HEALTH SELECT COMMISSION
11th June, 2015

Present:- Councillor Mallinder (in the Chair); Councillors Alam, Burton, Elliot, Evans, Fleming, Hunter, Khan, Reeder and Smith.

Apologies for absence:- Apologies were received from Ellis, Godfrey, Rushforth, Sansome, M. Vines, Victoria and Robert.

1. DECLARATIONS OF INTEREST

Cllr Fleming raised his employment with the NHS in Sheffield.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

3. COMMUNICATIONS

The Chair welcomed everyone to the first meeting of the Health Select Commission in the 2015/16 Municipal Year.

Information pack
In addition to the Agenda papers for the meeting, a separate information pack with other documents of interest to the Commission which may not need discussion in the meeting may be circulated. If any Member wanted to raise an issue or ask a question in relation to any of the papers in the pack they should be raised under Communications. It included information on the Health and Wellbeing Strategy which was being refreshed and would be on the July agenda.

GP Limited Liability Partnership (GP LLP)
All of the Rotherham GP practices (now reduced from 36 to 35 following a recent merger) had formed a GP LLP which was registered at Companies House. Currently the LLP was not conducting any business but possible future actions could be to benefit from economies of scale or as a means of attracting investment which had happened elsewhere.

Treeton Medical Practice
This was a long running issue with regard to securing new premises as the present surgery premises were too small for the practice which had a growing patient list and likely to increase substantially with new housing developments close by. Originally it had been hoped to have a new building near their present site but this had stalled. Discussions had now commenced with Howarth Estates regarding the medical centre the developer was building at Waverley. A business plan application form had been submitted to NHS England on 11th May, 2015. The practice has not had a response as yet.

Care Quality Commission Inspection of the Rotherham Foundation Trust

It was standard practice after a CQC inspection to hold a Quality Summit with the Hospital, Health commissioners and stakeholders to discuss the findings and improvement plans. This had been due to take place on 12th June but had been postponed with a new date to be agreed. The Chairman, Interim Director of Adult Social Care and Interim Strategic Director Children and Young People's Services would be invited.

Joint Health and Overview Scrutiny Committee

(1) Representation

In keeping with previous years, the Select Commission was requested to consider representation on the JHOSC.

Resolved:- That Councillor Sansome and Councillor Mallinder (substitute) represent Rotherham on the Joint Health and Overview Scrutiny Committee.

(2) Yorkshire Ambulance Service

The Joint Health and Overview Scrutiny Committee, through Wakefield Council, was also being represented at the Care Quality Commission Quality Summit for the Yorkshire Ambulance Service on 15th June, 2015.

Health and Wellbeing Board

Councillor Roche, Advisory Cabinet Member, reported that a meeting had taken place with some of the key players to look at how the Board was going to run in the future, membership, agenda items, roles of the Chair and Vice-Chair and integration as much as possible. The Board would meet at various locations around the Borough and not in the Town Hall. A report would go to the Board's July meeting following by a report to the Select Commission.

Councillor Roche reported that Alison Iliff, Public Health, had been awarded a British Heart Foundation Hero Award for her work in promoting Rotherham as a Heart Town.

The Board had also held a special meeting in May to discuss Rotherham's Suicide Prevention Action Plan. The Plan had been agreed and would be sent to all the relevant partners.

It was also reported that central funding to local authorities for Smoking Cessation Services and Sexual Health Services was likely to be reduced.

4. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the Health Select Commission held on 16th April, 2015, were noted.

Further to Minute Nos. 87 and 89 (Rotherham Foundation Trust Quality Accounts and RDaSH Quality Accounts), it was noted that the Select Commission had submitted its statements for the Quality Accounts for the Foundation Trust, RDaSH and the Yorkshire Ambulance Service in accordance with the deadlines.

It was noted that a progress report on the Continence Review was to be submitted to the July meeting. Incontinence was often a key factor for people going into residential care but it was not inevitable with age and many forms such as stress and urge incontinence could be treated. It was also relevant to falls prevention.

Further to Minute No. 88 (Nurses in Special Schools), Tracey McErlain-Burns (Chief Nurse) had spoken with members of the Family Health Directorate regarding the query raised with respect of the level of support that might be provided when a young person leaves education.

