HEALTH SELECT COMMISSION
Thursday, 12th April, 2018

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

Councillor Roche, Cabinet Member for Adult Social Care and Health, and Councillor Steele, Chair of the Overview and Scrutiny Management Board, were in attendance at the invitation of the Chair.

Councillor John Turner was in attendance as a member of the public.

Apologies for absence were received from Councillors Allcock, Marriott, Rushforth and Robert Parkin (Rotherham SpeakUp).

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

80. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

81. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

82. COMMUNICATIONS

The Chair reminded Select Commission Members that the deadline for comments on the Rotherham Clinical Commission's Commissioning Plan was 12th April.

Terri Roche, Director of Public Health, drew attention to an email Members would be receiving regarding a free conference to be held on 24th May, 2018, in Leeds organised through Minding the Gap which would discuss poverty and debt. Places would be limited so if any Members were interested they should respond promptly.

83. MINUTES OF THE PREVIOUS MEETINGS HELD ON 18TH JANUARY 2018 AND ON 1ST MARCH, 2018

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 18th January and the inquorate meeting held on 1st March, 2018. Members noted that:-

Resolved:- (1) That the minutes of the previous meeting, held on 18th January, 2018, be approved as a correct record.

(2) That the recommendations contained within the minutes of the inquorate meeting held on 1st March, 2018, be approved.

Arising from Minute No. 64 (Integrated Locality Evaluation), it was noted that the final report on the evaluation of the Health Village was now available and would be circulated to Members. The working group established to consider the final report would meet on 1st May, 2018.

Arising from Minute No. 65 (Adult Social Care – Outcome Framework), it was noted that future reporting of the Adult Social Care Outcome Framework would be discussed as part of the 2018/19 work programming.

84. URGENT AND EMERGENCY CARE CENTRE UPDATE

George Briggs, The Rotherham Foundation Trust, presented the following powerpoint presentation on the Urgent and Emergency Care Centre (UECC):-

Background

- The new Rotherham UECC opened in July 2017 on the Rotherham Hospital NHS Foundation Trust site
- The new UECC provided an integrated response to urgent care for the Rotherham population – integrating the urgent and emergency care component of what was the Rotherham Walk-in Centre, the GP Out of Hours Service and the Hospital Emergency Department
- The UECC provided one front door for all urgent and emergency care in Rotherham – it opened 24 hours a day, 7 days a week, 365 days a year
- The aim of the UECC was that the local Rotherham population could access the right care, first time
- It was staffed by a mixture of General Practitioners (GP), Emergency Department medical and nursing staff, Advance Nurse Practitioners, Advanced Care Practitioners and other essential non-clinical staff
- It also co-located the Care Co-ordination Centre (CCC) and had work space to facilitate multi-disciplinary working with Mental Health Workers, Social Care Worker and ambulance staff

Initial Challenges

- The original model was based on The Rotherham NHS Foundation Trust as prime provider, but working in partnership with a third party provider – Care UK. This changed when Care UK withdrew from the working arrangements
- Despite doing some organisational development work, merging different cultures into single integrated service provided some initial challenge
- Clinical staffing challenges across both the Primary Care element of the Service and the Emergency Department Service
- Transferring the GP Out of Hours Service
- New ways of working for all teams – embedding change

- Increase in wait times to be sent for patients
- Communication – managing patient and public expectation

Where are we now?

- The original model has been modified as the teams have developed their ways of working
- Teams were starting to work well together – in the intended integrated way
- Recruitment was improving – 2 new Emergency Care Consultants commenced in post in November 2017 and more GPs were joining the team
- More Advanced Nurse Practitioners/Advance Care Practitioners had been appointed
- The Trust had commenced a development programme to train Senior Emergency Department Doctors which would support recruitment
- Rapid Assessment and Triage and See and Treat ways of working were starting to really become embedded
- Quality reviews had been implemented – reviews of the patient experience and outcomes

How are we doing/Performance

- The national 4 Hour Access target was that 95% of patients were seen, treated and admitted or discharged within 4 hours
- This was not being achieved locally or nationally – the national recovery trajectory was to achieve 90% by December 2018 and return to achieving the 95% target in 2018/19. The Trust was aiming to achieve 95% by 31st March 2018 (81% as of 11th April)
- Rotherham was now starting to see a month-on-month improvement in performance
  November 2017 81.36%
  December 2017 85.64%
  January 2018 87.1%
  February 2017 87.25% (as at 25th February 2018)
- This compared to England performance in January 2018 for all attendances – 85.3%
- The Rotherham NHS Foundation Trust currently ranked in the top 40 out of 133 Trusts

