HEALTH SELECT COMMISSION
22nd September, 2016

Present:- Councillor Sansome (in the Chair); Councillors Albiston, Andrews, Brookes, Cusworth, Elliott, Ellis, Fenwick-Green, Marriott, John Turner and Williams and Robert Parkin (Rotherham Speakup).

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

Apologies for absence were received from Councillors Ireland and Roddison.

27. DECLARATIONS OF INTEREST

Councillor Sansome declared a non-pecuniary interest (relative works for the NHS at a local hospital)

28. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

29. COMMUNICATIONS

Improving Places Select Commission
The Chairman reported that a number of Select Commission Members had attended a recent meeting of the Improving Places Select Commission. An item for discussion was the Housing Strategy which related to those residents who had learning disabilities, disabilities or any other specialist needs. The Cabinet Member and respective officers had been challenged with a number of issues around the impact assessment, the number of houses which were being built for those with specialist needs against the ratio being built for those without needs etc.

CQC
There were to be follow-up inspections looking at the progress made on areas identified in previous inspections – the Yorkshire Ambulance Service inspection had started last week with the 111 Service in October. The Rotherham Foundation Trust inspection would commence on 27th September with the RDaSH inspection due to commence on 10th October, 2016.

Commissioners Working Together Programme
Last week six Select Commission Members had discussed the consultation materials for the proposed Service changes with feedback submitted to NHS England as requested by 15th September. Helen Stevens (NHS England) would like to thank Members for their considered and helpful feedback.

The comments fed back had included slight rewording, more precise information/greater clarity on some of the details particularly regarding impact for Rotherham patients, including twitter/facebook links on posters/postcards and suggestions for a couple of additional questions.

30. MINUTES OF THE PREVIOUS MEETING HELD ON 20TH JULY, 2016

The minutes of the previous meeting of the Health Select Commission held on 17th March, 2016, were noted.

Arising from Minute No. 18 (Transforming Rotherham Adult (18+) Mental Health Services), it was noted that proposals for the Adult and Older Persons Mental Health model would be submitted to the RDaSH Board at the end of October.

Arising from Minute No. 20 (Adult Social Care – Performance Clinics), Councillor Roche reported that he had enquired about this issue and had been informed that the new system was different from that operated previously. It was not a decision and, therefore, officers decided who was invited to a performance clinic. The Democratic Services Manager sent out performance data on a quarterly basis, Cabinet Members received a briefing and it was then discussed by the Senior Leadership Team/Cabinet Members at their monthly meeting. If a Member from this Commission was invited it would have to be opened to all the Commissions.

Councillor Ellis expressed concern that it was a new regime which involved all officer meetings with no Members; you could not have a performance tool without Members having no knowledge of it. Previously a member of the respective Scrutiny Panel was always invited with the Cabinet Member chairing the clinic so it had changed considerably. How could Members have governance over poor performance if they did not know what the tool was?

Additional information provided after the meeting:
The new system above was specifically with regard to meetings to discuss performance on the Corporate Plan, which had a varying number of Indicators for each Directorate. Officers have offered to brief Health Select Commission once a quarter Health Select on this data.

In the past there had been a system whereby a particular topic was examined in detail in a deep dive, with Members involved, but these were not currently in place.

Arising from Minute No. 21 (Caring Together Supporting Carers in Rotherham), it was noted that the Carers Strategy was to be submitted to the Health and Welfare Board in November for information and discussion in relation to the key themes aligned to the Health and Wellbeing Strategy.

31. ROTHERHAM'S INTEGRATED HEALTH AND SOCIAL CARE PLACE PLAN

Keely Firth and Lydia George, Rotherham Clinical Commissioning Group, and Nathan Atkinson, RMBC, gave the following powerpoint presentation:-

National Strategic Context
- Five Year Forward View
- Delivering the Forward view: NHS Planning Guidance 2016/17-2020/21
- General Practice Forward View
- The Five Year Forward View for Mental Health

Rotherham CCG Plan takes account of 5 year Forward View
- Unscheduled Care
- Ambulance and Patient Transport Services
- Community Services
- Clinical Referrals
- Medicines Management
- Mental Health
- Learning Disabilities
- Maternity and Children’s Services
- CHC and Funded Nursing Care
- End of Life Care
- Specialised Services
- Joint Working (including Better Care fund)
- Primary Care
- Child Sexual Exploitation
- Cancer Commissioning

