NHS
Rotherham
Clinical Commissioning Group

Minutes of the Rotherham System Resilience Group
Wednesday 6 January 2016, 9.00am in room G.04, Oak House

Attendees		**RCCG:** Chris Edwards – Chair (CE), Julie Kitlowski (JK), Sue Cassin (SC), Ian Atkinson (IA), Dominic Blaydon (DB), David Clitherow (DC), Gordon Laidlaw (GL), Tim Douglas (TD), Lydia George (LG), Rebecca Chadburn (RC), Jacqui Tufnell (JT), Jo Martin (JMa) **TRFT:** Maxine Dennis (MD), Chris Holt (CH), Louise Barnett (LB), Shaun Nakash (SNak) **RMBC:** Sam Newton (SNew), Richard Hart (RH), Sarah Farragher (SF) **RDASH:** Debbie Smith (DS) **NHSE:** Mark Janvier (MJ), Jodie Deadman (JD) **YAS:** Sharron Nelson (SNel) **Care UK:** - **VAR:** Janet Wheatley (JW) **LMC:** Bipin Chandran (BCh) **In attendance:**
Apologies		Alex Henderson-Dunk
Conflicts of Interest		None registered
1	**Community Transformation Update**	
	DB presented an update on the work of the Community Transformation Programme highlighting areas of progress for year 2 as: • Locality teams and Care Co-ordination Centre (CCC) working effectively • Community therapy services aligned • Integrated Rapid Response Service implementation • Clear system for management of long stay patients • Coherent system for managing outliers • Site co-ordination service fully operational • Weekly ward rounds expediting discharge of medically fit • Effective use of spot purchase beds during winter period • Allocated social workers to medical wards • MDTs focussing on supported discharge DB reported that the majority of KPIs are on track, with the exception of the number of patients seen by a GP in A&E. The next steps for the programme are: • Development of integrated health and social care teams • Review of intermediate care services • Develop an integrated supported discharge service • Develop MDTs as vehicle for decisions on discharge • Introduce new governance arrangements • Clarify process for commissioning spot purchase beds • Increase number of patients seen by GP in A&E • Increase number of weekend discharges • Memorandum of understanding on social care support JK added that a substantial amount of work is taking place to support discharge such as: • Expansion of the CCC and use as a triage to alternative levels of care prior to admission • Aspire to achieve the Sheffield model for discharge to assess	

	• Improvements from the alignment of care homes with GP practices • Development of the 'perfect locality' • Addressing the concern over patients medically fit for discharge • Inclusion of end of life care as part of the overall conversation and development of a single pathway • 7/7 working LB confirmed that all the above aligns with TRFT internal plans. TD highlighted that GPs need further clarity on the process for commissioning spot purchases in intermediate care. ***Action: DB to send communications to GPs. MD to ensure that the CCC notifies appropriate GPs.*** Following concerns over patient readmissions. ***Action: DB to ask the Community Transformation group to consider the addition of a KPI around readmission rates to establish if the issue is localised or Rotherham wide.*** It was highlighted that Mental Health Transformation should link with the 'perfect locality' work. ***Action: DB and DS to discuss. DS to consider RDaSH representation at the Community Transformation Group.***
2	**Urgent Care Position**
	A&E Performance - as at 6 January, performance for Q4 was 84.83% and YTD 92.75%. LB reported that achieving the target is a system issue but recognised key areas of improvement are internal. Bed capacity and flow have been issues affecting performance previously, whereas currently the issues are at the front end of the service. There still remains pinch points in winter as a result of bed pressures. The executive team held a meeting between Christmas and New Year focussing on actions to be taken, these will be incorporated into the high level action plan. CH reported that the winter planning arrangements began 2 weeks prior to Christmas. The national requirement was to have 20% of beds empty going in to the main Christmas period, TRFT achieved nearer 30-40%, this performance was maintained into the second of the 4 day holiday period. MJ confirmed that there had been a lot of anxiety in the week leading up to Christmas at national and regional level. A high level discussion had taken place with Monitor. The discussion had been very successful and commissioners had come across very well presenting examples of good practice at Trust and SRG level. Enc 2 **Care UK Performance Report** was noted.
3	**Full review of the TRFT A&E High Level Action Plan**
	CH explained that an action plan is being produced which incorporates actions from the winter plan, 4 hour access actions and the contract query. SNak provided a summary of the key workstreams which include: • Emergency Department team development plan • Divisional Structure and Governance • IT/Data quality and Workforce • Closer working with Care UK • Work with internal speciality teams to ensure patient flow