Patient Feedback

- Friends & Family response rate required was 15% of attendees – currently average was 5% per month
- Positive score target was 85% - UECC average was 92-99%
- January 2018 there were 320 responses. Of these 267 were extremely likely to recommend the Service; 50 were likely to recommend the Service, 3 were extremely unlikely to recommend the Service

- Positive feedback comments included “great staff attitude”, “staff very professional”, “staff friendly”, “team were very caring”, “excellent facilities”, “reception staff were polite and caring”, “they reassured me when I was ill”
- Negative feedback comments – “wait times – I waited over 5 hours to be seen”, “poor staff attitude”, “the waiting room was cold”

Current Challenges

- The development and opening of the new UECC was (and still was) a significant change management initiative
- Working together across the Primary Care, Emergency Department and GP Out-of-Hours Services needed to continue to develop
- Recruitment was improving but Rotherham would have to continue to be innovative to recruit and retain staff
- Work with patients and the public to manage demand and direct people to the right service, first time – the UECC was for urgent and emergency care
- Continuing to improve and maintain performance against the 4 hour access target was not solely attributable to the UECC

Future Plans

- Continue to develop a truly integrated urgent and emergency care service where teams worked effectively across all the urgent and emergency care pathways
- Further develop partnerships with Social Care, Mental Health Services, Primary Care, Voluntary Sector – project this winter working with Age UK Rotherham and the Red Cross
- More joint working between the Care Co-ordination Centre and the GP Out-of-Hours Service
- Improve the engagement with the public and patients
- Provide a first class service for urgent and emergency care for the population of Rotherham

Discussion ensued with the following issues raised questions/clarified:-

- Disappointment that the presentation did not reflect the integrated work that was already taking place between the Council and the Rotherham Clinical Commissioning Group (RCCG). The UECC came under the remit of the Health and Social Care Place Plan which in turn was under the remit of the Health and Wellbeing Board

- Care UK provided the original Out-of-Hours GP Service. It was a private company who had decided there was insufficient money in the business model so had made a commercial decision to withdraw; the Foundation Trust had stepped in and taken over the contract. Any staff who had wished to transfer to the Trust had transferred across under TUPE regulations to the NHS Terms of Conditions (approximately 30%). Over the past few months the Trust had used its Emergency Centre staff to cover the vacancies. There was the

same number, if not more, of staff than Care UK had been offering. As the RCCG were the commissioners it was not known what financial penalties, if any, there had been but Care UK had given 6 months' notice

- The figures stated in the original presentation had been correct at the time of collation i.e. 2 months ago. However, Winter Pressures had increased. Over the past 6-8 weeks the number of patients through the door and attendance at the Emergency Department had increased. The flow through the Hospital had not improved as one would have predicted and the additional Winter capacity would not close until the end of May. Performance of 87.25% had been very good for February with 84.9% for the year. The national average was 88-89%. The figure in Rotherham for March had been 83% which was a drop from the previous month but this was unsurprising given the snow and the number of respiratory illnesses. Whilst disappointing, nationally the position was the same with Rotherham still in the top 40-50 Trusts in the country but it needed to improve

- The patient feedback data was a national indicator with the associated method of collection that Rotherham was compared against across the NHS. The NHS had a duty to collect that data with an expectation that 85% would fill in the survey to say they were happy with the service. Rotherham scored 92% but it was acknowledged as a very rough measure

- Performance was monitored against a number of factors e.g. how the hospital treated patients, how it discharged patients etc. If the Trust had difficulties due to access to Mental Health/Social Workers, it shared the responsibility

- "Safer" was a national initiative about discharging people earlier in the day, making sure they had the right care at the right time by the right partner earlier in the day. It was about the way Ward rounds were done making sure consultants/junior doctors were appropriate, that TTOs and discharge letters were written in the morning and the plan of discharge done the day before so that patients would be moved out of the organisation in the morning. The national target was 35%; the Trust was at 19% some days and 12% on others. There was a long way to go to get discharges out in the day. An issue that was affecting that performance currently was the 40 extra beds that could not be staffed. It was the plan over the next 3-4 weeks to close as many of those additional beds as possible and get the medical and nurse teams back to their Wards so they could implement "Safer". They could not discharge patients any earlier if they were undertaking what were known as "safari ward rounds".