Rotherham Integrated Health and Social Care Place Plan
- Rotherham’s health and social partners have joined together to look at how we can make the most of our services with the public at the very centre of everything we do
- By changing the way we approach health and social care in Rotherham we can improve our lives
- Our vision is “supporting people and families to live independently in the community with prevention and self-management at the heart of our delivery”

Rotherham Context
- Health and Wellbeing

  Life Expectancy in Rotherham is less than the England average by more than one year

  Life expectancy varies by eight years between different parts of Rotherham

  Increasing numbers of older people with long term conditions

- Care and Quality
  Hospital attendances, admissions and waiting times continue to rise
  There are opportunities to manage growth in emergency admissions to hospital
- Finance and Efficiency
  The NHS in Rotherham has a £75M efficiency challenge over the next five years
  RMBC has in the region of a £40M financial gap to close over the next three years

Our Five joint priorities within the Place Plan

- 1. Prevention, Self-Management, Education and Early Intervention
- 2. Rolling out our integrated locality model – “the village” pilot
- 3. Opening an integrated Urgent and Emergency Care Centre
- 4. Further development of a 24/7 Care Co-ordination Centre
- 5. Building a Specialist Re-ablement Centre

1. Prevention, Self-Management, Education and Early Intervention

- We will better meet the needs of local people by targeting individuals that can gain most benefit through:
  - Expanding our award winning Social Prescribing Service both for those at risk of hospitalisation and for mental health clients
  - Expanding systematic use of Healthy Conversations and advice by ensuring every statutory organisation signs up to Making Every Contact Count (MECC) and by training front line staff to talk about sensitive issues such as alcohol use, healthy eating habits, increasing physical activity and quitting smoking. We will also ensure quick and easy referral to evidence based lifestyle services (e.g. smoking cessation) to support those that are ready to change and in a way that is right for them

2. Roll out our integrated locality model “The Village” pilot

- Our pilot “the village” is in Rotherham’s town centre. It was established in July 2016 and covers 31,000 patients in one of our seven localities
- It showcases joint commissioning arrangements that drive the integration of services and promote multi-disciplinary working between Primary Care, Social Care, Secondary Care, Social Care, Mental Health, Community Services and the voluntary sector reducing the reliance on the acute sector
- We will be rolling out the model throughout our six other localities
- The aim is to provide seamless care to the designated GP practice cluster population, ensuring the client receives co-ordinated care from a single case management plan and lead professional
- Transformation of the Care Home Sector
  - Approximately 15%-18% of emergency admissions into hospital are from care homes. These patients also have longer lengths of stay than average admissions

- Partnership with the care home sector is therefore critical to reducing demand for acute services
- We will further develop our care home liaison service, introduce “trusted assessors” and upskill staff in care homes in assessments in practical skills to manage residents with higher medical problems
- Our aim is that this will result in fewer admissions from care homes into hospital, more proactive management of length of stay and less people automatically placed in care homes

3. Urgent and Emergency Care Centre

- The Urgent and Emergency Care Centre will be complete by Spring 2017 and open by July 2017
- It will be Rotherham’s 24/7 single point of access and triage for urgent cases
- It will use an innovative multi-disciplinary approach to reduce waiting times, support patient flow through the hospital and improve patient experience
- We will pioneer an innovative ‘next available clinician staffing model’ which integrates GPs, ED consultants and highly trained nurses
- It will also accommodate Social Workers, Mental Health Teams and Care Co-Ordination Teams
- It is expected to reduce emergency admissions savings over £30M over 10 years
- The aim is for patients to be assessed and possibly treated within 20 minutes if you are an adult or 15 minutes if you are a child
- Expanding our Adult Mental Health Liaison Service
    - In April 2015, as part of our wider Mental Health Services Transformation Plan, we launched the Rotherham Mental Health Liaison Service to provide round the clock mental health care to patients who attend Rotherham Hospital
    - We aim to expand access to this Service to improve the outcomes and experience of people experiencing a mental health crisis and to improve access, reduce waiting times, admissions, re-admissions and lengths of stay, reduce use of acute beds by patients with dementia and enhance the knowledge and skills of hospital

