HEALTH SELECT COMMISSION
23rd October, 2014

Present:- Councillor Wyatt (in the Chair); Councillors Dalton, Havenhand, Hunter, Jepson, Kaye, Swift, Vines, Whysall and Wootton and Robert Parkin (Speak-up).

An apology for absence was received from Councillor Sansome.

44. DECLARATIONS OF INTEREST

There were no declarations of interest made at this meeting.

45. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

46. COMMUNICATIONS

Better Care Fund
Shona McFarlane, Director of Health and Wellbeing, reported that Rotherham had been required to submit a revised version of the Plan in accordance with a September deadline. It had gone through a process of moderation and feedback was awaited. Every Plan was checked by an independent assurance process commissioned by NHS England and a telephone conference call had taken place to check a few matters of fact and accuracy in the document.

The revisions to the Plan had included an additional action (BCF15) regarding End of Life. Each of the action plans were currently in the process of implementation and would update the Select Commission in due course.

Minor Oral Surgery
NHS England (NHSE) Area Team was consulting on proposals to commission dental procedures such as wisdom tooth extraction and removal of retained roots from specialists based in general dental practices rather than from the local hospital as at present. The proposals affected Rotherham and Sheffield as Barnsley and Bassetlaw had had such services based in the community for a number of years and NHSE planned to recommission them. There would be no overall reduction in the amount of activity commissioned.

The proposal was to have 1 contract for Rotherham to treat 600 patients per annum (which equated to 1 dentist seeing 14 patients per week).

The deadline for comments on the proposal was 6th November.

Resolved:- That a response on behalf of the Select Commission be submitted including comments with regard to location, access and disability access.

Joint Health and Overview Scrutiny Committee
2 meetings were to be held in November to develop consultation responses to the proposed standards for Congenital Heart Disease Services for both children and adults.

(2) That Councillor Wyatt be nominated as the Select Commission's representative on the Joint Health and Overview Scrutiny Committee.

(3) That Councillor Sansome be nominated as Councillor Wyatt's deputy on the Joint Health and Overview Scrutiny Committee.

MyNHS
The above were the new web pages on the NHS Choices website containing health data that facilitated comparison with other areas on a number of measures/indicators for hospitals, social care, Public Health, services and outcomes and mental health hospitals.

NHS England Road Map
The Chairman commented on the information released in the press regarding the major issues facing the NHS and the budgetary pressures that needed to be addressed.

47. MINUTES OF THE PREVIOUS MEETING

Consideration was given to the minutes of the meeting of the Health Select Commission held on 11th September, 2014.

Resolved:- That the minutes of the meeting held on 11th September, 2014, be agreed as a correct record for signature by the Chairman.

Arising from Minute No. 33(7) (Joint Health and Overview Scrutiny Committee), it was noted that the meeting had not taken place in September as previously reported due to issues with regard to parental consent for some of the information in the reports. The meeting would now take place on 21st November, 2014.

Arising from Minute No. 37 (Progress on Plans for New Emergency Centre), it was noted that the travel plan and IT procurement proposal were not ready for sharing with the Select Commission as yet. A representative would attend a Select Commission meeting in due course to give an overview on the IT system and what this would mean for patients and services.

48. HEALTH AND WELLBEING BOARD

Consideration was given to the minutes of meetings of the Health and Wellbeing Board held on 2nd July, 27th August and 1st October, 2014.

Resolved:- That the minutes of the meeting be received and the contents noted.

49. ISSUES FROM ROTHERHAM HEALTHWATCH LTD.

It was noted that Melanie Hall was to leave her post at Healthwatch. The Chief Executive post was out to advert.

50. ROTHERHAM FOUNDATION TRUST

Resolved:- The minutes of the meeting with the Rotherham Foundation Trust held on 29th September, 2014, be noted.

