HEALTH SELECT COMMISSION
7th March, 2013

Present:- Councillor Steele (in the Chair); Councillors Barron, Beaumont, Beck, Dalton, Goulty, Hoddinott, Kaye and Wootton.

Apologies for absence:- Apologies were received from Doyle, Wyatt, Middleton and Roche.

58. DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

59. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

60. COMMUNICATIONS

Councillor Hoddinott reported that the Secretary of State's Judicial Review into the proposed closure of the Children's Cardiac Surgical Hospital in Leeds had found that the consultation process was unfair and legally flawed.

61. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the minutes of the previous meeting of the Health Select Commission held on 1st February, 2013.

It was noted that the Childhood Obesity Review Group had not met as yet.

Resolved:- That the minutes of the previous meeting be agreed as a correct record.

62. HEALTH AND WELLBEING BOARD

It was noted that the minutes of this meeting would be submitted to the next meeting.

Councillor Hoddinott asked why Community Alcohol Partnerships had been commenced in Deprived Communities when most of the evidence suggested that it was those in employment that had issues with alcohol. Had the Board taken the evidence into account?

Dr. John Radford reported that 1 of the aims of the Partnerships was to reduce the supply of alcohol particularly to children under the age of 18 and hopefully see less violent behaviour in that cohort, less street drinking and also reduce street drinking in the older age groups where it was clear

that abuse was taking place. He agreed that the evidence base suggested that there was a significant hidden problem that Partnerships would not address.

63. CLINICAL COMMISSIONING GROUP

Chris Edwards, Chief Officer, NHS Rotherham/Rotherham Clinical Commissioning Group, gave the following powerpoint presentation:-

What do the changes mean for Rotherham?

- Rotherham Primary Care Trust/NHS Rotherham would be abolished in March, 2013
- There would be (at least) 6 new bodies in its place:-
  - Rotherham Clinical Commissioning Group – Expected to be authorised to formally start in April, 2013
  - RMBC – Public Health responsibilities transfer from NHS to RMBC in April, 2013
  - National Commissioning Board (NHSCB) – would cover all of South Yorkshire and Bassetlaw based at Oak House, Bramley. Includes GPs/Dentists/Pharmacists/Opticians contracts and specialist commissioning
  - HeathWatch – would be formed to promote the views of patients and Service users
  - NHS Property Services – all estates owned by NHS Rotherham e.g. health centres
  - Public Health England – Health Protection Agency would also lead on commissioning support to the Commissioning Board – specialist commissioning covering vaccination and immunisation

Funding

- NHS Rotherham £460M
  - RMBC Public Health = £14M
  - Rotherham Clinicial Commissioning Group - £330M
  - NHS Commissioning Board GPs/Dentists/Pharmacists = £116M

Who is CCG represented by?

- David Tooth, Chair, Long Term Conditions/Urgent Care
- Chris Edwards, Chief Officer
- Richard Cullen, Vice-Chair, Finance
- Ian Turner, Primary Care
- Phil Birks, Rotherham Foundation Trust
- Julie Kitlowski, Clinical Referrals and Pathways
- David Pokinghorn, Children and Young People
- Jason Page, Prescribing
- Russell Brynes, Mental Health, End of Life Care and Equality and Diversity
- David Plews, Medical Director, NHS Rotherham Metropolitan Borough Council

What Services will the CCG commission?

