HEALTH SELECT COMMISSION
20th February, 2020

Present:- Councillor R Elliott (in the Chair); Councillors Bird, Brookes, Cooksey, Ellis, Jarvis, Short, John Turner, Walsh and Williams and Co-optee Robert Parkin (Rotherham Speak Up).

Apologies for absence:- Apologies were received from Councillors Albiston, Keenan and Vjestica.

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

61. DECLARATIONS OF INTEREST

There were no declarations of interest in respect of any of the items of business on the agenda.

62. EXCLUSION OF THE PRESS AND PUBLIC

The Chair advised that there were no items of business that would require the exclusion of the press or public from the meeting.

63. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the public or press in respect of matters on the agenda for the meeting.

64. COMMUNICATIONS

Members were advised that there was an opportunity to take part in the development of the respiratory rehabilitation service if they were current respiratory care patients. More details would follow and if anyone was interested in taking part they were asked to contact the Governance Advisor.

Michael Wright, the new interim Deputy Chief Executive at The Rotherham Foundation Trust was welcomed to the meeting as an observer.

65. MINUTES OF THE PREVIOUS MEETING HELD ON 23RD JANUARY, 2020

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 23rd January, 2020.

Resolved:- That the minutes of the previous meeting held on 23rd January 2020 be agreed as a correct record.

66. ROTHERHAM RESPIRATORY PATHWAY

Jacqui Tuffnell, Head of Commissioning at Rotherham Clinical Commissioning Group (CCG) delivered a short presentation to update Members on developments since September following the public consultation.

Context
The NHS 10 year plan stresses the need to develop better integrated care pathways with emphasis upon Primary Care Networks, with *practices working together at scale*, with a *combined workforce* to better care for patients.

Right Care Data – highlights

- Rotherham has high cost respiratory services, high admission levels and poorer outcomes for our patients than our counterparts across the integrated care system – as things had moved on quicker elsewhere.
- Non elective admission levels are high particularly for chronic lower respiratory, especially COPD.
- Asthma, influenza and pneumonia were also highlighted as areas where Rotherham admitted more non-electively than the right care peer group.

Respiratory health outcomes – Under 75 mortality rate 'preventable'
2015-17 data showed Rotherham had a rate of 25.4% and a ranking of 12th highest of the 15 local authorities in Yorkshire and Humber, where the average was 22%. The England average was 18.9%. Deprivation was a factor in Rotherham being an outlier.

Respiratory disease in the North East and Yorkshire
Impact on Urgent and Emergency Care (2017-18)

- Highest rate of emergency admissions for (Chronic Obstructive Pulmonary Disease (COPD)
- Last two winters non-elective admissions (NEL) for adults up to 4.400 admissions in a single week
- Opportunities to reduce respiratory bed days (136,000), primary care prescribing (£25m) and NEL spend (£38m)

Opportunities

- Flu and pneumonia
    - 33,500 more patients could receive the PPV vaccine
    - 25,500 more patients aged 65+ could take up the seasonal flu vaccine
    - 4,200 more patients with COPD could receive an influenza immunisation

- COPD
    - 24,400 more people with COPD could be registered
    - 2,500 more people with COPD could have diagnosis confirmed by spirometry
    - 6,000 more people could have a review by an HCP

Right Care was part of the NHS which looked at peers and changes achieved elsewhere. Although people may choose not to have vaccines, Rotherham could do better on this.

Local Challenges

- Fragmentation across the respiratory pathway
- Fragmentation of the home oxygen service
- Inconsistent diagnosis across Rotherham – it was important to get the diagnosis right at the beginning
- Inconsistent management of respiratory patients across the system
- High admissions to hospital, which could have been prevented
- Low uptake of smoking cessation
- No respiratory Community team – now best practice

56% of the admissions to Breathing Space could have been avoided with support in the patient's own home from a Community Respiratory Team, saving 156 bed days.