51. NHS ROTHERHAM CLINICAL COMMISSIONING GROUP - COMMISSIONING PLAN 2015-16

Chris Edwards, Chief Officer, Robin Carlisle, Deputy Chief Officer, and Lydia George, Rotherham CCG, referred to the powerpoint presentation which had recently been given to SCE/GPs which covered:-

- 2014/15 commissioning plan was available on the intranet – www.rotherhamccg.nhs.uk/our-plan.htm
- 2015/16 Plan was a refresh rather than a complete re-write
- CCG transformation capacity was finite so it was important that if new initiatives were prioritised some exiting initiatives were stopped
- Strategic Clinical Executive
- Clinical Referrals, Medicine Management and Mental Health
- Medicines Management
- Mental Health

2014/15 Progress and Issues

- Clinical Referrals
  Early 2014/15 data show referrals and electives rising after 2 flat years
  Audit programme and feedback via PLT working well, TRFT starting medical directorate 'PLT'
  Follow-up audits failing to identify many opportunities to reduce follow-ups

- Medicines Management
  Cost growth currently on track
  33 out of 36 practice plans agreed
  Service redesign projects performing well but some risks regarding TRFT re-organisation
  Waste

2015/16 Proposals

- Clinical Referrals
  Develop a "Plan B" for the increase in referrals
  Monitor and address issues with "other referrals"
  Closer involvement of CCG in the development of RFT medical pathways
  Improve access to neurology and develop appropriate pathways
  Bench marking for GPs to improve quality and consistency
  Development of pathways to provide advice on access to blood tests and imaging
  Explore opportunities for self-care and non face-to-face consultations
  Explore the market for primary care based Dermatology and Diabetes Services
  Develop the prevention agenda with Public Health England

- Medicines Management
  Same priorities plus realising the benefits of electronic prescribing (decreased waste)
  Address the high admission tate for respiratory conditions and prescribing rates
  Consider local and national risk of reducing waste
  Address waste in term of general waste and in particular nursing home waste
  Plan for the risk to special projects due to TRFT restructuring

- Mental Health and Learning Disabilities
  3 reviews carried out (Adults, CAMHS and Learning Disabilities)
  Learning Disability – following consultation would implement the decision taken at 3rd September Governing Body
  Action plan for RDaSH Services due to be agreed in September/October, common messages agreed, included being minded to contract with RDaSH as main provider but investing QIPP in voluntary sector or general practice
  Adult and Older Peoples Mental Health Liaison Services most urgent issue
  Issues with partnership working

- Adults and Older People
  Implement action plan including improved data and pathways, Adult Mental Health liaison, primary care focussed model, improved IAPT, improved Dementia Services
  Increase the number of mental health patients on the case management programme
  Develop a dementia pathway with more focus on Primary Care and "one stop shops"
  Involve the voluntary sector on the dementia pathway
  Improve RDaSH communication with stakeholders and providers
  Support RDaSH management of change

Obtain patient experience of instances of poor service in respect of long waiting times and poor communication
Parity of esteem and 7/7 working
Long term impact of Child Sexual Exploitation
Learn from CRMC referral pathway work
Address the acute management of the physical health of mental health patients
Address the variations in Mental Health care (IAPT/Dementia)
Extend Community Transformation to include IAPT and Dementia
Measurable outcomes

- Mental Health CAMHS and Learning Disability
  CAMHS
  Ensure that 2014/15 improvements were maintained and that the extra consultant improved capacity
  Impact of Child Sexual Exploitation

  Learning Disability
  Evaluate the impact of Governing Body approved ATU/community investment decision

- Unscheduled Care and Transforming Community Services
  Urgent Care redesign
  Care Co-ordination Centre
  Transforming Community Services – Locality Based Nursing
  Increased use of Alternative Levels of Care to Hospital

- Transforming Community Services
  Priority 1: A better quality Community Nursing Service
  Priority 2: Integration across Health and Social Care
  Priority 3: An enhanced Care Co-ordination Centre
  Priority 4: Utilisation of alternative levels of care
  Priority 5: A Better governance framework