- Unplanned (unscheduled care)
- Planned (scheduled care)
- GP prescribed medication
- Mental Health and Learning Disability
- Children and Young People
  Policy decided that most of Children's Services would be commissioned by the CCG but School Nursing would remain the responsibility of the Council and Public Health. Health Visitors would come under the NHSCB for 2 years and then transfer. This was a risk area
- End of Life Care
- Transport services for patients
- Any qualified provider services
- Services jointly commissioned with RMBC
- Services the CCG commissions from GPs (small)

Financial Challenges

- Nationally the NHS had to save £20B
- Rotherham would have to save approximately £80M by 2014/15

Challenges for the CCG

- Overall the NHS spent approximately £2,000 per person
- Approximately ¾ of the £2,000 per head was the responsibility of the CCG
- Some areas which were very important for patients such as GP services and very specialised services were the responsibility of others (NHSCB or Public Health)
- Costs and demands for services were increasing faster than NHS spending
- Much of the balance of the spend was hard to change e.g. most of the money was spent on urgent hospital care
- There was a chicken and egg problem in that the CCG could not spend more on prevention until it decreased the cost of acute services

CCG Urgent Care Review

- A new Urgent Care Centre for Rotherham
  - Would be open 24/7
  - Purpose-built at Rotherham Foundation Trust Hospital
  - Staffed by experienced and specially trained nurses and GPs
  - Joined up with Accident and Emergency
- Re-investing money from the Walk-in Centre into Urgent Care
  - Urgent Care Services currently provided at the Walk-in Centre would transfer to the Urgent Care Centre
  - The Walk-in Centre would close (but not the building)
  - New NHS 111 service would provide advice and support for non-urgent care (to be launched on 19th March, 2013)

Next Steps

- Finalising proposals
- Continuing discussions with providers, patients and stakeholders
- 12 weeks public consultation starting in the Spring
- Recognition that for some the proposals would raise issues. They would be listened to and work with the local community to address them where possible
- Proposal to open the new Urgent Care Centre in Autumn 2014

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

- The Legislation governing CCGs recognised that the nursing voice had to be heard and that there should be a hospital doctor. Sue Casson was on the Governing Body representing nursing and a Dr. Ashurst from Bradford Hospital. Any suggestions of a forum that could be engaged would be useful

- There was no requirement in the national guidance to include a specialist health professional on the Governing Body

- The CCG Strategy was to decrease unscheduled hospital admissions. If Rotherham could reduce its number to the national average, the plan was to spend £5M more on Community Services to ensure patients received the appropriate services

- The move of the Walk-in Centre to the Hospital would cause logistical problems for visitors from a car parking/bus route point of view. Consideration would be given to accessibility

- The demolition of the former Mental Health block fronting the main road would provide additional car parking spaces

- A GP practice would remain at the Walk-in Centre for a period of time following its transfer to the Hospital

- There was an efficiency target for the whole health community of £80M over 4 years. A large proportion would be passed to the Rotherham Foundation Trust but the CCG still had to make significant savings. The CCG's annual commissioning plan, available on the website, detailed what it intended to do in terms of efficiencies

- The Health and Wellbeing Board, Healthwatch and Health Select Commission would be responsible for scrutinising the CCG

- Currently there were no plans to move any services outside of Rotherham. It was not a case of stopping delivery but delivering differently. All CCGs across the country shared the strategy that hospitals were expensive. Rotherham had a lot of people that went

into hospital unnecessarily and would receive better treatment outside of it. A big issue was follow-up out-patient appointments a large number of which could take place at GP practices.

- Conflict of interest – GPs were not involved in the decision making; they were involved in the discussion and working up of the business case but the decisions were made by the lay people and independents. This was in accordance with the national Policy

- The Department of Health was introducing Payment by Results not Rotherham CCG. It would be based on a national price rather than a local price for Mental Health Services. The Department of Health had tried to introduce it since 2005 but had struggled due to the difficulties in getting an average price due to the varieties of the client group. It was proposed that it be introduced in 12 months and run in shadow form as from 1st April, 2013, to understand whether it would be realistically possible and whether it was a far way of recompensing providers for providing those services. It would be about numbers going through the Service rather than outcomes. Rotherham CCG had in its contract additional payments on top of the tariff for improving quality

- Rotherham CCG had 2 lay members – 1 for governance (John Gomersall) and 1 for patient engagement (Sue Lockwood)

- The CCG Audit Chair met with the Council's Audit Chair. It was expected that the current arrangements would continue. Due diligence had been completed

Chris was thanked for his presentation.

