HEALTH SELECT COMMISSION
14th December, 2017

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

Apologies for absence were received from Councillors Bird and Ellis and Robert Parkin (Rotherham Speakup).

54. DECLARATIONS OF INTEREST

There were no Declarations of Interest.

55. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

56. COMMUNICATIONS

The Chair informed the Commission that The Rotherham Foundation Trust (TRFT) would be holding a stakeholder event on 31st January to discuss their quality priorities for 2018-19. Further details would follow.

The Joint Health Overview and Scrutiny Committee meeting scheduled for 11th December 2017 had been cancelled due to the inclement weather so there would be no updates until the new year.

57. REFRESH OF THE HEALTH AND WELLBEING STRATEGY AND THE INTEGRATED HEALTH AND SOCIAL CARE PLAN

Councillor Roche, Cabinet Member for Adult Social Care and Health and Terri Roche, Director of Public Health delivered a detailed presentation on the Rotherham Health and Wellbeing Strategy 2018-25 and the Integrated Health and Social Care Place Plan (IHSCP). Ian Atkinson and Lydia George from Rotherham Clinical Commissioning Group were also in attendance to provide additional information regarding the IHSCP.

The IHSCP was Rotherham's local plan within the wider South Yorkshire and Bassetlaw (SY&B) Sustainability and Transformation Plan, now known as the Accountable Care Partnership (ACP).

Rotherham Health and Wellbeing Strategy 2018-25

Purpose of session

- Provide an overview of the current strategy and why a refresh is needed
- To outline key data and intelligence
- Present a framework for the refreshed strategy for scrutiny to consider

- Provide an overview of how the Integrated Health and Social Care Place Plan aligns to the new strategy
- Present a timeline and next steps

Health and Wellbeing Board (HWBB)

- Statutory board since 2011 – sub-committee of the council
- Includes statutory members, plus providers on the Rotherham board
- Duty to prepare Joint Strategic Needs Assessment (JSNA) and local Health and Wellbeing Strategy (HWBS)
- Duty to encourage integrated working between health and social care commissioners
- Provides a high-level assurance role; holding partners to account for delivery

Membership of Health and Wellbeing Boards (HWBB) varied across the country and Rotherham HWBB was deliberately quite large in order to develop the partnerships with all local key providers. The Council had previously been criticised for its lack of partnership with health partners, which had been addressed with excellent relationships now with the Clinical Commissioning Group (CCG) and Rotherham Hospital.

The JSNA summarised key features about Rotherham and informed the local HWBS.

Integrated working was going exceedingly well, with joint posts and joint commissioning developing, for example in midwifery.

The role of the HWBB was now primarily a strategic one, although it did provide high level assurance. The board focused on what was best for Rotherham rather than coming from individual organisational perspectives.

Health and Wellbeing Strategy

- Sets strategic priorities of the HWBB
- Not intended to include everything that all partners do
- Based on intelligence from the JSNA and other local knowledge
- Enables commissioners to plan and commission integrated services
- Service providers, commissioners and local voluntary and community organisations all have an important role to play in identifying and acting upon local priorities

Health and Wellbeing Strategy 2015-18 Principles

- Shared vision and priorities
- Enables planning of more integrated services
- Reduces health inequalities
- Translates intelligence into action - JSNA and information from partners. One example last year was partners sharing concerns about care homes and this area was now working better, for example with a nominated GP attached to each care home.

From when Commissioner Manzie had been in post there had rightly been a strong stress on children, and children would still be a key part, but other elements and health inequalities needed to be worked on and included.

Need for a refresh …

- Existing strategy runs until end of 2018 – but number of national and local strategic drivers now influencing the HWBB
- An early refresh ensures the strategy remains fit for purpose, strengthening the board's role in
  - high level assurance
  - holding partners to account
  - influencing commissioning across the health and social care system, as well as wider determinants of health
  - Reducing health inequalities
  - Promoting a greater focus on prevention
- LGA support to the HWBB:
  - Self-assessment July 2016
  - Stepping Up To The Place workshop September 2016
  - Positive feedback given about board's foundation and good partnership working
- The current strategy was published quickly after the board was refreshed (September 2015)
- Now in stronger position to set the right strategic vision and priorities for Rotherham

The refresh would help to move at a faster pace with greater emphasis on prevention and early intervention, which was the key to what the HWBB were trying to do. For example, weight management at Tiers 3 and 4 was high cost but if this was tackled earlier it was both more effective and cheaper and achieved more long-term benefit.

The Place Board was one of the key drivers for the change and as partners in Rotherham worked well together it was decided to bring things together under the HWBB rather than the Place Plan being a separate entity.

