NHS ROTHERHAM

Minutes of the Professional Executive of NHS Rotherham held on 3 November 2010 in the Elm Room, Oak House

Present: *Dr R C A Collinson (Chairman) ..... 
Dr R Brynes *Dr P Macfarlane 
*Mr A Buck Mrs J Pearson 
Dr S Burns Dr J Radford 
Mr P Chapman Mrs G South 
Mr C Eades Mrs J Thacker 
Mr C Edwards *Dr D Tooth 
Mr M Foster Dr I Turner 
**Mr M Hamstead Mrs C Wright 
Dr J Kitlowski

In Attendance: 
Mr Dominic Blaydon, Programme Manager for Mrs Atkinson 
Miss Stacey Blueitt, Chief Executive’s Office observer 
Dr R Carlisle, Director of Intelligence and Performance 
Mrs P Fryer, Director of OD, Workforce and Governance 
Mr A Tenancy, Board Secretary 
Mrs F Topliss, Head of Communications 

(Item 216/10) Prof Walid Al-Wali, Medical Director, Rotherham Foundation Trust 
(Item 218/10) Ms Ruth Bastin, Rotherham Metropolitan Borough Council 
(Item 220/10) Ms Lisa Fendall, Stop Smoking Service Specialist Midwife 
(Item 220/10) Mrs Wendy Griffiths, Stop Smoking Service Specialist Midwife 
(Item 227/10) Dr Nagpal Hoysal, Consultant in Public Health Medicine 
(Item 220/10) Ms Alison Iliff, Public Health Specialist (Tobacco Control) 
(Item 219/10) Dr Andrew Lee, Public Health Specialist Registrar 
(Item 226/10) Dr Sarah Lever, Deputy Director of Contracting 
(Item 225/10) Ms Julie Slatter, Rotherham Metropolitan Borough Council 

(Items 216 & 217/10) Mrs Kathy Wakefield, Infection & Quality Strategic Lead 
(Item 226/10) Mrs Judith Wild, Head of NHS Continuing Healthcare & FNC

* Absent from item 227/10 onwards 
** In the chair from item 227/10 onwards

212/10 Apologies for absence

Apologies were received from Mrs Atkinson, Dr Coates and Dr Plews.

213/10 Declaration of Pecuniary or Non-Pecuniary Interests

a) 215/10a Direct Access MRI

Dr Tooth declared an interest in the above item.

b) 224/10 Neurological Conditions

Mr Chapman and Mr Eades declared an interest in the above item.
214/10 Minutes

The minutes of the Professional Executive meeting held on 6 October 2010 were confirmed as a correct record, subject to the following amendment.

The list of apologies should include the name of Dr Burns.

215/10 Matters Arising

a) 185/10b Direct Access Magnetic Resonance Imaging (MRI)

Dr Tooth reported that the Practice-Based Commissioning (PBC) Group was proposing a means of continuing the funding of the service until end March 2011. That element of the PBC incentive scheme relating to individual practices’ activities, had encountered a difficulty in agreeing what sum was due to any one practice. The unallocated funds were now being offered to continue the contract for another five months.

Action: Director of Finance and Contracting

b) 186/10 Flu Vaccination Programme

Dr Radford reported that the proposed arrangement was compliant with Standing Orders and Standing Financial Instructions. It would now start before January 2011.

c) 189/10 Performance Report – Use of the Walk in Centre

Dr Kitlowski was assembling a record of reasons why patients were using the centre.

d) 191/10 Mental Health Services Configuration

The concern which had been aired about the process of reconfiguring Rotherham services, and about the lack of indicators by which it might be evaluated, had been amplified at a PBC Group meeting. It seemed that commissioning staff shared the concerns, but had not made any challenge to the provider’s plans. Next steps would be considered by the Management Executive, although a group of 3 GPs was to meet with staff from Rotherham, Doncaster & South Humber Mental Health Foundation Trust.

Action: Director of Strategic Planning

216/10 Managing MRSA in the Community - Risk Screening

Prof Al-Wali introduced a paper, prepared by Mrs Wakefield, which responded to the issues identified at the PE discussion in June 2010. The proposal was to change the management of MRSA colonisation in community settings.

