

HEALTH SELECT COMMISSION

- Date and Time :-** Thursday, 5 September 2019 at 2.00 p.m.
- Venue:-** Town Hall, Moorgate Street, Rotherham.
- Membership:-** Councillors Albiston, Andrews, Bird, Brookes, Cooksey, R. Elliott, Ellis, Evans, Jarvis, Keenan (Chair), John Turner, Vjestica, Walsh, Williams, Wilson and Yasseen)
- Co-opted Members – Robert Parkin (Rotherham Speak Up),**

This meeting will be webcast live and will be available to view [via the Council's website](#). The items which will be discussed are described on the agenda below and there are reports attached which give more details.

Rotherham Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair or Democratic Services Officer of their intentions prior to the meeting.

AGENDA

1. Apologies for Absence
To receive the apologies of any Member who is unable to attend the meeting.
2. Declarations of Interest
To receive declarations of interest from Members in respect of items listed on the agenda.
3. Questions from members of the public and the press
To receive questions relating to items of business on the agenda from members of the public or press who are present at the meeting.

For decision/discussion:-

4. Enhancing the Respiratory Pathway - Jacqui Tuffnell, Head of Commissioning NHS Rotherham CCG, to present (Pages 1 - 5)
5. Home First - Intermediate Care and Reablement - NHS Rotherham, CCG and Adult Social Care, RMBC to present (Pages 6 - 13)

6. Developing Rotherham Community Health Centre - Jacqui Tuffnell, Head of Commissioning, NHS Rotherham CCG to present (Pages 14 - 30)
7. Maternity and Better Births - June Lovett, The Rotherham Foundation Trust, to present (Pages 31 - 37)
8. Healthwatch Rotherham
9. South Yorkshire, Derbyshire, Nottinghamshire and Wakefield Joint Health Overview and Scrutiny Committee Update
10. Minutes of the previous meetings held on 13th June and 11th July, 2019 (Pages 38 - 78)

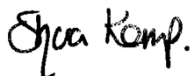
To consider and approve the minutes of the previous meetings held on 13th June and 11th July, 2019 as a true and correct record of the proceedings.

11. Communications

12. Urgent Business

To consider any item(s) which the Chair is of the opinion should be considered as a matter of urgency.

13. Date and time of next meeting - Thursday, 10th October, 2019, commencing at 2.00 p.m. in Rotherham Town Hall



SHARON KEMP,
Chief Executive.

Enhancing the respiratory pathway

Jacqui Tuffnell, Head of Commissioning
NHS Rotherham CCG

5 September 2019

Your life, Your health

Why do we need to make changes

- Poorer outcomes for our patients than our counterparts across the integrated care system
- Fragmentation across the respiratory pathway
- Fragmentation of the home oxygen service
- Improve diagnosis across Rotherham
- Improvement the management of respiratory patients
- High numbers of patients going into hospital
- Longer stays for patients when they are in hospital
- Long term plan states care should be provided closer to home



Your life, Your health

What changes are proposed?

The development of the enhanced respiratory pathway has been a clinically led process, developed in line with best practice and the clinical benefit for patients has been at the forefront of discussions

The enhanced model for respiratory includes:

- Standardising the care across primary care for diagnosis and management
- Improving patient education and access to support patients to self manage
- Delivering care closer to home, with a specialist community respiratory team, reducing the requirement for inpatient care
- Delivering care during the day, at evenings and weekends to fit in with patients lives
- For those who do require inpatient support a dedicated respiratory unit at TRFT
- Increased support for high intensity users to help stabilise their conditions

Your life, Your health

Service user/carer/stakeholder engagement

Patient and public and stakeholder engagement on the proposed changes is scheduled throughout September and will be via the following forms:

- Surveys, online and paper
- Face to face drop in sessions across Rotherham, including breathing space
- Mjog messages to patients, aimed at those with a specific respiratory condition
- Media messages

- ***Animation if available to be shown here***

Your life, Your health

Next steps

- Incorporate engagement responses into the business proposal
- Governing body 2 October 2019/ Trust Board
- Commence recruitment to the new structure



Your life, Your health

Rotherham Intermediate Care and Reablement Project

September 2019



Why Change?

- * **People have told us**
 - * They would like to be at home wherever possible
 - * They would like to regain their independence
 - * Current services are disjointed and can be hard to navigate
- * **Care Quality**
 - * Evidence shows people do better at home
 - * We know that a large number of people receive care in a community bed when they could have gone home with the right support
 - * Rotherham has significantly more community beds than other similar areas
 - * Current services are focused on older people and their physical needs
 - * Through changing the way we work, more people are going home and our community beds are not fully utilised

Current Services

Community based services

Integrated Rapid Response (TRFT)

Community Locality Therapy (TRFT)

Independent and Active at Home Team (TRFT and RMBC)

Reablement (RMBC)

Bed based services

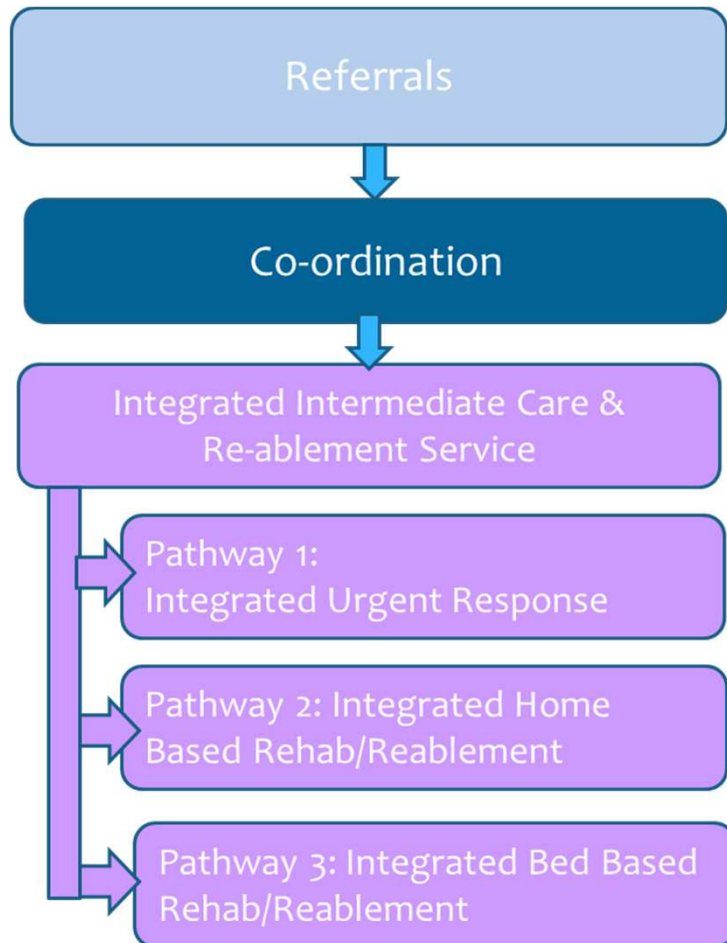
Intermediate care at Davies Court and Lord Hardy Court (RMBC and TRFT)

Oakwood Community Unit (TRFT)

Waterside Grange (Independent Sector)

- Services currently provided by a range of teams and bed-based sites
- In addition, several teams of social workers and therapists working into the bed-based provision
- People move through multiple services rather than an integrated pathway
- Significant duplication and some capacity issues in a number of services

Project Aim



- * To simplify current provision to provide an integrated, multi-disciplinary approach to support individual needs across health and social care
- * To re-align resource to increase support at home, reducing reliance on bed based care

Future Services

Community based pathways

1. Urgent response
(integrated team)

2. Home-based reablement and rehabilitation
(integrated team)

Bed based pathway

3. Community bed-base – rehabilitation and reablement without nursing
(integrated team)

3. Community bed-base – rehabilitation and reablement with nursing
(integrated team)

- Three core integrated pathways
- Services align to work as a single team to provide the three pathways
- Increase in community capacity to meet the demand to support people at home (urgent response or rehabilitation / reablement)
- Reduction in community bed-base (phased and double-running for a period with increased community capacity)
- Integrating processes for triage and coordination to ensure people get the right support
- Reduction in duplication

Benefits

Patients and carers

- Improved experience of services
- Telling story once
- Reduced duplication and hand-offs
- Improved outcomes
- More people able to be supported at home

Commissioners (CCG and RMBC)

- Supports Rotherham Plan for 'Home First' and integration of service delivery
- Reduces over-reliance on bed base where Rotherham is an outlier
- More cost effective model

RMBC (service delivery)

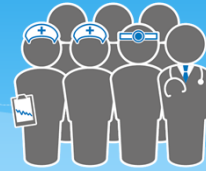
- Supports delivery of the Council's target operating model and future sustainability
- Improving flow through the social care system

TRFT

- Supports the Trust's wider plans for bed configuration / estate moves
- Improving flow through the hospital and community services