- 2014/15 Progress and Issues
  New Service model agreed for Community Nursing
  Locality Nursing Teams serving GP practice populations
  Extended Care Co-ordination Centre hours to 24/7
  Development of the supported discharge care pathway
  Reconfiguration of the Community Unit to support frail elderly
  Discharge to assess (D2A) Care Pathway for CHC patients
  Commissioning of specialised nursing home beds for D2A and winter
  New governance framework in place for Community Health Services

2015/16 Proposals
- Development of locality based Health and Social Care Teams
- Development of an Integrated Rapid Response Service
- Integration of the Care Co-ordination Centre with Rothercare
- Introduction of integrated telehealth and telecare packages

- Extend use of Care Co-ordination Centre to support case management
- Clarify arrangements for medical cover in alternative levels of care
- Primary care engagement in performance management framework

2014/15 Progress and Issues Emergency Centre
- Governance structure for project management in place
- Service model designed and work underway to establish patient flow pathways
- Capital development designed and planning permission approved. Capital scheme proposed includes adaptions to the existing A&E department at a cost of £12M
- External review from the Emergency Care Intensive Support Team
  Service model was innovative, safe, provided a quality service to Rotherham residents and made the best use of resources
  Review of workforce to staff the Service model undertaken for each of the scenarios which may prevail
- Finance and contracting discussions ongoing
- Draft IT service specification being firmed up
- Business case for approval
  TRFT Board – 31st October, 2014
  CCG Governing Body – 5th November, 2014

2015/16 Proposals/Next Steps
- Agree finance and contracting arrangements
- Commence with capital development
- Continue service model development – testing out pathways at simulation events and ratifying via CRMC and MH QUIPP group
- Develop pathway back to GP practices and implement
- Procure, develop and implement IT system
- Implement workforce development strategy to move away from reliance on locum cover
- Develop clear transition arrangements and monitor progress
- Robust strategy on culture change to be developed and implemented
- Establish regular clinician to clinician meetings
- Implement communications strategy (a) public campaign (b) internal communications across organisations

Maximise Partnerships and Primary Care
- Better Care Fund – incorporating GP Case Management and additional investment in care outside hospital
- To effectively align secondary and primary care plans with NHS England (co-commissioning of Primary Care and specialised services)
- To deliver ‘working together’ in collaboration with other CCGs

Better Care Fund (BCF)
2014/15 Progress
- No new money

- £23M total fund (13.5M Health/£9.5M Local Authority) to a single pooled budget for Health and Social Care Services to work more closely together supporting Adult Social Care Services
- 15 agreed schemes within the plan
- BCG plan contributed to 4 of the strategic outcomes of the Health and Wellbeing Strategy
- Rotherham recognised as 1 of the top 15 plans nationally
- On track for the resubmission of plans by 19th September
- BCF now incorporated the schemes from the investment in care outside hospital

2014/15 Issues
- Nationally expected to see a 3.5% decrease in non-elective admissions within the plan – Rotherham's ambition was 0% as a result of the significant reduction (10%) over the last few years
- Nationally expect 'benefits' to be attributable to BCF – but BCF was 1 part of the overall commissioning plan and needed to ensure the picture was not 'skewed'
- Capacity to deliver on the 15 agreed schemes and to meet ongoing reporting requirements
- The second evaluation event for the additional investment in care outside hospital was arranged for 22nd October. As part of BCF, continuation of funding was a joint decision, the main criteria for evaluation was to demonstrate impact on hospital admissions

2015/16 Proposals
- Implement the revised plan agreed and submitted on 19th September
- Continue to work in partnership with RMBC
- Agree realistic timescales for the 15 schemes and ensure capacity to deliver

GP Case Management

2014/15 Progress
- Currently 6,687 active care plans
- 35 out of 36 practices were signed up
- Inclusion of 75 and over health check – 1,410 completed

