HEALTH SELECT COMMISSION
Thursday, 11th July, 2019

Present:- Councillor Keenan (in the Chair); The Mayor (Councillor Jenny Andrews) Councillors John Turner, Albiston, Cooksey, R. Elliott, Ellis, Jarvis, Williams, Vjestica and Walsh

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

Apologies for absence were received from Councillor Bird, Tony Clabby (Healthwatch Rotherham) and Robert Parkin (SpeakUp).

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

12. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting

13. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

14. COMMUNICATIONS

The Chair introduced William Brown from Rotherham Youth Cabinet who was on work experience with the Council.

The Chair formally thanked Councillor Short for his hard work as Vice Chair on the Select Commission.

Improving Lives Select Commission
Councillor Jarvis would supply a written report to be circulated to the Select Commission Members.

Hyper Acute Stroke Care
The changes to the Service were being implemented with patients going to one of the three hub hospitals for the Hyper Acute phase. Additional staff had been recruited to manage the increased numbers of patients in the hubs.

Integrated Discharge Team
The joint team, which comprised staff from RMBC and Rotherham Hospital, had won an award in Acute Service redesign for their work in ensuring care and support were in place for patients on their discharge from hospital. Three other teams at the Hospital had also been commended at the awards.

15. MONITORING REPORT ON DRUG AND ALCOHOL TREATMENT AND RECOVERY SERVICES

Anne Charlesworth, Head of Public Health Commissioning, Joy Ainsworth, Deputy Director CGL North East and Michaela Bateman, Associate Nurse Director for the Rotherham Care Group, Rotherham Doncaster and South Humber (RDaSH**)** delivered the following presentation:-

Original purpose of scrutiny spotlight review
"To ensure that the drug and alcohol service, operating within a reduced budget, would provide a quality, safe service under the new contract"

Specific updates from the commissioning perspective

- CGL were still having monthly Performance and Quality meetings with Public Health to ensure transparency of performance, look at serious incidents and ensure implementation of recommendations of CQC Report.

- After the CQC inspection delivered its findings of 'Requires Improvement' a joint report was produced with Bradford Services, but this was amended to have a Rotherham specific report to enable specific Rotherham improvements.

- 'Requires Improvement' was due to issues in at least two areas, and some related to building specific concerns which had been rectified. CGL had an internal team that prepared for CQC and were expecting a return visit this year.

  By the end of August all tasks that had been identified by the CQC should have been completed. With regards to the concerns around the building, the CQC inspectors were used to looking at secure mental health facilities where the standard was different rather than community-based drugs and alcohol services.

- There were several performance areas of concern – 'exits' generally. Non-opiate exits were under particularly scrutiny as it may have received less focus due to a push to improve opiate exits.

- Alcohol pathways needed more work, as did keeping the number of patients flowing through into Shared Care as Rotherham had quite a tight target for making sure as many patients as possible were with their own GP.

- Original predictions were that it would take 18 months to see any real improvement with regard to opiate exits due to the clinical time required to change long term care packages. Rotherham was still within that timeframe, but a close eye was being kept on progress.

- Despite looking for trends and patterns in the deaths information, no clear picture was emerging as yet. The overview of deaths in service were being built into the Strategic Suicide Review Group, chaired by the Strategic Director for Adult Social Care and Health to ensure strategic oversight.

- Pre-tender soft market testing was now taking place regularly – a recent example was Children's Weight Management, as a result of which the approach was changed significantly.

Service Perspective from CGL
Background – CGL Rotherham
April 2018
- ✓ Fully integrated Drug and Alcohol Services
- ✓ Shared Care provision - 24 GPs/46 % of Service users
- ✓ Pharmacy Contracts for Supervised Consumption and Needle Exchange – 28 pharmacies

Service Users
1,537 clients entered structured treatment April 2018-March 2019 (NDTMS)
- ❑ 1,018 opiate users (66%) – National average 52%
- ❑ 361 alcohol clients (23%) – National average 29%
- ❑ 103 Non-opiate or crack users (Non-OCU) (7%) – National average 9%
- ❑ 55 Non-OCU & Alcohol clients (4%) – National average 10%

891 clients were recorded as receiving a brief intervention equalling a total of 2,428 people who had engaged with CGL Rotherham in the first year. A brief intervention was someone who did not require access to a service but required advice and information on substance or alcohol use.

Graphs and Pie Charts
- Opiate Successful Completions (Public Health Outcome Framework - PHOF)
- Opiate Successful Completions May 2019 (CGL Data)
- Opiate Representation Rates May 2019 (CGL Data)
- Non Opiate Successful Completion Rates May 2019
- Rotherham: Expected and Unexpected Deaths

The target for opiate exits in the first year was an increase of 1.5%. Successful completions were going in the right direction with re-presentations remaining low and the PHOF indicator would catch up.

Targeted work with all Service users on low doses of medication was taking place. Staff completed a detox readiness tool and, through their medically assisted treatment modules on the case management system, identified the cohort of people that were ready to reduce and would be the next people to successfully leave the Service.

Expected deaths tended to be deaths of service users with really complex health issues and who had an end of life care package in Hospital, not through an overdose.

