HEALTH SELECT COMMISSION
21st September, 2017

Present:- Councillor Evans (in the Chair); Councillors Andrews, R. Elliott, Jarvis, Marriott, Rushforth, Short, Whysall, Williams and Sansome.

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

Apologies for absence were received from The Mayor (Councillor Eve Rose Keenan) and Councillor Bird.

24. DECLARATIONS OF INTEREST

There were no Declarations of Interest.

25. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

26. COMMUNICATIONS

1. An information pack had been circulated separately, including:-

   RDaSH Child and Adolescent Mental Health Services (CAMHS) Performance Report – the Health Select Commission (HSC) would be having an update on CAMHS in October and this might help to inform Members' key lines of enquiry
   Social Prescribing overview
   Health and Wellbeing Board minutes from July

2. Schools Mental Health pilot evaluation event on Wednesday 25th October – the Chair asked if one of the Members who had been involved in the monitoring visits to the schools would be available to attend the event to represent the Select Commission

   After the meeting it was confirmed that Cllr Marriott would attend.

3. An early date to note for diaries was a two part event facilitated by the LGA on health prevention, with all Select Commission Members encouraged to attend. The sessions would be on 23rd and 30th November. More detail would follow but it was noted that useful Ward profiles would be available

27. MINUTES OF THE PREVIOUS MEETING HELD ON 20TH JULY, 2017

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 20th July, 2017.

Arising from Minute No.16 Membership of the Health, Safety and Welfare Panel 2017/18, it was noted that there was still a vacancy for a Member from HSC. Expressions of interest were requested.

Arising from Minute No. 17 (Adult Social Care Provisional Year End Performance 2016/17), follow up information for performance measure No.14 (permanent admissions to residential care of people aged 18-64) on sub-cohorts by age and service user group had been included in the agenda pack.

Arising from Minute No. 19 (Health Select Commission Work Programme), it was noted that the item on the refresh of the Health and Wellbeing Strategy had been postponed to November but there was still a good opportunity for the Select Commission to be involved at an early stage.

Arising from Minute No. 21 (Healthwatch Rotherham), Councillor Roche confirmed that the Autism Partnership Board had met on 20th July, work on the Autism Strategy was underway and an officer had recently been appointed who had been involved in developing the national Autism Strategy.

Resolved:- That the minutes of the previous meeting, held on 20th July, 2017, be approved as a correct record.

28. TRANSFORMATION INITIATIVES - CARE CO-ORDINATION CENTRE AND INTEGRATED RAPID RESPONSE

Dominic Blaydon, The Rotherham Foundation Trust (TRFT), presented a briefing paper to update the Health Select Commission on progress in relation to further development of the Care Co-ordination Centre (CCC) and Integrated Rapid Response (IRR) services currently provided by TRFT. The ambition within the Rotherham Place Plan was to extend both services to include mental health and social care, providing a multi-disciplinary approach to address the whole needs of the service user, resulting in an improved experience and more effective use of resource.

The role of the Care Co-ordination Centre, which was developed about five years ago, was to provide a telephone based nurse-led approach providing advice to health professionals on the correct care pathway for patients in urgent need. This could be through a district nurse, community physician or a referral to intermediate care. It was intended to address the high number of GP initiated hospital admissions and to act as a portal to community health to see whether they were able to support a patient rather than them going to hospital. It has been very successful, for example reducing GP referrals to the Medical Assessment Unit by around 20%.

A phased approach was being taken to implementation to realise benefits within the available resource and to manage risk. The first phase was to include urgent mental health referrals; work on this had commenced and from a local authority perspective was quite straight forward. Then they would be looking at linking up with RMBC and the work that they were doing on social care referrals, for people in crisis or with a high level of need.