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

(2) That an item entitled "Walk-in Centre" be included on the next Select Commission agenda.

(3) That the Health Select Commission be provided with a copy of the Clinical Commissioning Group's annual commissioning plan for information.

64. ROTHERHAM FOUNDATION TRUST

The Chairman introduced Peter Lee, Chairman of Rotherham Foundation Trust Board, and Michael Morgan, Interim Chief Executive of Rotherham Foundation Trust.

Peter gave a brief resume of recent events at the Trust. As a result of the Nicholson challenge, the NHS had been required to save £20Bn across the country of which Rotherham's proportion was £50M over 3-4 years. It

was fair to say that the Board had not acted quickly enough in terms of recognising it had to make the savings.

As a result, the Trust had come to the attention of Monitor, the independent regulator of NHS Foundation Trusts, who assess the quality of service provided, financial stability and sustainability of a Trust. When examining the Trust's finances, the Trust had been downgraded to a 2 from a 3 as it had not achieved the required savings. They then examined the plans for the organisation and the way the organisation was moving forward and decided that they had concerns about the financial stability of the organisation. Monitor had declared the Trust to be "in significant breach" but decided not to exercise Intervention Powers as they were satisfied with the quality of care but not the financial recovery. A recovery plan had to reach them by 18th March together with monthly meetings and reports.

Work on the plan was underway and would be submitted in accordance with the deadline.

Michael stated that it was important to note that Rotherham was in a situation that was not unique to other Trusts within the UK. Included in the report to Monitor would be the first year very robust budget process together with years 2 and 3. Monitor had also requested a 3 year strategic plan to be submitted in September, 2013, looking at all the services throughout the Trust.

Michael had started in Rotherham on 1st December, 2012, to work on transformation issues but it had soon become clear that it was a turnaround company that was required. An interviewing process had commenced and Bolt Partners appointed. Michael had commenced in his new role at the beginning of February, 2013.

A question and answer session ensued with the following points raised/clarified:-

Financial Situation

- How had the Trust gotten into such deep financial troubles? Financial performance was flagged up as an issue in February, 2011. What has been done since then? Would the Trust be able to achieve the required savings? Could the Trust go "bust"?
  The Trust had always spent its income on its services which did not have a reserve fund. The impact of the required savings and the Trust not acting quickly enough in certain areas resulted in it finding itself in a position where it was spending the money it was not receiving as well as not making the efficiencies at a sufficient pace. The Trust had been in breach in 2010/11 because it had not achieved savings required then by Monitor. In the past funding had always appeared and the problems solved. In the new regime that had not happened. There had been a lot of effort to recover in ways which did not involve job losses and efficiencies tried but had not achieved the

required savings. Eventually the decision had been made that the Trust needed to look at immediate efficiencies and to look at the question of redundancies which had lead to the 90 days consultation with staff.

The Trust could go "bust" but it was not going to. The steps that were being taken involved, not only a realisation by the Board that the savings had to be achieved as part of the overall financial requirement, but also that it could save money by working/creating a different structure within the organisation. Huge efficiencies in terms of admissions, length of stay and the way in which patient pathways were designed all of which would achieve efficiencies and save money at the same time were being considered. The recovery programme would take 3 years but would not prejudice patient safety.

- Why would it work this time? What was different?
  In late 2012 it had become obvious that there was a need for a specific post of Turnround Director whose job it was to deliver the required savings. Tremendous headway had been made with every line of finance being challenged and contracts renegotiated. The work was being carried out in parallel to the delivery of services.

- Being mindful of the Mid-Staffs review, focussing on financial aspects could be at the expense of patient care. Was it correct that the Trust was not achieving its 2 week target on breast cancer at the moment?
  No that was not true. Since 15th September all targets for breast cancer had been met. It was believed that there were 4 patients in August that had symptomatic breast cancer. 1 of those individuals decided not enter into the 2 week field. The Trust had very low counts of symptomatic breast issues going through so the numbers would be hard to meet from the stand point of 85%.

