HEALTH AND WELLBEING BOARD

Venue: **Town Hall, Moorgate Street, Rotherham S60 2TH**

Date: **Wednesday, 5th September, 2012**

Time: **1.00 p.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972.

2. To determine any item which the Chairman is of the opinion should be considered as a matter of urgency.

3. Welcome and Introductions
   John Wilderspin, National Director, Health and Wellbeing Board Implementation, Department of Health

4. Minutes of Previous Meeting (Pages 1 - 6)

5. Communications
   - South Yorkshire Police and Crime Commissioner (pages 7-9)

   - Conference "Implementing Health and Wellbeing Boards"
   Capita Conferences
   17th October, 2012 held in Central London

6. Alcohol Strategy - Local Implementation (Pages 10 - 13)
   - Anne Charlesworth, NHS Rotherham, to present

7. Infection Prevention and Health Protection Annual Report 2011/12 (Pages 14 - 49)
   - John Radford, Director of Public Health, to present

8. Health and Wellbeing Strategy
   - Kate Green, Policy Officer, to give verbal update on consultation

9. Clinical Commissioning Group Annual Commissioning Plan (Pages 50 - 56)
   - Sarah Whittle, NHS Rotherham, to present

10. NHS Commissioning Board Update
    - David Plews, CCG, to give verbal update

11. Rotherham Healthwatch Update (Pages 57 - 62)
    - Chrissy Wright, Strategic Commissioning Manager, to present

12. Health and Wellbeing Board Self-Assessment (Pages 63 - 78)
    - Kate Green, Policy Officer, to present

13. Date of Next Meeting
    - Wednesday, 31st October, 2012 commencing at 11.00 a.m.

HEALTH AND WELLBEING BOARD
11th July, 2012

Present:-

Members	
Councillor Wyatt	**in the Chair**
Karl Battersby	Strategic Director, Environment and Development Services, RMBC
Helen Dabbs	RDaSH
Councillor Doyle	Cabinet Member for Adult Social Care
Chris Edwards	Chief Operating Officer, Clinical Commissioning Group/NHS Rotherham
Dr. Phil Foster	National Commissioning Board
Brian James	Rotherham Foundation Trust
Shona McFarlane	Director of Health and Wellbeing, RMBC
Dr. John Radford	Director of Public Health
Janet Wheatley	Voluntary Action Rotherham

Officers:-	
Claire Burton	Commissioning Officer, RMBC
Kate Green	Policy Officer, RMBC
Dave Roddis	Performance and Quality Manager, RMBC
Fiona Topliss	Communications Officer, NHS Rotherham
Dawn Mitchell	Democratic Services

Apologies for absence were received from Chrissy Wright, Tom Cray, Martin Kimber, Councillor Lakin, Joyce Thacker, David Tooth

S8. DR. PHIL FOSTER

The Chairman welcomed Dr. Phil Foster, representing the National Commissioning Board, to his first meeting of the Health and Wellbeing Board.

Agreed:- That a report be submitted to the next meeting setting out the duties of the National Commissioning Board.

S9. MINUTES OF PREVIOUS MEETING

Agreed:- That the minutes be approved as a true record.

With regard to Minute S2 (Joint Health and Wellbeing Strategy), it was clarified that there would be continual consultation and refinement. The priorities and outcomes were the outcome of the various consultation activities that had already taken place and would be fed back to those previously involved as a reality check to ensure they were correct for Rotherham.

S10. COMMUNICATIONS

(a) Obesity Strategy Group
It was noted that minutes of the above Group would be submitted to the Board in future.

It was also reported that a national event was hopefully going to be held in Rotherham in the New Year as part of Obesity Week.

(b) Carnegie Weight Camp
A visit to the Camp was to take place on 10th August, 2012.

(c) Sub-Groups – Tobacco Control Alliance, Warm Homes etc.
Agreed:- (1) That an annual report be submitted by the Board's Sub-Groups.

(d) Active Always 2012 Brochure
A copy was circulated for information.

(e) Obesity Observatory
Information from the above was circulated on the correlation between the number of fast food outlets in deprived areas.

(f) Report Writers
A comment had been received from a member of the public regarding the use of jargon and acronyms.

It was suggested that a glossary of terms be included on the Board's website.

(g) Visit
John Wilderspin, Department of Health, Health and Wellbeing Boards Implementation, was to attend the Board meeting to be held on 5th September, 2012.

(h) Rotherham Show
Discussion ensued as to whether there should be a Clinical Commissioning Group presence at the Show to promote awareness and also use it as an opportunity to publicise the Health and Wellbeing Strategy.

Agreed:- (2) That a sub-group meet to co-ordinate a presence at the show.

S11. HEALTH AND WELLBEING CONSULTATION

Kate Green, Policy Officer, reported that it was the intention to consult during July and August with a view to having a final Strategy by September. The consultation would:-

- Ask whether the outcomes and priorities in the Strategy were correct based on the intelligence gathered
- A web page was to be set up on the Council site containing the Strategy together with the Joint Strategic Needs Assessment and all supporting documents
- There would be 2 questions on the web page - (1) were these priorities right for Rotherham? (2) did people feel the actions within the Strategy were right to achieve the strategic outcomes? Responses would be made directly through the website
- An event, hosted by Voluntary Action Rotherham, on 24th July to present the Strategy to the voluntary and community sector and ask them how they could contribute to delivering the Strategy

- All those involved in the 2 workshops/involved in the health inequality consultation would received feedback
- A press release to be issued

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

(2) That Board members be notified when the website went live.

S12. HEART TOWN

The Board received, for information, a position statement on the Heart Town activity together with other work planned.

S13. HOUSING CONSULTATION: - BRIEFING PAPER

The Board noted a briefing note on the consultation process that was underway on the Housing Strategy.

It was intended to publish by November, 2012, a 30 year Housing Strategy with part 1 focusing on the next 3 years i.e. 2012-15. The draft Strategy and an accompanying on-line questionnaire was available at www.rotherham.gov.uk/housingstrategy.

The Chairman had commented that it needed to reflect the Health and Wellbeing Strategy and consider the contributions housing made to the health outcomes.

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

(2) That each organisation respond to the consultation independently.

S14. ROTHERHAM LSP SUMMIT - 26TH SEPTEMBER, 2012

It was noted that the Local Strategic Partnership was to hold a summit on 26th September, 2012.

S15. HEALTH AND WELLBEING BOARD UPDATE

Kate Green, Policy Officer, presented an overview and update on progress for the year one priority actions as set out in the Board's work plan for 2011/12.

Key activity in year one included:-

- Completed refresh and sign-off of the Rotherham Joint Strategic Needs Assessment
- Rotherham Health Inequalities Summit
- Development of a Joint Health and Wellbeing Strategy

It was proposed that a structured questionnaire be prepared for Board members the results of which would form the basis of a reflective session at the September meeting.

Agreed:- (1) That the progress made on the year one work plan be noted.

(2) That a structured questionnaire on the effectiveness of the Board during its first year of operation be circulated and returned by 8th August, 2012.

(3) That an analysis of the feedback from the questionnaire be submitted to the September Board meeting.

S16. PLANNING AND HEALTH

Karl Battersby, Strategic Director of Environment and Development Services, presented a report on the work completed so far in conjunction with Health in developing Planning Policy to ensure the best outcomes for health and future determination of planning applications. The report included:-

National Planning Policy Framework (NPPF)
- Required Planning to promote healthy communities by the provision of safe and accessible developments
- Work with Public Health leads to take account of health status and needs of the population
- New developments should include shared space and community facilities, opportunities for sport and recreation

Rotherham's Local Plan Core Strategy
- Supported the provision of local health facilities
- Supporting strategies for improvements to air quality and promoting a healthier lifestyle through walking/cycling and the provision of open spaces and recreation facilities
- Planners required to assess the amount and type of infrastructure required to support areas of growth identified within the Core Strategy
- Health colleagues fully involved in drawing up the Borough's Infrastructure Delivery Plan
- Health to be fully involved in the development of a charging scheme for developers which would replace the majority of Section 106 obligations

Public Health Agenda
- Stronger partnership working expected by the Government from April, 2013
- Spatial planning expected to make significant contributions to improving health and reducing inequality

Determination of Planning Applications
- Usefulness of establishing criteria for consultation and a point of contact for planning applications for larger residential developments or development which may have an impact on NHS services
- Harmful effects to human health could be considered as a material planning consideration
- Opportunity to develop Health Impact Assessment Guidance for developers – not a statutory requirement when considering a planning application but could be built into the requirements in a planning performance agreement

Agreed:- (1) That engagement take place with the Head of Health Improvement, Public Health, when developing policies for sites and policies

(2) That liaison take place with the NHS to establish contact and criteria for notification/consultation on planning applications to ensure their views were taken into consideration on appropriate applications

(3) That liaison take place with the NHS with regard to drawing up charging schedule for infrastructure delivery.

S17. RNIB

The Board noted a flyer from the RNIB entitled "Eye health and sight loss: local planning for the future".

S18. HEALTHWATCH CONSULTATION

Further to Minute No. S5 from the previous meeting, Claire Burton, Commissioning Officer, submitted the proposed consultation survey for the development of Healthwatch Rotherham and a survey to local community forums, networks and partnerships and voluntary and community sector organisations.

It was proposed that the 2 surveys be sent to members of the public and health and social care service users initially via an online survey on the Council website with a link from the Health and Wellbeing Board webpage. It would also be sent to a representative sample of health and social care service users. Voluntary and community sector networks and community interest groups would receive it via e-mail.

The surveys included a draft 'vision' for Healthwatch Rotherham. It was proposed that the vision be consulted on before final agreement to ensure it was representative of Rotherham people's aspirations for their local Healthwatch.

Agreed:- (1) That the vision for Healthwatch Rotherham be agreed for further consultation.

(2) That the submitted consultation plan and surveys be agreed.

(3) That a further report on the findings of the consultation be submitted to a future meeting.

S19. ANY OTHER BUSINESS

Dr. Polkinghorn reported that the General Medical Council had produced guidance entitled "Protecting Children and Young People". The document was available on the GMC website (www.gmc-uk.org).

S20. DATE OF NEXT MEETING

Agreed:- That a further meeting of the Health and Wellbeing Board be held on 5th September, 2012, commencing at 1.00 p.m. in the Rotherham Town Hall.

South Yorkshire Policing and Crime Commissioner

Template for PCC Candidate Briefing

General quality assurance and drafting points

The briefing:

- is aimed at potential PCC Candidates and will be posted on the South Yorkshire Police and Crime Commissioner's website.
- Should be clear and concise – plain English
- Aim to be between 4 and 6 sides of A4, using Ariel 12 size font

Title/Short Heading: (What is the briefing about?)

Key Points:

(If the PCC candidate hasn't time to read the detail what are the key points you would want them to know)

1.
2.
3.
4.

Background:

Provide context or details of the partnership/organisation in relation to community safety – a description of the aims/purpose and the work it carries out

Identify any community safety legal responsibilities

Provide an overview of the governance arrangements

Priorities& Outcomes

Set out the community safety outcomes being sought and their associated priorities

Provide details of the strategic needs assessment process, including timescales

Identify the key funding streams, amounts& any known planned changes

Set out any recent successes and developments in progress

Link to find out more information

Provide any links to other information

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1	**Meeting:**	**Health and Wellbeing Board**
2	**Date:**	**5th September, 2012**
3	**Title:**	**Alcohol Strategy – Local Implementation**
4	**Directorate:**	**Public health**

5. Summary

The 2012 Government Alcohol Strategy was launched in April; it gave clear strategic ambitions that as a partnership we strive to deliver. The outline was presented to SRP in June outlining the strategic response to the strategy. In order to deliver all aspects of the strategy a partnership meeting was held 4th July with partner agencies in attendance. The meeting enabled us to pull together an action plan.This request is that the board supportthe principle actions in this plan.

Taken from the key aims of the strategy the plan falls into 3 key areas:

- Developing 'Community Alcohol Partnerships' (CAPs), including Responsible Retailer Scheme
- Making those who cause the harm face the consequences – both individuals and premises
- Make 'every contact count' in delivering the culture change required.

An operational action plan has been developed, but confirming commitment from partners to actions and timescales is more challenging. The recommendations below summarise the key areas agreed.

6. Recommendations

1. That CAPs are started in Dinnington and East Herringthorpe and rolled out to all community first areas, unless alternative substantial alcohol initiatives are already underway.

2a That systems for identifying young people, adults and venues which repeatedly cause alcohol related harm are established and shared across agencies.

b That services both specialist and universal are commissioned to deliver voluntary (including FPN waiver) alcohol interventions to ensure the alcohol message is delivered and to open up opportunities for behavior change.

3a That all partner agencies staff undertake the alcohol learning package to raise their own levels of alcohol awareness and to ensure the public receive a single and accurate message.

b That this is supported by a communication plan for the message that including social marketing and use of e-communication.

That these outcomes will be overseen by the new alcohol strategy group chaired by Ian Womersley, Chief Inspector – Operations, South Yorkshire Police.

4 That Public Health will lead the re-commissioning of the specialist alcohol treatment services in line with the findings of the Payment by Results pilot (locally and nationally), to focus services on better outcomes for individuals, including promoting recovery and abstinence.

5 That work to continue to improve care pathways with RFT, in particular via A&E will continue. In particular the school nursing service need to be more active with under 16s who attend intoxicated.

6 That the GP identification/screening programme should be increased to identify more people with lower levels of problems for brief interventions, trying to bring forward the point at which patients receive help.

7 That the 'Lifeline' Tier 2 Services will be reviewed and re-commissioned before its contract expires in 2013.

That delivery of this will be managed by the Alcohol Treatment Group that reports to the Adult Substance Misuse Joint Commissioning Group. Chair Anne Charlesworth, Drug Strategy Manager, Public Health Department, NHS Rotherham.

7. Background

The Government strategy gives some estimates of the magnitude of alcohol as a problem; these have been recalculated to provide minimum local estimates below:

- 5,000 Rotherham people admitted to hospital with an alcohol related condition each year
- 2,500 people each year will be victims of alcohol-related crime
- Over 1,000 11-15 year olds will be drinking weekly
- Over 32,500 people each year in Rotherham will binge drink;
- Around 54,000 people in Rotherham every year will be regularly drinking above the lower risk levels;
- Over 7,500 people each year will be showing some signs of alcohol dependence; and
- Over 1,250 will be moderately or severely dependent on alcohol.

By successfully delivering all aspects of the action plan in partnership we have the potential to impact on some of these statistics and on the drinking culture of Rotherham for the future.

Recommendation 1

CAPs are not 'new' but appear as a recommendation in the government strategy for the first time. The CAP aim to reduce alcohol related Anti-Social behaviour, reduce underage and proxy sales and are supported by the Retail Alcohol Standards group who offer support in setting up and promotion. These will not require new resources or funding as they are very much about enabling all existing resources in a local area to be effectively targeted and compliment other agencies work by an increase in communicating 'intelligence' between all partners. This includes bringing local large and small alcohol retailers into the partnership and viewing them as part of the solution rather than the problem. Earlier in the year the partnership bid for monies from Baroness Newlove on the same theme of reducing alcohol related ASB. As part of this process several areas were put forward as options for the bid, due to a very tight timescale evidence was used that was to hand but Dinnington was

thought to be the best area to start the work, with this in mind we propose to put forward Dinnington as the initial area for a CAP.The Community and Area Partnership Manager has identified alcohol as an issue in Dinnington, there is also a request for a CAP in East Herringthorpe, where the community have also identified it as an issue and we propose this as the second development area.. We plan to compliment the CAPs with partnership roll out of the Responsible Retailer Scheme.