2014/15 Issues
- Range of uptake across Rotherham from 0.1% to 5%
- Capacity of practices to deliver this
- 35 different methods of delivery – wide disparity in uptake of supporting services
- Complexity of IT systems to support

2015/15 GP Case Management
- Continued funding of the service for at least 5 years with possible amendments to how it was delivered
- Annual evaluation

Align Secondary and Primary Care Plans with NHS England (co-commissioning of Primary Care and Specialised Services)
2014/15 Proposals
- NHS England have asked CCGs to express interest in co-commissioning Primary Care
- It was also expected that CCGs would be asked to take a greater role for the commissioning of some specialised services

2014/15 Issues
- Should we move towards being a 'one' place commissioner
- Finances would need to be delegated to CCGs from NHS England
- CCG would need to review staffing structures and governance arrangement if it wished to proceed with co-commissioning
  2015/16 Proposals
- The CCG proposed to co-commission Primary Care as from 1st April, 2015
- Further information regarding specialised co-commissioning was expected from NHS England in October, 2014

Deliver 'Working Together' in collaboration with other CCGs
2014/15 Progress
- 8 CCGs and the Area Team as commissioners of Primary Care and Specialised Services had initiated a programmed of work to collaborate on key priorities (smaller specialities, paediatrics, stroke)
- SYCOM agreed a Project Initiation Document in February, 2014 and programme director recruited in April, 2014 to work with each commissioning partners
- Project Initiation Documents had been agreed for 3 of the 4 clinical priorities
- Good progress made to date with 3 of the 4 workstreams
- Following agreement to take forward the Children's workstream jointly with provider colleagues, a joint document had been produced which would be shared and discussed at the joint meeting on 5th September

2014/15 Issues
- Identify shared resources to deliver projects between CCGs
- The Out of Hospital workstream had been placed on hold pending further details of Phase Two of the National Urgent Care Review

2015/16 Proposals
- Over the next we months to continue to deliver the 4 agreed key priorities:
  Acute Children Services
  Acute Cardiology and Stroke Services
  Smaller Specialities (Speciality Collaborative)
  Out of Hospital (currently on hold)

Discussion ensued with the following issues raised/clarified:-

- Regular updates would be presented to the Select Commission on the Urgent Care Centre which was currently anticipated to open in 2 years
- It was the intention to enhance Community Services and keep/treat patients in the community as long as possible to prevent hospital admissions
- The presentation was a refresh of the proposals presented last year, not new proposals, and comments could be fed in via the link in the presentation
- 2015/15 would see a continued emphasis on working together across South Yorkshire, Bassetlaw and North Derbyshire to deliver the 4 key agreed priorities i.e. Acute Children's Services, Acute Cardiology and Stroke Services, smaller Specialities and Out of Hospital (currently on hold due to the National Urgent Care Review).
- The provision would still be at Rotherham Hospital but would be a mix of clinicians from across the region. It was the desire to maintain services in Rotherham wherever possible unless there was a clinical reason not to. The provider had to make efficiencies but in a way that did not have a detrimental effect on the patients
- Proposed event in December, 2014, at the New York Stadium where clinicians would give updates on the Working Together schemes – invitations to Members to follow
- Business cases for the proposals were not complete as yet but any that involved major service change would be submitted to the Select Commission and Patient Groups for comment
- One area being considered was the overnight rotas for on-call consultants as this was very costly
- Business cases were being led by clinicians and would have patient care as an absolute priority
- Smaller specialties were discussed with emergency eye trauma given as an example - low admissions in Rotherham averaging two per week.
- Concentrating experienced clinicians tended to lead to better outcomes.
- The refresh took into account the Health and Wellbeing Strategy (underpinned by the Joint Strategic Needs Assessment), reflected the needs of the clinicians, the views of the public and mindful of national guidance and mandate
- The first draft of the 2015/16 refresh would be complete by December and a second draft in the New Year once the NHS financial guidance had been received. It would be submitted to the Health and Wellbeing Board in February, 2015
- Rotherham's Social Prescribing had been highlighted by the NHS as best direction of travel
- Further information would be submitted in due course regarding NHS England's intention for CCGs to take on a greater role on the co-commissioning of some specialised services and primary care
- The place based plan for GPs and primary care was important and should reflect the Access to GPs Scrutiny Review, building in the recommendations made

