# HEALTH AND WELLBEING BOARD

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

**Date:** **Wednesday, 16th January, 2013**

**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. Minutes of Previous Meeting

4. Communications (Pages 10 - 21)
   Challenge on Dementia/Dementia Strategy (pages 10-11)

   Friends and Family Test (pages 12-21)

   Conference – 'Tackling Health Inequalities in the North' – 8th March, 2013 – Durham

   ROSPA Big Book of Accident Prevention
   http://www.rospa.com/bigbook/ (Flash version)
   www.rospa.com/bigbook.pdf (PDF version)

5. Rotherham Clinical Commissioning Group Annual Commissioning Plan (Pages 22 - 90)

6. Performance Management Framework

7. Priority Measure: Alcohol
   Presentation by Anne Charlesworth

8. Date of Next Meeting
   - Wednesday, 27th February, 2013 at 1.00 p.m.

**HEALTH AND WELLBEING BOARD**
**28th November, 2012**

**Present:-**

**Members: -**

| | |
|---|---|
| Councillor Ken Wyatt | Cabinet Member for Health and Social Care (Chairman) |
| Councillor John Doyle | Cabinet Member for Adult Social Care |
| Mrs. Janet Wheatley | Voluntary Action Rotherham |
| Mr. John Gommersall | Non-executive Director, NHS Rotherham Trust Board |
| Ms. Kerry Rodgers | Chief Executive, NHS Foundation Trust |
| Dr. John Radford | Director of Public Health |
| Dr. David Polkinghorn | Clinical Commissioning Group |
| Mr. Chris Edwards | NHS Rotherham |
| Mr. Tom Cray | Strategic Director, Neighbourhood and Adult Services, RMBC |
| Kate Green | Policy Officer, RMBC |

**Also in attendance: -** Dr. Ian Turner, Ian Atkinson, Nizz Sabir, Gary Walsh and Gill Harris.

Apologies for absence had been received from: - Councillor P. Lakin, Mr. M. Kimber, Mr. K. Battersby, Mrs. J. Thacker, Mrs. S. McFarlane, Mrs. C. Wright, Mrs. T. Holmes.

## S43. MINUTES OF PREVIOUS MEETING

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

## S44. BRIAN JAMES, CHIEF EXECUTIVE OF THE ROTHERHAM FOUNDATION TRUST.

Councillor Ken Wyatt, Cabinet Member for Health and Wellbeing, noted that Brian James, Chief Executive, would be leaving his post at the Rotherham Hospital. The Health and Wellbeing Board wished to record their thanks to Brian for his support of the work of the Board.

All members present wished Brian all the best for the future.

## S45. COMMUNICATIONS

(1) Rotherham Tobacco Control Alliance Annual Report: -

The Board noted the annual report for 2011/12 outlining the activity undertaken by the Alliance and its constituent partners highlighting:-

- Highest ever number of 4-week quitters through NHS Services achieved. However, smoking prevalence remained at 24%
- Smoking at delivery rates reduced to under 20% and 194 women had been helped to stop smoking during pregnancy
- Higher than national average smoking rates for young people (11-15 year olds)
- Availability of cheap and illicit tobacco remained an issue and undermined other work to reduce tobacco use

- Performance measures would change in 2013/14 from 4-week quitters to smoking prevalence reduction
- Almost all tobacco-related funding currently invested in Stop Smoking Services

(2) Community Alcohol Partnerships (CAPs) – Progress as of October, 2012: -

The Board noted the progress report highlighting the following:-

- Estimated launch was January, 2013, and initial review in July, 2013, which would inform the next steps for the existing Partnerships. Two further deprived areas would then be identified for roll out
- Public Health representatives and CAP regional leadership met with South Yorkshire Police analysts to agree initial benchmarking required and issues to be measured - as anti-social behaviour issues were often seasonal, the analysts had suggested two years' data to be used as the benchmark
- They were to also provide 'hot spot' areas and crimes in each of the localities – anti-social behaviour highlighting all young and/or alcohol, crime (damage, shoplifting of alcohol, any offences where alcohol was an aggravating factor, alcohol-related violence including domestic and youth related offences) plus NHS A&E admission data, Environmental Health/Warden, litter offences and possibly Designated Public Place Orders, Section 27 Orders and Drink Banning Order data
- CAP regional lead identified the lead retailer (likely to be Tesco in Dinnington and Co-op in East Herringthorpe)
- A teaching pack of aids had been created for 11-16 year olds, and consideration would be given to engaging local colleges
- Stakeholder events would be organised to inform them of the CAP concept
- Residents of the areas covered by the CAPs would be provided with questionnaires, the answers to these would determine the service offer required. Whilst both CAPs would use the same key questions, there would also be the potential for them to add localised questions. The questionnaire outcomes would be incorporated into the benchmarking of the project.

(3) A National Conference for Childhood Obesity was due to take place on 24th January, 2013. The Conference would be held in Rotherham's New York Stadium and would include information relating to the children's agenda.

Agreed: - That the information shared be noted.

**S46. HEALTH AND WELLBEING NEEDS OF BME COMMUNITIES IN ROTHERHAM**

Nizz Sabir, Vice-Chairman, Rotherham Council of Mosques, was welcomed to the meeting. Nizz had prepared a presentation in relation to the identified health and wellbeing needs of Rotherham's Black and Minority Ethnic (BME) communities.

- Rotherham MBC estimated that there were 19,000 people from BME communities in 2009, which equated to 7.5% of the local population;
- The bulk of the BME community lived in the Central Ward according to the Index of Multiple Deprivation (2007). Key drivers of deprivation related to: -
  - Employment;

- Health and Disability;
- Education and Skills.

The presentation covered a number of underlying detriments to health and wellbeing in the BME community, these were: -

- The BME community was less likely to be in paid employment (e.g. 20% unemployed in Pakistani community compared to 6% in White British community);
- Less likely to have a formal educational qualification;
- Several years ago children and young people from BME communities were shown to be amongst the lowest attaining groups for GCSE results;
- Employment difficulties;
- Housing – impact of overcrowding relating to infant mortality, respiratory conditions in children, rates of serious infectious diseases in adults and infections with Helibacter Pylori, which could have implications for growth and diseases of the digestive system;
- Infant mortality –
  - Babies born to mothers who were born in Pakistan had twice the risk of dying in the first year of their life;
  - South Asian women had more stillbirths than average. This was because of birth defects caused by marriages with close relatives and problems with premature deliveries.
- Lifestyle and Risk Factors -
  - Smoking – more Bangladeshi and Pakistani men smoke than average;
  - High prevalence of smoking amongst Pakistani and Irish males;
  - The Health Survey England (HSE) 2004, also reported high levels of tobacco chewing in BME groups.
- Physical Activity -
  - Low rates of physical activity especially in women of Bangladeshi or Pakistani origin;
  - Female only facilities (Rotherham leisure centre, swimming);
  - Lack of independence;
  - Language barrier;
  - Knowledge of services.
- Diet -
  - Diet typically worse for those born in the UK, compared to first generation migrants;
  - Changing diet with migration;
  - Hard to find familiar foods;
  - Binge eating, a lack of knowledge about dietary intake and food content was an issue;
  - Increasing popularity of fast food, including cultural pressures and aspirations.
- Mental Health:-
  - Research into young Asian women suggested that the factors affecting emotional health were similar across ethnic groups, but access to support was worse for Asian women. Some barriers were: -
  - Male privilege;
  - Fear of not fitting into a tight-knit community;
  - Fear of offending family honour;
  - Social isolation;

  - Language problems;
  - Fear of racism;
  - Surprisingly little research into mental health needs of Asian men;
  - Caring for family members could create burdens on members of the community.
- High risk: -
  - Members of the Pakistani community were six times more likely to have diabetes. Highest risk was in Pakistani women, who also had an increased risk of heart disease, retinopathy, kidney disease and strokes;
  - In Rotherham hospital admissions due to diabetes problems in Pakistani people had increased by 77% between 2003 and 2007.

The members of the Health and Wellbeing Board thanked Nizz for his informative presentation. It was considered that much of the empirical evidence had contributed to the JSNA, but much of the commentary about the experiences of members of the BME community was not included but was an important resource to consider.

- Eleven deprived areas;
- Outline agreement for a project;
- Translation services.

Resolved: - That the information shared be noted.

**S47. THE ROLE OF THE LOCAL OPTOMETRIC PROFESSION**

Nizz Sabir, Rotherham and Barnsley Local Optical Committee, gave a presentation on the role of the Rotherham and Barnsley Local Optical Committee and the role of opticians and ophthalmologists in the heath sector.

- Primary Health Care specialists;
- Trained to identify defects in vision, signs of injury, ocular disease or abnormality and any problems with general health;
- Education, training and mandatory continuous professional development;
- Regulated by membership (with annual renewal process) of the General Optical Council.

Role of opticians in an aging population: -

- An RNIB report in 2008, 'Future Sight Loss', estimated that 1.8 million people lived with sight loss;

- A projection of needs exercise estimated that there were 102 adults living in Rotherham who required help with their daily activities due to a serious sight impairment;

  - This was predicted to gradually increase over the coming years.

- Since 2004, the Department for Health had been encouraging the delivery of routine and minor emergency eye care outside hospital in community optical practices. This aimed to free up hospital capacity to cope with increasing demand from both the ageing population and new technologies;

  - Community optical practices were successfully and safely delivering local enhanced services in primary care, with high levels of patient satisfaction reported, as part of local integrated pathways linking into secondary care as appropriate. A key benefit of these enhanced services was a reduction in referral rates to GPs, A&E and hospital eye departments.

- Early intervention was being encouraged to increase the effectiveness of the eye care commissioning strategy.

Primary Eyecare Assessment and Referral Service (Pears): -

- Support for national and local strategic priorities;
- Primary rather than secondary care;
- Evidence based practise;
- Patient choice;
- Closer to home.

Optical issues had many links to other health concerns, many of which were addressed as priorities within the JSNA: -

- Smoking's role in increasing the likelihood/severity of: -
  - Aged-related Macular Degeneration;
  - cataract development;
  - Diabetes' related sight-loss.
- Obesity's role in increasing the likelihood/severity of: -
  - Diabetic retinopathy;
  - Age-related Macular Degeneration;
  - Cataracts.

- Diabetes' role in changing eye sight: -
  - Diabetic control increased the risk of diabetes sight problems;
  - Dyslipidaemia;
  - Strategies that sought to prevent diabetes and improve the quality of diabetes care would help prevent avoidable diabetes sight loss.

- Mental Health: -
  - Higher incidence of mental health in those suffering from sight loss;
  - Higher incidence of falls due to low vision and cataracts.

- Social effects: -
  - Independence;
  - Confidence.

Role of Optometric profession: -

- Work with the local Health and Wellbeing Board and Clinical Commissioning Groups;
- Work with other health and social care providers;
- Encourage a multi-disciplinary approach;
- Early intervention;

- Quality, innovative, patient-centred, patient satisfaction, patient choice;
- Improve efficiency and reduce costs;
- GPS, Ophthalmologists, Orthoptists and social care providers.

The members of the Health and Wellbeing Board thanked Nizz for his informative presentation.

Resolved: - That the information be received.

**S48. HEALTH AND WELLBEING PERFORMANCE MANAGEMENT FRAMEWORK**

Tom Cray, Strategic Director for Neighbourhood and Adult Services, gave a presentation outlining a proposed Performance Management Framework, which represented the aims and priorities of the Health and Wellbeing Board. The proposed Framework sought to track progress against national outcome framework measures without overshadowing locally agreed priorities.

The proposed Performance Management Framework took into account the priorities and strategies of: -

- Rotherham's Joint Strategic Needs Assessment's Priority Measures: -
  1) Starting Well;
  2) Developing Well;
  3) Living and Working Well;
  4) Aging Well.

- Health and Wellbeing Board's Priorities: -
  - Smoking;
  - Alcohol;
  - Obesity;
  - (Dementia).

- Rotherham Partnership Priorities (as part of the 'Poverty' work-steam): -
  - NEETS;
  - Fuel Poverty.

The suggested reporting mechanisms in the proposed Performance Management Framework were: -

- Exception reporting based on the Board's 'Priority Measures';
  - Form and frequency needed to be agreed.
- Not all outcomes from the national Frameworks had to be reported or considered if they were not deemed to be local priorities based on the evidence available (JSNA);
- Other national measures were managed through other partnership/organisational arrangements.

It was intended that the proposed Partnership Framework would: -

- Contain SMART targets and action plans;
- There would be accountable lead managers for all measures;
- There would be a reporting and communication framework:

- All measures would be monitored and reported to the right people (across agencies);
- 'Exception Reporting' to the Health and Wellbeing Board;
- Enable challenge and problem solving at all levels;
- Address poor performance quickly and effectively.

Implementation of the Performance Management Framework: -

- Reports on the progress against all 'Priority Measures' would be considered at each Board meeting;
- One Priority Measure for scrutiny and problem solving would be the focus of each meeting;
- A quarterly report on national outcome measures, shared outcomes and customer experience would be provided.

Discussion ensued and the following issues were raised: -

- Six themes could be taken two per quarterly meeting;
- Theme Leads to be invited to the meeting to contribute to the discussion;
- There was support for the addition of dementia as the sixth theme;
- Children's issues, and impact on children, to be considered throughout the themes;
- A thread from conception to end of life should be represented throughout the consideration of each theme;
- Cultural differences and needs should be reflected.

The Board confirmed their agreement to the proposed Health and Wellbeing Performance Management Framework with the addition of information in relation to children's voice and cultural issues.

Resolved: - (1) That the proposed Performance Management Framework be agreed with the additions discussed.

(2) That each meeting of the Health and Wellbeing Board consider two themes (smoking, alcohol, obesity, dementia, NEETS and fuel poverty), with the theme's lead officer invited to attend the relevant meeting.

**S49. OVERARCHING INFORMATION SHARING PROTOCOL**

Gary Walsh, Information Governance and Quality Manager, submitted a proposal for the Health and Wellbeing Board to accept ownership of an Information Sharing Protocol. It was intended that the Protocol would be used by all agencies within the Health and Wellbeing Board.

The Overarching Information Sharing Protocol (OSIP) was a multi-agency protocol and used by many organisations within Rotherham as evidence and compliance to Information Sharing best practice. The previous OSIP was owned by the Rotherham Information Governance Group but, following recent organisational changes, no longer met.

The OISP was part of a 3 tier model enabling partner organisations to utilise well established appropriate and transparent information sharing systems

(either manual or electronic). Processes placed the Service user at the centre of how their information was processed in accordance with their rights to privacy and confidentiality. It was a statement of the principles and assurances that governed information sharing.

The protocol must not be seen as a legal document that allowed all information to be shared between organisations. All information sharing must be undertaken in accordance with the Data Protection Act, Human Rights Act, common law duty of confidentiality and any other specific statute that authorised or restricted disclosure.

Discussion ensued and the following issues were raised: -

- Was the proposed protocol compatible with professional information sharing codes for GPs, Social Workers and other professions? In particular, GPs/Doctors had specific guidelines around sharing of notifiable diseases.
- Need to ensure that all Partner Boards had the opportunity to comment and agree the Protocol.

Resolved:- (1) That the report be received and its content noted.

(2) That further work be undertaken on the proposed Protocol in relation to ensuring it was compatible with professional guidelines.

(3) That Partner Representatives present the revised Protocol to their Boards for comment and agreement.

(4) That the revised Protocol be presented to a future meeting of the Health and Wellbeing Board.

## S50. PUBLIC HEALTH RESPONSIBILITIES IN RELATION TO SEXUAL HEALTH

Resolved: - That the report be presented to the next meeting of the Health and Wellbeing Board.

## S51. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in Paragraph 4 of Part 1 of Schedule 12A to the Local Government Act, 1972 (as amended March, 2006) (information relating to any consultations or negotiations, or contemplated negotiations, in connection with any labour relations matters).

## S52. UNSCHEDULED CARE REVIEW

Consideration was given to the report presented by Dr. Ian Turner, GP Specialist in Unscheduled Care, and Ian Atkinson, Senior Commissioner, which outlined the scope of a review that had been planned into unscheduled (urgent) care provision in Rotherham.

The review planned to look at issues of access, whether clear pathways existed for patients and service users, to remove duplication and waste, and ensure that the highly skilled unscheduled care workforce was deployed in the most effective setting. The review aimed to ensure that sustainable and high quality access to unscheduled care was available to the people of Rotherham in the longer term.

It was envisaged that a full public consultation would be entered into between December, 2012, and March, 2013.

Consideration was given to the scope of the review and provided feedback on the content.

- Streamlining options available to patients to avoid confusion;
- Travel considerations relating to location of unscheduled care provision(s);
- Cultural norms and whether members of the Black and Minority Ethnic communities used a particular method of unscheduled care.

Whilst Rotherham's unscheduled care providers would form part of the review, other sources of unscheduled care and information would not be involved in the scope. These included: -

- NHS Direct help-line and the 111 NHS Service;
- Visit local pharmacists;
- Call 999.

Resolved: - (1) That the information shared be noted.

(2) That the Health Select Commission be informed of the scope of the review into Rotherham's unscheduled care provision.

**S53. DATE OF NEXT MEETING**

Agreed:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 16th January, 2013, commencing at 1.00 p.m. in the Rotherham Town Hall.

**To: Chairs of Health and Wellbeing Boards**

Dear Colleagues

As you may know, the Prime Minister launched a 'Challenge on Dementia' in March 2012 to deliver major improvements in dementia care and research by 2015.

The National Dementia Strategy Programme Board, chaired by the Minister for Care Services Norman Lamb MP, has been tasked with going further and faster to deliver for people with dementia and their family carers. Three sub-groups have been formed to lead on: creating dementia-friendly communities, better research, and driving improvements in health and care.

We are the co-chairs of the Health and Care Sub-Group and we, with the support of the Local Government Association, are writing to ask for your commitment to the Dementia Challenge and your assistance in taking this important agenda forward.

A number of key commitments were made by the Prime Minister as part of the March 2012 launch. I'd therefore like to ask that your local health and wellbeing board considers:

- Reviewing your local Dementia Strategy with particular emphasis on enablement and intermediate care access for people with dementia, accommodation solutions, end of life support and health and social care workforce development
- Ensuring the needs of people with dementia and their carers are part of the Joint Strategic Needs Assessment process
- Whether you need to make dementia a priority in your Joint Health and Wellbeing Strategies.
- Signing up to the National Dementia Declaration and joining your Local Dementia Action Alliance to work with local partners to drive forward improvements for people with dementia in your area (link below).

We are also asking health and wellbeing boards nationally to sign up to the *Dementia Care and Support Compact* – found in Annex B of the challenge document. Please consider publicising this on your websites, stating how you will fulfil this commitment and asking your local Health Trusts to do the same.

We would also encourage you to ask your Acute Hospital Trusts to sign up to the call to action – the Right Care: creating dementia friendly hospitals (link below). This will allow hospitals in your area to gain access to support and advice on becoming more dementia friendly including supporting people with dementia to be discharged back home.

The Prime Minister has asked the National Dementia Strategy Board to provide a formal update on progress by March 2013. We would encourage

you to share your progress through the Dementia Challenge 'Get Involved' website. Some useful online resources are listed below.

For more information or to send in best practice, please use the Dementia Challenge email address: dementiachallenge@dh.gsi.gov.uk

Yours sincerely

Sarah Pickup, President, Association of Directors of Social Services

Sir Ian Carruthers OBE, Chief Executive, NHS South of England

and Councillor David Rogers OBE Chair, LGA Community Wellbeing Board

Online resources:

**Number 10 Press Launch**
http://www.number10.gov.uk/news/a-day-to-remember-dementia-campaign-launches/

**Dementia Challenge Documents**
http://www.dh.gov.uk/health/2012/03/pm-dementia-challenge/

**Dementia Challenge – Get Involved**
www.dementiachallenge.dh.gov.uk

**Local Government Association – Adult Social Care resources**
http://www.local.gov.uk/adult-social-care

**National Dementia Declaration and Dementia Action Alliance**
http://www.dementiaaction.org.uk/info/5/join_the_alliance

**Right Care: creating dementia friendly hospitals**
http://www.dementiaaction.org.uk/info/2/action_plans/165/the_right_care_creating_dementia_friendly_hospitals

The Rotherham NHS
NHS Foundation Trust

**Report to:** **Board of Directors**

**Date:** **20th December 2012**

**Subject:** **'Friends and Family Test' Requirements and Implementation Plan**

**Status:** **To receive and approve**

**From:** **Brigid Reid, Deputy Chief Nurse**

**Contact Details:** Brigid.Reid@rothgen.nhs.uk **Ext 7096**



## 1. EXECUTIVE SUMMARY

The purpose of this paper is to advise the Board of the forthcoming mandatory 'Friends & Family Test' and our implementation plans to achieve full coverage of prescribed areas (In patients and A&E) by April 2013 when we will be required to submit data returns which will be published nationally. The main route for completion is anticipated to be via our recently purchased touch pads available on request on the day of discharge or on line within 48 hours of discharge. These options are resource neutral however we are currently exploring texting and Freephone options to ensure we have maximised the routes available (particularly for those who do not want to utilise technology and may have literacy issues) though these will require additional financial cost.

## 2. ACTION REQUIRED BY THE BOARD

2.1 The Board are asked to receive the report and approve the actions proposed noting the potential resource implications

## 3. EQUALITY IMPACT ASSESSMENT

Are there any Equality Impact Assessment (EIA) implications **Potentially if maximum access to the survey cannot be promoted.**

## 4. Background & Process adopted

4.1 **This paper** aims to ensure that Board members are fully briefed regarding the forthcoming 'Friends & Family Test' (F&FT) and TRFTs plans to implement it to meet the Department of Heath guidance issued in October 2012.