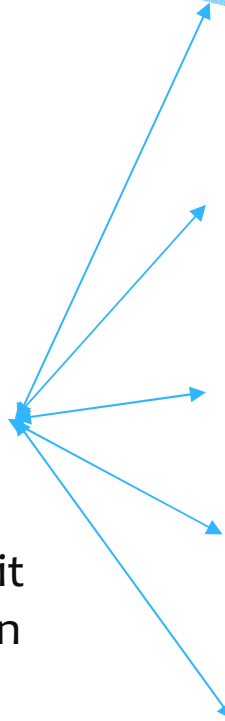
Taking the work forward

Workforce: HR & OD



Pathway
Redesign &
Implementation

Off-site
Community Unit
Implementation



IT , IG and analytics



Accommodation



Communications
and Engagement



Finance,
contracting and
commissioning

DRAFT

Proposed Timeline / Phasing

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	
Community IC and reablement																				
Approvals																				
Recruitment																				
Staff in post (inc. capacity)																				
Training / development of Generic Support Workers (core competencies)																				
Double-running of increased community capacity and full community bed-base																				
Clinical pathway engagement and redesign (staff, patients, carers)																				
New reablement model in place																				
Staff consultation																				
Staff enabled into new structure																				
Implement new pathways, ways of working and new model of care																				
New model of care fully operational																				

Pathway / Phase	Date
Integrated Model Home Based Pathways 1&2 Reduced Intermediate Care Bed Base	from 1 April 2020 from June 2020
Therapy Led Community Unit with Nursing (Phase 1: off site) Open off site unit	November 2019
Therapy Led Community Unit with Nursing (Phase 2: on- site)	November 2020

Developing Rotherham Community Health Centre

Jacqui Tuffnell, Head of Commissioning
NHS Rotherham CCG

5 September 2019



Your life, Your health

Rotherham Community Health Centre

- Rotherham Community Health Centre – purpose built to house the walk-in centre, GP practice, dental services and community/outpatient facilities
- Services have changed resulting in 2/3 of the centre now being empty – clear feedback from our population that it needs to be better utilised



Your life, Your health

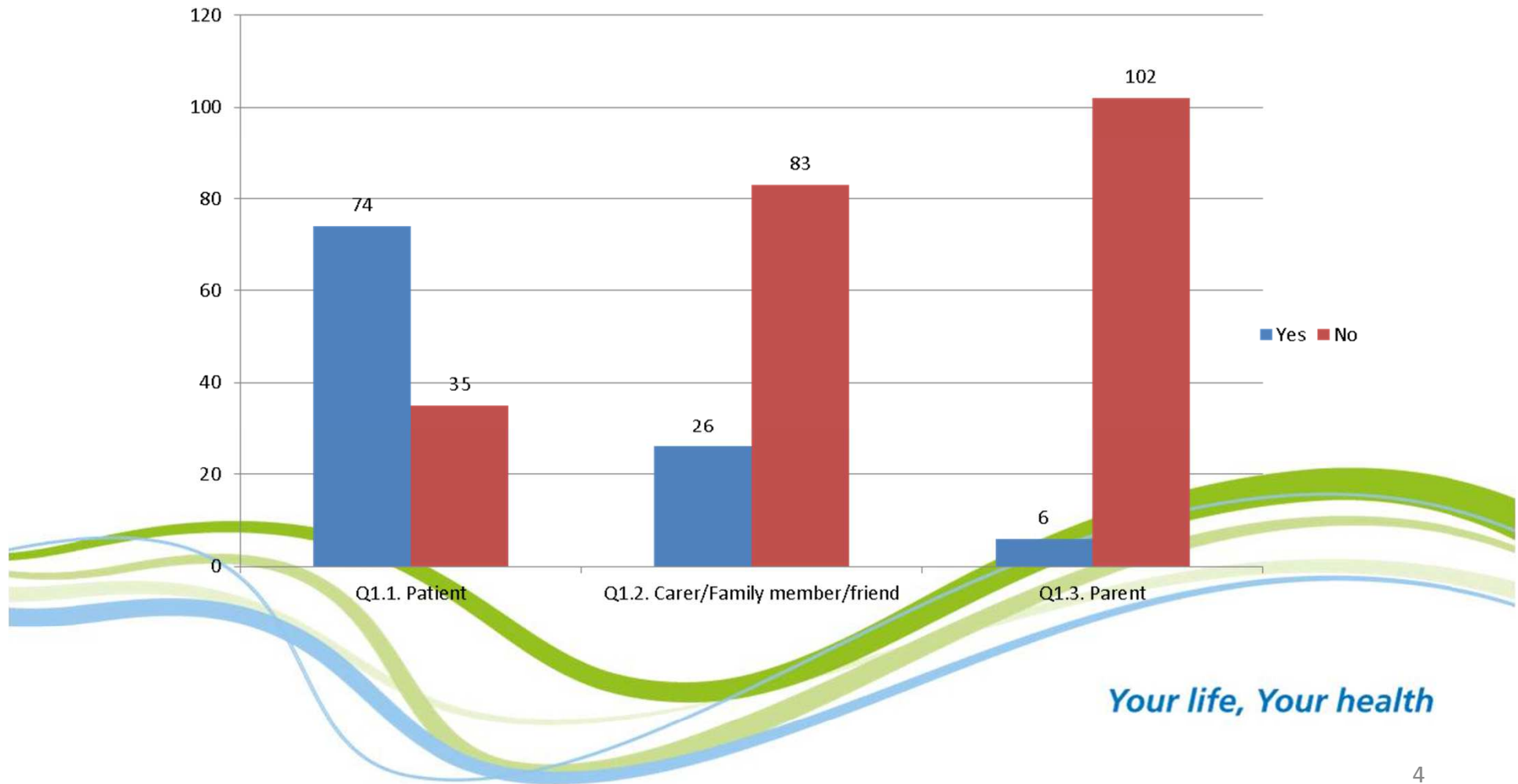
What will work best for the centre and our population?

- 5 options considered
- Recommended option to relocate **Ophthalmology outpatients** enabling:
 - amalgamation of the service
 - to meet CQC requirements separating children from adults
 - ensuring the estate is fit for purpose to meet current and future capacity
 - reducing the footfall substantially on the hospital site (by approximately 48000 visits per year) and increasing the footfall into Rotherham's town centre
 - responding to the public's request to utilise this central, good quality facility