Drug Related Deaths - Reporting, Investigating, Shared Learning
Reporting
- Incident Reporting Framework
- CQC Notification process
- Commissioner Notification

Investigating
- Death Learning Tool – all deaths
- Collaborative Approach, shared timelines

Learning
- Internal - Integrated Governance
- Collaborative - Death Review Meeting, Suicide Prevention Group, Loss of Life Forum

Actions in Rotherham to reduce drug related deaths
- ✓ Accessible Services
- ✓ Evidence based Clinical interventions
- ✓ Continued roll out of Naloxone to those most at risk via pharmacists/ GPs/housing providers
- ✓ Blood Borne Virus (BBV) Testing to all Service users in Rotherham;
- ✓ Smoking Cessation via Get Healthy Rotherham.
- ✓ Multi-Agency Working and Shared Learning: Death Review Panel, Suicide Prevention Group, Loss of Life Forum
- ✓ Development of a Dual Diagnosis pathway

Dual Diagnosis Pathway – RDaSH and CGL
Purpose
- To improve care and outcomes for Service Users with both drug/alcohol and mental health issues.
- To improve access to both Services
- To reduce duplication during assessment process
- To ensure Service users/patients received the interventions they needed in a timely way

What do we know about our Service Users?
- High percentage of SU's accessing both Services
- Many requiring input from Mental Health and Drugs and Alcohol Services due to complexity
- An ageing opiate using population with co-morbidity issues

Strengths
- Expertise across both Services
- Commitment to improving the way we work
- Services were passionate and Service user-focussed
- Familiar relationship between staff in both Services

Barriers
- Lack of co-ordinated approach/joined up care
- Different referrals/paperwork
- Different Data Systems
- Limited joint training

January-March 2019
- ✓ Dual Diagnosis pathway jointly developed and agreed between CGL and RDaSH

Pathway includes:
- Clarity around who co-ordinates care
- Process for escalation, joint ownership and training
- Mutually agreed Service Access

May 2019
- ✓ Training rolled out jointly between CGL and RDaSH to all relevant Mental Health and Substance Misuse Staff
- ✓ Champions from each Service self-nominated to lead on embedding the pathway
- ✓ Joint focus group established to continually monitor pathway effectiveness

40 staff attended and their engagement was really positive with a clear drive and willingness to work more effectively together to support the Service user population. One of the most positive aspects was setting up Champions meetings and groups with staff from both organisations and from different parts of RDaSH to look at joint shared learning on current issues in terms of the local footprint and how to best support people. Some of that progressed on to reflective practice work and how to share referrals in a more timely manner rather than through a traditional system through front-end services. Basic work took place on sharing contact details for both Services and attending each other's team meetings and Service meetings to provide an update on the respective footprints in terms of both Services at the time.

Copies of CGL's annual report had been circulated to Members which included more information around Service activity. The Dual Diagnosis Pathway flowchart and decision making matrix were also shared.

Members explored a number of issues following the presentation:-

- Changes from joint training and working arrangements were very recent, so how quickly would Service users see the effects of those changes?
    - Some were virtually instantaneous, such as direct communication elements and knowing where to seek information and support. If a member of CGL staff felt someone needed mental health input or assessment with this quicker pathway, staff would know how to access that information.

- Staff had been saying they did not have a really clear escalation process from substance misuse to mental health and vice versa, so that was now agreed and in place for staff to refer to. If there were any sticking points or barriers, or somebody felt the pathway was not working/a Service user was unable to go through the pathway as intended, the Champions would act as the point of contact to escalate the issue to either Joy or Michaela so they could understand the issue in more detail. People would see small changes soon and then once embedded it would be standard practice.

- Non-opiate successful completion rates - what was classed as successful and what were the reasons for the differential between successful completions in Rotherham and nationally, which was a concern? Did other areas use the same model of intervention?
  - Successful completions were measured on an 18 month rolling basis and re-presentations were over 6 months. It was not the same cohort of people who left and came back because of the different time spans in the data. Services counted everybody who left over a period of time and then checked on an individual basis if they came back. If a person left and then came back in 6 months that would be an unsuccessful exit and would not be counted as a successful completion. As this was the first year it was difficult with the data but the difference over 2 years would be measured in the light blue indicator from the PHOF.

  - Engagement work had been undertaken and Rotherham had a really small number of non-opiate users who accessed structured treatment. CGL had carried out a number of brief interventions with people who were not in structured treatment, as seen on the slide earlier, but did look to identify people who would benefit from structured treatment to engage and therefore improve the exits.

  - People came into Services who were not opiate users and who might be cannabis/spice/prescription drug users; anything that was not an opiate. For the last 20 years the Service had typically been dominated by opiate use, for which there was a very recognisable structured treatment in Methadone. Rotherham traditionally had had very low numbers of Crack and Cocaine users and lower numbers, for example, of users injecting Amphetamine, as seen in other areas of the country. Typically Rotherham had people who were unsure whether they wanted to come into structured treatment or not or for the more psychological treatments offered e.g. for Cannabis or Spice use. Nationally, it was more recognised that if somebody was involved in Crack Cocaine then escalation into difficulties in other areas of their life became very rapid, so in some ways it was easier to bring structure there than for somebody who was periodically using Cannabis and fairly undecided whether they wanted treatment or not. Thus in some ways, because the number of

presentations for this type of treatment was low, it was harder to achieve a good response rate but this was being looked at as something to improve on.