NHS-Friends-and-Family-Test-Implementa

4.2 The **F&FT Survey** is explained in a Question and Answer format in Appendix 1

4.3 A **TRFT F&FT Implementation Task Group** has been set up and met fortnightly since early October under the leadership of the Deputy Chief Nurse. See Appendix 2 for membership. The group has focused on 4 areas

- Survey Methods
- How and where patients will be approached
- Reporting Arrangements
- How to inform staff, patients and the public about the F&FT survey

4.4 There is also a **North of England F&FT Implementation Task Group** and in addition to participating in the teleconferences they have organised we have been required via NHSR to provide monthly status update reports to them.

## 5. Options considered for conducting the survey

5.1 The Department of Health guidance highlighted the following approaches-

5.1.1 On-line rating utilising a web link

5.1.2 SMS/Text message: patients are given a number they can text to receive and complete the survey by text

5.1.3 Smart phone apps: patients are given details of the app (or Q square) to access the on line survey by phone.

5.1.4 'Voting booth' kiosks or hand held devices: positioned in the location from which the patient is discharged

5.1.5 Telephone survey – patients can be given a freephone number to utilise within 48 hours of discharge

5.1.6 Postcard solutions: patients are given a postcard at discharge with an option to complete it then and there or return via a freepost option.

5.2 Whilst it is clear from the North of England teleconferences that many Trust's are adopting one methodology we felt that in order to maximise our response rate from an as representative as possible sample **we need to adopt more than one approach** and the following options appraisal was been undertaken:-

5.2.1 In the context of our current financial pressures and our recently procured Patient

Experience Data Capture contract with Meridian we felt that should promote 5.1.4 and 5.1.1 as much as possible (the F&FT will be an additional question we can add to our existing suite).

5.2.2 Whilst a significant amount of Trust's appear to be procuring complete packages utilising postcards (5.1.6) we excluded this on the basis of cost and concerns re literacy (Indicative costs from one supplier were £7,850 per anum (based on 15% sample of eligible patients) rising towards £11,000 if patients were offered and chose a freepost option.

5.2.3 The option of access to a Freephone survey was considered to be the best way to encourage uptake, within 48 hours of discharge, from people who do not have IT or mobile phone access and/or may have literacy limitations. Whilst other Trusts appeared to be exploring automated pre-recorded outgoing surveys we considered that although patients would be giving their numbers for this to happen it would be tantamount to cold calling and therefore possibly detrimental to the task in hand and our reputation. Unfortunately as most suppliers are offering complete packages we have had some difficulty in identifying information about such a service and it's indicative costs. The most fruitful line of inquiry has been with a company with whom we already have an existing contract (for the telephony system in the Contact Centre) and indicative costs have been obtained for utilisation of incoming interative voice recognition (IVR) Freephone calls INSERT

5.2.4 We have encountered similar problems with regard to sourcing a texting (5.1.2) supplier (despite this being stated as the preferred mode for organisations in the Northwest) INSERT

5.2.5 Technical advisors on the group have advised that collating data from different repositories should not be problematic providing the format is specified to be compatible with our on line data. In order to proceed with both the Freephone and Texting options we need to secure additional resources. Unfortunately no provider we have yet spoken to has been able to identify the likelihood of uptake of these options as part of achieving the target of a 15% response rate (for TRFT this equates to 1000 patients per month (1200 (A&E) + 600 (in patients) = 1800 per week)).

5.2.6 Whilst there are currently no financial incentives or penalties identified in relation to the F&FT it is anticipated that Clinical Commissioning Groups will be identifying CQUINs in relation to it.

### 5.3 Timescales and Engagement

5.3.1 Further to the roll out of the touch pads in December the Group will work with wards and A&E to start data collection in these areas from 7th January 2013.

5.3.2 Whilst we are not required to report data until April 2013 we have stated that we aim to report our February data in March 2013.

5.3.3 Our plans for sharing this information with staff, patients and the public are identified in Appendices 1 and 3.

## 6. RECOMMENDATIONS

The Board are asked to

- Receive the paper and discuss the contents and proposed actions.
- Approve the proposed implementation plan with guidance regarding additional resources required

**Appendix 1**

The Rotherham NHS
NHS Foundation Trust

## Friends and Family Test
## Question & Answers

### Background

- **What is the Friends and Family Test?**

  It is a stand alone short survey completed upon discharge, or within 48 hours of discharge, to ascertain the patients rating of care about the ward/department they have spent the most time in. The main question is :-

  **'How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?'**

  And the response must be selected from
  - Extremely Likely
  - Likely
  - Neither likely nor unlikely
  - Unlikely
  - Extremely unlikely
  - Don't know

  The main question will be followed by an optional follow up question 'Please can you tell us the main reason for the score you have given?' which is to be answered using free text and a request to complete demographic details (though patient identifiable data is not required).

- **Is the Friends and Family Test mandatory and when does it start?**

  From 1st April 2013, all providers of NHS funded acute inpatient services and A&E departments will have to undertake the Friends and Family Test and report results.

- **Which patients does the Trust have to survey?**

  All inpatients (aged 16+) who have stayed at least one night in hospital and patients (aged 16+) who have attended A&E and left without being admitted to hospital. From October 2013, the Test will include maternity services. It is expected that the Test will be extended to include other patient groups.

- **How ready are we to undertake this?**

  We have had a small working group focusing on this since October and feel that we are in a strong position to build on the ethos we already have that patient experience matters. Whilst for this survey staff can not directly approach or assist patients we are confident, because of their existing experience in asking patients about care experiences', in their ability to highlight our desire to know how patients rate us and the ways patients can do this. Most importantly will be what we do with the results to

reinforce good practice and remedy any shortfalls identified and that links into our existing framework for Patient Experience.

- **Do we have to achieve a certain response rate?**

  The Department of Health has stated in its guidance that a 15% response rate is expected. Although this is not mandatory, trusts should aim to achieve this.

## Data collection

- **When should the survey be completed?**

  Either at the point of discharge or within 48 hours of it.

- **Is there a standard survey methodology that all trusts have to use?**

  No. Trusts decide which methodologies to use. We will aim to use more than one approach to ensure as many as possible of our patient population have appropriate access though our main approach will be using our current Patient Experience Data capture contract with Meridian which is on line and accessed via either on site (using the Touch Pads) or within 48 hours via our Website (please see draft poster).

- **Can it be completed whilst the patient is in bed?**

  No. As the Department of Health guidance discourages completion at the bedside staff need, where ever possible, to highlight a quieter less clinical area where patients can utilize the touch pad if that is the method they wish to use. We are mindful though that this may not always be possible in which case, provided the patient's in patient care is completed and their discharge imminent (i.e. they are awaiting transport) then at their request the touch pad can be brought to them when they are seated by their beds.

- **Do we involve members of staff?**

  Not directly – the guidance is clear that we should not directly ask the questions however via the posters and flyers patients are encouraged to approach staff if they wish to utilise our touch pads on site.

- **What should we do if a patient asks us to complete the survey on their behalf?**

  If a patient wishes to complete the survey on our touch pads before they leave the ward/department and for any reason are unable to do so (a range of reasons are possible including considerations of literacy or mental capacity which need to be handled sensitively) then a nominated family member/friend may do so on their behalf; alternatively it may be that wards may have access to volunteers who could assist though clearly they are not always available.

- **How do we find out why patients gave a specific response?**

  We hope that patients will also elect to respond to the follow-up free text question, asking them the reasons for their response to the Friends and Family Test question.

- **How representative will the results be of our patients?**

  We plan to advertise the test widely using posters and flyers and will be relying on staff to reinforce these to maximise take up. In addition we hope that by having more than one mode of response and having access to relevant translations that as many patients as possible will be able to complete the survey and if they also elect to respond to our optional demographic questions (anonymously) we will be able to monitor the uptake across age, gender, ethnicity, religion and sexuality. Given the prescriptive nature of the Department of Health Guidance we are describing this survey as the 'closest to fairest way of obtaining wide scale patient views in real time and comparing a ward with other wards, A& E with other A&Es, and the hospital with other hospitals.'

- **Is there any survey publicity?**

  Yes. In addition to the poster we have designed (which will be used as a poster and a flyer) we will be utilizing Newsweek, Team Talk and opportunities to raise this at staff meetings. We also plan to raise awareness within Rotherham via the local media early in 2013.

- **How will patient's know which ward they were on for most of their stay?**

  The survey will require them to identify this and so it is vital that we assist them in identifying this before they are discharged.

- **How can we be sure that patients are not answering the survey more than once?**

  Some Trusts are utilizing a unique reference number which ensures that patients can only answer the survey once, using only one mode of completion. This is not a requirement of the Department of Health and as yet we have not yet elected to adopt this as we do not anticipate this being a major risk.

- **Will this replace the CQUIN surveys we currently undertake?**

  No. The CQUIN questions need to continue and will be adapted in negotiation with our Commissioners, it is important that the Friends & Family Test (F&FT) is kept separate so if patients are choosing to complete the CQUIN survey at the same time this is undertaken after they have completed the F&FT. As identified in our Patient Experience Strategy our approach to staff surveying patients is key to reinforce how important their views are and an opportunity for them to raise any issues which we can then resolve in real time.

- **What about patients who are on the End of Life pathway?**

  Whilst we expect staff to highlight access to this survey to all patients clearly it is important to be sensitive to the needs of each individual patient, and their family. In addition to noting that the choice to complete the survey must always be the patient's we should never make assumptions as to any patient's wishes or expectations as

this could lead to a patient/family feeling disenfranchised which we actively want to avoid.

- **How will the test be surveyed in A&E ?**

  The approach will be the same as for in patients though the question will refer to A&E and a secure Touch Pad will be located 'kiosk' style within the department to promote on site completion prior to patients leaving the department

## Reporting

- **Does the Department of Health intend to report nationally on the Friends and Family Test?**

  Yes. We will be required to submit our data each month from April 2013; we will be making pilot returns in February and March.

- **What level will the reports be?**

  The Department of Health requires ward level data.

- **Can we track our progress in real time?**

  Yes – for the on line surveys completed each Ward will be able to view their results in real time – the total results will be compiled by our Performance Team on a monthly basis and shared with wards requiring them to display them in a corporate format for the public to view, this data will also be available on our Trust website for the public to access and closely monitored by The Board of Directors.

**Appendix 2**

**Membership of the TRFT F&FT Implementation Group**

Deputy Chief Nurse (Chair)
Performance Team representative
Business Intelligence Team representative
IT representative
Communications Team representative
A&E Representative
Elective Care Pathway Representative
Urgent Care Pathway Representative
NHS R Representative
Finance Representative

**Appendix 3**


The Rotherham NHS
NHS Foundation Trust
Tell us what you think...
Would you recommend us to friends and family if they needed similar care or treatment?
Your feedback is really important to us. You can do this by:
Asking a member of staff to use our touch pad here
Alternatively (within 48 hours of discharge)
Texting INSERT
Accessing via our website INSERT
Freephone INSERT
Your health, your life, your choice, our passion

# Rotherham Clinical Commissioning Group

**Operational Executive – 24 Dec 12**

**Strategic Commissioning Executive – 2 Jan 13**

**GPRC – first draft, 19 Dec 12, second draft Jan 30 13**

**Clinical Commissioning Group Committee - 9 Jan 13**

**Rotherham Health and Wellbeing Board – 16 January 20913**

## Rotherham CCG Annual Commissioning Plan, *Your Life, Your Health* and the NHS Commissioning Board's 2013/14 planning guidance, *Everyone Counts*.

| | |
|---|---|
| Lead Executive: | **Robin Carlisle, Deputy Chief Officer** |
| Lead Officer: | **Lydia George, Project Team Manager** |
| Lead GP: | **David Tooth** |

**Purpose:**

For the Health and Wellbeing Board to comment and endorse the CCGs 2013/14 Annual Commissioning plan (ACP), *Your Life, Your Health.*

**Background and Key Issues**

The ACP is required to be based on local priorities identified in the JSNA and expressed in the Health and Wellbeing Strategy. The plan is expected to set out real levels of ambition and show how the CCG will address health inequalities as well as improve outcomes.

By the 25 January, the CCG is required to formally submit first draft of plans to the NHS Commissioning Board Area Team. One aspect is the choice of 3 local outcome measures to determine Rotherham CCG's quality premium payments. These are to be agreed by the CCG and NHSCB after discussion with the H&WBB. It is suggested that the H&WBB discusses the extent to which the 4 possibilities recommended on page 47 of the ACP are consistent with the JHWBS, but leave the final choice of 3 from the 4 possibilities to the CCG's Chief Officer and Clinical Chair depending on the technical definitions and required trajectories as these are clarified with the NHSCB.

The ACP is to be discussed at the Rotherham CCG Committee on the 9 January, the committee are to be asked to authorise the Chief Officer to make further amendments in light of comments by the H&WBB, GPRC and NHS CB Area Team, and to have further discussions with the NHS CB Area Team on the nature and timing of the assurance required prior to making submissions on the 25 January.

**Patient, Public and Stakeholder Involvement:**

Documents available on request describe the input to the plan prior to the first circulated draft and feedback and amendments made since the first circulated draft.

**Equality Impact:**

Section 6.2 relates to the CCGs Public Sector equality duty. Section 6.10 how the CCG will address inequalities

**Recommendations:**

- The H&WBB is asked to suggest amendments and then endorse the current draft of the ACP.

your life your health

NHS
Rotherham Clinical Commissioning Group

# Annual Commissioning Plan 2013/14

**Caveat: this draft is for discussion at the CCG Committee on Jan 9th and then H&WBB on Jan 16th and GPRC on 30 January. The CCG will engage in iterative dialogue with the NHS CB on the plan during January prior to submitting templates on 25 January and a formal meeting in February to discuss the locally agreed plan. Stakeholders who have commented on earlier versions of the plan will note there have been substantial amendments as a result of their comments and also in light of NHSCB planning guidance, '*Everyone Counts*' published on 18 December (see especially the sections on NHS Mandate 6.11 and Finance 9). There are still some financial details that have to be worked though prior to 25 January, mainly around understanding the implications of changes to the definitions and allocations for specialist commissioning. Note that throughout there are references to links to more detailed documents – these are not yet enabled, this will be done for the final version on 31 January.**

***Draft V2.2 (03 01 2013)***
**Author notes in purple**

# Contents

# 1 Executive Summary

This is Rotherham Clinical Commissioning Group's (CCG) first Annual Commissioning Plan (ACP) as an autonomous statutory organisation. A high level summary of our plan on a page can be found on page 6, and on page 7 we summarise our purpose, responsibilities, mission, values and priorities. Our ACP is the CCG's contribution to delivering Rotherham's overall Health and Wellbeing Strategy (H&WBS).

We face four substantial **challenges:**

- Although people's health improves each year Rotherham is below the national average for key outcomes. For example **life expectancy is more than a year below the national average**.

- There are unacceptable inequalities in health *within* Rotherham. **Life expectancy is seven years less in some parts of the Borough compared to others.**

- At the moment **too many health problems are dealt with by hospital admission.** Rotherham's Health Service needs to be reshaped to meet the needs of its population more effectively.

- **A £75 million efficiency challenge** over the next four years. This is because of the general pressures on public funding but is also a consequence of success; increasing life expectancy means that there are a growing number of people with multiple long term conditions. Whilst the CCG has met its 2012/13 efficiency plans the challenge for subsequent years still remains

We suggest three **solutions:**

- **Self care and home care are best care.** Too many people are admitted to hospital in Rotherham. Although this is what the public and clinicians in Rotherham are used to, in the long term it is unsustainable. For most problems, patients prefer to be treated at home. High quality home care is also safer because even the best hospitals cannot eliminate all the risks of hospital admission such as acquired infection and loss of independence. We will work with the public, Rotherham Council, the voluntary sector and health providers on better prevention and earlier interventions.

- **Improving community care** so that patients have more alternatives to hospital admission. In Rotherham the same provider, Rotherham NHS Foundation Trust (TRFT) provides both hospital services and many community care services. Our strategy shifts £5 million of resources from hospital care to community care, delivered by TRFT and a range of other providers such as the voluntary sector, Rotherham Hospice and Rotherham GPs.

- **Strengthening clinical leadership**. The CCG is a GP led, members' organisation of the 36 practices in Rotherham. We have made substantial progress in 2012 in working with clinicians across Rotherham to improve medicines management and the quality of clinical referrals. We have produced strong plans for improving unscheduled care which we will

deliver in 2013. There will be a new emphasis on clinical leadership of the mental health agenda including delivery of our plans to improve dementia services.

Our **strategic aims** are grouped across six areas:

1. ***Unscheduled care* is care for urgent problems:** We are delivering an ambitious pilot scheme to provide better support and co-ordination of care to eight thousand people at most risk of hospital admission. In 2012 we opened a Care Co-ordination Centre to help clinicians access more alternatives for people in need of urgent hospital assessment. In 2013 we will further develop the Care Co-ordination Centre and work with all clinicians across Rotherham to learn from feedback from the centre including audit of key clinicians involved in unscheduled care. We will also consult on proposals to re-design the way unscheduled care is to be provided in 2014 by services such as Primary Care Out of Hours, the Walk in Centre and Accident & Emergency services.

2. ***Clinical referrals:*** The CCG will build on 2012 successes in improving care pathways and providing best practice guidelines to clinicians about referrals. We will reduce unnecessary hospital follow-ups by 35,000 appointments. This will include the managed and funded transfer of some follow -ups to General Practice. We will also reduce waste from duplicated diagnostic tests.

3. ***Mental health:*** We will invest in a new adult mental health liaison service for people presenting to acute hospitals with mental health problems including dementia and improve timely interventions for people with alcohol problems.

4. ***Medicines management:*** We will build on our award-winning successes in medicines management, working with all practices on quality, efficiency and reducing waste and delivering six specific service re-design projects.

5. ***Continuing care:*** We will ensure patients are cared for in the right place and at the right time to minimise the need for inappropriate hospital admission.

6. ***End of Life Care:*** We will ensure that patients in need of end-of-life care are identified in a timely manner and ensure their care will be better co-ordinated allowing more people to die in their place of choice.

## Priorities

For all our aims and priorities we will consider the four Health and Wellbeing Strategy life stages (starting well, developing well, living and working well, and aging and dying well) and be responsive to the needs of all the communities of Rotherham both geographical and communities of interest.

***Delivery:*** The CCG will prioritise the vast majority of its efforts in 2013/14 towards delivering this strategy. Our leaders and groups will be flexible in terms of methods of delivery but given our finite management resources, substantial additions to this plan are unlikely in 2013 but will be considered for 2014.

***Quality, Safeguarding and GP quality:*** At a time of financial pressure we will give maximum priority to ensuring that all providers continue to secure improvements in quality and that children and vulnerable adults are safeguarded. A key priority will be ensuring that providers cost improvement plans can be delivered without reducing quality and safety. The CCG regards improving the quality of General Practice as key to delivering its aims. We will work in partnership with the NHS Commissioning Board (NHS CB) to contribute to improving General Practice quality and to clarify the responsibilities of the two organisations in this area.

***Partnership:*** We will work with partners to deliver the Rotherham H&WBS, including its emphasis on the most deprived communities in Rotherham. We will discuss and understand the impact of any decisions we make with our partners. We will work with the Rotherham Partnership particularly with regard to the sixth priority of the H&WBS, reducing poverty. We will develop relationships with the other two new health commissioners in Rotherham; Rotherham Public Health and the South Yorkshire and Bassetlaw Area Team (SY&B AT) of the NHS Commissioning Board, and with South Yorkshire and Bassetlaw Commissioning Support Unit (SY&B CSU) who will support us in delivering our plan.

## Outcomes

We will keep under review a wide range of outcomes for Rotherham patients. We will work with partners on the Health and Wellbeing Board (H&WBB) to develop outcomes in the six prioritised areas in the H&WBS. We will report to our governing body a range of outcomes from the national outcomes framework including the increasing number of measures that relate to patient experience. We will be especially mindful of the 4 national and three local outcomes that will determine the CCG's quality premium in 2014.