Recommendation 2

Agencies, led by South Yorkshire Police will identify individuals who would benefit from an educational intervention, eg, in binge drinking. South Yorkshire Police will utilise the Fixed Penalty Notice waiver scheme to encourage attendance at sessions, but this option should be considered by other partners whose customers/clients would benefit.

Recommendation 3

Making every contact count entails ensuring that all operational workers have an understanding of the alcohol message and the pathways on to further advice information and potentially interventions. An excellent starting point is that all employees of the partner agencies undertake the basic e–learning package on www.callitanight.co.uk then this can be built on for those who have contact with the public. Support from the highest level will be required for this as previous attempts have not been successful, but this is still the evidence based approach.

8. Proposals and Details

Those individuals/agencies identified within the action plans will be required to report at minimum quarterly on progress, any areas deemed not to be on target will be requested to report monthly. A strategic Alcohol Group will meet quarterly and updates on progress, or lack of, will then be reported upwardly both to the SRP (via the JAG) and the Health and Wellbeing Board. The Community Alcohol Partnerships (CAPS)will also require the full support of the local agencies – both statutory and non-statutory, councillors and local residents the ultimate aim being to have all 11 community first areas covered by them. The board will be updated regularly on the progress of these schemes.

The Alcohol Treatment Group also meets quarterly, and has already made progress with the treatment pathways but there is much more to do.

9. Finance

- NHS Rotherham Public Health continues to fund a dedicated alcohol post 0.8 wte
- Safer Rotherham Partnership have allocated a small amount of money for the continued development of this work (this will equate to around £3000) via the JAG.
- Retail Alcohol Standards Group (RASG) will provide some resources free for the development of the Community Alcohol Partnerships.
- The drug spend has been realigned and will be able to show significant increased allocation spend on services

NHS Rotherham and the Public Health budget currently spend at least £800,000 on treatment services and has allocated an additional £10k of non – recurrent funding to support the refresh of the single message.

This is still small in comparison to the scale of the alcohol problem.

10. Risks and Uncertainties

- Alcohol is a serious health, crime and social concern in the borough, but establishing commitment at middle manager level is historically challenging. (Numerous care pathways are being rewritten within the health community to accommodate this work). It is vital that the importance and seriousness of the issue is communicated throughout organisations and systems.

11. Policy and Performance Agenda Implications

Learning from the first two CAPs will need to be considered for replication in other areas of the borough where alcohol is having particular impact. Overall, other areas of policy may need to be reconsidered to ensure inclusion of alcohol is a priority.

12. Background Papers and Consultation

Alcohol Strategy
Action Plan
CAP toolkit
Building Safer Communities
LAPEwww.**lape**.org.uk
'Where are you at' young persons screening tool
Audit – Adult screening tool

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NHS Rotherham

INFECTION PREVENTION AND HEALTH PROTECTION

ANNUAL REPORT

2011/12

John Radford
Director of Public Health
Kathy Wakefield
Health Protection Manager
Approved by Strategic Infection Prevention and Control Committee May 2012

CONTENTS

1. BACKGROUND and OVERVIEW

The Health and Social Care Act 2008 (Code of Practice for the NHS on the prevention and control of infections and related guidance – Regulation 12) highlights the importance of good infection prevention and control practices across health and social care as a key part of the quality and safety agenda for patient care. The code emphasises the importance of strong leadership, management and governance arrangements, the design and maintenance of environment and devices, the application of evidence based clinical protocols and education, training and communication within commissioning and provider organisations, sharing the vision and responsibility to reduce and sustain a reduction in reducing the risk of Healthcare Associated Infections (HCAI's).

Compliance with the Code of Practice and registration with the CQC by primary Dental Practices came in to force from 1st April 2011, a process that has been supported by the Dental Public Health Team.

This report serves to provide assurance to the Board of NHS South Yorkshire and Bassetlaw, the Operational Executive of NHS Rotherham, the Rotherham Clinical Commissioning Group (CCG) and Local Authority Cabinet (shadow Health and Wellbeing Board) of the activities and risks related to the prevention and control of healthcare associated infections, communicable diseases, immunisation and where relevant wider health protection issues.

2. INFECTION PREVENTION AND CONTROL ARRANGEMENTS

2.1 Infection Prevention and Control Staff

Whilst there is no legal requirement for commissioning organizations to have a nominated Director of Infection Prevention and Control (DIPC), it is seen as good practice, this function is fulfilled by the Director of Public Health, supported by the Health Protection Manager. All providers commissioned by NHS Rotherham have nominated DIPC's or infection prevention Leads, and are members of the Strategic Infection Prevention and Control Committee.

2.2 Role of the strategic infection prevention and control committee

The Strategic Infection Prevention and Control Committee have continued to meet throughout the reportable period, providing assurance regarding compliance with all relevant guidance and legislation and escalating risks via the Operational Risk, Governance and Quality Management Group, respective contract quality review meetings or relevant member of the CCG. Terms of reference for the Committee are included as appendix 1; during the reportable period the terms of reference were reviewed to reflect the changing NHS architecture and ensure continued delivery of service and assurance throughout the transition period. Assurance from Yorkshire Ambulance Service is not provided directly to the Committee but is instead provided to NHS Bradford as the lead commissioner for ambulance services.

The purpose of the committee is not performance management, however in order to provide assurance to NHS Rotherham, each provider submits an assurance framework template stating assurance criteria, evidence provided/available, gaps in assurance/concerns and actions taken/required to each Committee meeting. In addition to this an annual programme, based on the NHS Operating Framework and local priorities is developed, agreed and monitored by the committee, escalating concerns as appropriate.

3. ORGANISATIONAL BOARD ASSURANCE

Minutes from each meeting are circulated to the Operational Risk, Governance and Quality Management meeting for information. These are reviewed and discussed at each meeting, with matters of concern been escalated to the Audit, Quality and Assurance Committee. In addition monthly patient safety and quality reports for MRSA and *C. difficile* are submitted to NHS South Yorkshire and Bassetlaw via the Lead Nurse at NHS Rotherham.

4. HEALTHCARE ASSOCIATED INFECTIONS

The reduction of Healthcare Associated Infections has remained a political and public priority, with commissioners of services and service providers being required to have in place a reduction plan to achieve and sustain a reduction in the number of MRSA bacteraemia and *C.difficile* infections, against the nationally agreed trajectories and plans formulated based on the previous year's outturn. In addition to monitoring by NHS Rotherham, the monthly outturns reported by The RFT are also monitored by Monitor as part of the governance assurance process. The use of broad spectrum antibiotics is well recognised as a risk for selecting resistant organisms and *C.diff*, Rotherham has continued to perform well in this area and has often been one of the top performers within Yorkshire and the Humber and the North of England (76 PCTS). Data from April 2010 to March 2011 shows NHS Rotherham to be the seventh lowest prescriber for Quinolones and 18th lowest prescriber for Cephalosporins. Whilst data for 2011/12 not available at time of writing this report, local monitoring suggests that this position will not be significantly different for the reportable period.

The mandatory reporting of Methicillin Sensitive *Staph aureus* (MSSA) bacteraemia introduced in January 2011 was followed by the introduction of enhanced E. coli bacteraemia mandatory reporting and surveillance from June 2011, although no reduction plan was imposed for either of these two elements.

4.1 Clostridium difficile (C.diff)

Nationally the downward trend for both MRSA bacteraemia and *C.diff* infections has continued. Rotherham health community continues to pursue a culture of zero tolerance in relation to preventable infection. Breaches against monthly plans were reported on four occasions for The Rotherham Foundation Trust (The RFT) and four occasions for NHS Rotherham, however both commissioner and provider organisations performed well against the annual plan. Breaches were discussed within the individual organisations with reports to the relevant committees. Health economy wide performance meetings were held with resulting action plans, which were monitored via the Strategic Infection Prevention and Control Committee.

The Commissioner out-turn includes isolates from laboratories and hospitals other than The RFT where NHS Rotherham is the accountable commissioning organisation i.e. where the patient is registered with a Rotherham registered GP and hence the NHSR responsible population. Out of areas isolates are followed up by the Health Protection Manager.

The trajectory and out-turn for 2011/12 was as follows:

	Trajectory (Annual Plan)	**Actual Annual Out-turn**
The RFT Provider	42	35
Commissioner	84	82

4.1.1 MRSA Bacteraemia

Outturn for 201/12

	Trajectory	Actual
RFT	2	1
Commissioner	6	4

The RFT have continued to perform well, having reported zero incidence of MRSA bacteraemia up to March 2012 (23 months). In March a baby was transferred to the RFT Special Care Baby Unit from out of area and whilst the baby was known to be colonized with MRSA at the time of transfer, went on to develop an MRSA bacteraemia some time after admission. Whilst the bacteraemia was reported as a serious incident, the root cause analysis confirmed appropriate care and management of the baby by the RFT. As the baby was registered with a Sheffield GP this isolate was not allocated to NHS Rotherham. Of the remaining 4 (NHS Rotherham allocated), one was confirmed to be a contaminant, one was a patient who underwent surgery at Bassetlaw and one patient who was a renal patient under the care of Sheffield and the Rotherham Renal Dialysis Satellite Unit had two samples taken more than 14 days apart, which therefore counted as two isolates. Following root cause analysis those areas where practice and management could have been improved were identified, as all three cases (4 isolates) could have possibly been prevented.

One outstanding action for an MRSA bacteraemia occurring in January 2011 which required prescribing training within a practice was completed and closed during the reportable period.

4.1.2 Methicillin Sensitive *Staph aureus* (MSSA) Bacteraemia

Whilst no trajectory was set for the reduction of MSSA bacteraemia there was the expectation that root cause analysis would be carried out to identify lessons that could be learned to reduce future risk and incidence, although it is widely accepted that there are far more variables in relation to MSSA than for MRSA. For the reportable period the following were reported:

The RFT	11
NHS Rotherham	48 (12 of these were reported by STH)

4.1.3 E. coli Bacteraemia

E. coli continues to cause nationally due an increasing level of drug resistance. In an attempt to address this growing concern mandatory reporting and enhanced surveillance was introduced in June 2011, although the complexities of these infections are well recognized. To date no reduction plans have been set. Between June 2011 and March 2012 the following was reported.

The RFT	163
NHS Rotherham	172 (21 of which were from STH and 7 of which were DBH)

4.2 Outbreaks

Information on outbreaks is received via a variety of sources, including Food, Health and Safety (RMBC), The Rotherham NHS Foundation Trust and The South Yorkshire Health Protection Unit. To aid detection of and ensure appropriate management of potential outbreaks in schools, the Local Education Department reported levels of absenteeism

above 10% to the Consultant in Public Health and Health Protection Manager at NHS Rotherham. In addition to the Norovirus outbreaks reported below the following outbreaks were reported:

- Flu like illness/confirmed influenza A – 4 outbreaks were reported, three involving care homes and one involving a primary school.
- Viral outbreak – an outbreak of sickness and diarrhoea was reported from people who had been to a hotel/restaurant. The investigation confirmed this was norovirus.
- There was a family outbreak of E.coli 0157 which involved excluding food handlers from work.
- Parasitic Infections – two outbreaks of scabies were reported within care homes and one outbreak of threadworm among staff in a care home.
- Enterovirus – 2 outbreaks were reported, one affecting a nursery and one affecting a secondary school.
- Water Quality Incident – this involved a family with raised blood lead levels. This investigation is ongoing at the time of writing the report.

4.3 Gastroenteritis/Norovirus

The winter period of 2011/12 saw high levels of Norovirus/gastroenteritis, which had a significant impact on both secondary care and care homes. However bed closures within secondary care were minimized as a result of cohorting affected patients in bays/side rooms. Due to the resulting pressures and potential impact on services, daily surveillance and monitoring was established supported by the South Yorkshire Health Protection Unit. Activity and impact was reported via the SitRep to the NHS South Yorkshire and Bassetlaw Executive Team.

Care Homes	20
Education	3
Hotel/Catering	1
Nursery	1

5. INFLUENZA

Flu activity throughout the 2011/12 season has remained relatively low, within baseline thresholds. Whilst this was reflected generally within Rotherham, the number of GP consultations for flu like illness was consistently higher from week 2 to week 14 compared to other areas across South Yorkshire and Bassetlaw. Whilst there were some reports of Influenza A H1N1 (2009) and influenza B, the predominant strain reported was influenza A (H3) and influenza A (unknown type), prescriptions for anti-viral treatment remained low. There was also generally a high level of other respiratory viruses such as Respiratory Syncytial Virus and Rhinovirus,

The number of patients requiring admissions to secondary care was low, all of these cases were confirmed as influenza A (unknown type), none of which required critical care intervention. There were no admissions during 2011/12 as a result of influenza A (H1N1 – 2009).

Location	Number confirmed	Number admitted to Critical Care	Number of Deaths	Risk Factors
The RFT Admissions	8 (3 children's unit, one to labour ward, 5 medical unit)	0	0	None identified
Community Isolates	1		0	
A/E	1 clinical diagnosis (no laboratory confirmation)		1	Asthma – patient was invited for vaccination on two occasions by the GP, but the patient failed to attend/respond to the invite

The age ranges of those where influenza was confirmed was as follows:

Under 10 years	3
ears	3
> 65 years	4

5.1 Influenza Immunisation Vaccination Programme

The flu vaccination programme remained unchanged from the previous year in terms of the eligible cohorts, however a target of 60% was introduced for the under 65 at risk groups. The campaign was actively supported by NHS Rotherham and its partners within primary care. Following a success pilot of Community Pharmacists to administer flu vaccine to eligible patients over the age of 18 years in 2010/11 the scheme was commissioned again via a service level agreement for a managed service. Eight pharmacists were commissioned to deliver this service, however only 167 vaccines were administered via this route. Contract variations were put in place with The RFT to administer vaccines to eligible groups within general medicine, care of older people wards and maternity services (in patient areas and ante-natal clinic only), however this arrangement failed to be delivered by The RFT, resulting in no additional vaccinations being administered. Despite a fairly quiet flu season and the lack of a lack of national media campaign uptake in Rotherham was generally good, with performance being above the national and the Yorkshire and Humber average in all elements other than pregnant women, however an improvement in all areas of the programme was noted compared to the previous year.

Year	Patients 65 and Over % Cover	National Average	Patients Under 65 at Risk % Cover	National Average	Pregnant Women NOT in clinical risk group	National Average	NHSR Staff	National Average
Sept.2007-Jan.2008	76.2		50.3					
Sept.2008-Jan.2009	76.1		51.2					
Sept.2009-Jan.2010	74.4	72.4	55.0	51.6			17.9	26.4
Sept.2010-6.Feb.11	74.9	72.8	50.8	50.3	38.2	37.7	52.7	Unavailable
September 2011-March 2012	76	74	53.6	51.6	All pregnant women 21.8	27.4	67.4	Unavailable

There was a strong media campaign aimed at carers, facilitated by NHS Rotherham, supported by Rotherham Metropolitan Borough Council, this resulted in an uptake by carers of 51.2%. As there is no definitive list of carers and not all are coded on the GP clinical system, the difficulty in identifying people in this group must be recognized. Engagement of this group often relies on the carers identifying themselves to the practice.