Your life, Your health

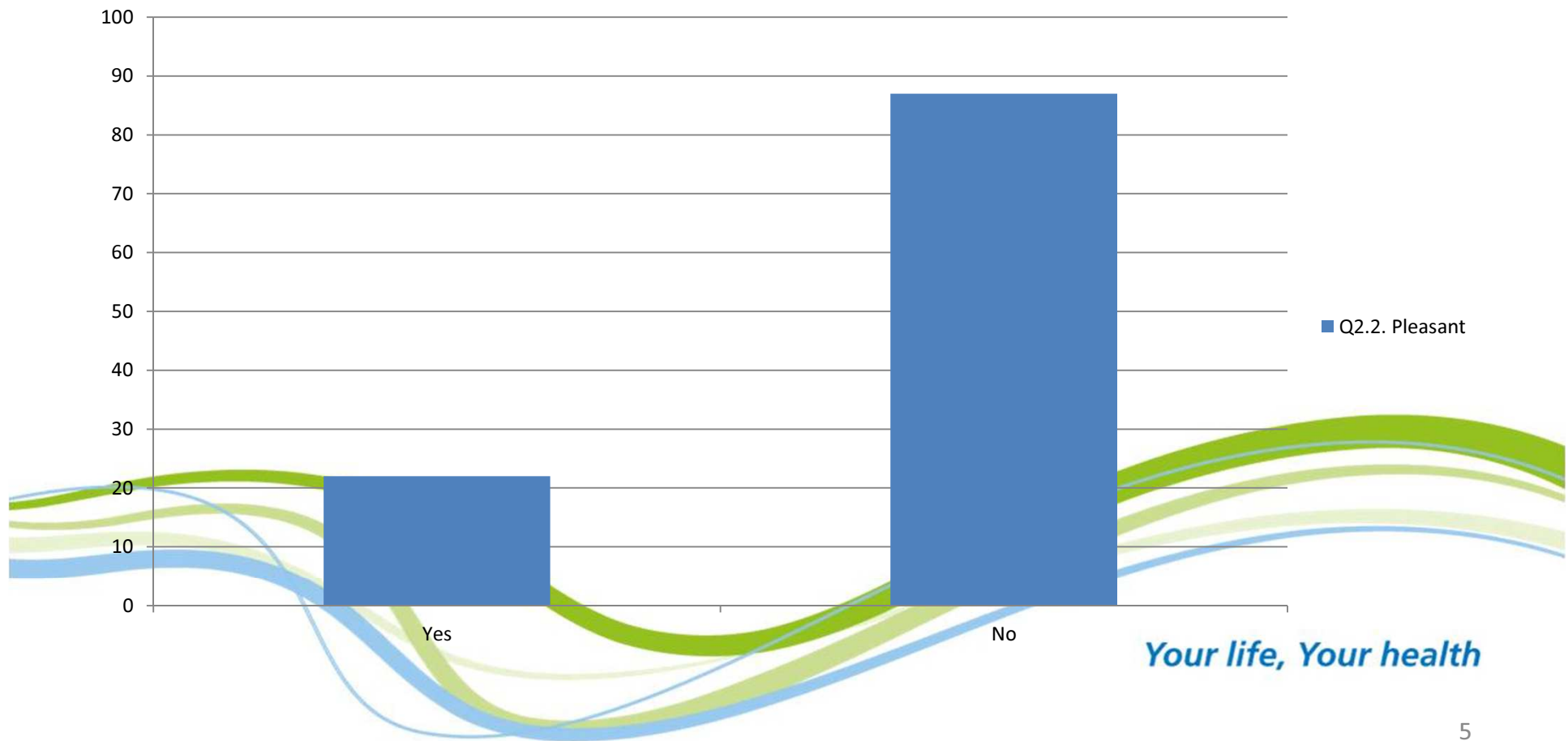
Service user/carer engagement

Q1 - Are you a Patient, Carer



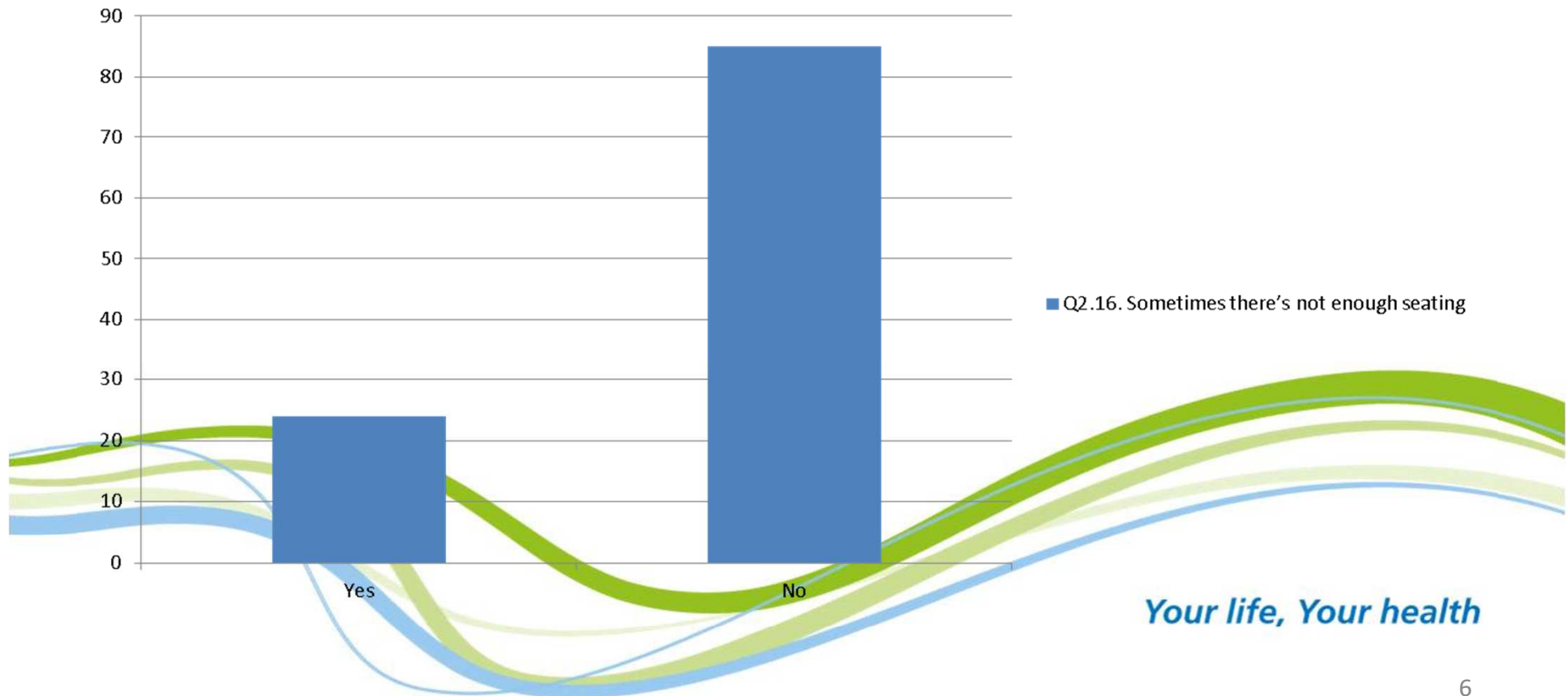
Service user/carer engagement contd.

Q2 What words or phrases would you use to describe the Ophthalmology
Out-patient environment today?



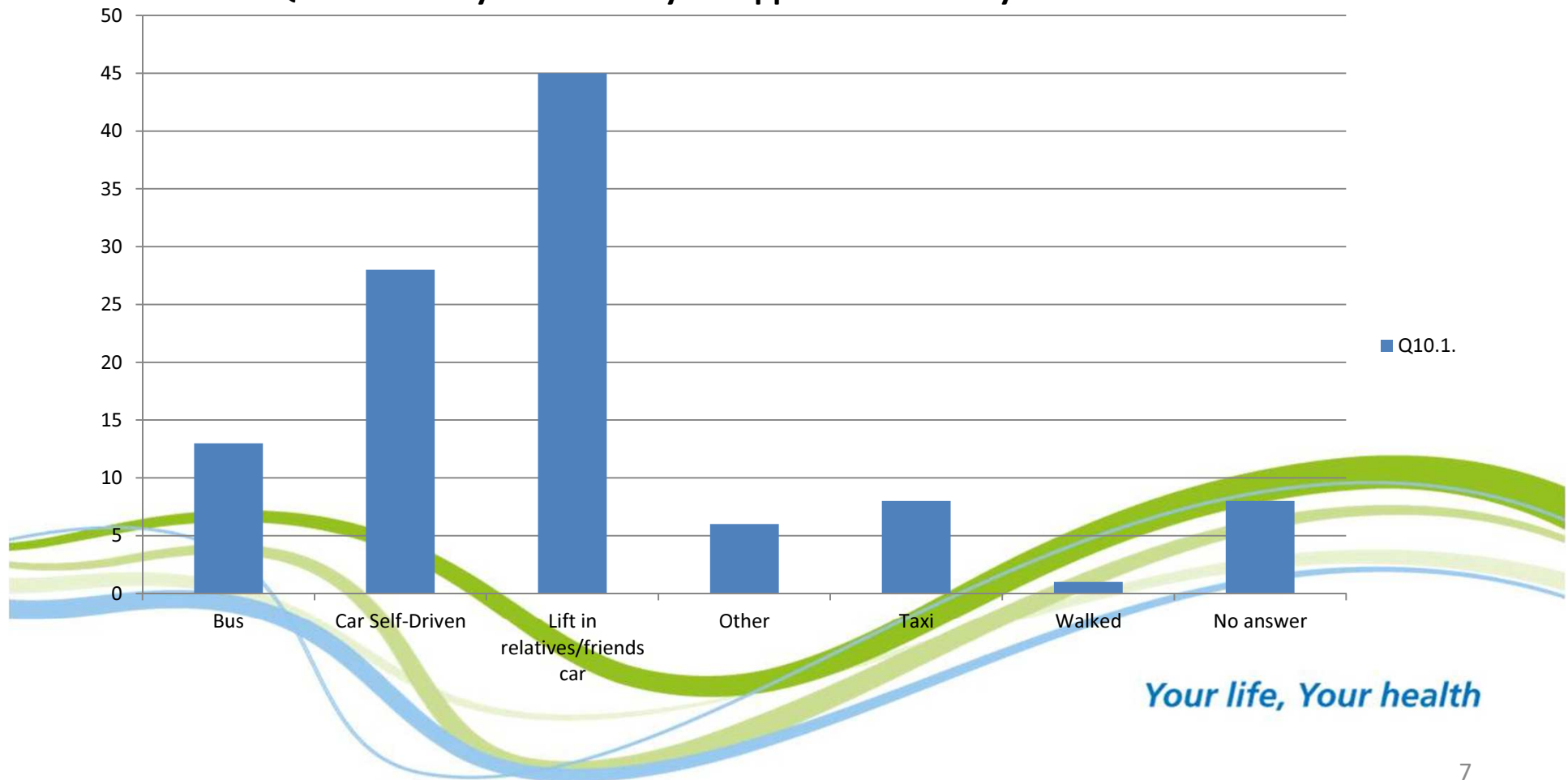
Service user/carer engagement contd.

Q2 What words or phrases would you use to describe the Ophthalmology
Out-patient environment today?