  There are 2 ways to undertake turnarounds for hospitals. 1 was the slash and burn method and secondly the leadership style which was very inclusive and an encompassing style for the organisation to make the changes in a way that did not harm the quality or patient safety within the hospital. The company used a very inclusive management style and one that utilised the consultants and specialists within the hospital. The Trust's 11 Clinical Directors would be very important when the issue of staffing was considered. A past decision of the Trust was to close a Ward and had stopped hiring nurses because if 1 Ward was closing the nurses could be transferred. However, the company had quickly become aware that the hospital was short of nurses. 1 of the company's stipulations was that the Trust hire new nurses and, as a result, 60 nurses had been interviewed. 50 had been signed up to come to the Trust and over time there would be approximately 60-70 new nurses.

  The consultants and specialists' working methods had to be revised. They had met recently and committed to have a new rota in place by

18th March which allowed rounds to be made in the hospital and getting to patients that should be discharged quickly.

A further change that needed to be made was the Walk-in Clinic which would help the hospital reduce the amounts of funds it required and increase the efficiencies of the Trust. There were patients in the hospital that really did not need to be treated in an Acute Care setting and, once in hospital, was difficult to get them turned around quickly.

- How did it fit with the planned redundancies?
  The company approached redundancies and/or changing staffing patterns within a Trust was by not considering any areas that touched patients initially. It looked at areas of Corporate spend in the first instance and that was the area the plan to be submitted to Monitor was concentrating on. For example, Corporate spend at Rotherham was approximately £22M; other Trusts in the area and within the UK spent closer to £16M. The Clinical Directors had been asked to re-look at their areas and come up with a £5M reduction in Corporate spend. Estates (domestics, porters) was exempted as that was an area that touched patients directly.

- How many professional staff had taken voluntary redundancy? Were the 60 nurses new appointments or from within the organisation?
  They were new appointments. The redundancy 90 days consultation started in December, 2012 and finishes on 14th March, 2013.

- What were the numbers you are looking for in redundancies and from what areas? Had redundancy costs been budgeted for? Were the new nurses employed full-time on permanent contracts?
  The Trust had required 60 full-time equivalent nurses. The CCG had provided some additional funding for the Trust as it went through the recovery process. It was believed that there needed to be a slimmer executive group.

- The 3 year plan and progress would not be in a straight line. What interim measures were there to review and correct that process? How would you intervene when/if they dropped below the target?
  The organisation needed a very strong project planning process put in place. An inclusive strategic planning process, part of what Monitor was requesting, illustrating what needed to take place in the next 3 years as well as what was happening on an interim basis, had been pulled together. In the future the Trust would no longer receive funding on the number of patients but on the efficiency and care that was provided. It would mean a huge amount of change in the organisation had to happen and some by the Board.

- Would the nurses be newly qualified?
  They were qualified nurses. A problem had been identified at the Trust some time ago in that the nurses at Rotherham were banded at a very high level, higher than other Trusts in the area. However,

those nurses concerned would be pay-protected for 2 years and that change would probably need to be made to make it competitive with other Trusts.

- Monitor identified concerns that last time consultants came in, they improved the situation but 1 of the risks is that interim arrangements were not permanent. Does not change need to come from within and to ensure that that change was still happening 2-3 years down the line?
  The Interim Chief Executive's role was to look at the organisation and its culture. The process for changing the culture at the Trust had started. Almost daily staff forums were held from which information was gained on what exactly needed to be incorporated into the strategic planning process. Whilst ever a Trust was receiving funding and progressing everyone was happy and not a lot of problems; when a big change happened the weaknesses of the organisation came to the forefront. The plan was to institute a more inclusive management process. It was a leadership process from the top down.