- The existing 5 year plan did not contain great detail on specialised commissioning or on Primary Care commissioning as they currently sat with NHS England. Discussions were ongoing as to whether those services were to be directed back to CCGs and if so would necessitate a change in the CCG's constitution and greater involvement of lay members to avoid potential conflicts of interest. Resourcing would also be an issue

Chris, Robin and Lydia were thanked for their attendance.

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

(2) That the CCG's commitment for further engagement with the Select Commission be noted.

52. UPDATE ON SCRUTINY REVIEW - HOSPITAL DISCHARGES

Further to Minute No. 42 of 12th September, 2013, Michaela Cox, Service Manager, and Maxine Dennis, RFT, presented an update on the action plan in response to the recommendations arising from the spotlight review that had taken place in 2013.

The recommendations had been welcomed and addressed through effective joint work between NHS Rotherham and the Council with good progress having been made in addressing the recommendations.

The potential for unsafe discharges had reduced. The Care Co-ordination Centre and the Hospital had done a lot of work on managing how it planned and co-ordinated discharge including talking and having written communication to both patients and carers about predicted date of discharge.

An update on the actions was appended to the report the majority of which were now complete. Maxine highlighted the following:-

- In 2013 there were approximately 75,000 attendees at the Emergency Department every year together with 70-75,000 admissions both elective and non-elective. To put into context there had been 33 complaints regarding delayed discharges in 2013/14 and 49 in 2012/13
- The Trust was in the process of, through work with the Emergency Care and Intensive Support Team, implementing SAFER Care Bundle which had addressed some concerns. It pre-empted discharge problems and involved talking to patients about their predicted date of discharge and having written communication with patients and relatives. It had already been implemented on the Medical Wards
- The Community Transformation Programme was under way
- A report on the Care Co-ordination Centre and the Supported Discharge Service, which included an assessment tool for risk of hospital admission, was being compiled

- The hospital and patient agreed a time for a post discharge follow up call within 72 hours of discharge
- Out of 70 patients discharged only 2 had been re-admitted
- The Care Co-ordination Centre worked until 10.00 p.m. with some cover at weekends. It was hoped to run it 24 hours a day as it was a good single point of access.
- The Operational Discharges Group had now been replaced by a Forum that met 3 times a week including Hospital and Social Services colleagues to review delayed discharges and operational issues. Continuing Health Care colleagues joined the Forum once a week. Currently developing a Discharge to Assess model which would support earlier discharge whilst ensuring a robust assessment process. There were a number of patients in hospital who required a complex assessment process prior to discharge. A pilot was to be launched of 14 beds in the community where the patients could go whilst the assessment process was completed rather than stay in hospital. Patient choice is important as choices can effectively be rest of life choices.

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

(2) That a further update, including details of the Community Transformation Programme, be submitted in January, 2015,

(3) That the following information be submitted to Members:

- Up-to-date figures for delayed discharges and complaints relating to discharges
- Report on Care Co-ordination Centre
- Information about the SAFER care bundle

53. HEALTH AND WELLBEING BOARD - MAKING EVERY CONTACT COUNT

Dr. John Radford, Director of Public Health, presented an overview of the Making Every Contact Council (MECC) initiative.

MECC had been discussed at the Health and Wellbeing Board and, although partners agreed in principle with the concept, actual engagement with and tangible implementation had been disappointing.