- There were 3/4 national initiatives:–
  - PJ Paralysis - making sure patients were not left in their nightclothes and in the morning get them up, dressed, talk to them and treat them as if fit to go home.
  - Red-Green – looking at a patient's pathway and journey. A Red Day – a patient has been sat in Hospital waiting for something e.g. CT scan, test result – if they have been waiting 2/3 days the Trust was not doing anything for them but if they got the result early they could be progressed to a Green Day. A Green Day - do something for a patient and move them through the hospital in a safe and appropriate way
  - Safer – see above point

- The partnership worked mainly on the Admissions Medical Unit (AMU) rather than in the UECC. If the UECC Team/GPs/Nurses/Emergency Consultants, decided that a patient required some extra support and was not ready to go home there and then (within 4 hours), they would send the patient through for assessment in the AMU where they would be seen by a Consultant, Junior Doctor, Red Cross, Frailty Team etc. and a view taken as to whether they could get the patient home there and then (within 8-12 hours) or within 12-24 hours. If the person was very frail they would have a comprehensive assessment and if in need of something else they would have an assessment by Occupational Therapist, Physiotherapist, Red Cross, any voluntary organisation the Trust could pull into help, involve family and friends, all within 10-12 hours of coming through the door. If it was clear that it was not going to be suitable to move that day an assessment would take place the following day

- The Trust found that 90% of patients were elderly frail. Recently a Care of the Elderly Consultant has moved into the AMU who would work between the AMU, Emergency Department and UECC to try and see those patients earlier. The Frailty Team would be increased to work alongside the Consultant and it was hoped that in 6 months' time the AMU would become a Frailty Assessment Unit. The emphasis had to change and required Age Concern, Red Cross, Therapists and Frailty Team to work together along with Mental Health Teams and Social Care Teams to ensure Social Services Teams were included within the AMU and Frailty Team in order to turn more people around at the door rather than admit them to hospital.

- There was a National course for Advanced Nurse Practitioners and courses that were funded by Health Education England. The Trust had recently submitted a bid for 6. There were 8 members of staff going through training and 6/7 that were fully trained. It was a problem in that the more trained qualified experienced nurses were pulled out of the Wards the standard of care decreased on the Ward, however, there was an issue around the recruitment of junior doctors; the Trust's vacancy rate around middle grade doctors was

phenomenal and it was trying to balance the act somehow. The Team had been asked to submit a bid for more training places

- It was hoped to develop the Trust's Hospital at Night Service so it would be available 7 days, 24 hours a day and that would be made up of Practitioners who would support and maintain the organisation. In the next 2 years there would be a need for approximately 30+ Advanced Practitioners which would make a big difference

- Typically across England a consultant had 1/2 Junior Doctors on the Ward round and started at one end of the Ward and worked their way through. The full Ward round was taking too long and at the end the Consultant would send the Junior Doctors back to manually write up the medication and letters. There was no electronic prescribing service or system in Rotherham, although one had been discussed. There was a national programme to change Ward rounds and it was planned to get them to visit Rotherham to change the method i.e. the first 6 patients were seen, the Consultant left the Junior Doctor behind to complete the paperwork and moved onto the next 6 taking an Advanced Practitioner/Junior Doctor and then left them to complete the paperwork with the first Junior Doctor rejoining for the next 6 and so on. In theory at the end of the Ward all patients should have their paperwork complete apart from the last 6 patients

- The Trust had space for Mental Health Teams and Mental Health practitioners and had very good facilities for patients with Mental Health needs but what it did not yet have was 24 hours 7 day Mental Health cover. A national project, Core 24, which Rotherham would be part of, would identify, recruit and place a core team of Mental Health practitioners in acute hospitals 24 hours a day so that anyone who needed care, support and treatment from a Mental Health Team could be done. It was Mental Health Commissioner-led with Mental Health, Acute and commissioners working together to provide the service for which there was national funding for it. There may be an issue with regard to the recruitment of nurses and practitioner from a Mental Health point of view because they were scarce

- The Trust had made the decision that if someone arrived at the UECC who had an illness/a need to see someone they would be seen but the message would be reinforced that, if their symptoms could have been treated by their GP, that was where they should have gone

The Chair thanked George for his presentation.

