HEALTH SELECT COMMISSION
Thursday, 22nd October, 2020

Present were Councillor R. Elliott (in the Chair); Councillors John Turner, Albiston, Bird, Cooksey, Ellis, Jarvis, Williams, Evans, Brookes, Vjestica, Walsh, Short, Clark and Fenwick-Green.

Apologies were received from Councillor Keenan and the Mayor, Councillor Jenny Andrews

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

107. MINUTES OF THE PREVIOUS MEETING HELD ON 03 SEPTEMBER 2020

The minutes of the meeting held on 3 September 2020, were approved as a true and correct record of the proceedings.

108. DECLARATIONS OF INTEREST

There were no declarations of interest.

109. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

The Chair confirmed that no questions from members of the public or press had been submitted.

110. EXCLUSION OF THE PRESS AND PUBLIC

The Chair confirmed that there was no reason to exclude members of the press or public from observing any of the items of business on the agenda.

111. WINTER SURGE AND COVID-19 PLANNING

Consideration was given to a place presentation illustrating the system winter plan. A winter plan is developed each year in anticipation of the winter months and the associated increase in demand from flu. This year, however, the plan also incorporates preparedness for COVID response as well. The learning from the first wave of COVID has informed preparations for the winter months. The presentation described in depth the preparations in place in primary care, acute care, flu response, social care delivery, care home support, and staff support—all of which were integral to the winter response.

The presentation went on to summarise the key challenges faced across Rotherham this winter, including the risk of further bed reductions due to cohorting flu and Covid-19. The presentation illustrated the pressures of

social care provision, in particular, as the home care and reablement resource strives to meet demand. Anticipated workforce challenges were also identified, specifically, self-isolation, sickness, morale and mental health concerns. As the pandemic continues, inability to recruit to key capacity was expected to create especial challenges for the acute wards. Challenges also existed related to the Emergency Care Centre, and further difficulties were described around managing elective care amid the pressures of COVID combined with the seasonal winter surge. The flu programme would also need to be prioritised along with changes to GP hubs. It was noted that the plan has actions in place to mitigate the above risks. The various programmes and signoffs were described which are responsible for delivering these actions.

In discussion, Members requested clarification around any overlap in symptoms of flu and those of COVID-19 that could lead to confusion. The response conveyed that the uptake of flu vaccine is positive and that demand is high. The pharmacies are waiting for another round of vaccinations to be delivered. The rates of flu nationally are very low, which could perhaps be attributed to social distancing and hand washing measures. It was asserted that the presentation with each kind of virus is different, and these patients will not be mixed up. It was encouraged that people get the flu vaccine first before getting the forthcoming COVID-19 vaccination.

Members sought additional assurances that provision of urgent dental care was available. Officers noted that this was an NHS England question outside their remit, but that the answer could be found and related to Cllr Fenwick-Green.

Members also requested assurances around A&E demand versus capacity. The response from Partners explained that the A&E department was under considerable pressure and has been for several months, so much so that some elective patients had had to be cancelled in the previous week. For example, 17 people were awaiting a bed on the day preceding the meeting, with about 80 people awaiting treatment. Some services were being moved into outpatient centres, and the movement of ophthalmology will create more available surface area. People are asked not to attend unless in emergencies, and there are people on the doors to help with admitting.

Members also requested clarification around how many patients contract COVID in hospital during treatment for some other condition. Partners confirmed that everyone admitted to hospital is tested. Anyone testing positive is separated into their own area or into a COVID designated ward. There have been a handful of individuals who have tested positive several days after being admitted, and if that happens, they are immediately separated. This was noted as being on par with the national picture.

More information was also requested around what happens when the allocated beds for COVID are full. The response conveyed that a ward was opened in particular for COVID to ensure the availability of empty beds on a COVID ward. Each time high demand for COVID beds was received, the hospital opened another ward for COVID by first moving the COVID negative patients to a different area to clear the ward for COVID. At the time of this update, partners were readying to open a third ward for COVID.

Members also asked whether it was expected that the new restrictions would have an impact on the pressures in the hospital? Officers responded that the new restrictions absolutely would have an impact on reducing transmission between households. This would also reduce the need for hospitalisation, which would keep the hospitals from being more and more COVID occupied. Partners had seen a marked increase in COVID patients: 100% increase over a matter of three to four days. Therefore, partners were very hopeful that the measures would indeed help.

Members asked for more information about the risks and effects of contracting both the flu and the COVID-19 viruses at the same time. The response emphasised the importance of getting the flu vaccine so that this scenario would not be encountered. The goal was for people to be well and not get flu. Partners had performed scenario testing to see if the systems could cope with a flu pandemic, and now a COVID pandemic. National Health advice suggested that the viruses do not work together, but it was acknowledged that if anyone were to get both, the individual would be very ill indeed. Anyone with either virus would be isolated in any case.

Members requested clarification whether the flu programme was currently behind. Officers averred that, compared to where we were at this time last year, numbers were actually ahead. Currently the programme awaited a letter from Central Government announcing the next stock of vaccines to arrive for distribution. Each partner had a flu programme and an action plan, and all of these were monitored very closely. It was noted that tier 3 areas would not be prioritised, because Rotherham, from a national numbers point of view, had already achieved the necessary uptake required. It was noted that these distributions were determined by Central Government and NHS England.