Patient Engagement Feedback

- Timely access to primary care - Day time, evenings and weekends for reviews and feel unwell
- Pulmonary rehabilitation closer to home and at evenings and weekends – at more convenient times
- Alternative access to care and information via APPs and websites, phone and video – being confident to use these
- Faster discharge from hospital with specialist support at home
- Consistent information on how to manage their conditions

Rotherham Opportunities

- We could detect and diagnose 2,366 more patients with COPD
- Spirometry – diagnosis and measuring disease progression
- Annual reviews of people with COPD and asthma
- We are doing well on pneumonia and influenza vaccination over 65s compared with elsewhere in the North East and Yorkshire
- RCCG spending just over £1 million more on prescribing than lowest 5 peers – this related to types of inhaler and also to inappropriate use of inhalers that led to waste

Proposed Model

Graphic representation of the new model as presented.

Self care would be promoted at all levels across the system and was an important element of the model. Community Matrons were doing and excellent job, especially this winter when the system faced greater pressures. the Specialist Respiratory Pharmacist was a new role and would help to ensure people had the right inhaler and their expertise would be used to advise GPs.

Tier 1 – Primary Care

- Supports patients requirements for day, evening and weekend reviews
- Supports PCN requirements of working at scale
- Provides consistency and equity of care
- Good feedback from present hub services across primary care
- Hub can be supported by a specialist respiratory clinical pharmacist , who also supports in the community
- Hubs could support new roles such as physiology apprentices and physician associates

This would entail delivery of the right training to be able to provide better support. New roles would supplement the existing workforce and help to address the shortage of GPs and Advanced Nurse Practitioners. Regarding consistency and equity of care, the 30 practices in Rotherham all did things slightly differently at present, so this would lead to the same level of care in all.

Tier 2 - Community Respiratory Service based at Breathing Space

- Outpatient clinics
- Rapid access clinic/hotline – same day appointments
- Housebound patient management
- Assessment and management
- End of life care management
- Pulmonary rehabilitation /physiotherapy
- Enhanced CBT: psychology input & support
- Discharge management for inpatients
- Early supported discharge follow up within 2 days
- Clinic reviews (caseload)
- Management plans for primary care follow up - good, consistent plans for all patients
- Discharge to tier 1 &Community Matron
- Telephone Advice for Tiers 1 & Community Matrons
- Training for primary care (PCN footprint) – upskilling so this was uniform
- High intensity User – Targeted support
- Admission avoidance
- Virtual clinic/MDT – reviews could be by telephone or Skype

Tier 3 – Acute Care hospital based

- Acute admissions
- Inpatient pulmonary rehabilitation
- NIV assessment & management
- Inpatient discharge to tier 3
- Outpatient discharge back to tiers 1 and 3
- Complex co-morbidities
- Deterioration beyond expected rate

Positive feedback had been received regarding the respiratory unit at Rotherham Hospital which focused on all acute admissions.

Following the presentation, Health Select Commission (HSC) watched a short animation about the proposed service changes, which was welcomed as a positive means of presenting information for the public: https://youtu.be/cNKaV32h_uY

Members commented that access to services rather than existing services would be modified and wondered what the impact would be on primary care. It was confirmed that first and foremost people would go to primary care, as with diabetes, with support to GPs from Breathing Spaces rather than directly to a specialist team.

This was followed up by a question around the ability of GPs to do this in a timely way given that access to GPs for an appointment was a mixed picture and whether this issue could have a negative impact on the whole model. The CCG confirmed that a significant amount of work had gone in to increasing the number of appointments, with more available last year than ever and greater capacity in the system than the required number of appointments. As discussed before, the issue was often one where patients wanted an appointment with a specific GP at a certain time and if that GP only worked two days each week that would create a wait. For regular health checks patients were able to get a routine appointment in five days. This was one of the reasons for working on a hub basis sharing resources, so not all 30 practices would be trained on spirometry as some did not see sufficient volumes of patients to undertake the diagnostics. There would also be a hotline between Breathing Spaces and GPs for patients who needed support at home. It was agreed that concerns about a specific practice would be taken back.