Joint Strategic Needs Assessment

- Ageing population – rising demand for health and social care services
- More people aged 75+ living alone, vulnerable to isolation
- High rates of disability, long term sickness (more mental health conditions) and long term health conditions e.g. dementia
- Need for care rising faster than unpaid carer capacity
- High rates of smoking and alcohol abuse, low physical activity & low breastfeeding
- Rising need for children's social care, esp. related to safeguarding
- Relatively high levels of learning disability
- Growing ethnic diversity, esp. in younger population, with new migrant communities

- Growing inequalities, long term social polarisation
- High levels of poverty including food and fuel poverty, debt & financial exclusion

Inequalities in Life Expectancy
Graphs showing Life Expectancy at Birth and Healthy Life Expectancy for Rotherham and England – males and females.

Proposed refreshed strategy
- Sets strategic vision for the HWBB – not everything all partners do, but what partners can do better together
- Includes 4 strategic 'aims' – shared by all HWBB partners
- Each aim includes small set of high-level, shared priorities
- Which the Integrated Health and Social Care Place Plan 'system' priorities will align to

Strategic aims
Aim 1. All children get the best start in life and go on to achieve their potential and have a healthy adolescence and early adulthood

Aim 2. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

Aim 3. All Rotherham people live well and live longer

Aim 4. All Rotherham people live in healthy, safe and resilient communities

Consultation and engagement
- HWBB received proposal for refresh September 2017 and framework November 2017
- IHSC Place Board received an update September 2017
- New framework shared with HWBB sponsors and theme leads for comments
- Health Select Commission December 2017
- All partners to consider taking through their own governance structures Nov – March 2018
- VAR audience with to take place January 2018
- Consider what other stakeholder engagement may be needed…

The final version of the strategy was due in late February 2018, and would go to Cabinet for endorsement before the final approval from the HWBB on 14th March. It would be a living document but not undergoing a full refresh for three years.

Integrated Health and Social Care Place Plan

Integrated Health and Social Care Place Plan (IHSCP)
Current Place Plan agreed November 2016
Work taking place to re-align with the refreshed HWBS

How the Rotherham Health and Wellbeing Strategy and Integrated Health and Social Care Plan will align

- Structure for overall strategy and delivery
- Structure charts for strategic HWBS aims 1,2 and 3 and the HWBS priorities under each aim and how these then linked to the Place Plan Transformation Groups and their respective priorities to help deliver. Prevention and early intervention were key elements in everything. Aim 1 merged the previous two aims for children in one.
- Structure chart for strategic HWBS aim 4 and the HWBS priorities under each aim and how these link in with other workstreams/strategies as they are not directly aligned with the Place Plan.

The Rotherham Care Record (RCR) shared between partners would be a key step forward in integration. The governance arrangements were key in ensuring integration and communication between partners and working effectively together. As part of the delivery of the IHSCP, which was a true partnership approach, there were three transformational groups chaired by very senior managers to ensure this work happened. It was an integrated approach and integrated effort to deliver effectively together.

HWBS Aim 1 – All children get the best start in life and go on to achieve their potential and have a healthy adolescence and early adulthood

HWB Priority 1 Ensure every child gets the best start in life (preconception to age 3) – includes pre-conception, healthy pre-pregnancy and pregnancy – lifestyle including smoking and alcohol consumption, health, diet and seeing a midwife early (cross reference to Marmot).

HWB Priority 2 Improve health outcomes for children and young people through integrated commissioning and service delivery – linked back to previous HSC work when the under 5s and school nursing services were brought together in the integrated 0-19 service, delivered through effective health visiting and school nursing, bringing in other services as appropriate.

HWB Priority 3 Reduce the number of children who experience neglect – lot done on safeguarding and looked after children and now the focus would be on neglect as this can lead to children and young people becoming looked after, with support offered at an early stage.

HWB Priority 4 All children and young people are ready for the world of work - universal proportionalism and the need to be brave in terms of what level of resource goes to different groups of people. Everyone gets

some resource but some groups might get more to help them to achieve at school and feel confident and enabled to get into good employment.
The transformation group, chaired by Ian Thomas, would oversee delivery of the 0-19 contract (but not undertake contract management), ensuring real added value.

Children's acute and community integration – 14-16 year olds having a choice of admission to an adult or children's ward and ensuring that either was able to meet their clinical needs as Rotherham hospital is too small to have an adolescent ward.

HSC already had a good knowledge and overview of implementation of the local CAMHS transformation plan which needed to continue.

Embedding children's voice - reality not tokenism. Linked in with Children and Young People's (C&YP) Partnership Board.