## Rotherham CCG 'Plan on a Page'

# *Your Life, Your Health*

*"Working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities"*

### Challenges

- *Health outcomes for Rotherham people are worse than England average*
- *There are striking health inequalities within Rotherham*
- *Rotherham is a marked outlier for hospital admissions*
- *Rotherham has an £75 million efficiency challenge*

### Solutions

- Self Care and Home Care are Best Care
- Delivery of effective community services
- Clinical leadership

### Strategic Aims

*Health and Wellbeing 'Strategic Aims'*

- PE *Priority 1: Prevention and Early Intervention*
- EA *Priority 2: Expectations and aspirations*
- DI *Priority 3: Dependence to independence*
- HL *Priority 4: Healthy Lifestyles*
- LC *Priority 5:Long-term conditions*
- PT *Priority 6: Poverty*

*Unscheduled Care*
- *Clinical leadership*
- *Case management of 8,000 people with long term conditions*
- *Care Co-ordination Centre and unscheduled care re-design*
- *Personalisation*

*Clinical Referrals*
- *Clinical leadership*
- *Improving care pathways*
- *Efficient follow-ups*

*Medicines Management*
- *Clinical leadership*
- *6 service redesign projects*

*Mental Health*
- *Dementia*
- *Clinical leadership*
- *Improved alcohol services*

*Continuing Care*
- *High quality equitable provision*

*End of Life Care*
- *High quality equitable provision*

### Corporate Priorities

**Delivery**

**GP quality**

**Commissioning for quality**
(safety, patient experience and outcomes)

**Partnerships**
(with existing and new organisations)

### Outcomes

**Health & Wellbeing Strategy prioritised outcome areas**
- Dementia
- Smoking
- Alcohol
- Obesity
- NEETs (employment)
- Fuel Poverty

**National Priorities** including Constitution Rights and Pledges on waiting times

**Quality Premium Outcomes**
1. *Potential years of life* lost
2. *Avoidable Emergency admissions*
3. *Friends and Family Test*
4. Incidence of *Health Care Acquired Infections*
5. *Admissions for alcohol related conditions*
6. *Dementia diagnosis*
7. *Cardiovascular Disease mortality under 75*
8. *Number of people dying outside acute hospitals*

**Across all life stages: 'Starting Well' 0-3 yrs / 'Developing Well' 4-19 yrs / 'Living & Working Well' 20-64 yrs / 'Ageing & Dying Well' 65+ yrs, And for all communities both geographical and communities of interest**

## *Rotherham CCG 'Purpose on a Page'*

### NHS ROTHERHAM CLINICAL COMMISSIONING GROUP

***Our Responsibilities***

*NHS Rotherham CCG is a membership organisation of 36 practices which is responsible for commissioning a range of health services on behalf of the people of Rotherham.*

*We are responsible for commissioning acute hospital and mental health services, community health services, GP out of hours services, GP prescribing, ambulance and hospice services.*

*We do not commission primary care and specialist services (which are the responsibilities of the NHS Commissioning Board) or public health services (which are the responsibility of Rotherham Metropolitan Borough Council).*

***Our Mission***

*"Working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities".*

***Health and Wellbeing Board Vision for Rotherham***

*"To improve health and reduce health inequalities across the whole of Rotherham".*

***Our Values***

In **everything** we do we believe in:

- Clinical leadership
- Putting people first, ensuring that patient and public views impact on the decisions we make
- Working in partnership
- Continuously improving quality of care whilst ensuring value for money
- Showing compassion, respect and dignity
- Listening and learning
- Taking responsibility and being accountable

***Our Priorities***

Our **four key priorities** are:

1. **Delivery** – making sure services are safe, improving outcomes and quality, ensuring vulnerable people have effective safeguarding and meeting our financial targets
2. **GP quality** - achieving consistent improvements in primary care in partnership with the NHS Commissioning Board Area Team
3. **Commissioning for quality (safety, patient experience and outcomes)** – leading system wide efficiency programmes
4. **Partnerships** – establishing strong relationships with existing and new agencies in Rotherham

# 2 Introduction

## CCG Chair and Chief Officer

This plan sets out our commissioning intentions and summarises all the other plans the CCG requires to enable it to deliver its responsibilities. The CCG is a new organisation in an NHS that is just completing a complex restructuring. In section 3 of this document we explain, who we are, our responsibilities, and our key relationships.

The CCG is one of three health commissioners contributing to Rotherham's overall Health and Wellbeing Strategy (H&WBS), and is responsible for commissioning community health services, hospital health services, health aspects of social and continuing care, GP prescribing and GP out of hours services for Rotherham. Public health services are commissioned by Rotherham Public Health (part of Rotherham Council) and primary care services (GPs, pharmacists, optometrists and dentists) are commissioned by the South Yorkshire and Bassetlaw Area Team of the NHS Commissioning Board (SY&BAT). The three health commissioner's work with other organisations and communities to deliver the Rotherham's overall H&WBS (summarised in section 4 of this document).

The whole public sector faces considerable challenges to continue to improve quality and outcomes in the face of a real term reduction in resources. In section 5 we set out our plans for 11 specific commissioning areas and in sections 8 and 9 we comment specifically on the efficiency and financial challenges. We are confident that Rotherham is well placed to meet these challenges. There are four key solutions proposed in this strategy; self care, a recognition that home care is the best care in most circumstances, improving community care and strengthening clinical leadership, these have been strongly supported when we have discussed our strategy with stakeholders. The CCG starts from a strong foundation and has already established excellent relationships with its partners.

We emphasise that to continue to have a successful health system in Rotherham substantial change is required. Rotherham's health system is over-reliant on hospital admission as a solution to acute medical problems; our strategy will reduce this reliance. We will reduce investment in hospital services to allow us to increase investment in community services and other alternatives to hospital admission. This will be very challenging, to acute hospitals whose services will have to change substantially, to clinicians who will have to change patterns of care, and to patients who will receive different services. We are convinced this is the best approach; whilst a hospital admission can often seem to be the safest option it is in fact a risky process. Even in the best hospitals there is a 1 in 10 risk of a harmful event occurring during admission. It is therefore incumbent on us to develop high quality community alternatives for as many patients as possible.

This is the first plan the CCG has produced as an autonomous statutory organisation. We have gone to considerable lengths to discuss our plans with the public and other stakeholders, a process described in section 14. There are substantial challenges in having high quality discussions with public, patients, stakeholders and clinicians:

- the current NHS re-organisation is complicated and confusing to many; it will take time for people to understand the roles and responsibilities of the new organizations.

- 'big picture' conversations about the whole of our £329 million portfolio sometimes struggles to do justice to important individual details and concerns.

- there are nationally imposed constraints on our planning timetable. We do not receive financial allocations and important payment rules until mid December but our providers require clear intentions from us in time to negotiate contracts well before the 31 March.

This plan sets out our agreed intentions for 2013/14 together with outline for the subsequent two years. We will continue dialogue with stakeholders during 2013/14 to further develop and re-fresh our intentions for 14/15 and 15/16.

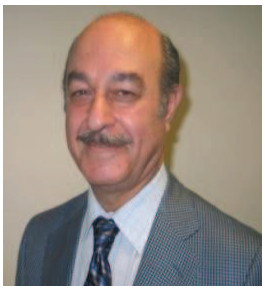
Throughout this document we have tried to keep to key points but make reference to additional information so that this single document serves as an index to all the CCG's plans. We are aware there are a lot of acronyms and NHS terms, these are explained in the glossary in section 15. We are also aware that stakeholders wish for as short a document as possible, however this year because of the complexity of the NHS reforms we have felt it necessary to go into some detail about our new responsibilities. Hopefully future plans can be shorter as the new NHS commissioning structure becomes both clearer and more familiar.

We are mindful that a transformation has to occur in order for the CCG to meet its efficiency challenges. This makes it even more important to have clear assurance mechanisms for quality across the whole of the CCGs portfolio. In section 5 we set out our plans across our whole portfolio, in section 6.1 we describe the important new responsibility for CCGs to assure providers Cost Improvement Plans and in section 8.5 we describe the four key multi agency efficiency committees.

Although the CCG has a wide range of responsibilities and a £329 million commissioning budget, we are a small organisation compared to our partners and our providers. We have very limited management resources with around 10 days per week of GP leader time, supported by approximately 50 whole time equivalent staff. This means that during 2013/14 we will have to keep focused on our agreed priorities which have been prioritised as the most important to continue to improve the quality of health care for the people of Rotherham.

***David Tooth, GP***
***Chair CCG***

***Chris Edwards***
***Chief Officer CCG***



***Leonard Jacob, GP***
***Chair GP Reference Committee***

## Chair of Health and Wellbeing Board

The Rotherham Health and Wellbeing Strategy sets out the key priorities that the local Health and Wellbeing Board will adopt over the next three years to improve the health and wellbeing of Rotherham people. The Joint Strategic Needs Assessment, Health and Wellbeing Strategy, agencies' Commissioning Plans and the three outcomes frameworks demonstrate the journey from gathering data, to understanding whether we are achieving our goals.

There are great benefits from working in partnership, bringing together planning, funding and delivery of health and social care. The CCGs Annual Commissioning Plan aligns with the H&WBS and sets out, as a key partner, how they will support its delivery.

***Councillor Ken Wyatt JP***

# 3 About the Clinical Commissioning Group

## The Clinical Commissioning Group (CCG)

The CCG is a membership organisation, the **36 GP practices** in Rotherham are its members, and they are grouped into eight localities. The CCG's main decision making body is the **Governing Body**, four GPs, three executives, a nurse, a hospital consultant, a lay member overseeing patient engagement, and a lay member overseeing finance and audit. The CCG will ensure it accesses the expert advice that it requires which includes having Rotherham's Director of Public Health and the Chair of Rotherham's Health And Wellbeing Board attending CCG Governing Body meetings. The **GP Reference Committee** is a strong advisory body to the CCG Board and Strategic Clinical Executive with a responsibility to ensures member practices are linked into all the wider commissioning decisions.

In terms of executive delivery the CCG has **eight executive GPs** who each lead on specific clinical areas. The eight GPs are supported by approximately 50 other directly employed staff. In addition the CCG has a contract with **South Yorkshire Commissioning Support Unit** which supports the CCG in areas such as intelligence, IT, human resources and some financial services.

The links show the members of our three committees: Governing Body, GP Reference Committee, and Strategic Clinical Executive[1].

## CCG responsibilities

The CCG's full responsibilities are detailed in its constitution put in link. The main responsibilities are listed below and in section 6 of this plan we set out how we meet these responsibilities:

- Upholding the NHS constitution, CCG constitution and governance standards
- Quality assurance and quality improvement of commissioned services
- Quality improvement of GP services in partnership with the NHS Commissioning Board (NHSCB)
- Safeguarding children and vulnerable adults
- Reducing Health Inequalities
- Public sector equality duty
- Public involvement in CCG and promotion of choice
- Training, innovation and research
- Environmental sustainability
- Delivering on relevant areas of the Governments mandate to the NHS CB and the NHS CB's planning guidance, '*Everyone Counts*.'
- Achieving Financial Balance

[1] Add link to website to show committee structure and detail

## Relationships

As a new organisation we aim to have constructive relationships with existing stakeholders and with the new NHS organisations established by the 2012 Health and Social Care Act.

The CCG is working with individual practice patient user groups to develop its **CCG patient forum** and with stakeholders including the voluntary sector to develop its **stakeholder forum**. The CCG will work closely with **Healthwatch** to ensure patient opinion informs CCG strategy

The CCG is an active member of the **Rotherham Health and Wellbeing Board** and the **Rotherham Local Strategic Partnership.**

The CCG is accountable to the **NHS Commissioning Board** for delivery of agreed outcomes. In addition the CCG will work in partnership with the NHS Commissioning Board in areas where the responsibilities of the two organisations overlap such as the interface between CCG and specialist commissioning. The NHS Commissioning Board commissions General Practice and other primary care services; the CCG as a membership organisation of local General Practices who will work in partnership with the NHS Commissioning Board to improve the quality of General Practice in Rotherham.

The CCG will work closely with **Rotherham Metropolitan Borough Council (RMBC)** to ensure that Rotherham's Health and Wellbeing Strategy is delivered. Where appropriate we will enter into joint commissioning arrangements and pooled budgets. We will also work closely with RMBC to ensure that Rotherham's health and social care system uses resources efficiently and delivers high quality, seamless services for Rotherham patients.

The CCG will work in partnership with **Rotherham Public Health** to help them deliver their responsibilities and has a memorandum of understanding which sets out how public health specialists will support the CCG with our responsibilities.

The CCG will maintain strong relationships with **other CGGs** including meetings between Chairs and Chief Officers to share best practice and to jointly commission services where appropriate.

**CCGCOM** is a formal structure for areas where local CCGs choose to commission jointly and share best practice. The link shows the December 2012 CCGCOM work plan. Put in link. CCGCOM also enables the 5 CCGs in South Yorkshire and Bassetlaw to have collective discussions with the NHS Commissioning Board about the interface between CCG and specialist commissioning.

Add something about **networks** and **senates** when arrangements become clear in January.

# 4 Context

## 4.1 Joint Strategic Needs Assessment (JSNA)

The CCG has worked with partners to produce a comprehensive assessment of the needs of the people of Rotherham[2]. The following section summarises the key findings.

The health of people in Rotherham is generally worse than the average for England. There is significantly higher than average deprivation, unemployment and long-term unemployment. The overall health of people in Rotherham has continued to improve year on year; life expectancy at birth rose by 2.7 years for men and 1.8 years for women during the last decade and premature death from heart disease has halved since 1991. However, the rate of improvement has not kept pace with elsewhere and remains below the England average. The relative position of Rotherham has slipped and is now the 51st most deprived borough out of 326.

One of the most striking health issues in Rotherham is the degree of inequality within the borough. The gap in overall life expectancy between Rotherham and the national average is one and a half years (based on 2008-10 three years combined) but the gap in life expectancy between the most and least deprived parts of Rotherham for males is 10.2 years and females is 6.9 years (based on 2006-10 death rates).

The gap in life expectancy between the most and least deprived has widened during the last decade. The most disadvantaged communities appear to be improving less quickly than Rotherham overall.

The impacts of benefits changes are likely to be more profound in Rotherham because of the pre-existing levels of disadvantage. The links between poverty and ill health are well established and the pace of improvement in health is likely to be threatened leading to widening inequalities. The emphasis on narrowing inequalities, targeting resources towards areas of greatest need and poverty reduction are focuses for the Joint Health and Wellbeing Strategy.

The population of Rotherham continues to grow and is projected to reach 267,000 by 2020. The age profile will be increasingly dominated by the elderly; the number of people aged over 65 is projected to grow by half and those aged over 85, by almost double by 2028. This is likely to be associated with an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. At the moment there are more than 11,000 people in Rotherham with diabetes, and 5,500 on GP stroke registers, by 2025 there will be over 4,500 people in Rotherham living with dementia; however, it is important to bear in mind that people are increasingly living longer with multiple long term conditions and this presents a challenge to services that are designed around managing individual conditions.
As a consequence of the post war baby boom, the growth of the older population is unlikely to be steady. The next two decades will see the baby boomers coming of retirement age and this is likely to create a bulge in need rather than a steady increase.

[2] Add link to JSNA

Rotherham has a relatively small black and minority ethnic (BME) community but one that is growing and becoming increasingly diverse. The single largest minority ethnic group is Pakistani (Kashmiri) and the second is White Other which includes EU migrants.

Staying healthy remains a significant challenge for many people in Rotherham. The following issues are likely to compound the effects of the ageing population and are likely to amplify the increase in the prevalence of long term conditions:

- In 2010/11, 8.3% of children at Reception were classed as obese or overweight which is significantly lower than the national average; however, 21.6% of children at Year 6 were classified as obese/overweight. In addition, estimated adult obesity prevalence was estimated to be 27.6% (2006-08). Both are significantly worse than the national average.
- Smoking prevalence is estimated to be 23.9% (2010-11) in Rotherham which is significantly worse than the England average.
- Physical activity levels and prevalence of healthy eating in adults are estimated to be significantly worse than the England average.
- Levels of substance misuse and admissions to hospital due to alcohol related harm are significantly worse than the England average.

Maternal, infant and childhood health give quite considerable cause for concern, with smoking in pregnancy, low birth weight, breast feeding initiation and teenage pregnancy being significantly worse than the national average. This remains a significant barrier to Rotherham achieving the best start in life for its citizens.

Over the last decade, all cause mortality rates have fallen. While early deaths from cancer, heart disease and stroke have fallen, they remain worse than the England average.

Another striking feature of the changing demography of Rotherham is the increasing number of people living alone. Potential consequences of this include poverty, loneliness and mental ill health. Mental ill health is the biggest cause of morbidity and incapacity and the growing burden of dementia is an increasing concern.

In response to the growth in long term conditions and care needs, the number of informal carers has increased and is currently estimated at 35,000. The age profile of carers is following the same pattern as the general population and is believed to reflect the increasing number of spouse carers. The increase in the number of younger carers is more modest and this is likely to result in a widening of the “care gap” which could lead to greater demands on formal care services including acute care.

In summary, health needs in Rotherham are significantly greater than the average for England and are associated with a striking level of inequalities; while there have been improvements in life expectancy, the key causes of early death remain largely preventable and related to lifestyle. Impacts of benefits changes are likely to compound this and threaten gains to health and the pace of improvement. Many people in Rotherham are living longer and healthier lives; however, a significant number are not and the demands for healthcare from people with multiple co morbid long-term conditions are likely to grow. Healthcare priorities remain promotion of the best start in life, early detection and effective management of long term conditions and secondary prevention.

## 4.2 Rotherham Health and Wellbeing Strategy

The CCG has worked with partners to develop and implement Rotherham's Health and Wellbeing Strategy in response to the finding of the Joint Strategic Needs Assessment and consultation about health inequalities. The strategy emphasises four parts of the life course:

- Starting well (0-3)
- Developing well (4-19)
- Living and working well (20-64)
- Aging and dying well (65+)

The strategy has six priorities for what we want Rotherham to look like in three years.


**Priority 1 - Prevention and early intervention**
Outcome: Rotherham people will get help early to stay healthy and increase their independence.


**Priority 2 - Expectations and aspirations**
Outcome: The expectations and aspirations of Rotherham people will be understood and matched by services that are delivered to borough-wide standards, tailored to an individual's personal circumstances.


**Priority 3 - Dependence to independence**
Outcome: Rotherham people will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances.


**Priority 4 - Healthy lifestyles**
Outcome: People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.


**Priority 5 - Long-term conditions**
Outcome: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life.


**Priority 6 - Poverty**
Outcome: Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skills and employment.

We will work with partners to identify and monitor key local outcomes discussed further in section 11 of this document.

# 5 Commissioning Areas

## 5.1 Unscheduled Care

| | |
|---|---|
| **Lead Officer** | **Chris Edwards – via Unscheduled Care Management Committee (UCMC)** |
| **Lead GP** | **David Tooth – via UCMC** |

**Why are we planning to invest in this area?**

Unscheduled care refers to unplanned health or social care admissions. Rotherham patients receive unscheduled care from a wide number of acute services but in terms of emergency hospital admissions 85% are to the NHS Rotherham Foundation Trust (TRFT), 6% to NHS Doncaster and Bassetlaw Foundation Trust and 4% to NHS Sheffield Teaching Hospitals Foundation Trust.

Rotherham health community is an outlier for emergency admissions to hospital. Emergency admissions are 13% higher than the South Yorkshire and Bassetlaw average and 32% higher than the England average. This is partly due to high morbidity but also because Rotherham has few alternatives to acute hospital admission. There is also evidence that individual clinicians involved in hospital admissions such as GPs, ambulance staff, and accident and emergency doctors have different thresholds for admission. Whilst hospital admission is often seen as the safest and easiest way of dealing with an emergency, for many people high quality care at home is a better, safer option. Our strategy will provide more alternatives to hospital admission, treat people with the same needs more consistently and deal with more problems by offering care at home or close to home.

In 2012/13 RCCG spent £59.2 million on unscheduled care. Planned spend for 2013/14 is Y.

**What will we achieve for our investment including efficiencies?**

The CCG will build on the successes of 2012/13 to transform the way patients with long term conditions, the frail elderly and others who access urgent care services are managed. Emergency admissions will be reduced by 12% over the next 2 years, instead more patients will receive immediate assessments followed by treatment at home or in the community. A full description of planned activity for both unscheduled and clinical referrals is in section 7.

In 2013 we will have an increase focus on incentivising audit and peer learning of conversion rates for key clinicians across the Rotherham. This is likely to include specific incentives in TRFT, Care UK and Yorkshire Ambulance Service (YAS) contracts. We will invest in additional GP capacity to give feedback to clinicians of key messages from the Care Co-ordination Centre.

A key part of the case management pilot is better co-ordination of care including co-ordination with carers. This will be set out in an action plan to deliver Rotherham's Joint Carers Charter.[3].

Acute and chronic problems caused by alcohol are the reason for many A&E attendances and hospital admissions. The CCG will improve acute alcohol services described in the mental health section 5.4.

Providing better children's services and better services to people with mental health problems including dementia have important implications for unscheduled care (described later).

[3] Add link to carers strategy

The table below lists the four 2012 workstreams within the programme and the projects within these workstreams.

| | Workstream | Project | |
|---|---|---|---|
| 1 | GP led integrated care | • Self Care<br>• Case Management<br>• Nursing and Residential Homes | |
| 2 | Efficient access to unscheduled care | • Unscheduled care review<br>• NHS 111<br>• Care Co-ordination Centre<br>• Alternative levels of care | |
| 3 | Personalisation | • Personal budgets for continuing care patients | |
| 4 | Pathways | • Dementia<br>• Falls<br>• Frail Elderly<br>• End of Life Care<br>• Acutely ill child<br>• Alcohol | The following will be managed by the Clinical Referrals Management Committee:<br>• COPD<br>• Cardiology/CVD<br>• Diabetes<br>• Asthma |

**How are we going to achieve our intentions?**

The programme is overseen by the fortnightly Unscheduled Care Management Committee (UCMC) which is attended by the CCG chair and chief officer, two GPs, TRFTs Chief Operating Officer/ Deputy Chief Executive, the Director of Neighbourhoods and Adult Services from RMBC and Consultant in Public Health. The UCMC reports to the multi-agency Quality, Innovation, Productivity and Prevention (QIPP) Delivery group and then the CCG Strategic Clinical Executive (SCE).

**Quality improvements**

1. **GP led integrated care:**
   **Self Care:** we will support to patients to take more control over their condition and management. Our approach is described in detail at the following link[4]. Key elements of the support are through the GP case management and social prescribing projects described below and by our continuing care services described in section 5.8. **Case management** is made up of several projects: the **risk stratification** project enables accurate identification of people at increased risk of hospital admissions so that care can be tailored to individual needs to help avoid hospitalisation. The **GP case management** project funds additional clinical time in primary care to case manage patients at highest risk of hospitalisation (as identified by the risk stratification tool). Community nursing and social workers are re-focussed to provide input into patient reviews. There is a direct link with the **social prescribing** pilot where care co-ordinators refer people with non-clinical support needs to voluntary and community sector providers to help patients manage their own conditions. **Nursing and Residential Homes:** this project will reduce A&E referrals and hospital admissions from care homes by supporting the case management of residents at high risk of admission.
2. **Efficient access to unscheduled care:** Rotherham **Care Co-ordination Centre** introduced in November 2012 provides a single access point to health professionals so that they can make informed choices about the most appropriate levels of care for patients and this will link with the national implementation of NHS 111. **Unscheduled care review;** in 2013 we will consult on proposals to re-design the way unscheduled care will be provided from 2014 by services such as GP Out of Hours, the Walk in Centre and Accident and Emergency services.