Mrs Wakefield explained that the additional workload for community nurses (including care home nurses) had been accepted by the manager(s); she was trying to quantify the overall impact on primary and community care services of the extra swabbing. The PE concluded that the benefits appeared to out-weigh the likely workload.

General practitioners’ records could (and usually were) flagged for patients with any
history of MRSA – as they were at risk of re-infection.

Community pharmacists could act as gatekeepers for the prescribing of certain antibiotics known to increase the risk of MRSA.

Whilst the PE supported the proposed changes, Prof Al-Wali had to assure members that the level of intervention for patients would acknowledge their circumstances eg. those in end of life care. The arrangement should not be “one size fits all”.

The agreed recommendations were to :-

- support the implementation, on behalf of all stakeholders, of the proposal to improve the management of MRSA colonisation in the community,
- screen MRSA positive patients weekly until three screens have been reported where MRSA has not been isolated,
- screen high risk patients (once they had been deemed ‘negative) every two months - to allow early intervention should re-colonisation occur,
- screen patients prior to catheterisation (urethral or supra-pubic),
- discuss, with the Consultant Microbiologist, future management of those patients who remain positive after two courses of treatment,
- have the hospital issue antiseptic skin wash (and where necessary nasal treatment) as take-out medication for patients who remain positive at discharge. Follow-up screens to be carried out by a practice nurse (unless the patient is under the care of the district nurse).
- will be
  - to refer to the GP/practice nurse for treatment (and follow-up screens) those patients identified as positive from samples submitted via the GP.
  - to flag primary / secondary care records so as to highlight positive status and thus inform antimicrobial prescribing

217/10  Infection Control - 2009/10 Annual Report

Mrs Wakefield presented the Annual Report, highlighting some of the key achievements of the year. The period prior to her appointment in autumn 2009 had been dominated by the NHS response locally to the threat of swine flu.

Developments of note had been:-

a) The incorporation of prevention requirements in the Rotherham Metropolitan Borough Council’s standard contract with care homes.

b) Incorporation of dental practitioners into the assurance framework.

c) The improvement in immunisation and vaccination rates for children.

The PE congratulated those involved in controlling and preventing infection.

218/10  Primary Schoolchildren - 2009 Lifestyle Survey

Ms Bastin was welcomed to the meeting and ran through the key findings from the 2009 sample-survey of Year 5 school pupils (c.9 years old).
The PE was alarmed by the number of children who had reported smoking and drinking regularly. If that was true then safeguarding issues arose. The Local Safeguarding Children Board would be discussing the report. The PE wished to be kept informed.

Action: Joyce Thacker

219/10 Migrant Health

Dr Lee presented a paper reporting on the trends / issues in meeting the health of migrants in Rotherham. Migrants came from a variety of backgrounds, with differing health needs, but typically used services differently to the wider population. The paper invited consideration of what further actions might be taken to address the issues identified. The PE’s suggestions included:-

a) Consider the duration / level of funding for the community advocacy support worker.

b) Ask the Emergency Care Network group to look at how services were accessed.

Action: Programme Manager for urgent care

c) Develop further recommendations via the planned new strategy for public health.

Action: Director of Public Health

Some statements in the report would be removed, to reflect today’s observations from Local Authority colleagues.

Action: Public Health SpR

220/10 Managing Smoking in Pregnancy - clinical pathway

Ms Fendall, Ms Iliff and Mrs Griffith were welcomed to the meeting for a presentation on a revised clinical pathway. Key to this was a more coercive approach with those women who appeared not to want to stop smoking ie the potential damage from smoking was described regularly and they were nonetheless referred to the stop-smoking clinics.

The new pathway was already improving the quit rates and there was national interest in Rotherham’s techniques. The PE congratulated those involved. The service was seen to be achieving a huge health gain for Rotherham’s mothers and babies.

221/10 Shaping Our Future - update

Mr Buck explained that the prospective providers were actively assessing transfer offers. External agencies had suggested that the transfer to the Hospice ought to be market tested, but this had been resisted. The Gate-Canklow/Rosehill practices were working on a social enterprise solution and the Board was to consider the proposal in December.

It was noted that the Rotherham Foundation Trust had been offered the opportunity to manage Bassetlaw’s community services.
222/10  White Paper - update

Mr Buck reported that central directions on future organisational structures were expected in December, as was the 2011/12 Operational Framework and a white paper on public health.