- CGL had recently implemented a specific psychosocial intervention package for non-opiate users within Rotherham, obtained from other services. The specific package was based on their substance of choice, as, for example, work with a Cannabis user would be different to how the Service would work with an Amphetamine user. As the packages had been rolled out very recently within the Service the impact had not yet been seen.

- Characteristics of Naloxone - what did it do and how successful was it? What did it mean that those most at risk could obtain it via a pharmacist, GP or housing provider?
  - Naloxone was quite a novel drug and had only been available in Rotherham since April of last year. Services had never had anything like Naloxone before that was as easy to administer, including by non-medical staff, which could bring someone back from an overdose. A recent example was a kit in one of Rotherham's housing providers where a couple of people living there were felt to be at risk of overdose. Having that kit available for non-medical staff to use, including some security staff who operated in some of those housing accommodations, was a means of giving a faster first response than an ambulance could get there because it would bring someone back from overdose. Obviously there was a role for a Naloxone kit to be given to family members if they had an opiate user in the family and were worried they might overdose.

  - Naloxone basically reversed the effects of opiates, so whereas before someone would call an ambulance and a paramedic would come and administer an equivalent to the Naloxone, once people were trained it was very easy to administer and quicker. CGL trained staff, family members and anybody who might come into contact with someone in this situation so they could use and administer Naloxone. It did save lives and nationally CGL had recorded that it had saved hundreds of lives. Naloxone was being made available nationally in police cells because of the risk that someone might come into police custody or in prison. It reversed the overdose effect initially but the person would still need medical attention as opiates were still in their system so they could not go out and use again straight away without experiencing a really negative impact. People would be given that advice once it had been administered.

- Borough-wide figures for expected and unexpected deaths – were these broken down by the Service, for example by Ward, to spot any local patterns or trends within a specific area and then responded to proactively target any specific issues?

- Although they seemed large numbers, they were relatively small for services to start to break down, with a risk that it might make Service users identifiable. They would be looked at in the detail of the review. For example, checking addresses to make sure it was not people in close proximity to one another as there might be a connection/knew each other or had a relationship. No emerging trends had been identified but Services were second in that process after the Coroner whose job it was to look at that in great detail.

- Was there specific learning from each case even if some may have looked similar?
  - Every death was investigated separately and the learning shared separately even though trends and themes were looked for. No staff member would be investigating 2 deaths at the same time although they might involve some of the same people e.g. if it was the same prescriber that was involved. Learning from each death informed Service quality improvement plans, not just around the themes of deaths but the themes around improving Service quality as a whole.

- Contacts - had there been any delays when the new Service commenced or were there pathways in place if someone presented with depression or suicidal ideation?
  - Everybody who was with the RDaSH Substance Misuse Service on the 31st March automatically transferred on 1st April, so their case went live immediately. It was a seamless transfer for everyone in Service at the time. The dual diagnosis pathway had been implemented recently and before there had been a process of staff individually making contact and making a referral through to the other Service in the same way as others such as a GP would. The pathway had been there but was less responsive and not as quick to access. Staff in CGL could now bypass some of that lengthy pathway because they already had a Mental Health Assessment which RDaSH would accept, remembering that the CGL service had a consultant psychiatrist.

- At the last meeting, Members learned that a pharmacy had withdrawn from providing the prescription drugs and this meant some people had to travel a lot further. Had that been looked at since?
  - This had been the unexpected closure of the pharmacy at the Community Health Centre from which a high number of substance misuse service users picked up their prescriptions. The pharmacy gave the minimum term of legal notice to NHS England. All those Service users were successfully relocated, with the majority not needing to travel very far having gone to a pharmacy near the old football stadium which offered the same flexibility in terms of opening hours. In the end it was useful because it led to reviews with all Service users to check if this was still the best place for them to go.

- Regarding the low positive Service exit rate, was there confidence in achieving where we needed to go. Offset against this it was positive that Rotherham maintained success longer than the national picture, so what was being done differently here?
  - On transition to CGL the first priority was to have a safe service so that all drug-users transferred safely to the new Service provider. It was reassuring that once people were leaving the Service they were not re-presenting; if the re-presentation rate had been higher that would have been more of a concern. The Commissioning Officer visited the Service several times a month, met with Service Managers monthly and reviewed the Service Improvement Plan in great detail. Clinical tools to determine which Service users were most recovery ready had been introduced in a safe manner. Rotherham had a legacy of Methadone users who were concerned that if they gave up their Methadone the Methadone offered a second time around might not be as good because the ethos around Methadone had changed. It was a difficult task but the tools used by CGL showed some slight improvement and it would be more concerning if exit numbers were doubling in case this meant people were leaving treatment too early. Any issues raised by GPs were considered and as almost half the client group had care with their own GP that provided assurance their care was safe. CGL and the GP jointly agreed the best course of action for each Service user.

  - The number in shared care could act against us because as people were receiving long term care from their GP, they were quite comfortable. Many were in work and had had their children returned to live with them and were stable and safe and, therefore, not exposed to the recovery community at Carnson House. In the longer term it might be a case that more people would have to be brought in centrally to get them talking around recovery.

- With regards to the dual diagnosis pathway, domestic abuse did not feature despite the close links between mental health, domestic abuse and drug use in terms of being quite a toxic trio. Was that something that could be looked at going forward and why had it not appeared as a risk factor, even in terms of family history.
  - The pathway included a sheet for staff for escalation between Substance Misuse and Mental Health Services and behind that sat a full assessment that would ask about domestic abuse, which was a priority. The escalation risk matrix was taken from national guidance and was not a standalone document but one supported by a range of assessments and information about the whole picture around that person.