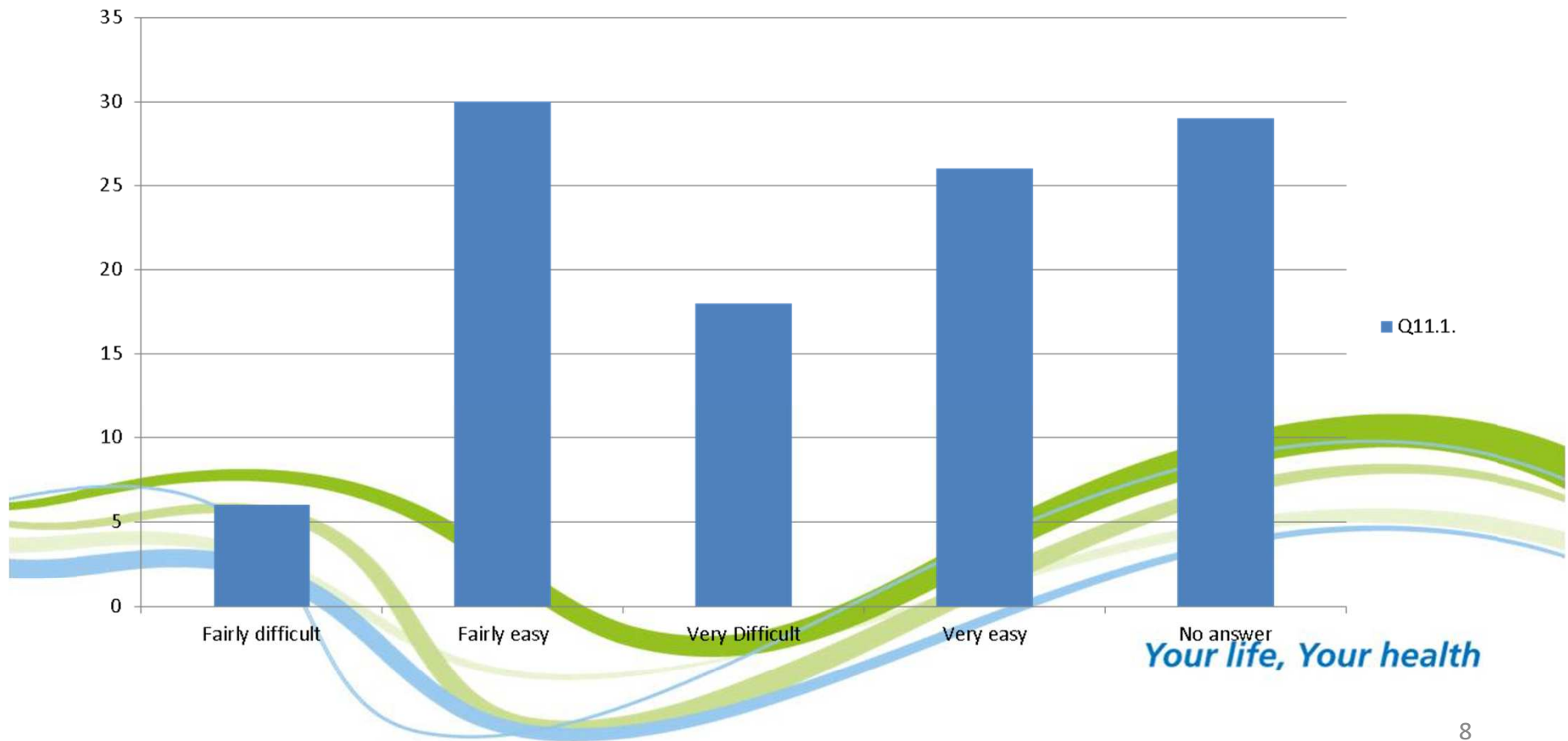
Service user/carer engagement contd.

Q10. How did you travel to your appointment today?



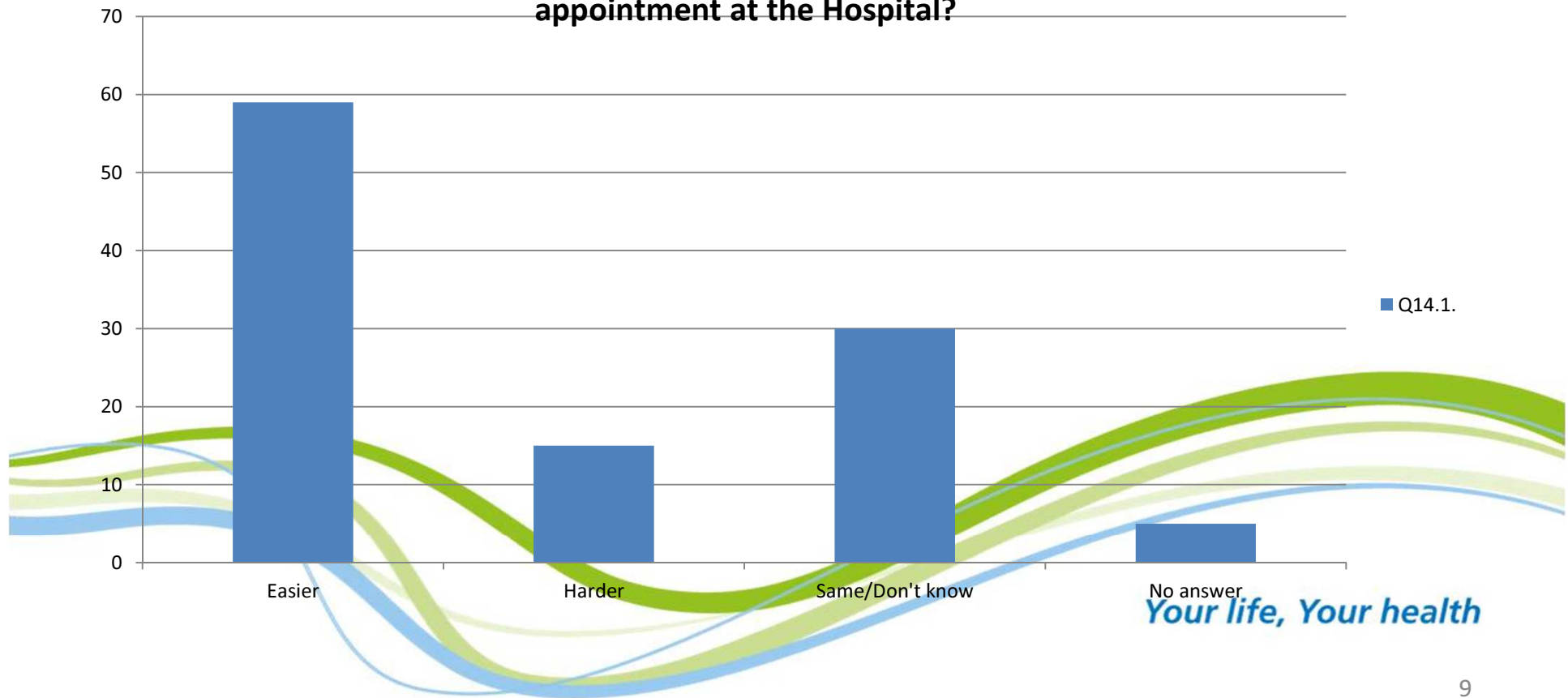
Service user/carer engagement contd.

Q11. If 'driven' or 'lift' how easy was it to park or get dropped off at the hospital?



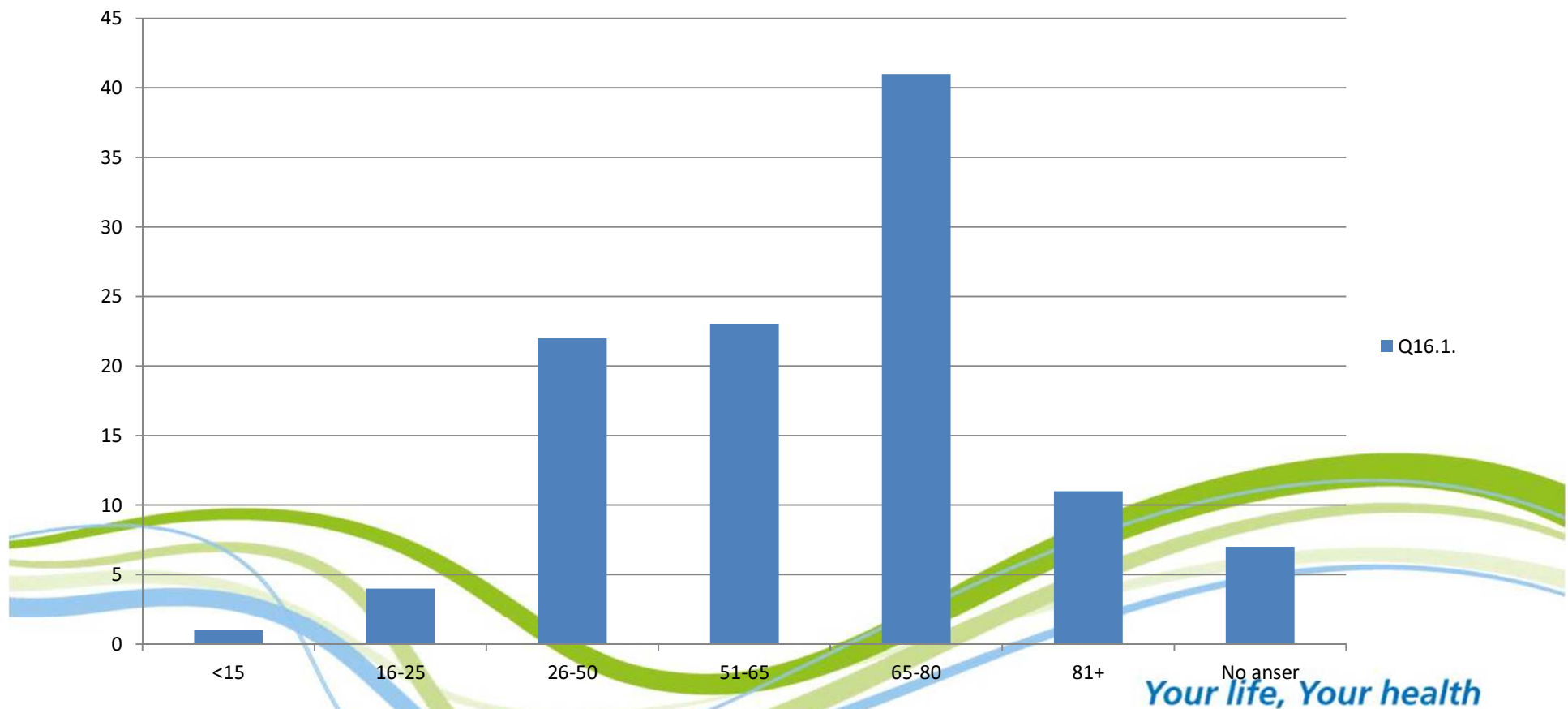
Service user/carer engagement contd.