The current position was that School Nurses would provide support to young people leaving school/education if requested by that young person or parents or if another partner agency requested it provided the School Nursing Service had accessed their ability to provide ongoing support. That was provided on a 1:1 ad hoc basis.

Further to Minute No. 90 (Scrutiny Review – RDaSH CAMHS), it was noted that the CAMHS report and the updated response to the Access to GPs review had been approved by the Overview and Scrutiny Management Board. They would be submitted to Commissioner Manzie and the Health and Wellbeing Board.

5. HEALTH SELECT COMMISSION WORK PROGRAMME

Janet Spurling, Scrutiny Officer, presented a report setting out the priorities for Scrutiny and the specific work programme for the Select Commission in light of the changes to the Executive decision making arrangements of the Council.

Since their appointment in March, 2015, the Commissioners had engaged with Elected Members to determine a realistic and focussed Scrutiny programme for 2015/16 clearly identifying the areas they would like Members to prioritise. It had been discussed and agreed by the Overview and Scrutiny Management Board at its meeting on 24th April and approved by Council on 22nd May, 2015 as follows:-

Budget plus statutory work	Overview and Management Scrutiny Board
Task and Finish work on Litter/Waste	Improving Places Select Commission
Scrutiny of Child Sexual Exploitation	Improving Lives Select Commission
Health/Social Care Integration	Health Select Commission

Accordingly, the proposed programme for the Health Select Commission was as follows:-

Initial overviews of Health Services and Adult Social Services
Better Care Fund and the Fund Finances
The Care Act including support for carers
Updates on previous Scrutiny Reviews
Capturing Service User/Patient Feedback and Experience
Children and Young People
Quality Accounts
Year End Performance
Visits to other local authorities and/or Health bodies
Monitoring Previous Scrutiny Reviews

The Commission's amended Terms of Reference were also submitted for information.

Discussion ensued on the proposed programme and the new way of working with most of the indepth scrutiny being carried out in the meetings by the full Commission rather than in smaller review sub-groups. The exception would be the Quality Accounts where it was proposed to have three sub-groups for Rotherham Hospital, RDaSH and Yorkshire Ambulance Service respectively.

Resolved:- (1) That the overall priorities for Scrutiny for 2015/16 and the focus for Health Select Commission on Health and Social Care integration be noted.

(2) That the Select Commission's 2015/16 proposed work programme be approved.

(3) That the Health Select Commission's Terms of Reference, as outlined in Appendix C submitted, be noted.

6. PRIMARY CARE UPDATE

Jacqui Tuffnell, Head of Co-Commissioning, Rotherham Clinical Commissioning Group (RCCG), gave a powerpoint presentation on the Primary Care update:-

- From April, 2015, the RCCG had taken on delegated responsibility for GP practices but not for the whole of Primary Care. There was the potential for conflicts of interests

- The Primary Care Sub-Committee met in public on a monthly basis, the meeting papers for which were available on the website. The Sub-Committee was Chaired by a Lay Member and was made up of members of the RCCG and 3 GPs who were elected to sit on the Sub-Committee to provide advice. At the point of making a decision, the GPs would leave the room

- A big piece of work that needed to take place was to set the GP Strategy for Rotherham. There would only be 1 plan which would align with other strategies such as the Health and Wellbeing Strategy and the Commissioning Strategy. There were 10 key priorities

  – Quality Driven Services
  Services were "RAG" rated so a warning would be received as to which practice's performance was raising concern. This was the first time this had been seen and Rotherham was paving the way. It enabled bench marking of practices as well as the sharing of good practice with others. The LLP gave practices the opportunity to look at working together rather than in silos. Work was starting on looking at new models of delivery regarding the integration of Health and Social Care and what possible models could look like

  – Services as local possible
  There were a number of challenges associated with this priority. Rotherham was around the national benchmark level for Doctors but new ways of managing patients were being explored including a new role of associate physician to support GPs in practice and looking at the wider health workforce including pharmacists and therapists.

  The RCCG was also looking at using IT and technology such as Skype. The Emergency Centre would integrate urgent care and out of hours care seamlessly.