HWBS Aim 2 − All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

HWB Priority 1 Improve mental health and wellbeing of all Rotherham people
HWB Priority 2 Reduce the occurrence of common mental health problems
HWB Priority 3 Improve support for enduring mental health needs including dementia

It was important to note this was mental health not mental illness as good mental health was an enabler and helped to promote good quality of life. Levers included the Better Mental Health for All Strategy and the Suicide Prevention Action Plan and also good work at a local level. Dementia still needed to be included. It involved early identification and treatment of common mental health problems and support for people with enduring conditions. The key was getting more people behind it to commit to delivery.

The Suicide Prevention Action Plan needed to include communities so people were confident to ask questions, knew where to refer people and could talk about mental health in a much more open way. HSC were already familiar with the Rotherham Doncaster and South Humber (RDaSH) transformation plan and changes at Woodlands. It was about a good balance across prevention, early intervention and treatment at the right level.

HWBS Aim 3 − All Rotherham people live well and live longer

HWB Priority 1 Prevent and reduce early deaths from the key health issues for Rotherham people such as cardiovascular disease, cancer and respiratory disease - reflected lifestyle related issues and the industrial legacy. It included working with primary care to ensure people attended

screening and to catch people earlier, both to prevent ill health and to ensure treatment was more effective.

HWB Priority 2 Promote independence and enable self-management and increase independence of care for all people – social care offer to enable people to remain more independent but being confident about self-care knowing they had access to support/advice when needed.

HWB Priority 3 Improve health outcomes for adults and older people through integrated commissioning and service delivery ensuring the right care at the right time – through working with the CCG there were already seven joint commissioning posts. Partners were looking to commission things more effectively together, so no silos and no residents slipping through the gaps. Levers included Making Every Contact Count (MECC) with all front line staff being confident to have some of these conversations about lifestyles and knowing where to signpost people. The Wellness Service would be a one stop shop for that as well.

Priorities that sit under the transformation group, with prevention and early intervention key to all were:

- Improving the reablement and intermediate care offer so that people had their physio and were back in their own environment
- Integrated locality model roll out – HSC would be scrutinising the evaluation in January - what had worked well, what needed to be done differently and how we could make that happen
- Single point of contact for care needs – hub
- Autism – further deep dives into needs analysis needed
- Transforming Care – not easy but partners were trying to overcome barriers around who pays for what and different targets, including by seeking advice from elsewhere and lobbying central government to reduce some of the restrictions
- Expand Integrated Rapid Response - so people had a timely, quick response when needed
- Integrated Discharge Teams - Home First Home Safe
- Co-ordinated approach to care home support

HWBS Aim 4 − All Rotherham people live in healthy, safe and resilient communities

HWB Priority 1 Increase opportunities for healthy sustainable employment
HWB Priority 2 Ensure planning decisions consider the impact on health and wellbeing
HWB Priority 3 Ensure everyone lives in healthy and safe environments – influencing the housing strategy and making sure people are in warm, sustainable and safe homes. Domestic abuse was a priority for the Safer Rotherham Partnership and it was important that front line staff were aware of the signs and how to access support.
HWB Priority 4 Increase opportunities for all people to use green spaces – new Cultural Strategy included sport, leisure and green spaces.

No prevention was possible without working on the environment as a whole, as the wider determinants of health were a key reason behind the inequalities in life expectancy, so aim 4 was important, as was having housing fully on board.

Priority 1 was about getting people into employment but also ensuring that employment was as sustainable and health promoting as it could be. Funding had been obtained through Sheffield City Region for employment support workers working in a holistic way with people facing barriers to work to try and help them into work. They would also be working with people at risk of losing employment through musculo-skeletal or mental health conditions to try and keep them in work. Terri Roche chaired the local implementation board and it was a good opportunity to work with people in a different way. Work can have a massive role in improving people's health but with the changes in benefits it was important to ensure people were getting a reasonable wage and in sustainable employment.

What next …

- Full draft of strategy and IHSC Place Plan to be presented to HWBB 10 January 2018
- Continue to gather comments and feedback from stakeholders up to March 2018
- CCG Governing Body, IHSC Place Board and Cabinet to endorse strategy and IHSC Place Plan February/March 2018
- IHSC Place Board to sign off IHSC Place Plan March 2018
- HWBB to sign off strategy by April 2018

Questions for scrutiny

- Are the strategic aims and priorities clear about what they mean?
- Is there anything missing or needs more emphasis?
- Reducing loneliness and isolation is an emerging issue in the JSNA – how do we ensure this is addressed through the strategy?
- How can elected members, partners and residents work together to help deliver the strategy aims within neighbourhoods?