Q14. Would an Ophthalmology Out-patient appointment at Rotherham Community Health Centre be easier or harder for you to get to than an appointment at the Hospital?



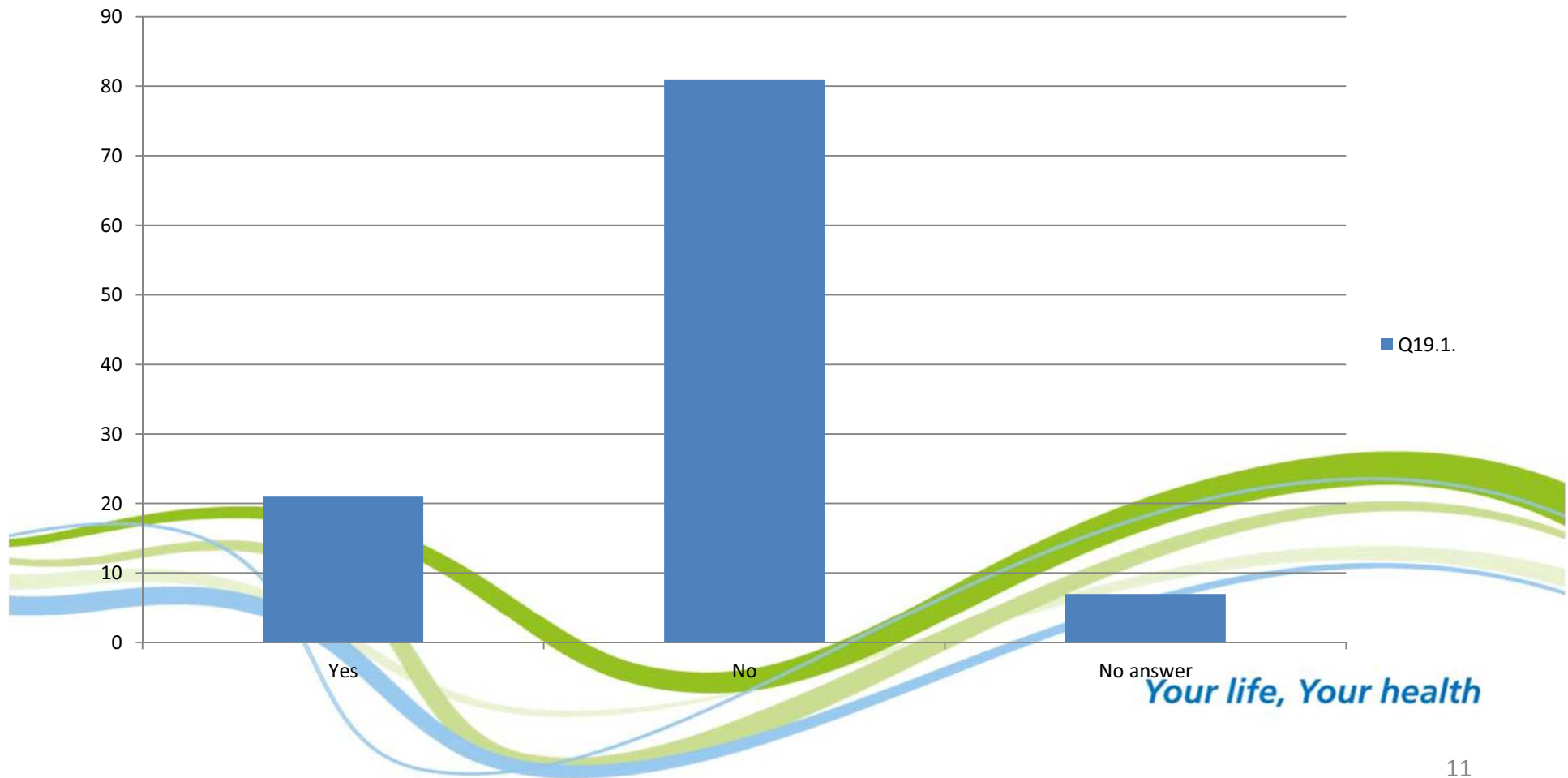
Service user/carer engagement contd.

Q16. Demographics - Age



Service user/carer engagement contd.

Q19. Disability



Headlines from the engagement

- **107** surveys completed; this was well over 200 contacts as many people were accompanied by one or more family members
 - This was over 2 days 13-14 august
 - Conversations took place in ophthalmology outpatients and B6; covering a variety of clinics
 - People from a wide variety of ages and background took part; we had no refusals, and spoke to the majority of people attending
 - The clinics were not as busy as usual, due to the time of year, in particular a number of the paediatric appointments DNA'd
- **Positive/negative re proposal**
 - **Generally, most people were very supportive of the proposal; a substantial number were extremely enthusiastic**
 - 61 felt it would be easier, 22 felt it would be harder; 24 were neutral; either they felt it would be the same or were unsure.

Your life, Your health

Headlines from the engagement continued

- Those that felt it would be harder cited the following reasons
 - Longer journey
 - Parking was an issue for a large number of people
 - Not liking the town centre/road crossing/walk across town
 - One person felt there were issues with the building structure
 - They were familiar with the current service and location, and did not feel it needed to change – this in particular from those attending regularly, for years (ie monthly)
- Those that were neutral
 - A majority of these felt there would be no difference
 - Some people were not familiar with the location of the CHC, so felt they did not know

Your life, Your health

Headlines from the engagement continued

- **Main points**

- The majority of concerns were around parking
- A small number of people noted they live close to the hospital or on a bus route/road where they would pass the hospital, so it would be further for them
- Several people wanted assurance that the staff would be the same
- Even though the walk from car to unit would be shorter, some people will still need a wheelchair to be available
- From the patients attending B6 often on a monthly basis, there was more concern and apprehension about a change of location; often with no concrete reason (i.e. *'I like it here'*); this is felt to be due to the fact that these are likely to be the most dependent patients, who have become very familiar with the current location and process

Your life, Your health

Headlines from the engagement continued

- We felt that there were generally fairly low expectations around the environment- *'its OK as it is' 'it's a hospital isn't it'*.
- Other concerns raised were around traffic in the town centre, waiting for appointments and in clinic, not being called in
- Several people asked how much it would cost; so assurance that we are spending the Rotherham pound well
- It was also noted that patients are brought to ophthalmology from other areas of the hospital – those mentioned were neuro and the UECC. It was queried how this would work if the department was to move, how often this is needed, and what the impact could be on appointments if staff are called to TRFT site, or the implications for moving patients round the site.

Your life, Your health

Supporting the change

- Parking – there is some on-site parking at RCHC and a drop off zone will be created, there are a number of car parks in a short walking distance
- Urgent patients from other areas – a small ‘urgent’ service will continue at TRFT connected to the staff who will be providing surgery
- Rotherham pound – the department is in need of an upgrade particularly to split paediatrics from adult services and insufficient space currently therefore investment is required whether this is at the hospital or RCHC
- Long term attenders – consideration of the impact of the change for this group – support and assurance *Your life, Your health*

Next steps

- Incorporate the findings from the engagement into the business proposal
- Business proposal to Governing body and Hospital Trust Board in October
- If approved, building work to commence in the autumn and service to move by next April



Your life, Your health

Rotherham Integrated Care Partnership

Health Select
Commission
September 2019

Children & Young People
– Maternity & Better
Births



Children & Young People's Transformation Group

Maternity & Better Births

What's working well ?

- * *Partnership working across the place e.g. Personalised Care Plan*
- * *Local Maternity System (LMS) and Hosted Network (HN) Collaborative approach*
- * *TRFT representation and attendance at the SY&B ICS Local Maternity System*
- * *Local Maternity System Board and place working*
- * *Rotherham Maternity Transformation Plan including new tracker development and Funding Plan*
- * *Robust governance arrangements and reporting structures set up:*
 - *Better Births Group – Key external stakeholders including Maternity Voices Partnership (MVP)*
 - *Sub Groups in place for progression of the 7 Key Lines of Enquiry (KLOE)*
 - *Action and Monitoring Logs created and maintained*

Children & Young People's Transformation Group Maternity & Better Births

What's working well ?

- * *Reporting into the Maternity Governance Group*
- * *Maternity Voices Partnership enhancing women and families engagement*
- * *Leadership, dedicated, energised and enthusiastic Team to drive forward transformation*
- * *Place Partnership working to improve the health and wellbeing of mum and baby such as smoking cessation, and sub groups with appropriate representation*
- * *LMS Achievement of Continuity of Carer LMS trajectory 20% and Use of a Personalised Care Plan 40%*
- * *Commitment and support from CCG Communication Lead regarding a communication Strategy*
- * *Involvement in the development of the Rotherham Health App – early stages*

Children & Young People's Transformation Group

Maternity & Better Births

What are we worried about?

- * *Achievement of all future key trajectories and sustainable support*
- * *The Rotherham NHS Foundation Trust Estates provision that is required to progress the Place Plan – such as a Alongside Midwifery Led Unit, Hubs, Delivery Suite alterations including Bereavement Suite and Greenoaks relocation*
- * *Achievement of 35% Continuity of Carer by 31 March 2020 and embedding a new service model*

Children & Young People's Transformation Group Maternity & Better Births

What are we worried about?

- * *Sustained funding and commitment in relation to workforce staffing for achievement of continuity of carer*
- * *On call processes and business continuity at times of increased capacity*
- * *Improvement in relation to Maternity Data set information and Performance Dashboard information regarding Smoking Cessation Service*
- * *Marketing of Rotherham Maternity Services*

Children & Young People's Transformation Group

Maternity & Better Births

What needs to happen, by when?