  – Equality of Service Provision
  Dependent upon where you lived and the size of your practice, there could be real inequality in relation to the Services provided. Encouragement was being given to having "baskets" of Services through co-operation between practices so that if a practice did not deliver a particular Service it may be that the practice down the road could do so on their behalf thereby ensuring everyone received the same service. Some of the commissioning arrangements around Public Health were due to the way it had been divided up; the RCCG wanted to stop those barriers and all

work together and avoid whose responsibility for commissioning services

- Increasing Capacity and Capability
  It was hoped that there would be 5,000 more GPs nationally. Currently once trained, many Doctors opted not to go into GP practice. It was felt that it should be made easier for those coming back into the country to start practising again as currently you had to retrain to certain degree. There was a ten point national plan to attract and retain GPs. Rotherham would have its own local workforce plan associated with that. Sheffield Hallam University and Sheffield University were now running courses for associate physicians with Sheffield Hallam already having an oversubscribed allocation. Rotherham had managed to fill its cohort for GP training as it had a really good reputation but it was hoped to secure associate physicians to support GPs. Associate physicians would free up GPs to deal with the more complex issues and enable successful succession planning. Work was also taking place on a Recruitment Strategy, finding out what attracted people to Rotherham, what it could do to keep them in Rotherham and improve the profile as a place to work and achieve an improved fill rate.

- Primary Care Access
  Questions asked at a recently held Health event had revealed:-

  89% would be happy with telephone consultations
  87% wanted an allocated appointment time and wanted to be seen very close to that appointment time
  35% wanted Saturday opening
  24% wanted 7.30 a.m. opening
  41% wanted the surgery to be open until 8.00 p.m.
  19% wanted to use technology to self-care (mainly older people)
  80% supported usage of the extended workforce as they felt confident in the nurses and the advice they received from them

  Approximately 70% of the audience were the more mature of those who attended the event. The feedback derived from the event would be fed into the Strategy which would be subject to a number of engagement events, with the Patient Participation Groups as well as localities

- New Models of Care
  Currently 1 of the barriers was the contractual complexity which the formation of the GP Limited Liability Partnership would help with. Work had started on collaboration and engaging with GPs to get the right services within a catchment area to support the whole of the population. The opportunity of the Emergency Centre would be exploited.

- Self-Care
  There had been significant developments in health care resulting in people living longer as their health was better, but that had led to increased demand on Services which were not seeing an increase in the same way. There would need to be a real focus on educating the public on way services were available because for some time the message has been if you could not get in to see your GP you would be seen within 4 hours at A&E. There was some good work being carried out on social prescribing. The CQC on their recent visits to practices had commended the case management work – the report would be on their website soon

- Robust Performance Management
  Practices were far more robustly performance managed than ever before. This gave the ability to spot where there may be a problem with a practice. An intelligence system known as Radar had been developed by the North East which 10 practices were currently piloting which would also give information. Satisfaction surveys were also used

- Improving Medicines Management
  Significant steps had been made but the Service redesign would continue. Prescriber was also used which focused practices' attention on ensuring patients were on the right medication and had regular medication reviews

- Engaging Patients to Optimise Pathways
  It was known that those that are experiencing the pathway were the ones you would get the best information from and the best routes for that were being explored. There were Patient Participation Groups and Healthwatch Rotherham had been engaged to help with the 30% that were less successful and looking at what was right for that particular population 1 size did not fit all in how patients were engaged

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

- **Had there been any progress on matching computers between the Hospital and GPs?**
  It had been hoped to move to 1 system but it had been agreed to move to inter-operability between the 2 systems. Given the new Emergency Centre would be opening later in the year, everyone would be able to see the same medical record for a patient. The governance arrangements were being worked upon so that a patient understood that their record was being shared across the Services.