  - From an RDaSH perspective, if they were providing advice,

support or conducting any assessment, that would definitely be a key feature and they had really positive links with the 3 non-statutory organisations in Rotherham so there were very clear pathways. Going forward in terms of the Champions' work, discussion had taken place with the Trauma and Resilience Service staff to look at embedding some of that work. The pathway was a starting point and would develop to incorporate many non-statutory organisations within it for that whole breadth of knowledge and experience to support anybody along their journey.

- What was the routine questioning and data collection around domestic abuse?
  - At CGL when questions were asked at assessment that would be recorded on their system. It was not something routinely asked about by commissioners but the facility was there to ask CGL specifically about their current caseload, to make sure that section was completed and to ask how many people had disclosed domestic abuse. Usually it was a relatively low figure in terms of numbers coming in to Service but did form part of the assessment.
  - CGL undertook full risk reviews which captured that information in a separate module on the database. They also had a designated Safeguarding lead in the Service who had links with the Domestic Abuse Services and could also people who had experienced domestic abuse.

- It would be good to make sure the pathways were really clear and in place and to develop our understanding about the inter-connectivity and complexity of people's lives and what their most pressing issue was at that time.

- Some measures described in the slides were not very specific and talked in general terms about reduction or improvement. Were these more specific in the action plans and were people content with the rate of improvement?
  - The 1.5% improvement target on Opiate exits had not been reached by CGL in the first 12 months of the contract, so they had been asked to roll that requirement forward into the next year, which would make year two of the contract delivery more challenging. The current rate of improvement showed the number of Opiate exits were going up and had been for the last 3 months. It was hoped this improvement seen at Service level would be borne out in the national end of year data from NDTMS. It was difficult to do anything other than compare itself with neighbouring areas because strictly speaking there could not be an enforceable target. When Opiate exit recovery was first talked about, some areas set very high targets for Services and Public Health England had concerns as the only sure fire way to get someone off Opiate use was to stop their

prescription, which would lead to high rates of re-presentation. The performance improvement plans demonstrated that CGL were doing all the right things based on good practice from elsewhere in the country. Not meeting the target was disappointing but it was felt that it would happen and officers knew it would take time to change the culture.

- Was there confidence in being able to meet the target in year 2 after incorporating the deficit from year one?
  - There was an absolute number that the Service would have needed to meet to get the 1.5% increase last year and Services were actually working with all the people that would be the target group but they were just not ready to leave yet. Looking at the overall number of people who were prescribed in Rotherham, it was right to be ambitious because the Service was so far behind the national picture that it had to keep pushing to get somewhere near it. It had been the case for too long that people on Methadone in Rotherham were less likely to exit than in other places in the country. There was no reason for that other than cultural history around Service users getting a Methadone offer and sticking fast to their prescriptions. CGL had been very keen to work with the Service and in other areas had pushed the rate up quite quickly from 3.5% to 7%. The tools used in some other areas were the same ones being implemented here and as they had worked elsewhere that gave the confidence, coupled with a detailed Service Improvement Plan that adhered to national guidance.

- Was it possible to separate out historical cases from ones coming through more recently or which were not so embedded.
  - The longer somebody stayed on a prescription the more difficult it was for them to exit treatment. When the recovery process started about 5 years ago the average length of stay on a Methadone prescription in Rotherham was around 6 years and if people had not left the average grew longer every year. For someone starting a method of substitution prescription today it would be a different offer to the one 5 years ago, with people now quicker to come into Service, become stabilised, reduce and go back out. It was the legacy numbers that were the most difficult and linked back to the earlier point about GP care and shared care. People's general health had improved as a result as they could have all their other health issues sorted out. Rotherham had an ageing drug-using population with people now in their forties and fifties so it got more difficult with every year. The aim was to get somewhere in the region of statistical neighbours and the national position and to make sure everybody had had that offer in the Service and to understand that recovery was possible.

Councillor Roche, Cabinet Member, reminded Members that CGL had

come into Rotherham at very short notice to establish a "holding service" when Lifeline, the previous provider of recovery services, entered administration. They had made a good start but things needed some time to bed in. They were moving in the right direction but the figures needed to improve.

Resolved:- (1) To note the information provided with regard to progress on the outstanding recommendations from the spotlight review.

(2) To note current performance and service developments in the Drug and Alcohol Treatment and Recovery Service.

(3) To be updated on pathway developments to include wider issues such as domestic abuse.

William Brown assumed the Chair for the following agenda item.

16. HEALTH SELECT COMMISSION WORK PROGRAMME 2019-20

Janet Spurling, Scrutiny Officer, submitted the final draft of the Select Commission's work programme for the 2019/20 Municipal Year.

The overall priorities for the Select Commission for 2019/20 included:-

- Rotherham Integrated Health and Social Care Place Plan
- Adult Social Care - performance and development (in conjunction with Overview and Scrutiny Management Board)
- Autism Strategy and Diagnosis Pathway
- Social and Emotional Mental Health
- Sexual Health
- Developments in Primary Care
- Health and Wellbeing Strategy implementation
- South Yorkshire and Bassetlaw Integrated Care System – NHS transformation (Joint Health Overview and Scrutiny Committee)
- Monitoring past reviews

Appendix 1 of the report submitted showed the schedule to date for agenda items and sub-group meetings, with a small number of Adult Care items still to be scheduled.

