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

Date:-	**Thursday, 21st September, 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 20th July, 2017 (Pages 1 - 14)

For Discussion

8. Transformation initiatives - Care Co-ordination Centre and Integrated Rapid Response (Pages 15 - 19)
   Dominic Blaydon, TRFT to present

9. RDaSH Rotherham Care Group Transformation Plan - Update (Pages 20 - 24)
   Steph Watts and Michaela Bateman to present

10. Delayed Transfers of Care (Pages 25 - 31)
    Nathan Atkinson, Ian Atkinson and Claire Smith to present

11. New National Ambulance Standards (Pages 32 - 38)

For Information

12. Improving Lives Select Commission Update

13. Joint Health Overview and Scrutiny Committee for the Commissioners Working Together Programme (Pages 39 - 62)

14. Healthwatch Rotherham - Issues

15. Date of Next Meeting
    Thursday, 26th October at **3.00 p.m.**

SHARON KEMP,
Chief Executive.

Membership:

Chairman:- Councillor Evans
Vice-Chairman:- Councillor Short
The Mayor (Councillor Rose Keenan), Councillors Allcock, Andrews, Bird, R. Elliott, Ellis, Ireland, Jarvis, Marriott, Rushforth, Sansome, Whysall, Williams and Wilson.

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

HEALTH SELECT COMMISSION
20th July, 2017

Present:- Councillor Evans (in the Chair); Councillors Andrews, Bird, R. Elliott, Jarvis, Marriott, Short and Whysall and Vicky Farnsworth (SpeakUp).

Councillor Roche, Cabinet Member for Adult Social Care, Councillor John Turner and Tony Clabby (Healthwatch Rotherham) were in attendance at the invitation of the Chairman.

Apologies for absence were received from Councillors Allcock, Ellis, Tweed, Williams and Robert Parkin (SpeakUp).

12. DECLARATIONS OF INTEREST

Vicky Farnworth declared a personal interest regarding Learning Disability as a member of Speak Up.

13. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

14. COMMUNICATIONS

- Councillor Marriott – Visit to Rawmarsh School (mental health pilot)
  A positive and interesting meeting took place with school staff who explained the work being undertaken and answered a number of questions. The children and young people were now coming forward. In some cases parents did not like one-on-one meetings so the school had replaced these with a successful coffee morning with 12-15 attendees. It was important that the good work continued.

- Councillor Elliott – Visit to new Urgent and Emergency Care Centre at Rotherham Hospital
  A visit had been organised on 22nd June 2017 prior to the opening, which included a comprehensive tour and introductory talk. It was a new and impressive centre built on time and on budget, with good décor, equipment and nursing stations. Clinical Lead Dr Kay Stenton and Acting Matron Kerry Barnard explained how A&E staff had been consulted on the design and layout of the unit and their ideas incorporated. This was a cutting edge facility and one the people of Rotherham should be proud of.

- Schools mental health pilot
  Councillor Cusworth would circulate notes from the whole school steering group meeting for information.

  An information pack had been circulated to Members.

- Yorkshire and Humber Joint Health Overview and Scrutiny Committee
  As in previous years the Commission was asked to nominate a representative to the Committee.

Resolved:- That the Chair be confirmed as the representative for RMBC to the Yorkshire and Humber Joint Health Overview and Scrutiny Committee.

15. MINUTES OF THE PREVIOUS MEETING HELD ON 15TH JUNE, 2017

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 15th June, 2017. Members noted that with regard to Minute No. 6 the text under key messages should say:-

- Older people play a significant role as care givers

Arising from Minute No. 8 Joint Health Overview and Scrutiny Committee (JHOSC) for the Commissioners Working Together Programme, the Scrutiny Officer provided the following update:

Children's Surgery and Anaesthesia
The Joint Committee of Clinical Commissioning Groups approved the preferred option for the reconfiguration proposals for children's surgery and anaesthesia on 28th June. This proposal was for three hubs - Doncaster Royal Infirmary, Sheffield Children's Hospital and Pinderfields General Hospital in Wakefield to provide out of hours, emergency surgery for certain sub-specialties.

Further work on patient numbers showed that this would impact on a relatively small number of children, with the majority of surgical procedures carried out locally. From a total of approximately 11,000 surgical procedures each year, it would affect between 65 and 106 p.a. across the whole area (approximately 14 in Rotherham).

There were no cost savings with the proposal but rather investment was required for ambulance transfers and for the Managed Clinical Network which would organise and sustain service provision across the area through workforce planning and training etc.

The JHOSC would be meeting on 31st July, 2017 to discuss implementation and future scrutiny. There would also be an update on timescales for a decision on the proposals for Hyper Acute Stroke, which was likely to be in the autumn following further work on developing the business case, on costs, workforce implications and wider implications for partners.

Resolved:- That the minutes of the previous meeting, held on 15th June, 2017, be approved as a correct record.

16. MEMBERSHIP OF THE HEALTH, WELFARE AND SAFETY PANEL 2017/2018

Members would be requested to send expressions of interest to the Chair.

17. ADULT SOCIAL CARE - PROVISIONAL YEAR END PERFORMANCE 2016-17

Councillor Roche, Cabinet Member for Adult Social Care and Health, introduced the agenda item highlighting that all local authorities had to produce annual statutory returns. The performance indicators had to be viewed in the wider context where RMBC was in the top quarter/third of Adult Social Care directorates nationally and ranked second in Yorkshire and Humber on the national statistics. There were concerns over some measures and for some individual measures Rotherham did not compare so well with the national figures. Overall the outcomes were mixed and the majority of measures that had declined were the perception measures. Perceptions were important as the Service needed to take users with it in light of some of the other changes that would be brought in to Social Care.

AnneMarie Lubanski, Strategic Director of Adult Care and Housing, and Scott Clayton, Performance & Quality Team Manager, presented a report outlining the provisional year end 2016-17 Key Performance Indicator results for the Adult Social Care elements of the directorate.

The Council had implemented a new case management recording system, Liquid Logic in year, with a go live date in December 2016. Migration and recording onto the new system highlighted some operational and performance reporting challenges. All national reporting requirements were met in relation to 2016-17.

Performance overall had been mixed with approximately one-third of measures improving and two-thirds declining. Perception results from Service User and Carer surveys accounted for most of the declining performance indicators. Some Indicators, for example the Service user surveys, had declined since last year but not necessarily over the last two years.

Continued improvements to pathways, embedding of user data recording, plus enhanced reporting functionality during 2017/18 were being delivered.

Year-end benchmarking data would be available later in the year and not all the Adult Social Care Outcome Framework (ASCOF) measures had a provisional result at this stage as mental health data was awaited from RDaSH.

It was important to note that in terms of local waiting times performance measures the data had become unreliable as it was not now reported in the same way.

Discussion ensued with the following issues raised/highlighted:-

- Was any KPI data collected monthly? – Reporting periods varied with a mixture of monthly, quarterly (including RDaSH) and annual reporting, such as for reablement.

- Where was data recorded regarding people who drop out of the system, possibly homeless people or people no longer with us? – We work actively with some people so they did not need an ongoing personal budget from the Council as they regain independence. If people did not meet Service eligibility criteria they should be signposted elsewhere, such as to the voluntary sector. The Data Protection Act limited data that could be held with stringent record procedures. Data was held for people who had passed away. If people had chosen to move away from Rotherham our involvement stopped and hopefully it could also be through greater independence and no longer being in service. This would be captured in reablement data.

- Measure No. 14 permanent admissions to residential care (18-64) covered a large age range, could this be broken down further by age, bearing in mind differences in needs at different ages? – The indicator was a national one reported to the DWP because of benefits. We would be able to drill down into our data and provide the Commission with information on sub-cohorts by age and Service user group. In total for Rotherham this referred to approximately 20 people, so a very small actual number.

- Survey sample sizes and response rates as smaller samples would be more sensitive to change – Requirements were set nationally calculated from the number of people on Service. There had probably been some changes in the number of carers recorded on the system since the Care Act.

  Service users 2015-16 1016 surveys sent out and return rate 41%.
  Service users 2016-17 1000 surveys sent out and return rate 39%.
  Carers 2014-15 896 surveys sent out and return rate 46%.
  Carers 2016-17 702 surveys sent out and return rate 47.4%.

- Although the survey sample sizes were small and the final figures were not yet available, there had been a decline on a number of measures at a time of ongoing service reconfiguration, such as the measures for people with learning disabilities on long term service and for social contact. Similarly for the measures for ease of access to information about support, suggesting people were encountering barriers to accessing information - Councillor Roche

commented that he was concerned but not surprised by some of the responses given that questions were asked about Services that people know were in a state of flux and transformation. From conversations with carers it was known that some opposed the proposed changes for Learning Disability Services, others agreed with them and some agreed but wished to wait until their family member had been through the system. Results were likely to decline again next time in this time of uncertainty and many false rumours were circulating about Learning Disability Services when no decisions had yet been made.

- Did surveys go to people in private care homes? – The survey sample had to include people in the community and those in receipt of 24 hour care with no distinction made between local authority or privately operated care.

Following discussion on the report a short presentation entitled *Adult Social Care – Thematic review of provisional year end performance report 2016/17* outlined four key themes and how the Performance Indicators linked into these. This enabled the Commission to have an overview of areas that were doing well and areas where the challenges remained, by means of a type of traffic light system.

