HEALTH SELECT COMMISSION
18th January, 2018

Present:- Councillor Evans (in the Chair); The Mayor (Councillor Eve Rose Keenan), Councillors Andrews, Bird, Jarvis, Keenan, Marriott, Rushforth, Short, Whysall and Williams.

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

Apologies for absence were received from Councillors R. Elliott, Ellis, Sansome and Robert Parkin (Rotherham Speakup).

The webcast of the Council Meeting can be viewed at:-
https://rotherham.public-i.tv/core/portal/home

60. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

61. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

62. COMMUNICATIONS

LGA Health and Prevention
The Chair reminded Members of the above event to be held on 15th and 16th February, 2018.

Please contact the Chair or Janet Spurling, Scrutiny Officer, to book.

Y&H JHOSC and Congenital Heart Disease (CHD) Services
Janet Spurling, Scrutiny Officer, reported that last November NHS England had made a decision regarding the future commissioning arrangements for CHD Services for adults and children with a standards-based approach at all tiers of provision.

After several years of intensive scrutiny on CHD, Members were pleased with the positive final outcome. They had requested a further report around progress/implementation specifically in terms of assurance on Leeds Teaching Hospitals Trust’s progress in meeting all the standards (including any that remained outstanding) and the development of the Y&H Network (including its relationships with other network areas). The further report might also include an update on the redevelopment of Leeds General Infirmary and its specific impact and/or implications on CHD Services for children and adults.

The above information would be shared across the region. However, whilst recognising the positive outcomes from the JHOSC's work, Members also recognised that its work had essentially been completed and there were no further plans for the JHOSC to meet in the future.

Improving Lives Update
Councillor Jarvis gave the following update from the Improving Lives Select Commission which had met on 12th December, 2017, the main agenda items had included:-

- Update on the Domestic Abuse Strategy – voice of the victims, outcomes of the Peer Review and details of the Perpetrator Programme:-
  Perpetrator Programme - had received further funding and would probably start to come into place in March, 2018
  Voice of the victim – increased contact with 3rd sector organisations involved with victims and developing means for talking to victims who were already going through the system
- Virtual Schools
- Adoption

63. MINUTES OF THE PREVIOUS MEETINGS HELD ON 30TH NOVEMBER AND 14TH DECEMBER, 2017

Consideration was given to the minutes of the previous meetings of the Health Select Commission held on 30th November and 14th December, 2017. Members noted that:-

Minute No. 50 (Implementation of the Carers' Strategy)
Councillor Short had joined the Improving Lives Select Commission's recent visit to Barnardos. Barnardos currently looked after over 200 vulnerable Rotherham children providing a range of outreach support and support. They also visited schools with their "Real Love Rocks" training and CSE prevention training, a programme training teachers on CSE and an outreach programme working with local providers. He would urge Elected Members, if they had the opportunity, to visit the organisation.

Minute No. 51 (Joint Health Overview and Scrutiny Committee)
It was noted that the meeting scheduled to take place on 11th December, 2017, had been cancelled due to the bad weather conditions. The re-arranged meeting would take place on 29th January, 2018, in Matlock the agenda for which would be published shortly. Any questions or issues that Members would wish to be raised should be forwarded to the Chair/Scrutiny Officer.

Minute No. 56 (Communications)
The stakeholder event on 31st January would be held between 9.30-11.30 a.m. in the Lecture Theatre at the Hospital.

Minute No. 57 (Refresh of the Health and Wellbeing Strategy and the Integrated Health and Social Care Plan)
The Select Commission's recommendation regarding strengthened links and governance for delivery of the Carers' Strategy had been agreed by the Health and Wellbeing Board and a new priority included under Aim 3.

Minute No. 58 (RCCG Commission Plan 2018-19)
Information on the CQC ratings for the 31 GP practices had been attached as an addendum to the minutes.

With regard to the new GP surgery for Waverley, it was still hoped that building would start in April with a view to it opening in April, 2019 but much would depend upon the developer.

Resolved:- That the minutes of the previous meeting, held on 30th November and 14th December, 2017, be approved as a correct record with the inclusion of the apologies of The Mayor (Councillor Eve Rose Keenan).