Influenza Immunisation Uptake for RMBC for eligible staff groups

2009 -10	10%
2010 - 11	34%
2011-12	176 staff vaccinated, although it is difficult to estimate as a percentage due to the constantly changing staff base.

Uptake for healthcare workers employed by The RFT was 62%, and whilst this was a slight reduction on the previous year, it should be noted that The RFT staff base now includes community services.

Planning for the 2012/13 programme/season has already commenced.

6. COMMUNICABLE DISEASES

6.1 Infectious Diseases in Pregnancy Screening

Following the completion of a gap analysis against the new standards in April 2011, a group consisting of representation from The RFT and NHS Rotherham was established to oversee implementation of the standards. A new policy document was developed by the Maternity Services at The RFT with support from colleagues in GUM, Hepatology, Paediatrics and Pathology, the policy was approved in March 2012 for full implementation from April 2012. It is intended that compliance against the standards will be audited during

2012/13, although there is regular monitored by the South Yorkshire and Bassetlaw Ante-natal and Newborn Screening Programme Board.

As a result of this work, the key outstanding area is in relation to the vaccination of Rubella susceptible women with 1st dose MMR prior to discharge. This issue is still under review, with work continuing through 2012/13 to ensure implementation of this standard.

6.2 Blood Borne Viruses

The multi-agency viral hepatitis steering group has continued to meet and has provided valuable contribution to the work of the regional HPA and public health department within the Strategic Health Authority on the development of a regional quality standards framework, to be used by commissioners and providers, to ensure access to hepatitis B and C services, testing and management in line with national standards. The group has continued to review the clinical pathway including testing methods and identifying ways to reduce the number of patients failing to attend appointments and improve treatment outcome. In July Rotherham participated in the World Hepatitis Day by having a stall in Rotherham Town Centre, to raise awareness, signpost people to their GP for testing where indicated and provide information and reassurance to anyone concerned regarding possible exposure – in addition to NHS Rotherham, the event was supported by Rotherham, Doncaster and South Humber Foundation Trust, Rotherham Foundation Trust and the South Yorkshire Health Protection Unit. A scoping exercise was undertaken to assess the possibility of a shared care protocol for Hepatitis C. whilst following review it was agreed with the Lead for the CCG not to pursue this at the present time, it was agreed that a shared care pathway for Hepatitis B should be developed, to include financial and resource implications – this work is still in progress at the time of writing this report and will be incorporated into the work plan for 2012/13.

The number of individuals within structured drug treatment recorded as being current or previous injectors who have received a Hep C Test shows an increase year on year with a significant rise over the last 2-3 years due to a strategic focus on Blood Borne Viruses, increasing from 22% in 2008/09 to 74% in 2011/12 (source: ndtms). Further local data indicates that a further 206 individuals have been screened during the reportable year with 83 positive tests being reported. Whilst referrals to treatment via the local pathway continue to increase, concerns remain regarding the DNA rate, investigation and analysis suggests this could be a reflection of 'readiness for treatment' for those individuals.

Rates of individuals entering drug treatment in year being offered and subsequently vaccinated for Hep B has been a local priority and is part of service improvement plans within the main contract with RDaSH. Whilst only 61% of these individuals have been vaccinated in year there is evidence that a wider group of drug treatment clients have also benefitted from this intervention. In an attempt to improve the take up of Hep B vaccinations a local six month pilot utilising a 100 hour town centre pharmacy commenced with a focus on those placed with the pharmacy for supervised consumption and also those accessing the pharmacy needle exchange provision. As the pilot had very limited take up by the client group the decision has been made by drug alcohol treatment (DAT) commissioning team not to roll the programme out wider. An evaluation of the pilot is available upon request from the DAT commissioning team.

6.3 TB Services

The multi-agency steering group facilitates a multi-faceted approach to the reduction, management and the provision of TB services to improve clinical outcome. Work streams have included reviewing the clinical pathway for children, adults and healthcare workers against the revised NICE Guidelines, identifying any gaps and service development needs. The group review and assess the impact of immunization provision, this has contributed to the work of the Rotherham Immunisation Steering Group and also the Rotherham Ante-

natal and Newborn Screening Operational Governance Group, as work progresses to introduce neonatal BCG vaccination prior to discharge. Changes have been made in relation to the diagnosis of latent TB, with the introduction of T-Spot testing, it is envisaged that this change will allow more patients with latent infection to be diagnosed and treated, reducing the risk of onward transmission due to reactivation on untreated disease. Rotherham has seen a significant increase in the number of new entrants, both direct and transferring from other towns and cities in the UK, who have a higher risk/incidence of TB, existing services and regional variances in screening do not necessarily allow for the timely and comprehensive follow up and assessment of these residents, which increases the risk of active infection to the individual and onward transmission to others. Work has commenced through one of the Public Health Specialists to develop a pilot new entrant health check/assessment which include assessment for TB, this would supplement the service that already exists for the asylum population. As of the 1st April 2011 the TB nursing service became integrated with TRFT and whilst this role is primarily a community service, due to the lack of TB specialist nursing resource within TRFT the transition has resulted in increased demand on current resources.

6.4 Sexual Health

6.4.1 Chlamydia

The Chlamydia screening programme is now commissioned from our local, core services in line with national guidance. Rotherham CaSH (Contraception and Sexual Health) service has been commissioned to deliver the programme until March 2013. The programme has changed nationally with the emphasis shifting from overall coverage to a model based on detection and prevalence rates. The delivery of the existing programme reflects this change by having a more targeted approach whilst still operating within an open access framework. As a result of the changes in provider and overall direction of the programme the overall screening during 2011 has dropped, however it is anticipated that rates will increase over the coming year. It is also anticipated that monitoring of Chlamydia testing via the newly implemented CTAD reporting system will provide more accurate information of the levels of infection within the population.

6.4.2 HIV

Whilst the rate per 100,000 population has increased from 41.11 in 2006 to 61.45 in 2010 Rotherham continues to manage relatively few cases of HIV and as such remains a low prevalence area having a rate lower than 2 per 1,000 population. Of new HIV diagnosis in Rotherham,14% are diagnosed late (CD4 count <350 cells/mm3). In line with new national guidelines, work has commenced involving NHS Rotherham Public Health Specialists and the Rotherham GP Champion for Sexual Health to raise awareness in Primary Care and to educate public and patients ensuring that patients do not present late to GUM clinics, to avoid delay in treatment, reduce the risk of complications, improve survival rates and reduce the risk for transmission of infection to others.

6.4.3 Sexually Transmitted Infections (STI's)

Although rates of STIs have shown an overall decrease Rotherham still has higher levels of infection than the average for the Yorkshire and Humber Region. An increase in the uptake of LARC (Long Acting Reversible Contraception) among young women in Rotherham has shown a decrease in teenage pregnancy but has not shown a corresponding decrease in STI levels within this population. We have also seen an increase in STIs among the 40 plus age group. This highlights a need to promote the use of barrier contraception as a preventative measure against the spread of sexually transmitted infections within these population segments. NHS Rotherham Public Health has commissioned a social marketing company to research both of these groups and develop and evaluate suitable marketing tools.

6.5 Food borne Illness

The Health Protection Agency report on calendar quarters, the data provided is therefore for 2011 (January – December 2011) as opposed to the reportable period (April 2011-March 2012).

	2010	2011
Campylobacter	374	368
Cryptosporidiosis	23	20
Giardiasis	10	10
Listeriosis	1	1
Rotavirus (b)	55 (Jan-Sept)	168 (Jan – sept) (175 total year)
E. Coli 0157	6	9
Salmonella	36	33

Whilst seasonal fluctuations were noted, the overall epidemiology remains largely unchanged, with increases noted in E.coli O157 notifications and rotovirus; these were mainly in the first six months of the year, with no specific reason being identified. A novel strain of E.coli O104 (H4) was identified in some parts of the UK; however this did not cause any problems for Rotherham residents.

7. VACCINATION AND IMMUNISATION

The reduction of vaccine preventable disease through timely immunization of eligible groups remains a priority for NHS Rotherham and public health. Work has continued throughout the reportable period to improve uptake of all programmes. Some key points include:

Ensuring there is a timely flow of data between GP practices and the Child Health Department about attendees and those children who failed to attend. Children/babies who do not attend are reported to and followed up by practice staff and health visitors.

For targeted programmes such as Neonatal BCG and Neonatal Hepatitis B, babies/children who fail to attend at The RFT are referred to and followed up by the Health Protection Manager. For children who are missing serology following 4th dose Hepatitis B vaccination dried blood spot testing may be used to check hepatitis infection status has been introduced.

Immunisation uptake data/QUILT is collated monthly and quarterly and is sent to all practices to allow benchmarking. Practices that do not meet the uptake targets for the quarter are asked to undertake a root cause analysis to identify possible reasons and identify actions/changes to practice to improve uptake.

A pilot project has been undertaken to improve the information provided to parents and engage children in an attempt to improve uptake of pre-school booster immunisations. This project will be evaluated and future plans agreed.

7.1 Childhood Immunisation Programme (0-5 years)

Uptake of this programme is monitored nationally via the Health Protection Agency COVER data. Whilst the targets for uptake were increased from a public health perspective, with the aim being to achieve herd immunity, the payment targets for GP's remain unchanged, this continues to pose a risk in that once the upper payment threshold (90%) is reached, and efforts will be reduced. Although the annual data shows a shortfall of less than 5% against the targets, there is still improvement on the previous year, with five of the six elements achieving above 90% and two out of six achieving above 95%, however the uptake

suggests that some parents continue to have concerns regarding the safety of the MMR triple vaccine and the preschool booster remains a difficult group to engage. Outbreak reported elsewhere in the country have been used to promote uptake among the population of Rotherham. Root cause analysis has identified the problems experienced by some practices as a result of changing demographics such as transient populations and Eastern European migrants for who healthcare in general is not a high priority. Work has commenced with partners to try and address some of these issues.

Vaccine / Age	Target 09/10	Actual 09/10	Target 10/11	Actual 10/11	Target 2011/12	Actual 2011/12
DTaP/IPV/Hib- age 1	92%	94.8	95%	96	97%	96.2
MMR- age 2	88%	88.4	92%	91.8	95%	92.2
Hib/MenC age 2	85%	94.7	90%	95.4	96%	95.3
PCV Booster- age 2	80%	90.0	85%	92.8	95%	93.8
MMR 2 - age 5	85%	85.5	90%	89.1	92%	89.5
DTaP Booster – age 5	85%	86.7	90%	90.8	93%	91.1

Source – HPA Cover Data

7.2 Immunisation Programmes (5-18 year olds)

7.2.1 MMR Catch-up (5-24 year olds)

The programme for the 5-18 year olds continues to be delivered via the School Nursing Service, which is now part of The RFT. The national report run by ImmForm for August 2011 showed an uptake of 85.6%, this showed no significant improvement on the previous year (85.5%). Vaccination has also been encouraged via GP's for the 19-24 year olds, although as there is no formal reporting mechanism or survey which covers this group uptake cannot be calculated.

Tetanus, Diphtheria and Polio 13-18 year olds (School Leavers Booster)

This element of the programme is delivered via the School Nursing Teams and reported to and by the Child Health Information Department. At the time of writing the report no uptake data is available however plans have been put in place to run reports based on the academic year, the report to the end of August 2011 is awaited.

7.2.2 HPV Vaccine

The HPV programme has continued in line with national guidance, the routine cohort being girls between the age of 12 and 13 years, with uptake based on academic year as opposed to financial year. Uptake for the 2010/11 academic year to July 2011 was 84.4% against a target of 90%.The programme has continued to be delivered by a designated team within Children and Young Peoples Services, although the number of staff within this team has been significantly reduced, which has had an impact on the number of catch up clinics they are able to deliver. Concerns have been raised regarding performance via the contracting team at NHS Rotherham, who have in turn raised these with the contract team at The RFT. Reassurance has been provided via this route that the planned schedule will deliver the target by the end of July 2012.

12-13 year olds	Dose 1	Dose 1+2	All Three doses
uptake as of the end of March 2012	83.8%	81.3%	05.%

7.3 Pneumococcal Immunisation Programme

Following a review by the Joint Committee for Vaccination and Immunisation (advisors to the Department of Health regarding efficacy and cost effectiveness of Pneumococcal vaccination in the over 65's, the decision was taken to continue with the current programme, which is therefore offered to those aged 65 or over and those under the age of 65 years with risk factors for invasive pneumococcal disease. Uptake is assessed by a single annual survey and whilst there is no national target for uptake for the over 65's, NHS Rotherham aimed for a year on year improvement.

2009/10	73.9%
2010/11	74.5%
2011/12	74.6%

7.4 Vaccine Efficiency and Supply

One incident has been reported by the ImmForm fridge failure and vaccine storage reporting template. This was a human error; the fridge door was left open, which resulted in a significant loss of vaccine. Vaccine wastage and fridge failures continue to be monitored by the Department of Health Immunisation Team.

7.5 Targeted Vaccination Programmes

7.5.1 Respiratory Syncytial Virus (RSV)

Following an evaluation by the JCVI on the cost effectiveness of this vaccine to provide passive immunization, NHS Rotherham worked with colleagues in Children and Young Peoples Services within Community Health Services and The RFT to ensure that all children in the identified risk groups received the appropriate course of vaccination as per the national guidance. A summary of year on year comparison is provided below.

Financial Year	Number of Children Requiring Vaccination
2004/05	2
2005/06	4
2006/07	8
2007/08	13
2008/09	11
2009/10	9
2010/11	15
2011/12	26 (£100.956.49)

7.5.2 Neonatal Hepatitis B

The multidisciplinary group has continued to meet to review the clinical pathway to ensure compliance with national standards. The audit carried out on mothers delivering in 2009 showed a significant improvement of outcomes compared to those delivering in 2008, particularly in relation to recording the mothers Hepatitis B positive status in the hospital notes, explanation of results, access to verbal and written information, babies receiving the fourth dose of vaccine and recording of subsequent doses on the Child Health Information System.

7.5.3 Neonatal BCG

Babies identified as being at an increased risk of exposure at birth require vaccination with BCG. Currently this is not always offered prior to discharge from the hospital. Babies are required to attend the children's outpatient department to receive vaccination, and whilst this is generally within 6 weeks of birth this system is not without failing, firstly it allows

continued exposure to a susceptible baby and secondly it is associated with a high failure to attend rate. Monitoring of failures to attend commenced in September 2011, with all such babies being referred to the Health Protection Manager for follow up. Between September 2011 and 31st March 2012 41 babies failed to attend for their first appointment for BCG vaccination.

7.6 Training

Staff requiring immunization training has been directed to the Core Learning Unit e-learning programme which consists of a number of modules covering the core elements of the Health Protection Training programme. Latterly training has been sourced from Sheffield University, funded by the Strategic Health Authority, whilst sessions have been planned; this programme of training will not come into effect until 2012/13.
Training will be available to all providers.