Theme 1 Prevention & Delay

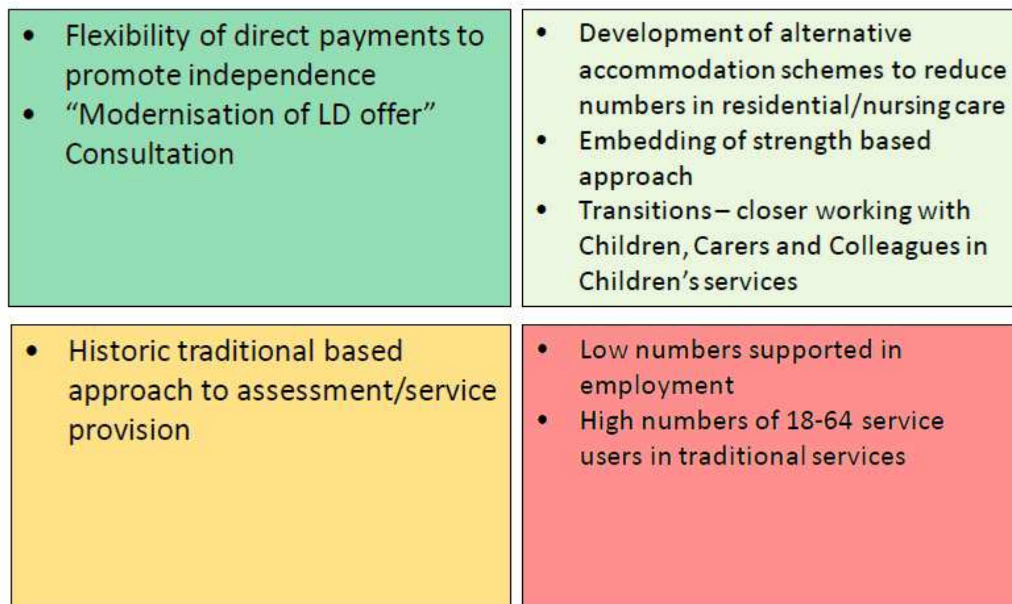
• Outcomes from Reablement are good. High percentage living at home without formal support • Positive trend in numbers of older people admitted to long term residential/nursing care	• Community Connectors are providing information/advice to promote independence and delay access to service.
• Worsening trend in delayed discharges from hospital – performance remains good. • Budget impact of high cost cases transitioning from Children's services	• Numbers offered Reablement remains low. One of the lowest in Rotherham's peer group. • High numbers of younger adults in residential and nursing care.

With regard to the Community Connectors that was interesting in terms of the performance measures discussed earlier and further work would be needed to get the messages out there.

Performance on delayed discharges from hospital was a challenge nationally and although this measure had declined it remained good as previously Rotherham had been in the top 20.

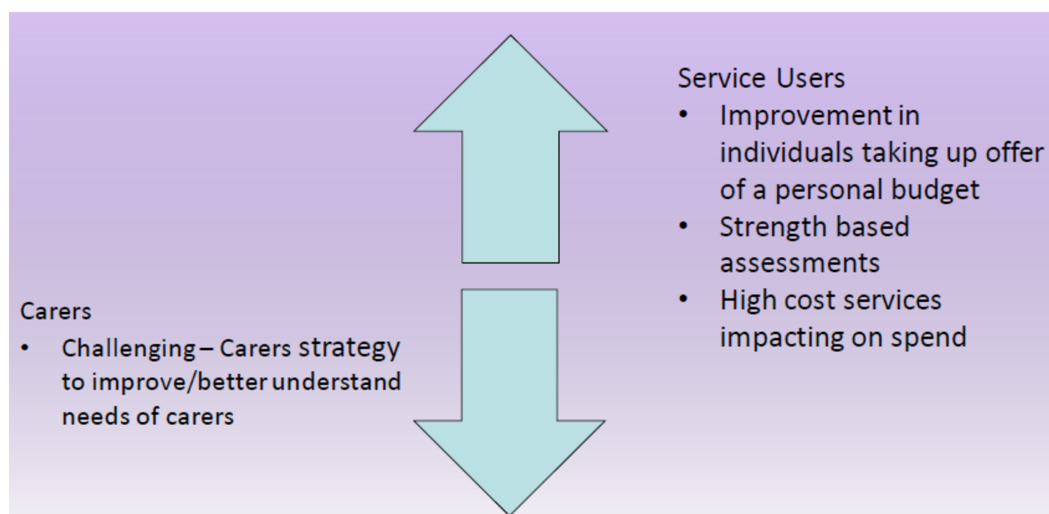
Rotherham was doing well on the effectiveness of reablement measure (91 days) but the numbers offered the service were low - bottom quartile ranking.

Theme 2 Independence

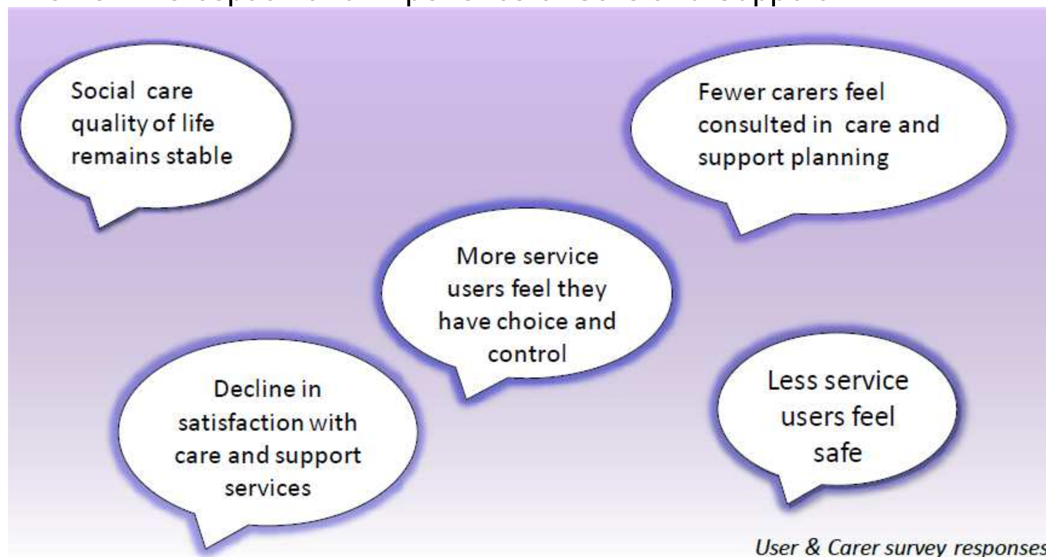


One challenge was to move the people from the bottom right quadrant using traditional services, including for learning disability, into the top left quadrant, resulting in a double benefit.

Theme 3 Personalisation



Theme 4 Perception and Experience of Care and Support



Resolved:- (1) That the content of the provisional summary ‘high level’ year-end performance results be noted.

(2) That a further report be presented to the Health Select Commission January 2018 meeting, showing the final submitted detailed results and analysed benchmark comparisons against regional and national data due to be published from late Autumn 2017.

18. LEARNING DISABILITY UPDATE

AnneMarie Lubanski, Strategic Director of Adult Care and Housing, provided a verbal update on the work to transform Learning Disability Services.

In July a report on Learning Disability and the recommendations within the report were agreed at Cabinet and a number of consultations were now being planned and would be commencing in early September. No decisions had been taken yet with regard to closure of any centres.

The Directorate had been working with carers of people with learning disabilities to keep them well involved. This included two events where officers talked through the report with the carers as soon as it had been published.

Based on feedback from the earlier consultation, it had been agreed that carers would be involved in designing the consultation, alongside SpeakUp, together with another organisation the Service hoped to procure to provide additional support to people with learning disability through the consultations.

Consideration was also being given to the on-line questionnaires and how these could be done differently, although there had been over 900 responses through the various means. The consultation materials could be shared with the Commission.

It was stressed that this was not just the in-house Learning Disability offer but modernisation of the wider learning disability offer for everyone, although this message was sometimes being lost.

Out of 780 people on Service, across internal and external commissioning, there were around 20 people with complex needs whose packages costed between £160,000 to £250,000 p.a. There was a need to start doing things differently for such packages such as trying and testing the use of technology as a substitute for direct care.

Other challenges in undergoing this transformation and service modernisation, both for Adult Social Care and for families, were highlighted, including:

- people with learning disabilities perhaps wanting something different to what their families wanted for them
- the need for sophisticated conversations and being very clear about the Mental Capacity Act and who made the decision
- difficult conversations with families
- difficulties for families when someone with learning disability or autism reached 18 and had the right to choose and the family member was no longer their next of kin
- as much as carers had parity of esteem through the Care Act the central focus was what the person wanted
- how new high cost support packages as people come into service may increase budget pressures in Adult Social Care

These were reasons why it was so important that the learning disability offer was widely understood. Our money was locked into very traditional services and it needed to be reiterated that this was not a quick journey but would happen over two to three years.

- Clearly improving the quality of provision and driving up standards was important but the other side was the economics, so was cost a driver as well given that in the future there will always be people with complex need and high cost support packages? – The premise of personalisation was about putting the person at the centre. Absolutely there would always be people with very complex needs, whether through learning disability, brain injury, or drug or alcohol related physical complexities and that would be there. What was needed as we worked in a different way was to maximise the people who did not need those high end services, regardless of the cost of those services. This was why it was about getting the front door right and getting reablement right so in the end the service was working with the people with the complex high

end needs, whether safeguarding, physical, mental, emotional or psychological. In Rotherham there was a legacy of responding to complexity through using residential care and that had resulted in too many people aged under 65 in residential care across all groups, especially mental health. Costs did come into it but it was about maximising the use of the personal budget if a person needed one, getting the right information at the right time and starting to use technology as a positive.

Councillor Roche reiterated his concerns regarding national cutbacks on Adult Social Care but highlighted that many of the changes were positive and we would have wanted to make them irrespective of the period of austerity. Case studies of people using direct payments showed positive outcomes. Examples from other local authorities such as Wigan had shown it was possible to reduce costs and provide a better service.

- Consultation needed to involve people with autism as well as people with learning disability and some people had found the previous questionnaire difficult so more easy read questions and better explanation would be helpful - One of the challenges in Rotherham was that people with autism and people with learning disability tended to be lumped together and sometimes that was right but it had also led to some services not being designed for people with autism. The Strategic Director would be chairing the first Autism Partnership Board meeting on 20th July, 2017. Initial work would focus on increasing awareness of autism system-wide as overall it was agreed there was a lack of confidence in working with people with autism.

Resolved:- That the Health Select Commission receive further updates as the work progresses.

With regard to wider work on Learning Disability Services Vicky Farnsworth provided a brief update on the work of the Transforming Care Partnership across the sub-region. SpeakUp was closely involved as both Vicky and Robert Parkin sat on the panel as experts by experience. A lot of good work had been carried out although there was still more to be done in relation to people with learning disability or autism moving out of hospital and back into the community.

19. HEALTH SELECT COMMISSION WORK PROGRAMME

Janet Spurling, Scrutiny Officer, presented a report setting out a detailed draft work programme for 2017-18 and provisional memberships for the three NHS Quality Account sub-groups.

Health and Social Care Services were undergoing transformation, including closer integration through joint commissioning, joint posts, locality working and multi-disciplinary teams. This work was an important

long term programme that the Health Select Commission had been scrutinising since 2015-16 and would continue to be rolled out over the next few years.