Communications were important and there was still a lack of awareness about the hubs. An additional extended access hub had been established on site at the hospital to support them with capacity and people would be triaged and moved to that and seen within an hour. It would also be made clear to patients when they did not need to have gone to the Urgent and Emergency Care Centre (UECC) for care and should have been seen either by their own GP or at a hub. The Chair asked whether take up of Sunday appointments at the hubs had increased and it was now approximately 50%. The extended hours hub at the hospital was there

seven days a week including all day on Saturdays with around 30 patients moved from the UECC and some direct bookings there from a patient's own GP.

In terms of patients going to the hospital by ambulance, for example with a severe asthma attack, the question was asked about rapid access into hospital and whether patients would go directly to ward A3 rather than to the UECC given the potential waiting times reported recently. It was clarified that they would go to the UECC first for assessment and once their condition was settled would then be transferred to the respiratory ward. Reassurance was provided that patients with breathing difficulties would be seen quickly.

Regarding the statistics presented for the North East and Yorkshire, Members inquired about specific indicators for Rotherham and what success would look like and how it would be reported. A clear specification had been developed which was an amendment to the present one as community services had been planned but not implemented. Reduced hospital admissions would be one measure but full detail on the key performance indicators would be shared with HSC.

With regard to the response rate to the survey, it was noted that 773 people accessed the survey but only 443 fully completed responses were received and if this signified difficulties with completion. Some surveys were only partial responses as not all questions were relevant to all patients. The response rate was around 62%. Clearly it would be better to have a 100% response rate and questions had been asked about the ease of completion in some of the sessions but no-one had reported any difficulties. It was clarified that the service was for over 18s so no children and young people had been surveyed. Further detail around survey responses and numbers would follow.

The new model would be implemented in a phased approach working towards the full structure being in place by winter 2020. Recruitment processes had commenced with the hospital, the business case had been signed off and the service specification developed. Funding for staffing resources also been agreed, with the first three staff members for the new structure recruited. Members requested a progress update in the autumn.

Members reiterated their previous concerns about digital inclusion with the focus on apps, websites and twitter and sought assurance that other means of contact and communications would continue to be employed. Telephone calls and letters would still be used and patients would identify their preferred means of contact.

Regarding the inconsistency referred to between GPs it was clarified that some GPs proactively managed patients with respiratory conditions whereas others referred them straight to Breathing Space without attempting to manage those conditions. So the ambition in the new pathway was to provide the same level of care. In terms of referring to

end of life care assurance was sought that this would be handled sensitively with patients due to the potential psychological impact.

In terms of asbestosis and where this fitted in the model this was a more specialised service and the Sheffield respiratory team provided support for Rotherham patients.

The Head of Commissioning was thanked for her presentation.

Resolved:- To note the information provided and to schedule a further update in the work programme for October 2020 when the full new structure would be in place.

67. ROTHERHAM LONELINESS ACTION PLAN 2020-2022

The Cabinet Member for Adult Social Care and Housing introduced the draft Rotherham Loneliness Plan 2020-22, which was important given the strong negative impact that loneliness could have on people's mental and physical health. Loneliness is a priority within the Health and Wellbeing Board Strategy (Aim 4) and the plan was a key aspect of the Health and Wellbeing Board's agenda on the preventative side. There was also an important role for ward members in this work.

It was essential to recognise the difference between loneliness and isolation and also to be aware that loneliness could affect people of any age; it was not confined to older people. The causes of loneliness were difficult to determine but known trigger factors could be seen at an individual, community and societal level. In order to tackle loneliness and promote good social connections a collective response was required from individuals, communities, statutory partners, voluntary and community sector and local businesses. Actions to tackle loneliness could be very simple and in many cases low cost, building on local assets.