- * *Continued strong and focused leadership and committed Team*
- * *Refresh Maternity Transformation Plan by 30 August 2019 and including the plans regarding the prevention and digital agenda*
- * *Continue with TRFT robust governance, monitoring and reporting arrangements*
- * *Plans in place for estates requirements and Hub set up support*
- * *Continuity of Carer Sub Group actively progressing plans to achieve the trajectory – increase in staffing for the new model*

Children & Young People's Transformation Group

Maternity & Better Births

What needs to happen, by when?

- * *Maternity Escalation Plan in place and Maternity On call Rota for acute services - commenced on 19 August 2019*
- * *Set up of the new Maternity Hosted Network and Local Maternity System (LMS) Collaborative Group – 10 September 2019 and appointment of Maternity Clinical Lead*
- * *New Smoking Cessation Service Performance Dashboard from August 2019*
- * *New Maternity Digital Group established - commenced 14 August 2019*
- * *Raise the profile of Rotherham Maternity Services – Communication Strategy and marketing - Maternity and Family Showcase commencing 4 September 2019*

HEALTH SELECT COMMISSION
Thursday, 13th June, 2019

Present:- Councillor Keenan (in the Chair); Councillors Bird, Brookes, R. Elliott, Ellis, Jarvis, Walsh, Williams and Wilson.

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

Apologies for absence were received from The Mayor (Councillor Jenny Andrews), Councillors Cooksey, Short and Vjestica.

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

1. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

3. MINUTES OF THE PREVIOUS MEETING HELD ON 11TH APRIL, 2019

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 11th April, 2019.

Further to Minute No. 83 (Intermediate Care and Re-ablement Project) it was hoped that the basic principles of the business case would be available by September, 2019 as this had to take into account new requirements regarding Primary Care Networks.

With regards to Minute No. 84 (My Front Door) a seminar was in the process of being arranged in July when the evaluation was complete. It was also noted that only five people remained at Oaks Day Centre and this this would have reduced to nil by the end of the month.

Further to Minute No. 85 (Implementation of Health and Wellbeing Strategy) it was noted that the Autism Strategy was likely to be on the November meeting agenda and A date for the Carers' Strategy was yet to be confirmed.

Reference was made to Minute No. 87 (Work Programme) where it was suggested that the Commission revisit the transition from CAMHS and check on its progress.

The Scrutiny Officer would also liaise with officers and partners on the full draft work programme for agreement in July. Any further suggestions

were welcome.

In regards to the JSNA – Public Health working with I.T., this had moved from October to be listed in either November or December.

It was also noted that Ward Plans helping with prevent work and JSNA profile modernisation should be available in the near future.

With regards to Minute No. 88 (Healthwatch Update) no feedback had yet been received on maternity complaints.

In addition, the database regarding access to GPs issues had been checked and showed comments regarding access to GP appointments that same day with a named GP of choice. If patients wanted an appointment with a specific GP that usually had to be booked in advance. Most G.P. surgeries offered a same day appointment with an ANP (Advanced Nurse Practitioner) who could prescribe, or offer a telephone appointment with a G.P.

Further to Minute No. 91 (date and time of the next meeting) the 17th October, 2019 meeting had since moved to the 10th October, 2019.

Resolved:- That the minutes of the previous meeting held on 11th April, 2019, be approved as a correct record.

4. COMMUNICATIONS

- (a) The Chair advised the Commission that an issue had been raised in connection with Yorkshire Ambulance Service. This would be followed up and brought back to a future meeting.
- (b) Councillor Jarvis provided an update following the last meeting of the Improving Lives Select Commission where it was noted the meeting had considered key challenges for education in Rotherham via John Edwards, Regional Schools Commissioner (East Midlands and the Humber Region). Officers took on board his comments for consideration.

The agenda also included Rotherham Education Strategic Partnership Update where an overview and update of progress was provided in respect of the key areas for action identified within the RESP strategic plan. Four meetings had so far taken place and feedback on what was working well, what was not and any issues needing development. Further detail was provided on the seven issues including SEND, Gypsy, Roma and Traveller students, Early Years, Primary, Secondary, Post-16 and Social Emotional and Mental Health (SEMH).

A report on the Children and Young People's Services 2018/2019 Year End Performance provided a summary of performance under

key themes and headlines.

- (c) The Scrutiny Officer provided an update on the membership for the three quality account sub-groups TRFT, RDaSH and Yorks Ambulance, plus the performance sub-group.

It was, therefore, proposed to keep the same membership as last year unless any Member wished to change if they had particular commitments or if any new Members had a particular preference. Discussion had already taken place with some Members, but as a reminder the membership would be re-circulated.

5. SEXUAL HEALTH STRATEGY FOR ROTHERHAM (REFRESH 2019-2021)

Consideration was given to the report introduced by Councillor Roche, Cabinet Member, which detailed how the Strategy, previously approved by the Health and Wellbeing Board, had since been refreshed and an action plan agreed ready for consultation.

Gill Harrison, Public Health Specialist, was welcomed to the meeting who presented the 2019-2021 refresh of the Sexual Health Strategy for Rotherham.

The Strategy set out the priorities for the next three years for improving sexual health outcomes for the local population. It provided a framework for planning and delivering commissioned services and interventions (within existing resources) aimed at improving sexual health outcomes across the life course.

It aimed to address the sexual health needs reflected by the Public Health England sexual and Reproductive Health Epidemiology report 2017 which highlighted areas of concern. The following were identified as concerns to identify actions for 2019-2021:-

- Sexually Transmitted Infection diagnosis in young people.
- Sexual health within vulnerable groups.
- Under 18 conception rate.
- Pelvic Inflammatory Disease admission rate.
- Abortions under 10 weeks.

The refreshed Strategy also reflected concerns expressed in the Rotherham Voice of the Child Lifestyle Survey 2018 which showed increased numbers who said that they did not use any contraception and a significant increase in those reporting that they had had sex after drinking alcohol and/or taking drugs.

Sexual Health had since moved on and it was timely to look at new changes and new priorities.

A PowerPoint presentation highlighted:-

- Definition – sexual health.
- Strategic Ambitions.
- Improving sexual health.
- Rates of gonorrhoea (2013-2017) – success stories – public awareness and good contact tracing and working with partners.
- Priorities STI.
- Improving Reproductive Health – downward trend reduced the rate of under 18 conceptions by 60% between 2008 and 2017 higher, but started off a lot higher. A range of factors contributed – access to clinics, contraception, good reputation good relationship and sex education – range of other interventions self- esteem and aspirations.
- Priorities – under 18 conception rate, access to contraception and timely access to abortion services.
- Focusing on vulnerable groups – showing young people affected.
- Priorities – diagnosis of new STIs, prevention, treatment and care.
- Building on successful service planning and commissioning.
- Priorities – provision of integrated services and building on success.
- Key indicators for success.
- Implementation and monitoring – action plan.

Discussion ensued with the following issues explored:-

- What had been successful in the 2015-19 Strategy, what had not been delivered on and why was the focus on repeat abortions?

It was not just repeat abortions but it was important to focus on problems with ongoing care and with relationships. The Pause Programme dealt with repeated pregnancies, identified problems and how issues could be dealt with.

The refresh of the Strategy looked further as it had not previously had a fully integrated service delivery model which was viewed as a priority and was now in place.

- The statistics appeared to be incorrect, especially in relation to Chlamydia.

The populations were different as the figures for Chlamydia focused on 15-24 year olds so they were correct.

- How did the national graph or local graph compare with other areas and were specific areas of concern targeted.

Public Health England had a fingertip tool that showed the national figures and individual areas and allowed an individual to manipulate and compare across the country. The Services were keeping an eye on trends around the country and would target specific areas if there

appeared to be an issue. If there was a specific issue or an increase of STI's in Rotherham then Public Health England would be in touch.

- It would appear that one of the diseases was identified as borderline untreatable.

Certain strains were resistant which required a combination of antibiotics to treat. So far the Service had not found one that was not treatable. However, a watching brief would continue and any particular issues were plotted for the area. There were, however, a couple of highly resistant strains in the country that had hit the national news, but this was being closely monitored.

- There had been a marked improvement in Gonorrhoea so what intervention had been effective.

There had been no specific interventions put in place, but awareness raising in populations with increased contact tracing has probably had an impact.

- What was the cost of this awareness raising and could the Service pick the next worse one and do the same thing.

Awareness raising had all been within existing resources so there had been no extra funding. Some partner organisations would have had extra workloads that had the cost of staff time. Commissioned services worked within a financial envelope and some infections would require more work than others and national campaigns would be used.

- There had been a reported rise in men who have sex with men contracting STI's, but were there any indications this was happening in Rotherham.

The proportion of reported new STIs from men having sex with men was a relatively small number, but there had been seen a significant increase within that small population. Specific work had been undertaken and they had identified as one of the vulnerable groups to work with.

- Was there a profile of groups most likely to present with PID?

There were no profile as such. One of the things planned as a group was to unpick this by looking at the data with partner organisations such as the Foundation Trust to find more about it, see if there was a profile and identify what partners should be doing.

- Often a different story was heard around this including changes in sexual practices of young people and young women's confidence and esteem. Information earlier said this was more than about infection

control which was what we seemed to measure success by. Was there any evidence to document this?