The approach to MECC was currently subject to review and alternative strategies to engage partnership organisations considered. Discussion ensued on the approach and the resources required to promote MECC and whether it was viable:-

- In principle it was a great idea that whilst in hospital or your path crossed with any health care worker you would be spoken to about any issues that affected your health and possible interventions

- It had been hoped to integrate the initiative into an employee's training (health and social care) and, although that had not happened in a system-wide approach, it did not mean that it did not take place, but there were not the resources to ensure that it did
- It would require 2-3 members of staff dedicated to producing a framework that could be used to persuade organisations to implement the initiative
- Asking someone who was visiting/treating a client/patient to engage in MECC would cut into the time allocated for that person so it needed to be a proportionate response
- A lot was being done in this regard through NHS Healthchecks (see below)
- Hard evidence was required as to what the actual benefits of MECC were, including examples of effectiveness elsewhere
- Need to engage commissioners to understand there would be additional resources required to deliver the initiative
- Resources were also required to collate the information once it was gathered in order to measure the scheme's impact, which could lead to a danger of it becoming a "tick box" exercise
- Safeguarding concerns for both adults and children should be reported/identified by staff as a matter of course in their professional roles

Resolved:- That information be provided following the current review of the approach to MECC for consideration by the commission

54. HEALTH AND WELLBEING BOARD STRATEGY PROGRESS - PREVENTION AND EARLY INTERVENTION - NHS HEALTH CHECKS

Dr. John Radford, Director of Public Health, gave the following powerpoint presentation:-

- Risk Assessment
  - Cardio Vascular Disease (CVD)
  - Type 2 Diabetes
- Risk Communication
- Risk Management
  Lifestyle advice
  Referral for behaviour modification
  Prescribing

Our Objective
- Screen 18% of eligible 20% of population annually
- Challenge to deliver this in the most deprived communities

Lipid Modification NICE 2014
- Systematic approach 40-74
- QRISK2
- Ethnicity, BMI, family history

- High intensity statin for risk conditions with 10% risk
- High intensity 20 mg atorvastatin for primary prevention

Diet
- Reduce saturated fats
- Replace saturated fats with olive oil and rapeseed oil
- Reduce refined sugar and fructose
- Fruit and vegetables whole grains
- 2 portions of fish
- Signpost to NHS Choices

Exercise
- High risk CVD 30 minutes of at least moderate activity daily
- If unable to do this offer exercise to maximum capacity
- Recommended physical activity could be built into daily living
- Additive 10 minutes or more accumulated as effective as longer sessions

Q Risk 2
- Age
- Gender
- Smoker
- Premature family CVD
- Hypertension treatment
- Social deprivation
- Total HDL cholesterol
- Ethnicity
- Rheumatoid
- Chronic Kidney Disease
- AF

Risk Communication
- Individual risk and benefit
- Numerical presentation
- Signpost to appropriate information
- Feelings and beliefs
- Readiness to change lifestyle
- Shared management plan
- Check what had been discussed

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

- Health Checks were aimed at everyone over the age of 45 years and were repeated every 5 years
- It gave the opportunity to assess lifestyle and risk of heart disease/stroke and offer interventions for that risk

- Since Public Health had joined the Council there had been a 30% increase in the number of health checks undertaken
- A promotion programme would run from January, 2015
- The prescribing of Statins could greatly reduce mortality from chronic heart disease
- The participation rates at GP practices varied across the Borough
- Stress and anxiety were not specifically included in possible causes of Q Risk 2 which were drawn up many years ago. Social deprivation had been added as a means of acknowledging that if you were in control of your life you were less stressed
- Timing of interventions and the life course approach of the Health and Wellbeing Strategy
- The importance of winning “hearts and minds”

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

(2) That Select Commission Members consider ways to champion and publicise NHS healthchecks, for example through town and parish council magazines.

(3) That details of the current membership of the following working groups be provided at the next meeting - Obesity Strategy Group, Rotherham Heart Town, Tobacco Control Alliance and the Self-Harm and Suicide Prevention Group.

55. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health Select Commission be held on Thursday, 4th December, 2014, commencing at 9.30 a.m.