[4] Add link to Self Care document

3. **Personalisation:** Piloting personal health budgets prior to full roll out in April 2014, will test whether personal budgets improve choice and quality of care as well as delivering efficiencies.
4. **Pathways:** re-designing care pathways initially focusing those that account for the highest proportion of admissions.

**Innovation**

- GP Case Management Pilot – a major innovation at scale where Rotherham has invested substantially (£1.3 million in 2013/14) to fund additional community support
- Social prescribing – a significant investment (£500 K in 2013/14) in the third sector to provide non medical support for people with long term conditions
- Risk stratification – an innovation at scale which involves identifying the 8,000 people in Rotherham at most risk of hospital admission.
- Clinical dashboard – a joint innovation with Doncaster CCG to present information to clinicians in a more meaningful way.

**Alignment with H&WB strategy**

Long term conditions is priority 5 of the H&WB Strategy. The outcome is 'Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life'. Rotherham CCG leads this priority for the 'living and working well' life stage and supports its partners in its delivery through the three other life stages. The UCMC has an agreed set of principles that are derived from the H&WBS.

**How will we address health inequalities?**

Much of the £X million we spend in this area is spent caring for people from disadvantaged groups because the JSNA shows that they are the groups who suffer most premature morbidity. Currently most of the CCGs spend is on acute hospital treatment for conditions that have already become emergencies. The case management pilot, the social prescribing pilot, the risk stratification tool, the personalised budgets pilot will all promote earlier intervention, individualised care and self care to help people live and work well. We will use Commissioning for Quality and Innovation (CQUIN) incentives to address health inequalities, including improving services for people presenting to acute hospitals with problems related to alcohol.
The redesign of care pathways will reduce blockages and increase flow through the system and enable more care to be provided at home or close to home. The care co-ordination centre will ensure that vulnerable social get access to appropriate urgent care.

We will carry out equality impact assessments on all polices and procurements

## 5.2 Clinical Referrals

| | |
|---|---|
| **Lead Officer** | **Robin Carlisle via Clinical Referrals Management Committee (CRMC)** |
| **Lead GP** | **Julie Kitlowski** |

**Why are we planning to invest in this area?**

GPs and other community clinicians making referrals to hospital specialists for outpatient opinions and outpatient and in-patient procedures is a major part of how the CCG responds to patients' health needs. The aim is to provide patients with the right care in the right place at the right time.

In 2012/13 RCCG spent £77.7 million on scheduled care. Planned spend for 2013/14 is Y.

**What will we achieve for our investment including efficiencies?**

The CCG will continue its approach based on clinical leadership and peer influence. We will work with GPs and other referring clinicians and providers to ensure that referrals and elective procedures are kept within affordable limits.

In 2012 we made substantial progress, GP referrals and first outpatient appointments have reduced.

Rotherham is a marked outlier in the number of follow up appointments each patient receives over the next two years we will reduce follow up appointments towards national average follow up ratio. This will reduce the number of follow up by 38000 over the next 2 years. Most of these follow ups do not need to be seen at all, some will be managed by telephone and there will be a managed and funded transfer of some follow -ups to General Practice.

Activity trends and plans for first outpatients, follow ups and elective admissions are described in section 7.

**How are we going to achieve our intentions?**

Policies and efficiency programmes for scheduled care are agreed at the fortnightly Clinical Referral Management Committee (CRMC) which is attended by four GPs and TRFTs Medical Director and Chief of Hospital. The CRMC reports to the multiagency QIPP Delivery Group.

Key to the work is effective communication with all clinicians in Rotherham, by face to face meetings, working with GP localities and hospital specialist through the Hospital Management Team and Medical Staff Committee, educational events, monthly newsletters, top tips for important pathways and by providing benchmarking information.

Several of the workstreams particularly those on care pathways interact with unscheduled care and medicines management. The CCG is aware that the care provided to people presenting to A&E or the acute admission ward with problems caused by alcohol mainly addresses immediate needs. We will invest a further £300K in an additional evidenced based service to reduce future demands by addressing the underling causes.

| | Workstream | Project |
|---|---|---|
| 1 | **Benchmarking, trend analysis, and clinical interpretation.** | 1. Regular review of trends in GP referrals, consultant referrals, A&E referrals and other referrals and elective activity.<br>2. Speciality specific discussion of areas identified by benchmarking or changing trends.<br>3. Discussion of consultant referrals, A&E referrals and other referrals |
| 2 | **Two way dialogue with all clinicians on benchmarking, trends and improved care pathways** | 1. GP communication/Education; Bite sized newsletter, SCE newsletter, Protected Learning Time, Top tips/Map of Medicine Guidelines<br>2. Communication within TRFT<br>3. Better information on self care e.g. spinal pathway |
| 3 | **Outpatient follow up reduction programme** | 1. Reduction in Follow ups<br>2. Secondary to primary care Locally Enhanced Service |
| 3 | **Diagnostics** | 1. Reduction in duplicate and inappropriate diagnostic testing |
| 4 | **Care Pathways (with Unscheduled Care Management Committee and Mental Health and Learning Disabilities QIPP Committee)** | 1. Alcohol (with mental health QIPP group)<br>2. Falls (with UCMC)<br>3. Dementia (with Mental health QIPP group)<br>4. COPD<br>5. Cardiology / CVD<br>6. Children's care pathways (including the acutely ill child, fever, asthma and gastroenteritis). |
| 5 | **Safe effective non face to face 'referrals'** | 1. Review of virtual Haematology clinic and consideration of extension to other specialities<br>2. Explore other ways of safe, effective non face to face contacts |

**Quality improvements**

Patient experience will be improved by improving the quality of referral information to consultants and high quality discharge letters back to GPs with advice and management plans.

Alternative ways of getting secondary care opinions such as expanding the current virtual haematology clinic will be more convenient for patients. Moving towards electronic transfer of all communications such as letters and results.

**Innovation**

Key to the success of the workstreams is the involvement of all clinicians who make referrals we will use technology to make it easier for GPs and consultants to communicate with each other including web-based top tips videos, webinars to reduce the need for formal meetings and electronic surveys with survey monkey to get feedback from all clinicians and from patient members of the CCG patient user group.

**Alignment with H&WB strategy**

Quick access to high quality, evidenced based health care interventions are essential to ensure people start, develop, live, work and age well.

**How will we address health inequalities?**

We will reduce unnecessary variation between practices by benchmarking with reference to the burden of diagnosed ill health and carry out dialogue to understand the causes of high and low referral rates and utilisation of diagnostics
We will carry out equality impact assessments on all polices and procurements

## 5.3 Medicines Management

| | |
|---|---|
| **Lead Officer** | **Stuart Lakin via Medicines Management Committee (MMC)** |
| **Lead GP** | **Jason Page** |

**Why are we planning to invest in this area?**

The CCG is responsible for all GP prescriptions issued by its member practices.

These medications are extremely important in relieving patients' symptoms and in many areas such as cardiovascular disease and diabetes, the use of medication can prevent disease progression and prolong life. There are however patients who could benefit from medication who do not receive optimal treatment, some patients receive unnecessary side effects from their treatment and there is considerable waste in the system when patients are issued with medication that they do not take.

The JSNA shows that Rotherham has high levels of premature mortality so prescribing spend has historically been above the national average.

The CCGs track record on effective medicines management is very strong. Cost growth has been below the national average for 5 of the last 6 years and compares favorably to neighboring CCGs with similar demographics.

The Medicines Management Team have for the past four years produced a range of Practice Key Prescribing indicators, these are a range of prescribing interventions proven to reduce mortality and or hospital admissions. Practices are benchmarked against each other and any areas of concern addressed via the annual practice prescribing action plan and practice quality visits.

In 2012/3 the CCG will spend £46.6 million on prescriptions and on commissioned services (Nutrition and continence). We plan to increase this by 2.5% in 2013/14. This is less than the expected drug price inflation so in order to continue increasing benefits to patients the CCG will have to continue to deliver substantial efficiency savings.

**What will we achieve for our investment including efficiencies?**

- To maximise benefits to patients from the appropriate use of medicines, decrease side-effects, increase the cost-efficiency and decrease waste.
- Improve the ability of GPs in Rotherham to react to price changes in the drug tariff allowing savings to be delivered from switch programmes.
- To improve prescribing benchmarking against other CCGs with regard to cost and quality
- To continue to deliver six medicines management service redesign projects that improve services to patients and produce efficiency savings.
- To source an audit tool for the prescribing of "drugs outside tariff" to ensure Rotherham CCG's prescribing is in accordance with NICE and other national guidance

**How are we going to achieve our intentions?**

Medicines management is overseen by the fortnightly Medicines Management Committee (MMC) which is attended by three GPs, a local pharmacist and the CCGs Medicines management team. The MMC reports to the multi-agency QIPP Delivery Group. Joint prescribing agreements with local partners are agreed at the Area Prescribing Committee (APC). Seven medicines management workstreams are listed later in this section, they divide into two overall approaches:

**1 Working with all 36 GP practices.**

An SCE GP and the CCGs medicines team work with all 36 practices to advise on best practice, produce and disseminate guidance, produce benchmarking reports. Quality and efficiency outcomes and good practice are incentivised through the CCG Local Incentive Scheme (LIS). Currently the CCG medicines management receives very positive feedback from member practices and the strength of relationships is resulting in above expected efficiency savings in 2012/3. In 2013/14 the medicines management team will invest in new prescribing information systems (ECLIPSE) to Improve reporting to practices, accurately predict the financial implications of switch programs, and to give immediate notification of price changes.

**2 Specific service re-design projects**

The CCG has six specific prescribing projects where prescribing responsibility has been removed from GPs to either dietitians or nurse led services. Nutritional supplements, specialist food stuffs and continence equipment are now prescribed by specialist services. This has improved the service provision to patients and delivered financial efficiencies. Further work is ongoing with stoma equipment and wound care.

| | Workstream | Project |
|---|---|---|
| 1 | **Cost efficiency programmes** | • **4 specific drug switch schemes** (levetiractam, venflaxine, vitamin D and macrodantin).<br>• **A basket of generic prescriptions:** Making sure that there are no missed opportunities when drugs come off patent.<br>• **Dressings:** Greater compliance with the CCG wound care formulary focusing on independent prescribers |
| 2 | **Performance Benchmarking** | Financial and quality benchmarking against other CCGs and agendas such as national QIPP reports and Antipsychotics in dementia. |
| 3 | **Key Prescribing Indicators** | Monitoring and helping practices to improve performance on a series of 14 evidenced based prescribing interventions. |
| 4 | **Prescribing Guidelines** | Production and review of prescribing guidelines |
| 5 | **RDASH prescribing pathways and share care agreements**. | • Dementia prescribing pathway.<br>• Better prescribing for Attention Deficit Hyperactivity Disorder<br>• Addressing antidepressant prescribing in the community. |
| 6 | **Scoping and reducing waste** | Stakeholders emphasise how much wastage of medicines occurs. We will initiate a new project to reduce this. |

**Quality improvements**

- The Key Prescribing Indicators described above which are evidenced based interventions that improve mortality or reduce hospital admissions. Practices are benchmarked against each other to encourage practices that appear to perform less well to examine the relevant area.
- Improving the quality of each practices prescribing through annual prescribing efficiency plan.
- Monitoring and advising practices on NICE guidance and national safety alerts.
- The stoma service redesign project will improve the patient experience; significant unmet need has been discovered, whilst delivering real and potential cost savings.
- The wound care project will ensure that dressing use is in line with the evidence base. It will also improve the timely access dressings for patients and decrease the time spent by nurses obtaining dressings via prescriptions.
- The nutrition and continence projects will continue to work with their patient service user groups to improve the customer focus of the services.

| Innovation |
|---|
| • The six service re-design projects are award winning examples that have improved service provision and addressed unmet need as well as resulting in substantial cost savings.<br>• The nutritional and continence procurements have created unique commercial partnerships that have released further efficiencies.<br>• Rotherham has an innovative practice budget setting mechanism, that ensures practice prescribing budgets are equitable. This is used by the prescribing incentive scheme to stimulate cost effective prescribing.<br>• Our Key Prescribing Indicators described above. |
| **Alignment with H&WB strategy** |
| • The Key Prescribing Indicators ensure that a patient's chance of receiving a prescribing intervention that is vital in the management of their long term conditions is the same across all Rotherham practices.<br>• The continence service redesign project uncovered a number of patients whose mobility and independence had been compromised due to unsuitable equipment. The project has enabled the CCG to meet this unmet need and improve patients' independence. The stoma redesign project will produce similar outcomes. |
| **How will we address health inequalities?** |
| • The Key Prescribing Performance indicators promote the equal access to key medications that are vital for long term condition management by reducing variations between individual practices.<br>• The service redesign projects ensures that there is equity in the provision of the redesigned services across Rotherham<br>• We will carry out equality impact assessments on all polices and procurements |

## 5.4 Mental Health

| | |
|---|---|
| **Lead Officer** | **Kate Tufnell via Mental Health and Learning Disability QIPP Committee** |
| **Lead GP** | **Russell Brynes** |

| Why are we planning to invest in this area? |
|---|
| One in four adults experience mental illness at some point during their lifetime. Mental ill health is the single largest cause of disability in the UK, contributing up to 22.8% of the total burden, compared to 15.9% for cancer and 16.2% for cardiovascular disease. The JSNA shows that the economic downturn is having an adverse affect on people's mental health. Dementia is a particular challenge with the number of cases predicted to increase by more than 50% by 2025.<br><br>The CCGs largest mental health contract is with Rotherham Doncaster and South Humber Mental Health NHS Trust (RDaSH) (around £30 million for mental health), we also have smaller contracts with Sheffield Care and Social Care Trust (SHSC) and South West Yorkshire Partnership Foundation Trust (SWYPFT). We spent £1.5 million on out of area mental health placements and some of the CCGs Continuing Care costs are for mental health patients. In 2013 mental health providers will be expected to deliver 4% efficiency savings after an inflationary uplift. The CCG will also work with providers to achieve 'commissioner' efficiency savings. This will enable additional investment in improved dementia services and for patients with alcohol related conditions. |

**What will we achieve for our investment including efficiencies?**

- We will invest an additional circa £500K in services for dementia. Key aspects of the CCGs Dementia strategy[5] include:
  - To align our commissioning with those of our partners (RMBC social services and public health)
  - Achieving timely diagnosis and improving the care pathway, including reviewing the use of screening tools prior to referral and reviewing scanner capacity.
  - Investing in an additional acute Mental Health Liaison service – similar services in other areas have improved care and generated savings in acute hospital spend.
  - Improving support to carers
- We will invest circa £300K in an Acute Alcohol Service to provide a seven day a week service offering immediate brief interventions for all patients presenting to TRFT with medical problems related to alcohol. The service would liaise closely with TRFT acute medical services and existing alcohol services provided by GPs and RDASH. Similar services in other areas have improved care and generated efficiencies in acute hospital spend.
- Establish an adult autism diagnosis process.
- We will review the efficiency of all mental health services as part of the work to introduce mental health, payment by results in 2014 and in order to maximise the additional resources that are available for dementia, alcohol services and autism. Key areas for mental health efficiencies are: delivering the dementia strategy as efficiently as possible, reviewing all out of area treatments, joint work between GPs and specialists on referral thresholds and improved discharge planning, estate costs, reviewing the number of beds for learning disability assessment and treatment, and medicines management efficiencies.

**How are we going to achieve our intentions?**

- The CCG will establish a MH & LD QIPP Committee as a new fourth group reporting to the QIPP Delivery Group. This group will be responsible for delivery of the CCG Dementia Strategy and mental health quality and efficiency improvements. A key aspect will be increasing the dialogue between GPs and mental health specialists about efficient care pathways and benchmarking clinical behavior
- Work in partnership with Rotherham Public Health on mental health promotion
- Improve support to carers as part of Rotherham's overall carer strategy put in link
- Improve links with unscheduled care to respond better to the mental health needs of people with long term conditions (especially those on the case management pilot) and to recognise the impact of mental health issues on acute medical admissions.
- Improve the quality and efficiency of medicines management for people with mental health conditions

**Quality improvements**

- Dementia: improve health promotion, diagnosis rates and waiting times
- Reductions in waiting times for adult service psychological therapy services
- Fewer people with mental health problems will be placed in out of area placements.
- More people with long term conditions will have access to psychological services
- People with mental health illness will have equitable access to mainstream services.
- Increase the diagnosis of adults with autism.
- Improved services for recognising and treating depression in older people

**Innovation**

Clinical engagement on pathways and referrals. Being an early adaptor of payment by results for mental health services. Implementing learning from other health communities adult mental health liaison services and acute alcohol services

[5] Add link to Dementia Strategy

| Alignment with H&WB strategy |
|---|
| • **Dependence & Independence -** Rotherham people with mental health illness will increasing identify their own needs and choose solutions that are best suited to their personal circumstances.<br>• **Aspiration & Expectation -** The expectations of Rotherham people with mental health illness will be understood and matched by services that are delivered according to their needs and where they live<br>• **Healthy Lifestyles -** People with mental health illness will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles. |
| **How will we address health inequalities?** |
| • Using the contract process to ensure that providers comply with the Equality Act 2010, Reasonable Adjustment Standards, Autism Statutory requirement etc.<br>• Working with partners to tackle the inequalities that result from poor mental health, such as lower employment rates, poor housing, education and poorer physical health.<br>• Working with primary and secondary providers to raise awareness of learning disabilities and improve their delivery of care. Central to this work will be the promotion of the 'Reasonable adjustment' agenda to enable equitable access to services.<br>• Working in partnership with local authorities and the wider public services to improve the health of the population and tackle inequalities.<br>• We will carry out equality impact assessments on all polices and procurements |

## 5.5 Learning Disabilities

| | |
|---|---|
| **Lead Officer** | **Kate Tufnell** |
| **Lead GP** | **Russell Brynes** |

| Why are we planning to invest in this area? |
|---|
| The CCG has a Partnership Agreement in place with RMBC. People with learning disabilities have higher levels of ill-health and much higher rates of premature death than the population as a whole. It is estimated that people with a learning disability are 58 times more likely to die prematurely. They are more likely to receive poor levels of health treatment as a result of 'diagnostic overshadowing', where people's health needs are overlooked due to focusing on their learning disability. Such health problems typically include respiratory disease, poor oral health, coronary heart disease, sensory impairments, Autism Spectrum Disorder, obesity, epilepsy and mental Illness.<br><br>Although the life expectancy is lower for people with learning difficulties, the number of people living with a learning disability is increased from previous decades, due in part to increased life expectancy, especially among people with Down's Syndrome; the growing numbers of children and young people with complex and multiple disabilities who now survive into adulthood; a sharp rise in the reported numbers of school age children with autistic spectrum disorders, some of whom will have learning disabilities; and greater prevalence among some minority ethnic populations of South Asian origin.<br><br>Recent national publicity on abuse of patients at Winterbourne View near Bristol have highlighted the importance of good quality commissioning for people whose behaviour challenges services, and those with complex needs. Rotherham CCG will work in partnership with RMBC to ensure that good local services are available to support people who challenge services and those with complex needs to prevent the need for expensive, out of area placements.<br><br>For the health element of the Partnership Agreement (£3.3 million) there is NHS Contract in place between RMBC and RDaSH, 2013/14 spend will be is X. |

| What will we achieve for our investment including efficiencies? |
|---|
| • Investment in services for people with learning disabilities will ensure the provision of high quality, cost effective services for people with learning disabilities.<br>• Review and service redesign of Rotherham Assessment and Treatment Unit and community services reducing the number of beds in line with Winterbourne Report recommendations.<br>• Ensure equitable access for people with learning disabilities to mainstream services.<br>• Winterbourne lessons learnt / reduce out of area placement / reduce length of stay in out of area placements. |
| **How are we going to achieve our intentions?** |
| • Undertake a review and redesign of the Rotherham Learning disability in partnership with RMBC, Service users, carers and Provider services.<br>• By working in partnership with RMBC, Public health, TRFT, RDasH, YAS and Primary Care the CCG will promote and implement 'Reasonable adjustment' processes and policies across services. We will work with these providers to gain a greater understanding of the needs of people with learning disability and autism when accessing their services.<br>• Work in partnership with Rotherham Public Health and Primary Care to increase access by people with Learning Disabilities to the Annual Health GP Assessment and preventative screening initiatives. |
| **Quality improvements** |
| • There will be a reduction in the number of admissions to the Assessment and Treatment Unit by providing greater community support to service users and their carers.<br>• More people with a Learning Disability will have equitable access to mainstream services.<br>• More people with a Learning Disability will be supported to live in the community (reduction in out of area placements / length of stay in out of area placements)<br>• More people with a Learning Disability will have access to a wide range of preventative and screening services.<br>• More people with a Learning Disability will have a Health Action Plan (HAP).<br>• More people with a Learning disability will receive an annual health check. |
| **Innovation** |
| Rotherham CCG will work with RMBC, Service users, Carers and Provider Partners to review and redesign Learning Disability Services and in particular the provision of Assessment & Treatment, Community Services and Out of Area placement provision. This work will review good practice from across health care system and will include lesson learnt from the recent Winterbourne Review to develop new models of delivery for Rotherham Learning Disability services. |
| **Alignment with H&WB strategy** |
| • **Dependence & Independence -** Rotherham people with learning disability will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances.<br>• **Aspiration & Expectation -** The expectations of Rotherham people with learning disabilities will be understood and matched by services that are delivered according to their needs and where they live<br>• **Healthy Lifestyles -** People with learning disabilities will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles. |

| How will we address health inequalities? |
|---|
| People with learning disabilities die younger and have poorer health than the general population. We will address this by:<br>• Working with primary and secondary providers to raise awareness of learning disabilities and improve their delivery of care. Central to this work will be the promotion of the 'Reasonable adjustment' agenda to enable equitable access to services.<br>• Improving communication through the development of 'easy read' information and materials, such as 'easy read' questionnaires, menus, disease specific booklets etc.<br>• Ensuring that people with Learning Disability have good access to preventive healthcare (GP Learning Disability annual health check Designated Enhanced Service, screening programmes, Stop Smoking Services, Alcohol services etc) as well as healthcare provision.<br>• Reports, such as *Death by Indifference* and the *Six Lives Progress Report* demonstrate that much still needs to be done in acute services to address inequalities. We will work with Rotherham Public Health to audit deaths of people with Learning Disabilities by a process similar to the existing Child Death review process.<br>• Using the Contractual process to ensure that providers comply with the Equality Act 2010, Reasonable Adjustment Standards, Autism Statutory requirement etc.<br>• We will carry out equality impact assessments on all polices and procurements |

