract to commence from 1 April. Marketing and launch of the new 0-19 service is being developed. TRFT have a competition open to 11-19 year olds to design the new 0-19 Integrated Public Health Nursing (IPHN) logo, and young people will be directly involved in the design. There are prizes for the winning designs. Core offer and individual offer for schools to be developed in preparation for new Autumn term 2017.		
8	That the forum for practitioners from TRFT and RDaSH, which includes school nurses and health visitors, works more closely with young people to identify and embed good practice, by 31 March 2017.	Accepted	**TRFT** Establish joint forum and plan activities. **RDaSH** As per comments in section 6 Need to ensure that there are regular opportunities for professional networking and development throughout the year. Update for 2/3/17 The joint forum has still to be established and will be progressed across all localities when the SNS meet with the new CAMHS locality pathway lead.	Juliette Penney	March 2017 Revised date 31 July 2017

9	That an update on the new Family Support Service is reported back to RYC by November 2016, to include: a) work taking place to address stigma b) capacity to comply with requests for support c) demonstrating evidence-based practice	Accepted	An initial update has been received from the Rotherham Parents Forum relating to the service which outlines:- • 3 Co-ordinators in place. • Volunteer training package pulled together & anticipate will have 6 volunteers in place by September. • To date, 21 families supported directly & 47 through groups, telephone, and social media contact. • Good links with local services including RDaSH CAMHS, Healthwatch & Early Help teams. A report could be provided at the end of October, 2016, by which time the volunteers will be in place and trained. *Additional information provided at HSC meeting 27/10/16* • *The Forum were doing a good job leading the Family Support Service. They were facing a high level of demand: by quarter 2 they had supported 38 families and 50+ children, mainly aged 5-11, a significant number with issues around ASD.* • *Evidence of helping to avoid admission to CAMHS, in a positive example of true prevention and early intervention.* • *Support was not just around CAMHS but also with Education, Health and Care plans and school and home as well.* • *The CCG was proposing to increase funding for 2017-18 by £15k.* • *Contact was available via phone, email, facebook or face-to-face.* Update for 2/3/17 Verbal report given to RYC meeting in November.	Paul Theaker	November 2016
10	That the CAMHS Strategy and Partnership Group continues to develop and promote the "My Mind Matters" website, taking account of feedback on content and accessibility from young people.	Accepted Accepted	**RMBC** The My Mind Matters Website has been 'live' for 12 months and is currently being refreshed. The refreshed young people's section of the website will be consulted upon with young people to ensure that it remains young people friendly and accessible. **TRFT** CAMHS Strategy and Partnership Group continue to promote this website. School Nurses & Health visitors (0-19) continue to promote	Nigel Parkes Paul Theaker Ruth Fletcher-Brown Juliette Penney	September 2016 & ongoing

			this website and are to consider adding this link on the TRFT website. School nurses continue to direct and refer Young people to this website. 0-19 service work in partnership with young people in shaping and developing any new service. **RDaSH** Appendix 2		
			Additional information provided at HSC meeting 27/10/16 – *My Mind Matters web hits – over the last 6 months average of 341 hits per month, 57 of whom were new users, so some repeat visitors. 57% hits from YP, 25% from carers and 18% from practitioners. There is ongoing work to raise the profile and keep promoting it.* – *IYSS Young Inspectors were involved with an unannounced inspection of CAMHS and were very positive regarding a "Rotherhamised" website rather than only the generic sites. A very detailed review has been done of the My Mind Matters website recently – review of every page in all three sections with extensive notes made regarding the wording and to ensure up-to-date statistics.*		
11	That RDaSH CAMHS ensure all practitioners discuss treatment and the range of options available with young people so that they may make informed choices: a) during their initial assessment b) during transition from CAMHS		• Demonstrated through anonymised case notes. • Reflective practice • Clinical supervision • Regular feedback from service users • Motivational Interviewing and Appreciative Inquiry techniques training Reviewing the RDaSH Transition policy against National Guidance and in collaboration with Adult Services, this will include making improvements to the MDT approach for discussing transition cases as well as identifying an appropriate link person in adult services at the earliest opportunity. Use of transition questionnaire with young people to evaluate their experience of transition. 29/9/2106 Draft policy completed and submitted to board.	TBC	Ongoing

			Transition toolkit to be released by Y&H Clinical Network – to be reviewed for implementation following launch on 28.06.2016		
			Additional information provided at HSC meeting 27/10/16 *RDaSH had carried out an initial draft of scoping against the toolkit which had been shared with the CCG. This is a CQUIN target.* *New transition board was being set up to be chaired by the Director of Adult Services. First meeting scheduled for January 2017.*		
			Update for 2/3/17 Transition Policy developed and there will be a CQUIN for 2017-18 for transition from CAMHS. See also Appendix 3		

Appendix 2 **The collaborative network**

The idea behind this is to create a collaboration of service users and services to jointly share and work in improving services for children and young people in Rotherham.