7.7 Policy Development

The Rotherham Mass Vaccination and Seasonal Flu plans were both reviewed and approved by NHS Rotherham Board (as stood at the time).

8. INFECTION PREVENTION AND CONTROL IN CARE HOMES

The Health Protection Manager continues to attend the Residential and Nursing Care Liaison Forum, providing support for the Local Authority Contract and Assurance Review Officers Care Quality Commission as required.

The pilot to improve the management of MRSA positive patients in the community commenced in March 2012 across the Central Locality of Rotherham, this pilot includes all practices, District Nursing Teams and three care homes within that area. The pilot will run for three months with monthly progress reviews by the steering group.

9. INCIDENTS

Local incidents, MHRA alerts and Food alerts have been reported and the appropriate action taken and assurance being received via organizational reporting mechanisms. Details of specific incidents are available upon request.

9.1 Child Death following Chicken Pox

A one year old child developed chicken pox, which initially followed the normal course for the infection. Four days later the child developed signs of secondary bacterial infection for which the parents sought medical attention, anti viral treatment was commenced by the GP. The child subsequently died two days later after a further 2 hospital attendances. Following the inquest a rule 43 letter was issued to the general practice concerned. It was concluded by the Coroner that had the child be managed differently by both the hospital and GP it is likely that they would have survived.

10. AUDITS

10.1. Primary Dental Care

The Dental Public Health Team have continued to support dental practices in ensuring compliance with HTM 01-05 and requirements for registration with care quality commission. Whilst practices are compliant with the essential standards required by HTM01-05 movement to and compliance with the best practice standards is more difficult to achieve and enforce due to the lack of mandatory timescales. The self audit was repeated early in 2012, the results of which are in the process of being analysed.

10.2 Cold Chain

In accordance with guidelines from the National Patient Safety Agency, an audit was carried out in March 2011 across The RFT (Health and Wellbeing, Child Health and Respiratory Outpatients), Primary Care (28 practices returned the audit, 31 failed to return) and HPV Team to assess compliance in maintaining the cold chain for vaccines. Areas within The RFT have developed action plans and are in the process of implementing these actions. Practices were required to develop individual action plans, which will be assessed by re-audit during 2011/12, however a generic summary and action will be collated and circulated to practices. Key themes identified include:

- Inventory's not being maintained
- Daily recording of fridge temperatures
- Items other than vaccines stored in the fridge
- Vaccine fridge not kept locked
- Vaccine fridge not having a dedicated marked or switchless socket
- Details of fridge failure and action taken not logged
- In Primary Care, Most Health Care Assistants administering vaccines do so under patient specific directives.
- Not all staff involved in immunisation have received two yearly update training

Audit work has also been commenced for the following areas, however the results cannot be reported on at the present time.

- Neonatal hepatitis B immunization pathway
- TB services
- Cold Chain

11. CONCLUSION

The Rotherham Health Economy has achieved much in ensuring safe quality care for the people of Rotherham, reducing the risks associated with Healthcare Associated Infections and improving uptake of vaccination to reduce the risk of potentially life-threatening and debilitating communicable infections in most areas across the majority of all of the programmes. The year ahead will continue to pose significant challenges as we move through a transition year into a new architecture for commissioning and public health. All organizations will be required to ensure robust plans for the continued and sustained reduction of healthcare associated infections such as RSA and C. diff and whilst no specific reduction targets exist for *E.coli* and MSSA bacteraemia very effort should be made to raise awareness and understanding to achieve a reduction in these areas.

Whilst separate outcomes frameworks exist for the NHS, Public Health and Adult Social Care, NHS Rotherham along with its partners across health and social care will need to work collaboratively focusing on shared goals and common priorities to ensure the commissioning and provision of safe high quality care during the remaining phases of transition.

Appendix 1

Strategic Infection Prevention and Control Committee

TERMS OF REFERENCE (2012/13)

Contact Details:			
Lead Director/ Clinician:	John Radford	Lead Officer:	Kathy Wakefield
Title:	Director of Public Health	Title:	Health Protection and Infection Prevention Manager

Purpose:
The purpose of the Committee is to provide strategic direction and oversee infection prevention and control activities and other associated health protection functions across the Rotherham health economy. Providing assurance during the period of transition to the South Yorkshire and Bassetlaw Cluster Board, Rotherham Metropolitan Borough Council and NHSR Operational Executive that all necessary actions are being taken to safeguard the people of Rotherham, reducing the risk of healthcare associated infections and other infection threats. To work collaboratively, exchanging information and sharing knowledge and where appropriate pool resources for mutual benefit to achieve a common purpose.

Responsibilities:
• Provide strategic direction to all providers to ensure high standards of care and practice in relation to infection prevention and control. • To ensure compliance with all relevant legislation, national and local guidelines and policies. • To receive assurance of the above. • Support and inform the commissioning process to promote health and well-being in relation to healthcare associated infections, communicable infections and threats to public health and vaccine preventable diseases including immunisation. • Identify issues that would present a health and safety or clinical risk to patients with regards to infectious agents, members of the public or staff and escalate to the appropriate Committee/Board or body. • Monitor performance of all providers with regards to reducing the risk of healthcare associated infections and communicable diseases. This includes compliance with educational requirements as stipulated in the Health and Social Care Act 2008 (Code of Practice). • Receive surveillance data and act accordingly. • Oversee the vaccination and immunisation programme – receiving reports and feedback from the Rotherham vaccination and immunisation steering group. • Ensure the provision of high quality front line services to patients. • Consult with and seek the views of stakeholders and partners as appropriate. • Monitor and review incidents and outbreaks, identifying the lessons to be learned and ensuring these are shared as appropriate. • Review and make recommendations following serious untoward incidents that occur in relation to Infection Prevention and Control and/or Vaccination/Immunisation and HCAI Root Cause Analysis/Reports. • Produce an annual report covering all aspects of the infection prevention and control agenda which will be presented to the Governance, Risk and Quality Committee each June. • Develop an annual work programme to incorporate all aspects of the infection prevention

and control together with the health protection agenda. • Provide expert advice and support as required to the Clinical Commissioning Group and RMBC/Health and Wellbeing Board during the transition period.

Chair:
Health Protection and Infection Prevention Manager – NHS Rotherham

Composition of group:
Health Protection and Infection Prevention Manager Representative from South Yorkshire Health Protection Unit Senior Representative The RFT Infection Prevention and Control Team Senior Representative for Infection Prevention and Control – RDASH RMBC Representative - Neighbourhood and Adult Services RMBC Representative – Children and Young People's Services Representative from Dental Public Health Representative for Performance and Risk Representative from Medicines Management Representative for Primary Care Representative from Food, Health and Safety (Environmental Health) Representative from Sexual Health NHSR Head of Clinical Services – Rotherham Hospice

In Attendance:
Director of Public Health (Director of Infection Prevention and Control for NHSR/RMBC) Contract Leads as appropriate Screening Co-ordinator Departmental Heads as appropriate RMBC Contracting Leads as appropriate

Deputising:
All members must make every effort to attend. If members are unable to attend they must send formal apologies and should send a nominated deputy where possible. Members who do not attend and who have not given formal apologies will be recorded as absent/did not attend.

Quorum:
Chair or Deputy Representatives from two external organisations

Accountability:
Reports to Operational Risk, Governance, Quality Management Group Accountability to the Boards of the South Yorkshire and Bassetlaw Cluster, NHSR and RMBC will be supported by the submission of an annual report. It is the responsibility of members to ensure appropriate feed back to their respective organisations.

Frequency of meetings:
Bi-monthly (alternate Months)

Order of business:
Normal Confidential Section will be applied.

Agenda deadlines:
Items to be received two weeks prior to meeting Agenda to be circulated within two weeks of meeting.

Minutes:
Minutes will be circulated within two weeks of the meeting. These will take the form of action points/notes as opposed to full minutes. Minutes will be circulated to all committee members plus the Director of Public Health. Minutes of non confidential section will be available to non members and members of the public upon request. Minutes will be forwarded to the Chair of the Operational Risk, Governance, Quality Management Group

Administration:
Chair

Attendance:
Members (or their nominated deputies) are required to attend a minimum of 4 meetings annually. This will be audited annually (April of each year). Where the standard has not been met, the individual member will be contacted with regards to addressing the issue, where non compliance persists; this will be reported to the Chief Executive of the relevant organisation.

Review Date:
April 2013 following establishment of the new NHS architecture.

Membership List

John Radford Director of Public Health (Director of Infection Prevention and Control NHSR – Commissioning)

Kathy Wakefield	Health Protection and Infection Prevention Manager
Suzanna Matthew	Consultant for Communicable Disease Control
Ann Kerrane	Matron for Infection Prevention and Control – RFT
Rachel Millard	Head of Clinical Assurance - RDASH
David Morgan	RMBC Representative – Neighbourhood and Adult Services
John Heyes	Dental Advisor Public Health
Claire Rees	Performance and Risk
Richard Potter	Representative for Primary Care
Jason Punyer	Medicines Management
Janice Manning	Food, Health and Safety, RMBC
Jo Abbott	Sexual Health Lead NHS Rotherham.
Dean Fenton	RMBC Representative Children's Services
Paula Hill	Head of Clinical Services, Rotherham Hospice

Infection Prevention and Control and Immunisation Work Plan

2012/13

Outcome/Indicator/ Domain	Target/Aim/Standard	Actions Agreed	Lead Officer	Assurance Process/Data Source	Progress/Update
Public Health Outcomes Framework, Domain 3 (health protection)	Population Vaccination Coverage				
	a) Seasonal Flu Vaccination uptake: • Over 65's • 75% - WHO target • Clinical risk groups Under 65 years of age including pregnant women 70% (as per CMO letter Gateway: 15653 March 2011) • Health Care Workers –Target 70% NB targets maybe amended following receipt of CMO guidance for 2012/13 programme	GP's to review and ensure robust call and recall systems to ensure patients identified according to ImmForm business rules. GP's to arrange vaccination of housebound not on D/N caseload, including care homes Local Media Campaign to be developed and pursued throughout flu season Ensure adequate vaccine supply – complete spread sheet to identify potential shortfall. The RFT to support vaccination programme by assessing patients at admission/outpatient appointments and vaccinate opportunistically.	Richard Potter Kathy Wakefield Practice Manager Ken Clayton/ Fiona Topliss Kathy Wakefield/ Practice Managers Kathy Wakefield Supported	Automated upload to ImmForm – frequency determined by DH Monthly reports from provider organizations including primary care	

		Maternity Services to vaccinate all pregnant opportunistically at all/any antenatal contact/clinics (in primary care and RFT sites) with the exception of domiciliary visits. Maternity Services to work with Practices to ensure pregnant women denominator is accurate Ensure timely sharing of administration between secondary and primary care. District Nursing Teams to vaccinate the housebound already on their case load – aim to complete this process by end of November. Consider training HCA to deliver flu programme For children in clinical risk groups – vaccination status to be checked on attendance/admission to The RFT – staff to vaccinate where necessary Contract variation to be agreed with RFT LES may need to be developed to cover carers and other groups not specifically listed in the guidance but deemed at risk.	by RFT Medical and Nurse Directors as Exec Leads. Theresa Woodward/ Jayne Manderson Ann Douglas Yvonne Weakley/ Dr Hashmi Ian Atkinson Richard Potter		

		Vaccination offered through workplace, health and wellbeing and by individual employers – this includes Social care staff (RMBC) Independent Social Care Providers Requirement to ensure provision of vaccination has been incorporated into the Care Home contract – this includes providing action plans of provision and final uptake data.	Pam Wright and Practice Managers Dave Morgan/ Sarah McCall					
	b) Childhood immunization programme 0-5 years	Uptake data by practice to be issued in form of 'QUILT' monthly Quarterly 'QUILT' to be followed by root cause analysis for practices under achieving and actions identified. Quarterly QUILTs to be reviewed by Health Protection Manager Missing Imms and DNA reports to be issued to practices by Child Health Vaccination COVER data part of annual contract review for practices. MMR media campaign to boost MMR uptake	Marcus Williamson Kim Jones Kathy Wakefield Kim Jones Richard Potter Kathy Wakefield/ Fiona Topliss	HPA COVER data from Child Health Department – monthly and quarterly	Q1	Q2	Q3	Q4/ Annual
	DTaP/IPV/Hib age 1 97%							
	Hib/Men C age 2 96%							
	PCV Booster age 2 95%							
	MMR age 2 95%							
	MMR 2nd dose age 5 92%							
	DTaP Booster age 5 93%							

		Review pilot of birthday card for 3 year olds to increase uptake of Pre school booster – consider how the initiative could be developed.	Kathy Wakefield Ken Clayton		
	MMR Catch up (5-18 year old) – 90%	Annual uptake report to be provided based on academic year	Ian LoveKim Jones	Immform survey annual CHID report annually	
	MMR catch up 19-24 year olds – no target as there is no formal reporting mechanism	Practices encouraged to call/recall patients not having received two doses. LES to be maintained for this age group	Kathy Wakefield Richard Potter	No formal reporting mechanism	
	c) HPV for girls aged 12-13 years – completing all three doses 90% completing programme by the end of August 2011 Cohort (denominator) = 1771	Continue to offer vaccination to girls outside of routine cohort to ensure completion of three doses. Programme for girls in routine cohort (entering Y8 , 12-13 year olds) in September 2010 to be completed by end of July 2011 Non school attenders access via GP (LES in place) or HPV Team. Systems to be established to ensure continuation as per Service Spec from Sept 2012 to August 2013.	Sue Gittins/Jo Marsh Richard Potter Kathy Wakefield	Data via HPV team/Child Health Recorded on ImmForm – monthly monitoring – annual report	Q1 Q2 Q3 Q4

		Ensure timely reporting of uptake on CHIS HPV vaccination to be recorded on Exeter system minimum of quarterly to facilitate national cancer screening programme for cervical screening	Jo Marsh/ Kim Jones Kim Jones/ Alicia Gray	Monitoring by QARC (Yorks and Humber) and national cancer screening programme	
	d) Td/IPV Booster for 13 -18 year olds Ensure young people are adequately vaccinated prior to leaving school 90%	Programme delivered through school nursing service Need to develop a system for monitoring uptake	Sue Gittins/ Kim Jones Ian Love	Annual Report via CHIS based on academic year.	Q1 | Q2 | Q3 | Q4 | | | |
	e) Pneumococcal. Over 65's - Based on uptake for 2011/12(74.6) – local target of 76% should the programme be continued Under 65 at risk groups	Programme delivered through General Practice. Practices to call patients in this group. Delivered as per 'green book' by primary care. Practices to identify and call all at risk patients. Pneumococcal programme to be supported by RFT – relevant groups attending for outpatients or admission	Richard Potter Medical and Nurse Directors/ Kathy Wakefield	ImmForm annual survey April/May 2013 for 2011/12 uptake	

	f) Targeted Programmes Neonatal Hepatitis B	Midwives to be vaccination trained to administer BCG and Hepatitis B prior to discharge. To improve DNA rate for BCG attendance	Jayne Manderson		
	Neonatal BCG	DNA's for 4th dose hep B and BCG to be referred to Health Protection Manager for investigation and follow up.	Kathy Wakefield		
		Continue multi-agency work to review and develop care pathway to ensure full course of vaccination given.	Kathy Wakefield		
		Dried blood spot testing to be used for children not attending RFT for serology for Hepatitis B,	Kathy Wakefield		
	RSV	Children identified as per national protocol and decision tool. Activity to be monitored by paediatric pharmacist at RFT.	Kathy Parke/Diana Mowbray		
	Rotavirus	Agreed between DPH and CCG to investigate possibility of local implementation of vaccination programme.	Kathy Wakefield		
	MMR for Rubella Susceptible women	Rubella status to be assessed as part of any new entrant health check.	Alison Iliff/ Kathy Wakefield		
		1st dose to be offered by Maternity	Jayne		