## 5.6 Joint Commissioning with RMBC

| | |
|---|---|
| **Lead Officer** | **Sarah Whittle** |
| **Lead GP** | **Dave Polkinghorn** |

| Why are we planning in invest in this area? |
|---|
| Joint commissioning is where commissioners choose to act together to co-ordinate their actions. This includes acting jointly throughout the commissioning cycle, from shared analysis of need, through all other commissioning stages to the joint review of outcomes. Features of joint commissioning are pooled/aligned budgets, an agreed lead commissioner and integrated provision.<br><br>The CCG has inherited the following pooled budgets and shared grants**:**<br>• Learning Disabilities – Pooled budget £28m (RMBC) £3.3m (RCCG)<br>• Occupational Therapy – Pooled budget £800k (RCCG £400k)<br>• Intermediate Care Services - pooled budgets £3.7m (RCCG £2.5m)<br>• Rotherham Equipments and Wheelchair Service £1.4m (RCCG £1.1m)<br>• Re-ablement grants - £1.6m<br>• Social Care support grants – £4.8m in 2013/14 (a 38% uplift from 12/13)<br>• Child and Adolescent Mental Health – partnership Grant RCCG lead commission £140k<br><br>The CCG will consider joint commissioning in any area where there is clear benefit for the people of Rotherham including areas such as:<br>• a single domiciliary care panel for social care and continuing health care<br>• an integrated approach to management of nursing and residential homes<br>• social prescribing for people with long term conditions<br>• a joint approach to assisted technology |

| Why are we planning to invest in these areas? |
|---|
| • They address the prevention agenda. Early intervention in long term conditions will have a knock on effect to service costs in the future<br>• Joint Commissioning can achieve economies of scale; reduce duplication and achieve efficiencies across all services |
| **What will we achieve for our investment including efficiencies?** |
| • The investments will enable patients to receive the right care in the right place at the right time and are important for the unscheduled care efficiency programmes discussed in section 5.1. |
| **How are we going to achieve our intentions?** |
| **Adults Board**<br>• Joint work programme across Health & Social Care which sets out joint priorities and joint action<br>• Joint funded posts hosted by RMBC<br>**Children and Young People's Partnership**<br>• Children & Young Peoples Plan (see section 5.7)<br>• Think Family Steering Group |
| **Benefits / improvements** |
| • Benefits for clients are that services are joined up, simple to access and with minimal bureaucracy.<br>• Benefits commissioners by efficiencies of scale, avoiding duplication and ensures that commissioning intentions are aligned. |
| **Innovation** |
| **Social prescribing:** The model provides a framework for a third sector contribution to an integrated case management approach to caring for people with long term conditions, with the aim of improving health outcomes and reducing unplanned hospital admissions. |
| **Alignment with H&WB strategy** |
| This H&WB strategy discusses the journey from gathering data, to understanding whether the partners are achieving their goals, which include:<br>• Joint Strategic Needs Assessment: our intelligence<br>• Health and Wellbeing Strategy: our vision and how we will achieve this<br>• Commissioning plans: funding and leadership<br>• Performance management framework: evaluating success.<br>The strategy states that there are obvious benefits from bringing together planning, funding, and delivery of health and social care. This is demonstrated through the publication of three outcome frameworks for the NHS, public health and adult social care. |
| **How will we address health inequalities?** |
| Partnership Working is essential to reduce health inequalities across Rotherham. Through working closely with public health, RMBC and voluntary sector we can support people with Long Term Conditions.<br>e.g. Social prescribing approaches are very suitable for:<br>• vulnerable and at risk groups, for example low-income single mothers, recently bereaved elderly people, people with chronic physical illness, and newly arrived communities<br>• people with mild to moderate depression and anxiety<br>• people with long-term and enduring mental health problems |

## 5.7 Maternity and Children Services

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|---|---|
| **Lead Officer** | **Sarah Whittle** |
| **Lead GP** | **Dave Polkinghorn** |

**Why are we planning to invest in this area?**

Health commissioning for children in 2013/14 will involve close partnership between the CCG, Rotherham Public Health, RMBC and the NHS CB Area Team.

The CCG is formally responsible for commissioning; maternity services, hospital and community services for ill children including services for children with complex health needs, continuing care needs (see section 5.8) and child and adolescent mental health services (CAMHS).

The CCG has important responsibilities to work with partners to safeguard children (discussed further in section 6.6).

The CCG is **not** responsible for the commissioning of:

- General Practice services for children – transferred from NHS Rotherham to NHSCB April 2013
- Health Visiting – transferred from NHS Rotherham to NHSCB April 2013
- Family Nurse Partnership – transferred from NHS Rotherham to NHSCB April 2013
- School Nursing – Transferred from NHS Rotherham to Rotherham Public Health April 2013
- Public Health initiatives e.g. Obesity, Smoking, Breast feeding – transferred from NHS Rotherham to Rotherham Public Health April 2013

Whilst the CCG will not be commissioning the services above, it will work in partnership to enable our partners to meet their objectives.

The CCG invests around £12 million in maternity services and around £17 million in children's services (these figures do not include the children's components of continuing care and CAMHS)

**What will we achieve for our investment including efficiencies?**

**The Acutely Unwell Child/Care Closer to Home**

When children become ill it is a worrying time for parents and carers, especially in the care of children under 5 years. Decisions about which services to access are less clear for children than for adults. Evidence suggests that parents often resort to taking their child to A&E when an alternative level of care was available in a community setting. We aim to support patients to access the right service, first time by educating patients about the acutely unwell child and increasing the capacity in the community nursing teams to support care closer to home. This work is important for both our Unscheduled Care and Clinical Referrals efficiency programmes.

**Maternity services**

Supporting children to get the best start in life is a H&WBS priority. Through the implementation of the maternity tariff we aim to ensure that the money follows the patient across the pathway to ensure the best outcomes for mum and baby. We will work with partners to ensure that maternity services are aligned with health visitor services and with the family nurse partnership.

**CAMHS**

Ensure positive emotional health and well being very early in life can impact on health outcomes, improved aspirations and expectations and increased dependence in later years. Rotherham CCG is committed to ensuring that; staff in commissioned services are trained to deliver psychological therapies to children and young people. Integrated working is developed with third sector providers.

**How are we going to achieve our intentions?**

Rotherham CCG is an active member of the Children and young Peoples partnership. We have recently developed our 'plan on a page', see figure 5.1 below.

The CCG will:

- invest in the paediatric community nurse team to increase capacity in the community to support care closer to home
- work with partner organisations to roll out a core service offer for children 0-5 to ensure children get the best start in life
- The percentage of CAMHS staff accessing safeguarding training is monitored by the contracting performance management process
- Funding has been secured and training for staff in Psychological therapies has been commissioned, in CAMHS and MIND
- Reconfiguration of the child development centre into a community setting

**Quality improvements**

- Continue to improve the transition for children and young people moving from CAMHs to adult services
- Continue to support the A&E initiative that has resulted in children and young people presenting at A&E being seen by a CAMHS clinician within 4 hours 24/7
- Implementation of national service specification for asthma, epilepsy and diabetes raises the quality of care for long term conditions
- The implementation of the maternity tariff will increase the link between payment and quality of care, incentivising best clinical practice and better patient outcomes. The upfront payment means that women can access the most appropriate pathway of care immediately.
- Implementation of the children's key performance indicator (KPI) dashboard will provide assurance that Rotherham families are receiving the care they need.

**Innovation**

Care closer to home will transform the way acute care is delivered in the future. Newly designed care pathways starting in primary care, all the way through community and acute, will ensure that patients are seen in the right place at the right time, by the most appropriate person, reducing unnecessary hospital attendances and improving the patient experience.

To reduce unnecessary A&E attendances by children, we will be innovative in how we educate parents. We will ensure the same messages are delivered by General Practice, midwifery, health visiting, school nursing and the hospital. We will develop a parenting guide for the acutely ill child to aid in these conversations to support behaviour changes.

**Alignment with H&WB strategy**

- Early intervention and Prevention
- Best Start in Life – a child who is healthy, safe and supported, is more likely to learn and thrive.
- A joint initiative that includes MIND will provide children and young people with access to early intervention treatments
- Improved aspirations and expectations, and giving new families the confidence to be good parents

**How will we address health inequalities?**

Our acutely ill child initiative is based on pilot work that we carried out in one of the most deprived areas of Rotherham.

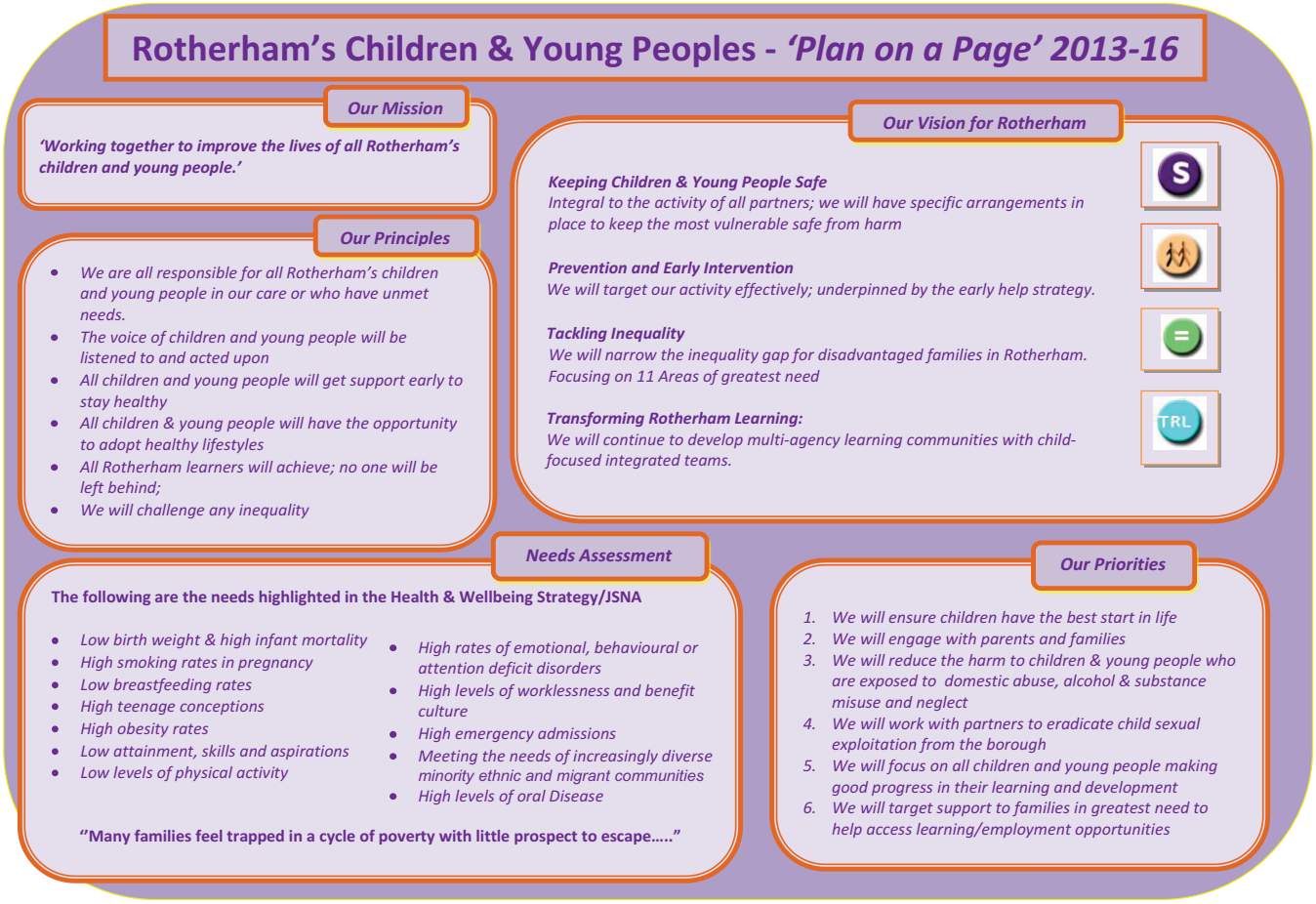
We will carry out equality impact assessments on all polices and procurements.

We will work with TRFT to carry out an equity audit of mothers who book their pregnancies late and work with partners to implement findings.

Partnership working is essential to reduce health inequalities across Rotherham. Through working closely with public health, RMBC and voluntary sector we can support:

- increased breastfeeding rates
- reductions in childhood obesity
- teenage pregnancy
- reductions in infant mortality though a reduction in smoking during and after pregnancy and ensuring the delivery of the safe sleeping policies
- Though working with children centres we can try and improve the number of people accessing courses to support non working families to gain employment and reduce the amount of children living in poverty.

Figure **5.1: Children and Young Peoples 'Plan on a Page'**



## 5.8 Continuing Care and NHS funded nursing care

| | |
|---|---|
| **Lead Officer** | **Sarah Lever** |
| **Lead GP** | **Richard Cullen** |

**Why are we planning to invest in this area?**

The CCG has a statutory obligation to fund care for clients outside hospital with ongoing healthcare needs. Care can be in any setting, including the patients own home or in a nursing home. In domiciliary settings, the NHS pays for healthcare through mainstream services such as community nurse or specialist therapists. In a nursing home, the NHS pays for the care home fees, including board and accommodation.

The CCG supplements care from mainstream community providers with five domicillary care providers. There are 20 nursing homes in Rotherham.

The forecast spend for 2012/13 on Continuing Healthcare (CHC) and funded nursing care (FNC) is £15.4 million. In 2013/14, we expect this to rise to £16 million.

**What will we achieve for our investment including efficiencies?**

High quality, value for money aftercare for patients who meet the criteria for CHC and FNC in their place of choice. Patients will be cared for in the right place at the right time and by the right professional and the need for acute hospital care will be minimised.

**How are we going to achieve our intentions?**

- Assess patients for CHC eligibility in line with the requirements of the national framework for CHC and FNC
- Undertake timely review to ensure that health care packages are commensurate with patients' needs
- Implement the standard contract for care homes to ensure a consistent pricing mechanism and robust performance framework is in place
- Maximise the use of mainstream services in delivering CHC
- Work in partnership with the RMBC, TRFT, Rotherham Hospice, primary care, domiciliary providers, care homes and the voluntary sector
- Continue to commission individualised services for children with complex health needs
- We will pilot the introduction of personal health budgets in 2013/14. This will demonstrate where opportunities for efficiency savings, improvements in quality and choice of care exist.
- The GP case management pilot (section 5.1) will improve the coordination of care for CHC patients ensuring a seamless journey along the pathway for patients

**Quality improvements**

Quality improvements will be driven through robust contracting arrangements. GP case management will improve the care of these patients by ensuring a more coordinated and holistic approach to care. We will engage patients to empower them in reaching decisions about their care: the personalisation agenda will improve self care and give patients ownership of their care.

**Innovation**

By April 2014, the CCG will be required to provide all patients in receipt of CHC a personal budget. This is part of a wider roll out of personal health budgets to all patients with a long term condition. In 2013/14, we will pilot personal health budgets to ensure that care is centred around the needs of the patients and scope for efficiency savings is realised.

| Alignment with H&WB strategy |
|---|
| • The JSNA highlights the changing population demographics and the impact this will have on the number of elderly people with complex care needs: These patients will be eligible for CHC. CHC aims to deliver high quality aftercare for patients in their own home or care home setting.<br>• The personalisation agenda will put recipients of CHC in control of their care and links to the GP care coordination will ensure that opportunities for self care are maximised and the use of alternatives to acute hospital admission maximised. |
| **How will we address health inequalities?** |
| We will ensure that all patients are assessed for CHC in line with the requirements of the National Framework to ensure that care packages are commensurate with need. We will engage hard to reach minority groups to increase awareness of continuing healthcare and the personalisation agenda and to understand their needs and wishes. |

## 5.9 End of Life Care

| | |
|---|---|
| **Lead Officer** | **Kate Tufnell** |
| **Lead GP** | **Russell Brynes** |

| Why are we planning to invest in this area? |
|---|
| Most end of life care (EOLC) is provided by families and by general services such as GPs, community clinicians, hospital clinicians, and continuing care workers working both in patients' homes, residential homes, nursing homes and hospitals. In addition to this the CCG will invest around £2 million in specialist End of Life Care from Rotherham Hospice. This provide a multidisciplinary service for patients with complex problems and provides specialist educational and practical support to other primary and secondary care staff.<br><br>The CCG holds a contract with the Rotherham Hospice for circa £2 million, planned spend for 2013/14 is X. The non-recurrent investment for the two year End of Life Care Project is £750K for 2013/14 and the same for 2013/14. |
| **What will we achieve for our investment including efficiencies?** |
| We will ensure that patients' care is better co-ordinated by improving the quality of conversations with patients who are approaching the end of life, better records, improved case management, including more use of advanced directives and better co-ordinated responses when peoples' conditions deteriorate unexpectedly.<br><br>This will mean that more people will be identified as being in receipt of end of life care, more people will have advanced directives and more people will die in their place of choice. |
| **How are we going to achieve our intentions?** |
| The CCG will invest £750K non-recurrently for the second year of a two year pilot delivered by Rotherham Hospice to provide additional community hospice services and to complete a whole systems review of the current end of life pathway. The pilot will continue to provide additional community EOLC capacity, a 24/7 helpline and reduced hospice bed occupancy so that more people who suddenly deteriorate can have access to the hospice.<br>Two important action plans will be delivered as a result of the pilot:<br>1. A plan to deliver an electronic EOLC register, to enable better case management and communication between patients families and professionals[6].<br>2. A plan to improve communication, care co-ordination, advanced care planning, role clarity and 24/7 access[7]. |

[6] Add link to EOLC register plan

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|---|
| The pilot will be evaluated in September 2013. If the pilot is able to demonstrate savings by reducing unnecessary hospital admissions or by reducing spending on fast track continuing care spend a case will be made for recurrent investment in additional EOLC capacity.<br><br>A key part of successfully improving EOLC is ensuring that EOLC initiatives are integrated with other initiatives for people with long term conditions particularly the case management pilot and the Care Co-ordination Centre described in section 5.1. |
| **Quality improvements** |
| • More patients will have better conversations about the fact that they need End of Life Care<br>• More patients and families will have advanced directives.<br>• Patients care will be better co-ordinated.<br>• More patients will die in the setting of their choice. |
| **Innovation** |
| Improvements to advanced planning, communication and co-ordination between professionals will be delivered by rapidly adapting the learning that has been acquired by the successful Leeds End of Life Care Register project. |
| **Alignment with H&WB strategy** |
| This work is key to the aging and dying well part of the strategy. |
| **How will we address health inequalities?** |
| • Currently there are variations in the quality of EOLC received by patients from different General Practices depending on their practices level of training and capacity. This will begin to be addressed in 2013 by the EOLC community pilot and will need to be addressed in subsequent commissioning plans in the context of learning from the community pilot.<br>• Currently patients with some conditions such as dementia do not always receive EOLC services to the same standard that patients with cancer receive. We will address this by working with all referring clinicians as part of our case management pilot and dementia strategy.<br>• The local Pakistani community has complimented Rotherham Foundation Trust for the work that they have done in 2012 to make their services more attuned to the needs of the Rotherham Muslim community particularly by enabling a responsive service when deaths occur at the weekend. The CCG will work with other community providers to spread the lessons learnt. |

## 5.10 Ambulance and Patient Transport Service

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|---|---|
| **Lead Officer** | **Dominic Blaydon** |
| **Lead GP** | **David Tooth** |

| **Why are we planning to invest in this area?** |
|---|
| The CCG has an emergency ambulance contract with Yorkshire Ambulance Service (YAS). The CCG also has five other contracts for patient transport services:<br>• YAS for outpatient and inpatient activity at TRFT and other acute locations in South Yorkshire<br>• Ambuline for acute activity at Bassetlaw hospital<br>• First4Care for on-day discharge service at TRFT and renal dialysis transport to Bassetlaw<br>• Premier Care Direct for renal dialysis transport to DRI and Montague satellite<br>• City Taxis for renal dialysis transport to Sheffield Teaching Hospitals NHS Foundation Trust (STH) and Heeley satellite |

[7] Add link to plan

An effective ambulance service will;

- Respond quickly to a patient with an urgent health care need
- Provide alternative advice for patients who do not require ambulance transport
- Ensure that the patient is transported to the correct and most cost-effective service for treatment

YAS had the 3rd highest conversion rate for 999 calls in England for 2009/10 and Rotherham also has a high conveyance rate compared to other Commissioners within Yorkshire and the Humber. This means that the outcome of the vast majority of 999 calls are that patients are conveyed to hospital rather than being offered an alternative solution. YAS have introduced a Clinical Hub which triages calls and can redirect to alternative care pathways. However it is recognised that further work is needed in this area.