"**Prevention Matters**"

- The Local Government Association (LGA) will be running a workshop looking at how elected members can improve the health of their communities
- Taking place over two half days: 15th and 16th February 2018 - ideally people would attend both sessions as the first would be the LGA talking about prevention and public health and the second would focus on the local ward profiles.

Discussion ensued on the presentation with the following questions and issues raised:-

Whilst agreeing with the principles, my concern is the achievability of the aims, which are deep and demanding, including concerns around the finance available and the level of achievability. On a rating of one to ten what was the likelihood of achievability?

- There had been financial cutbacks but the key funding for the HWBB priorities was from the CCG not the Local Authority. There were also Better Care Fund and Improved Better Care Fund (IBCF) monies of around £20m. As the SY&B ACP was a pathfinder extra money was also available to drive that forward. The belief was that the aims were deliverable but the pace could alter depending on funding availability. For example, whether locality working would move to seven health villages across the borough all at once or on a staggered basis. Other health partners were eligible to bid for funding that the Council could not, for example for mental health. Undeniably there was a lot to do but it was a good team and a good partnership. 8.5 out of 10.

- Aims should be ambitious and the important point here is that if we were talking about outcomes based accountability it was what were we going to do to turn the curve? The strategy would run until 2025 and some of the issues, such as the difference in life expectancy, would take much longer, even generations, to turn around. On delivery it was finding the key things that could be done that would make the most difference and committing with partners to address those, things that would be amenable to change over time. For example, breastfeeding also included longer term health benefits and we were working with the midwives and the hospital trust to see how breast feeding could be improved and then we would need to work with our communities to see how people could be helped to sustain breastfeeding. We would not be able to achieve absolutely everything but it was important to agree on some key things to take us on that journey. It was a case of whether the committee felt we should have ambitious aims with clear plans underneath of how we would work towards them.

- IBCF money did come to the Council but the key metric was reducing Delayed Transfer of Care (DTOC), and although the main driver was the hospital, if the targets were not met money was taken away. Targets had easily been met this year and confirmed by NHS England.

- Within the system everyone was under financial pressure but the step change that we were witnessing in the borough, with the strength of our HWBB and also our place-based approach, was that increasingly we were seeing “how could we best use the Rotherham pound?”, whether the money was flowing down from the local authority or the CCG, in terms of how we deliver our strategy. So we were not pulling away from each other on strategy but aligning that and trying to make the resource follow. That did not provide an answer on deliverability but provided assurance on working increasingly together on both the

commissioning side and the provider side in trying to achieve our plan.

It was really pleasing to see the aspiration and the depth in these aims and it was good to aim high. Aspiration should be built into everything we do in Rotherham and it was a positive sign that the work of the HWBB in putting this together reflects that. HSC would be giving this due consideration and scrutiny and the Chair requested that the committee see the final draft, which would probably be in February.

You mentioned life expectancy in Hellaby ward, would the forthcoming boundary changes skew the health data at ward level as the changes mean losing part of Wickersley which is a more affluent area?

- Yes, the formulae would have to be recalculated again following the boundary changes as data was at ward level. Measuring life expectancy was a statistical calculation and when the populations changed recalculations would be made as soon as possible, as the changes will bring together some very affluent and some very deprived areas. Similarly the gender profile would need to be recalculated.

- Recognising that pockets of real deprivation existed in wards not classed as deprived overall, it was important to try and capture data below ward level.

How do we manage or challenge fast food outlets and schools to ensure greater influence or governance regarding what we want to achieve on obesity?

- Other Local Authorities have implemented planning rules which say no fast food outlets within a certain distance from schools. It was suggested here but challenged successfully on appeal by a fast food company. It had been raised again with Planning and the Strategic Director was looking at other ways to tackle this. Some evidence did suggest there was a limit as to how far people would be prepared to walk to get fast food so if fast food outlets were located beyond that they would be less likely to go. Creating a healthy environment overall to help people make healthier choices was covered in the strategy in aim 4 but it would be a challenge going forward as some of the big fast food outlets had very robust legal support.

Would the Autism Strategy be coming back to HSC?

- It was under development with a working group established that included Healthwatch. It was still early days but there was no reason why it could not come to HSC if the committee wished to see it.

From the previous HWBS, to what degree are we reinventing the wheel and is there a need to look at what we were doing previously and what we are doing now to try and pull them both together to have a strategy that is achievable?

- The draft proposals did take account of the existing strategy and what was still relevant and needed to be taken forward or needed further work, so it was not a case of reinventing the wheel. Many of the aims would have happened anyway, for example we needed to influence the SEND and CAMHS plans and although there were a number of other strategies the intention was to bring them together through an integrated approach with all services working together. The C&YP partnership plan would have existed without the HWBB but now it was part of it this allowed that integrated approach.