  There was also an issue with the Trust having taken over Community Nursing 2 years ago. Acute Care and Community Nursing were 2 different entities and synergy was needed between the 2 so they could work together and ensure care to the patients in the right setting.

  The plan to be submitted to would be scrutinised by Monitor as well as external scrutiny to ensure that it was deliverable. There would then be monthly meetings with Monitor.

Electronic Patient Record System

- There had been reports in the media that the system was not working and costing a lot of money. How much was being spent on it? Was it being used elsewhere in the United Kingdom?
  There were such systems in the United Kingdom that were functioning but not the version of the system which was the latest version. The process had been commenced 4 years ago and at that time there had been engagement by physicians, clinicians, specialists and nurses to get the system in. There was then disengagement by the specialists, nurses and consultants. The system worked very well in most instances but the biggest problem was that, the way in which the system had been built, physicians were having to input the initial front end information themselves which was timeconsuming for them. The way in which the information was inputted by consultants and specialists had to be redesigned and it would then be a very robust and good system. Having an electronic system was very efficient for a Trust and a hospital.

  Approximately £20M had been spent on the system over the 4 years. There was a system which worked very well for Community Nursing, however, that was not a full blown Acute Care hospital EPR system

and probably would not work well for a full EPR system in a UK hospital. The Board had been requested to bring in outside independent help. That help had now been looking at the system and was to submit a plan to Monitor.

- If the system had been in for 4 years and was still not working correctly how much would it cost to put right?
  Although the system had been in for 4 years it had only actually been installed in June, 2012. The Trust had already purchased the hardware and infrastructure and everything was in place even the additional modules. There would not be a big cost as far as additional hardware and infrastructure were concerned; it would only be the cost of retraining of staff and redesigning the method of inputting the information.

  As it was the latest version there would be no upgrade for a while.

- What were the lessons learnt from this process and could it happen again?
  Some of the largest hospitals had had problems with such systems and had to reinstall. They were very difficult systems to install and to do so properly.

Patient Quality

- There was a very skilled Community workforce at the Trust and it was very important that the pathways of care were clear
  It was believed that the integration process was not working between Acute Care and Community. Since 4th February, 2013, the weekly meetings now included the leadership from Community together with executives of the Acute Care hospital. This had not happened previously. Until there was synergy between the 2, there would never be the efficiencies the hospital required to move forward.

- Were there cultural issues to be addressed in terms of perception of each other's view of the work that was done? Often it was thought that money would be saved by delivering care in the community but it was not necessarily so
  There were cultural issues to be addressed on both sides. Community was and currently still funded by grant i.e. not funded in the same way as the Trust so there were fundamental differences. The culture was also different in both organisations and that had to be synthesised. It was the intention that each of the executives and stakeholders within the Acute Trust and Community were together and worked through their strategic planning process. It would be a very intense process and really the only way to get to the cultural changes that needed to take place. It was also the only way you could reach the 2nd and 3rd year financials that needed to take place within the process.

- There was varied feedback about the care received from the hospital Even though the Trust had needed additional nurses the Wards were not short of nurses. The Trust had been bringing in nurses from outside agencies and using nurses within the organisation through their bank system. This, however, was a costly practice.

- How did the patient voice fit into the strategies?
  Michael reported that for years he had used "Dear Michael" which was a very easy way for employees, patients, consultants, specialists etc. to be able to write directly to him concerning their experience at the hospital. However, the NHS had introduced Friends and Family, a survey that had to be filled out by the patient. So as not to cause confusion, "Dear Michael" was to be available on the website.

The Chair thanked Peter and Michael for their attendance at the meeting.

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

(2) That Peter Lee and Michael Morgan be invite to the 13th June meeting of the Health Select Commission.

65. SCRUTINY REVIEW - AUTISTIC SPECTRUM DISORDER

Deborah Fellowes, Scrutiny Manager, submitted the findings and recommendations of the Scrutiny Review of Autistic Spectrum Disorder in Rotherham.