		Services prior to discharge – as per IDIP screening standards 2010 (implemented April 2012)	Manderson/ Theresa Woodward		
	g) Immununisation Training All staff involved in immunization to provide evidence of compliance with HPA core standards for training	Providers will be responsible for ensuring training records for their staff are maintained, these may be requested as part of an audit or contract review. National skills for health e-learning package may be used for induction and/or updates Training days are available via Sheffield University for all providers – these are coordinated by the Health Protection Manager	Practice Managers Practice/ Departmental managers. Kathy Wakefield	Providers of immunization services to issue compliance statement/ assurance framework to Performance and Risk Department	
Public Health Outcomes Framework – Domain 3 (health protection)	Communicable Disease and Sexually Transmitted Infections				
	Tx Completion for patients with TB	Ensure compliance with NICE guidelines, and service delivery in line with CMO TB action plan and commissioning toolkit Ensure at risk people are identified, screened and treated to minimize the risk of transmission. Develop patient pathway to ensure	Kathy Wakefield/ Tracey Turton	TB steering group minutes	

		comprehensive service delivery Monitor incidence and trends of TB including treatment outcome and drug resistance patterns. Identify areas for improvement in screening, diagnosis and management e.g. new entrants – develop business cases as necessary – consider T spot Test pilot Evaluate impact of social deprivation and other health inequalities/determinants in relation to the incidence of TB Undertake a Strategic Needs Assessment Ensure provision for targeted vaccination where indicated. Undertake annual audit of TB service	Alison Iliff/ Kathy Wakefield Kathy Wakefield/ Elaine Barnes Kathy Wakefield Michelle Scott/ Jayne Manderson Ian Baker/ Tracey Turton	HPA reports via enhanced surveillance	
	Chlamydia diagnosis for people aged 15-24 year.	Reduce transmission of Chlamydia by identifying positive cases/carriers in a timely manner. Target 2400-3000 positive results	Gill Harrison		

		per 100,000 population = to approx 769-962 actual cases per year Promote testing, safe sex messages and access to testing. Ensure good access to services and appropriate onward referral and management.			
	People presenting with HIV at late stage of infection	**All** pregnant women should be offered HIV screening in each pregnancy as per IDIP screening standards 2010. Promote awareness through sexual health forums and networks Ensure access to GUM services for testing and management Encourage early referral and testing as per national guidelines. Work collaboratively with Clinical Referrals Management Committee. Report late diagnosis/referral as exceptions	Theresa Woodward Gill Harrison Gill Harrison	RFT positive reports HPA data GUM data	
Public Health Outcomes Framework – Domain 4 (Healthcare public health and preventing	Reducing mortality from Communicable Diseases	Implement vaccination programmes in line with national programme Aim to improve uptake of	Kathy Wakefield	Mortality Rates published by HPA.	

premature mortality)		vaccination to levels which achieve herd immunity. Ensure communicable diseases are diagnosed, reported and managed promptly. Through IDIP screening implementation group consider other infections that could be detected in pregnancy which would improve outcome for mother and child Monitor mortality due to HCAI		HPA cover data and immunization uptake data	
Public Health Outcomes Framework – Domain 2 (health improvement)	Access to non cancer screening programmes i.e. infectious diseases in pregnancy screening – Hepatitis B, HIV, Syphilis and Rubella susceptibility	Ensure national standards are implemented and embedded. Audit implementation annually Report to Rotherham antenatal and newborn screening operational governance committee Agreed as a KPI with RFT	Theresa Woodward	RFT data	
Public Health Outcomes Framework – Domain 2 (health improvement), Domain 4 (healthcare public health and preventing premature	Successful completion of drug treatment. Reducing mortality due to liver disease Reducing premature	Ensure timely and appropriate referral and management of people with Hepatitis B or C (all ages) Ensure support mechanisms are in place to increase compliance with	Kathy Wakefield (Viral hepatitis steering group)	Reports to steering group NTA data HPA data	

death). NHS outcomes framework – Domain 1 (preventing people dying prematurely)	mortality from the major causes of death – under 75 mortality rate from liver disease	treatment Monitor referrals for treatment, aim to improve DNA rates and monitor treatment outcome. Promote vaccination where available to at risk groups Ensure compliance with national and NICE guidelines Review and implement new treatments as appropriate Develop work plan to be monitored by steering group to include JSNA.			
NHS Outcomes Framework – Domain 5 (treating and caring for people in a safe environment and protecting them from avoidable harm). Adult Social Care Outcomes Framework – Domain 4 (safeguarding adults – protecting them from avoidable harm)	Reducing the incidence of MRSA and C.diff. People are protected as far as possible from avoidable harm, disease and injury	Assurance report to be submitted to Strategic Infection Prevention and Control Committee by all providers. Monthly quality reports to be submitted to Lead Nurse for NHS Rotherham All HCAI related deaths to be reported to Health Protection Manager within one working day and to be reported as serious	Kathy Wakefield	Number of incidents/ positive reports – HPA MESS data	

		incident. Zero-tolerance culture to be adopted across by commissioners and providers for avoidable infections Performance against plans to be monitored at least monthly. Out of area reports followed up by Health Protection Manager Establish monthly RCA meetings Ensure MRSA screening in line with national policy	Sue Cassin Walid Al-Wali		
	MRSA bacteraemia RFT annual plan = 0 NHSR annual plan = 3	All cases to have RCA within 7 days of notification MDT to follow RCA Action plans to ensure lessons identified are learned and shared	Walid Al-Wali		
	C. diff RFT annual plan = 31 NHSR annual Plan = 73	Ensure prudent antibiotic prescribing across primary and secondary care All cases to have RCA within 7 days of notification MDT to follow RCA where appropriate Action plans to ensure lessons identified are learned and shared	Walid Al-Wali/ Jason Punyer Walid Al-Wali		

		Implement and embed CDT management initiatives	Kathy Wakefield		
	Reduce the incidence of MSSA Bacteraemia	Mandatory surveillance via MESS Lessons learned and shared where identified. Monthly monitoring	Walid Al-Wali	HPA MESS data	
	Reduce the incidence of E. coli bacteraemia	Mandatory reporting via MESS Use surveillance to identify lessons to learn and share. Monthly monitoring	Walid Al-Wali	HPA /MESS data	
	NHS Safety Thermometer	Ensure compliance with CQUIN requirement by all relevant providers. Data collection and reporting to commence in July 2012 – this data will be used to determine quality goals for future years Quarterly reports to be provided by Contracting Team to Strategic Infection Prevention and Control Committee	Caron Smith/Kate Tuffnell	1/4ly Reports to SIPaCC	
Public Health Outcomes Framework – Domain 4 (healthcare public health and preventing premature mortality)	Emergency readmissions within 30 days of discharge	Monitor number of patients readmitted with SSI Monitor number of patients readmitted due to HCAI	Walid Al-Wali/ Kathy Wakefield	Report to SIPaCC	
Work streams not					

directly to an outcomes framework					
Policy Development	a) Mass Vaccination Plan	Review to take account of organizational and service redesign	Kathy Wakefield		
	b) Pandemic Influenza Plan	Review in line with DH pandemic preparedness and response guidelines	Kathy Wakefield		
	c) Infectious Diseases Outbreak Plan	Develop policy in line with SYHPU and SHA Identify roles and responsibilities/accountabilities within the Local Authority and Public Health Department. Policy to be developed using principles of the national decision tool	Kathy Wakefield		
	d) Cold Chain Policy	Ensure policy content compliant with NPSA guidance/alert on maintaining cold chain and integrity of vaccines. Develop policy to ensure all aspects related to the cold chain are adhered to by all providers of immunization services. Audit policy annually.	Kathy Wakefield Rachel Garrison		
	e) Seasonal Flu Plan	Review annual plan to take account of CMO guidance for 2012/13 vaccination programme.	Kathy Wakefield		

Infection Prevention and Control in Dental Practice	Ensure all General Dental Practitioners are fully compliant with the CQC requirements , HTM 01-05 and other relevant legislation	Support Dental Practitioners to achieve the 'best practice' elements of HTM01-05 by including them as a QID marker. Repeat audit of HTM 01-05 compliance across all Dentists in February 2012 - action plans to be produced by practices to demonstrate move to best practice Support practices in relation to the implementation of the EU Directive to prevent sharps injuries	John Heyes	Reports to SIPaCC	
Infection Prevention and Control in Care Homes	Ensure compliance with regulation 12, outcome 8 of the Health and Social Care Act and code of practice	Infection prevention and control to be included in Care Home contracts Work with LA to develop assurance framework/standards for infection prevention and control Support Contract and Assurance Review Officers at LA and CQC – carrying out formal inspections/visits as required, followed by the submission of a report Implement and review the pilot for the management and treatment of MRSA in Care Homes Consider how NHS Safety Thermometer can be incorporated	Kathy Wakefield/ Sarah McCall Kathy Wakefield Walid Al-Wali		

		into care home contract to improve standards. Health Protection Manager to attend Care Home Managers and Domiciliary Forums			
Infection Prevention and Control in General Practice	To ensure high standards of infection prevention and control in primary care. Prepare practices for registration with CQC from April 2013 and other relevant legislation.	Work with practices and GP Commissioning and Quality Teams to provide advice and support as required. Infection prevention and control to be included in contract review processes. Support practices to implement the EU Directive for the prevention of sharps injuries	Richard Potter/ Angie Brunt/ Kathy Wakefield	Primary Care Team	
Audit	Neonatal Hep B immunisation	Audit of babies born to Hepatitis B positive Mums in 2010 To identify the number of babies requiring and receiving Hepatitis B vaccine and assess the dropout rate between dose 1 and dose 4.	Ian Baker		
	TB Services	Audit of services in line with TB toolkit Assess the current level of service and identify gaps and areas of service development	Ian Baker		
	Cold Chain Audit	All providers of immunisation services to complete audit	Rachel Garrison/		

		Comply with NPSA recommendations	KW		
	Hepatitis B to at risk groups	Annual assessment of which groups practices routinely offer hepatitis B vaccination, to identify shortfalls and encourage promotion of vaccination	Kathy Wakefield		
Mandatory Surgical Site Surveillance	Requirement to conduct a minimum of one module of orthopaedic surveillance per year.	RFT to notify NHSR of the category to be surveyed.	Walid Al-Wali	RFT Hospital Statistics. National Report from Nosocomial Surveillance Unit	

Rotherham CCG

Annual Commissioning Plan and CCG Annual Cycle

H&WBB 5th September 2012

Contact Details:			
Lead Director:	**Robin Carlisle**	**Lead :**	**Lydia George**
Title:	**Deputy Chief Officer**	**Title:**	**Planning and Risk Manager**

Purpose:

To inform the H&WB Board the proposed development and timetable of the 2013/14 CCG Annual Commissioning Plan (ACP).

To set this in the context of the CCGs calendar and Annual Report.

To establish a position where the development of the Annual Commissioning Plan is a year round cycle rather that a discreet event.

Recommendations:

- H&WBB to note and comment on the proposals for discussing, producing and agreeing the 2013 ACP
- H&WBB to note the implications for the CCG calendar
- H&WBB to note the proposals for annual meeting and report

Background:

The CCG Constitution requires an Annual Commissioning Plan (formerly known as SIP) and an Annual Report. Numerous stakeholders need to be engaged and the plan has to be agreed as set out in the Constitution. This paper makes proposals to discuss, produce and agree an ACP by mid March 2013, an Annual Report by the end of June and sets these in the context of the overall CCG's annual calendar.

Feedback from the Rotherham wide consultation on the H&WB Strategy and feedback from the GPRC, the Patient Forum and the Stakeholder Forum will be especially important in the 2013 ACP.

H&WBB are receiving the following appendices as part of this paper:

- Appendix 1 – sets out the proposed inputs required for the ACP. These need to be discussed with the groups involved.
- Appendix 2 – sets out the 'plan for a plan'.
- Appendix 3 – sets out the 4 iterations of the ACP.
- Appendix 4 - sets out what the CCG Constitution requires regarding ACP, Annual Report and Annual Meeting.
- Appendix 5 – sets out he CCG Annual Calendar

Analysis of Risks:

The NHS CB could issue instructions on the format of ACPs or delay the release of key financial information that could require substantial modification of this plan for a plan.

Return on Investment:

Is part of the ACP.

Analysis of Key Issues:
ACP timetable. Appendix 2 of the attached sets out a timetable for producing the ACP. **ACP format**: There will be 4 iterations of the ACP, see appendix 3: • This Plan for a Plan document so stakeholders are informed in advance of timescales. • A consultation presentation to encourage initial feedback in September /October. • A written version which will include 2013/14 financial allocations to be completed in early January. • A final version modified after the conclusions of 2013/14 contract negotiations to be completed by 31 March 2013. **CCG Annual calendar:** This sets out likely key financial and contractual deadlines which are likely to be similar each year. **Annual Report and stakeholder meeting:** the CCG is required to report annually to the public. The most appropriate time is after completion of the annual accounts by the end of June. This is an opportunity to get public feedback on the extent to which the CCG delivered against its previous years plan, to present its plan for the current year and be the first event in consulting for the subsequent years ACP.

Patient, Public and Stakeholder Involvement:
The plan for a plan make proposals to do this effectively.

Equality Impact:
Will be a component of the plan.