- This was a refresh of the strategy so people familiar with the current one would see aims that needed to continue because some of the things we still needed to do and were not going to change. It was hard but needed to be there. It was a refresh building on what we had before and learning from that rather than starting again. The key was consistent effort on some key priorities over a longer period of time

With regard to older people's aspects and reducing loneliness and isolation, what approach would be taken to contacting people who we think this might apply to without causing offence? And how do older people also fit in with green spaces and age friendly Rotherham?

- Loneliness was becoming increasingly important as seen in the Jo Cox report and the impact on health approximated to smoking 15 cigarettes per day. It was felt important to talk to partners first to check what was already happening and Members were recently given a leaflet from Rotherham Older People's Forum about their activities. Befriending services, social prescribing and luncheon clubs were happening but not everyone knew what was available. Information collation would take place followed by a meeting early in 2018 to consider what was in place and the gaps, then what to do. Funding from the IBCF from April onwards would help take this forward.

- Reviewing the evidence showed trigger points such as key life events such as retirement or bereavement could make people more lonely, and more awareness raising was needed about this with people needing to be confident and better at talking about, it in the same way as for mental health. In addition to the mapping work there was also ward work such as that in Wingfield where loneliness had been prioritised. An asset based approach with communities and the powerful impact of word of mouth about activities taking place was important and this was also perhaps a challenge back to Elected Members in their ward role. Loneliness was intergenerational, not only affecting older people, and carers also experienced isolation.
- In terms of age friendly borough, activities within the child friendly borough workstream were complementary for older people and would be revisited. Actions on loneliness, having the conversations and community cohesion would play a part.

- Some places had introduced a badge system saying “you can talk to me”. Befriending was an important step but not a long-term answer, hence the need to change a person’s long-term involvement in things and the community approach.

How did the carers’ strategy dovetail with the HWBS and how did you see the two joining together?

- It was probably not as explicit as it ought to be and consideration was needed about how it was embedded in the assurance process, for example how the HWBB and HSC worked together, but it could be stronger within it.

- Cllr Roche also agreed it could be strengthened but stated that it needed to go back to the HWBB.

Referencing the work done by HSC last year, it would be nice to see more detail around the housing strategy and specialist housing, including what percentage would be specialist housing.

- This came under aim 4 and it was still early days but the HWBB had received a presentation from Housing and discussed how this fitted in, including decent homes and housing design fit for purpose for the life course, such as wheelchair access. The right design helped to save on adaptations later and contributed to the key aims of increasing independence and choice.

- Improving Places Select Commission led on scrutiny of the implementation of the Housing Strategy and any key issues would be fed back to HSC.

Has there been an opportunity yet to consider the impact of universal credit as this keeps cropping up in housing, health and on Improving Lives?

- It was early days but with the pilots prior to roll out officers were trying to calculate the numbers of people potentially affected and how the Council might be able to mitigate for that when it was a national programme coming in.

- Members had been briefed on the key aspects and it was a concern. As were possible changes to funding for housing to support people experiencing domestic abuse which were going through parliament.

Looking at gathering data on reducing loneliness and isolation, how many partners were you looking at? Could parishes be involved as they did a lot of good work and had a number of groups?

- More people who could suggest things so this could grow as a movement was good. After the small sharing event by starting working in communities hopefully more people would become involved in like a ripple effect. We could also work with others such as hairdressers and publicans in the long term so they feel confident about this. Parishes would be a good group to consider.

Loneliness is a big issue for retired people and people who are out of work. Volunteering can be a good opportunity to improve mental health and people in our community have a lot of skills that are often under-used.

- Agreed and we had seen elsewhere and in the past examples of older people going into schools and passing on their skills and experience. Another example being considered from the Netherlands was where university students had a room free of charge in a care home in return for some time spent each week talking with and befriending the residents, so everyone benefitted.

Education and awareness raising with residents on the health and care system.

Councillor Roche and the officers were thanked for their presentation and contributions.

Resolved:-

(1) That the final draft Health and Wellbeing Strategy be circulated to the Commission in February 2018.

(2) That Aim 4 should strengthen and embed becoming an age-friendly borough.

(3) That the links and governance for delivery of the Carers' Strategy be strengthened and made more explicit within the Health and Wellbeing Strategy.

(4) That partners consider working with Parish Councils on tackling loneliness and isolation.

(5) That information on the implementation of the Housing Strategy with regard to specialist housing be reported back to the Commission from Improving Places.

(6) That the Autism Strategy is considered at a future Health Select Commission meeting.