Members also inquired whether Rotherham patients would be cared for in Rotherham hospitals or would be sent elsewhere. The answer averred that 90% of Rotherham patients were from Rotherham. If there were a large influx of patients, some patients may be moved to Nightingale Hospital which was not yet in use but was still in preparations in case of need. It was noted that 10-12 staff members from all the local hospitals had been asked to volunteer, and the 12 Rotherham staff members who volunteered previously would be asked to do so again if possible.

Details were also requested around the percentage of the hospital workforce that had had COVID-19, and whether there were sufficient supplies of PPE. Partners responded that these numbers are recorded, COVID and non-COVID sickness. Sickness was usually at 7-8% during the winter but was 4% at the time of the update. The number of staff off work for contact isolation, track and trace isolation, recovery from the virus, etc., was around 11%, which was somewhat high. Assurances were provided, however, that PPE was plentiful, supplied by a push system of stock replenishment. The equipment does vary by manufacturer, but there is plenty of it.

Members also asked for more information around where and how they could reliably get a flu jab. The response provided clarification that some GP practices opted to offer the flu jab through the drive through, but not all were prepared to do it that way. Positive feedback from the drive through route would inform decisions next year, however. There were a range of different routes. Some pharmacies were asking people to come back because they did not have access to the vaccine at that time, but people were being asked to come back and keep trying.

Assurances were requested that any patients who would potentially be sent to the Nightingale hospital, who would likely be those who were most gravely ill, would have access to their family members. Assurances were provided that those patients who would be moved would be those who were stable enough and unventilated, because it is too dangerous to move a ventilated patient. It was expected that, if Nightingale has to be used, the numbers sent there will be few and these would be stable patients.

Clarification was also requested as to why COVID patients were kept in the same hospitals as other patients. The response conveyed that previously, Hallamshire had been the designated hospital where COVID patients were taken, which worked fine for the first five weeks, but the numbers had gone up so quickly that Hallamshire would soon be overwhelmed, decimating their ability to provide specialist services to all of South Yorkshire. A special door had been designated for COVID patients coming into the hospital. What the hospital calls ‘blue’ or very, very clean wards were being maintained for cancer services, orthopaedic elective, and haematology wards. These exceptionally clean wards would be maintained as long as possible. As COVID numbers increased, however, that means there would be fewer non-COVID areas in the hospital, but efforts were being made to maintain those ‘blue’ areas.

Assurances were also requested that proactive steps were being taken to ensure that the system meets the needs of people who cannot connect to digital services. The response from Primary Care partners conveyed that digital services were but one of the avenues that were available now. Many services have converted to telephone and video to protect patients and staff within practices, but for those who cannot access those, face to face would be provided as the default, as well as in first and second visits.

Digital inclusion projects had been undertaken to help improve access to digital services, and whilst these efforts were currently on hold, it was noted that this was an area of focus.

Members raised the possibility of natural air purification techniques. The response noted that this kind of trial would be outside the remit of Public Health, the Council and its partner organisations.

Resolved:-

1. That the update be noted.

112. TRANSFORMATION OF PRIMARY CARE

Consideration was given to a presentation by the Rotherham CCG in respect of changes to GP and Primary Care Networks. The new long-term plan included the transformation of the Primary Care Networks—six of which are in Rotherham. Practices had been working together in terms of telephone systems, hot and cold site visiting, etc. These strong relationships also strengthened multidisciplinary working across all the networks. Funding had been received to recruit for 48 more posts added since this time last year. Care navigations had therefore been streamlined so that patients received their care appointments quickly. None of the extended access had been utilised since March, so this had been converted into hot and cold services. Population needs had been assessed by geographical area, to try to identify and meet better the needs of the patient population on a more granular level. With these arrangements, clinicians could support their practices even if they were self-isolating at home. Funding had also been put in place to look at the conditions most affected by COVID.

The update further showed that COVID had accelerated progress with telephone triage. Most people preferred video consultation, which was also supported by the Rotherham Health App. It was noted that the information was also recorded efficiently. The login and the triage processes had also been streamlined to minimise the impact on clinicians. If there were particular issues, the Primary Care Network had been able to mobilise to respond.

A new home visiting service had also been deployed since July. This service also supported care homes. The entirety of this service had been moved to hot visiting, while the GPs continued to do cold visiting. It was noted that the entire place has responded powerfully to the demanding circumstances. Details were presented as to measures in place to prevent transmission and to maintain safety. Tele-dermatology was a further area of innovation. Ophthalmology had also been adapted to continue to provide services to people throughout COVID. Details were provided as to the measures in place to ensure high quality care is provided to care homes during COVID.

Details were provided as to progress with Clinical Thresholds. The priorities had included provision of rapid access to smoking cessation, weight management, etc., for patients who needed to have surgery but were not quite fit enough to have that surgery. It was noted that some invasive procedures, especially in trauma and orthopaedic areas, were able to be avoided because when the patients lost weight, they no longer needed the procedures. The new practice, with positive results so far, was to schedule people for surgery and health optimise at the same time, instead of deferring scheduling until health optimisation had taken place.