Dr Collinson reported that a well attended meeting of GPs had agreed in principle to the Board-endorsed proposals for enhancing GP input to commissioning arrangements. The detail of agreed arrangements had yet to be finalised, but expressions of interest for GP places on the new commissioning executive and the GP Reference Group were about to be invited.

223/10  Abdominal Aortic Aneurism (AAA) - Risk Screening

An agenda paper updated the PE on implementation of the AAA screening programme. The aim was to begin screening the target population - men aged 65 - in April 2013. Dr Radford invited direct contact on any queries.

Action: All

224/10  Neurological Conditions

Mr Blaydon presented the recommendations from a review of community-based neurological services. Points of note in discussion included:-

a) The main change would be the integration of various specialist staff, currently spread across Rotherham in a range of services, into one team. Such an arrangement would aid delivery of the standards issued by the British Society for Rehabilitative Medicine (BSRM) and could be delivered inside the current financial envelope.

b) The workload estimates would be checked to see if cerebral palsy had been included.

c) The Hospice did offer care for conditions other than cancer, but prospective patients may not wish to use it as their need was for occasional palliative/respite care rather than end of life care. A reduction in voluntary sector provision elsewhere (nb. York) may see younger patients directed inappropriately to acute/elderly services.

d) It was desirable to reduce overall current spend, and not simply contain it within the current overall amount. Calculation of the latter needed further discussions with the provider(s).

e) The specialist team could communicate directly with hospital neurology staff.

f) Dr Tooth noted the commissioners’ efforts to put in place all the various elements of an integrated service. However, a more streamlined approach might be to acknowledge that there was a dominant provider and so contract with them simply for delivery of the BRSM standards.

The PE supported the development of a specialist community team and asked that commissioner staff work with the provider to develop a service that complies fully with BRSM standards for long term condition management.

Action: Programme Manager for Long term Conditions
Ms Slatter, of RMBC, explained that the RMBC’s review of its corporate plan had taken the opportunity to develop a single-page summary of the plan. Doing this had enabled the focus on identifying the most important things and had aided consultation with stakeholders. A more detailed plan (but still less than 20 pages) was to be produced by spring 2011. The public’s views on priorities, eg employment opportunities, had been factored in. The impact of the government’s Comprehensive Spending Review had not yet been addressed.

PE observations included:-

a) The goals were very worthy, but the challenge was to develop programmes that could deliver the goals during a time of financial stringency.

b) It may be helpful to reference the need for good mental health at a population level.

c) RMBC could not do everything and the state’s expectations of citizens exercising personal responsibility must be raised.

Action: RMBC Head of Policy & Performance

226/10 Continuing Health Care Spending

Mrs Wild presented a paper which analysed the pattern of expenditure on NHS continuing health care for adults. The current level of spend far exceeded the (uplifted) budget for 2010/11. Mr Edwards regarded the risk of exponential growth as the greatest financial risk facing NHS Rotherham.

Rotherham had a strong system and process for assessing individual cases.

There had been a relatively low rate of expenditure, but this was changing rapidly. The rapid growth of the previous two years reflected the introduction of national criteria that were more ‘generous’ than the local ones which had preceded them. The creeping growth of recent years reflected the success in treating people outside of hospital and (probably) improvements in life expectancy featuring an extension of morbidity.

The RMBC Chief Executive and his team had discussed the analysis with Mr Buck. It had been agreed to carry out an audit of local adherence to the national criteria and to the agreed local processes. The PE wished to keep the topic under careful review and asked for an update before April 2011.

Action: Deputy Director of Contracting

The management of continuing health care for children was being monitored.

227/10 Re-admissions to Rotherham DGH (RDGH) - audit paper

Dr Hoysal presented a significant event analysis of 37\(^1\) re-admissions to RDGH.

\(^{1}\) It had not been possible to analyse 13 other cases because the case notes were in active use.
Whilst none of the discharges prior to re-admission could be deemed unsafe, there were some where alternative arrangements been in place upon discharge, then the likelihood of re-admission would have been reduced. The Rotherham Foundation Trust (RFT) was considering strategies to reduce such re-admissions, particularly in complex cases and elective care. The PE supported their implementation.