58. RCCG COMMISSIONING PLAN 2018-19

Ian Atkinson, Deputy Chief Officer, Rotherham Clinical Commissioning Group gave a presentation on the review of the CCG's Commissioning Plan for 2018-19. Extensive consultation had been undertaken when the 2015-20 plan had been developed but the CCG had a statutory duty to update its plan.

After earlier discussion of the strategic priorities across the Rotherham health and care system with the HWBS and the IHSCP, this focused on the CCG's plans and how Members would see joined up working on how the CCG planned to prioritise spending the healthcare pound across the borough.

Presentation Overview

1) Where we are now:
– Financial position
– Demographic Challenge.
– Our Current Priorities, Delivery and Performance
2) The plan, and how we put it together
3) Review of priority areas
4) PPG Feedback

Finance Allocation

- 17-18 £399 million
- Savings of £75million over 5 years 2015-20
- 17-18 savings of £15.9million
- 18-19 and beyond awaiting settlement following Autumn statement

There was an efficiency challenge but no cuts in allocation and the CCG expected a small uplift for next year, although final confirmation would be in the new year.

Where we spend our money

48% Acute Care – hospital based, planned or urgent
12% Prescribing - nearly £30m p.a.
10% Primary Care
9% Mental Health
9% Community – district nursing, physiotherapy and occupational therapy
9% Joint commissioning including the LA and CHC
2% Corporate
1% Central Budgets

The CCG were seeing a reduction in spending on acute care which had previously been around 51% and was in line with the strategy to provide more care in a community based setting. Spending on mental health had increased around national requirements linked to the parity of esteem agenda.

System efficiency

Graph showing 2017-18 efficiency schemes
£75m over 5 years, £15m 17-18
2017-18 efficiency schemes were:

- Corporate savings
- Planned care - reducing unnecessary referrals to hospital and improving pathways and guidelines through GP colleagues. Introduction of clinical thresholds. Reducing unnecessary follow up activity where best practice suggests it was not needed.
- Urgent care - wrapping care around the person, reducing urgent admissions and where possible supporting people in the community.
- Mental health
- Medicine management – waste management and repeat prescribing schemes, but challenged by drug costs which were volatile.
- Continuing healthcare

- Hospital payment system – national tariffs were set for each hospital episode with inflation included and then the efficiencies taken out that the hospital had to make.

The efficiencies were on track so the CCG expected to deliver a balanced position.

Changing demographics

- Rotherham is the 52nd most deprived out of 326 districts
- 50,370 Rotherham residents (19.5%) live in the most deprived 10% of England (this has increased)
- Rotherham has 8,640 residents (3.3%) in Ferham, Eastwood, East Herringthorpe and Canklow living in the most deprived 1% of England.

2015-20 Priority Areas

Strategic aims – The CCG strategic aims seek to address all five Health and Wellbeing Board Strategic Aims across all life stages and for all communities, both geographical and communities of interest.

1 Primary Care
2 Unscheduled Care
3 Transforming Community Services
4 Ambulance and Patient Transport
5 Clinical Referrals
6 Medicines Management
7 Mental Health
8 Learning Disabilities
9 Maternity and Children's Services
10 Continuing Health and Funded Nursing Care
11 Palliative Care
12 Specialised Services
13 Joint working – local and regional
14 Child Sexual Exploitation
15 Cancer

Most priorities fed directly into the IHSCP although the CCG also had a wider remit, like other statutory organisations, on other areas that were less closely linked to the place plan such as palliative care, cancer targets, and continuing health and funded nursing care. A delivery plan and key performance indicators sat below and were monitored quarterly.

Strategy delivery

- Planned Care - contained growth in referrals and our system is in the top 10% nationally for 18 week performance.
- Urgent Care - New Urgent and Emergency Care Centre now open and now refining the model and ways of working. Focus on improving performance
- Primary Care - 31 practices now inspected by CQC, 27 rated good four require improvement. Primary Care access data suggests best in South Yorkshire. Update due to HSC in March.

- Mental Health – Talking Therapies (referred to as IAPT) high performing in access, treatment and outcomes, having moved into top quartile. Dementia diagnosis rates highest in Yorkshire & Humber and now it was a focus on onward care and care in the community as Rotherham still had rather a historic model.
- Child and Adolescent Mental Health – CQC rated as good. Improved access times, ongoing journey of improvement with HSC having a good oversight and recommendations progressing.
- Delayed Transfer of Care – System wide success, although it had been a challenge and performance was currently 1.8% (national target below 3.5%). IBCF monies have supported some real transformational work.