The overall aim of the review was to achieve a better understanding of patterns of Autistic Spectrum Disorder (ASD) in Rotherham leading to the development of appropriate support and assistance to families affected by it. It had taken place in a climate of budget reductions and, therefore, also wanted to look at the potential for more effective use of existing resources.

The review had been structured around 4 objectives:-

- The reasons for the higher diagnosis rates
- Services required at diagnosis stage and after
- 16+ support and transition
- Budget implications.

The Key messages from the Review were as follows:-

- Early intervention and prevention work was key for children with ASD
- Mental Health needs of children and adults with ASD could arise because of the lack of support
- Lack of clarity about where the lead of support laid – Education, Health etc.

- It was difficult for many parents to make sense of all of the different agencies that were involved in the area of work
- There had been significant progress made with the area of work and this needed to continue with clear leadership and direction
- To ensure the best outcomes for children and young people with ASD, parental voice and influence was absolutely crucial
- All of the recommendations formed as part of the review were about more effective use of existing resources, achieving better value for money and becoming better organised in delivery of support. It was the view of the review group that there should not be a need for additional resources to implement the recommendations

Resolved:- (1) That the findings and recommendations set out in the report be endorsed.

(2) That the report be forwarded to the Overview and Scrutiny Management Board and Cabinet.

(3) That the Cabinet response to the Scrutiny Review recommendations be fed back to this Select Commission.

66. ROTHERHAM HEART TOWN - ANNUAL REPORT

This item was deferred due to the absence of the Cabinet Member for Health and Wellbeing.

67. EXCLUSION OF THE PRESS AND PUBLIC

Resolved: - That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972 (as amended 2006 – information relates to finance and business affairs).

68. TRANSPORT AND LEARNING DISABILITY DAY SERVICE CATERING CONSULTATION

The Service Manager, Adult Community Services, submitted for information the final proposals for Transport and Catering arrangements for the Learning Disability Day Care Service based on the recent consultation with customers and carers.

Transport Provision
Extensive work had been undertaken with a number of officers who were aware of customers and carers' needs to review the change to current transport provision.

Catering Provision
At present the current in-house Day Service catering arrangements, delivered on site, were underutilised by customers and therefore not cost effective. Recent consultation had shown that customers were accepting of the choice of taking their own packed lunch or purchasing a meal from the café.

Discussion ensued on the proposals with the following points highlighted:-

- Approximately 30% of the clients were in receipt of the higher level Mobility Allowance

- Concerns raised at the consultations with regard to those who had learning difficulties and not able to feed themselves or have the ability to choose what they wanted to eat. There were a significant number with complex needs that needed support with feeding and that would not stop

- Some would need a bus buddy – consideration was to be given to this in the consultation

- Running alongside these proposals was a tendering exercise across Adult and Children Services with private providers. Work had been undertaken with Procurement who were conducting the tendering process and having discussions with private providers so they were well aware of the proposals

- £39.10 quoted in question 10 of the consultation questionnaire was the unit cost. It was a flat rate charge which was less than the lowest DLA rate. Clients were not financially assessed. If it was raised with the Service it would be looked at but not assessed as part of their care package cost

- Routes were being taken into consideration to ensure the length of time a client could possibly be on the transport was kept to a minimum

- There would still be cafes on site available for customers who wished to purchase snack items – it was the old dining rooms that were being closed – or there was the option of making their own meal

- People had the choice whether to attend a Day Centre. Some were taking the choice of taking their Direct Payment instead. Younger people found that Day Centres did not meet their needs. If there was a reduction in the number of people using day centres it would be seen by a rise in the number of Direct Payments. Then there would be a need to change the way in services were provided

Resolved:- That the report be noted.

69. DATE AND TIME OF NEXT MEETING

Resolved:- That a further meeting be held on Thursday, 18th April, 2013, commencing at 9.30 a.m.