- **Had the issue of budgets been resolved i.e. did all the Services/agencies share 1 budget?**
  It had not been completed resolved but steps had been made with the Better Care Fund and agencies were looking at increasing that so as to prevent silos. Primary Care and GPs had been subject to the Equitable Funding Review so everyone would get paid the same amount for a patient. The setting up of the GP Limited Liability Partnership would be able to help, once the contracting arrangements were in place, either to deliver it or be responsible to ensure patients received delivery of the services so the contract would be internally between the GP practices

- **If a GP did not provide a particular Service had any consideration been given to accessing the Service across boundary?**
  Work had commenced on this issue. Barnsley had opted for co-commissioning and, therefore had delegated responsibility. It was not easy but there was a network working together as there was a similar with Sheffield. It would not be helpful having different levels of service so plans were being shared to understand the impact of where there was an issue. The intention was to try and work closely but it would be for Barnsley to decide what it did with its own Strategy

- **A number of senior GPs are retiring and we are struggling to recruit. Was there succession planning so have part-time GPs. Need to look at this**
  Work was taking place, but would be really hard to achieve, what that a patient would always see the same doctor. However, work was taking place within the workforce plan that, instead of having locum agency staff, a bank of trainees that did not want to base themselves in a particular practice but wanted to remain in Rotherham would be developed in an attempt to reduce the need to bring in outside help and utilise our own GPs. There were more Rotherham GPs involved in the Out of Hours facility so when doctors were away our own workforce was utilised so it was the same people seeing patients across Rotherham

- **How do we develop more understanding about disability including learning disability in practices?**
  It was difficult to achieve that a patient always saw the same doctor. However, work was taking place within the workforce plan that; instead of having locum agency staff, a bank of trainees that did not want to base themselves in a particular practice but wanted to remain in Rotherham would be developed in an attempt to reduce the need to bring in outside help and utilise our own GPs. There were more Rotherham GPs involved in the Out of Hours facility so when doctors were away our own workforce was utilised so it was the same people seeing patients across Rotherham.

- **How would you ensure patients with Mental Health issues are getting access to Services?**
  1 size did not fit all. GPs had expressed the need for additional Mental Health training for themselves and their staff or resources to support practices and it was the development around the pharmacies and how to direct patients in the right way. 1 practice was using telephone consultations but some patients did not want to feel they were being triaged by a receptionist. 1 practice was trialling triage by a GP. That would not work in every surgery but it was working for that particular practice

- **With regard to the CQC Duty of Candour, would the CCG take the role of moderator?**
  Currently complaints and incidents were still managed by NHS England and that responsibility had not been delegated. Work was taking place with NHS England but it was felt that it would remain with them as statutory body but issues with practices would be dealt with by the CCG.

- **How easy or difficult was it to keep all the GPs on side? What were the sort of issues that came up from GPs? Were some issues more difficult to deal with?**
  Some practices had been significantly affected by the Equitable Funding Review and work was taking place with them to achieve sustainability. There were some practices that were GP-led with very little practice nursing input when it was known that some tasks could be done with a different workforce. Practices were worried about their funding and their recruitment at the same time as wanting to deliver good services to their patients. Work was taking place on gaining an understanding on what "extras" practices were paying for and what were the right services to provide for the whole population and not just across GMS and PMS so there was no difference

- **Was Rotherham working towards 7 day access to GPs?**
  It could be argued that Rotherham already had it due to the availability of the Walk-in Centre 7 days a week. Barnsley did not have such a facility open 7 days. Events had been run with health professionals who had expressed concern with regard to capacity issues as there was no additional funding associated with it. Investigation was taking place on what access meant, what the need was rather than the want and ensure the need was addressed

Jacqui was thanked for her attendance and presentation.

Resolved:- (1) That the presentation be noted.

(2) That the Select Commission receives further information from the Rotherham Clinical Commissioning Group on the final Strategy in September.

7. OVERVIEW OF ADULT SOCIAL CARE

Profession Graeme Betts, Interim Director of Adult Social Services, gave the following powerpoint presentation on Adult Social Care Services:-

Changes in Adult Social Care Nationally – from Dependency to Resilience

- From institutions to community and home-based services
- Improvements in supporting people to live their lives independently
- Greater use of information and advice, one-off interventions and advocacy
- Greater focus on prevention, early intervention, rehabilitation, recovery and reablement and enablement
- Greater use of housing-based support, telecare and other technologies
- Focus on supporting carers
- Greater use of personal budgets to increase choice and control
- Better joint working with the NHS

The Challenges facing Adult Social Care

- Demography
  In Health there was a gradual increase in the spending on people as they got older
  In Care, the costs were reasonably low until the age of 85 when the costs then soared
  Rotherham's population was declining with regards to its younger adults – these were the ones that provided informal care to older people