The plan and how we put it together

- RCCG has to have an up to date commissioning plan
- Our GP Members, the 31 practices, recommend the plan for approval by our Governing Body
- This year we are aligning the Rotherham Place Plan & Health and Well Being Strategy.
- In the process, we include: CCG member practices & stakeholders, patients and the public
- Our Governing Body and Clinical Executive have already reviewed the existing Plan and have endorsed the continuation of existing priority areas

The review did highlight support for care homes to prevent hospital admissions and a need for better coordination between the various services commissioned that supported care homes.

Refreshing our plan

To date GP Members, Patients groups and the PPG forums have supported the CCG in giving feedback around many of the 15 priority commissioning areas;

In particular we would welcome further views regarding our proposed approach for the following strategic priority areas:

- Urgent care – National drive to integrate, linking 111/Out of Hours and urgent access to Primary Care – Urgent Care Model for centre by 2020.
- Primary care – 7 day Access – big push for 7:7 and evenings. Capital development at Waverley and new GP. Workforce - issues with GPs and a need to utilise the wider skill mix.
- Mental health
  - Talking Therapies
  - Crisis care, known as Core 24, in the urgent care centre and community crisis care.
  - Dementia - community diagnosis by GPs is positive. The follow up is through the memory service provided by RDaSH but it could be

GPs for ongoing care if trained appropriately. Support for carers of people with dementia.

- End of life care – Care in Community. Work with hospice, hospice at home services across the borough and into care homes to keep people in the community setting as far as possible.
- Maternity and children – Better Births national strategy, probably consultation in next year or so across SY&B.
- Care homes – Support to prevent admission

Things had moved on in the last two years with the publication of the Five Year Forward View for Primary Care and the Five Year Forward for mental health plus the system changes at local level. These were the main proposed changes with a detailed consultation document underpinning these that could be circulated so the HSC could go into the 15 priorities in more depth. It covered what the CCG had said it would do, what it had done and what it planned to do.

Other sections in the plan

The following list are areas not covered in the presentation but are very important to the CCG, feedback is welcome:

- Health & Wellbeing Strategy
- Joint Strategic Needs Assessment
- Medicines Management
- Continuing Care & Funded Nursing Care
- End of Life Care
- Ambulance & Patient Transport Services
- Specialised Commissioning
- Public Involvement & Promotion of Choice
- Health Inequalities
- Statutory Responsibilities
- Efficiency
- Finance
- Information Management & Technology
- Communication
- Performance & Assurance
- Risk
- The prevention of Child Sexual Exploitation will remain a priority

What does this all mean?

- Increasing and significant financial challenge for local health and social care economy.
- RCCG will work with partners across the Rotherham Place, to best meet the needs of the Rotherham population.
- Generally, and where this is better for patients, RCCG wants to move services from Secondary (hospital) to Community/Primary Care.
- CCG wants to commission services in Rotherham.
- Where patient quality and outcomes can be improved, we will consider commissioning on a geographical area

Feedback from stakeholders
The CCG welcomes all feedback and any comments can be sent via the CCG email address Rotherhamccg@rotherham.nhs.uk

The current 2016/17 Commissioning Plan is available at http://www.rotherhamccg.nhs.uk/our-plan.htm

The first draft version of the 2018/19 Commissioning Plan will be circulated to stakeholders for comment mid-January.

CCG transformation capacity is finite so it is important that if new initiatives are prioritised some exiting initiatives are stopped.

The following questions were raised by Members following the presentation:

Could you update us on how we are performing against the 4-hour A&E target even though it is still early days for the new centre? And if we are not meeting the target what were the problems associated with it?

- It had been a challenge to meet the 95% target as under the previous configuration before the new centre opened they had worked for the last two winters out of a decanted ward. Although the new centre opened in July they were still challenged, averaging around 85% year to date but the focus was there to get performance up. They had seen improvements in the last couple of weeks, averaging 90% in line with other hospitals in South Yorkshire and nationally.

- Key challenges were bedding in a new facility and new ways of working with triage and flow through of patients. Flow in and out of the hospital was closely scrutinised. The A&E Delivery Board met monthly and had significant focus and support across the system to improve performance.

Would it be possible to have information on the CQC ratings for the 31 GP practices so that Members could look at the surgeries in their own wards and see how they were doing?

- All the information was in the public domain and a summary for the 31 practices would be provided.

With regard to DTOC, could savings from one area go elsewhere in the system, for example to mental health, or were they ringfenced?