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

The overall priorities for 2017-18 were:

- Rotherham Place Plan – health and social care integration
- Adult Social Care performance and development programme
- Learning Disability
- Child and Adolescent Mental Health
  plus
- NHS Commissioners Working Together Programme (through the JHOSC)

Attention was drawn to items in the work programme that linked in with issues raised earlier in the meeting such as implementation of the Carers' Strategy and Learning Disability transformation.

The April meeting had been earmarked for a spotlight review with a theme to be determined by the Commission. However following a recent seminar on Care Homes and the establishment of a new Quality Board under the auspices of the Health and Wellbeing Board, this could present an opportunity to consider how that work was progressing.

Councillor Roche confirmed that with regard to the Health and Wellbeing Strategy in September this would be a good opportunity for the Commission to be involved at a very early stage in the refresh.

Resolved:- (1) That the draft work programme for 2017-18 be approved.

(2) That the proposed membership for the quality account sub-groups for 2017-18 be approved.

(3) That it be noted that if any urgent items emerge during the year this might necessitate a review and re-prioritisation of the work programme.

20. NOTES OF FROM QUARTERLY BRIEFING WITH HEALTH PARTNERS

The summary of discussions at the quarterly briefing with health partners held on 4th May, 2017, was noted.

21. HEALTHWATCH ROTHERHAM - ISSUES

Healthwatch had lobbied Rotherham Clinical Commissioning Group and the Council to produce an Autism Strategy and although not yet in place the new Autism Partnership Board was a first step.

Councillor Roche confirmed he would report back to the Commission on progress in developing the Autism Strategy.

The Care Quality Commission were undertaking a national review of Child and Adolescent Mental Health Services which was expected to lead swiftly to a Green Paper. Tony Clabby had been asked to sit on the expert advisory group.

Healthwatch sat on the Safeguarding Adults Board and part of their contribution to the Strategy was a guide to Lasting Power of Attorney, a much needed tool as people do not make provision and plan ahead for difficult decisions around care.

Hard copies of the Healthwatch Annual Report were circulated and it was available on the link below:

http://healthwatchrotherham.org.uk/wp-content/uploads/2015/07/Annual-Report-2016-17-Final.pdf

22. HEALTH AND WELLBEING BOARD

Councillor Roche confirmed that new Sensory Impairment Centre on Ship Hill would be opening shortly and a visit could be arranged for Commission Members.

The minutes of the meeting of the Health and Wellbeing Board held on 31st May, 2017, were noted.

23. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 21st September, 2017, commencing at 9.30 a.m.

Supplementary information for Health Select Commission

Follow up from Minute No. 17 (Adult Social Care - Provisional Year End Performance 2016-17)

Supplementary information requested by Health Select Commission following meeting held 20th July 2017

Chart 1 below displays data on the 27 new admissions (18-64) to residential/nursing care (2016-17) by the age of the service user at the time of admission. Chart 2 further displays detail relating to the primary support reason of the service user and the setting into which they were admitted.

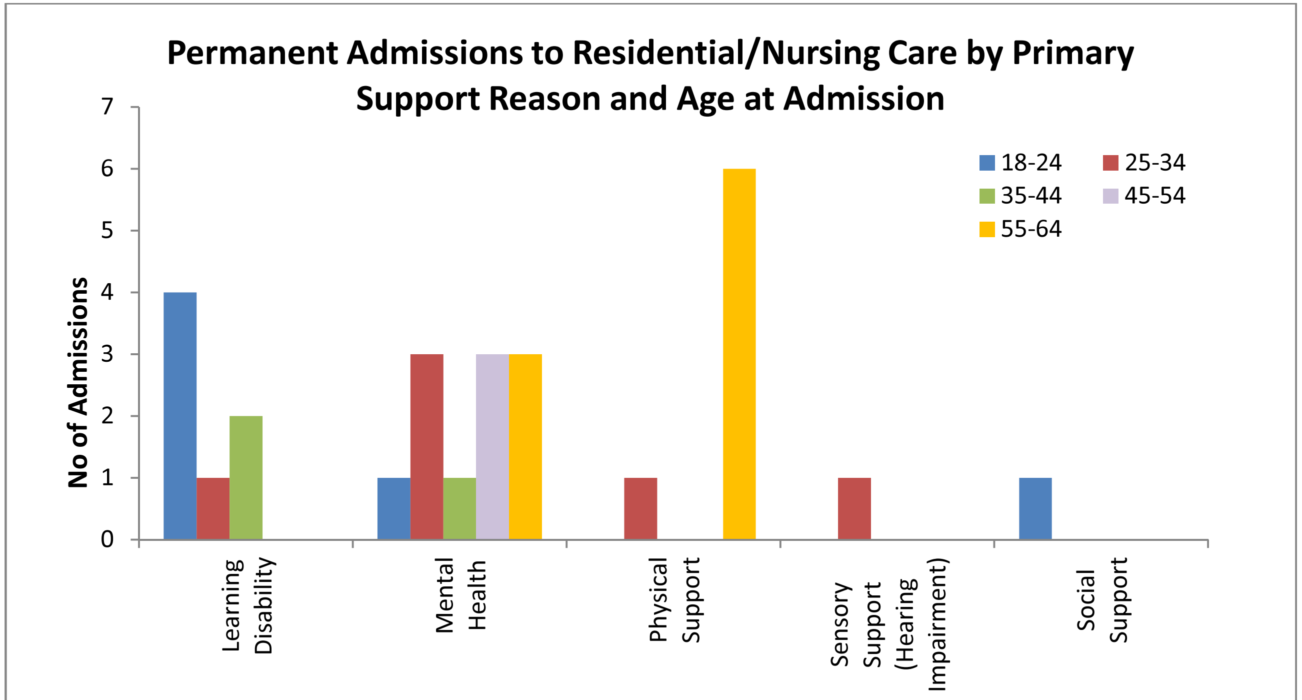


Chart 1

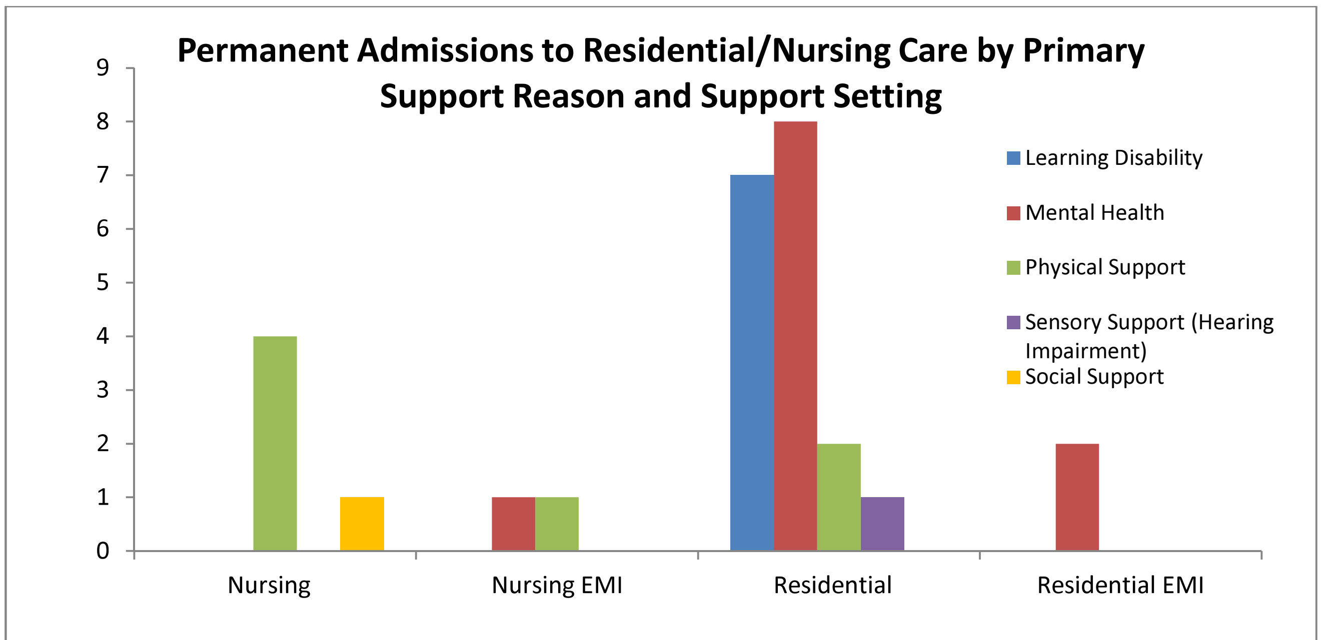


Chart 2

Key: EMI – Elderly Mental Infirm

Chart 3 details number of long term service users as at 31st March 2017 by extended age group.