4. 24/7 Care Co-Ordination Centre

- The CCC has been in place for 18 months and currently takes 4,000 calls a month 24/7
- Its aim is to act as a central point of access for health professionals and patients into community and hospital based Urgent Care Services
- Our aim is to expand the scope of the CCC to include mental health, voluntary and social care sector services, improving access for patients through a comprehensive directory of services, driving efficiency and cutting down waste
- The purpose is to manage system capacity, carry out initial assessment and deploy appropriate teams to provide support, avoid

potential hospital admissions and ensure people are in the most appropriate care setting

5. Specialist Re-ablement Centre

- We want to develop a more integrated approach to the provision of intermediate care services for those patients who cannot be treated at home but do not need to be treated in a hospital setting
- Our aspiration is to locate all rehabilitation services on a single, co-located, non-acute setting to create an environment that supports integrated working
- A fully integrated team of health and social care professionals will provide a mix of community rehabilitation services, residential intermediate care and the current discharge to assess beds for people living in the community and for people leaving a hospital setting
- This model will allow Rotherham people to remain in their community longer than would otherwise be possible
- We anticipate the Re-ablement Centre will be more cost efficient through better deployment of professionals and teams and supporting and integrated multi-disciplinary way of working

Enablers

- We will
  - Make good use of our public buildings and resources
  - Make better use of technology. We are planning a major upgrade to the way we all communicate with services, healthcare professionals and patients
  - Working together and sharing information will become the norm
  - Encourage everyone to use technology to care for themselves and manage their own wellbeing

Expected Benefits and required Investment
Priority 1

- 'Making Every Contact Count' could show a return of £10 per £1 spent - £1.8M per annum
- Expected savings for households and employers up to £28 per £1 spent - £1.1M per annum
- Social prescribing evaluation shows improved outcomes for patients and system benefits of £1.98 for each £1 invested - £45K for VAR website and £25K for VAR Health Champions

Priority 2

- Improved patient outcomes and proactive management of care – one-off funding of £1.5M
- Reduced utilisation of secondary services - £1.25 per annum to trial new staffing models in Primary Care and to fund transformational support
- Reduction in non-elective bed days by 10,000 (estimated £1.5M saving per annum

- Management of high acuity patients in care home sector - £0.6M for appropriate equipment and training in the care home sector

Priority 3
- Investment to go further and faster in developing the model and to support the realisation of £30M system savings over 10 years - £0.45M for new capital guild and transformation investment
- Investment in integrated liaison service for people with dementia could show a return of investment of £4 for every £1 invested

Priority 4
- Formal evaluation shows at least £0.86 additional system-wide efficiencies
- Further integration of Health and Social Care Services - £0.46M non-recurrent infrastructure costs

Priority 5
- Transition to new staffing and skill mix model of care and enhance clinical and caring environment
- Transition of long stay residents from existing provision into care home provision
- Evidence from Plymouth's review of re-ablement services achieving financial objective of £500K savings in the first year - £3M per annum

High Level Implementation Plan
Priority 1
- Evaluate Mental Health Social Prescribing – April 2016-March 2017
- Increase target from 5% to 10% of patients at risk of hospitalisation – April, 2017-March, 2018
- All key statutory organisations signed up to MECC and first cohort of front line staff trained – April, 2017-March, 2018

Priority 2
- Implement integrated locality pilot and final evaluation – April 2016-March, 2017
- Roll out integrated locality model across Rotherham – March, 2017-March 2018

Priority 3
- Scope and plan expansion to Health and Social Care Services
- Evaluate upscaled service

Priority 4
- Completion of the capital build for Urgent and Emergency Care Centre
- Full implementation of the model of working
- External evaluation of the Adult Mental Liaison Service

Priority 5
- Full implementation of the Rapid Response Service
- Full review of acute and community respiratory pathway
- Development of the re-ablement hub

Work still to do
- Overall governance structure
- Finance
- Agreement through partner governance arrangements
- Alignment to wider STP Plan and workstreams
- Finalisation of illustration and infographics