Appendix 2 set out the proposed membership for each of the NHS Trust Quality Account Sub Groups and the Performance Sub-Group for consideration. The membership was based on the previous year's membership to retain the knowledge developed by Members of those Health partners' services.

With regard to the Health Select Commission undertaking a review on gambling/gaming, liaison would take place with the Cabinet Member and Director of Public Health (Minute No. 4 Health and Wellbeing Board) This would ensure added value and avoid duplication with work currently

taking place on Harmful Gambling.

The Commission had agreed to hold a single session on the national Adult Social Care Outcomes Framework once the final data and benchmarking was available rather than 2 sessions, which would free up a sub-group meeting to look at another area of performance.

Members asked when an update on progress with My Front Door would be considered. A Member seminar on July 16th would cover progress with Oaks Day Centre and lessons learned and, following full evaluation, a further update could probably be scheduled from October, including plans for respite.

It was suggested that inequalities in health in Rotherham, and whether enough was being done in Rotherham to address those issues, could be a possible spotlight review in 2020-21. This was acknowledged as an important issue and attention was drawn to the ensuing agenda item on Primary Care Networks where one of the national workstreams coming on board would be addressing health and economic inequalities, which might provide an opportunity to link in with Services such as Planning and Housing that also influenced health inequalities. Councillor Roche welcomed the suggestion for the Commission to look at the work of the Health and Wellbeing Board in this area as it was one of the Board's 2 main priorities, together with the work of Primary Care.

Ward profiles, which had been introduced through the Health and Wellbeing Board to support work on early intervention, were being refreshed and would soon be available with detailed information on each Ward with regard to health inequalities.

Resolved:- (1) That the draft work programme for the 2019/20 Municipal Year be approved.

(2) That the proposed membership for the Quality Account Sub-Groups and Performance Sub-Group for 2019/20 be as follows:-

Rotherham Doncaster and South Humber (RDaSH)
Councillors Keenan (Chair), Andrews, Ellis, Jarvis, John Turner and Walsh
plus Councillor Brookes or Councillor Yasseen (to be confirmed)

Rotherham Hospital
To be confirmed - Councillor Keenan or Vice Chair to Chair
Councillors Albiston, Bird, Cooksey, R. Elliott, Vjestica and Williams

Yorkshire Ambulance Service
Councillors Keenan (Chair), Vice Chair, Councillors Evans and Wilson
plus Councillor Brookes or Councillor Yasseen (to be confirmed)

Performance
Councillors Keenan (Chair), Bird, R. Elliott and Ellis
The Mayor (Councillor Andrews) and Councillor Jarvis to be confirmed

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

Cllr Keenan re-assumed the Chair of the meeting.

17. INVESTMENT AND EVOLUTION - PRIMARY CARE AND DEVELOPING ROTHERHAM COMMUNITY HEALTH CENTRE

Jacqui Tuffnell, Head of Commissioning NHS Rotherham CCG, gave presentations on Primary Care and Developing Rotherham Community Health Centre as follows:-

Investment and Evolution – Primary Care

NHS Long Term Plan: Overview
Published in January 2019
Sets out the key ambitions for the NHS over the next 10 years
Produced in response to a new five- year funding settlement

1 New Service Model
2 Prevention and Health Equality
3 Care Quality and Outcome Improvement
4 Workforce Pressures
5 Technology
6 Sustainable Financial Plan
7 Next Steps

A New Service Model for the 21st Century
Five major changes to the NHS service model:

- Boosting 'out-of-hospital' care and finally dissolving the historic divide between Primary and Community Health Services
- Redesigning and reducing pressure on emergency Hospital Services
- People will get more control over their own health, and more personalised care when they need it
- Digitally-enabled primary and outpatient care will go mainstream across the NHS
- Local NHS organisations will increasingly focus on population health and local partnerships with local authority-funded services, through new Integrated Care Systems (ICSs) everywhere - in relation to concerns about health inequality population it was about making sure the population's health would be managed appropriately.

What this means

- Urgent Community Response and Recovery Services – integrated rapid response and care home liaison
- Primary Care Networks of Primary and Community Teams – localities

now in place renamed PCNs and strengthened
- Guaranteed NHS support for care homes - already had care home alignment with GP practices so one GP practice tended to look after a care home instead of everybody being assigned to different care homes, getting different levels of care and it being reactive instead of proactive
- Supporting people to age well – right support services when needed
- Increasing patient choice
- Same day emergency care – ensuring people were in and out of hospital on the same day by increasing the kind of conditions managed within a 24 hour period so people went back home
- Personalised care when needed
- Reducing delays in patients going home
- Digitalisation of Primary and Outpatient care
- Integrated Care systems everywhere by 2021 – focussing on population health

Rotherham already had some of these Services, therefore, the long-term plan did not bring any big surprises in relation to the direction of travel already taken.

Investment and Evolution: A Five Year Framework for GP Contract Reform to implement to NHS Long Term Plan
- Introduces automatic entitlement to a new Primary Care Network Contract
- Gives five-year funding clarity and certainty for practices

This was quite significant in relation to how GP practice currently operated. It had not been expected to be so clear on the expectations in relation to how Primary Care would change.