The work had exposed errors in activity-recording that may be distorting the true re-admission rate e.g. recording post-discharge ward attendances as admissions (nb. gynaecology and children). RFT managers were addressing some of the issues. It was noted that the Audit Commission had studied hospitals' coding work and had ranked RFT as “good”. NHS Rotherham would seek further joint local audits of coding.

**Action: Director of Public Health**

**228/10 Winter Plan**

Mr Blaydon presented a report on winter planning with the (13.10.10) “Surge & Rapid Discharge Plan.”

The PE noted the arrangements to cover winter pressures and endorsed the Surge & Rapid Discharge Plan. The following observations were made:-

a) The potential pressures included the possibility of industrial action.

b) Evidence from a number of sources suggested that patients were sometimes ‘retained’ in wards longer than was clinically necessary.

c) ‘Buddying up’ by GPs was typically between neighbouring practices. However, the neighbouring practice may also be experiencing staff absences and the option of seeking help from further away in the borough may become necessary. It would be helpful to GPs if NHS Rotherham could again undertake a ‘broker’ role in finding the staff support for practices in difficulty.

d) The report’s descriptions of Social Care Services’ availability during December 2010 would be amended.

e) Mrs Wright understood that the information on learning disability and children services had been supplied, but the report stated otherwise.

**Action: Director of Strategic Planning**

**229/10 Performance Report – Reporting Framework**

Dr Carlisle reminded the PE that the new government had ceased assessments under World Class Commissioning, and by the Care Quality Commission, and was considering responses to its White Paper proposals for an Outcomes Framework. In the meantime the Strategic Health Authority had introduced a Single Assurance and Accountability Process.

In the light of these developments, the performance reporting arrangements for Board and PE had been reviewed by officers. An example of a new set of metrics in a report was attached to the paper. The PE supported the changes.

Dr Carlisle drew attention to the reporting of C. Diff rates not MRSA rates and to the data
on teenage pregnancy rates - where a favourable trend appeared to be emerging.

230/10 Performance Report – Efficiency Programmes

Dr Carlisle presented the report on attainment of improved efficiency. The next iteration would contain fresh data and was eagerly awaited.

A meeting with Strategic Health Authority officers in November would look closely at the work on clinical referrals and on the potential benefits of Shaping Our Future.

231/10 Performance report - Contracts and Finance

Mr Edwards presented the performance report on contracts and finance, drawing attention to the following:-

a) Despite the escalating overspend on community health care, NHS Rotherham was still on course to meet its financial targets - due to exceptionally good control of prescribing spend and corporate overheads.

b) The latest national ruling on Cat-M drugs meant that community pharmacists were predicted to lose, on average, £2K per month. The impact for NHS Rotherham (with 60 businesses in its patch) could be as much a £120K saving per month.

c) “GP and other” referrals to the Rotherham Foundation Trust in Q1 had fallen in comparison to Q1 in 2009/10. However, this may be due to an extra high value in 2009/10 rather than a generally downward trend. Dr Brynes pointed out that the report’s distinction between “GP” and “other” referrals may not be meaningful.

Action: Director of Intelligence and Performance

232/10 Clinical Referrals Management Committee

The minutes of the Clinical Referrals Management Committee meeting held on 1 September 2010 were received and noted.

The minutes of the Clinical Referrals Management Committee meeting held on 29 September 2010 were received and noted.

The (unadopted) minutes of the Clinical Referrals Management Committee meeting held on 13 October 2010 were received and noted.

233/10 Medicines Management Committee

The minutes of the Medicines Management Committee meeting held on 1 September 2010 were received and noted.

The minutes of the Medicines Management Committee meeting held on 15 September 2010 were received and noted.


234/10 Practice-based Commissioning Group

The (unadopted) minutes of the Practice-based Commissioning Group’s meeting held on 29 September 2010 were noted.

235/10 Yorkshire and the Humber Specialised Commissioning Group

The “Decision Summary” and (unadopted) minutes of the Yorkshire and the Humber Specialised Commissioning Group’s meeting held on 24 September 2010 were noted.

236/10 Future Agenda Items

December 2010
Cancer Network Performance Report

January 2011
Teenage Pregnancy Strategy Work (JR)
CVD screening (2011 funding) (JR)

237/10 Date, Time and Venue of Next Meeting

The Professional Executive’s next meeting was scheduled to take place on 1 December 2010 at 1.00 pm at Oak House, Moorhead Way, Bramley, Rotherham.