- Expectations

- Quality Standards
  There had been an incredible rise in the standards of residential care but it came at a cost

- Safeguarding
  Agencies were better at identifying the level of emotional, physical and financial abuse – again at an increased cost

- Resources
  Net expenditure of approximately £70M
  Over the past 3 years the Authority had had to make £14M savings
  Rotherham Adult Social Care Services was a high spender

Headline Figures 2014/15

- Over 6,400 people had received a Service during the year (excluding Occupational Therapy only Services)
- Approximately 4,000 Social Care Assessments or re-assessments were undertaken during the year
- 90% of Service users on Service for more than a year received a review of their needs
- 1,700 adults and older people placed in residential and nursing care

Pyramid of Care

- Contact received during the year with the outcome
  Service Cost £371,517
  Age 18-64 – 889
  Age 65+ - 1,828

- In long term Community-based Service
  Service Cost £22,399,007
  Age 18-64 – 2,051
  Age 65+ - 2,204

- Residential/Nursing Service
  Service Cost £22,139,903
  Age 18-64 – 234 (Residential 195 and Nursing 39)
  Age 65+ - 1,462 (Residential 1,090 and Nursing 372)

Connect to Support Rotherham

- A website for adults in Rotherham who needed support to live independently
- The website offered information and advice and was also an e-marketplace offering 1,905 products and 414 services
- Generated an average 800 hits a month
- www.connectosupport.org/rotherham
- Self-serve and channel shift
- Dependence to Independence
- Preventative
- Supported the Care Act through advice and information
- Had the potential to be further developed to provide personalised guidance, self-assessment, financial assessment, care accounts, support planning and more

Shared Lives

- Shared Lives offered opportunities for vulnerable adults to live or spend time with approved carers and their families
- This could be for a few hours or a few days a week (befriending), short stays in the home of the Shared Lives carer or living as a member of their family
- There were over 50 users of the Service. Currently all long term and respite users had a learning disability. Befriending was mostly used by older people and/or people with dementia or physical difficulties

- Carers were approved and supported by Shared Lives Workers and received fees and expenses. Shared Lives was registered with the Care Quality Commission
- Person-centred and was cost effective

Changes to Eligibility Criteria
- A new national Eligibility Framework – a single, consistent route to determining people's entitlement to care and support
- Based on principles of wellbeing
- Assessment to be based on 'strengths' instead of deficits and to be asset based
- Portability of assessments
- National consultation being undertaken by the Department of Health
- Shift from Dependence to Independence

Delivering Adult Social Care in the Future
- Resilient residents accessing mainstream services
- Focus on prevention, enablement and support for carers
- Personalised services with high use of direct payments
- Strong commissioning function
- Well-developed market for social care maximising choice and control
- Wide range of micro-enterprises, Personal Assistants and Shared Lives Schemes
- Strong partnerships with Health and the third sector
- Well-developed co-production and co-delivery with users, carers and residents underpinning all of this

Discussion ensued with the following issues raised/clarified:-

- The Integrated Mental Health Services was not operating as well as it should and work was taking place with Doncaster and North Lincolnshire who worked with RDaSH.

- The Learning Disability Service was an area that was being looked at in more detail particularly with regard to integration.

- **Following Winterbourne, were there any safeguards in place to ensure people with learning disabilities or mental health issues were protected and supported?**
  An assurance was given that Winterbourne was taken very seriously in Rotherham and there was a whole programme to ensure Services knew where people were in the system and what the plans were for them. That is being handled well .

- **There was no mention of dignity which was something that quite often was omitted?**
  Dignity went hand in hand with independence and was at the heart of everything the Service did.

- **As the criteria had changed nationally and was now based on substantial and critical needs, an individual's needs may increase which have an effect on Services. Was an increase anticipated?**
  As a result of the Care Act, it was anticipated that the introduction of assessments for carers would see an increase in the workload together with self-funders being able to now request an assessment even though they may not get access to funding from Rotherham.