The Vision for Primary Care Networks (PCNs)
- The key building block of the NHS long-term plan
- All GP practices in geographical based PCNs with populations of around 30,000–50,000 patients - < 30,000 probably too small to be able to provide shared services across the network and ensure you could almost share staff/back-office staff as well between practices. > 50,000 would start to get a little too big
- Intended to dissolve the historic divide between Primary and Community Medical Services – latter ultimately provided from PCNs with leadership arrangements changed not necessarily contractual
- Proposals from practices submitted and agreed in May 2019 by CCG
- Small enough to provide valued personal care;
- Large enough to work with other practices and organisations
- General practices working at scale together, to
    - recruit and retain staff;
    - manage financial and estates pressures;
    - provide a wider range of services to patients
    - integrate with the wider health and care system.

What will PCNs do?
They would be more flexible in relation to how they would operate in terms of providing care for generally healthy people. Some practices had only a 1,400 population and were starting to struggle in terms of resource for the wider remit of care expected from general practice. As part of that Network somebody else might provide the more complex care on their behalf for a particular patient. Some practices did not have any female GPs or male GPs and some people only wanted to see a female GP or a male GP, so it was to provide that support to ensure the population got the appropriate care and also enabling patients.

- Provide care in different ways to meet different needs, e.g.
  - flexible access to advice and support for generally healthy people
  - joined up care for those with complex conditions

- focus on prevention and personalised care,
  - supporting patients to make informed decisions
  - to look after their own health
  - connecting patients with statutory and voluntary services

- provide a wider range of services through a wider set of five funded staff roles i.e.
  - First Contact Physiotherapy, Associate Physician, Paramedic
  - extended access
  - Social Prescribing (100% funding, others 70%)

- deliver 7 national Service specifications.
  - 5 would start by April 2020: Structured medication reviews, enhanced health in care homes, anticipatory care, personalised care & supporting earlier cancer diagnosis
  - 2 would start by 2021: Tackling local health inequalities, CVD case finding

- join up the delivery of urgent care in the community

- Be responsible for providing enhanced access services and extended hours requirements

- Publication of GP activity and waiting times data alongside hospital data
  - New measure of patient-reported experience of access

- Will be the base for:
  - integrated community-based teams
  - Community and Mental Health Services

- will consider population health,
  - from 2020/21, will identify people who would benefit from targeted, proactive support.

- will represent Primary Care in integrated care systems, through the Accountable Clinical Directors from each Network

How will the funding work
Practices have to be part of the network to receive payments, which will include:

- Separate national funding for digital-first support from April 2021
- Funding for additional roles to support general practice: Clinical Pharmacists and Social Prescribing Link Workers in 2019/20,
- funding for physiotherapists, physician associates and paramedics to follow (worked through in terms of the numbers being trained and supported)

PCN Accountability
- Practices were accountable to commissioners for the delivery of Network services.
- A legally binding agreement
- An accountable clinical director for each Network
- Publication of GP activity and waiting times data alongside Hospital data
- New measure of patient-reported experience of access

Benefits for Patients
- More co-ordinated services; where patients do not have to repeat information many times (Rotherham Health Record)
- Access to a wider range of professionals in the community – patient education needed to explain for example how physiotherapists had greater experience on musculo-skeletal (MSK) issues than GPs)
- Appointments that work around patients' lives; shorter waits & treatment and advice delivered through digital, telephone and face to face
- More influence when people want it, with more power over how Health and Care Services were planned and managed
- Personalisation and a focus on prevention and living healthily

Benefits for Practices and the Wider Health System
- Greater resilience; using shared staff, buildings and other resources to balance capacity and demand
- Better work life balance
- More satisfying work; each professional able to do what they do best
- Improved care and treatment for patients,
- Greater influence on the wider health system
- Better co-operation and co-ordination across services
- Wider range of services in community settings, meaning patients do not default to Acute Services – for example DVT this year
- Using the expertise in Primary Care on local populations to inform system-wide decisions and how resources were allocated – Housing and Social Care involvement expected in understanding health

impacts for our population and what we can do better together

Rotherham Primary care Networks
6 Primary Care Networks all over 30,000 population:

– Health Village/Dearne Valley PCN - Clifton Medical Centre, Crown Street Surgery, Market Surgery, St. Ann's Medical Centre
– Maltby Wickersley PCN - Morthern Road Group Practice, Wickersley Health Centre, Manor Field Surgery, Blyth Road Medical Centre, Braithwell Road Surgery, Queen's Medical Centre
– Raven PCN -Gateway Primary Care, Treeton Medical Centre, Stag Medical Centre and Rose Court Surgery, Brinsworth and Whiston Medical Centre, Thorpe Hesley Surgery
– Rother Valley South PCN - Dinnington Group Practice, Village Surgery, Swallownest Health Centre, Kiveton Park Medical Centre
– Rotherham Central North PCN - Greenside Surgery, Woodstock Bower Group Practice, Greasbrough Medical Centre, Broom Lane Medical Centre, Broom Valley Surgery
– Wentworth 1 PCN - Magna Group Practice, High Street – Rawmarsh, Parkgate Medical Centre, Shakespeare Road, York Road Surgery, Rawmarsh Health Centre

A number of the Clinical Directors had been in this system and supported either CCG projects or were Deputy Chairs of Committees. However, others were new to undertaking this type of work so there would be development programmes, both national and local, as this was a big ask for Primary Care in what they were being asked to do in terms of change.

