HEALTH SELECT COMMISSION
6th September, 2018

Present:- Councillor Evans (in the Chair); Councillors Andrews, Bird, Cooksey, R. Elliott, Ellis, Jarvis, Rushforth, Short, Taylor, John Turner, Williams and Wilson

Apologies for absence were received from Councillor Albiston and Keenan and Robert Parkin (Speakup). Councillor Roche, Cabinet Member, had also submitted his apologies.

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

26. DECLARATIONS OF INTEREST

Councillor Jarvis made a non-pecuniary Declarations of Interest in relation to Minute No. 33 (The Rotherham Foundation Trust Quality Priorities 2919-20) as she was a Governor of The Trust.

27. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

28. MINUTES OF THE LAST MEETING

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 19th July, 2018.

Resolved:- That the minutes of the previous meeting held on 19th July 2018, be approved as a correct record.

Arising from Minute No. 16 (62 day wait for treatment for cancer), the Trust had focussed on addressing this atypical dip in performance and at the quarterly briefing with health partners in July reported that it appeared to be back on track so far in Quarter 2.

Arising from Minute No. 19 (savings from Integrated Sexual Health Service), it was noted that the Chair was to provide feedback to the Overview and Scrutiny Management Board at its 12th September meeting.

Arising from Minute No. 20 (Adult Residential and Nursing Care Homes), all Select Commission members had been emailed the recent “Guide to Residential and Nursing Care for Older People”.

Arising from Minute No. 21 (Health Select Commission Draft Work Programme), it was noted that further work on co-production was taking place on the Autism Strategy so would now be submitted to the Commission later in the year.

It was also noted that Councillor Keenan would be a representative on RDaSH as well as YAS.

29. COMMUNICATIONS

There were no communications to report.

30. UPDATE ON HEALTH VILLAGE AND IMPLEMENTATION OF INTEGRATED LOCALITY WORKING

Nathan Atkinson, Assistant Director Strategic Commissioning, presented the following 2 powerpoint presentations, the second on behalf of Chris Holt, Director of Strategy and Transformation, TRFT:-

Health Village – Update on Integrated Working in Rotherham

Key Activity Under Development

- Integrated Point of Contact – alignment of Single Point of Access (SPA) and Care Coordination Centre (CCC)
- Integrated Discharge Team
- Intermediate Care and Reablement - “Home First” strapline
- Integrated Rapid Response – better triage
- Integrated Care Home Support – Red Bag, End Of Life pilot, named GP, links to Quality Board
- Developing Integrated Pathways as the default

What is Working Well

- Clear priorities and vision, agreed by all partners
- Shared agendas and the ‘right conversations’ taking place
- Governance framework in place
- Momentum building in a number of areas
- Changes happening on the ground (Single Point of Access, Care Co-ordination Centre, Integrated Discharge Teams, Integrated Rapid Response)
- Technology

What are we Worried About

- Balancing (often competing) priorities
- Capacity to deliver – balance of new vs existing
- Engagement, communications and language
- Organisational development across all parties
- Capturing key milestones and measures from a very comprehensive data set across the system

What needs to happen next

- Continue to develop areas of practice where joint outcomes can be achieved
- Develop an Unplanned Care Team
- Focus on Home First and new delivery models

- Preparation as a system for Winter Plan requirements to meet NHS England requirements and applying learning from 2017/18 plan outcomes

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

- There would be a multi-disciplinary team approach in the community as to which professionals would visit a client in their home, rather than a stay in a nursing home, depending upon their individual requirements. The Winter Plan would factor in the issue of capacity as it was quite a sea change. It was acknowledged that there was an element of risk as it was easier to identify a building/number of beds compared to multi-disciplinary teams in the community. Incremental steps were being taken to mitigate having sufficient resources

- Acknowledgement that capacity was an issue and there were challenges in recruitment across Health as well as the independent sector. A key piece of learning from the Health Village pilot was that you could not transform if members of staff came with existing work and caseloads that they could not exit from; a phased approach was required. Healthwatch and similar organisations were key in referring in issues/difficulties in the system

- Capacity was the biggest concern. It was known that there were gaps in the Hospital in terms of staffing and that there were challenges around recruitment. A full complement of staff within staffing budgets to deliver maximum capacity was required, at the hospital and to deliver the new models.