The proposed stakeholders for the group are:

- Rotherham Youth Cabinet
- Rotherham Parent Forum
- RDASH PALS (Patient Advice and Liaison Service) lead
- RDASH CAMHS operational manager & pathway leads
- RDASH CAMHS peer support worker
- Clinical lead for CAMHS RDASH
- Rotherham MBC
- Early Help
- Clinical Commissioners

The purpose of the group is to meet either every four or six months, where the following items would be discussed and shared, with the emphasis on reflecting on the services offered and involving all parties to shape and improve them for the children and young people of Rotherham.

Proposed topics discussed.

- Performance markers for all services waiting times, referral times etc. compared against national guidelines (not commissioned targets)
- Share service user feedback from all services, not just CAMHS. This will allow cross learning and gain better overview of the experience of people in different areas of the system.
- Service development – raising awareness of CAMHS services in Rotherham Doncaster & South Humber NHS Trust
    - Raising awareness of Child and YP mental health in Rotherham
- Discuss the political and environmental challenges on CAMHS, both locally and nationally
- Improving transitions from CAMHS to adult mental health services
    - What is available?
    - Finding out what exactly YP need and aspire to?
    - How can all stakeholders help in achieving this?

The meeting will be chaired by an elected stakeholder and this will change annually.

It is my vision that all stakeholders have a shared ownership in improving services for children and young people. That all services have productive working relationships where focus is on the service users.

Appendix 3 **Rotherham CAMHS assessment against priorities November 2016**

9 top priorities: mapping	**1.In place and effective; 2.In place, but needs improving; 3.Currently being established; 4.Not in place**

	What's the evidence of meeting the indicator?	**What do the children and young people say about how this indicator is being met?**	**Score 1-4 (as above)**	
Feeling good: Initial assessments are undertaken in a timely manner, with a holistic approach and involving the young person throughout and parents, carers or friends where agreed	Waiting times for initial assessment is reducing, the assessments cover a range of issues which are holistic		2	PLANNING →
Feeling good: Session by session monitoring is standard practice, involving the young person in reviewing process, goals and progress	Over 95% of people who come into the CAMHS service have a goal set with them. Outcome questionnaires are collected at initial assessment and further work or required to support practitioners repeating these questionnaires and using the information in meaningful way with young people		3	
Feeling good: A complaints procedure and independent advocacy are available and accessible, well signposted and sufficiently resourced	There is a clear Trust complaints policy which is displayed at Kimberworth place and available via the internet. Advocacy is available via Healthwatch. There are also posters displayed within Kimberworth Place to encourage people to speak with the operational manager if they have any concerns		1	

Doing the job right: Staff training for trainees and existing workers systematically includes young people in its design, delivery and evaluation	Staff training does not currently directly include young people in the design and implementation.		4	
Doing the job right: Recruitment and selection of staff (internally or externally) involves children and young people throughout	Young people and parents have been involved in the recruitment of most posts recently within the service, either in person or an identified set of questions which were set by young people have been used- this has been where the interview process has been most labour intensive- with 4-5 full days of interviews taking place		1	
Doing the job right: Supervision and appraisal of staff includes children and young people's feedback through a range of accessible methods	Feedback from young people and families is reflected within PDRs for staff if there have been specific compliments or development needs identified, but this is not routinely used currently		3	
Running service well: Commissioning of services involves children and young people in their design, procurement and evaluation	There are young ambassadors and peer support workers invited to attend the partnership and strategy meeting where commissioners and providers of service discuss the needs of the local population and service developments and investment		2	
Running the service well: Influencing senior managers occurs through a range of approaches and feeds into strategic decision making	As above, the operational manager invites people to contact him in relation to the service delivered, this is fed back to the team and		3	

	senior managers within the organisation to shape the service development. CAMHS staff have accessed the Youth Council to consult about changes to services and processes. The Trust Public and Patient Engagement Strategy is currently being reviewed. Focus groups run within the special schools for learning disability CAMHS pathway			
Running the service well: A mission statement or charter about the involvement of children and young people in the service is in place, accessible and used to review progress	Not in place. There is an area for development- see below. There has been a pledge previously developed as part of the CYP-IAPT collaborative, this requires review within the service.		4	

9 top priorities: planning

	We have identified the following areas for improvement	Priority 1-10 (1 is high)	Who?	Resources needed	Barriers and solutions	By when?	How are we planning to involve children and young people?
MAPPING ↑	Improved use of outcome measures with young people in sessions and regular review of progress towards goals		Pathway leads	Supervision training for pathway leads and clinical supervisors for staff	Dedicated time to deliver training and ensure necessary time within supervision sessions to discuss	June 2017	Use of u-tube clips re use of Routine Outcome measures with young people
	Incorporating young people into training for staff- particularly use of Routine Outcome Measures		As above	Young people who have used ROM within sessions	Identifying young people who are willing to engage in the training and able to attend sessions with staff	June 2017	Young people to be involved in training for staff
	Need to deliver recruitment training for young people to be involved in interview processes		Team manager and Peer Support Workers	Willing young people, training package and venue	Need to confirm the on-going appreciation payment/ process for young people who contribute time and resource	May 2017	Young people to attend recruitment training and then be involved further in recruitment of staff
	Mission statement to be developed to clearly reflect the involvement of young people in the service development		Team manager and Peer Support Workers	Dedicated time with young people in a focus group	Identifying young people willing to be involved in the development of a mission statement	June 2017	Co-production of mission statement.