An effective Patient Transport Service will:

- Ensure that patients are transferred in or out of health services in a timely manner
- Filter out patients who are not housebound and/or can co-ordinate their own transport
- Transport patients to a range of sites for treatment and care

In 2012/13 the CCG expects to spend £6.8m on emergency ambulances and £2.5 million on Patient Transport Services (PTS). In 2013/14 we intend to spend the same amount on ambulance services and to reduce the spend on PTS.

**What will we achieve for our investment including efficiencies?**

The key areas that that the Rotherham CCG will focus on over the next year include;

*Patient Transport*

Rotherham CCG will revisit the eligibility criteria for Patient Transport to ensure that it continues to target those in need. We will work with GPs and other Health professionals to filter out those patients who do not require the service and in so doing deliver significant efficiencies within the contract. We will continue to reduce volumes of patients transported by PTS through rigorous application of eligibility criteria

We will move existing activity from the hospital, extending PTS so that it is able to transport eligible patients to Intermediate Care, Breathing Space, Community Rehabilitation Services, Residential Care and community based outpatient clinics.

We will extend the centralised brokerage service which assesses eligibility and identifies an appropriate provider. The brokerage service is independent of the PTS provider removing the incentive to take patients who do not qualify.

We will explore the potential for an integrated PTS/Community Transport Service to the Badsley Moor Lane Rehabilitation Hub. The Badsley Moor Lane site currently incorporates three rehabilitation services; Breathing Space, Park Rehabilitation Centre and Rotherham Intermediate Care Centre. Each of these services has separate patient transport arrangements delivered by a combination of PTS and RMBC Community Transport. Rotherham CCG will work with RMBC to better integrate transport services onto this site.

*Emergency Ambulance Service*

Rotherham CCG will work with YAS to ensure that patients are triaged effectively at the first point of contact. Patients who do not require an ambulance will be transferred to NHS 111 for support before they are conveyed.

Currently most patients conveyed by ambulance are taken straight to A&E. Protocols are in place to

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| transfer patients to other services such as Breathing Space or Fast Response but these are rarely used. Rotherham CCG will work with YAS to ensure that patients are transported to the most appropriate care setting. We will introduce local performance measures to monitor the use of alternative levels of care. We will develop protocols with the Care Co-ordination Centre so that it can be used by paramedics as a service hub, providing advice and support on the most appropriate level of care. The Care Co-ordination Centre will facilitate referral to Breathing Space, Mental Health Services, Rotherham Hospice, the Community Hospital, Fast Response and Intermediate Care Services. It will ensure that the receiving service is ready to take the patients within agreed timescales. |
| **How are we going to achieve our intentions?** |
| • Rotherham CCG is currently investigating the potential for a more localised system of contract management. Currently the ambulance service is commissioned regionally with NHS Bradford acting as lead commissioner. The PTS contract is managed by NHS Rotherham on behalf of South Yorkshire. The NHS 111 contract will be delivered by YAS but commissioned regionally.<br>This section to be re-written as soon as new commissioning arrangements are clear |
| **Quality improvements** |
| • A broader range of service destinations for patients who required emergency or planned transport into health services<br>• Better access to rehabilitation services at the Badsley Moor Lane Rehabilitation Hub.<br>• Better integration between the ambulance service, primary care and community services |
| **Innovation** |
| • Use of the Care Co-ordination Centre as a Clinical hub providing support on identification of appropriate level of care<br>• The development of an integrated transport service to the Badsley Moor lane Rehabilitation Hub<br>• The development of a hub and spoke approach to PTS, so that it can transport vulnerable patients to a range of sites |
| **Alignment with H&WB strategy** |
| H&WBS priority 3: Dependence to Independence, clear eligibility criteria will encourage patients who are not housebound to utilise alternative transport.<br>H&WBS priority 5: Long-term Conditions, the integrated transport service into the Badsley Moor Lane Hub will enable people to better manage their long-term conditions. |
| **How will we address health inequalities?** |
| Vulnerable groups such as older people will receive a service which is more responsive to their needs. They will not be taken to A&E regardless of their condition but they will receive a proper assessment to enable the most appropriate care pathway to be offered. |

## 5.11 CCG Commissioned Primary Care

| | |
|---|---|
| **Lead Officer** | Chris Edwards |
| **Lead GP** | Ian Turner |

| **Why are we planning to invest in this area?** |
|---|
| Commissioning General Practice is the responsibility of the NHS Commissioning Board but high quality General Practice in Rotherham is essential for the CCG to commission effective hospital services. In section 6.5 we set out how the CCG will work in partnership with the NHSCB Area Team to continue to improve General Practice in Rotherham. In 2013 the NHSCB will commission all GP Directly Enhanced Services, for Locally Enhanced Services some will be commissioned by the NHSCB, some by Rotherham Public Health and some by the CCG.<br><br>Overall the CCG will commission with GPs as providers in four areas: |

1. A Local Incentive Scheme (LIS) to ensure the CCG has GP engagement/member engagement
2. A Secondary to Primary Care Local Enhanced Service (LES) to enable care to be moved to our of a hospital setting and into primary care and deliver our clinical referrals efficiency plan (section 5.2)
3. The Case Management Pilot LES to improve the case management of patients at risk of hospitalisation which is key to our unscheduled care efficiency plan (section 5.1)
4. CCG commissioned LESs with GPs; including anticoagulation, disease modifying agents, acupuncture and cryotherapy. We will review all CCG LESs to ensure they are still fit for purpose.

In 2013/14 spend in this area includes £0.9m for the LIS and £1.3m for the Case Management Pilot, plus funding for the CCG commissioned LESs.

**What will we achieve for our investment including efficiencies?**

- High quality engagement with member practices to enable us to deliver our QIPP plans.
- An agreed funded transfer of some outpatient services from hospital to General Practice
- Better case management of people 'at risk' of hospital admissions

**How are we going to achieve our intentions?**

- We will develop a LIS that maximises GP engagement with the CCG and its QIPP plans
- We will develop LESs that allow patients to be treated in primary care rather than in hospital outpatients
- We will further develop the case management pilot to ensure patients are managed effectively in the community and hospital admissions are avoided
- We will develop plans to resolve clinical human resource issues (e.g. training GPs and nurses) so we can increase resources in primary care
- We will commission services from local optometrist so we can implement better care pathways for patients with cataracts and glaucoma

**Quality Improvements**

- The CCG runs a well regarded programme of Protected Learning Time events aimed mainly at General Practice staff, which as strong involvement of community and secondary care clinicans
- The case management approach will increase the quality of care plans and reduce the number of patients requiring hospitalisation.
- The secondary to primary care LES will allow patients to be treated locally at their GP practice.

**Innovation**

- The case management approach uses the latest risk stratification tool and by involving all sectors it coordinates a whole system approach to managing long term conditions
- The secondary to primary care LES is an innovative scheme that all Rotherham GPs have agreed to participate in
- Personalisation–personal budgets will be used in procuring bespoke care packages for continuing care patients

**Alignment with Health & Well Being Strategy?**

- The case Management approach promotes prevention and early intervention and self care.
- The secondary to primary care is part of an overall approach towards self care

**How will we address health inequalities?**

- Secondary to primary care LES ensures universal coverage of provision
- All LES's will reviewed and decommission or rolled out to ensure universal coverage of provision and to a uniform quality
- Case management approach selects the patients on the basis of clinical need
- We will work with NHSCB to reduce unexplained historical funding variations to GPs so that all practices have equal opportunity to provide the best services to patients.

# 6 Statutory Responsibilities

The CCG is a statutory organisation with 'assumed liberty' from the NHS Commissioning Board. The CCG is required to deliver on three areas: all its statutory responsibilities, the NHS constitution, including rights and pledges, and against relevant areas of the Governments Mandate to the NHS Commissioning Board.

*Everyone Counts*, the 2013/14 planning guidance from the NHS CB is discussed in Section 6.11. The CCG is benchmarked on outcomes against the National Outcomes Framework, which is discussed in Section 11.

The table below sets out lead officers and GPs for each of our statutory responsibilities and the section in which they are discussed.

| Section | Statutory Responsibilities | Lead Officer | Lead GP |
|---|---|---|---|
| 6.1 | Quality Assurance and Quality Improvement of Commissioned Services | Sue Cassin | Phil Birks<br>Russell Brynes |
| 6.2 | Role in GP Quality | | Ian Turner |
| 6.3 | NHS Constitution, CCG Constitution and Governance | Sarah Whittle | Richard Cullen |
| 6.4 | Public Sector Equality Duty | Sarah Whittle | Russell Brynes |
| 6.5 | Public Involvement in CCG and Promotion of Choice | Sue Cassin<br>Lay member - Sue Lockwood | David Polkinghorn |
| 6.6 | Safeguarding | Chris Edwards<br>Sue Cassin | David Polkinghorn<br>Russell Brynes |
| 6.7 | Research and Innovation | Robin Carlisle | Richard Cullen<br>David Polkinghorn |
| 6.8 | Education and Training | Robin Carlisle | Ian Turner |
| 6.9 | Environmental Sustainability | Keely Firth | Richard Cullen |
| 6.10 | Health Inequalities | Robin Carlisle | David Polkinghorn<br>Russell Brynes<br>Phil Birks |
| 6.11 | How we will deliver Mandated Areas | Robin Carlisle | David Tooth |
| 8 | Efficiency | Keely Firth<br>Robin Carlisle | Dave Tooth |
| 9 | Finance | Keely Firth | Richard Cullen |
| 11 | Performance | Robin Carlisle | Dave Tooth |
| 12 | Risk | Robin Carlisle | Richard Cullen |

## 6.1 Quality Assurance and Quality Improvement of Commissioned Services

The CCG's Lead Nurse works with the GPs responsible for acute and mental health contracts to maintain oversight and assurance of all quality issues. Quality assurance of commissioned services is closely linked with GP quality, public involvement with the CCG and safeguarding (sections 6.2, 6.5 and 6.6).

The CCG works with our providers to secure continuous improvements in the quality of services, with particular regard to clinical effectiveness and outcomes, safety and patient experience. This includes ensuring that health services are provided in an integrated way and that provision of health services is integrated with provision of health related or social care services, where it would improve quality of services or reduce inequalities.

As well as working closely with providers the CCG requires assurance from providers, regarding their responsibilities. This is obtained in the following ways:

- Requiring assurance that providers' Cost Improvements Plans (CIPs) have robust quality impact assessments and can be delivered without compromising quality and safety. CIPs are required to be signed by providers' Medical and Nurse Directors and provide a 'line of sight' so that the commissioner is aware of any risks to clinical safety resulting from the requirements to make efficiencies.
- Monthly contract quality meetings with main providers, discussions include: outcomes, experience, hospital mortality rates, CIPs, Commissioning for Quality and Innovation (CQUIN), Serious Incidents, patient safety agenda, Care Quality Commission inspections, audit, safeguarding, and healthcare associate infections.
- Monthly quality reports to both open and closed sections of the CCG Governing Body covering issues, complements, incidents and complaints
- Serious Incidents – monitoring and performance management.
- An agreed programme of 4-6 annual clinically led visits to providers
- Taking part in monthly Senior Nurse walk round programme at TRFT
- Obtaining assurance from providers on the implementation of high impact innovations such as improvements of fluid balance as part of new CQUINS pre-qualification thresholds.
- Working with providers to ensure their Quality Accounts are informative public facing documents and providing formal commissioner commentary for inclusion in the final draft.
- Assurance from contract quality meetings for contracts where Rotherham is not the lead commissioner such as Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Children's NHS Foundation Trust.
- Sharing contract monitoring information with other commissioners to pool intelligence
- The CCG uses a process of appreciative enquiry approach developed to collate evidence relating to quality of commissioned services, gaining assurance, assessing risk and undertaking in depth assessment where appropriate http://websrv.rotherhampct.nhs.uk/?FileID=23060

The CCG seeks additional assurance whenever required. For example in autumn 2012 we have sought assurance following the nationally publicised abuse of patients at the Winterbourne View near Bristol. The CCG is mindful of the implications of the quality failings at Mid Staffordshire Trust

and will implement any additional actions as soon as the second Francis report is published in 2013. It is expected that CCGs will have to develop stronger more effective means of holding all providers of health care to account and be able to demonstrate alongside value for money to the public that services are safe, effective and of a standard that is acceptable to the public, commissioners and inspectorate, this is likely to include a tightening of the evidential trail.

We make full use of Commissioning for Quality and Innovation (CQUIN) incentives. These are additional payments for providers who deliver improvements above the baseline requirements of the NHS Standard Contract. In 2013/14 the maximum value of CQUIN is set at 2.5% of the value of the contract.

To achieve CQUINS providers have to meet pre-qualification requirements of compliance with the national High Impact Innovations: 3 Million Lives & Digital first (see section 11); better services for carers of people with Dementia; Intra-operative Fluid Management; Child in a Chair in a Day; and International & Commercial Activity.

There are four national CQUIN goals (0.5% of contract value): the Friends and Family Test, NHS Safety Thermometer, Dementia and Venous Thromboembolism.

Local CQUINs (2% of contract value) will include: Clinical Communications (Timeliness and quality of discharge and clinic letters, Handover plans); Safeguarding Standards; End of Life Care (EoLC); Reducing Emergency Admissions; Improving Long Term Conditions and Urgent Care Pathways; Respiratory Goals (COPD, Asthma, Community Acquired Pneumonia); Reducing Health Inequalities including identifying people accessing acute services with an underlying alcohol problem.

In section 5 we list quality improvement initiatives in each of the CCGs commissioning areas. These include:

- A programme of six Protected Learning Time events aimed at primary care, with strong input from secondary care clinicians
- Improvement in self care through the personalisation agenda
- Reduction in waiting times for psychological therapy services
- Better meeting the National and Local priorities for health and social care
- More people being able to access treatment locally at their GP practice
- Annual prescribing efficiency plan
- Improving outcomes for babies born to teenage parents
- More people with a learning disability will be supported to live in the community

In Section 6.11 we describe the outcomes that we will monitor to determine the CCGs eligibility for quality premiums.

## 6.2 Role in GP Quality

**CCGs have a statutory duty to assist and support the NHS CB in securing continuous improvement in the quality of primary medical services**

**To complete this section after meetings with the NHSCB in January and decide whether to have a separate section or be part of section 6.4**

## 6.3 NHS Constitution, CCG Constitution, Governance and Authorisation

The CCG abides by the NHS constitution[8] and promotes its awareness among patients, staff and the public. The NHS Constitution establishes the **principles** and **values** of the NHS in England. It sets out **rights** to which patients, public and staff are entitled, and **pledges** which the NHS is committed to achieve, together with **responsibilities** which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

The CCG has a detailed constitution[9] which sets out its governance arrangements, how it complies with the responsibilities of the Health and Social Care Act 2012 and how it is accountable to its members. The constitution covers the responsibilities covered later in this section and requirements such as to maintain an accessible register of interests of its members, to have arrangements to manage conflicts of interest, to publish an annual report and hold annual meetings.

The CCG received formal notification that it has been authorised as a CCG from the 5 of December 2012, with three conditions to be discharged, all of which we fully anticipate to be discharged before the end of March.

Section 6.11 describes the CCGs accountability to the NHS CB in delivering the requirements of the NHS Mandate. Section 11 describes the outcomes the CCG is expected to deliver as part of the NHS Outcomes Framework, this includes the rights and pledges in the 2013/14 NHS constitution and the thresholds the NHS CB will use when assessing CCGs delivery.

## 6.4 Public Sector Equality Duty

The CCG will eliminate discrimination, promote equality of opportunity and foster good relations between people in protected groups and those who do not. This includes having ***'due regard'*** in all that we do. D*ue regard* means thinking about these aims when acting as an employer and when developing, evaluating or reviewing policy and designing, delivering and evaluating services.

The CCG has four equality objectives:

1. Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within Provider contracts.
2. Ensure appropriate and accessible targeted communication with local communities to facilitate improved access and patient experience.
3. Develop consistency of Equality approaches across the South Yorkshire and Bassetlaw Clinical commissioning Groups in respect of equality leadership, staff empowerment and access to development.
4. Demonstrate leadership in advancing the equality agenda internally and with partners and providers to ensure inequalities are addressed within a partnership approach to ensure equity of access experience and outcomes for patients.

[8] Add link to NHS Constitution
[9] Add link to RCCG Constitution

We use the ***NHS Equality Delivery System (EDS)***[10] toolkit to support meeting our duties. We have a contract with SY & B CSU to provide specific dedicated resource to support this area.

## 6.5 Public Involvement, Promotion of Choice and complaints

The CCG will involve and consult with patients and the public in developing our plans and proposals for change. One of the two CCG lay members provides specific oversight on public and patient involvement. Our engagement with the JSNA and the Rotherham's H&WBB are described in sections 4.1 and 4.2. The CCG will work closely with RMBC's Oversight and Scrutiny Committee and with local Healthwatch once it is established. We have established a patients group and a stakeholders group which are described together with our overall approach in our engagement strategy[11] . We describe how the public and other stakeholders were involved in developing this plan in section 13.

The CCG has a duty to promote the involvement of individual patients, their carers and representatives in all decisions that relate to the prevention and diagnosis of illness and treatment. Within the NHS Standard Contracts, there is a requirement to engage, communicate and liaise with services users, carers and guardians in addition to carrying out service user and carer surveys. Providers are required to review the responses from those surveys, identify and implement any actions, and publish the outcomes and actions taken. With respect to patient choice, there is a contractual requirement for providers to make available information about the services it offers to patients through NHS Choices to promote their awareness. This is in addition to publishing all relevant services on Choose and Book so that patients can choose their provider when being referred by their General Practitioner.

The Friends and Family test is an important new survey to identify whether patients would recommend their hospital to those with whom they are closest. Benchmarking information will be available for acute hospital services and A&E in April and for Maternity services October 2013. The CCG will incentivize this via CQUINs (see section 6.1) and it will be used for CCG quality premiums (see section 6.11).

The CCG's approach to dealing with complaints, in line with DH Guidance, is to 'listen, respond and improve'. All feedback is welcomed including complaints about the CCG itself or about our providers services. We will do everything possible to try and resolve complaints. Complaint letters should be addressed to the Chief Officer or the Patient Relations Officer, detailed information about how to make a complaint is available via the link http://www.rotherham.nhs.uk/advice/Concerns-and-complaints.htm

## 6.6 Safeguarding

For **children and young people** the CCG is required to have regard to the need to safeguard and promote the welfare of children; ensure robust governance arrangements are in place and to be active members of the Rotherham Safeguarding Childrens Board. The draft Care and Support Bill sets out comparable requirements with respect to safeguarding **vulnerable adults**, including membership of Safeguarding Adults Boards. For **looked after children (LAC)** it is expected that

[10] Add link to EDS
[11] Add link to engagement strategy

CCGs will inherit the PCTs' responsibilities to provide Looked After Children with healthcare assessments, on placement and annually/bi-annually review thereafter and provide for identified health care. The CCG is expected to inherit responsibilities to work with partners to reduce **domestic abuse**, these include participating in Multiagency Public Protection Arrangements (MAPPA) and Multiagency Risk Assessment Conferences (MARAC).

The CCG is committed to:

- work in partnership with Local Safeguarding Boards
- to ensure that identified clinicians have the seniority and capacity to lead on safeguarding agendas
- to increase the health visiting workforce by 24 by 2015 to ensure that early help is timely
- to delivering the Family Nurse Partnership to support vulnerable families
- monitor health providers work with healthy child programmes and early identification of health needs
- work with central government, partner organisations and RMBC to ensure that LAC receive timely and effective health care. Achieved through active membership of Corporate Parenting Group.
- continue to monitor safeguarding standards in contracts, service specifications and compliance with Section 11 children Act expectations
- by establishing a children's dashboard of performance indicators that include safeguarding across service delivery.

The CCG will produce an Annual Safeguarding Children and Adult report[12] providing assurance that all vulnerable clients in Rotherham are given significant consideration at a senior level and that the safeguarding reassurance is sought from health commissioners and providers and shared with and challenged by partner agencies, namely Rotherham Local Safeguarding Chilldren's Board (RLSCB) and Rotherham Safeguarding Adult's Board (RSAB). Full information of how we will meet our responsibilities is in the CCG's Safeguarding Policy. Lydia put in link

## 6.7 Research and Innovation

High quality research is a core NHS role. The CCG will ensure that it and its providers will meet the treatment costs of government funded and charitable research that is agreed at national level.

The CCG is a member of **South Yorkshire Comprehensive Research Network** to ensure that patients in Rotherham have the opportunity to benefit from high quality research. The CCG will also be a member of South Yorkshire Collaboration for Leadership in Applied Health Research and Care (**SYCLAHRC**). This contributes £10 million to the South Yorkshire Health Economy. The CCG with TRFT manages the Chronic Obstructive pulmonary Disease theme and hosts a CLAHRC researcher. The CCG, with TRFT is a member of **Rotherham Research Alliance**. This promotes health research in Rotherham and manages local governance.