The overall vision in the plan stated: "People of all ages in Rotherham feel more connected to others and loneliness is reduced". Underpinning this vision, a high level action plan had been developed, informed by a stakeholder event, focus groups and needs analysis work. It was based on four broad aims, as follows:

1. To make loneliness everyone's responsibility.
2. Improving how organisations and services in Rotherham connect people
   at risk of experiencing loneliness to support.
3. Make it easier for people living and working in Rotherham to access information about local community groups, activities and support services for loneliness.
4. Spread good practice and encourage knowledge sharing on tackling loneliness across Rotherham.

Members recognised the difficulties in detecting loneliness and that it was hard for people to admit to feeling lonely. They welcomed having a good plan in place and asked whether it was likely to be further developed and refined over time. This was confirmed as the evidence base was still emerging so any local initiatives would to be thoroughly evaluated and reported on, taking the learning and building from that.

Raising awareness with partners of what was already happening in communities, such as the coffee mornings organised by Churches Together was highlighted. Officers were mindful that a lot of good practice was happening and were attempting to bring everything together in one directory by encouraging people to include activities in GISMO the on-line database hosted by Voluntary Action Rotherham. The Making Every Contact Count initiative would play a key part in identifying loneliness through staff sensitively asking questions and spotting triggers such as life events.

As GISMO was central to informing people about activities and groups, assurance was sought in relation to funding to maintain and update the information. The CCG had provided funding to update it but there was uncertainty regarding funding for the next few years, although it was hoped to access South Yorkshire and Bassetlaw funding for the "connectedness" workstream.

A question was asked about the research citations in relation to loneliness being more harmful than smoking 15 cigarettes a day and for loneliness as a factor in higher demand on public services. Some of this had emerged from conversations with front line staff and partners, health data and also some pieces of national research, for example that of the Jo Cox Foundation who continued to work on this topic. In terms of commissioning further research, this would be likely nationally but given the tightness of resources it would be more a case of using local assets in Rotherham. More could be done and the findings from the focus groups with tenants, older people and young people had been helpful as groups could often identify a simple solution. For example, raising having a trusted adult to talk to for young people. Members added that if this harm could be proved empirically a case could be made for shifting resources, including into preventative work. There was a reliance on the voluntary and community sector as well with costs involved in ensuring a body of volunteers could be trained and retained, which might merit dialogue with Voluntary Action Rotherham about their plans for volunteers. Officers reiterated the need for individual and collective responsibility across agencies and that much could be done at low or no cost.

The value of social prescribing through GPs was acknowledged and potentially could assist with some of the people going to health services with more of a social than a medical need, but again this linked back to people being able to get a GP appointment. Work was taking place with the Primary Care Networks' Link Workers who did the signposting but they were still fairly new in post. Existing social prescribing was available

only for two specific routes, mental health and long term conditions, but the hope was to expand this more widely by working with the Link Workers. Rotherham was already well ahead in this field through the work introduced by Voluntary Action Rotherham which pre-dated the national requirements.

8 out of 10 carers had reported feeling lonely and Members sought verification that the Loneliness Plan would link in with the Carers Strategy. Cllr Roche confirmed that it would do and admitted that the Carers Strategy had been delayed whilst the new Target Operating Model had been developed and implemented in Adult Care. An officer had now been appointed to develop the strategy which was an essential piece of work as being a carer could be very lonely, especially if the person they supported had complex needs and required a lot of hours of care.

In relation to concerns with the move towards digital by default a query was raised about the potential to use some of the associated savings to establish relationships that may be lost through the move to greater use of technology. Conversely, the positive benefits of technology in helping to address loneliness were raised, including robotic cats that had been positive for people with dementia and enabling the development of on-line communities that helped people make connections around the world.

As the plan was a more strategic high level plan, officers were asked for a follow up once the plan was being implemented to see what was happening as the engagement was a concern.

Members talked about good initiatives they were involved in to help bring people together such as lunches, day trips and a fishing group but had been less successful with projects for men on their own. This challenge was recognised although there had been some successes through the small grants scheme under the suicide prevention work which had been running for two years and did include criteria around addressing loneliness and isolation. A further suggestion was made about trying to bring people together initially through a type of matching process akin to some of the Apps.