- It was imperative that the key milestones for the implementation of locality working were set and agreed as soon as possible because they had to be held to account and measurable; each organisation had its own particular drivers and finding the crosscutting drivers that were consistent across every piece of the pathway was the challenge

- There was a commitment from the Council and partners to influence the change for integrated working

- With regard to cohesion and coordination between services there was a commitment from the Council and partners to influence the change for integrated working but there was still a way to go. Shadowing and “stepping into other shoes” at all levels helped to build an understanding of other job roles.

- Numbers of readmissions to hospital and reasons for these – statistics to follow

Progress Report – Locality Working

What have we learned about Locality Working

- The Health Village Pilot was a great start
- There is evidence of a positive impact on emergency admissions from locality working
- All localities saw an increase of 0.7% in emergency admissions between 2015/16 to 2016/17, excluding the Health Village. The Health Village saw a 2.1% decrease however between these periods
- All localities excluding the Health Village, seeing a 3.5% and 11% increase in 65+ and 85+ respectively. Emergency admissions from the Health Village locality however saw lower increases 1.8% (65+) and 9.5% (85+)

The Emerging Model

- Re-alignment of GP practices across 7 localities
- Localities split into 3 partnerships areas
- Community Nursing working directly into 7 localities
- Adult Social Care and Community Health Teams (including Mental Health) working across 3 partnerships North, Central and South
- Information sharing via Rotherham Health Record
- Integrated Management (Partnership level)
- Integrated MDT approach – some still more virtual at present

What will be different

- Develop a joint culture of prevention – early work has been more reactive and focused on frailty and long term conditions
- 'Blurring' of professional boundaries
- Develop new ways of supporting Primary Care
- Enhanced Social Care Assessment and Care Management
- Management of Long Term Conditions
- Focus on the needs of Physical and Mental Health
- Work into hospital-based services to reduce length of stay
- Improved opportunities for post-discharge follow-up

Timelines and Implementation

0 to 6 Months

- Teams aligned/co-located
- Baselines agreed
- Outcome Framework agree
- Joint caseloads developed
- Ways of working outlined
- Team configuration defined
- Leadership team in place
- 1 Partnership/2-3 localities model 'operational'

6 to 24 Months

- Pooled budget principles agreed
- Outcomes being 'realised'
- Outlying performance addressed

- Transition model (Phase 3) being defined
- 3 Partnerships/7 localities 'operational'

>24 Months

- New models and transition defined
- Organisational alignment clear
- Integration of teams
- Pooled budgets and investment

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

- There were benefits from co-location but there also had to be an understanding of the pathways and dealing with the caseloads/management. There had been some real positives and relationships built up from the pilot but there had also still been some divisions because of the physical building.

- The Trust would be able to provide information as to how work had progressed on finding possible locations for hubs. The CCG were leading on colocation which was a priority.

- There was some blurring of professional boundaries but it was anticipated that a Social Care Green Paper would be announced in the autumn. Some of the legislation was in place as part of the Greater Manchester Devolution Deal but there was recognition across the system that the legislative frameworks would have to be reviewed as the agencies all operated from slightly different guidance. Some roles needed clinical supervision and required certain levels of training and health and social care assessments were different.

- To assist with the blurring of boundaries with regard to decision making, Rotherham had appointed a joint role holder to oversee the work in an attempt to remove some of the boundaries and recognise that hierarchy and matrix management would need to take place. Regarding professional boundaries, it might not be appropriate for a manager who knew absolutely nothing about a particular area or who has no clinical oversight to make a clinical decision and that was part of the challenge. There was a lot of practical things that could be done and was being done in the virtual teams but the ambition was to have new roles but it would take time

- Clear timescales were required for the implementation of locality working as the presentation only had broad blocks – detail to follow

- The Select Commission had previously recommended that it was important to capture the deeper more qualitative data based on patient experience to supplement the quantitative measures. What was presented was a systemic overview. Was this data being captured and recorded and could the Select Commission have a

formal response that summarised and presented data that the Commission could scrutinise in more detail at a later date? – to go back to Chris Holt to respond

- In terms of outcomes for the Health Village, was there evidence to show that diagnostics such as blood tests were being received quicker?