The Integrated Rapid Response Service, formerly known as both the Fast Response Service and as the Community Assessment Rehabilitation and Treatment Scheme (CARATS), was commissioned to provide short term care packages at home for people at risk of hospital admission. It could also be used to expedite hospital discharges of vulnerable patients who no longer had a medical need and to prevent hospital re-admissions, and was working well. Instead of a patient being admitted to hospital because they were not safe at home, the IRR service went in and provided wrap around care, followed by a handover to Community Health after 72 hours.

The Service works alongside the CCC and the intention was also to extend IRR to include Mental Health and Social Care needs by working with the local authority, to provide time limited re-ablement for people experiencing a short term crisis. This would lead to a more holistic approach to care to support people with a greater level of need or more complex needs and would address any safety issues arising from providing a more one dimensional service.

Partners were also considering how IRR would link in with the integrated locality. The thinking was that urgent on the day care could be transferred to IRR, thus freeing up integrated locality workers to carry out the planned work with people with long term conditions and to be more proactive. Phase 1 of the Rapid Response Service would be co-location prior to full integration in phase 2.

The following issues were highlighted/discussed:-

- Patients calling the CCC directly and how long they might wait to speak with someone – At present the CCC was only accessed by health professionals not patients, mainly when there were working with someone and wanted information about care pathways. There had been discussion regarding expansion to specific groups of patients being able to make direct contact with the CCC. More broadly, how and where people access the NHS was almost a separate workstream.

  Under RDaSH's old structure, patients would contact each business division, which were set up and resourced differently, including different service hours. Then overnight calls went to clinical staff at one central contact point and if clinical staff were busy then they did have to wait. Under the new CCC arrangements the initial point of contact would be staffed by

administrative staff 24:7 who then passed on the record to the right people; this was a significant improvement.

- Amber risk regarding GPs, what were the issues and were there contingency plans to prevent this becoming red? – There was an issue around how the CCC fitted in with the sepsis care pathway they were trying to resolve. More generally GPs feared that a reconfiguration of the CCC would mean its existing functions were compromised by the changes as it was such a good service for GPs in providing advice about current care. A fuller response would follow.

  It was highlighted that from the RDaSH perspective it was a very phased implementation to help manage risk, so initially the administrators would just be working on mental health and then other RDaSH services would be gradually introduced, to help manage that, both for patients and for the existing service.

Resolved:-

That the Health Select Commission note the update.

29. RDASH ROTHERHAM CARE GROUP TRANSFORMATION PLAN - UPDATE

Steph Watt and Matt Pollard presented an update on the RDaSH Adult Mental Health transformation activity, as outlined to the Commission in Summer 2016.

Members were reminded of the key issues that had emerged from consultation with stakeholders, which had been drivers for the reconfiguration. In particular, care closer to home, “telling it once”, better access to health and not being bounced between services due to issues within the organisational structure had been raised by patients and carers

RDaSH had now moved from age related, cross-Trust business divisions to place based locality Care Groups. The Rotherham Care Group was comprised of Adult and Older People’s Mental Health Services, Learning Disability Services and Drug and Alcohol Services. A recovery and wellbeing ethos underpinned the services with care wrapping around the patient through multi-disciplinary teams and a new pathway framework. The new structure was based around two localities, north and south, although smaller specialist services, such as young onset dementia, continued to be borough-wide. A “deep dive” into access to front door services was also planned.

The Trust had also considered how IT would support the new structure and a new patient record system (PRS) would be introduced from April 2018 to be more streamlined and effective. Information governance was an important issue for mental health and processes were in development.

RDaSH were working with TRFT on Electronic Patient Records (EPR) to help with information sharing across physical health and social care, supported through funding from the Better Care Fund (BCF).

It was hoped to extend the two social prescribing pilots with the voluntary and community sector to "front door" work. Discussions were taking place with The Samaritans regarding work with people needing support but who did not necessarily meet statutory service requirements, again through the BCF.

The new management team was in place and work is underway on estates to move teams into the localities – on an interim basis initially, with a view to future co-location with health and social care, generating economies of scale and efficiencies as well as benefits for patients.