Timescales
- 21st September Health and Wellbeing Board
- 22nd September Health Select Commission
- 27th September – Final completion of illustration and interactive storyboard
- End September/Early October CCG GP Members Committee, RMBC Senior Leadership Team, TRFT Board RDaSH Board Development Session, CCG Governing Body, VAR Board
- Mid-October Rotherham Integrated Place Plan finalised and signed off by partners
- 21st October ST submission to NHS England

Discussion ensued with the following issues raised/highlighted:-

- The use of the term "efficiency challenges" in a public facing document may indicate that services were not being efficient and that it should be quite easy to take out a few things and would not mean cutting any services which could mislead the public. However, it was noted that from a Health perspective, nationally Health had had Growth money. The efficiency challenge in this context was about the growth of demand being higher than the growth in money. Health funding had increased but the pressures were increasing more and that was the efficiency challenge

- Why was the decision made to consult with GPs because it was felt they were best placed to know what patients needed and wanted? - Patients struggled to get a GP appointment and sometimes it was a telephone call - The principles of Clinical Commissioning Groups when they were originally formed by the Government was that they felt that GPs were well placed because they saw so many patients on a weekly basis. In Rotherham GPs had been visited in their localities with details of what the Plan may look like as well as engagement with Patient Participation Groups.

- The Plan had been discussed at the recent meeting of the Health and Wellbeing Board where there had been concern expressed about the lack of consultation with Elected Members, GPs and Healthwatch

Rotherham – Due the pace that the Sustainability and Transformation Plan (STP) had had to be developed and was still under development with a further submission to NHS England on 21st October, there had been concern nationally that there had been no opportunity to consult with citizens. Therefore, guidance was to be issued on the next steps. However, the focus today was on the Rotherham Place Plan which formed part of the overall STP

- Due to the national concern regarding the lack of consultation, Rotherham was very keen to ensure that members of the public were involved in shaping the Place Plan. It was important to note that it was still in draft so comments were very much appreciated

- How would the overstretched staff have time to talk about sensitive issues such as alcohol use, healthy eating habits etc.? - It would be a judgement call from the professionals as to whether it was the right time and opportunity to have those discussions. The training element, which would be dependent upon funding, would also ascertain whether and how that could be rolled out in a more consistent fashion

- Were we in danger of setting the public's expectations too high and therefore more complaints? - People were already complaining that things were rushed and did not have enough time to spend with a professional. The emphasis around this item was self-management and self-care and people taking a degree of responsibility for their own lifestyle and lifestyle choices. It was hoped that it would be light touch support where people could access and make informed decisions about what was the right thing for them

- Given that Rotherham had massive levels of inequalities in health increasing numbers of people having to access foodbanks, homelessness, increasing levels of poverty etc. how were we realistically going to support people having healthy lifestyles when they did not have the income to make healthy choices? - This was where the link with the wider priorities for the Borough would come into play. There was a lot of activity around Welfare Reform, food poverty, advice services etc. which were being looked at currently in the Council. Early Help Services was very much about trying to bring in support for families and individuals to address those issues. Some of the wider society issues were beyond Rotherham but we had to try and support people where possible to access things such as foodbanks if that was what they needed but also to work with foodbanks to look at what food they were distributing

- It seems that it was relying too much on the public making the right decisions. A lot of people would think that they paid enough taxes when they bought alcohol and cigarettes so why should they not do what they wanted and have a takeaway every night? – It was about people making informed choices and not professionals mandating what people should do

- At the moment the Plan was not saying new staff but it was about bringing together the existing staff in the localities. There were bigger concerns in terms of the national cuts in Public Health and the serious impact on Rotherham services

- When would the outcome of the STP bid be known? – The Place Plan was part of the STP and would be submitted on 21st October. It was not clear from any information received nationally when it would be known if there was any additional funding and for what purpose it had been determined for

- It was difficult to understand in the Plan what was already provided and what would be additional if there was additional funding. It gave the impression that the 5 priorities were in place and not aspirational – The feedback was appreciated and it would be made clearer in the document

- Was there up-to-date information on levels about obesity, specific age groups etc.? - Public Health data was 1 of Rotherham's strategic data sources