- We would all welcome people being treated in the community rather than being in a hospital, but how confident were you that the out of hospital services could cope as in some areas a lack of trained staff has been reported for example.
  - It was about being cleverer in terms of utilising and bringing resources together and losing the divide that currently existed because of employment, although a lot was already happening. Staff would do things such as take bloods because they were already with the patient or this could be done in general practice rather than patients returning to the hospital as before. Work currently happening included understanding the Home First model and ensuring the right resources were in place for this.

- On communications, an officer attended a Ward event to talk about the Rotherham App and people were very impressed. Had it been rolled out well enough and did people know about it? Surgeries did not seem to offer appointments at the hubs and previously the Select Commission had suggested that surgeries could play a recorded message when people were holding on the phone alerting them to the option to go elsewhere, so could that be considered.
  - Regarding the app, the CCG were working with practices in relation to the release of the appointments. This had held them up as they did not want large scale communication when

practices had not actually enabled the appointments yet. The marketing plan included going to big companies in Rotherham and the Council to make sure they knew about it and would hopefully send messages in turn so that everyone knew about the app. The CCG wished to ensure that every single practice released that 25% capacity so people could see there was an appointment, see extended access and see that you could have a Physio First appointment. These would all be bookable but needed to be up on the app so no-one would be disappointed.

- The phone message suggestion could be taken back and as practices tended to use one company across Rotherham it should be quite easy to do.

- What had been the geographic rationale for the grouping of practices into Primary Care Networks as they did not seem to follow natural communities.
  - A lot did and they were predominantly based on how the district nursing structure. Thorpe Hesley did not really fit with Raven but as it would soon become part of the Gateway Primary Care grouping that had been done immediately thinking ahead.

- The idea of amalgamating Primary Care into bigger entities made perfect sense, so why not just merge the practices.
  - For GMS practices a lifetime guarantee existed in essence that there would be no change to how they operated so the CCG had to negotiate to make any changes and a merger could not be enforced on a practice.

- First Contact Physiotherapy - what would that service look like.
  - First contact physios were not physiotherapists providing actual physiotherapy; they were doing the diagnosis/assessment that would have been done by a GP if a patient had gone to them with a MSK issue. They would sort immediate pain relief and determine whether additional physiotherapy was required or referral to the hospital. They could also provide physiotherapy leaflets.

- The Primary Care Network names seemed rather odd, for example having Rother Valley South but not having Rother Valley North and also Rotherham Central North but not Rotherham Central or Rotherham Central South, so did these need another look.
  - The Networks determined the names, some of which were just historical but all were recognisable other than Raven.

- What were the advantages of links with other Services, particularly between Primary Care and Adult Social Care, for the older person?
  - Social Workers would not be seen out in PCNs but staff in RDaSH and the Council had been digitally enabled to be able to link in with MDT discussions without all being in the same room unless they really needed to be.

- Tackling health inequalities - how would links be made with other departments such as Housing.
  - This was probably one of the most significant changes in General Practice in 70 years, so the first thing they needed to do was work together as GPs. They all knew each other but had never had to share resources or how they operated and it probably meant changing their operating models to align together. One joint bank account had been set up for the monies coming in for Primary Care Networks. So without wishing to push too quickly in relation to developing these, the expectation was that it would bring all that care together having those conversations rather than it just being one individual GP trying to resolve things.

- Would there be consistency of care for older people who might go into residential care and have to change their General Practice because they no longer lived in the area covered by the Practice, and would that reduce their choice and control.
  - When care homes were aligned people were not told that they would have to change Practice but they started to see that people who were all connected to that Practice were getting a different service to them. No significant change in relation to care homes was anticipated from the PCNs as they had already aligned. As new people went into care homes they could still choose to remain with their current GP but most of them chose to move.

- We needed to build more engagement into this model, with patients and people in the community. Are we taking choice away from people about where they go for care? Other concerns were early intervention picking up cancers early and how waiting times for GPs would be measured.

- What about holistic care rather than treating individual things? Could medication reviews be done over the telephone rather than taking up an appointment, unless bloods were needed, and then people who wanted to see a GP might be more able to see one? How would this model enable Practices to recruit GPs who were holistic and had often known families for years and had more background knowledge? There were reports that Practices were unable to recruit GPs and if that became a growing issue could it destabilise the model or would it exist with the other provision.
  - In terms of holistic care the concerns were recognised but there were not enough GPs, which meant supplementing the workforce. Pharmacists would not detract from holistic care as they would be working within the Practices not remote from them and for some PCNs it would be almost one per Practice. Next year's funding was for 36 additional posts for Rotherham and by year 5 there would be about 100 extra people working in General Practice in those new types of role. As a number of

pharmacists already worked in Practices, the benefits for patients and the Practice were known, including freeing up GPs to spend longer with patients who needed more time. Physio First had been in place for a year and freed up significant time for the GPs and the numbers referred into secondary care had levelled off after a huge hike nationally in terms of the numbers going to physio.