A phased roll out of the new pathways was commencing with brief interventions initially - prevention and stopping deterioration. RDaSH would be working proactively with TRFT and RMBC on the Integrated Rapid Response service mentioned above.

Benefits for patients would be a better experience through care closer to home, improved access and a more unified structure. There were also efficiencies, firstly from the management restructure and the PRS, plus an admin review was taking place. Efficiencies had been looked at from back office functions rather than clinical teams.

More integrated working had many positives but changes did bring about anxieties and the trust was continuing to work closely with stakeholders and patients.

Discussion ensued with the following issues raised/highlighted:-

- Patient records kept and stored in paper files, including off-site, and practical issues and timescales for moving fully to EPRS – Services were trying to be "paper-light" but there would still be a need to archive paper records for a period of time. To follow up with a written response.

  The development of the Rotherham Care Record would enable information sharing across partners when they were directly involved in patient care, including Primary Care and Social Care. This would enable services to see what care a patient was receiving and also patients who were in hospital, which linked back to the CCC and IRR service and who they could support. The strategic intent was there within the appropriate information governance arrangements for each organisation to develop this to improve patient care.

The local Accountable Care System came under the auspices of the Health and Wellbeing Board and there had been discussions about the development of the common record with Adult Social Care fully involved and willing to share information as appropriate to improve care.

- Would the economies of scale mentioned have an impact on clinical face-to-face provision over time? - A staff skills review was under way and there may be changes but no intention to reduce front-line staffing but rather to improve the quality of the service. The other areas mentioned had been looked at first in terms of efficiencies.

- Would there be an increase in generic working or was the intention to retain all the specialisms? – The intention was for staff integration into teams to avoid the "patient hand offs" referred to, but there were specialist skills within the teams that need to be retained. So although there might be a generic front point of access and a generic process for people to work through, there would still be specialist workers who could deal with individual service user/patient's needs.

- Dovetailing RDaSH's two localities with other different locality models and the distribution of resources aligned to need – RDaSH had started with two localities as they needed to change but they were working really closely with TRFT and RMBC around how services would be delivered and managed in the community going forward. They were very aware of other plans and would map in the RDaSH services and where possible co-locate as this would bring so many benefits.

  A piece of work had been undertaken mapping demand for RDaSH services which had shown extra demand in the smaller north locality, so they were looking at mapping staff/team volumes for localities and overlaying these with demands from other services or placed on other services from outside RDaSH.

- More information on the RUST project, such as uptake and how to access – It was early days still so more information would be provided in November. This work had already been taking place at Rotherham United through Sport England funding. RDaSH made contact with them at a social prescribing event and the activity they were doing had developed and was now underpinned by professionally trained workers providing some additional support.

Resolved:-

(1) That the Health Select Commission note the update.

(2) That the Health Select Commission receive a more detailed update on the pathway framework at the meeting in November 2017.

30. DELAYED TRANSFERS OF CARE

Ian Atkinson, Rotherham CCG introduced an update on progress with regard to reducing Delayed Transfer of Care (DTOC) at TRFT. As with the other workstreams discussed this was again very much a partnership approach.

NHS England defined patients as ready to transfer out of the hospital setting when:

a) A clinical decision had been made that the patient was ready for transfer

AND

b) A multi-disciplinary team decision had been made that the patient was ready for transfer

AND

c) The patient was safe to discharge/transfer.

Delays in discharge could be linked to a number of different reasons; common areas of delay related to patients waiting for assessment and decision regarding Continuing Care, patients waiting for care packages to be established in the community or awaiting a care home package.

One of the four national conditions set out in the 2017 Better Care Fund planning guidance required health and social care systems to work jointly to reduce DTOC to a level of no more than 3.5% of patients at any one time being classified as DTOC within the hospital setting (equates to an average 15 patients at any one time).

Historically Rotherham health and care community had performed well on DTOC, consistently delivering below the 3.5% target. However throughout 2017 (although comparable to many other areas of the country) TRFT had reported a more challenged position.