- What they were trying to do was improve the flow of patients through the hospital so that as soon as they were well they would go home to their normal place of residence or to other supported care if required.
- When patients were admitted to hospital there was a tariff for each admission of between £1000 and £2000 and the key was reducing the length of stay when someone was medically fit, prioritising patient health and the quality of care. By that point the payment had already been made within the system so the focus was on the patient flow, both for the quality of care for the patient and for other patients who

needed to come in to the hospital. In terms of driving efficiency there were efficiencies if the length of stay could be reduced but taking out money directly around length of stay would certainly be a challenge.

What was the level of savings from actions taken on medicines management following the conference approximately 18 months ago?

- The three areas involved were medicines waste, practice repeat prescribing and using the most cost appropriate drugs at any one time. The £3m referred to was an aggregate of savings across all three and the breakdown was in the public domain as savings were reported to the governing body.

- All three were considered successful including positive feedback from the public on the first two as many people had unwanted stocks of medicine due to unnecessary automated prescriptions.

Did the primary care budget include claims for compensation?

- The budget was for the core GP contract and any additional enhanced services provided by GPs. To discuss further following the meeting.

Following previous scrutiny work by HSC on improving access to GPs can you tell us if access has improved?

- This had been a focus with extended hours and the three Saturday satellite hubs established in response to local need and the national direction. The CCG's primary care committee was considering how this could be extended to seven days to include Sundays and their work would conclude in the new year.

- As mentioned earlier we are high performing and data could be provided on the availability of slots, although this will be covered in more depth in the March update.

Can you give an update on the new GP for Waverley as with increased houses going up this is creating additional pressure on the existing GP practice?

- This is currently out to tender and the procurement process is due to close shortly. Mobilisation would follow but the precise date would have to be confirmed as it linked in with the new building, but there would be a new practice within the next 12 months.

Ability to provide seven day cover if there were only two GPs in a practice.

- The 2000 responses received for the recent CCG survey was positive in terms of engagement. With the workforce challenges we could not expect all GPs to be 7:7, either locally or nationally. Proposals would be more at scale in the system based around the hub model to ensure seven day population cover. Plans are being developed and will be reported back in March.

With the reduction in nursing home places compared to residential care places, would patients be able to be placed appropriately in residential care homes if these did not have nurses on site?

- This was a challenge within our system and the strategy for both nursing and residential care was about supporting people in the community and in the care setting as far as possible, working with the local authority. Pressures on nursing homes to have beds and available beds was significant. The challenge regarding nursing capacity in the system was acknowledged including for step up/down, to avoid hospital admissions and support hospital discharge.

Would there be a need to keep revisiting capacity for dementia follow up post diagnosis?

- With high diagnosis rates and population projections we would expect to diagnose more people with dementia, so part of the strategy is to work with primary care colleagues to do that, placing it at the heart of community care. The existing resource for dementia follow up is not insignificant but we may need to change how families and carers are supported. We probably would need to invest in post diagnostic support in the community, using GPs and community services to deliver that. For more complex needs central provision would still be needed to try and keep individuals within their community setting and their homes. Dementia is central to mental health and is frequently discussed.

Did the RCCG plan support the aims of Public Health for prevention?

- The Rotherham pound was finite but where the CCG could it would invest in and support on prevention. It was very clear from the Place Board that prevention was at the heart of the place plan.

Could you give an update on the Rotherham Care Record?

- This was a positive development and was a clinical system interface that would enable clinicians to have appropriate access to patient records. For example if a patient came to the Urgent and Emergency Care Centre, with appropriate permissions, clinicians would be able to see some of the activity from primary care or mental health, providing a good understanding of the patient's needs so they could offer the best support.

- The information governance and IT behind developing the record was significant. The right information governance for data sharing was in place, privacy impact assessments had been undertaken and the data sharing agreement developed, which had been endorsed by the Place Board in September. The CCG, RMBC, TRFT and RDaSH were taking the agreement to enter into the RCR through their governance processes by the end of December 2017 with a view to starting to flow data in February.

There had been a significant performance improvement on DTOC in the last few months, how had this been achieved so rapidly?

- We had been at 6% earlier in the year making us an outlier in the Yorkshire and Humber. RMBC commissioned an external review providing an independent view of our system which resulted in all partners signing up to a range of actions and recommendations. The Council also committed a significant part of the IBCF to supporting DTOC, which was positive for the system as it was seen as new money.

- Key things worked on were information sharing, looking at flows of patients and integration of discharge teams from care and health, which were bedding in well. The issue was to sustain this position over winter, which would be a challenge.

Ian was thanked for his presentation.

As the commission had become inquorate during the meeting, Members agreed rather than resolved to:-

(1) Note the six strategic priority areas.

(2) Receive the final draft of the 2018-19 Rotherham Clinical Commissioning Group Commissioning Plan in January 2018.

59. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 18th January, 2018, commencing at 10.00 a.m.