From work that was taking place with various people there were models of good practice in relation to young people and attitudes to sexual health. The latest voice and influence survey raised a few concerns around risk taking behaviour in relation to alcohol, drug use and anti-barrier contraception, which appeared to be at odds with other surveys when risk taking tended to be lower than it used to be. This needed to be unpicked. Traditional interventions needed to change and move on. Whilst some concerns were shared, from experience there was some good practice taking place.

- There were lots of different experiences targeting vulnerable groups and issues. Around healthy relationships and education in schools, what percentage of schools were taking this up and what was happening in primary and secondary schools including how many schools were not doing it? It was disappointing in that there was more information on infection control and a focus on this in the measures rather than on consent, sexual abuse, reduction of CSE, reduction of rape and sexual assault healthy relationships.

All information had come from the Sexual Health Strategy Group. An annual update from the Schools' Effectiveness Services highlighted what information was provided to primary and secondary schools in relation to sex and relationship education. Overall a good number of schools were providing good sex and relationship education. There were some pockets where this was not happening, but this would happen more widely when it became a statutory duty to do so. The Strategy Group would look at this as to how partners could assist schools to maintain that level of education.

- The numbers of participating schools and information from schools needed to be shared on how this would be delivered and whether this had an impact on young people if the data was sophisticated enough to show that.

This would be taken back to the Strategy Group to discuss, but it was noted that the data was provided by schools and questions about education should be addressed to Children and Young People's Services. Data about Child Sexual Exploitation fell under the remit of the Safer Rotherham Partnership.

- Was the Strategy made up a variety of partners and multi-agency?

The Strategy was signed up to by range of partners originally from the Health and Wellbeing Board as a Sub-Group and was multi-agency.

- With regards to the media coverage of a faith school talking about gay relationships, did this have a knock-on effect with regard to about

healthy sexual relationships?

Rotherham had laid out its policy on sexual health and PSE and all schools should adopt it.

- Teenagers socialised more in a virtual world so to what extent did this have an influence?

There was no research available.

- Data access to contraception was concerning as it had been good up to 2017, but then contracts were terminated for LARC (long-acting reversible contraception) to be supplied through GP services. The Strategy did not seem to recognise or mitigate for that. There appeared to be a bottleneck for LARC for non-contraceptive services which had been effective and very safe for debilitating conditions such as fibroids or endometriosis. Recent information from the Pause Project indicated that people were having trouble accessing appointments for LARC so what could be done to resolve this to give patients better access?

Contracts with GP's were terminated, but not completely as the Integrated Sexual Health Service sub-contracted these after the first year. There had been issues with regard to clinical governance and maintaining GP competency, but it was important to have a main provider and training. Performance meetings had taken place with services and information provided on the GPs who provided the range of different LARC services to all ages.

In terms of endometritis the LARC IUCD (COIL) tended not to be used for young women other than for regulating menstrual difficulties or gynaecology issues rather than contraception. Long waiting lists had not been reported so this information would be taken back to the partnerships within the Strategy Group.

- Gynaecological issues were intertwined as these conditions affected fertility.

There had to be a cut-off point for the Sexual Health Strategy. The Group had had discussions on a whole range of issues, but was it universal and, if so, why had the Service chosen to go down that path?

- Young people had a particular vulnerability, especially those who were Looked After. Had there been any targeting of resources or reversal as to why the Service had chosen to go down that path.

Younger people were likely to be more disadvantaged by STI's and Looked After Children were a vulnerable group. One of the things the Group was looking at was how to target and get information out to

young people and tease this out. An action plan was being re-introduced with targets to see how this could be done better.

- Could data be drilled down further as part of an EIA?

This was recognised and more details would be provided on the EIA as part of the Strategy.

- Did we know what the origins of the gender imbalance were as it appeared to affect more females than males at an early age?

It was not apparent, but this would be looked into further about what was happening in other areas and to be able to see the difference.

- Some of the priorities in the action plan were contracted to other people; how was this monitored, were there any issues and if there were was there consideration to bring this back in-house to give some reassurance how the contract was managed?

There were some direct contracts in relation to the Integrated Sexual Health Service at the hospital. There were regular performance monitoring meetings to discuss and monitor the Service specification. Actions in the action plan were assigned to specific partners.

- Delivering awareness - quality was important with young and vulnerable people so how did the Service ensure the quality was good?

Yorkshire Mesmac were contracted to provide this service and were successful following a tender process. Evaluation had taken place to drill down using nationally accredited information and techniques with quality assurance built in.

- What measures were being taken to make access to Sexual Health Services more accessible in circumstances where vulnerable teenagers lived with prudish parents who were against pre-marital sex?

Information was easily accessible. The Voice and Influence survey asked where did teenagers go for sexual health information and the vast majority identified peers, but this information needed to be culturally acceptable with the young people themselves to ensure the right messages and information were passed on. A presentation had been made on ten week abortions at one of the Strategy Group meetings by two providers and consideration given as to how this information was easily accessible to people and who young people could talk to.

- Some of the indicators were a bit woolly and it would be better to have smarter targets and indicators so that hard information could be

interpreted in measuring the impact for good sexual health. If social issues around consent and safe, healthy relationships were not going to be measures within the Strategy should they be left out?

This would be taken on board.

Resolved:- (1) That the refreshed Sexual Health Strategy and the associated action plan be noted.

(2) That school data questions be sent to Children and Young People's Services for a response to be scheduled into the work programme for future discussion.

(3) That the EIA be submitted to Health Select Commission for this Strategy and for any new or refreshed strategies.

(4) That consideration be given by the Sexual Intervention Group to developing a broader and SMART range of performance indicators to measure success.

6. RESPONSE TO THE SCRUTINY WORKSHOP - ADULT RESIDENTIAL AND NURSING CARE HOMES

Further to Minute No. 135 of the Cabinet Meeting held on 15th April, 2019, Nathan Atkinson, Assistant Director, Adult Care, Housing and Public Health, supported by Councillor Roche, Cabinet Member, gave an update on the recommendations and corresponding actions arising from the Scrutiny Review of Residential and Nursing Care Homes for Adults aged over 65.

The purpose of the review was to consider progress in bringing about improvements to safety, quality and effectiveness in the sector as well an opportunity to explore the impact of the Care Homes Support Service as the care home sector was one of the transformation initiatives under the Rotherham Integrated Health and Social Care Place Plan.

The Commission was advised that the Service had not closed any care homes, but three private care homes had closed so in two of these cases people placed by the Council had been withdrawn. One home was re-opening shortly under a new provider but people would not be placed there unless it complied with the Council's standards.

The Council's powers with private care homes were very limited. However, they were monitored under contract compliance and residents removed if there were issues about their care especially with regard to safeguarding. There were also close links with CQC and G.P.'s as every care home had a G.P. linked to them. Wherever possible, good relationships with private care homes were maintained.

In comparison to the rest of Yorkshire, Rotherham did not have a single

failing care home, which was an improvement. Work was still taking place to improve the direction of travel towards outstanding and it was pleasing to report that the Cabinet agreed to the recommendations which endorsed current and planned work in this area. Scrutiny were thanked for their work on this review.

All the recommendations were now in place and in recent weeks emails had been circulated to relevant Ward Members to update them on Care Quality Commission (CQC) ratings for homes in their Wards. Detailed briefings were also provided if there were any concerns or if the CQC had been in.

Discussion ensued with the following issues being raised and clarified:-

- Training for staff - how was this being monitored, were there any issues and how was it implemented?

Of the two care homes that were run by the Council, training was provided and monitored. However, in terms of private homes, it was made clear what the requirements were and what steps would be taken if they were not compliant. However, in terms of training, the Council could only suggest, cajole and recommend.

The Council had maintained the training offer for the independent sector. It also had its own services and needed to make sure these were of requisite standard with staff access to training and refreshers. Much was also open to the independent sector but the onus was on organisations to take up that offer. Part of the contract monitoring was to look at where staff were in regard to annual refresher training and any areas for additional training were welcomed or if there were issues identified.

Contract compliance required registered providers to carry out an annual self-assessment that related to the Council's contract, including policies and procedures, staffing and training. Validation work examined the annual training matrix and this was cross referenced against staff records. The Council found that when training had been booked staff had not attended and this was addressed to ensure the non-attenders were charged.

There was regular communication between Contract Compliance Officers and the training team who were available to be contacted for advice, guidance and support. Any issues were addressed to the home manager and a six week period improvement plan put in place to address issues.

The Service annually produced a training programme in consultation with care providers and commissioned on need. There was always an element of flexibility in the programme as not all staff could attend on the dates organised and the trainers did reschedule to get value

for money if numbers were low. Attendance at training was booked through Directions internally and all information was made available to providers direct. Training provided externally to the Council had to be ratified and identified through Skills for Care.

Work with the Care Homes Support Service had gone well and the Clinical Quality Advisor undertook a range of audits and the Service then targeted any additional training around the themes where issues have been found. It was confirmed that contractually providers were obliged to pay staff to attend training. Training and Development colleagues would be able to answer questions with regard to the use of Directions.

- Had there been any progress to increase the number of nursing beds within the local provision?

The closure of some nursing homes had seen the reduction in nursing beds, but Greasbrough nursing home would be re-opening shortly with some provision. This was a challenge nationally for the sector in securing nursing staff when competing for agency nurses and driving costs up. There were also challenges around standards as nursing homes tended to have lower CQC ratings than residential. It was the aim with all new providers to steer towards nursing care as there was still substantial over capacity on the residential side.