Although many of the initiatives discussed involved groups, for some people joining a group could be a difficult step and others might want to find someone to buddy up with instead or alternatively to do something in their own home. Some individual schemes were in place and had led to real friendships. A befriending scheme matched volunteers with an older person for an hour a week and were often mutually beneficial. Work was needed to make others aware of activities the Council offered that were free to attend such as guided walks and in parks.

Given that children and young people experienced loneliness, the Chair asked about work in schools about loneliness; awareness raising with young people, including what to look for and how to be supportive and whether this would be linked to the Trailblazer project. Rich information

had been garnered from the engagement with young people and partners needed to look at where to take this. This had been raised at the Trailblazer group so would be looked at to see how it filtered down to actions. It was being addressed in many schools but not necessarily badged as loneliness.

National performance indicators on loneliness were planned for inclusion in the Public Health Outcomes Framework but these measures would not be finalised until November although a number of suggestions were being discussed.

In summary, the feedback from Health Select to be considered to inform the final draft of the plan was:

- referencing of research sources to be clearer
- ensure a link to the Carers Strategy (which also links to the respiratory pathway)
- report back on progress with detailed examples (to link into agreed reporting)
- better links to schools – including Trailblazer
- importance of empirical evidence to support funding requests or resource shifts

Officers and the Cabinet Member were thanked for presenting the plan. If Members had any further thoughts, they were encouraged to submit them by 1 March 2020. The Chair also confirmed that the Carers Strategy would be included in the work programme for 2020-21.

Resolved:-

1) To note the draft plan and timescales for consultation.

2) To submit comments on the draft action plan.

3) To receive the final version after sign off by the Health and Wellbeing Board in March 2020.

68. OUTCOMES OF WORKSHOP ON REFRESH OF ROTHERHAM INTEGRATED HEALTH AND SOCIAL CARE PLACE PLAN

A short briefing paper summarised key points raised at the workshop held in January to scrutinise the refreshed Rotherham Integrated Health and Social Care Place Plan. The purpose of the session had been to consider and comment on the general thrust of the plan, priorities and focus – including any perceived gaps and any specific issues in relation to any of the three transformation workstreams. Delivery and governance arrangements and how partners would measure success was also covered.

Five recommendations resulted from the workshop

1. That consideration be given to renaming the Transformation Group as the Mental Health, Learning Disability and Autism Transformation Group to give Autism greater recognition as a discrete issue.

2. That the issues raised in section 3 be considered by the Integrated Care Partnership for inclusion within the plan or in existing workstreams as appropriate.

3. That a further update on the development of Primary Care Networks and transformation of Primary Care be presented to the Health Select Commission in 2020-21.

4. That the final draft of the refreshed plan be circulated to the Health Select Commission.

5. That following consideration of this paper written feedback is provided to the Health Select Commission for its meeting in March.

The Chair of Licensing Board and Licensing Committee praised the speedy responses from health partners to requests for information related to licensing. It was also hoped to make good use of the alcohol and licensing toolkit once in place. Officers were already using an excel based version and it would soon be available within the Rotherham Data Hub (formerly known as the Joint Strategic Needs Assessment or JSNA) in a more accessible way. All the information was now available to inform analysis of specific areas.

Members were advised that in relation to recommendation 1 above, it had already been confirmed that the name of the group would be changed but to include Neurodevelopment rather Autism, which was a broader term.

Resolved:- To note the recommendations made at the workshop as set out in section 4 of the briefing.

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

The Governance Advisor confirmed that the date of the next meeting had not been finalised but was expected to be in March. The Health Select Commission was informed that Wakefield Council had withdrawn from the joint committee.

70. URGENT BUSINESS

The Chair advised that there were no matters of urgent business to discuss at the meeting.

71. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission take place on Thursday, 26th March, 2020, commencing at 2.00 p.m. in Rotherham Town Hall.