- What were the other 6 localities – They had not been identified as yet and were part of the next stage. All partners worked on a slightly different geographic footprint so have to make sure it worked across the piste but it was hoped to cover the whole Borough. The basic idea currently was that they would be based on 7 key GP surgeries

- Would they be the bigger GP practices? - It had not got to that stage as yet. It was important that when the detailed plans came back that they were submitted to the Commission. The STP, once signed off, would be governed by the Health and Wellbeing Board so there would be a lot more input

- Some care homes did not have the expertise to know when a resident should be admitted to hospital - There was recognition that NHS staff could be more proactive in supporting some of the care homes; Rotherham Hospital was keen to do that. Some Homes had really experienced nursing staff but there was a need to ensure there was consistency. The aim was to support care homes to look after residents in the Home for as long as possible. There would be a time when a resident needed to go into hospital but it was felt that if health professionals worked with the independent sector care homes, upskill the staff, it could prevent that level of admissions

- What was the incentive for care homes to take on the extra responsibility? - The incentive, from a purely business perspective, was the much better fee rate for a nursing home than a residential home and potentially more income for the Home. It was not anything that would you not expect in terms of good quality nursing provision

but what was being recognised was the need for care homes to be more part of the overall system rather than "islands bringing in a team of professionals to support the sector where it was required. There was also a need to stimulate homes that had deregistered and become residential homes to go back to offering nursing beds. There was not a great deal of nursing provision in Rotherham

- As a nursing home with nursing staff what was the incentive not to ring 999 because it would be easier? – A lot would be around the Home's appetite for risk. There would be Homes that decided their risk factor was lower threshold than others but Homes would be encouraged to be more proactive

- Reassurance for residents and their families that the care they were getting in the Home was appropriate and that no more could have been given by admittance to hospital. If a relative died whilst in hospital you would be reassured that everything had been done possible whereas if they were still in the residential home you might always be left with some doubt – The focus was primarily on nursing homes but the care home service covered both residential and nursing so the principles of staff going in and supporting applied to both

- If there were not going to be the throughput of nurses due to the proposed change in the bursary system and talking about upskilling care workers what incentive was there? - If doing more skilled work, employees would want more money and that had to be taken through with the care sector

- Would companies that ran the care homes be approached to facilitate secondments and pay for the training? It was part of the approach to try and give people opportunities in the independent sector to have experience in a NHS setting and vice versa

- There would always be a higher figure of admissions to hospital due to the cohort of care homes i.e. frail elderly people more susceptible to fall, pneumonia etc. – It was accepted that there would always be a higher level of admissions but it was what could be done as a whole system to try and reduce that

- What would happen to the existing Walk in Centre building? - As a building it would remain and there would still be some elements of health care provided from it e.g. diagnostic and screening. From a funding perspective it was still the responsibility of the CCG. Part of the Locality Plan was to work out where patients and citizens would like to see services delivered from. The building and costing of it was part of the development of Locality Services and getting care much closer to where people wanted it to be

- Was A&E not already a 24/7 single point of access or was the Care Co-ordination Centre to replace A&E? - A&E was 24/7 but the Care Co-ordination Centre was 24/7 for Primary and Secondary Acute care. It was developed from various parts of the system such as Out of Hours, Walk in Centre, and trying to create 24/7 primary and secondary care service in 1 place. It was not replacing but enhancing what was on offer so the right people could go to the right place

- The target was that patients would be assessed and possibly treated within 20 minutes and 15 minutes if a child. How confident are you that those aims could be met? - We are confident. It was all about the demand on the workforce and, based on the assessment and estimates as a result of the audits conducted, there was confidence that the targets would be met. There had been an independent review from the Emergency Intensive Support Team of Clinicians who had visited twice reviewed the staffing structures based on rotas and the services to be provided

- Had the winter period been factored into the plan? - The workforce plan took into account all the different pressures because of the ability to actually call upon more resources. Nothing had been cut in the budget at all. The staffing structure was about getting the right people in at the right level

- How would you respond if the aim was not met? - The best and only way would be to say this was what was happening, look at what was happening and gain an understanding quickly. Rotherham was a national trailblazer on this initiative with only 1 other area with something similar