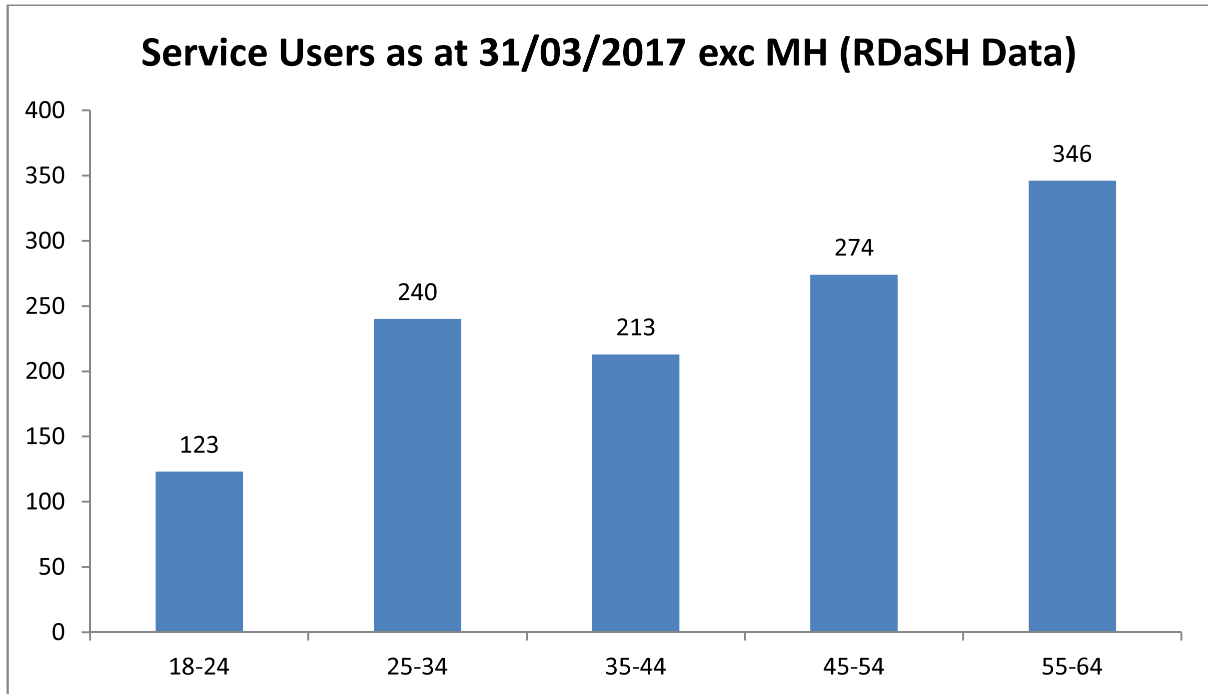


Chart3

Provided on behalf of

Scott Clayton

Performance Assurance manager

Charna Manterfield

Senior Performance & Data Officer

Performance and Intelligence

Adult Care and Housing

Rotherham Metropolitan Borough Council

Riverside House, Floor 2, Wing A, Main Street, Rotherham, S60 1AE

E: chama.manterfield@rotherham.gov.uk

T: (01709) 255344

 Agenda Item 8

Briefing Note for Health Select Commission

21st September 2017

Care Co-ordination Centre and Integrated Rapid Response

Lead Officer:	Ian Atkinson, CCG Nathan Atkinson, RMBC Chris Holt, TRFT Dianne Graham, RDaSH

Purpose

The purpose of the report is to update the Health Select Commission on progress in relation to the Care Co-ordination Centre and Integrated Rapid Response

Summary

This project focusses on the development of the Care Co-ordination Centre (CCC) and Integrated Rapid Response (IRR) Services. Both services are currently provided by Rotherham NHS Foundation Trust physical health services. These are predominantly second tier adult services which sit behind the prevention agenda working with individuals who are normally at a point in which provision of services is unavoidable.

The role of the Care Coordination Centre is to provide a telephone based nurse led approach to directing patients to appropriate levels of care. The Integrated Rapid Response Service is commissioned to provide an immediate short term response to meeting community based health and social care needs.

The ambition within the Rotherham Place Plan is to extend both services to include mental health and social care to provide a multi-disciplinary approach to address the whole needs of the service user, resulting in an improved experience and more effective use of resource.

A phased approach is being taken to implementation to realise benefits within the available resource and to manage risk. The first phase of care-coordination will be for physical and mental health, with a later phase for social care. Phase 1 of the rapid response service will be co-location prior to full integration in phase 2.

The Case for Change

Strategic

The Care Act places a duty on the local authority to integrate services to promote well-being, improve outcomes and contribute to prevention, reduction or delay in needs. The NHS Five Year Forward View sets a target of integrated health and social care services by 2020-21. These drivers are reflected in the Rotherham Together strategy, the Rotherham Health and Well Being Strategy and the Rotherham Place Based Plan. In addition NHSE have published/are publishing guidelines regarding Mental Health Hospital Liaison Services (Core 24) and crisis and home treatment functions (Core Fidelity) which will shape the design and development of the integrated CCC and IRR services to facilitate alternatives to acute admissions.

Operational Background

In addition to the strategic case for change there are also local operational drivers which require addressing to improve the service user experience. A triage practitioner commented at a stakeholder event that current arrangements make 'it easier to bring patients into service, than to keep them out' despite evidence that this may not be the most suitable option for them.

The reasons for this have been identified as:

i. There is no single view of options across the health, social care and voluntary sector system. Information is held in silos within respective services, in differing forms: electronic, written and personal knowledge.
ii. Current arrangements are largely based on referral criteria around eligibility for services. This creates an open or closed door which leads to people in need being passed around the system if they don't meet criteria
iii. Criteria are not well understood and require review
iv. Some patients are bought into service as there is a need for support and there is no (known) suitable alternative

Some distressed and isolated people who do not meet the current service criteria frequently contact the Care Co-ordination Centre and other public sector contact centres. These contacts tend to be time consuming and prevent other users accessing the service. An alternative support mechanism is required. In addition there are issues with the current mental health and social care out of hours crisis/urgent care provision, provided by RDASH

i. When Rotherham clinicians are involved with a patient, calls divert to Doncaster switchboard and a message is passed on when clinicians become free, this could take several hours on occasions.
ii. The service is predominantly staffed by specialist (higher paid) social care AMHPs. In the future service model there will be an expectation that social care staff focus on the roles they have been trained for, which will leave a gap in health cover
iii. For safety reasons high risk assessments are carried out in pairs, currently by two clinicians. This is unnecessary and inefficient, a support worker would be a suitable support

Progress Update

The Care Co-ordination Centre

The initial model for the CCC envisaged a structure whereby administrative and clinical staff covered both physical and mental health activity. Detailed analysis of the pathways highlighted a patient safety risk from a shared triage process. Similar models elsewhere have a combined referral process, with specialist triage. A change to the model has been agreed to reflect this. The CCC will therefore receive and record all referrals, with triage by specialist staff on a duty basis in the IRR. There will be a phased approach to implementing this. Subject to suitable accommodation, RDaSH

staff will transfer into the TRFT team from October 2017 initially focussing on physical health enquiries. Transfer of RDaSH referrals will be staged starting with mental health followed by Learning Disabilities and Out of Hours. Triage arrangements will remain as per current arrangements in the first instance and transfer with the development of IRR. Again, this phased approach will manage risk. Discussions are taking place with the voluntary sector to develop a network of referrals for ‘just to talk contacts’ ie lonely, isolated and anxious people who use the service inappropriately, but require non statutory support. **Integrated Rapid Response** Phase 1 will bring together the respective rapid response teams from health and social care. The Crisis and Home Treatment teams from RDaSH and RMBC AMHPs will join the already established TRFT teams. Discussions are underway regarding other social care resource including re-ablement. Phase 2 will be aligned to the roll out of the integrated locality model and the integrated discharge project to manage patients at risk of admission and facilitate early discharge. Evidence from the locality pilot highlights the benefit of a planned and unplanned model, which would reflect the new mental health Care Group structure. An update on risk management is set out at appendix 1.
Patient, Public and Stakeholder Involvement:
Proposals have been developed from a number of stakeholder events involving service users, carers, commissioners and colleagues from social care, health and the voluntary sector. Consultation meetings have been held with affected staff groups in RDaSH in relation to the CCC.
Equality Impact:
An impact assessment will be completed as part of the project plan. There has been targeted dialogue with traditionally underrepresented groups.
Financial Implications:
Referral and triage is being managed from within the current financial envelope. Initially 3 people will transfer from RDaSH to TRFT to manage referrals. Triage will be done through existing teams and will transfer in line with the implementation of IRR plans. It is intended to move resource to the front end as part of the locality formation process to provide a 24/7 service. There has been systemic financial benefit from cross organisation working. By working with TRFT RDaSH can access established call centre technology (Netcall), only incurring costs for extension of the system. The RDaSH Unity programme has shared development work done for the Doncaster SPA which has saved significant analysis and development time for TRFT.
Human Resource Implications:
3 RDaSH administrative staff have been appointed into the CCC contact handling roles following an expressions of interest process. The triage service will be developed as part of the next phase of change.

Procurement:
N/A
Approval history:
Summer 2016: approval of recommendations by CCG and Scrutiny Committee as part of the RDaSH Care Group formation process Update to Accountable Care System September 2017
Recommendations:
Health Select Commission is asked to receive and note the update

High Level Issues and Risks **Appendix 1**

Risk Description / Consequences	Risk / Issue	Mitigation	RAG
The RDaSH Unity programme may not deliver in time for the CCC go live timescales	Issue	Unity implementation has been delayed from October 2017 to April 2018. Alternative arrangements are being put in place. Development work from the Unity programme will benefit implementation	*Green*
If issues raised by GPs and the CCG are not resolved with the business as usual CCC and sepsis pilot, there is a risk that GPs will not support the development of the service	Risk	TRFT are working with the CCG to address the issues and develop solutions which work for primary care and the acute hospital. The CCC are monitoring the situation and reporting to the CCG	*Amber*
There is a risk that RDaSH staff will not want to join a physical and mental health service	Risk	This risk was managed for the CCC admin through targeted engagement highlighting the benefits. 3 wtes successfully appointed through an expression of interest process. The risk remains live for subsequent phases which will be managed in a similar way	*Green*
Staff do not have sufficient skills and knowledge to respond effectively to physical and mental health enquiries	Risk	This risk has been closed as it has been agreed to take a different approach with triage through specialist roles	*Closed*
The IRR co-located teams continue to work in individual silos rather than providing an MDT approach, drawing on the best use of resource available.	Risk	A clear brief and protocols will be co-produced with the teams. Out of hours management responsibility will be agreed. Monitoring procedures will be put in place.	*Green*
Staff will not have access to records held on different systems for decision making purposes. Patients and professionals may need to repeat information	Risk	Interim arrangements are being developed. Funding from the IBCF will ensure the development of the Rotherham Health Record for an integrated physical health, mental health and social care record.	*Green*
Information governance requirements may limit access to information	Risk	This is being managed through a cross organisation information governance group	*Green*
If the teams are not aligned with national Core 24 and Core Fidelity requirements there will be penalties These initiatives also have associated funding assumptions which are required to assume sustainability.	Risk	Proposals to be developed and cross referenced against Core 24 and Core Fidelity. Advice to being sought from NHSE regarding non compliance if there is a significant issue that cannot be resolved	*Green*