64. INTEGRATED LOCALITY EVALUATION

Dominic Blaydon, Associate Director of Transformation TRFT, and Nathan Atkinson, Assistant Director of Strategic Commissioning RMBC, gave the following powerpoint presentation on the evaluation of Integrated Locality:-

The Health Village Integrated Locality Pilot
- Commenced July 2016
- Integrated locality team serving the adult population – aged 64+
- Based at The Health Village, Doncaster Gate (2 GP practices – Clifton and St. Ann's) supporting 35,949 residents
- Multi-agency team – predominantly TRFT staff with a small number of Adult Care, Mental Health and voluntary sector staff

Overarching Aims for cohort of Adults 64+
- Reduce hospital admissions
- Reduce length of stay in hospital
- Reduce cost of health and social care
- Reduce duplication
- Improve communication
- Develop a holistic approach to care

Purpose of Evaluation
- Has the pilot contributed to attainment of key aims?
- Impact of the pilot service model
- Can the Service model be replicated?
- Recommendations for future implementation

Work done so far by Grounded Research@RDaSH
- Literature search and evaluation complete
- Compilation of background information
- Interviews and focus groups carried out
- Dataset analysis
- Final evaluation due on 31st January 2018

Key Learning thus far
- Development of an MDT approach is effective
- Separation of planned and unplanned care works well
- Benefits of co-location to all partners
- Enables the identification of high risk patients in a holistic way
- Encourages a culture of service improvement – bottom up
- Has stimulated further work to simplify referral pathways
- IT and Information Governance issues partially resolved

Key Metrics (People over 64 years)
Key Performance Indicators
- Non-elective admissions
- Non-elective bed days
- Length of stay

Contra-Indicators
- Discharge destination
- Elective bed days

Conclusion
Learning
- Positive TRFT acute activity impact
- Reduces duplication and fragmentation
- Improves communication across the system
- Provides a more holistic approach
- Improves the interface with Primary Care
- Provides opportunities for reablement
- Allows for better integration of referral pathways
- Splits planned and unplanned care
- Has informed the future footprint based on 7 GP practice clusters

Challenges
- Systemic impact unclear especially for Adult Care/Mental Health
- Future test of concept required at larger scale
- Integration of IT and Governance
- Capacity within the system
- Manging variation to match local requirements
- Embedding required changed across the system
- Consideration of a whole family approach
- Building in prevention and early intervention

Implementation

– Service model presented to ACP Board	Q4 – 2017/18
– Consultation carried out and completed	Q1 – 2018/19
– Implementation Plan developed	Q1 – 2018/19
– Separation of planned/unplanned care complete	Q2 – 2018/19
– Phase 1 implementation of integrated localities	Q4 – 2018/19

Discussion ensued with the following issues raised/clarified:-

- If the pilot was to be run again/scaled up, the wider pathway would need to be factored in and how it impacted/fitted in with the 2 Transformation Plans i.e. RDaSH and Adult Care Improvement Plan

- Capacity – staff teams that had joined the pilot had still had their existing workloads with the challenge of balancing their day-to-day activity with the new ways of working and taking on slightly different roles. The key for future implementation would be phasing so that when staff did move they did not bring huge existing caseloads

- The pilot in the central area had had easy travelling distances to where residents lived, however, there were large parts of the Borough that were green spaces and rural. If the principles of the pilot were applied in outlaying parts of Rotherham there would have to be a different approach i.e. not one size fits all

- Any future implementation would have to consider workforce development and organisational development to ensure staff were full au fait with the agenda

- Improved links with Early Help and Young People's Services still required to bring the whole family approach together

- Prevention and Early Intervention – a number of disciplines still worked in a traditional reactive way. Factoring in Early Intervention was something that was needed but was sometimes challenging for workers given their caseloads

- Consultation was required with a range of stakeholders as well as the public to ensure that whatever was rolled out/implemented was meeting their requirements. The Implementation Plan would be developed in early 2018/19 with a degree of phasing. There was an opportunity for the Trust as it was to consult on some of its community held services and around the locality structure developed by the CCG as well as part of the Place Plan