- If a person could not get a GP appointment then they would go to the hospital. Was it not thought that the increase in demand would be a real issue? - It had been considered and part of the assessment would possibly be to say to people you actually need a GP appointment or go to the hospital pharmacy. GPs from the CCG worked with the Centre and were willing to see how they could make slots available on a daily basis. It was something that had been thought about but local GPs would need to be part of that service and people would be diverted back

- GPs had agreed in their local practice to make slots available for those that turn up at the hospital and need appointments? – We need to see what happens and felt that had been resourced appropriately. GPs within the CCG were looking at how to feed that back to their colleagues. Part of it was giving them evidence from other areas where the expected increase in demand had not come through

- The lack of mid-level practitioners in Rotherham in the audits and how Rotherham could not attract those people? - The general trend was when students had gone through medical school and once completed

their training, a large proportion wanted to be attached to the bigger teaching hospital and, therefore, fewer doctors available after those selections made. This was a national picture

- Had extra parking spaces been provided? The hospital had built more spaces than were available at the existing WIC

- There was an unaffordable growth in demand in mental health admissions – every admission cost approximately £2,000. The additional funding from the CCG (£1M for the service) had been used to try and dampen down that growth At the end of the evaluation the question would be was there still the high level of growth despite the £1M additional funding. The aim was to get a more successful service for the patients first and then one that would not cost as much money

- Did the expanding Adult Mental Health Liaison Service rely on the voluntary sector at all? – Not with the £1M, however, social prescribing was working very well in Rotherham and had been expanded to include the voluntary sector for mental health. It would be expected to see a connection of those in the service to hopefully some of the voluntary sector aspects

- In relation to Dementia care and trying to reduce the amount of acute beds that were being used, the voluntary sector had been hit by the current economic climate. Dementia Action Alliance was to lose their co-ordinator post from November so there should be caution if relying on some support from the voluntary sector without knowing what the capacity would be – Part of the pilot for the social prescribing of mental health was to assess what could help the patients and prevent them from being admitted to hospital and how could the funding from the CCG as part of the pilot to VAR help groups bid for more funding

- What type of illnesses, disabilities would the Specialist Reablement Centre deal with? - This would cover quite a range of things but would not replicate Breathing Spaces. It would be for those with long term conditions where it was possible that with some intensive support they could be reabled

- Would the staff be skilled to deal with a possible relapse or would it mean a re-admittance to hospital? - It was very much an aspiration at the moment

- Were you confident that there were the skills to commission what you wanted with regard to new technology? - In terms of effective commissioning we have to work with the market and experts

- Was rehabilitation the same as re-abling? Reablement tended to be a very short period – 6 weeks of intensive support to get people back on their feet whereas rehabilitation did not necessarily have a timescale on it

- Disappointment that the plan appeared to support those that already accessed and engaged with services; the Plan did not address the health inequalities which would be growing over the next 10 years with the cuts in welfare and public services generally – The Plan was reactive other than the preventative Public Health issues. The primary purpose of the Plan was to keep people out of hospital. In terms of health inequalities, that was part of the wider proposals of Marmot and Public Health activity but should be mindful that Services the Plan was talking about were universal service which should be accessible to everybody; if there were issues about people not being able to access they needed to be considered and factored in. It was very much a high level plan

- Concern about using technology - Technology would not be the sole answer but would be more about the additionality it could bring and some of the additional benefits of using it

- Liquid Logic should provide staff with a lot of benefits in terms of sharing and accessing data which was due to be introduced in Adult Social Care in December

- The main thrust of the STP was to reduce the number of acute hospital admissions

Resolved:- (1) That the following issues be fed back:-

Issue around language and being very clear with the public about what was happening and explaining what was really meant by efficiency challenge and whether that equated to cuts or managing growth in demand;

Concerns about time to fit in Making Every Contact Counts activity;

Overall for the Plan to be realistic in what could be achieved and separation between the actual and the aspirational and what would be taken forward if drawing down the additional funding;

Concerns about reaching those who were more remote and most in need of services i.e. addressing health inequalities;

How localities would be determined around the GP practices;

Request for data about what was happening with the changes that were being brought in care homes with the upskilling of staff and the impact this would have on hospital admissions;

Concerns raised about getting the care homes on board to support moving that work forward;

Clarity about when talking about nursing and residential care homes;

Reassurance on the level of care provided would be critical for patients and family members with the project of upskilling of staff

National shortage of nurses and the impact that had across the wider workforce;

Reassurance for the public that the A&E times would be feasible and not over raising expectations;

Members wanted to see a more detailed Plan at some point and greater clarity when available across some of the higher level outcomes.