- Given the volume of different tests that must be requested, how many staff worked in the laboratories on the tests? Was there a central laboratory?

Nathan Atkinson was thanked for covering both presentations.

(1) To note the presentation and progress made on integrated working.

(2) That the findings feed into the development of the Select Commission performance sub-group's work programme.

(3) That the progress on locality working and plans for implementation be noted.

31. RDASH ESTATE STRATEGY

Dianne Graham, Director of Rotherham Care Group, RDaSH, and Rachel Cadman, Transformation Lead for Rotherham Care Group, RDaSH, presented the following powerpoint presentation:-

Rotherham Estates Consultation
- Aim – To seek stakeholder views on the two preferred options within the estates transformation plans"
- Part of wider consultation, 700 staff, service users, other stakeholders events

Outcomes
- Improved access for local people
- Aligned to GP surgeries
- Part of place based plans
- Integrated mental health, all age, Learning Disability Services
- Town centre facility
- More efficient use of resources

Present Estates
- Badsley Moor Lane – Learning Disability Services
- Ferham Clinic – Adult Mental Health
- Clifton Lane – Improving Access to Psychological Therapy (IAPT)
- Howarth House – Older Persons Mental Health (OPMH) and Dementia Clinics
- Swallownest Court – Adult Mental Health (AMH) inpatient/community

- Woodlands – OPMH inpatient

Proposed Estates
- Swallownest Court – South services
- Woodlands – Borough-wide/front end services
- Clearways – Town centre facility/clinics and base for IAPT team
- Then:
  North Services
  Option 4 – Badsley Moor Lane (BML) (plus Ferham annex)
  Option 5 – Ferham (plus Ferham annex)

Buildings we will no longer require
- Reduce buildings from 6 to 4
- No longer require Clifton Lane (IAPT)
- No longer require Howarth House (OPMH)
- Impact of agile working

Options considered
- Riverside (local authority building)
- The Bank
- Rawmarsh Health Centre
- Maintain status quo

Key Messages
- Best use of Rotherham pound
- Best value out of estates
- Reducing from 6 to 4 buildings
- Providing town centre clinic based services
- Services will continue to be delivered

The estate plans were temporary with some moves for one to 2 years and further consideration with partners about a possible health clinic in the North for integrated health, mental health and social care. Savings would be around £100,000 for RDaSH but there were other benefits from co-location and greater integration and possibilities for other efficiencies, so it was a stepping stone.

Discussion ensued with the following issues raised/clarified:-

- Work was taking place to identify whether Ferham or Badsley Moor Lane was the best option. Both facilities compared favourably with regard to cost and both were accessible to their localities. It had formed part of the stakeholder consultation with questions asked as to what it was like for them in terms of accessibility, environment, how difficult it was to get to both places, with the outcome being that Badsley Moor Lane was the preferred building. Having said that Ferham had not been discounted. Ferham Clinic Annex would remain whatever the final option was

- Whilst recognising the ambitions behind the review in terms of joint working and close working with GPs, in the days of austerity how much was financial pressures or was it purely just reconfiguring services? It was both. RDaSH needed to be much more integrated. It was the vision that in the future all Mental Health and Learning Disability Services would be provided in every Health and Social Care setting in Rotherham. Progress had been made to provide that particularly at front end services and there were a range of examples outside the estate strategy:-

  - RDaSH was also integrated with the Care Co-ordination Centre and Local Authority Single Point of Access
  - a ward which was a joint venture between the Hospital and RDaSH for people with Dementia with physical health staff and mental health staff
  - IAPT staff were in GP surgeries working with people with long term physical health conditions as well as mental health conditions
  - working with Police in the Central Neighbourhood Team to try and integrate mental health in the Police and Local Authority
  - Peri-Natal mental health working with the Hospital, District Nurses and Health Visitors
  - Hospital Liaison Service which was an integrated service with the Hospital making sure Mental Health, Alcohol Liaison and Learning Disability Services were integrated into the Hospital

- The Efficiency Strategy was not looking at reducing staffing levels and in fact NHS England had put extra funding into Mental Health Services over the last few years as part of the 5 year plan. There was an increasing workforce but there were concerns about the change and transformation in Mental Health Services and the numbers of new people coming into the health system to cope with the pace of change

Dianne and Rachel were thanked for their presentation.