- The holistic care approach would streamline the process for an individual/family considering the whole health and care needs instead of a number of referrals to different agencies

- The scale and ambition was ultimately to have 7 clusters of multi-disciplinary teams which may be of different sizes and composition. The difficulty was that a range of organisations were going through significant transformation looking at how they were deploying their resources and different ways of working. At the time of developing the pilot it had been known what disciplines were needed and the particular individuals who could be brought in from existing capacity. It required much more thought as to how quickly it could be done and how it would be resourced. Some organisations had the structural capacity to move a bit quicker than others; TRFT already operated in the community and locality so how it morphed and changed was a little easier than Adult Care

- Ultimately there could be fully integrated localities across the 7 GP clusters supporting those GP practice populations, incorporating Mental Health, Therapy, Social Work and the Community Nursing offer with an Integrated Leadership model. The Leadership Team would have full responsibility for delivering a joint set of outcomes incorporating both Social Care, Mental Health and Health outcomes, separately commissioned by both CCG and the Council

- In terms of the unplanned offer, more consideration needed to be given but there would be a multi-disciplinary team supporting those with an urgent care need working alongside the localities. In terms of integration there were policy, legal and cultural barriers between health and social care organisations and a hostile financial environment

- If successful in reducing the numbers of non-elective admissions it would alleviate some of the pressures on A&E. It was not known if it would save substantial amounts of money and was not the main purpose of the pilot; the purpose was to provide a better offer within the financial envelope available and to get the whole of the Health and Social Care economy on more sound financial footing. The Trust needed to try and provide a better offer for the finances available in transferring care from acute into community. However, a reduction in patients admitted to hospital meant the Trust lost income; from next year the Trust would be paid per person admitted to hospital and not for being looked after in the community

- From the Social Care side, the impact in terms of the resources within the pilot was fairly minimal and the impact on the package reduction side had not really been seen as yet. This was not surprising given that there was only 2 members of staff within the pilot

- The challenge of integration of IT and governance had often been one of the reasons for not being able to integrate because of the different systems within organisations. There would not be a single system that integrated localities could use but proper processes needed to be in place to make sure the interaction between the systems was

streamlined. A big advantage to Rotherham was that of the Rotherham Health Record which allowed Community Health Teams to see who from their locality was in hospital/A&E and allowed them to interact and get information about those patients and act as a trigger for when they should go in and support the hospital in trying to discharge the patient. Social Care would be added so that information would be used by integrated locality teams as well

- When the model pilot was launched in July 2016 it had been very much with an Adult focus, however, as the Accountable Care Partnership had developed there had been a much stronger presence from CYPS and the voluntary sector services that supported CYPS. The future design would very much centre on the whole life journey pathway. There was a lot of good work going on in other parts of the system around the whole family approach and it would be missing a trick if work in the locality and working with individuals was not picked up and resources used wisely and widely to make as big an impact as possible. The whole point of integrated working was to reduce silos. A lot of Health and Health and Social Care integration tended to focus on old people and frailty conditions but that could be at any age

- It was known that Learning Disability and Mental Health had higher prevalence rates across all ages in Rotherham and their needs were just as important as anybody else within the community and must be considered and any resulting additional needs for individuals must be considered

- There was no hard data as to whether there had been any improvement in treatment times and support but there was feedback from teams, together with case examples, of where that integrated approach had delivered those type of things

- Integrated locality working provided opportunities for supporting care homes. Historically care homes had huge difficulty in accessing medical, nursing and social care support. Each of their residents would have different GPs and therefore have different district nursing teams etc. The integrated locality consolidated it all with each care home having one GP and one integrated locality team to work with. The feedback was that it was of huge benefit because they knew where they could get that support, develop a relationship with that GP and the team and get continuity of service

- Feedback would be provided on the second staff evaluation of the Health Village

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

(2) That a working group be established to consider the final report when available and feedback thereon to the Commission.