(2) It was noted that an All Member Seminar was to be held on 13th October on Sustainability and Transformation Plan.

32. COMMISSIONERS WORKING TOGETHER PROGRAMME

Janet Spurling, Scrutiny Officer, reported on the above Programme.

There were a number of workstreams in the programme with options for substantial changes to Hyper Acute Stroke Care and non-specialised Children's Surgery and Anaesthesia being consulted on in the Autumn.

The report and appendices provided an overview of the work already undertaken and the development of operations appraisals for both Services which included:-

Stroke Care

- Hyper Acute (first 72 hours) – would be in one of the proposed centres (Doncaster, Sheffield or Chesterfield)
- Acute – would be in patient's local hospital once well enough to transfer
- Rehabilitation – local sites

Hyper Acute Stroke Care

- Recognised minimum number of patients per annum – 600
- Rotherham Hospital – 482
- Barnsley – 554
- Chesterfield 586
- Doncaster – 677
- Sheffield – 1,009

Children's Surgery – 6 sub-specialities
- Ear, Nose and Throat (ENT)
- Trauma and Orthopaedics (T&O)
- General Surgery
- Opthalmology
- Urology
- Oral

Children's Surgery – Patient Numbers for Rotherham Hospital 2014/15

	No Stay	Elective in-patient	Non-elective
ENT	214	96	71
T&O	109	26	238
General Surgery	56	5	294
Opthalmogy	71	6	5
Urology	70	0	10
Oral	446	5	94

Model for the 6 sub-specialities
Surgery Tiers
- Tier 1 Day case
- Tier 2 Elective in-patient/non-elective in-patient – where most of the changes were proposed
- Tier 3 Tertiary

Discussion ensued with the following issues raised/highlighted:-

Hyper Acute Stroke Units
- The first hour was the most important part of a stroke. A paramedic had to try and assess whether it was a bleed or a blockage and that was very important in how to begin to treat a patient. It would be more onerous for Rotherham patients if they had to travel further afield

- 45 minutes travel time did not give much time once arrived at hospital for assessment and treatment – this did not include the waiting time for the ambulance to arrive

- Concern that the ambulance crews would have the skills to be able to make that diagnosis to carry out the appropriate treatment (bleed v blockage) and have the equipment in place

- National shortage of skilled staff and the importance of maintaining those skills through the volume of patients seen each year in line with recognised minimum numbers. Both Rotherham and Barnsley Hospital had vacancies for senior staff with the requisite skills

- The need for statistics or data for assessing the outcomes for people admitted to Rotherham and Barnsley versus admittance to Sheffield and Doncaster in terms of survival rate etc?

- Did Sheffield and Doncaster have the capacity to take additional patients in terms of bed availability?

- Importance of assessment process for clots and the time. Not everyone was suitable for the assessment but staff had to have had training to carry it out

- The hour was based on how long it took an ambulance to arrive – the proposal should be looked at in conjunction with ambulance response times

- Travel time to Sheffield Hallamshire Hospital taking into consideration peak hour traffic

- Would it be better/less risky for patients to stay longer at the centres with HASU for their acute care rather than transferring

- Possibility of bed blocking pressure if people had to stay longer

- The Rotherham Place Plan's aim was to see patients within 20 minutes in the Emergency Centre – would it not be better/safer for patients to be seen at Rotherham?

- Would any Rotherham patients be taken to Chesterfield?

- Adequacy of public transport infrastructure for patients' families from Rotherham to Sheffield and Doncaster

- Ensuring staff with appropriate skills for quality care at all 3 phases – hyper, acute and rehab

- Consideration to the scheduling of post and pre-op appointments and prioritisation for families who had to travel further to take account of work, travel time etc.