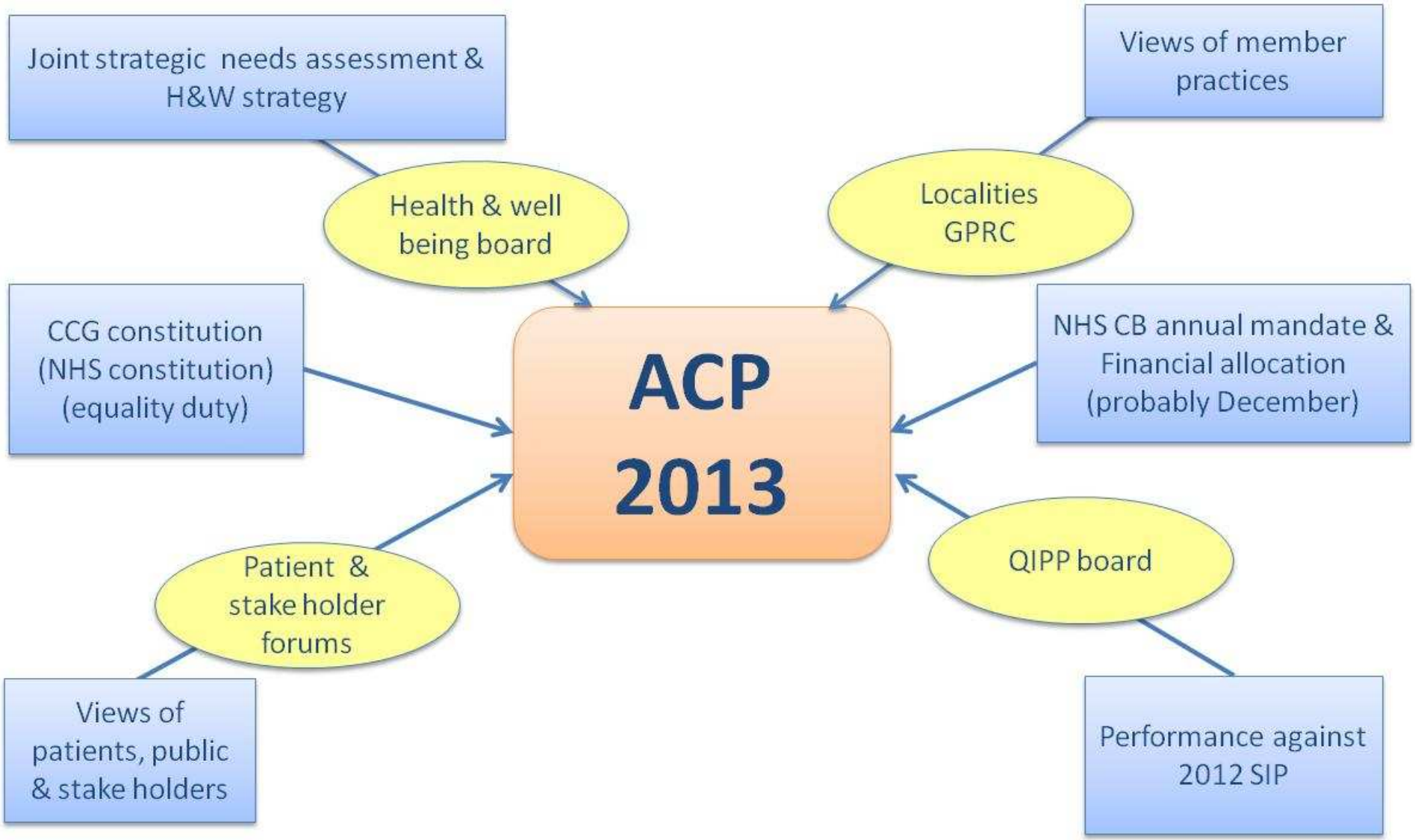
Financial Implications:
Will be a component of the plan
Approved by:

Human Resource Implications:
Will be a component of the plan
Approved by:

Procurement:
Individual elements of the plan may have procurement implications.
Approved by:

Key Words:
SIP, Annual Commissioning Plan

Inputs required for 2013 Annual Commissioning Plan (ACP)



Rotherham CCG Annual Commissioning Plan (ACP) 2012/13
Draft Timetable for 'plan for a plan' v1.1 13 08 12

There will be 4 versions of the ACP produced, their purpose and timescales are shown below (also see appendix 3):

P4P	**'Plan for a Plan'** – (this paper) to outline the necessary consultation/approvals process and timeframe	**CV**	**Consultation Version of the ACP** – powerpoint presentation to encourage initial feedback (produced in September for use up to December)	**V1**	**Version 1 of the ACP** for first submission (produced in December for January submission)	**V2**	**Version 2 of the ACP** for final submission (produced in February for March submission)

The consultation and development periods are outlined below:

	Development of 'plan for plan'		**Views from member practices, patients, public and stakeholders**		**Production of plan to meet national and local requirements**		**Suggested meeting and version**

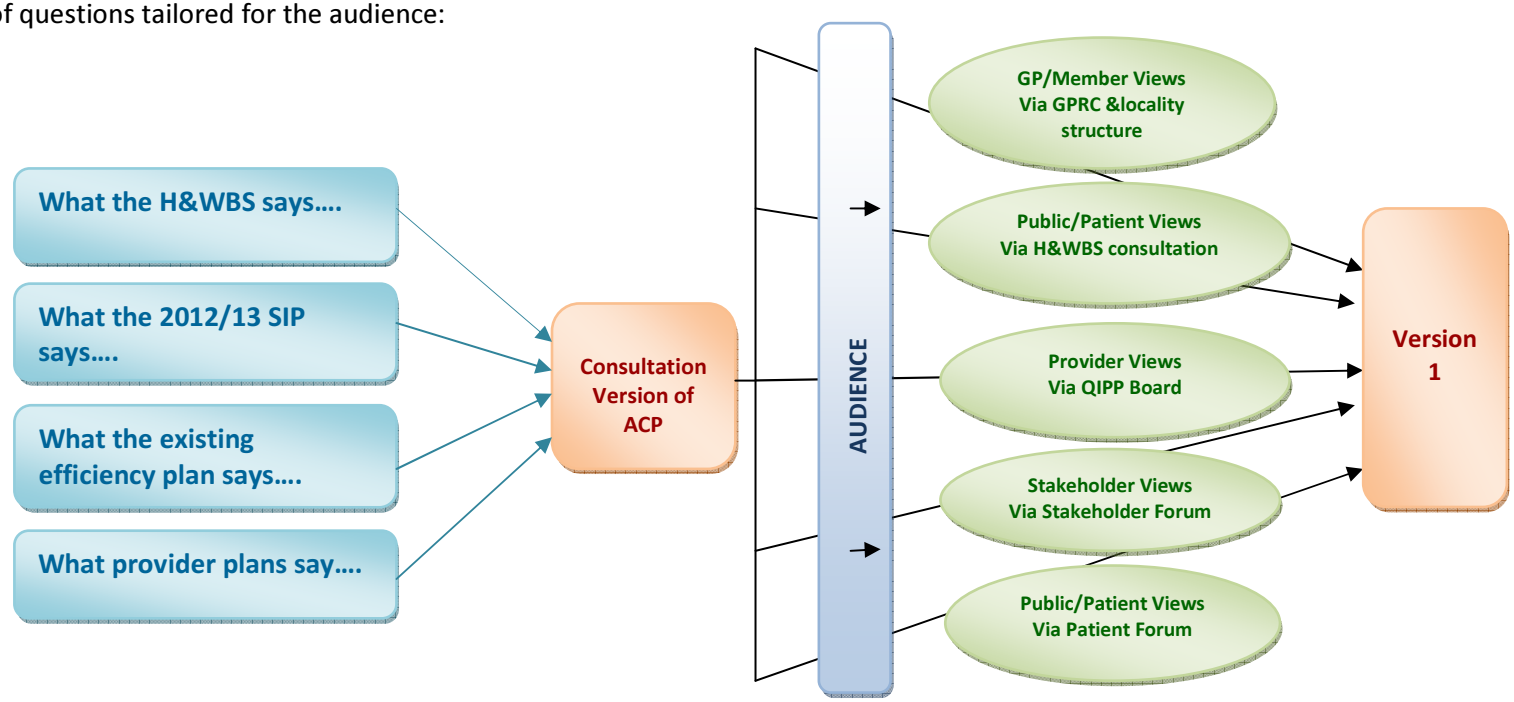
The following table outlines the consultation, approvals process and timescales for the development of the ACP (some meetings for 2013 have not been fixed, so dates are estimates):

	Frequency (if a meeting)	AUGUST 2012	SEPTEMBER 2012	OCTOBER 2012	NOVEMBER 2012	DECEMBER 2012	JANUARY 2013	FEBRUARY 2013	MARCH 2013	APRIL 2013	MAY 2013	JUNE 2013
Meetings												
GPRC	Monthly		**P4P** 26.09	**CV** 24.10		**V1** 19.12		**V2** 27.02				
Locality Meetings	Monthly			***Feedback***	***through GPRC***							
CCGC	Monthly		**P4P** 05.09				**V1** 02.01		**V2** 06.03			
CCGC/SCE(?) Away Day	Annually			**CV** (?)								
AQA (QIPP, risk, governance)	Bi-monthly		**P4P** 19.09				**V1** 16.01					
H&WBB	Monthly		**P4P** 05.09	**CV** 24.10			**V1** 16.01	**V2** 27.02				
QIPP Board	Bi-monthly		**P4P** 05.09				**V1** 02.01					
SCE	Weekly	**P4P** 15.08		**CV** 10.10		**V1** 05.12		**V2** 13.02				
CRMC (only relevant sections)	Every 2 weeks		**CV** tbc			**V1** tbc						
MMC (only relevant sections)	Every 2 weeks		**CV** tbc			**V1** tbc						
UCMC (only relevant sections)	Every 2 weeks		**CV** tbc			**V1** tbc						
Patient Forum	TBC		**P4P** 19.09									
Stakeholder Forum	TBC			**P4P** tbc								
GP Commissioning Events	Bi- Annually					**CV** 06.12						
Scrutiny	By request			***By***	***Request***							
Stakeholders												
RMBC	n/a											
TRFT	n/a											
RDaSH	n/a											
VAR	n/a											
Hospice	n/a											
NHSCB/DH	n/a								Mid-March			
Other Communications												
Website	n/a								Mid-March			
Annual Report and Event	Annually											Mid June

Produce 'P4P' — **Produce 'CV' for consultation** — **Produce 'V1'** → **Submit 'V1'** — **Produce 'V2'** → **Submit 'V2'**

Appendix 3

The 4 versions of the Annual Commissioning Plan that will be produced…..

Version	Description
P4P: Plan for a Plan (produced September)	The cover paper and appendices (this report).
CV: Consultation Version (produced October)	This will be a powerpoint document produced for consultation purposes. It will have a core set of slides and then a flexible set of questions tailored for the audience: 
V1: Version 1 (produced December)	Version 1 of the ACP will be produced from the views collected from member practices, patients, public and stakeholders, and to meet the requirements of the National mandate (due December?).
V2: Version 2 (produced February)	Version 2 of the ACP will be further refined following feedback from the initial submission (possibly January).

Rotherham CCG Constitution

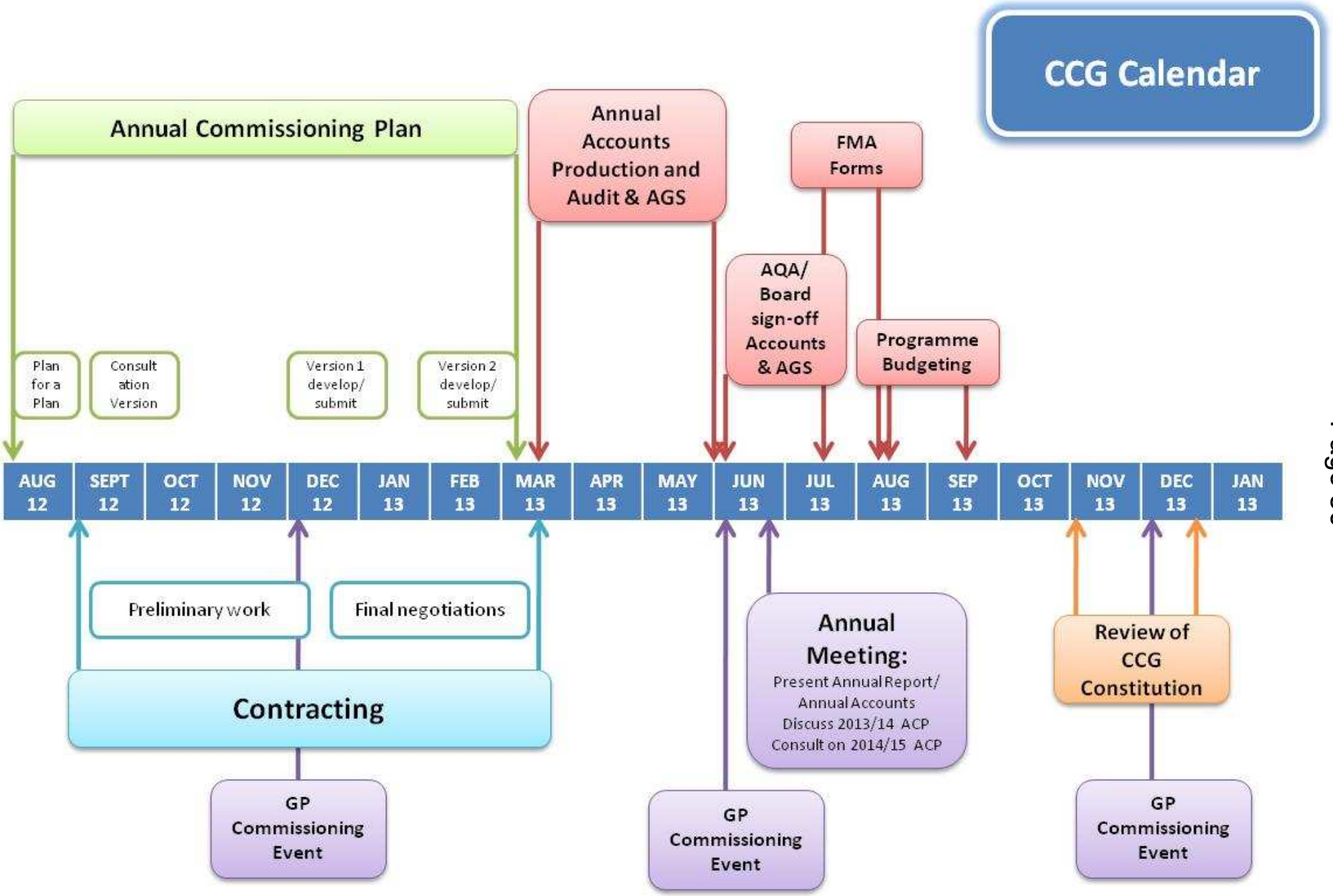
The Constitution must be reviewed on a regular basis and at least every other year by the GPRC and CCG Board.

What the RCCG Constitution says about the Annual Commissioning Plan, the Annual Report (and Annual Accounts) and the Annual meeting…

- The Board will delegate to officers the requirement to produce the Annual Commissioning Plan to promote a comprehensive health service and to respond to the mandate published on an annual basis by the Secretary of State.
- The CCG will hold (at least) annual meetings to present the Annual Report and discuss the Annual Commissioning Plan.
- The CCG must publish the Annual Report which will summarise how the CCG has delivered against its intentions in regards to Promoting awareness of, and acting with a view to securing that health services are provided in a way that promotes awareness of, and has regard to the NHS Constitution:
- The GPRC will ensure that the opinions of the wider GP Community on strategic commissioning decisions are communicated to the SCE through the locality representatives including agreeing the Annual Commissioning Plan.
- The GPRC will agree the Annual Commissioning Plan before submission to the Board for approval.
- The DCOO will be responsible for the development of the Annual Commissioning Plan and co-ordinating the Annual Report.