In discussion, Members requested clarification as to how it was that one practice belongs to the PCN associated with a different geographical area of the Borough. The response illustrated that this association reflected the relationships of the branch sites and reflects the contracts. Assurances were provided that there was no impact on the service provided at the practice.

Members also asked if the Rotherham Health App would eventually expand to become a universal gateway to health services. The response suggested that several expansions were in progress. The challenge was that TRFT have quite a complex system, so the question became whether this system could be integrated with the app.

Clarification was requested around how many practices were using the Rotherham Health App. The response emphasised that all practices had access to the Rotherham Health App. They also had access to AccuRx, which was preferred by some clinicians. Numbers were not currently captured as to the uptake of the App among practices. Numbers were available showing how many appointments are face to face versus technology mediated, but it was not possible to know how many had been conducted by telephone versus video.

Clarification was requested around how many people are using the app? The response indicated that 10% of the Rotherham patient population were using the app, which is high in comparison to Birmingham, which remained at 6% after more than a year since the service was rolled out.

Assurances were requested that health checks could be conducted even where the presence of autism or disability presents challenges to communication. The response identified inclusion as an important area of work. Clinicians strove to have flexibility built in so that if there were a carer available, that person would be invited to join in the consultation, although this practice otherwise would be discouraged generally in accordance with the current practice of limiting face to face appointments. For some patients, it was important to have phone consultations available.

Resolved:-

1. That the report be noted.

113. RESPIRATORY SERVICES

Consideration was given to a verbal update from the CCG in respect of Respiratory Services. Prior to COVID, the team with the commissioners had worked on a new process designed to care for people at home, looking after people as a day case, or preferably at home whilst providing rehabilitation at home. This process was intended to free up beds in the hospital and in breathing space service area. This programme had unfortunately been a casualty of COVID. Despite the hindrances presented since March by COVID, the respiratory service had implemented some new approaches such as providing more support to people who need additional help with Respiratory conditions as well as Complex Patient Case Management. All referrals now came through the central intake system which was always open so that care could be accessed quickly anytime. Some people, it was noted, virtual services do not work for, and the team was working with those people, but entire classes of face to face rehabilitation could not currently be scheduled for safety reasons. The team would still offer home care, and a home support team for COVID recovery would be going live soon. The spirometry and testing process had greatly slowed by COVID safety measures, but it was noted that it did continue. It was emphasised in conclusion that the teams had worked hard to keep the service going.

Resolved:-

1. That the update be noted.

114. MATERNITY SERVICES

Consideration was given to a verbal update on maternity services. The overall rating for the service following the transformation programme had remained the same, amber. 28% in February and 27% in September. The teams had to stop due to COVID-19, reducing the number of face to face conversations and limiting visitors, which was understood to be unpleasant for service users.

The service had reviewed this and had tried to restore normal levels of visitation for the time being, but it was really difficult due to COVID. So far the government had not asked the service to change the way it was working with maternity and mothers. So far, the service had not had to go back to phase 1 actions. They hoped to be able to get to 35% by March, and the service was optimistic.

Resolved:-

1. That the update be noted.

115. OPHTHALMOLOGY AT ROTHERHAM COMMUNITY HEALTH CENTRE

Consideration was given to a verbal update on the move of Ophthalmology Services to the Community Health Centre. The building work had not been possible during the first phase of the pandemic, partly due to movement of COVID positive patients through the area. Screens had been added, but this did slow down the process. The move had been therefore delayed by two weeks. Work had been completed and signed off by building contractor and surveyors, additional equipment was in place and emergency pathways for patients with eye injuries had been agreed with A&E. At the time of this update, the first clinic had been scheduled for the following Monday. It had been previously agreed not to charge for parking, but it had been noticed that a lot of cars are in the car park that do not belong to patients.

Resolved:-

1. That the update be noted.

116. UPDATE FROM HEALTHWATCH

Consideration was given to a verbal update from Healthwatch. Two new members of staff were now in post: Engagement Officer and Campaigns and Research Officer. Work on the discharge from hospital tying in with work by Healthwatch England and the CQC had also been completed, and powerful case studies from local residents had been compiled. The report would be available to the public very soon. Reflections on the drive through flu vaccine programmes were also being collected for inclusion in a forthcoming report. Currently, scoping activities were underway for a study on care homes in which residents have not been able to have visits with family members and loved ones. This study comes as part of the national attention on mental health in care homes that is currently underway. A newsletter is underway with the first edition forthcoming.

In discussion, Members requested further information regarding technology available to residents to be able communicate with relatives and loved ones. The response confirmed that technology would be considered, certainly as it was relevant for collecting the data and perspectives of care home residents as well.

Resolved:-

1. That the update be noted.

117. URGENT BUSINESS

The Chair confirmed that there were no matters of urgent business.

118. DATE AND TIME OF NEXT MEETING

The Chair confirmed that the next virtual meeting had been scheduled for 10 December 2020, at 2:00 pm.