Pay remained an issue in care homes and some providers had gone bankrupt due to rising costs.

- Training pathways for young people in partnership with local college had been discussed previously.

The Council was involved in work taking place with the Health Education England Skills for Care to develop these. The trainee Nurse Associate course was attracting more people to make a career in nursing. Other work would take place with regard to the new Home Care Service to make careers in the Service a more attractive proposition for younger people.

- Under-provision of nursing care had been mentioned. Were there waiting lists given that there was an excess of residential care?

There were no waiting lists per se but capacity in the system was limited and, for example, as part of the Winter Plan, block buying of nursing beds was often done by Health colleagues. There had never been a situation that did not have a solution within the Borough but there was more provision of residential than nursing beds but much depended upon location. Choice was part of the assessment.

The first choice was always to return a person home, but there could be delays if adaptations were required. There was a redefined

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pathway for intermediate care and enablement under the principles of Home First to get people back home independently and for them to continue to live in their community.

- What were the current vacancy rates?

There were 1,686 beds across the Borough with a 31.6% vacancy factor, which equated to 84 residential, 92 residential EMI beds, 36 nursing beds and 18 EMI beds.

- With vulnerable children and adults there was the environment for potential abuse and neglect especially when people were not properly trained or paid enough. Was the Council sufficiently confident to spot neglect and abuse at an early stage for families in residential care to ensure issues were picked up quickly.

In terms of older people, there were thirty-four homes in the Borough, of which two were Council-owned. There was regular monitoring from the Local Authority, which was very frequent, along with health professionals who were also going into the care homes, so the eyes and ears were good. Rotherham did not have any inadequate homes as the sector had been proactive in dealing with issues. The number one priority was to work with providers to address some of the concerns and raise standards and there were excellent working relationships with the CQC with joint working and sharing of intelligence to ensure joint visits were effective.

There were often concerns about the potential for abuse in people's own homes and some of the smaller establishments for people under 65 were monitored closely. There were 111 smaller establishments in the Borough and all were monitored.

The CQC did a recent league table relating to quality ratings and Rotherham was third out of fifteen in the Yorkshire and Humber. Everyone was doing their best and, whilst there would still be challenges, the aim was to be a proactive Borough and remain passionate about quality.

- Was anyone talking to residents?

Performance colleagues were resourced to carry out this work and ensure the Service user was heard. There was also free independent advocacy for people which they were encouraged to use and the Service worked closely with Healthwatch Rotherham but did want to get more Service user voice.

- Were there any plans to have a "trip adviser" type review for care homes?

An older people care home guide identified homes available in

Rotherham and another explained what a family or resident should be looking for in a care home in order to make the best choice.

- Recognising that work was being developed on Service user voice, could the Select Commission contact Healthwatch Rotherham to ascertain how they captured the Service user voice?
- How was the work of the Quality Board progressing, including the Quality Matters initiative and the Leadership Academy?

Work on the Quality Board was in progress. Plans were in place to expand membership to wider health partners. Quality matters and principles of good contract monitoring were in the Service Plan working on a quality strategy. It was recognised there were real challenges, but progress was on an upward trend and the workforce, availability of quality and adoption of the key principles remained a priority.

- The issue of choice and whether to go back into the home required lots of professionals to work together and evidence showed that was being successful.

Resolved:- (1) That the response to the recommendations of the Scrutiny Review of Residential and Nursing Care Homes for Adults aged over 65 be noted.

(2) That consideration be given to inviting Healthwatch Rotherham to submit a response to the meeting should they be unable to attend.

7. 2018 ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Councillor Roche, Cabinet Member, introduced the 2018 independent annual report. For the previous three years, the annual reports had focused on the life course; the 2018 report took a new approach and sought to champion the strengths of Rotherham's local communities and share experiences of what kept its residents healthy, happy and well.

The general public had been asked to submit photographs which showed what kept them healthy, happy and well where they lived. These were then grouped by theme and found that they fell into two main themes – community and the environment – as well as capturing all five of the 'five ways to wellbeing'.

The 2018 annual report was broken down into chapters on:-

- What does keeping healthy, happy and well in Rotherham mean to you
- Our communities
- Five ways to wellbeing
- What can we do to support health and wellbeing

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- Recommendations
- What we will do together
- Progress on last year's recommendations

The key recommendations in the report were:-

- Consider 'health and wellbeing' in the wider context of being influenced by everything around us
- Seek first to understand what is 'strong' in our communities and what assets we can build on together to support the health and wellbeing of our residents.

Terri Roche, Director of Public Health, gave a presentation via PowerPoint which highlighted:-

- What does it mean to be healthy in Rotherham?
- Health influencing factors.
- Recommendations – consider health and wellbeing in the wider context, what is strong and what assets can build on together.
- What can be done together?

A discussion and a question and answer session ensued and the following issues were raised/clarified:-

- How was Wickersley chosen to host the loneliness project, when it was thought other areas may have benefitted from the research more?

Multi-agency groups in Wickersley, Dinnington and Maltby explored projects to work on together. The group in Wickersley were aware of issues around loneliness for all services and chose to run with it. Comments on the choice of area and disjointedness would be taken back but loneliness did not demonstrate barriers and it was a factor for all age groups.

- The asset/strengths based approach was positive, as was the five steps to wellbeing being simple and evidence based. This process seemed increasingly disconnected and disjointed when much more impact could be achieved if there was joined up work with adults, community learning and some of the work with older people, neighbourhood working etc. Of concern was the growing level of inequalities in health with the need for discussion on this and how the resources could be targeted at communities who needed them most.

In looking at universal proportionalism and how inequalities could be addressed resources were getting tighter. However, it was time to make a real difference through our good partnership model, with a good Housing Strategy incorporating homelessness, neighbourhood ways of working and robustness in Equality Impact Assessments were

building blocks bringing the work together. This was about engaging with communities and using that intelligence in a different way.

- There were inequalities of health and it was appreciated that there was a universal approach, but how could this be driven to encourage others to be connected and for this to link some important areas of work in the community and adult learning. The five ways to wellbeing could be used to target some of the energy and resources in the most deprived areas suffering inequalities.
- The issues were bigger than Public Health and it was more about how a real difference could be made to the community to ensure the most deprived areas were supported.

There were strengths and a weakness in neighbourhood working as it was reliant upon relationships and personalities and there were opportunities and risks. It was about working better together; this was working in some areas, but it could always be better. Some of the work in Paul Walsh's team was more globally working well. In time there was more to scrutinise and to challenge ourselves on health equality in all policies. In the political arena there were opportunities for working differently, for good practice to be shared with a systematic way of working more widely.

- How many volunteers were there as some actions were channelled through areas that had Parish Councils. More broadly, it was about keeping volunteers going including how well the VAR volunteer scheme matched up people and opportunities. It was also about contract monitoring to ensure quality. So how could there be scrutiny of the work being undertaken and how it was being delivered to be equal.

It was not possible to comment on how VAR could be scrutinised, but they were part of the solution. Volunteers did not have to be outside their home to be able to offer valuable support. With the free flow of volunteers it was difficult to control, but different ways of working and different models sometimes stifled the flow. Some of the MESMAC activity was positive on how they reached people.

When the contract was up for renewal there might be an opportunity for more input around the volunteering scheme and this would be followed up.

- Consideration needed to be given to the best forum for volunteers and the offer and whether there was a role for Scrutiny.
- Wellness schemes only worked if people engaged. Wellness goes to the root, but did require individual citizens to change their own lives. In more deprived neighbourhoods this might be more difficult and somehow citizens had to be motivated and engaged. To what extent

would Social Prescribing help to achieve this?

Behavioural changes were challenging in addressing some of the inequalities. There was some reliance on individual experiences, but self-prescribing could work for some people. It was more about societal changes within the environment people lived, worked and played to make them more healthy.

- In terms of the Members' Cycling and Walking Group, what initiatives encouraged people to engage in cycling and walking as a means of getting active and was there a link with cycling with travel and transport planning.

There were many initiatives that encouraged walking with the health walks, the cycling hub located regularly outside Riverside House on a Thursday and staff could also try out the electric bike. There was also a link to active travel and Regeneration and Environment were looking to link the Members' Cycling and Walking Group to the Rotherham Active Partnership.

- The report referred to 13.4% people in Rotherham suffering with depression. How did this compare with other areas or nationally and was it increasing or decreasing over time.

Accurate figures would be provided.

Resolved: - (1) That this Commission's concerns about health inequalities be raised with the Health and Wellbeing Board and the Rotherham Partnership.

(2) That the actions below be supported:-

- Continuing to raise awareness of the 'Five ways to wellbeing' and working together to tackle loneliness and social isolation
- Supporting the continued development and expansion of Social Prescribing as laid out in the NHS Long Term Plan
- Continuing to support healthy work, through initiatives such as the 'working win' trial and promoting uptake of the BeWell@Work workplace award.

8. HEALTHWATCH ROTHERHAM

No issues had been raised.

It was suggested, however, that any written comments be provided when representatives were unable to attend.

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

There were no matters to feedback from the Committee as it had not met since March, 2019.

A further meeting would be scheduled shortly. Options were being developed around the hospital services programme.

10. URGENT BUSINESS

There was no urgent business to report.

11. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission take place on Thursday, 11th July, 2019, commencing at 10.00 a.m.

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.

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- 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 representations 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

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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

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- 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

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- 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.