In terms of numbers, on average the hospital had 400 beds for patients daily. 83 people per day were discharged from Acute Care, so 3.5% meant around 10 patients being delayed and 5.5%-6% was approximately 24/25 patients classed as being delayed for discharge.

DTOC had had a raised national profile recently and although Rotherham was not a significant outlier; it was a key performance indicator and was at the heart of three main indicators in the Improved Better Care Fund that needed to improve upon. In response partners commissioned an external review undertaken by the Local Government Association and a peer NHS Foundation Trust. This provided an objective view of how flows of

patients, assessment processes were managed and the capacity going forward.

Flow back end of patients out of hospital and bed availability also impacted on A&E performance. Therefore the multi-agency A&E Delivery Board had agreed and was overseeing the Rotherham DTOC action plan based on the recommendations from the review. Key points that partners wanted to challenge themselves on before the onset of winter pressures were highlighted in red in the action plan.

Key issues in the improvement challenge were:-

- integration of the discharge teams (Health and Hospital based Social Work Team) in terms of teams going and providing support around the patient and the family to expedite care out of the hospital
- data and information joined up by using similar data sets e.g. for the stop/start time for the assessment process
- discharging patients home first when it was medically safe to do so then the full assessment

Integrated Better Care Fund (IBCF) funding would help with these issues and the winter pressures, to assist with winter capacity and winter planning, with a good amount of transformation money to work across the system. A report on the IBCF was discussed at Health and Wellbeing Board on 20th September outlining the extra initiatives. The key was bringing those people involved in discharge together in a more coherent way in what was a high pressure environment. The intention was to bring in some jointly funded posts (TRFT and RMBC) to project manage the DTOC pathway and to look at different initiatives to improve practice. Rotherham could also benefit from sharing the learning from colleagues in Sheffield who had really struggled with DTOC so had invested in workforce and organisational development which partners were looking to do in Rotherham.

For patients DTOC was an emotive subject and the CCG had worked with Patient Participation Groups (PPGs) who raised other issues for consideration such as patient flow in the hospital and prescribing on discharge.

Re-ablement capacity was also being looked at as if people quickly accessed rehabilitative services there were benefits in terms of people's independence and moving through the system faster in addition to financial benefits.

The importance of the voluntary and community sector in the plan was emphasised, with £90,000 to be invested in Age UK's really successful Back to Home pilot which was limited to a small number of wards at present.

The following issues and questions were raised by Members:-

- Was there a time limit to get professionals together in order to move patients out more quickly and free up beds? – No target at this juncture but a commitment at multi-disciplinary team meetings to support discharge. As yet more co-ordination was needed.

- Reasons for the spike in March? – Although overall it was still small numbers it did have a ripple effect in the hospital and following winter there had been real reduction in system pressures.

- Information from care homes on their services and bed capacity to help people move out of hospital – The empty beds register was updated weekly. Patient choice of care home could lead to delay if there was no current availability or not until a specific week. In terms of specialisms of care homes a range was in place, including for intermediate care, such as Lord Hardy or Davies Court and health partners also used Ackroyd House.

  Rotherham had an allocation but across the system there was too much reliance on the care home bed base; the wish was to increase care at home where possible and not in residential settings. As highlighted previously a shortage of nursing beds existed in the Borough compared with over supply of residential beds which could be a potential challenge in the future.

- Was a weekly update sufficient given the pressures last winter and with some care homes having vacancies? – The ultimate driver was to keep people at home and it was always a challenge with homes with vacancies, quality and individual preferences. Initiatives were coming through the NHS on bed availability, with some councils having automated systems where care homes could log on and input availability. This would be looked at as at present it was a manual system, hence weekly.

  Within TRFT the award winning SEPIA interactive portal allowed staff to see the live bed base in the community and in hospital. Within the IBCF around £100,000 had been earmarked for IT development to try to get to grips with real time information across the whole system. This would assist with strategic planning and for staff on the ground to access to real time data facilitating discussion with individuals and families on bed/care package availability.