In addition to enabling new research the CCG will implement new innovations where they are proved to be cost effective. This involves seeking out best practice from other organisations and quickly implementing research findings that have demonstrated patient benefit elsewhere. Our delivery groups responsible for areas such as unscheduled care, scheduled care and medicines

[12] The 2011/12 report 2011/2012

management in particular will collaborate with other CCGs and agencies to implement what works elsewhere. The CCG will continue to work with providers to ensure they implement the NHS Institute Six high impact innovations (such as support for people with dementia, better use of technology and improved fluid balance) and will ensure we are assured of progress through CQUIN pre-qualification and through providers quality accounts. The CGG's IT strategy is summarised in section 11 and is informed by Digital by Default. The CCG is considering the benefits of the 3 million lives transformational change but is mindful that our approach starts from a consideration of the needs of individual patient pathways and then considers if technology provides the best solution.

In section 5 we describe specific innovations in each of the areas we commission these include:

- The case management pilot, risk stratification and social prescribing schemes (section 5.1)
- The haematology virtual clinic and the video top tips programme for clinical referrals (section 5. 2)
- The award winning nutrition and continence procurement projects and the set of key prescribing indicators (section 5.3)

## 6.8 Education and Training

The CCG is committed to maintaining the education and training of the NHS workforce. The CCG is represented on the **Yorkshire and Humber Local Education and Training Board** who are charged with ensuring that the planning, commissioning and quality assurance of NHS education and training is aligned with NHS commissioning plans. The CCG ensures that all its providers' contracts stipulate that they carry out their education and training functions. As an employer the CCG is committed to the education and training of its staff, these are co-ordinated via the South Yorkshire and Bassetlaw Commissioning Support Unit (SY&B CSU) and detailed in the CCGs organisational development plan[13] The CCG has developed plans for organisational sustainability and succession planning[14].

## 6.9 Environmental Sustainability

The Social Value Act 2012 requires the CCG to consider how to use its contracts to improve the economic, social and environmental well being of our communities. The CCG is committed to the NHS Carbon reduction scheme and will produce a report for the Governing Body early in 2013 on our environmental sustainability plans. This includes continuing work already in hand to reduce the CCGs direct building related greenhouse gas emissions, business travel and waste going to landfill. In addition the CCG will ensure that all procurements have clauses requiring sustainability actions and all our core providers have sustainability plans in place.

## 6.10 Health Inequalities

Section 4.1 of this plan summarises Rotherham's Joint Strategic Needs Assessment (JSNA) which emphasises the striking degree of health inequality within Rotherham. One part of the JSNA was a specific consultation about health inequalities[15].

[13] Add link to OD Plan
[14] Add link to sustainability and succession plan
[15] Add link to HI

The CCG is committed to working with partners to reduce inequalities. The CCG is a member of **Rotherham Partnership** which has three priorities: helping local people and businesses benefit from a growing economy; ensuring the best start in life for children and families; and supporting the vulnerable within our communities. Two important partnership projects are improving life in parts of the borough that are most deprived and the Families for Change project, which involves working with the 244 families in Rotherham with the most complex needs.

Section 4.2 of this document summarise **Rotherham's Joint Health and Wellbeing Strategy**. Page 5 of the H&WBS lists 34 'big issues' that are being tackled following the JSNA and health inequalities consultation. All of these issues are reasons why Rotherham's health outcomes are lower than the national average such as: smoking rates, obesity rates, and low qualification and skill levels, or are reasons for substantial inequalities within Rotherham such as, meeting the needs of ethnic minorities and addressing gaps in life expectancy between the least and most deprived areas in Rotherham.

The CCG recognises that local supply chains are intrinsically good for the local economy. The CCG also has to comply with stringent procurement regulations, as part of our procurement strategy the CCG will be mindful of local supply chains whenever possible.

The CCG will work in partnership with **Rotherham Public Health** to influence and help implement the boroughs plans for Public Health commissioning. These include important areas such as NHS Health Checks which provides screening for cardiovascular disease and other conditions and services for important causes of inequalities in Rotherham such as smoking, obesity and substance abuse.

The CCG is acutely aware of the inequalities in funding of different General Practices in Rotherham and the potential impact this can have on patients. We will support the **NHS Commissioning Board** as they address this through the implementation of the national single operating model.

In section 5 of this document we describe **our actions to address inequalities** in each of our areas of commissioning responsibility. These include:

- Children: actions on infant mortality (smoking during and after pregnancy and safe sleeping policies), breast feeding and teenage pregnancy.
- Long term conditions: the case management pilot is targeted at the 8000 people who are most at risk of hospital admission. The social prescribing scheme offers non medical interventions to those people with long term conditions who are most in need.
- Hospital Care: we will make us of the Commissioning for Quality Innovation Scheme to incentivise interventions for areas identified in the JSNA such as alcohol, smoking and obesity.
- Mental health: the CCG commitments to prioritising investments in dementia services and services for people presenting with conditions caused by alcohol.
- Learning disabilities ensuring equitable access to services for all condition, working with all providers to be sensitive to the needs on minority populations.
- GP: benchmarking with all practices to reduce unexplained variations in treatment, referrals and admissions.

## 6.11: How we will deliver mandated areas

The Government published its 2013/15 Mandate to the NHS CB in November 2012[16]. The NHS CB published its 2013/14 planning guidance, '*Everyone Counts'* in December 2012[17]. This section gives a brief summary of the implications of the planning guidance and how Rotherham CCG will meet its requirements.

The NHS CB makes 5 offers:

- *NHS Services, seven days a week* (starting with emergency services and diagnostics).
- *More transparency and more choice* (including publishing case mix adjusted outcomes for more specialties).
- *Listening to patients and increasing their participation* (including providers capturing real time feedback from patients and carers, the introduction of the Friends and Family test and the requirement for CCGs to work with H&WBBs and Healthwatch).
- *Better data* (including standard contract sanctions for poor or incomplete data)
- *Higher standards, safer care* ( including: assurance on CCG actions following the Winterbourne View and Mid Staffordshire reports; actions on the Chief Nursing Officer's Compassion in Practice initiative; and medical re-validation, which will be delivered by the NHS CB).

The NHS CB notes there are three inter-related 'lenses' through which planning can be viewed; area based planning through the H&WBB, CCG organisational planning, and direct commissioning by the NHS CB. Rotherham CCG will be held to account by the NHS CB for its areas of direct responsibility, but will work with the NHS CB in the areas of primary care commissioning and specialised commissioning to ensure that care pathways are joined up.

The CCG is required to reduce inequalities (see Section 6.10), obtain appropriate professional advice (see Section 3), ensure public involvement (see Section 6.4), meet its financial duties (see Section 9) and to take account of the Joint HWBS (see Section 4.2).

The CCG is required to provide specific assurance that:

- rights and pledges set out in the NHS constitution will be met in 13/14 (see Section 12),
- performance standards in the NHS CB mandate will be delivered in 13/14 (see Section 12)
- we are assured that providers cost improvement programmes are deliverable without impacting on the quality and safety of patient care (see Section 6.1 ),
- we will meet trajectories for improving the diagnosis rate of dementia and completing the roll of the improving access to psychological therapies programme
- we will meet trajectories set by the NHS CB for health care associated infections. For MRSA there is zero tolerance in 2013/14, for Clostridium difficile a reduction on Rotherham's current low rates is required.

In addition to the specific submitted assurance, *Everyone Counts* stipulates four other improvements; the elimination of long waiting times, improved turn round times for ambulances,

[16] Add link to Government Mandate to NHSCB
[17] Add link to NHSCB Planning guidance 'everyone counts'

penalties in contracts for cancellations and completion of the improving access to psychological therapies rollout.

In 2014 the CCGs will be eligible for a quality premiums payment based on our performance in 2013. It is anticipated the maximum payment will be £5 per head of population (circa £1.3 million for Rotherham). To quality for the payments the CCG must have no significant in-year quality failures, meet the NHS constitution rights and pledges (see section 12) and not overspend its resource limit. In addition the CCG should improve or achieve high standards in seven measures. Four are set by the NHS CB and three to be chosen by the CCG after consideration with key stakeholders including the Health and Wellbeing Board.

The four metrics stipulated by the NHS CB are:

- *Potential years of life* lost from causes considered amenable to healthcare.
- *Avoidable Emergency Admissions*
- The *Friends and Family Test*. An important new patient survey. In April 2013 it will include adult inpatients and A&E attendees, later it will expand to include other categories including outpatients, under 16s and maternity patients. .
- Incidence of *Health Care Acquired Infections* (MRSA & Clostridium Difficile).
- 3 Locally Identified Measures which should focus on outcomes, where local performance is poor when compared to others, and should be agreed after consultation with H&WB Board and key stakeholders.

The CCG has considered possible indicators that could be chosen as local outcomes, bearing in mind the H&WB Strategy, the priorities identified in this plan and the desirability of using metrics that are already collected and for which benchmarking information is available. The CCG is minded to choose three outcomes from the following list of four:

- *Alcohol – Admissions for alcohol related conditions*. This is an area identified in the JSNA and JHWBS and for which the CCG is investing additional resources in this plan.
- *Dementia – Number of people diagnosed.* This is an area identified in the JSNA and JHWBS and for which the CCG is investing additional resources in this plan.
- *Cardiovascular Disease mortality under 75*. This is still a leading cause of premature mortality and is an area where Rotherham has directed substantial efforts over the last decade.
- *Number of people dying outside acute hospitals*. End of life care patients being able to exercise choice over where they are cared for is in the JHWBS and the CCGs is committing resources in this plan.

# 7 Activity

## 7.1 Introduction

This section sets out the draft affordable activity trajectories for Rotherham CCG for the next three years. It is a considerable challenge to keep activity within overall affordable limits whilst maintain high quality services.

Figure 7.1 gives trends for key activities for the previous three years, forecast outturn for 2012/13 and affordable trajectories for the next three years. Trajectories have been approved by the CCGs QIPP groups as providing the best clinical balance between different areas (Figure 7.2)

Later in the section individual trajectories are discussed in detail. Our overall plan is to reduce hospital admissions by providing alternatives including increasing the number of emergency assessments and admissions to alternative levels of care such as Oakwood Community Hospital. The CCG will continue to keep prescribing cost growth below inflation and has an ambitious programme to reduce follow up outpatient appointments by 38,000 per year by 2015/16. This allows outpatient appointments to be kept at 2011/12 levels and for modest growth in firsts outpatient activity.

For both electives and non electives TRFT is the main provider of services to Rotherham CCG patients. Our activity is split between main providers are as follows: non electives; TRFT 84%, DBH 6% STHT 6%: for electives, TRFT 74%, STHT 14% DBH 6%.

## 7.2 Non elective trajectories

Rotherham is an outlier for emergency admissions to hospital. In 2010/11 Emergency admissions per 100,000 in Rotherham were 13% higher than the South Yorkshire and Bassetlaw average and 32% higher than the England average. The CCG's strategy is to reduce emergency admissions through the workstreams described in section 5. Figure 7.3 shows planned reductions of 12% in acute admissions by 2015/16. There will be an increase in emergency assessments and 600 patients a year will have their needs met by the newly established community hospital service.

**Figure 7.1 Changes in Trajectories from Previous Commissioning Plan**

| Activity Type | Actual for Context *(08 / 09) unless otherwise indicated* | Trend - % Change on Previous Year | | | 2012 Plan - Planned % Change | Expected - % Change | 2013 Plan - Cumulative % Change from 2012 / 2013 (FOT) | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 08 / 09 To 09 / 10 Actual | 09 / 10 To 10 / 11 Actual | 10 /11 To 11 / 12 Actual | 11 / 12 To 12 / 13 Plan | 11 / 12 To 12 / 13 (FOT)** | 12 / 13 (FOT) To 13 / 14 Plan | 12 / 13 (FOT) To 14 / 15 Plan | 12 / 13 (FOT) To 15 / 16 Plan |
| Electives | 40814 | 4.4% | -6.8% | 2.3% | -1.2% | -2.3% | 0.0% | 0.0% | 0.0% |
| Non Electives | 30196 | 1.0% | 4.2% | 1.0% | -18.9% | -13.0% | -6.0% | -11.6% | -11.6% |
| Emergency Assessments | New activity type from 2012 / 2013, so FOT provided as number not % change | | | | | 5983 | 11.1% | 21.5% | 21.5% |
| Community | | | | | | It is anticipated 600 patients per year will be admitted to Oakwood Community Hospital as an alternative to admission | | | |
| First Outpatients | 78806 | 7.5% | 2.1% | -3.8% | 1.9% | -6.4% | 0.5% | 1.4% | 1.4% |
| Follow Up Outpatients* | 214126 (11 / 12) | Commentary provided in main body | | | | -3.4% | -15.4% | | -15.4% |
| Pathology Tests | Efficiency plan in 2012 set out a 10% reduction in 2014 / 2015 from 2010 / 2011 | | | | | | | | |
| A&E* | 73848 (09 / 10) | | 1.3% | 0.7% | No 2012 efficiency plan | 0.8% | 0.8% | 1.6% | 1.6% |
| Walk in Centre | 28807 (09 / 10) | | 40.7% | 16.5% | No 2012 efficiency plan | 10.1% | 10.0% | 20.0% | 20.0% |
| Prescribing budget | £39,177,874 | 3.3% | 2.4% | -0.5% | 2.5% | -4.5% | 2.5% | 5.0% | 7.5% |

**Please note these forecast outturns have been derived on a purely pro-rata basis from October year to date data. It is anticipated that levels of elective and outpatient activity will increase in subsequent months and FOT will move closer to the plan for 2012 / 2013.

*Main provider only

**Figure 7.2 Balance between Electives, Non Electives, Assessments and First Out patients**

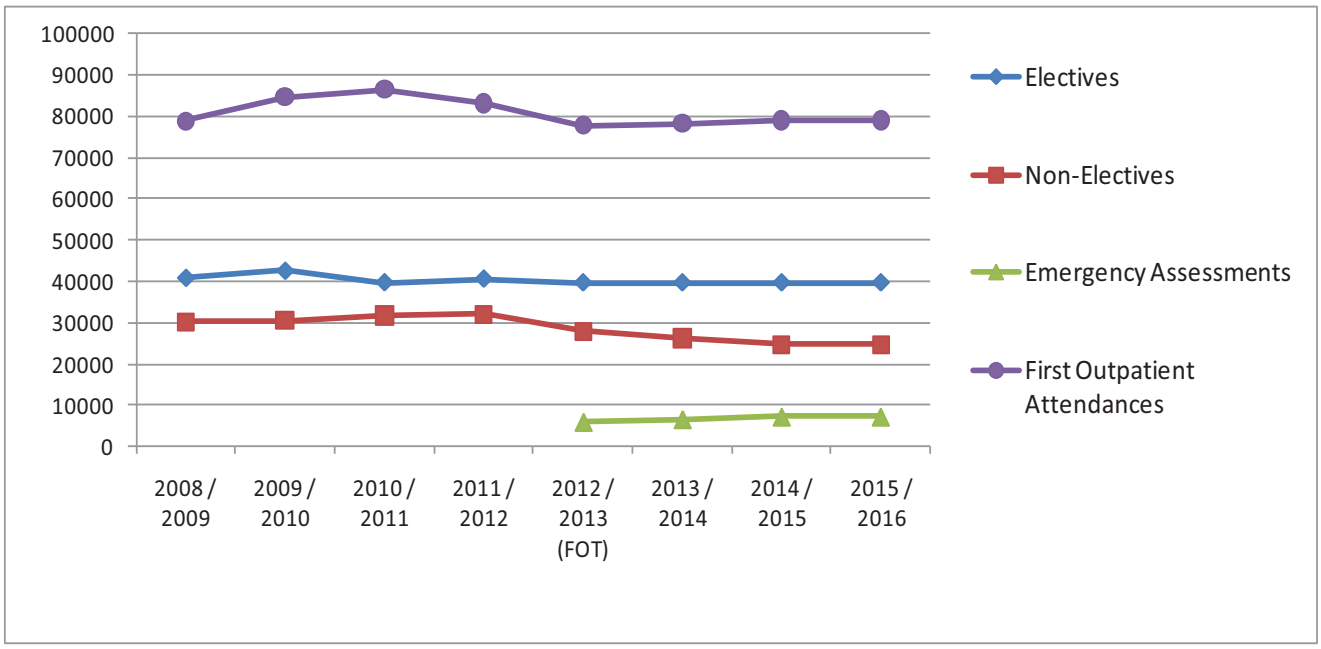
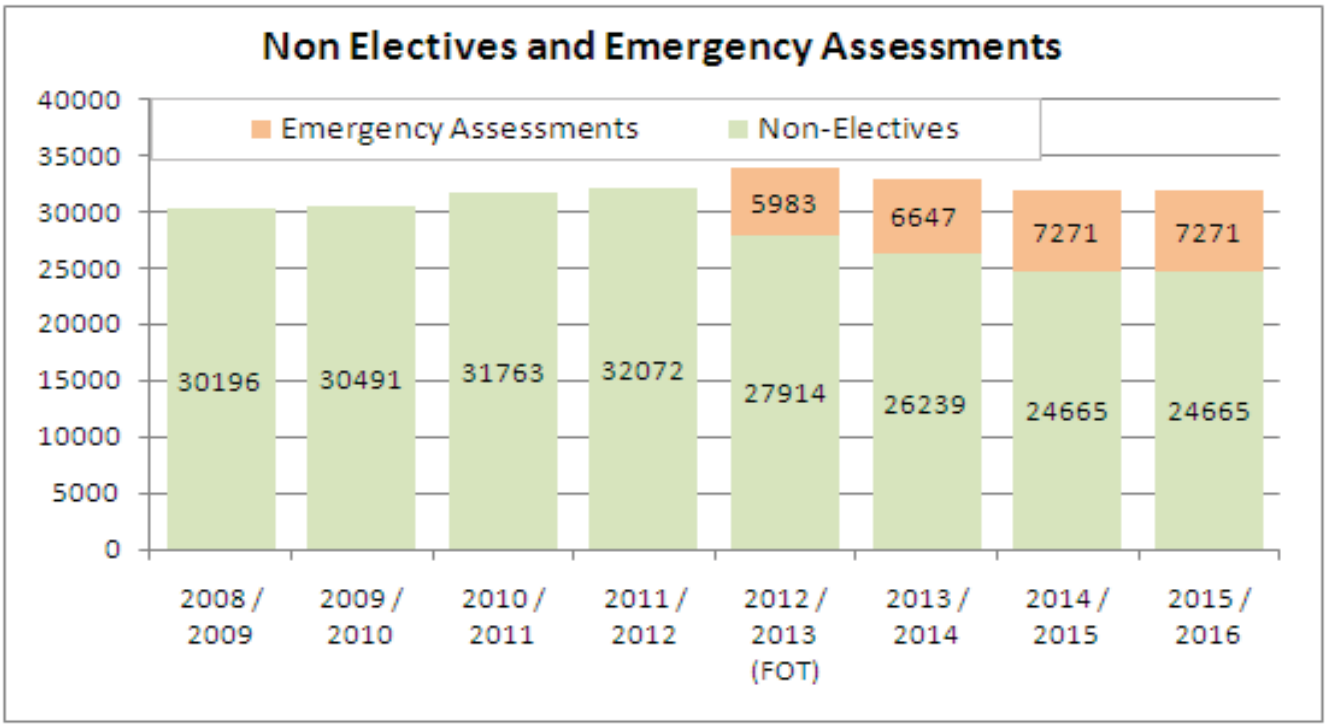


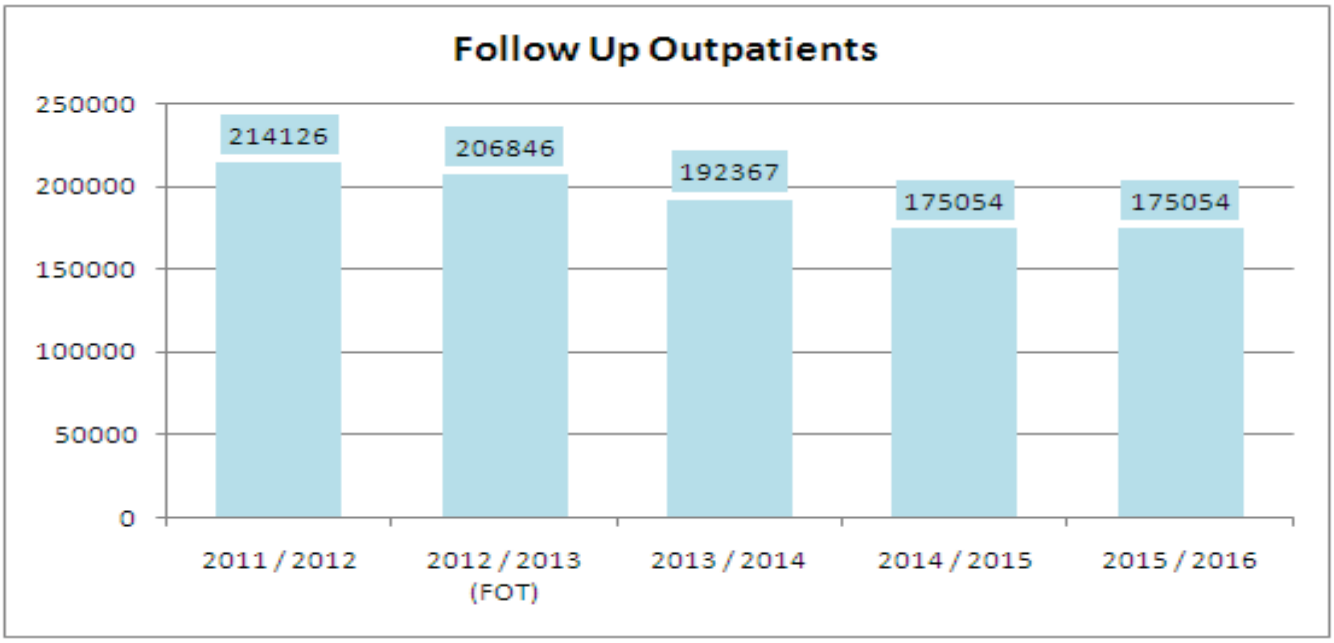

**Figure 7.3 Non electives and emergency assessments**




## 7.3 Follow up activity

CCG follow up appointment ratios are substantially above the national average. Over the next two years we will move towards national averages by making an 18% reduction (38,000 appointments).