Agenda Item 9

Rotherham Doncaster
and South Humber
NHS Foundation Trust

Update on the RDaSH Rotherham Care Group Transformation Plan

Michaela Bateman
Service Manager
Steph Watt,
Strategy and Transformation
Manager

September 2017

1. Purpose

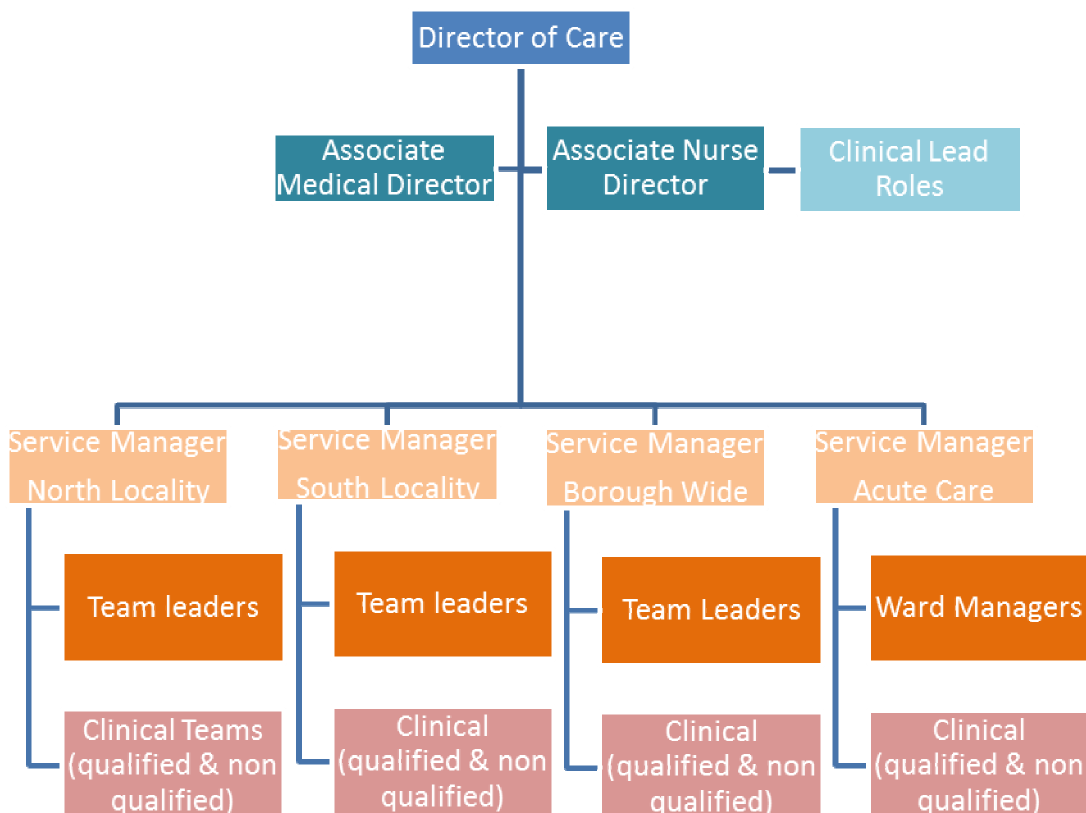
The purpose of this paper is to update the Commission on the RDaSH adult mental health transformation activity as outlined to the Commission in Summer 2016.

2. Group Formation

RDaSH have now moved from age related cross Trust business divisions to place a based locality Care Group. The management structure is in place. This is made up of three new Care Group senior management positions:

- Director of Care: Dianne Graham
- Associate Medical Director: Dr Graham Tosh
- Associate Nurse Director: Rachel Millard

The post of Rotherham Locality Manager was removed as part of the senior management re-structure. The service management structure set out below emerged from the pathway framework and service configuration work to support the delivery of a multi-disciplinary approach, where care wraps round the patient. The structure is based on a prevention and recovery model and has been developed in line with the Five Year Forward View, the Place Based Plan and in anticipation of the roll out of an integrated health and social care model. The new structure represents a reduction of 6.33 whole time equivalent band 8 service manager roles to 4.



3. Clinical Services Transformation

3.1 Care Co-ordination and Integrated Rapid Response

Currently there are multiple contact points for stakeholders (patients, carers and professionals) to access support. An integrated physical and mental health initial point of contact will be provided by Rotherham NHS Foundation Trust's (TRFT) Care Co-ordination Centre (CCC). Initially this will be for all-age adult mental health (excluding IAPT) and learning disabilities service users. This will include an all-age (including children's) single point of contact for mental health hospital liaison. Triage will be carried out in an extended Integrated Rapid Response Service. This will build on the current TRFT service and plans include the RMBC mental health social care services relating to Adult Mental Health Practitioners and RDaSH crisis and home treatment teams. The services will initially be co-located, leading to full integration. This phased approach is to ensure smooth transition and manage risk.

3.2 Locality Teams

The mental health locality services will map onto the new proposed locality model of North, South and Central. The mental health model will have two teams that work into the third locality as there isinsufficient resource to split three ways. Work is underway with the Council to identify opportunities to co-locate services and use community accommodation for group and therapy work. This needs aligning with the wider conversations around the role out of the Village Pilot.

It's anticipated that over 60 % of RDaSH staff will be based in locality teams. Staff within the locality will be attached to pathway teams, according to their skills and specialisms. A new pathway framework has been developed of brief interventions, complex care and longer term conditions. A skills audit and gap analysis has been carried out to identify current skills and shortfalls. Staff will predominantly work within a pathway stream, but may work across pathways according to patient need and their own specialism.

Staff from the memory service and older people's community team will form part of the complex care pathway. Roles will be reviewed to in the light of the primary care dementia pathway and in anticipation of growing demand over the next ten years. The role of the Care Home Liaison team will be reviewed alongside TRFTs team with a view to integration. It is proposed that IAPT services and Learning Disabilities and Drug and Alcohol community functions will be locality based to further develop links with primary care and improve integration with mental health services.

3.3 Adult Mental Health Hospital Liaison This successful early transformation project is now re-currently funded. Development funding has been secured from NHSEngland to enable the service to become compliant with the national Core 24 standard, which will enable the service to become 24/7.

3.4 Inpatients

We are developing all age services within our inpatient facilities in order to provide improved care based on need rather than age.

Woodlands
The Ferns ward has been open as a pilot since May 2017 aiming to provide cognitive rehabilitation for patients admitted initially to TRFT who are deemed to be medically stable. This is a joint pilot between RDASH and TRFT and it has been funded until the end of November 2017.

3.5 Social Care
Health and social care responsibilities have become blurred within working age adult teams. These have been reviewed with Council colleagues in the light of the Care Act and mental health guidance[1] A new model for integrated working is being developed to support the independent lives/recovery and wellbeing ethos and aligned with the pathway framework. RMBC Adult Mental Health Practitioner roles and social work roles will form part of an RMBC change process.

Social care for older people and learning disabilities are currently separate to RDaSH services which creates a disjoin for service users and is at odds with the stated place plan and the national 5 year forward requirement of integrated mental health and social care by 2020. It is hoped that the new integrated working age adult mental health model will be extended to an integrated all-age adult mental health and learning disability model.

3.6 The Wellbeing Hub
RDASH are currently piloting a centrally located well-being hub in partnership with Rotherham United Sports Trust (RUST). The aim is to address the needs of those members of the Rotherham community who struggle to sustain good mental and physical health as a result of challenging social circumstances, poor coping ability, lack of support network, and poor quality of life. Interventions are delivered via therapeutic and educational classes that are supported by a broader programme of sport based activity. Opportunities for peer support, voluntary work and preparation for employment are key objectives.

3.7 Social Prescribing
The Rotherham Social Prescribing Scheme is a nationally acclaimed, innovative project with a high profile within the NHS and voluntary sector. Social Prescribing involves funding social activity via the voluntary sector to support those needs that traditional health intervention cannot sustainably address such as social isolation and poverty. It sits alongside clinical interventions helping people live their lives in a way that feels like “living” rather than “coping” and “surviving”. It expands on Rotherham’s integrated response to patient care; it’s where the NHS ‘meets’ the community and its assets, shifting the focus from conditions or ages to localities and communities.

NHS Rotherham CCG has already used social prescribing to support people with long term physical health problems. Following on from the successful Long Term Conditions (LTC) social prescribing scheme, which found consistent reductions in the use of services, (a 6-11% reduction in non-elective in patient stays and a 13-17% reduction in the use of A+E services, more detailed analysis shows higher reductions in certain types of patients), this approach was extended in 2015 to mental health

patients within Rotherham for a one year pilot. The independent evaluation of the pilot scheme carried out by Sheffield Hallam University's Centre for Regional Economic and Social Research (CRESR), found that it helped increase the number of discharges from mental health services and improved social and emotional well-being of the service users. Within the first year 54% of the service users who had been referred to the service had been discharged from mental health services, some patients having been supported by secondary mental health services for between 5-20 years, with only 2 discharged service users being re-referred. The evaluation also showed that patients who had been through the mental health scheme have experienced wider social benefits.

4. Next Steps

The next steps include:

- Launch of the integrated CCC (phase one scheduled for October 2017) and IRR phase 1
- Completion of the clinical and administration review
- Roll out of the pathway framework (phased, brief interventions is currently being piloted)
- Roll out of locality teams, aligned to the roll out of Village Pilot model (from January 2018)

A more detailed update on the pathway framework will be provided to the Commission's November meeting.

Rotherham Health Select Commission

21st September 2017

Delayed Transfers of Care (DTOC)

Lead Officer:	Ian Atkinson – NHS Rotherham CCG Nathan Atkinson – Rotherham Met Rotherham CCG Dominic Blaydon – The Rotherham NHS Foundation Trust

Purpose:

The purpose of the report is to update the Rotherham Health Select Commission on progress with regard to reducing Delayed Transfer of Care (DTOC) at The Rotherham NHS Foundation Trust.

Background:

NHS England defines patients as ready to transfer out of the hospital setting when:

a) A clinical decision has been made that the patient is ready for transfer AND
b) A multidisciplinary team decision has been made that the patient is ready for transfer AND
c) The patient is safe to discharge/transfer.

Delays in discharge can be linked to a number of different reasons, common areas of delay relate to patients waiting for assessment and decision regarding continuing care, patients waiting for care packages to be established in the community or awaiting a care home package.

One of the four national conditions set out in the 2017 Better Care Fund planning guidance requires Health and Care systems to work jointly to reduce delayed transfer of care (DTOC) to a level of no more than 3.5% of patients at any one time being classified as DTOC within the hospital setting (equates to an average 15 patients at any one time).

Historically the Rotherham Health and Care Community has performed well on DTOC, consistently delivering below the 3.5% target. However throughout 2017 (although comparable to many other areas of the country) The Rotherham NHS Foundation Trust (TRFT) has reported a more challenged position is terms of delivery of the DTOC indicators, as highlighted below.

Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
4.1%	4.2%	6.0%	5.1%	5.9%	5.4%

Analysis of key issues and of risks

Taking a proactive approach in response to the increase in DTOC levels locally, TRFT and RMBC commissioned a joint external evaluation of discharge processes in the hospital in April 2017. The two day review of current transfer of care was carried out by a senior advisor from the Care and Health Improvement Programme, Local Government Association and a Discharge Planning Manager from University Hospitals of North Midlands NHS Trust.

The report recommendations (below) were agreed and signed up to by all Rotherham partners and these recommendations now form the basis of the Rotherham DTOC Action Plan.

i. Development of a 7 day a week integrated discharge team to develop a shared understanding and common approach to simple and complex discharges to improve patient outcomes and working relationships; aid management of overall discharge planning; improve effectiveness of referrals and reduce duplication
ii. Simplify Pathways and Assessment Processes including Home First
iii. Implement timely Escalation Process and Response, review who and how teams respond to pressures and how they are de-escalated including review of potentially 'stranded patients' to help improve patient flow and outcomes for individuals
iv. Agree Joint reporting and Data Set to have a standard, single version of the truth to provide a firmer foundation for problem solving as a system and allow for focus on the right problems rather than assumed issues
v. Awareness and Training to improve understanding of DTOC's and Care Act requirements

2. Activity to Date

Following a self-assessment based on the national High Impact Change Model and the review recommendations jointly commissioned by TRFT and RMBC, the following activity has taken place in relation to the action to integrate the discharge functions:

- 2 dedicated workshops with cross system stakeholders from the CCG, RMBC, TRFT and RDaSH including health, social care and therapy staff
- Visit to Doncaster Integrated Discharge Team combining physical health, mental health and social care
- Planned event with staff teams
- Identification of £135,000 from the Improved better care fund grant to support the transformation required within the DTOC action plan.

3. Approach

It has been agreed by partners that a two phased approach will be taken to the project to realise early benefits in time for winter resilience activity.

Phase 1: September 2017

- Integration of the Transfer of Care Team (TOC) and Hospital Social Care Team within a single leadership model
- Re-location of the TOC team to the current Social Care offices on D level, TRFT
- Scoping of phase 2 for wider integration based on successful models elsewhere including: development of a 7 day service, leadership, roles and responsibilities, data capture and reporting

Phase 2: April 2018

The vision for phase 2 is dependent on the scoping exercise, but early discussions would suggest the potential for an integrated team of nurses, allied health professionals (including physiotherapists and OTs) and social care who work together to provide integrated rapid assessments and co-ordinate services to facilitate discharge for patients who are medically well enough to be discharged but may require additional support in the community.

Patient, Public and Stakeholder Involvement:

Provider workshops have taken place over the last few weeks regarding integration of health and social care teams (hospital discharge). Further workshop and engagement will take place as progress is made.

RCCG has attended the Rotherham Patient Participation group to talk through DTOC plans and receive feedback.

Recommendations:

Health Select Commission is asked:

To note the content of the report including Appendix 1 DTOC Action Plan

APPENDIX 1- DTOC Action Plan linked to High Impact Change Model Self-Assessment (NHSE)

Key Milestone	Actions	Start Date	End Date	Lead Organisation	Progress/ Comments	Rag Rate
1. Full integration of discharge planning	Map out current teams/function of Transfer of Care Team, Hospital Social Work and MDTs	**July 2017**	**August 2017**	RFT/RMBC	Exercise undertaken through 2x workshops with staff to understand current position including FTEs across each service and main function.	
	Discussion with Doncaster re; their model including possible secondment of Doncaster colleague (6 month).		**August 2017**	RFT/CCG/ RMBC	Doncaster visit by all partners in late July to understand model and bring back learning. Secondment not available – however Rotherham staff experience of model is being utilised	
	Agree shared model for integration of discharge function		**September 2017**	All	Project Initiation Document completed on phased approach to implementation – to go through ACS governance in September	
	Integration of Hospital Social Work into new model for discharge. Formalise links with Mental Health and Community Teams		**December 2017**	RFT/CCG/ RMBC	Standard operating procedures in development. Identification of appropriate office space underway.	
					Overall Rag Rating	
Agree Joint Reporting and Data Set	Agree revised joint reporting structure and governance for reporting (acute, social care and non acute).	**July 2017**	**September 2017**	CCG/TRFT/ RMBC	**Change 2** Leads for performance (CCG/RMBC/TRFT) met and agreed process for sharing data set.	

Key Milestone	Actions	Start Date	End Date	Lead Organisation	Progress/ Comments	Rag Rate
	Agree process for signing off delays (acute, social care and non acute)	**July 2017**	**September 2017**	CCG/TRFT/ RMBC	Standard Operating Procedures are being developed to support appropriate and consistent identification of DTOC across the system. To be agreed shortly.	
Awareness training to include full understanding of Care act 2014	Awareness training required to ensure principles of Care Act implemented – Prevent, Reduce, Delay (Home First) All appropriate Health colleagues complete the E-Learning training commissioned by RMBC	**August 2017**	**March 2018**	TRFT Support from Nigel Mitchell RMBC	**Change 3** E-Learning packages available through RMBC – TRFT lead to be identified to ensure work is progressed	
Ensure a Universal Home First Approach is offered	Expanded Integrated Rapid Response – incorporate enabling/reablement into the provision to provide a universal offer of discharge home as pilot provision **NB** requires investment possible IBCF.	**July 2017**	**October 2017**	CCG/RMBC Jacqui Clark	**Change 4** Business Case for additional resource has been agreed and will be funded through IBCF. RMBC are currently in negotiation with provider for a proposed start date in October 2017	
	Map current DST activity in acute setting. Revise and implement new pathway to D2A provision at Waterside Grange Longer term solutions – • Review of Discharge to Assess beds (potential to shift financial resource to home model) • Review of enabling service provided by RMBC	**July 2017**	**October 2017** **March 2018**	CCG CCG/RMBC Support from partners	Pathway process has been developed for 3 of the 6 beds at Waterside Grange. New process to be phased in throughout September	
Agree escalation process and response	All partners on EMS	**July 2017**	**August 2017**	All partner leads	**All changes** All partners have triggers and actions agreed	

Key Milestone	Actions	Start Date	End Date	Lead Organisation	Progress/ Comments	Rag Rate
	TRFT revise triggers for acute and community		**September 2017**	TRFT	Report taken to TRFT transformation board to revise triggers – work is ongoing	
Social Care offer in new Emergency Centre	Consider how social care will support the new EC model of front end streaming (admission avoidance)	**July 2017**	**March 2018**	RMBC Jo Martin CCG/TRFT	**Change 4** RDASH integration progressing well. Social Care involved in the frailty team. Further work to embed model and understand role of social care as team becomes integrated	
Review 7 Day Offer	Review 7 Day services offer across acute/community – opportunities to expand or reconfigure provision to better meet need	**July 2017**	**September 2017**	RMBC	**Change 5** Helen Brown change lead working on therapy pathway and options for flexibility in provision (expansion of OT offer to meet need of service). Potential to take longer to implement service redesign.	
	Provision of robust 7 day week offer from social care providers (Dom Care/Residential Care)		**March 2018**	Jacqui Clark RMBC / CCG		
Develop trusted assessor model with social care providers	Pilot and look to roll out trusted assessor model in social care – Residential Care	**September 2017**	**March 2018**	Jacqui Clark RMBC / CCG	**Change 6** Work underway to integrate discharge team. Workshop took place July 2017 with partners and patients re; integrated assessment.	
Patient and Family Choice	Improve early identification of patient likely to need care home	**September**	**March 2018**	TRFT	**Change 7**	

Key Milestone	Actions	Start Date	End Date	Lead Organisation	Progress/ Comments	Rag Rate
(19% of DTOCs in 2015-16)	admission. Re-design of discharge leaflet.	**2017**			Reviewing this for IRR/CCC	
Review MoU Agreement	Review of MoU Agreement already in place, to reflect changes in the discharge teams (as above). All partners to implement MoU which includes Trusted Assessor	**December 2017**	**January 2018**	CCG/RMBC support from Partners	**Change 1 & 3**	
Review and streamline discharge pathways **NB** links to wider place plan priority re; reablemet review.	Map current position across the discharge pathways (currently 3 in place – discharge home, discharge to intermediate care beds, and discharge to nursing/assessment beds).	**July 2017**	**October 2017**	CCG/RMBC	**Change 1 & 3**	
	Streamline processes and ensure all relevant partners are aware of the pathways.		**March 2018**	Support from partners		

Briefing paper for Health Select Commission **21 September 2017**

Ambulance Response Programme

Introduction

In 2015 NHS England commissioned a pilot Ambulance Response Programme to test out new ways of working for the service to maintain and improve clinical outcomes for patients in the face of increasing demand. Yorkshire Ambulance Service (YAS) has been one of the services that participated in the pilot from the outset in October 2015.

The University of Sheffield undertook a full evaluation of the programme and on 13 July 2017 the Secretary of State for Health supported the formal recommendation from NHS England to roll out the programme to every ambulance service in England. The intention is for the new standards, outlined in Appendix 1, to be implemented by this winter.

Key issues

Concerns regarding the need to modernise how ambulance services are organised are set out in the appendix and relate to:

- the eight minute response time target for urgent “red” calls
- no response time target for calls classed as non-urgent i.e. “green”
- 60 second time for call handlers to determine the response for the patient
- time when the clock is stopped
- avoiding unnecessary ambulance dispatches

Pilot

The pilot tested a new operating model and new set of targets and involved over 14 million calls over an 18 month period. The evaluation was positive and the full report is available on the NHS England website at the following link: https://www.england.nhs.uk/publication/arp-evaluation/

Key points of the new model include:

- giving staff slightly more time to identify patients’ needs, allowing quicker identification of urgent conditions
- new target response times across four categories, covering every patient
- changing the rules around what “stops the clock”, so targets can only be met by doing the right thing for the patient
- introducing three standardised pre-triage questions to increase early recognition of cardiac arrest
- new clinical indicators for heart attack patients and stroke patients

Next Steps

As it is a national issue the intention is to ask YAS to explain the potential impact of the new standards and any changes that will be required to the Yorkshire and Humber Joint Health Overview and Scrutiny Committee.

Recommendations for HSC

Members of the Health Select Commission are asked to:

- Determine any specific questions to submit to the Yorkshire and Humber Joint Health Overview and Scrutiny Committee to ask the Yorkshire Ambulance Service in relation to the new standards.