Resolved:- That the presentation be noted.

32. RESPONSE TO RECOMMENDATIONS FROM SCRUTINY REVIEW- DRUG AND ALCOHOL TREATMENT AND RECOVERY SERVICES

Further to Minute No. 25 of the Cabinet and Commissioners Decision Making Meeting held on 6th August, 2018, Anne Charlesworth, Head of Public Health Commissioning, gave an update on the recommendations and corresponding actions arising from the Scrutiny Review of the Drugs and Alcohol Service Treatment and Recovery Services.

Rotherham's new Adult Substance Misuse provider, Change, Grow, Live (CGL), had been providing the Service since 1st April, 2018. Mobilisation from a client perspective had been very smooth, staff transferred from RDaSH to CGL and they had managed the Service very well. Work was progressing on the pathways.

Monthly meetings were held with CGL to consider all the key performance indicators. Progress so far had been steady, as had been requested, for the first 3 months. 6 clients had exited the Service positively in the first few weeks of the new contract due to being drug free. It was now back to its normal 2/3 new clients a month. CGL would now be looking in more detail of who now was ready to exit the Service.

Since the new Service started, there had been 8 deaths of clients in Service; 5 had died in Hospital as a result of long term conditions and not directly their substance misuse, 2 had died as a result of overdoses but not directly attributable to the drugs they were in receipt of from the Service and the Coroner's verdict was awaited for the 8th. None of the 8 clients would have been aged under 18 as the Service was for those aged 18 years and over; and there were none who were aged under 30.

The following update was given on each of the Review's recommendations:-

1. A full suite of Performance Indicators was to be submitted to the November Select Commission meeting

2. As stated above, monthly meetings took place and so far progress was good

3. More suicide prevention and self-harm work would take place as and when funds became available

4. MECC training was going quite well; as of yesterday 215 people had attended the training so the alcohol message was getting out. There was a clear pathway that those who received MECC training understood they also got Health Rotherham services as first point of contact but then screening tool then referred people into CGL

5. As mentioned at a previous meeting, drugs and alcohol soft marketing testing had taken place but needed to ensure that it happened in all the commissioning. Work was taking place with procurement to make it part and parcel of what agencies did

6. There was a new pathway around notification of death. A concern from the NHS, if the Service was no longer a NHS Service, was that it would stop some level of scrutiny, however, CGL reported all deaths on the national template, did their own death investigation and were reporting deaths to the CQC, Public Health and the Head of Service for Safeguarding, so a decision could be made as to brief the Adult Safeguarding Board about them. There would be a written pathway by the end of September

7. CGL's processes around risk assessment for suicide were very thorough and nationally agreed. They had supplied them to Authority and were to meet with RDaSH and ensure that all bases were covered. Both RDaSH and CGL's processes followed NICE Guidance. It would form part and parcel of the pathway that was currently being agreed

8. Safety and safeguarding had already been touched upon.

Discussion ensued with the following issues raised/clarified:-

- Had consideration been given to using Ward-based funding rather than the Community Leadership Fund? This would be fed back.

- £500K had been awarded to South Yorkshire and Bassetlaw Integrated Care System for suicide prevention work. It was understood that some progress had been made on the devolved monies and what it could be spent on but no specific details as yet, however, Rotherham had been a warded an allocation

- Hellaby Ward had ordered the posters that contained the helpline number for people to ring and the beer mats. They were to be distributed on the Hellaby Industrial Estate

- What type of treatment was a client offered? Were they get referred to the Consultant? The CGL Service was a clinical service headed up by a Consultant Psychiatrist. Clients received the same level of clinical assessment as they would have previously. Work was taking place to agree the boundary of when someone's problem became more Mental Health than substance misuse which agency they should access to remove any uncertainty as to which Service should be leading that package of care

Resolved:- That the response to the recommendations of the Scrutiny Review of Drug and Alcohol Treatment and Recovery Services be noted.