What the Constitution states the Annual Commissioning Plan will set out…

- how the CCG will promote awareness and have regard to the NHS Constitution
- plans to commission effectively, efficiently and economically and will detail the multi-agency governance arrangements.
- how the Group will reduce inequalities and will link with the overall Health and Wellbeing Strategy for Rotherham.
- how the Group will enable patients to make choices. This will include how information will be provided to patients at the point they make choices for example through the use of choose and book and also choice in terms of services available for example through services provided by any qualified provider.
- how the CCG will pay due regard to promoting innovation and to innovation developed elsewhere. Contracts will specify, for example via CQUINS, the innovations the Group has decided to accelerate.
- where applicable, how the CCG will promote integration of both health services with other health services and health services with health-related and social care services where the Group considers that this would improve the quality of services or reduce inequalities.


CCG Calendar
Annual Commissioning Plan
Annual Accounts Production and Audit & AGS
FMA Forms
AQA/ Board sign-off Accounts & AGS
Programme Budgeting
Plan for a Plan
Consult ation Version
Version 1 develop/ submit
Version 2 develop/ submit
AUG 12
SEPT 12
OCT 12
NOV 12
DEC 12
JAN 13
FEB 13
MAR 13
APR 13
MAY 13
JUN 13
JUL 13
AUG 13
SEP 13
OCT 13
NOV 13
DEC 13
JAN 13
Preliminary work
Final negotiations
Contracting
GP Commissioning Event
Annual Meeting:
Present Annual Report/ Annual Accounts
Discuss 2013/14 ACP
Consult on 2014/15 ACP
GP Commissioning Event
Review of CCG Constitution
GP Commissioning Event

ROTHERHAM BOROUGH COUNCIL – REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**5th September, 2012**
3.	**Title:**	**Rotherham Healthwatch Update**
4.	**Directorate:**	**Resources**

5. Summary:

This paper highlights progress achieved in relation to commissioning Healthwatch Rotherham and provides an update on government guidance, funding and secondary regulations. Work has included comprehensive consultation and analysis of current information, advice and guidance available on health and social care services.

6. Recommendations

Health and Wellbeing Board members are asked to:-

6.1 Note the progress achieved in relation to commissioning Healthwatch Rotherham.

6.2 Note the intentions of the DH in relation to the secondary regulations.

6.3 Note the proposal at 7.3 for an Elected Member to be a trustee on the Rotherham Healthwatch Board of Trustees

6.4 Note the revised level of funding available.

6.5 Receive further papers on the outcome of the tendering process including the outcome of the evaluation process and the recommended provider.

7. Proposal

7.1 Background

The Health and Social Care Act 2012 amends the Local Government and Public Involvement in Health Act 2007 to make provisions about Healthwatch as the consumer champion for health and social care services. This will include the national Healthwatch England and the provision for a local Healthwatch which the Local Authority must commission.

Rotherham Healthwatch will replace the current model of Local Improvement Networks (LINks) carrying forward the functions while taking on new, additional functions.

The main functions of a local Healthwatch are to:-

- Provision of information and advice to the public about accessing health and social care services and choice in relation to aspects of those services eg signposting;
- Consultation on people's views and experiences of health and care and feed these into Healthwatch England;
- Making recommendations to Healthwatch England to advice CQC to carry out special reviews or investigations into areas of concern;
- Promoting and supporting the involvement of people in the monitoring, commissioning and provision of local care services;
- Obtaining the views of people about their needs for and experience of local care services and make those views known to those involved in commissioning, provision and scrutiny of care services; and
- Make recommendations about how those services could or should be improved.

7.2 Secondary Regulations

The Healthwatch secondary regulations are still being developed by the DH, however Children and Young People are now included in the Healthwatch requirements. The DH's 'Summary Report' key issues are set out as:

- The organisation does not need to be a Social Enterprise but must have the "principles of a Social Enterprise" with at least 50% of profit/surplus reinvested to further the social objective

- The constitution of the organisation must state that the main objective is to benefit the community.

- The secondary regulations will include further criteria about having lay people and volunteers in the local Healthwatch.

- In relation to the contract between the Local Authority and Healthwatch, the details of the 2008 regulations will be carried forward, with the

intention of ensuring that the local Healthwatch operates in an open and transparent way.

- There will still be a requirement for providers to respond to reports, recommendations and information requests including to children's social care. The DH also prefer not to impose a duty to respond to information request given the current situation seems to be working well.

- Referrals to scrutiny committee will be carried forward into Healthwatch.

- The 2008 Entry Regulations which set out the duty of service-providers to allow entry to residential care provision, will be carried forward, including in relation to "excluded activities" (children's social care).

- Directions in relation to what should be addressed in the local Healthwatch annual report will be part of the regulations. The DH state that this includes finance, how the local Healthwatch has been representative of its local area, how it has carried out engagement, a focus on outcomes and a 'forward look'.

The regulations will be laid in October (Contracts elements) and November (enter and view elements) and come into force on 1st April, 2013.

7.3 Representative on the Health and Well Being Board and Board of Trustees

The local Healthwatch Rotherham (HWR) will be a member of the Health and Well Being Board and as such will be integral to the preparation of the JSNA and the Health and Well Being strategy and priority setting on which local commissioning decisions will be based.

It is proposed here that an Elected Member is also a member of the Healthwatch Board of Trustees. It is suggested this is a voluntary nomination.

7.4 Healthwatch Project Group

The commissioning project group includes representatives from the Local Authority and Rotherham Clinical Commissioning Group (CCG). The activity that has taken place in line with the action plan includes:-

7.4.1 Vision

A vision for Healthwatch Rotherham has been developed and been included in the consultation that has been undertaken. The vision is:-

Healthwatch Rotherham will work with local people to ensure that they receive the best quality health and social care services by:

- *Providing information, advice and support that will enable Rotherham people to make choices and access health and social care services.*

- *Providing leadership and support to strengthen the collective voice of local people.*

- *Ensuring that service user's views and experiences influence, shape and improve health and social care services and reduce health inequalities.*

- *Working collaboratively with local community networks, building on existing information, advice and local knowledge*.

7.4.2 Consultation

Information on Healthwatch has been added to the website. Two surveys were issued to members of the public, health and social care service users and to the voluntary and community sector networks and community interest groups.

The surveys seek the views about the three main functions of Healthwatch. The questions also relate to the current service provision so that a baseline position can be determined for future performance monitoring and also inform the drafting of the service specification.

The consultation ends on the 24th August so unfortunately the results cannot be presented in this report**.**

Consultation has also taken place through organised meetings such as the Health network and Voluntary and Community Sector consortium. Partner colleagues on the project group have also been raising the awareness of Healthwatch and promoting the consultation.

Best practice has been determined through attendance at the Regional Healthwatch Commissioners Group and attendance at LGA events.

7.4.3 **TUPE Arrangements**

TUPE discussions with the CCG have taken place regarding two members of staff (0.8 w.t.e. and 0.5. w.t.e.) who currently provide the PCT Patient, Advice and Liaison Service (PALS). Other roles that are subject to TUPE will be considered. The TUPE information will be place in the tender documents to make potential providers aware of this requirement.

7.4.4 Service Mapping

This has been completed with the assistance from the Health Information Manager and PALS Co-ordinator.

This work has informed the service specification and enabled a position statement of the existing information services, signposting undertaken and complaints advocacy used across NHS and Social Care Services in Rotherham. The work included but was not restricted to, the mapping of information, advice and guidance provided by Rotherham CCG Patient Liaison Service (PALS), Rotherham Foundation Trust (RFT), Rotherham, Doncaster and South Humber Mental Health Trust (RDaSH), RMBC Adults and Children's Social Care.

All the current information provision will be very helpful to Healthwatch and a good starting point for them to build their knowledge about what services are available. It is not proposed at this stage that the current information provisions are changed as it appears there are not significant gaps but it is recognised that efficiencies may be possible in the future.

The funding that was previously just for the 'signposting' element of the PCT PALS service will now be provided to the Local Authority but this is to cover the signposting requirements for all NHS services. The PCT PALS service currently responds to 'concerns' by patients and it could be argued that it is often difficult to separate the 'enquiry' from the 'concern'. However, given the level of funding it is proposed that Healthwatch will take on the signposting functions that were previously PCT PALS but not the 'concerns'. This would remain the responsibility of the CCG, presumably as part of their complaints team.

7.4.5 Commissioning and Procurement Plan

The commissioning timeline presented in the last report is on track. The Pre Qualification Questionnaire (PQQ) will be issued on the 3rd September, 2013.

The service specification will be built on the current legislative guidance that is available recognising that secondary regulations will not be available until the end of the year. It will include that the organisation will need to adopt social enterprise principles and act for the benefits of the community in Rotherham with primarily social objectives, and a minimum of 50% of profits/surplus will be reinvested.

The specification is being drafted and will circulated for consultation on the 3rd September for comments back by 28th September.

The Invitation to Tender (ITT) will therefore be issued by 22nd October.

7.5 NHS Complaints Advocacy

There is a requirement under the Health and Social Care Act for the Local Authority to commission a NHS complaints advocacy service that operates effectively and delivers value for money. Whilst it will be for the local authority to decide the level of funding, it is important that sufficient funding is made available to ensure that the quality of service provided is not compromised. Funding of £80K has been provided by DH for a commissioned NHS complaint advocacy service.

The Independent regional complaints advocacy service that currently exists, ICAS, will end on the 31st March, 2013. It was agreed at the last meeting that NHS complaints advocacy will be part of the Healthwatch contract and not provided by a separate organisation.

From consultation with NHS providers it was clear that ICAS was a service that they encouraged their complainants to use but the take up was relatively low and it was recognised that the support provided related in the

main to complex complaints, those that had been through the complaints procedure or even to the Ombudsman without resolution. Therefore although the number was relatively small they were complex cases and therefore could take up to 6 months to complete.

It is proposed that Healthwatch will be asked to provide NHS complaints advocacy at all the levels of complaint process to ensure value for money.

7.6 Local Healthwatch Funding

In 2013/14 the current funding for LINks will become funding for local Healthwatch until 2014/15. Additional funding will be made available to local authorities from 2013/14 to support both the information/signposting functions but also for commissioning NHS complaints advocacy.

Further to the indicative budget provided by the DH in June 2012, the DH has issued further guidance on the level of funding. This is a reduction on the amount originally indicated. This funding level will be included in the specification and tendering documentation.

8. Finance

The financial aspect of funding Healthwatch Rotherham has been highlighted in section 7.6.

9. Risks and Uncertainties

Although the DH have provided a summary report on the consultation which gives some of the intentions in the secondary regulations, the actual regulations will not written until November and in place by 1st April.

There is a risk that a small number of organisations will tender for this contract. Contingency arrangements for the service from 1st April 2013 will be in place should this occur and these will continue until the service is retendered.

10. Policy and Performance Agenda Implications

The performance of and work programme of Healthwatch Rotherham will be clearly linked to the priorities of the Health and Well Being Strategy.

11. Background Papers and Consultation

DH: Summary Report Issues relating to local Healthwatch regulations (August 2012).

Consultation on the Development of Healthwatch – Report to HWBB (July 2012)

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ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**5th September, 2012**
3.	**Title:**	**Health and Wellbeing Board Self-assessment**
4.	**Directorate:**	**Resources**

5. Summary

At the Health and Wellbeing Board (HWBB) meeting in July, a report was given on the progress of the board's work plan from September 2011. A number of key achievements of the HWBB were noted, including the development of the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy. The report also highlighted the need for the HWBB to reflect on its progress to date and consider how to achieve continued success as it moves into its second year in operation, and April 2013 when the board will take on statutory responsibilities.

It was agreed that a structured questionnaire be completed by all board members, which would be collated and reported back to the September meeting to form the basis of a reflection and learning session. This report provides an overview of those responses and draws attention to a national development tool for Health and Wellbeing Boards, which board members may wish to consider.

6. Recommendations

That the Health and wellbeing Board:

- **Discusses and comments on the views and suggestions put forward**
- **Receives a further report setting out the actions required to bring about improvements in the areas agreed**

7. Proposals and Details

The Rotherham Health and Wellbeing Board (HWBB) has now been in operation for 12 months. It has therefore been considered timely by members to reflect on the progress of the board to date.

At the meeting in July, board members were presented with an update on the work plan, which included a number of key achievements since September 2011, such as the JSNA, local health summit and development of the Joint Health and Wellbeing Strategy. The next step to this was for the HWBB to have a reflection session at the September meeting to look at how the board has been operating and relationships between the key partners. Following agreement by board members, a structured questionnaire was circulated to all members to complete a range of questions in relation to operation, strategy and delivery. The purpose of this was for responses to form the basis for discussion at the meeting in September.

Responses include a range of views and suggestions for the board's future development and success. An overview of the responses is attached.

At the meeting in September, John Wilderspin (National Director of Health and Wellbeing Board Implementation, Dept. of Health) will also be in attendance to observe the Rotherham Board. This provides an opportunity to consider the progress of the HWBB alongside insight and learning from a national perspective.

Development Tool for Health and Wellbeing Boards

The Local Government Association has worked with the NHS Leadership Academy, other national organisations and representatives of health and wellbeing boards to co-produce a new development tool for Health and Wellbeing Boards.

The development tool can be used by local boards to measure levels of preparedness through a 'maturity matrix' which allows boards to track their progress over time.

The tool asks users to assess how their board is performing in relation to 17 key issues under 5 broad headings:
1. Strategy, purpose and vision
2. Leadership, values, relationships and ways of working
3. Governance
4. Roles and contributions
5. Measures and accountabilities

It is suggested that to get the most out of this tool, board members act collectively to discuss and agree scores together. The responses to the questionnaires which have been received could be used to help guide this discussion and help board members agree where they feel they best fit.

8. Finance

There are no financial implications directly related to the contents of this report.

9. Risks and Uncertainties

Not having an agreed, appropriate plan in place will be detrimental to the success of the Board going forward. Reflecting on the progress of the board in relation to operation and relationships between key partners will help shape future development needs of the board and the work plan.

The Health and Well Being Board is entering a critical phase which will need to see intentions translated into implementation on the ground. It is vital that the board is equipped for this task.

10. Policy and Performance Agenda Implications

The strategic plan for the Board for the next three years is set out in the Health and Wellbeing Strategy, which is currently published in draft form whilst we seek views from local people and professionals.

11. Background Papers and Consultation

Overview of Questionnaire Responses (attached)

A New Development Tool for HWBBs (attached)

12 Contact

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Health and Wellbeing Board Self-Assessment Questionnaire

Overview of Responses

Operation of the Board

1. Have we got in place the right governance framework and right structure for the board?

The general view from board members is that the governance framework in place is effective at present, but it will be important for the board to keep this under review and revise as appropriate, particularly as the Board is yet untested in relation to making challenging decisions in terms of commissioning and delivery of services.

The inclusive nature of the board's membership, which enables providers to participate in the meetings, is a positive aspect; however it is seen as important to make the distinction between commissioners and providers, particularly when making commissioning decisions which may result in a conflict of interest.

There is a general view that the governance structure in relation to other decision-making boards needs to be considered and clear arrangements agreed. This is particularly true in relation to clarifying links with the Local Strategic Partnership and strengthening links to the Rotherham Local Safeguarding Children's Board, which has been commented on by Ofsted. Good links to other service areas are also needed if the board is to influence beyond the traditional 'health and wellbeing' services, such as transport and housing.

Developing a performance management framework was also seen as important to measure population outcomes for health and wellbeing and ensure the board is successful.