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

NHS England

Professor Sir Bruce Keogh
National Medical Director
Skipton House
80 London Road
SE1 6LH

Jeremy Hunt
Secretary of State for Health
By email and hard copy

13 July 2017

Dear Jeremy,

Ambulance Response Programme

In recent weeks we have seen countless examples of the outstanding work done by the ambulance service in the most tragic of circumstances, from the response to terrorist attacks in London and Manchester to the devastating fire at Grenfell Tower. The extraordinary response to these terrible events came on top of the everyday heroics by paramedics that save countless lives day in, day out across the country.

We have also marked the 80th anniversary of the introduction of the 999 emergency telephone number. The ambulance service has changed beyond recognition during this time, from little more than vehicles transporting patients to hospitals, often staffed by volunteers, to the “mobile hospital” model we see today.

It is a timely reminder that the NHS is constantly evolving and, as leaders of the NHS, we must always ensure that we move with the times – supporting staff to provide the best possible service to our patients, rather than putting obstacles in their way.

Yet, in the case of the ambulance service, it has become increasingly obvious that we have failed to keep up. Since the mid-1970s most aspects of the service have changed beyond recognition: a large number of responses now focus on the frail elderly rather than traditional medical emergencies, half of all calls are now resolved by paramedics without the need to take patients to hospital, and for specialist care the focus of the ambulance service is increasingly on getting patients to the *right* hospital rather than simply the nearest. Over the last four decades, however, the service has remained organised around an eight minute response time target.

Amidst all of this change that standard has become an anachronism, with anxious callers placed into outdated categories that are no longer fit for purpose. Half of all calls are classed as urgent with an 8 minute response time target – but one that has to be met in only 75% of cases. The other half of calls are deemed non-urgent with no national response target at all. Response times for that second group of patients have, unsurprisingly, doubled in some trusts in the last two years alone.

For those covered by the 8 minute target the system is equally dysfunctional. Ambulance staff are given just sixty seconds to decide what resource each patient needs. While this may have worked many years ago, it is hopelessly unsuited to modern medicine. A stroke patient, for example, will gain little benefit from a paramedic on a motorbike when what they need is an ambulance that can rapidly convey them to a specialist treatment centre.

There is also the problem of "hidden waits" for those patients needing urgent hospital treatment. At present, the clock is "stopped" by the arrival of the first vehicle, not the arrival of the vehicle that the patient actually needs. A quarter of all patients who require hospital treatment have the clock stopped by a vehicle – often a motorbike – which is in fact incapable of taking them anywhere. There are few better examples of hitting the target and missing the point.

Most worryingly, the target can increase response times and cost lives. Multiple vehicles are often dispatched to the same patient in a race to "stop the clock". When calls where a patient's needs only become known after the one minute has elapsed are factored in, one in four ambulances dispatched are now stood down before they reach the scene. Every year hundreds of thousands of patients fail to get an immediate response because ambulances are dispatched in this wasteful and illogical manner. Correcting this anachronism would free up to fifteen thousand ambulance responses every week.

These criticisms are not new. They have been highlighted by the National Audit Office, by the Health Select Committee, and by countless paramedics and ambulance staff. So when I wrote to you in 2015, I said that we were determined to finally tackle this problem. I commissioned the Ambulance Response Programme (ARP) – an independently evaluated trial to test new ways of working for the service, led by Professor Jonathan Benger and Professor Keith Willett.

Over the last 18 months the ARP has covered over 14 million calls, testing a new operating model and new set of targets. Further details are annexed to this letter, but in summary this new system would:

- Change the dispatch model of the ambulance service, giving staff slightly more time to identify patients' needs and allowing quicker identification of urgent conditions.
- Introduce new target response times which cover every single patient, not just those in immediate need. For the most urgent patients we will collect mean response time in addition to the 90th percentile, so every response is counted.
- Change the rules around what "stops the clock", so targets can only be met by doing the right thing for the patient.

The results have been impressive. The trial has demonstrated that, should these changes be adopted nationally:

- Early recognition of life-threatening conditions, particularly cardiac arrest, will increase. Based on figures from London Ambulance Service, it is estimated that up to 250 additional lives could be saved in England every year.
- Up to 750,000 patients every year would receive an immediate ambulance response, rather than joining a queue.
- The differences in response time between patients living in rural areas and those in cities would be significantly reduced.

All of this has been achieved with no patient safety or adverse incidents attributed to the ARP in those 14 million calls.

Given this comprehensive and compelling evidence, I am writing to you formally to recommend the roll out of the Ambulance Response Programme to every ambulance service in England. Patients across the country deserve to benefit from the significant improvements seen in the trial areas, from ambulances reaching cardiac arrests in London 30 seconds faster to the one minute improvement on stroke responses in the West Midlands. These changes, together with ambitious new clinical standards for heart attack and stroke patients, will end the culture of "hitting the target but missing the point." They will refocus the service on what actually counts: outcomes for patients.

These trials, the most extensive ever conducted, have provided us with an unrivalled evidence base for these changes. They also come with the strong endorsement of every expert organisation we have spoken to – whether the Royal College of Emergency Medicine, the Stroke Association, or the College of Paramedics.

If these recommendations are accepted then we intend to fully implement these new standards by the beginning of winter 2017, a little over six months before the NHS's 70th birthday. As we inevitably use this moment to reflect on both the achievements and challenges of the NHS, I am confident that the ambulance service would approach this landmark in a much stronger position to continue its remarkable work even more effectively.

Yours sincerely,

Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP
National Medical Director
NHS England

Annex 1 – Changes to the current national standards

Changes to triage questions

The “Nature of Call” system introduces three standardised pre-triage questions to increase the early recognition of cardiac arrest. Based on London Ambulance Service figures obtained by Sheffield University, it has been estimated that up to 250 additional lives will be saved in England every year.

Changes to clinical standards

To ensure the ARP changes drive improved clinical outcomes, we will be introducing a new set of clinical indicators.

For serious **heart attack** patients, who have specific ECG changes, we will measure the proportion of patients that receive definitive treatment (balloon inflation during angioplasty at a specialist heart attack centre) within 150 minutes of making a 999 call. We expect 90% of patients to meet this standard by 2022.

For **stroke patients**, we will measure the proportion of patients that complete their pathway of care (thrombolysis where appropriate, or first CT scan for those where it is not) within 180 minutes of making a 999 call – again with an expectation that 90% of patients will meet this standard by 2022, up from an estimated 75% of stroke patients currently completing their pathway of care within that timeframe.

Changes to dispatch practices, call categorisation and clock start/stop definitions

A comparison of the current operational standards and new operational standards is shown below.

Current standards

Category	Percentage of calls in this category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Red 1	3%	75% within 8 minutes	The clock starts at the point the call is connected to the ambulance service	The first ambulance service-dispatched emergency responder arriving at the scene of the incident
Red 2	47%	75% within 8 minutes	The earliest of: •The problem being identified •An ambulance being dispatched •60 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident
Green	50%	No national standard	The earliest of: •The problem being identified •An ambulance response being dispatched •60 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident

Proposed standards

Category	Percentage of calls in this category	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	8%	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arriving at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	48%	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport, the first ambulance service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 3	34%	120 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance, service-dispatched emergency responder arriving at the scene of the incident stops the clock.
Category 4	10%	180 minutes 90th centile response time	The earliest of: •The problem being identified •An ambulance response being dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

The Health and Care Working Together in South Yorkshire and Bassetlaw Plan and the Hospital Services Review - stakeholder briefing

October 2017

Background: the South Yorkshire and Bassetlaw Plan

The NHS and local authorities across South Yorkshire and Bassetlaw have formed a partnership which is looking at how greater collaboration and working more closely together can help everyone in the region have a great start in life, with support to stay healthy and live longer.

Known as 'Health and Care Working Together in South Yorkshire and Bassetlaw', the partnership has been recognised nationally as one of the first accountable care systems in the country.

In October 2016, we published our vision, ambitions and priorities for the future of health and care in the region in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP). It was the result of many months of discussions across the partnership, including with patient representative groups and the voluntary sector.

The vision sets out how we will make improvements to health and care services, like making it easier to see a GP, speeding up access to appointments which will allow people to receive their diagnosis at the earliest possible time, and offering help faster to people with mental ill health problems.

It also acknowledges the challenges we face, such as growing demand for services, tough financial pressures and staff challenges.

Why change?

- People's needs have changed and they are living longer
- There are some big staff challenges
- We've got some tough financial pressures

Since its creation in 1948 the NHS has constantly adapted and it must continue to do so as the world and our health needs change. We have many great people working in our services – and we want to support staff to continue to do an excellent job; providing safe care for everyone in the future.

There have been some big improvements in health and social care over the last 15 years. For example, people with cancer and heart conditions are experiencing better care and living longer. However, **people's needs have changed and they are generally living longer.** They want their health and care services in a place and at a time that is right for them. For many, this means care that is provided at home, or in local healthcare centres - not in a hospital.

At the same time, people are waiting longer for treatment and spending lengthy periods of time in hospital when they could be at home, or seen by their GP or at a local healthcare centre.

Things can also seem unnecessarily complicated sometimes. For example, people having to repeat themselves to doctors, nurses and care workers and sometimes having to go to lots of different

appointments in different places. This could work better and services could be more joined up and easier to understand and use.

There are some big staff challenges that we need to deal with. Even though in recent years the number of qualified clinical staff in the NHS rose by 3.9 per cent, there are not enough nationally for some services. As healthcare has developed, so has the role of doctors and nurses. Care and treatment can be provided by a wide range of healthcare professionals - not just doctors. Working like this would mean people being seen and treated more quickly.

We've got some tough financial pressures too which is mostly down to increased demand on services and people living longer. It's a good thing that so many people are living longer but it means the way we work needs to change to meet the needs of an ageing population, so they can live well. We will also make the NHS more efficient.

What's the vision?

We want to run some healthcare services in local community clinics instead of hospital buildings. The idea is to make things more convenient for people who will no longer have to travel to a hospital for routine check-ups or for treatments that can be done in local healthcare centres or at home. We want services to be about keeping people well for longer, so they can live independent lives and avoid being admitted to hospital.

We need to use our hospitals for the things they are best for and make sure other services are available elsewhere. **We are committed to keeping all our local hospitals and providing urgent care in them all** so people will always have somewhere to go in an emergency.

We also need to keep up with new developments, technology and treatments and make sure we are taking advantage of the best ones.