33. THE ROTHERHAM FOUNDATION TRUST QUALITY PRIORITIES 2019-20

Janet Spurling, Scrutiny Officer, presented the following powerpoint presentation on The Rotherham NHS Foundation Trust Quality Priorities 2019/20.

It was noted that TRFT was to hold a public consultation event on their Quality Priorities, however, it clashed with a meeting of the Select Commission. It had been agreed that the Select Commission's discussion would feed into the consultation.

Quality Improvement Priorities

- Every year The Rotherham NHS Foundation Trust developed a set of Quality Improvement Priorities for the year ahead
- These priorities helped ensure that there was a continuous drive to improve the quality of care provided for patients
- Each of the priorities had a lead who developed the details for each and what the aims, objectives and measures would be

Reminder for 2918/19 Priorities

- Patient Safety
  - Missed or Delayed Diagnosis
  - Deteriorating Patient (including Sepsis) (new focus)
  - Medication Safety
- Patient Experience
  - End of Life Care
  - Discharge
  - Learning from the views of Inpatients (new)
- Clinical Effectiveness
  - Improving the quality of services provided through preparing for Care Quality Commission (CQC Inspection (new)
  - Mental Capacity Act (increasing staff knowledge and awareness)
  - Effective outcomes for women and baby (new)

Initial Quality Priorities for 2019/20

- Patient Safety
  - Embedding the use of the National Early Warning Score (NEWS2)
  - Improving the assurance regarding the implementation of national safety alerts
  - Improving the learning and changes in practice arising from action plans from Serious Incidents and Inquests
  - Improving the safety of care provided to patients requiring respiratory support
  - Embedding the ambition of zero avoidable pressure ulcers
- Patient Experience
  - Improvement in Patient and Public Involvement and Engagement
  - Improving the experience of children receiving care in non-paediatric focused services
  - Embedding the treatment of all patients in an equal and diverse manner
  - Improving the experience of patients transitioning from Children to Adult Services
  - To be identified following the outcome of the Patient Experience Framework (NHS Improvement June 2018) and Trust Wide Diagnostics

- Clinical Effectiveness
  - Improving the quality of services provided through implementing the findings from the CQC Inspection
  - Effective outcomes for women and babies
  - Improving conversations about public health matters
  - Improving the outcomes from the Sentinel Stroke National Audit Programme (SSNAP)
  - Improving the outcomes from a National Audit (exact audit to be confirmed)

With regard to a query regarding Sepsis, Janet Spurling, Scrutiny Officer, reported that there had been a national focus on this, not just Rotherham Hospital, and training had taken place with YAS telephone call handlers. Janet would follow this issue up. Further information would be sought.

Councillor Andrews provided more details about the National Early Warning Score tool for recording patient observations.

Resolved:- (1) That the Select Commission feedback their views to TRFT through Janet Spurling, Scrutiny Officer.

(2) That the Quality Account Sub-Group meet in December to discuss the final set of priorities as part of the half year update.

34. SOUTH YORKSHIRE, DERBYSHIRE, NOTTINGHAMSHIRE AND WAKEFIELD JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE UPDATE

Janet Spurling, Scrutiny Officer, presented papers requested by JHOSC at its previous meeting for information regarding progress with the implementation of Children's Surgery and Anaesthesia and the designation process and an overview of the South Yorkshire and Bassetlaw ICS areas of future scrutiny.

When the papers for the next JHOSC meeting were published these would be circulated to all Select Commission Members with regard to identifying any questions or issues to raise through the Chair.

Resolved:- That the information be noted.

35. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

36. HEALTH AND WELLBEING BOARD

Consideration was given to the submitted minutes of the Health and Wellbeing Board held on 11th July, 2018.

Resolved:- That the minutes of the Health and Wellbeing Board held on 11th July, 2018, be noted.

Arising from Minute No. 3 (Questions from Members of the Public and Press), it was clarified that the original application for a Judicial Review had been for the Hyper Acute Stroke Services which was rejected as it was also on appeal.

37. DATE AND TIME OF NEXT MEETING

Resolved:- That a further meeting be held on Thursday, 18th October, 2018, commencing at 10.00 a.m.