	Key issues include the recent move of ED and significant changes in the nursing establishment, including the loss of some staff, the need to improve and invest in triage and lack of middle grade doctors. Solutions are being put in place to address, such as: work with consultants, securing long term locums, events to look at how the floor in being run, focus on data and IT, embedding consultant rounds 4 times a day, introduction of patient champions and a weekly 4 hour access standards meeting. The new ways of working the acute medical unit are functioning well. ***Action: AMU to be discussed at a future meeting.*** Front end issues include significant number of patients from midnight to 4am (27-32) and disproportionate numbers by ambulance. MD questioned when TRFT would receive a HALO, explaining that this would be beneficial during peak times. There was confusion over the offer from YAS and take up from TRFT. SNel reported that TRFT had not contracted YAS to request a HALO at any point. CH suggested that the HALO should be rota'd in at fixed periods. MJ reported that this was raised Regionally with the expectation that a conversation was brokered with YAS as it forms part of the agreed high level action plan. ***Action: CH and SNel to meet urgently.*** SNel added that numbers have increased for all areas. Agreed principles have not been followed and due to internal diverts from Doncaster and Bassetlaw patients have been diverted to Rotherham. ***Action: CE to flag with the relevant SRGs. SNel to pick up with Head of Operations.*** CE added that SRG needs to understand if there are issues in other areas that affect Rotherham. SNel offered to undertake a post code analysis. ***Action: priority for SNel to produce a post code analysis including time zones and to share asap.*** It was agreed that the action plan will be managed through the formal contracting route and shared at SRG. SRG will oversee the 'partner' actions, which will be sent out to members for update. CH reported that work with social care has been positive but further work needs to take place to look at out of hours and 7/7 working next year. ***Action: it was agreed that CH and SNew would liaise in regards to the number of social workers available on any given day.*** Care Uk out of hours and walk in centre services functioned well over the Christmas period, with only 2 occasions where 'immediate and necessary' was implemented and only for a short period of time. ***Action: DB to work with Care Uk to understand the issues which led to its implementation and to ensure that dialogue is directed through the clinical site manager.*** BCh added that at busy times Care Uk have moved ANPs to the Trust to provide additional support. All members agreed that it would be beneficial if a representative from Care Uk attended SRG. 111 was on level 4 on Saturday and Sunday which puts pressure on to the on call service. CH reported that there is an increasing number of Continuing Health Care patients waiting for assessment and queried how TRFT can access the CHC team. DB recognised that there are issues to be resolved and suggested that the escalation process may help. ***Action: a deeper analysis of CHC at the next meeting and to invite Alun Windle to attend.***
4	**Escalation process for medically fit patients**
	DB informed SRG of the progress around the escalation process and triggers for patients who are medically fit for discharge, it includes expectations for GPs, social care and TRFT.

	Members were very supportive of the work and it was agreed that Community Transformation would be asked to progress further and produce a paper for consideration. CH added that there is a well established Regional 'web-based' escalation process that all organisations are required to undertake at specified times. It was thought that further discussion was needed at both SRG and at Urgent and Emergency Care Network level. ***Action: CH to share the escalation tool at the next SRG.***
5	**Ambulance Performance**
	The 8 minute response time for Rotherham in November was 66%. SNel reported increased pressure in Sheffield at the moment. MJ added that this was covered in the recent teleconference and that SRG needs to continue to be sighted on the issues. The post code analysis work will provide further insight.
6	**Winter Communications**
	GL reported that the winter communications plan is on track. A substantial amount of work has taken place to promote self-care. Health information/advice was made available prior to Christmas in the usual places such as the press, radio and on the NHS Choices website. The script for GP out of hours was circulated prior to Christmas. A weekly teleconference has been introduced for SRG communication leads to cover the system pressures. Head of Communications for each organisation are meeting to develop a forward plan of joint campaigns for 2016. CH added that communications in relation to the junior doctor strikes had been distributed.
7	**Development of a Rotherham 'hub' for access to Health and Social Care services**
	DB reported that proposals have been discussed at MH/LD QIPP group for a multi-agency Single Point of Access model. The group wanted a wider discussion at SRG to assess if this is the right direction of travel and to ensure that the work is not taken forward in isolation. There has been engagement work undertaken with staff and GP's. Members discussed the proposal, exploring whether the SPA would be for patients, professionals or both, the use of the Care Co-ordination Centre and the responsible group for the work. Members agreed with the principle, recognising that further work and clarity is needed. It was suggested that the Community Transformation workstream would be the correct place for the work to progress, but a representative from mental health would be needed on the community transformation group to enable the discussions. SF added that RMBC are undertaking a similar piece of work and have set up a series of multi agency meetings to explore further. SRG agreed with the principle but recognised that substantial further work was needed to bring clarity to the proposal. Community Transformation would become the responsible group and a mental health representative would join the membership.
8	**Seasonal Flu Vaccine Update**
	For information. Members to note the positive performance for Rotherham.

9	**Minutes of the Meeting held 11 November 2015**
	All actions were complete or picked up earlier in the minutes, with the following exceptions: • CE asked NHSE if they were aware of any CCG that had made decisions in relation to Avastin and Lucentis. ***Action: MJ to investigate and respond to AB/IA.*** • At the previous meeting JAbb, following a conversation with a colleague at NHSE, had suggested calling an exceptional meeting with regard to Pandemic Flu and to invite members of the SRG. However, it was confirmed that pandemic flu is not within the remit of the SRG. MJ had confirmed this and suggested that a conversation took place outside the meeting to clarify. RH queried this discussion and it was re-confirmed that this is not within the remit of SRGs. However, it was suggested that it may be appropriate for the Local Health Resilience Partnership. ***CE and MJ agreed to consider if appropriate.***
10	**Outstanding Matters Arising not covered in the Meeting**
	DC and SC reported that the findings from the unannounced quality visit to A&E which took place before Christmas raised no significant issues.
11	**Standard Agenda Items**
	February Meeting • Update from 4 QIPP Committees (MH/LD QIPP in February) • Urgent Care Performance • Ambulance Performance • Winter Communications • DTOCs (quarterly)
12	**Risks and Items for Escalation**
	No additional risks identified.
13	**Date of Next Meeting**
	3 February 2016, 9.00am in room G.04 Oak House

Minutes approved at 3 February meeting.