- Delays due to medication not being available did not count towards the DTOC measure but could be an issue and impacted on patient experience, affecting both discharges and transfers of care.

- How quickly was discharge planning initiated when a patient came into hospital and was it linked to an overarching view of capacity? – It was a mixed picture but moving forward on development of the discharge process there was a role for the wards to plan for discharge dates as soon as someone was admitted. There was also a role for the Integrated Discharge Team (IDT) to expedite discharge where the patient needed more complex care, plus set legal guidelines to comply with, which were part of the process.

  It was worth noting that in terms of length of stay TRFT was in the top quartile and doing well on the amount of time people spent in hospital but there were still improvements, as had been mentioned with prescribing. An internal pharmacy resource was needed.

  In terms of care homes, the focus in the TRFT had been on preventing admissions but providing more support to people transferring from hospital to a care home through the Care Home Liaison Service could be looked at. The service had been working more on supporting people who were already there. The IDT would also provide a more streamlined process.

  Coming into winter a significant increase in influenza was anticipated which had not occurred last year but still experienced pressures so the IBCF was very important to help to address this.

- To help reduce delays could patients be discharged with a generic prescription that could be used at any chemist rather than having to go to the hospital pharmacy? Response to follow.

Resolved:-

That the Health Select Commission note the content of the report, including Appendix 1 the Delayed Transfers of Care Action Plan.

31. NEW NATIONAL AMBULANCE STANDARDS

The Scrutiny Officer introduced a short briefing paper on forthcoming changes to national ambulance standards. Following positive evaluation of a national pilot (which Yorkshire Ambulance service had been involved in) new ambulance response categories and standards were being introduced nationally.

Key drivers for change to modernise the service to be suitable for patient demand and current care pathways were outlined.

This issue would be considered by the Yorkshire and Humber Joint Health Overview and Scrutiny Committee as it was a regional service with Wakefield Clinical Commissioning Group (CCG) as the lead commissioner for the region.

Clarification was provided on the targets being applicable to 90% of calls and a request would be made to see if performance data on meeting the response time targets could be disaggregated between urban and rural areas and what performance data could be disaggregated to CCG level, as most data reporting is at regional level.

Rotherham CCG confirmed that YAS would be collecting data based on the new standards from September and would begin to report from October. This data would be available via the CCG website, including any that was reported at a Rotherham level.

Resolved:- That the Select Commission determine any specific questions to submit to the Yorkshire and Humber Joint Health Overview and Scrutiny Committee to ask the Yorkshire Ambulance Service in relation to the new standards.

32. IMPROVING LIVES SELECT COMMISSION UPDATE

There was no update to report.

33. JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE FOR THE COMMISSIONERS WORKING TOGETHER PROGRAMME

The Chair gave an update from the last meeting of the Joint Health Overview and Scrutiny Committee (JHOSC) held on 31st July, 2017:-

Children's Surgery and Anaesthesia - plans for implementation would be in place by the end of December 2017, with a further update to the JHOSC, probably in October.

Hyper Acute Stroke – the decision from the Joint Committee of CCGs was due in the autumn with an update expected for the next JHOSC.

South Yorkshire and Bassetlaw Hospital Services Review – a new workstream under NHS transformation had commenced recently:-

- to define the criteria to help understand what a sustainable hospital service would be.
- to look at services and define those which were non-sustainable.
- to advise on future models of delivery to ensure long term sustainability.

JHOSC Terms of Reference – a refresh was under way and would be communicated to the Select Commission.

Copies of a powerpoint presentation about the hospital services review and a stakeholder briefing were circulated to Select Commission Members at the meeting.

34. HEALTHWATCH ROTHERHAM - ISSUES

There were no issues to report.

35. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 26th October, 2017, commencing at 3.00 p.m.