65. ADULT SOCIAL CARE - FINAL PUBLISHED YEAR END PERFORMANCE REPORT FOR 2016/17

Further to Minute No. 17 of 20th July, 2017, Nathan Atkinson, Assistant Director Strategic Commissioning, presented the final published year end performance report 2016/17 for Adult Social Care.

Appendix 1 of the report submitted was a refreshed final table of year end performance which also showed the Direction of Travel and relative benchmarking positions against comparative councils in Yorkshire and Humber region and national rankings.

The performance highlights for 2016/17 included:-

- Of the 28 Adult Social Care Outcome Framework (ASCOF) measures outcomes, 8 had improved, 3 maintained performance and 16 declined (one Indicator was new for 2016/17)
- Performance on Delayed Transfers of Care attributable to Social Care or both NHS and Social Care continued to improve
- Outcomes for people after a period of short term support (Reablement) remained in the top 3 of all Yorkshire and Humber authorities
- Areas of challenge included supporting individuals in receipt of services within Learning Disabilities and Mental Health needs to gain and sustain paid employment
- Performance with regard to how care and support was personalised continued to place Rotherham in the bottom 3 of the Yorkshire and Humber authorities
- Satisfaction of service users and carers remained high when compared regionally and nationally

Discussion ensued with the following issues raised/highlighted:-

- The implementation of Liquid Logic had led to better data and a better understanding of what was happening. Good real time information and engagement with customers and carers was emphasised

- The Cabinet Member had challenged and tasked Rotherham Adult Social Care to be outstanding within 3 years

- The Improvement Plan was refreshed every 3 months. It was currently in the process of being refreshed as one of the things that the first tranche had really focussed upon was stabilising and making safe so the focus had very much been on sorting out unallocated work, ensuring Safeguarding was as robust as possible and dealing with any issues that had not been dealt with in as timely manner as they should have been. The Strategic Director had made it very clear that the actions within the Plan had to be delivered to time and in accordance with timescales

- The Improvement Plan was governed by the Adult Care Improvement Board which was Chaired by an Independent Person (Andrew Cozens from the Local Government Association). Within that there was professional challenge which was required because there was a lot of work to be done in Adult Social Care to get to where it wanted to be as an outstanding service

- The journey was showing positive signs in terms of the direction of travel, some of the data around the Single Point of Access and the referral routes of where people were going

- There was a lot to do. It would be worth having some degree of scrutiny of the Plan

- The Directorate wanted to strengthen the "front door" in response to some of the findings from the report. Historically, when someone presented to the Rotherham front door they received far more support per head than they perhaps would in other councils. This was part of the assessment process and one of the reasons why it needed to be resolved. In terms of the 18-64 year olds referred to in the report, the numbers were primarily those with learning disabilities, physical disabilities and mental ill health whose health prevalence rates in Rotherham were higher than most of Yorkshire and Humber again some of which was historical. In terms of the overall numbers in support this remained relatively static around 4,000 excluding mental health and 4,500 including mental health but they were much more complex needs requiring more support

- There was a legacy group of people that received support currently which, if presented today, might get a better offer

- 70% referred to new people that requested support last year. Last year the higher than average support for 18-64 (80% more) and 65+ (30% more) was largely due to historic practices

- Now seeing people diverted from first point of contact and providing more information and advice to prevent that reliance on services

Resolved:- (1) That the report and final published year end performance results be noted.

(2) That discussion take place with regard to future reporting of the Adult Services Care Outcome Framework measures.

66. LOCAL RESPONSE TO MENTAL HEALTH REGULATIONS UNDER THE POLICING AND CRIME ACT

The Panel noted the questions, together with the responses provided, which were submitted to the 15th December, 2017, meeting of the South Yorkshire Police and Crime Panel.

67. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

68. HEALTH AND WELLBEING BOARD

The minutes of the meeting of the Health and Wellbeing Board held on 11th January, 2017, were noted.

Councillor Roche reported that he was currently reading through the final draft of the revised Health and Wellbeing Strategy. Members should receive a copy of the final version some time during February.

69. DATES OF FUTURE MEETINGS

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 15th June, 2017, commencing at 9.30 a.m.