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

(2) That the Scrutiny Officer contact Rotherham Clinical Commissioning Group with regard to further information regarding Care UK's withdrawal from the UECC contract.

85. SCRUTINY REVIEW - DRUG AND ALCOHOL TREATMENT AND RECOVERY SERVICES

The Chair presented the main findings and recommendations from the cross-party spotlight Scrutiny Review of Drug and Alcohol Treatment and Recovery Services for Adults.

A spotlight review had been undertaken to ensure that the Service, which would be operating within a reduced budget, would provide a quality safe service under the new contract from April 2018.

The detailed overview of substance misuse in Rotherham had been received noting that the majority of Service users were male and white British. Although numbers in Service were declining over time, there were a number of older long term drug users many of whom now had associated physical health issues.

The bringing together of various aspects of the Service together under a single contract, including having treatment and recovery services available in one location, may facilitate a more personalised and holistic approach to treatment and recovery.

The members of the Review Group were thanked for their work on the Select Commission's behalf on this issue.

The Review's eight recommendations were as follows:-

1. That Public Health and Change, Grow, Live (CGL) present an overview of how the new service is progressing, including a summary of progress on the key performance indicators, to the Health Select Commission in Autumn 2018.

2. That Public Health ensure robust performance management is in place for the new contract from the outset in 2018, including exception reporting and a mid-contract review (to report back to the Health Select Commission).

3. That the Suicide Prevention and Self-Harm Group revisit the suicide prevention awareness raising work in Wentworth Valley in 2018-19 and roll it out more widely through sharing resources and learning, particularly in hotspot areas identified through the National Drug Treatment Monitoring Service.

4. That Public Health consider strengthening the messages under Making Every Contact Count around safe alcohol consumption and where to go for help, when it is refreshed.

5. That future commissioning of services by RMBC that exceed the Official Journal of the EU threshold, especially Public Health and Social Care Services, includes soft market testing with providers/potential providers in advance of going out to tender to ensure a successful process first time.

6. That drug and alcohol pathways and signposting, including protocols for links to other processes such as the Vulnerable Adults Risk Management process, are reviewed by RMBC and partners in 2018, to minimise any risk of people not being able to access support.

7. That in their initial assessments and reassessments with service users CGL include the additional risk factors identified from the RDaSH analysis into suicides from April 2018.

8. That Public Health and CGL continue to take a proactive approach to safety concerns in the service, including incorporating any lessons learned from elsewhere and the findings of any Serious Case Reviews when published.

Councillor Roche, Cabinet Member for Adult Social Care and Health, expressed concern with regard to recommendation No.3. Wentworth Valley Area Assembly had funded the good work that had been delivered. All Members had been sent a letter regarding rolling out the work to all Wards but they would have to provide funding. However, no Members had responded to the request.

It was suggested that once the geographical data was analysed that might trigger some specific work and lead to discussion on communications and an operational structure.

Resolved:- (1) That the Review findings be endorsed and the recommendations set out in Section 6 of the Review report at Appendix 1 be approved.

(2) That the report be submitted to the Overview and Scrutiny Management Board for consideration prior to submission to the Cabinet/Commissioners' Decision Making Meeting.

(3) That the response from the Cabinet/Commissioners' Decision Making Meeting be reported back to the Select Commission.

86. SOUTH YORKSHIRE, DERBYSHIRE, NOTTINGHAMSHIRE AND WAKEFIELD JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE UPDATE

The Scrutiny Officer reported that the Committee had not met since the last update.

The report on the outcome of the Hospitals Review was due to be finalised towards the end of the month and would be submitted to the Select Commission during the new Municipal Year as well as an update on Stroke Care and Children's Care and Anaesthesia Services.

87. CAMHS UPDATE

The Commission noted a report that had been considered by the Health and Wellbeing Board at its meeting on 14th March, 2018.

88. HEALTHWATCH ROTHERHAM - ISSUES

No issues had been raised by Healthwatch Rotherham.

89. HEALTH AND WELLBEING BOARD

The minutes of the meeting of the Health and Wellbeing Board held on 10th January, 2018, were noted.

Councillor Roche, Cabinet Member for Adult Social Care and Health, reported that a meeting had been held the previous day of partners to look at the new Strategy for the Place Plan which now came under the remit of the Health and Wellbeing Board.

90. DATE OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 14th June, 2017, commencing at 10.00 a.m.