Children's Surgery and Anaesthesia

- Travel for families and carers to visit inpatients and the effect this may have on other family members and those in paid employment

- Would treatment be based on proximity to where people lived or the sub-speciality?

- Would the changes have an impact on waiting times for electives?

- How the consultation question was worded with regard to "preparedness to travel" – parents would naturally say they were prepared to travel anywhere to ensure the best care/treatment for their child

- Adequacy of public transport for patients and visitors

- Would there be a staff drain from Rotherham Hospital?

- Would the removal of services from Rotherham Hospital put the sustainability of the Hospital at risk?

- Difference in the wording contained with the overview appendix and the consultation document with regard to "willingness to travel for right care" as opposed to specialist care"

- Need for the outcomes of patient satisfaction surveys to enable them to make an informed decision

- Would the 3 hospitals specialise in different sub-specialities or would they all provide all 6?

- Where would front line services for Rotherham actually start?

Resolved:- (1) That the work undertaken to date by the Joint Health Overview and Scrutiny Committee be noted.

(2) That with regard to Hyper Acute Stroke Units more information be provided on:-

– The same model successfully implemented in other areas (best practice)/other areas of health care e.g. coronary with regional specialist units

– Comparative data on performance of the 5 HASUs with regards to positive outcomes for stroke patients c/f SSNAP and other performance data

– The current rating of the Rotherham Foundation Trust and the HASU and up-to-date statistics on performance

– How had the first 72 hours been determined as the key period – was this a critical period for the likelihood of a further stroke or for monitoring?

– What was the incidence of patients having a relapse/further stroke shortly after the initial 72 hour period

33. HEALTH SELECT COMMISSION WORK PROGRAMME

Janet Spurling, Scrutiny Advisor, presented the final draft of the 2016/17 work programme for the Select Commission.

The proposed work programme helped to achieve corporate policies by addressing key policy and performance agendas, aligned to the priorities in the Corporate Plan with a clear focus on adding value.

It was agreed that the planning and prioritisation meeting in July 2016 that an underlying theme would be to ask questions regarding addressing health inequalities. A further consideration was the importance of meaningful public consultation and involvement of Service users, customers, patients and families/carers in Service transformation.

Priorities would be the major transformational projects which were interlinked:-

- Sustainability and Transformation Plan including the Rotherham Place Plan
- Health and Social Care Integration (continuing from 2015/16)
- Adult Social Care Development Programme
- Mental Health transformation (all ages)

Within these major projects specific issues/Services were identified including:-

- Learning Disability
- Carers
- Older people's housing

It was the intention that the majority of the work would be conducted through the full membership during scheduled agendas. Witnesses would be required to submit information two weeks prior to the meetings in order to allow time for full preparation in advance.

Resolved:- (1) That the draft work programme for the 2016/17 Municipal Year be approved.

(2) 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.

34. HEALTH AND WELLBEING BOARD

The minutes of the Health and Wellbeing Board held on 13th July, 2016, be noted.

It was noted that with regard to Minute No. 17 (Rotherham Local Digital Roadmap), the Select Commission wished to be informed if the assessment had been completed and what were the associated finances.

Additional information provided after the meeting:-

None of the CCGs in Yorkshire and Humber have had formal feedback on their Local Digital Roadmap as yet or further information on applications for funding. Requirements for interoperability had changed and it was expected that further work would be needed but no further detail had emerged.

35. QUARTERLY MEETING WITH HEALTH PARTNERS

The minutes of the meeting between the Select Commission and Health partners held on 12th July, 2016, were noted.

36. IMPROVING LIVES SELECT COMMISSION UPDATE

Councillor Cusworth gave the following update from the meeting held on 21st September on health related issues:-

- Lifestyle Survey – the number of young people identifying themselves as having an illness or disability
- Annual report of the Local Safeguarding Children's Board – dental and health assessments of Looked After Children to be monitored by the Corporate Parenting Panel but uptake for both was improving
- Audit of paediatric assessments May 2015 as delays had been experienced by Social Workers with regard to children experiencing physical abuse and neglect. Re-audit had not yet been carried out
- Domestic abuse – experienced in households with children and by children themselves

37. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised.

38. DATE OF FUTURE MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 27th October, 2016, commencing at 3.00 p.m.