2. How do you feel partners are working together (such as the CCG, local authority, NHS etc) to ensure open dialogue about commissioning and contracting decisions?

Partners are felt to be working closely together and relationships are more open and transparent than they have been in the past. However, as above, it is felt that the board is yet to tackle the more difficult challenges in relation to commissioning and contracting that will need strong partnership working. The production of the JSNA and Health and Wellbeing Strategy has set the context for such decisions however, which is a positive step forwards for the Board, and will help all partners to continue to develop this dialogue.

There is a view that although broadly all partners are working well together, it is felt the links between the CCG and local authority are strong, but there may be more development needed in relation to the Local Area Team/Cluster.

From a provider perspective there is a general view that the board does feel joined up and collaborative. However there are still considered to be some tensions and some feel agencies may be continuing to operate in silos. There is a view that not enough emphasis is placed on the need to develop better coordination and integration of services which are provided by the main provider agencies involved.

3. How do we ensure that real time intelligence regarding quality and efficiency comes through the board?

It is felt current reporting to the Board is an area which requires some development. When the strategy and implementation plan is finalised it is important that the board regularly reviews and challenges progress. Reporting mechanisms need to be put in place to assure the board of effective delivery, with appropriate exception reports taken, which report innovation in addition to good and poor performance.

All agree that key performance indicators need to be agreed to effectively measure against the Health and Wellbeing Strategy, with a performance management framework (PMF) that is SMART (specific, measureable, attainable, relevant, timely) and managed by responsible key managers across all agencies.

There is also a view that there needs to be more of a focus on actual quality and efficiency, rather than on data and process/compliance.

4. How can the board effectively influence and support in the following areas:

a) Influencing local commissioners and having the right skills and expertise to support commissioning (e.g. clinical advice from local providers)

Board members feel strongly that the Health and Wellbeing strategy is the tool needed to influence local commissioners, ensuring that the right direction, values and outcomes are set and achieved. The strategy therefore needs to be a living document which is regularly reviewed and used by partners to drive action and monitor progress.

It is felt there needs to be regular and timely discussions with both commissioners and providers within and out of board meetings. It is recognised that much of the expertise in managing/changing services lies with the providers not the commissioners, so the Board needs to properly engage providers in supporting the change agenda.

The Board also needs to ensure appropriate analysis and feedback from all agencies and HealthWatch (once in place) on impact of existing arrangements and gaps in provision.

b) Ensuring the right skills to local contracts

Again it is felt the key will be for the board to ensure that commissioning decisions are aligned to the Health and Well being Strategy, focusing on outcomes and less on inputs.

There also needs to be summary information provided from commissioner and provider forums to enable the board to deal with issues and check alignment to the strategic outcomes.

c) Influencing and supporting the CCG and its Single Integrated Plan (SIP)

There is a view that the SIP is largely a CCG document, and that any plan requiring sign-up by other agencies needs to properly engage those agencies in the actual development of the plan. To enable this to happen it is suggested that having clear direction and outcomes (through the Health and Wellbeing Strategy) will help ensure the SIP is aligned to the overall vision of the Board.

It is also suggested that having clear space on agendas to consider issues (by exception) which impact on delivery will enable the board to agree actions to deal with these jointly as appropriate.

There remains some uncertainly as to how some service areas can best influence the CCG, with a view that regular joint planning and review meetings are important to continue this development.

d) Influencing organisational development of partner organisations

It is felt there needs to be consideration as to what organisations need to look like in 12 months, 2 years, 5 years time etc and work together in a multi agency way to embed skills, beliefs and attitudes across the workforce to enable this change agenda to happen. However there also needs to be built into this an understanding of the pressures organisations are under and the impact of commissioning decisions on provider viability.

The Health and Wellbeing Strategy again is noted as a key document which needs to be considered and used by all partners to help shape organisations.

Strategy

5. Do you feel sure that the board's vision and priorities (the strategy) reflect and dovetail with Rotherham's population needs?

There is a general consensus that the strategy is true to the needs of local people.

The strategy has been developed through a range of intelligence gathered from the JSNA and consultation with local people; however board members will feel more reassured they have got this right once feedback has been received from people in Rotherham.

6. How do we ensure that local health and social care resources are understood and that this information is used to inform our strategy and help stakeholders improve resource allocation?

There is suggestion that the board requires a systematic analysis of activity and spending against the Health and Wellbeing Strategy to enable a better understanding of how the Rotherham pound is spent to avoid duplication and ensure system efficiency.

There needs to be more transparency on how resources are allocated, deployed and monitored and receive an evaluation of progress towards outcomes; it is suggested to have an annual finance session for the Board to receive this.

There is also a view that the Board needs to communicate with stakeholders to help them understand what resources have been delivered in relation to quality and efficiency and help them inform where they want the resources to be targeted going forward.

7. How do we ensure that the strategy effectively influences traditionally 'non-health' related areas (such as planning/transport etc)?

There is a view that this is an area which requires development. There are examples where encouraging all people to get on board and influencing a particular decision, rather than it being seen as a single agency issue, would have a positive benefit to others (such as reducing speed limits outside of schools and the impact this would have on accidents and air quality).

It is suggested that the governance structures and the strategy need to include clear links to these non-health related areas and there needs to be more effective engagement and involvement of those other agencies in the strategy development.

Much more explicit links need to also be made between decision making for all services through planning boards and Cabinet Members. It is also felt that public health needs to be embedded into local authority policy making.

Delivery and Work programme

8. How do we ensure that the board's agenda focuses on the delivery of the Health and Wellbeing Strategy over the next 12 months and beyond?

There is a clear view that when the strategy and implementation plan is finalised it is important the board regularly reviews and challenges progress. To enable the board to do this effectively, it is suggested to have regular space on agendas to consider "bite-sized" chunks of the strategy's priorities.

There needs to be quality time for partners to have meaningful discussions on the key issues and have regular symposiums which provide a current state in relation to each of the life stages. This should be done by setting out a clear work plan for the board which includes periodic items on each of the priorities and/or life stages and

reflective learning sessions. The agendas for the Health and Well Being Board need to be tightly managed so that there is a concentration on the most important issues.

It is also felt that the strategy needs action plans and sub-strategies that cover the next 3 years to enable delivery and set specific goals for each priority area. There also needs to be an alignment between NHS and local authority priorities, as well as that of the NHS Commissioning Board.

9. How does the board want to deal with performance and measuring outcomes?

It is felt that the board first of all needs to ensure action plans are measurable and outcome focused and that outcomes frameworks are embedded in the delivery of the strategy and its plans.

There is a view that performance monitoring should be a standing item on board agendas, although the preference is for exception reporting for specific issues, to enable thematic exploration of complex issues.

Board members agree that all partners should be held to account through Board meetings, yet be mindful that each of the agencies involved are also accountable to their own boards. It is therefore suggested that all board members be required to ensure that the HWBB minutes and performance indicators are routinely submitted to their own boards for review.

Local Government Association

Health, adult social care and ageing

A new development tool for health and wellbeing boards

directors of adass adult social services

ADCS Leading Children's Services

Association of Directors of Public Health

Faculty of Public Health

solace

nhsalliance

The King's Fund

NHS Commissioning Board A special health authority

NHS Confederation

NHS Leadership Academy

DH Department of Health

Introduction

Health and wellbeing boards are now operating in all parts of the country, and many have been working for a significant period of time.

Discussions with representatives of boards show that there is an appetite for products that support boards to assess their progress by reference to indicators of practice.

In response to this, a number of regions have already prepared self assessment documents that measure “levels of preparedness”. Moving beyond this the London Board Assurance Prompt tackles more complex themes, and introduces the idea of a ‘maturity matrix’ allowing boards to track their progress over time.

The Local Government Association has worked with the NHS Leadership Academy, other national organisations and representatives of health and wellbeing boards to co-produce a new development tool, building on the achievements of the previous documents.

Our aim is to provide health and wellbeing boards with a tool that will enable them to go beyond assessing how ready the board is, towards how effective it is being in practice, and how that effectiveness is enhanced over a period of time.

This tool aims to assist boards to explore their strengths and opportunities to improve, and to inspire their ambition to develop a clear sense of purpose and an approach which will help transform services and outcomes for local people.

There have been two design events with board representatives and health leadership partners. Views on ‘what good will look like’ were captured, and have been incorporated as key issues within this development tool.

The approach recognises that to deliver good outcomes on the ground partnerships require an effective structure (in common with all organisations). The model adapted is summarised below:

Strategy, vision, purpose, values			
Strong relationships, agreed ways of working	Good governance	Roles and contributions	Measures and accountability
Outcomes			

Using the development tool

The development tool asks users to assess how their board is performing in relation to 17 key issues. The issues have been identified based on the outcomes from the design events mentioned above. When using the tool it is important to promote dialogue amongst the partners on the board about these issues.

The development tool can be used in a number of ways:

- by board members acting collectively to discuss and agree scores together.
- with the help of an external facilitator, to assist exploration of the issues, and to promote discussion.
- individually completed by members of the board working independently, (however this approach has the significant disadvantage that a useful exchange of views between partners is less likely to occur, and the process may therefore be less helpful to mutual understanding and board development).

Boards are invited to evaluate their position against the suggested criteria that are expected to characterise the achievements of a board now; in one year; and in three years.

It is to be expected that boards in the early stages of development will respond positively to a limited number of the criteria, but as they progress to maturity that position should improve. It is quite possible that a board completing the assessment today may not yet be at the point suggested by all 17 criteria in the 'Now' column. On the other hand, for some criteria it may exhibit advanced behaviour as projected in the 'In three years' column.

The development tool can be found online at http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3638628/ARTICLE-TEMPLATE

Next steps

The aim of the development tool is to support boards to discuss challenging issues, to inspire them towards transformational outcomes for their community, and to help them identify what action they need to take. It is expected that boards will wish to use the tool as a stepping stone towards developing an improvement plan to address their next steps. We intend to keep the content of the tool under review to ensure it meets the future needs of boards; we would therefore welcome comments about how the tool might be further improved. Please send your feed back to healthy.admin@local.gov.uk

Support and assistance

Health and wellbeing boards are challenged to develop complex and innovative methods of working that require partnership of a new order. Help is available from several national and regional organisations to assist boards in finding their way.

A good starting place for assistance is with the LGA Health and Wellbeing Board Leadership Offer at healthy.admin@local.gov.uk where advice can be obtained on the development tool and a range of support options for boards.

Area	Now	In 1 year	In 3 years
Strategy, purpose, vision	1. The board understands its unique potential contribution and is ambitious to improve health and wellbeing.	1. The board has agreed a realistic set of priorities on which to focus its efforts.	1. The board has demonstrated achievement against its priorities. The board has a track record of enabling efficient, effective and integrated re-commissioning of service(s).
	2. The board has a clear statement of purpose and priorities. Existing JSNA reviewed and JHWS initiated.	2. JSNA and JHWS formally agreed. Individual commissioning plans of CCGs and LA align with JSNA/JHWS.	2. JSNA/JHWS embedded in annual plans of service providers. JSNA and JHWS reviewed and revised and commissioning plans of all relevant partners aligned.
	3. HWB has a compelling narrative of its purpose and ambitions for its local community.	3. Partner organisations can describe how HWB will make a difference. A shared and effective communications plan exists (including media handling).	3. Community can describe how HWB has made a difference. The board can describe what it has achieved, the changes made for local people and future improvement plans.

Area	Now	In 1 year	In 3 years
Leadership, values, relationships, ways of working	4. Board members understand the concept of shared leadership and communicate effectively and respectfully.	4. Trust has been established, constructive challenge is the norm, a conflict resolution process is in place.	4. Continuous learning (from own experiences and from others) is well established.
	5. The board has a code of conduct which is explicit about expectations of behaviour, and which describes the values aspired to. The board models appropriate behaviours and has an agreement about minimum attendance at meetings.	5. The board uses both internal and external reviews to test that its code of conduct is effective. Board members attend regularly and make a positive contribution to meetings.	5. The board's annual self assessment incorporates agreed outcome measures against its code of conduct. Stakeholders agree that the board operates on a win-win basis.
	6. Members have effective working relationships and are beginning to influence each other's organisations.	6. Board members look for win-win solutions focused on beneficial health outcomes for the community. Relationships enable members to influence beyond their own organisations.	6. Local organisations seek to contribute to the work of the board.
	7. The board has interim arrangements in place to engage users and the public pending the establishment of local Healthwatch.	7. The board empowers the local Healthwatch member to act as an independent and effective voice for users and the public.	7. The board can demonstrate that it has considered and acted upon the views of local people.
	8. The board understands the needs of diverse communities and is clear about its responsibilities under Equalities legislation, and those of its partners.	8. The board can demonstrate that it promotes equality in all its actions including consultation, priority setting and service improvement, and undertakes equality impact assessment on its plans.	8. The board is a beacon of excellence in relation to equality and diversity and can show positive outcomes for the health and wellbeing of minority groups.

Area	Now	In 1 year	In 3 years
Governance	9. The board is clear on accountability for decisions and action, and has a scheme of delegation.	9. Decision making is clear and transparent, and effectively communicated to stakeholders and the public.	9. Decisions of the HWB are accepted and acted on by all organisations in the local system.
	10. The board has governance frameworks which align with those of the LA and CCGs.	10. Board membership, operational structures, and mechanisms for engaging partners, are clear.	10. The board has regular updates on the priorities of the wider LA, NHSCB and key local partners.
	11. The relationship between the HWB and the LA scrutiny function is clear.	11. The relationship between scrutiny and external regulators is agreed and an initial effectiveness review has been completed.	11. Scrutiny and regulators work constructively with the HWB.
	12. An agreement re pooling of resources is in place.	12. A risk sharing agreement exists between the LA and CCGs.	12. A risk sharing agreement exists between the LA, CCGs and other relevant partners.
Roles and contributions	13. The board knows what each member brings in the way of skills, experience, knowledge and potential contribution.	13. Each board member has a clear role description and acts in accordance with this. An annual board development plan has been agreed.	13. The board regularly reviews its own effectiveness and development needs.
	14. The board knows what's good about its existing partnership working and can describe what has been successful, what hasn't, and why.	14. A stakeholder map exists for external partners and each board member has agreed partners that they work with proactively. A 360 degrees feedback survey with partners has been completed.	14. A 360 degrees feedback survey is completed with stakeholders; with key partners; with the public and an appropriate action plan developed.

Area	Now	In 1 year	In 3 years
Measures and accountabilities	15. The board's priorities balance improvements in service provision with improvements in population health and wellbeing.	15. The board has an agreed set of outcome measures, matched to its priorities.	15. The board's annual report demonstrates achievement of outcomes.
	16. The board has reviewed the current position as regards service integration, population health and use of resources.	16. The board has identified outcomes with defined early wins in the areas of: a) more integrated and/or personalised services b) improved population health c) better use of resources.	16. The board has achieved defined outcomes in the areas of a) more integrated and/or personalised services b) improved population health c) better use of resources, including community based assets, and identified early wins in reducing health inequalities.
	17. The board has reviewed its current outcomes against its peer group.	17. The board reviews itself regularly against benchmarks and adapts plans as necessary.	17. The board consistently performs well against benchmarks.

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