- The biggest benefit has been people getting an appointment within 24 hours if prepared to go anywhere in Rotherham to one of the hubs. Patients could be seen the next day for Physio First when they could have waited 2 or 3 days to see their GP and are often getting earlier resolution. It was a dilemma in relation to how you ensured holistic care, but by having those regular MDT discussions there was wider understanding of what was happening with that patient and with that family.

- The other point was who would be screening patients, as currently this was done by non-medical receptionists in some Practices, and was it in the plan.
  - A number of receptionists from the Practices had been trained in relation to care navigation so the message already on the systems from the lead GP said that people would be asked a number of questions. That was to ensure people went to the right services. This had been supported by customer care training around how the questions were handled and people being treated courteously. More care navigation was likely to happen.

- Regarding the proposals that were submitted and agreed in May, would the Commission be able to have a summary of the content.
  - Yes, it was available publicly.

- Would this create parity across the Borough.
  - A lot of work had taken place in relation to ensuring a consistency of offer around the population. There were mandated local enhanced services so that wherever patients were they should get the same level of service and the same offer. Minor surgery and Dermatology happened across the Borough but there was a view that some Practices, particularly the single-handed practices, would gain by being able to check out what they were actually delivering. The big Practices held regular sessions where they review each other in relation to what they had done with patients so that was expected to happen more globally now in the Networks. The data used would be the population health data which would pinpoint areas where more support might be needed and that was how achieving parity was expected.

- Would extended hours and access go beyond what was currently in place through the hubs.

- Currently 132 hours per week were available and work would take place in relation to the offer. Very little use was made of Sunday appointments still yet the Hospital was under pressure on Sundays. It was a case of bringing those offers together and might mean the hours available would not need to increase, although it centred on providing what was required in terms of access into the system and some would say in-hours provision required boosting up.

Rotherham Community Health Centre

- Rotherham Community Health Centre – purpose built to house the walk-in centre, GP practice, Dental Services and Community/Outpatient facilities, already included quite a lot of therapy
- Services had changed resulting in 2/3rds of the Centre now being empty – clear feedback from our population that it needs to be better utilised

The Walk-in Centre had in essence been amalgamated within the Urgent and Emergency Care Centre although with a slightly different offer and diagnostics were difficult to provide from the Centre so were now provided on the main Hospital site.

What will work best for the Centre and our population?

- 5 options considered - CCG worked with its estates and advisers across our community and undertook a One Estate Review as well, including the Council, RDaSH and the Hospital.
- Recommended option to relocate Ophthalmology outpatients enabling:
  - amalgamation of the Service
  - to meet CQC requirements separating children from adults
  - ensuring the estate was fit for purpose to meet current and future capacity (double the floor space)
  - reducing the footfall substantially on the Hospital site (by approximately 48,000 visits per year), freeing up car parking and increasing the footfall into Rotherham's town centre, which should contribute to regeneration of the town centre
  - responding to the public's request to utilise this central, good quality facility

This was all subject to feasibility for the Hospital so had not been signed off but it was hoped that it would be achievable for the Trust and would go to their Board. One issue raised already was that the pedestrian crossing from the bus station to the centre was a silent one.

Next Steps

- Engage current Service users:
  - surveys with patients and carers in the department
  - publicise in the Hospital main reception outlining the plans and asking for comments

- Utilising social media to undertake surveys
- Identify relevant stakeholders and key audiences

- Incorporate comments into the case for change
- Work up a plan for changes required to accommodate Ophthalmology as there would be some estates work
- If finally agreed, facilitate relocation before the end of the financial year

Following the presentation Members sought clarification on the following points:-

- In terms of the figures, what proportion of the total footfall were the 48,000 visits per year.
  The exact proportion was not known but with 15,000 going to the Hospital site for Diagnostics, more than triple that number would come off site for Ophthalmology.

- Would Pharmacy Services in the Centre be sorted out from the beginning to enable people to get any follow-up medications swiftly or would they have to go to the Hospital, or return to the Centre later, to collect them.
  Prescribing had been picked up as part of the proposal to move the service and people would not be expected to go to the Hospital.

The Select Commission was supportive of making better use of Rotherham Community Health Centre and requested a follow up report with the outcomes from the public engagement.

Resolved:- (1) To note the information provided regarding the development of Primary Care Networks.

(2) To note the plans for ophthalmology services at Rotherham Community Health Centre.

(3) To receive a further report on the plans for Ophthalmology following the public engagement.

18. HEALTHWATCH ROTHERHAM

No issues were discussed.

19. HEALTH AND WELLBEING BOARD

Consideration was given to the minutes of the Health and Wellbeing Board held on 29th May, 2019.

Resolved:- That the minutes of the Health and Wellbeing Board held on 29th May, 2019, be noted.

20. SOUTH YORKSHIRE DERBYSHIRE AND WAKEFIELD JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE UPDATE

There were no matters to feed back from the Committee as it had not met.

21. DEPRESSION PREVALENCE

Further to Minute No. 7 of the Health Select Commission meeting on 13th June 2019, additional information had been provided showing comparative data with other areas and also ward-specific data.

Resolved:- That depression prevalence be a specific agenda item at a future meeting of the Health Select Commission.

22. URGENT BUSINESS

There was no urgent business to report.

23. DATE AND TIME OF NEXT MEETING

Resolved:- That a further meeting be held on Thursday, 5th September, 2019, commencing at 2.00 p.m.