- **More people were living longer and encouraging them to stay in their own homes caused a housing problem further down the line. However, if they moved into more appropriate housing that was not solving the problem as you would wish them to stay in an environment that was familiar to them**
  Housing was a challenge. The Authority had a Housing Strategy for Older People which we Adult Social Care would be feeding into. It needed to take account of the fact that people were living longer and on their own more. There was a project called "happy" project which basically looked at housing suitable for older people rather than older people's housing and the idea that people moved much earlier in their lives.

- **The Shared Lives Scheme was a great initiative but had not really been very successful in Rotherham**
  The Project Manager had been requested to draw up a 3 year growth plan. It was felt that Rotherham had huge potential for Shared Lives.

- **If Shared Lives was successful it would result in significant financial savings. Would they be reinvested in the Adult Social Care budget?**
  There were areas that needed to be reinvestment. Overall the Council would have to meet its budget responsibility as well as careful consideration given to what was invested in.

- **There was an issue around the transition of young people into Adult Social Care particularly within the wider integration agenda. What current work was taking place?**
  The Director of Children's Services had attended a meeting of the Adult Social Care Management Team to discuss how to improve integration. A meeting was to take place shortly with Commissioner Manzie regarding the overall commissioning and the issue of whether there should be commissioning and Service provision across the lifecourse and a much more integrated approach from cradle to grave. Work was taking place on making Services more integrated and giving residents a better service.

- **Personal budgets in terms of independence were really great but what were they based on? Were there any statistics?**
  A number of residents had been met who had personal budgets, Direct Payments etc. to discuss the quality of services. The feedback

was that the Authority needed to do more but the message was very much that Direct Payments had given them their lives back. Quite often it was the most complex cases that a Direct Payment could make sense of how they ran their lives. However, the Service did not do enough and needed to look at why.

- **The Connect to Shared Lives website received 800 hits a month but how did that translate into takeups?**
  It was not known at the present time but it would be looked into.

Resolved:- (1) That the presentation be noted.

(2) That further liaison with Adult Social Care take place to assist in developing the work programme.

8. UPDATE FROM CONTINUING HEALTH CARE REVIEW

Janet Spurling, Scrutiny Officer, presented an update on the progress to date on the final outstanding recommendations of the joint Scrutiny Review.

Since the review was undertaken, NHS restructuring had seen responsibility for Continuing Health Care (CHC), including the budget, transfer to the Rotherham Clinical Commissioning Group (RCCG) who had commissioned the Commissioning Support Unit to carry out assessments and manage the budget. There was also now greater focus on personalisation of Health and Social Care Services and the development of personal health budgets.

A Senior Management Working Group of both Council and NHS staff had agreed a set of actions to ensure effective multi-disciplinary working and delivering better outcomes for people.

CHC and Social Care Assessments were completed by Health and Social Care staff presently or recently involved in assessing, reviewing, treating and supporting the individual. A better working relationship now existed together with a greater understanding of each professional's role in participating in multi-disciplinary assessments and completing the Decision Support Tool. Improved engagement had been achieved through attendance at CHC Panels and it was now routine that the Council's CHC Champions attend ratification panel meetings as part of the Multi-Disciplinary Team and implement joint actions. The Champions also ensured issues were addressed in a timely manner.

RCCG and Council staff also met regularly to progress work regarding CHC for children with complex needs in relation to assessments and the timing of payments for care packages for children agreed as eligible for CHC funding.

Resolved:- That the progress on joint working on Continuing Healthcare be noted.

9. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

10. REPRESENTATIVE ON WORKING PANELS

Resolved:- (1) That Councillor Sansome and Councillor Mallinder (substitute) represent the Health Select Commission on the Health, Welfare and Safety Panel for the 2015/16 Municipal Year.

(2) That Councillor Sansome represent the Health Select Commission on the Rotherham Local Plan Steering Group for the 2015/16 Municipal Year.

11. FUTURE MEETING TIMES

Discussion on the future meeting times took place. The opinion of those Members present was split on a morning (9.30 a.m.) and afternoon (3.00 p.m.) starting time.

However, it was noted that a number of apologies had been received for the meeting.

Resolved:- That an e-mail be sent to the full membership of the Commission seeking the preferred starting time of the Health Select Commission for the 2015/16 Municipal Year.

12. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 9th July, 2015, commencing at 9.30 a.m.

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