The hospital services review

We want to future-proof local hospital services and are committed to having a local hospital in every town and city. The independent review of hospital services will look at how we can do this, identifying which services would benefit from being providing in different ways. It is just one part of the overall approach. At the same time as the review, we are continuing our work on developing more and more ways of treating and caring for people in their homes and local clinics, so that they don't need to go to hospital.

There are many examples of good work already taking place in our area:

- Primary care streaming in Doncaster
- Extended hours in primary care in Barnsley
- Consultant Connect in Bassetlaw (enabling a GP to dial a single number to immediately reach an appropriate specialist)
- New urgent and emergency care centre in Rotherham
- Direct booking out of hours appointments booked into four hubs in Sheffield

The Hospital Services Review will look at how services could be provided so that everyone in South Yorkshire and Bassetlaw has equal access to high quality, safe hospital services now and into the future.

Underpinning the review is a commitment to keeping all of our local hospitals and providing local urgent care.

Staff and citizen engagement

Existing staff will be giving their opinions as part of the review, so that recommendations are based on what the people who provide healthcare believe would make their services better and more equipped to deal with changing healthcare requirements. We will also be seeking the opinions of our citizens and patients throughout.

Fact finding and citizen involvement

In August, during the very early first stage of the review, we started to engage with members of the public. Members of the public from all localities engaged with us about the principles that underpin the review, and about the criteria being used for identifying the services that will be the subject of the review.

The review launches fully with the public in October, once the services that are being reviewed are confirmed. At this stage, a series of regular public, patient, staff, clinician and stakeholder engagement events will take place so that we can seek everyone's input throughout. We will have three events in every Place, organised with the local Healthwatches.

Hospitals included in the review

- Barnsley Hospital NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust]
- Mid Yorkshire Hospitals NHS Foundation Trust
- The Rotherham NHS Foundation Trust
- Sheffield Children's Hospital NHS Foundation Trust
- Sheffield Teaching Hospitals NHS Foundation Trust

The mental health trusts covering the region – Sheffield Health and Care NHS Foundation Trust and Rotherham, Doncaster and South Humber NHS Foundation Trust – are not included in the review as it is acute hospital services only. Exploring ways of improving mental health services is a key element of one of the workstreams in Health and Care Working Together.

Concluding the review

When the independent review concludes in March 2018 it is anticipated it will make a series of recommendations to the Health and Care Working Together Oversight and Assurance Group (OAG) about what changes could be made to future-proof the services.

The OAG is made up of chairs from Health and Wellbeing Boards, Foundation Trusts and clinical chairs from the Clinical Commissioning Groups.

It will decide if it wants to follow-up any of the recommendations. If the group decides to change any services on the back of the review recommendations, those changes would be subject to full public consultation.

The Hospital Services Review

Presentation to the Health and Wellbeing Board, Rotherham

20 Sept 2017

Outline

- Background: the Accountable Care System
- Aims, process and governance
- Progress so far
- Public engagement
- Next steps

Background: the Accountable Care System

South Yorkshire and Bassetlaw

- We know that we have some excellent services within South Yorkshire and Bassetlaw

- But the Sustainability and Transformation Plan identified a number of major challenges, particularly around workforce and rising demand

- SYB have been identified as one of the first 'Exemplar' Accountable Care Systems, giving more freedoms for organisations to work together to tackle all aspects of physical and mental health

- One strand of the work to develop the ACS is the Hospital Services Review, focusing on improving the acute sector

Hospital Services Review:

Aims, process and governance

The Review's Objectives

- **Define and agree a set of criteria** for what constitutes 'Sustainable Hospital Services' for each Place and for South Yorkshire and Bassetlaw, North Derbyshire and Mid Yorkshire

- **Identify any services** (or parts of services) **that are unsustainable**, short, medium and long-term including tertiary services delivered within and beyond the STP

- **Put forward future service delivery model** or models which will deliver sustainable hospital services

- **Consider what the future role of a District General Hospital** is in the context of the aspirations outlined in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) and emergent models of sustainable service provision

Design Principles

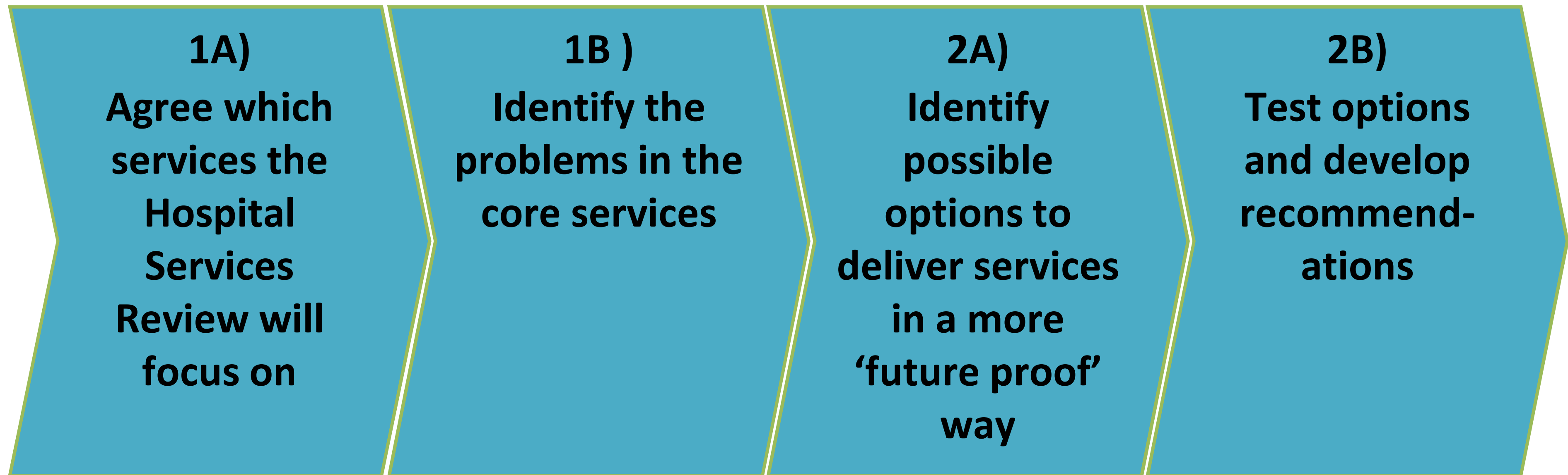
- The objective of the review is to **improve patient outcomes and reduce health inequalities**. Patients and the public will be involved throughout.
- The majority of patients who would currently require hospital care will continue to have most of their **needs addressed locally, with a hospital in every Place** which provides access to urgent care
- The review will find **solutions for unsustainable services** with inherent, systemic challenges, rather than providing quick fixes for services with short-term resilience issues. We will consider unsustainable services across the patch as well as those of local concern.
- The review seeks to address the issues of **sustaining services**, not organisations. In this context, recommendations will likely impact site- and organisation-specific service delivery.

Definition of a sustainable service

We think a service is sustainable / ‘future proof’ if it

- sees **the right number of patients** so that our staff are well practiced and can give good and safe care
- has the **right staff** (who are well trained in what they do) at the right times and in the right places to be able to look after people when they need it
- provides access to the range of **possible extra services** that hospital patients may need to keep them safe

Process



Jun-Sep 2017

Sep-Oct 2017

Nov-Dec 2017

Jan-Apr 2017

We are here

Where we expect to get to by the end of the Review

What we will be aiming to deliver

- An assessment of how far some core services are sustainable on each of the sites in South Yorkshire and Bassetlaw
- Some independent proposals on how these 5 services might be made more sustainable, with high level modelling
- An independent view on the role of the District General Hospital

What we will not be aiming to deliver

- A detailed list of exactly which services we think should be provided on each site in SYB
- Detailed financial or activity modelling

The Review will present **recommendations** for **commissioners to consider**, to decide which if any they want to take forward for further development and **public consultation**

Governance

Oversight and Assurance Group

Partnership Board

Provider Chairs and CEOs

JCCCG

Other CCGs

Review Steering Group

Chairs

Chief Execs or equivalent

All ACS member orgs plus Chesterfield: 6 x acute trusts; 4 x mental health trusts, 2 x community providers, YAS, CCGs, 5 Local Authorities, 5 County Councils, NHSE, NHSI, PHE, Healthwatches

Medical Directors for the 5+2 trusts, representation from all CCGs who commission from those trusts

Review Team:

- Professor Chris Welsh leads the review as the Independent Review Director

- Alexandra Norrish – Programme Director

- Independent Support Team

Progress so far

Activity to date

- **Agreed review principles** (with public and clinical engagement)
- **Established agreed criteria** for testing whether services are 'future proof' (with public and clinical engagement)
- **Assessed all acute services** across all services looking at it from the perspective of the hospital and the wider system, and discussed which services we should focus on
- **Shortlist of services** will be agreed by the Oversight and Assurance Group

Patient and public engagement to date

July – Sept:

- Shared the principles (rules that the review is based on) for people to give us their written comments (using existing networks)
- Held a regional event for people to input into the weighting that is being used to help identify the services that the review will focus on.
- Compiled a list of people who are interested in staying involved

Engagement

Patient and public engagement next steps

The review launches fully in October, when the services that are being reviewed are confirmed.

- We are working with Healthwatch to hold events to ensure we gather views from our seldom heard communities,
- We are also planning another online and paper-based engagement exercise and another regional event.

When the **review concludes in March 2018** it will make suggestions about what changes could be made to 'future-proof ' the services. If it is decided to change any services on the back of the review suggestions, those changes would be subject to **full public consultation**.

Staff and clinician engagement

- Medical Directors involved throughout as the Review Steering Group
- Clinical Working Groups will be established per service that is chosen for the review to focus on. These will include key clinicians from/ involved in those services (including General Practice)
- Engagement will take place specifically with the staff in services that are chosen for the review to focus on
- Wider staff / partners will be invited to be part of the patient/ public engagement

Engagement with local and national politicians

- Accountable Officers are briefing their MPs
- Local Authorities / elected members are being briefed by Accountable Officers and are also represented on the Partnership Board and Overview and Scrutiny Committee
- A paper went last week to the Joint Overview and Scrutiny Committee

Next steps

Next steps

- Confirm which services are in scope for the Review (Oversight and Assurance Group in October)
- Take forward clinical working groups for the services in Scope (October and November)
- Take forward public engagement events (October and November)