**Figure 7.4 Follow up reductions**




## 7.4 Other trajectories

Table 7.1 shows that we plan for a small rise in first outpatients (1.4% over 3 years) and for there to be no change in elective hospital admissions. The CCG is planning to make a 10% reduction in pathology tests over the next three years. The forecast out turn for prescribing costs is very favourable in 2012/13 with considerably more efficiencies being generated than planned. We plan to keep annual cost growth at 2.5% from this favorable outturn figure.

# 8 Efficiency

## 8.1 Introduction

NHS funding is expected to continue to increase each year, however the increased funding will not keep up with the growth in the aging population, rising patient expectations, and the costs of medical technologies. In 2011 the Chief Executive of the NHS set a four year, £20 billion efficiency challenge. This represents the gap between historical rates of cost growth that occurred up to 2011/12 and anticipated funding increases until 2014/15. For all health services in Rotherham, including those commissioned by the NHS Commissioning Board as well as the CCG, the challenge is to make £74.9 million of recurrent savings per year by 2014/15. We are on track to achieve the savings required in 2012/13 but the challenge will become harder each year. The term QIPP (quality, innovation, prevention and productivity) is used to emphasise the fact that it will only be possible to continue to improve quality whilst delivering the necessary productivity challenges if there is substantial innovation and early intervention to prevent problems.

### Shift to Community Care

In line with the CCGs overall belief that home and community care are the best and most efficient method of providing care, our plan sets out a shift over three years of £5 million from acute services to community services.

The CCG is making substantial non-recurrent investments to facilitate the transformation in delivery of unscheduled care and improve management of long term conditions. Providing that non elective activity is kept to affordable limits the additional £5 million of recurrent funding will become available to fund the community care of people with long term conditions. Figure 8.1 below summarises non recurrent investments. Each of these investments will be evaluated and the projects will potentially be re-commissioned recurrently depending on the degree to which they are successful in keeping non-elective admissions to affordable limits.

***Figure 8.1: Non recurrent investments***

| Initiative/Project | 2013/14 £000's |
|---|---|
| Case management pilot | 1,500 |
| Nursing homes pilot | 90 |
| End of life care project | 750 |
| Increased intermediate care community beds (nurse led) | 1000 |
| Increased capacity in fast response | tbc |
| Single point of contact - care enhanced call centre | tbc |
| Enhanced Community Care Services - additional medical and non-medical staff | tbc |
| Paediatrics OOH care | tbc |
| Access to urgent care | tbc |
| Falls care pathway | tbc |
| **Total Costs** | **TBC** |

## Reablement

The activity trajectories that are required to be delivered for QIPP (section 7) are extremely challenging, particularly the absolute reduction in urgent admissions by 2014/15 which will take our non elective expenditure back to 2008/09 levels. This requires a transformation to a system that is less reliant on hospital admission as a solution to most problems. There are two sets of investments that will enable this transformation. The first of these are the non recurrent initiatives set out in figure 8.1, the second are shown in figure 8.2 that sets out the £1.6 million that has been allocated for reablement and discharge support in 2013/14.

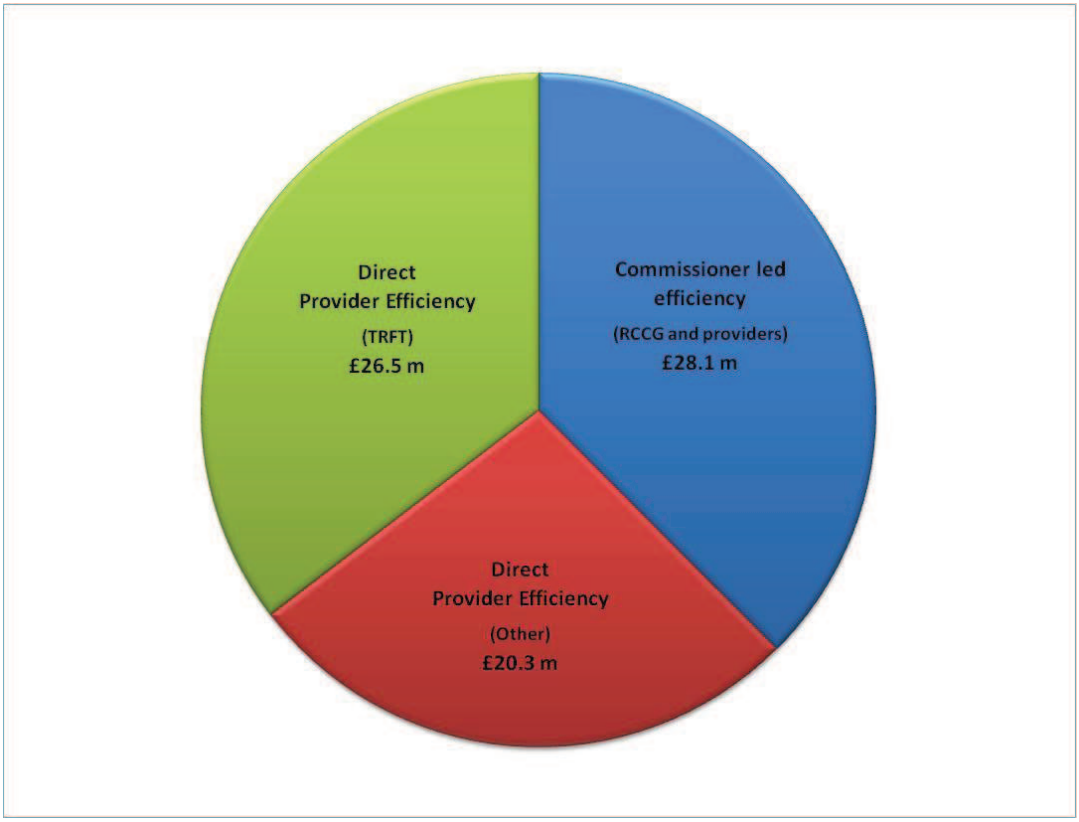
***Figure 8.2: Reablement and discharge support 2013/14***

| Allocations | 2013/14 £000's |
|---|---|
| **Intermediate Care** | |
| Therapy / nursing cover to support vulnerable patients | 170 |
| Increase residential capacity by 8 beds | 228 |
| Therapy and nursing cover for Fast Response Beds | 100 |
| Social work support for the Fast Response Service | 54 |
| Enhanced GP support for Intermediate Care | 30 |
| **Community Stroke Service** | |
| Continuation funding for posts from last year | 150 |
| Continuation of the Stroke Association Service | 50 |
| Social Work Support for Care Pathway | 27 |
| Psychological support for stroke care pathway | 25 |
| **Other Initiatives** | |
| Home Enabling Service | 300 |
| Fast Response Twilight Service | 60 |
| Implementation of Dementia Strategy | 70 |
| Establishment of a Social Work GP pilot | 130 |
| Integrated community neurological conditions service | 151 |
| REWS Urgent Response Service (Pilot) | 35 |
| Voluntary Sector – Otago Exercise Programme | 20 |
| **Total costs** | **£1.6m** |

## 8.2 Provider efficiency savings

All providers are under extreme pressure to deliver their contribution to the £20 billion efficiency challenge; £46 million (62%) of Rotherham's efficiency challenge is passed on directly to providers through tariff. Tariff for services provided by providers is usually uplifted for inflation and is then reduced by 4% to drive efficiency. This means that providers have to become 4% more efficient for every service they provide each year. Figure 8.3 shows the breakdown of the total system efficiency challenges for Rotherham.

**Figure 8.3 Breakdown of £74.9 million Total System Efficiency Challenges for Rotherham 2011/12 – 2014/15**




## 8.3 Commissioner efficiency savings

The CCG is directly responsible for working with providers to achieve the remaining 38% of efficiency savings. Up until 2011 NHS activity such as hospital referrals and admissions tended to rise at around 6% per year. This was affordable given the above inflation increments that the NHS received at that time. The NHS no longer receives above inflation uplifts so GP commissioners need to work with providers and the public to keep referrals and admissions within affordable limits. Keeping elective referrals within affordable limits is an additional challenge to acute providers because it means that they are unable to use growth as a strategy to cope with their efficiency challenges. Payment by results rules mean that acute providers are strongly incentivised to curb rises in non elective admissions because any increases in admissions above a 2008/09 baseline are funded at only 30% of the tariff.

In light of the efficiencies the CCG is required to drive from its providers it is important that every possible efficiency saving has been made from the costs of commissioning. As part of the NHS reforms total commissioning costs for the former PCTs have been reduced by 50%. The running cost of Rotherham CCG is now £6.2 million. Of this £4 million are direct costs and £2.2 million the costs of the Service Level Agreement with South Yorkshire and Bassetlaw Commissioning Support Unit.

## 8.4 Quality Innovation Prevention and Productivity (QIPP)

Until March 2013 commissioners were required to make reports on local progress to delivering the £20 billion national total. It was stipulated that QIPP reports should only cover a proportion of the commissioners areas of responsibilities. Rotherham's QIPP reports covered five areas; unscheduled care, scheduled care, medicines management, specialised commissioning and commissioner management costs. Specialist commissioner efficiencies are now the responsibility of the NHSCB and commissioner running cost efficiencies have been achieved by the 50% reduction in costs between 2011 and 2013.

In 2012 the CCGs had three main efficiency programmes: unscheduled care, scheduled care and medicines management. In 2013 the CCG will drive efficiency savings across its whole portfolio of responsibilities. In addition to the three areas mentioned above there are substantial efficiency challenges in mental health, learning disability and continuing care. In the area of mental health, efficiencies are required as part of build up to the introduction of payments by results in 2014, but also because the health and social care community has to find considerable efficiencies from other areas to address the needs of the increasing numbers of people who will be identified as suffering from dementia. Details of efficiency plans for each commissioning area are set out in section 5. I

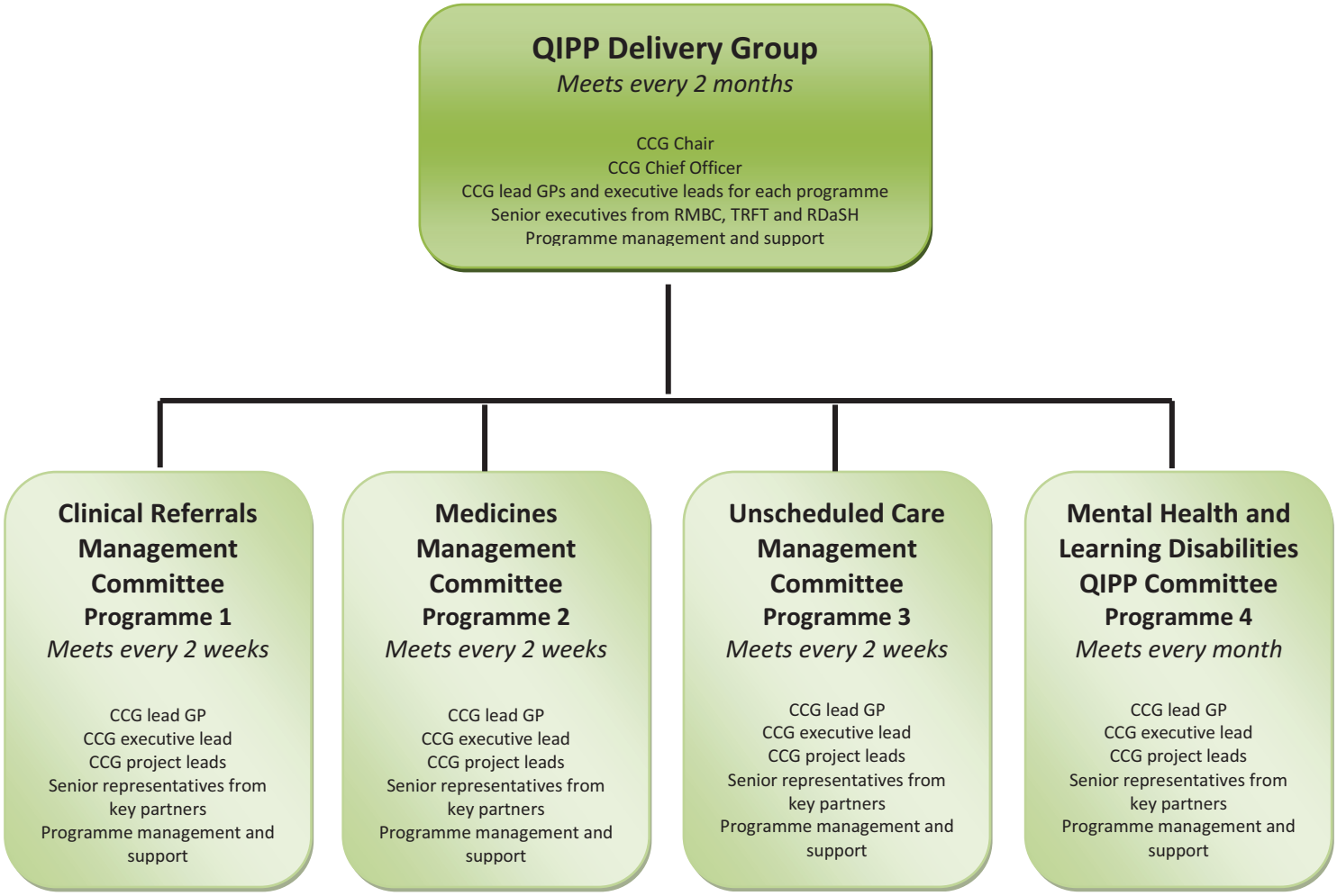
## 8.5 QIPP Governance

The CCG and RMBC together with TRFT and RDASH have an agreement not to de-stabilise partner organisations by introducing efficiency changes without considering and discussing their impact on other partners.

The CCG hosts a multiagency QIPP Delivery Group this meets every two months at chief officer and chief executive level.

In 2012 there were three clinically led delivery groups that met every two weeks with responsibility for the detailed delivery of the QIPP programmes; Unscheduled Care Management Committee, Clinical Referral Management Committee and Medicines Management Committee. From 2013, given the importance of the mental health and dementia agendas we will introduce a fourth meeting, that will meet monthly; the Mental Health and Learning Disabilities QIPP Committee.

*Figure 8.4: QIPP Delivery Structure*



# 9 Finance

The following sets out the assumptions inherent within the recurrent financial plan, highlights the associated risks and gives proposals for the appropriate action.

## 9.1 Financial Planning Assumptions

The financial assumptions are:

- A 2.3% growth in financial allocations in 2013/14 (£7.4m) and increases of 2% in subsequent years.
- The Social Care Grant to the Local Authority has increased by 38% to £4.8m.
- **First outpatients:** we are on plan to achieve the 2013/14 trajectories.
- **Follow-up outpatients:** we are on plan to achieve a 35,000 reduction from 2012/13 to 2014/15 which will progress the activity towards national average ratios.
- **Planned admissions:** we are on plan to achieve the 2013/14 trajectories.
- **Urgent admissions:** the assumption is that the 2014/15 trajectories will be achieved - this includes accelerating the rate of progress made in 12/13
- An additional £5 million recurrent investment is available for additional community services to deliver transformation but will only become available as the efficiency savings from reduced admissions are delivered.
- The costs of continuing care are estimated to rise by £0.6 million in 2013/14.
- The plan assumes that running cost reductions generated throughout 2012/13 will have achieved a recurrent reduction of £1.5 million by 2013/14 and leave the CCG within its required £25 per head limit.
- The plan maintains the 2% recurrent headroom as per the mandate.
- A contingency of £1.6m (0.5%) is built into the baseline.
- Prescribing growth is 5.5% **before** efficiency gains of 3%.
- Tariff rules remain stable from 2013/14 to 2015/16.
- The I&E projection is set out below:-

**The four year I & E is set out below**

| **Income and Expenditure (including non recurrent)** | **2012/13** *CCG Equivalent | **2013/14** | **2014/15** | **2015/16** |
|---|---|---|---|---|
| | **£000** | **£000** | **£000** | **£000** |
| Income | 330,311 | 340,576 | 347,159 | 354,052 |
| Expenditure | 328,111 | 337,285 | 343,687 | 350,512 |
| **Surplus** | **2,200** | **3,291** | **3,472** | **3,541** |

## 9.2 Efficiency Assumptions (QIPP)

a) **System Wide Efficiencies**

| Savings assumed in Financial Plan | 2012/13 | 2013/14 | 2014/15 |
|---|---|---|---|
| | £000 | £000 | £000 |
| **Achievement of system efficiencies:** | | | |
| Prescribing | (1,232) | (1,360) | (1,390) |
| Long term conditions, intermediate care and urgent care | (4,829) | tbc | tbc |
| GP referral management | (3,103) | tbc | tbc |
| Mental Health | | (370) | (400) |
| Specialised services | (211) | 0 | 0 |
| **Corporate Efficiency** | (353) | 0 | 0 |
| **Total** | **(9,728)** | **tbc** | **tbc** |

**NB: Detailed activity and finance information to be provided prior to submission thus totals incomplete**

**b) Provider Efficiency**

There is an additional 4% price reduction inherent in payments to providers through the national tariff. This is not included in this table however it is included in the national QIPP submission.

## 9.3 Risks to Recurrent Balance

1. The drive to reduce clinical referrals growth and unplanned admissions to hospital is reliant upon transformational change across the health community driven by clinical leaders and service providers. If clinical referrals and admissions are not managed within planned levels then cuts across a range of services will be inevitable.

2. Prescribing risks:
   - Shortages in the pharmaceutical supply chain can occur at any time forcing category M prices to suddenly increase.
   - Failure of the community pharmacy contract to deliver the agreed remuneration to pharmacy's can result in an increase in category M prices.
   - NICE guidance can at any time have an adverse effect on cost growth forecasts.
   - Failure to agree therapeutic guidelines with secondary/tertiary care providers

3. Changes to the structure of the tariff could generate (unplanned) financial pressures and the plan is predicated upon reductions in national prices of £1.3%. This saving is a direct efficiency which providers must deliver and is managed through the annual contract.

4. Diagnostic imaging tariffs are to be unbundled from the outpatient tariff which creates a risk. The potential impact of activity and coding increases is partly mitigated in 13/14 through a 50% marginal rate for activity over baseline growth trajectory

5. Continuing care is a high risk area as the impact of the change in criteria is difficult to

assess. The growth assumption of £0.6m per annum may be compromised in the current climate with additional risks from the retrospective caseload.

6. High cost patients are a risk to the plan, both Mental Health and Learning Disability patients can be high cost, and individual funding requests could increase in risk if NICE guidance changes.

7. There is a risk that the funds topsliced from CCG allocations may exceed the actual reductions in contracting obligations.

8. There is a risk that the national changes may have created unquantified financial obligations particularly around specialised services.

## 9.4 Further Actions Required

1. Sustained clinical leadership is required of the four efficiency programmes set out in section 8 (prescribing, mental health, planned care and unscheduled care). Chief amongst these is unscheduled care to realise the potential of GP leadership to lead a system which is less dependent upon hospital admissions (Rotherham wide QIPP leadership structures are show on page 60).

2. Monitoring of other financial risks not including the current efficiency programmes which could impact upon financial balance.

3. The investments to be made non recurrently require clear project management by a lead officer and the evaluation of the outcomes of the investment to quantify the scope for delivering the recurrent efficiency requirements.

4. There are downside scenario plans in place to mitigate the risks inherent within the plan. During 2012 the CCG's Clinical Executive and GP Reference Committee considered a range of scenarios to make additional savings should this ever be necessary. A range of additional actions with timescales and values are worked up and would be implemented if required but the CCG considers these far less preferable than successfully implementing the actions set out in this ACP.

## 9.5 Other Issues

The financial implications of dementia and alcohol plans have been assumed @ £0.5m and £0.3m respectively.

## 9.6 Capital

There is no capital expenditure in 2013/14 due to the asset base transferring to NHS Property Services.

## 9.7 Cash

Cash limits will be achieved and there are no major operational risks to this.

# 10 Workforce and Capacity

The NHS Commissioning workforce in Rotherham has been reduced by 50% over the last two years. The CCG will have total running costs of around £6.2 million which is within the nationally set running cost target. Approximately two thirds of our commissioning support will be provided directly by the CCG's 50 full time equivalent staff whilst further commissioning support will provided by the South Yorkshire and Bassetlaw Commissioning Support Unit, which will supply 11 specific services to the CCG. Reducing commissioning staff by 50% has the advantage of protecting front line clinical staff but does create substantial challenges in terms of delivering commissioning improvements. The CCG will strictly prioritise efforts to the activities in this plan; this means that some potentially worthwhile improvements will not be able to be delivered in 2013/14 and will have to wait until staff time is available.

## Rotherham NHS Foundation Trust

TRFT will continue to reshape its workforce in line with the strategy of the Trust and CCG. There will be changes in job roles for staff as the focus of care shifts away from hospital and closer to patients as possible. It is expected that there will be annual reductions in hospital staff numbers in line with joint efficiency plans to reduce emergency admissions and outpatient follow ups. TRFT will do quality impact assessments on staff reduction programmes and these will be shared with the CCG. The TRFT made changes for seven day week consultant working in December 2012.

## Rotherham, Doncaster and South Humber NHS Foundation Trust

RDaSH expects to maintain overall staff numbers relatively static. There will continue to be shift of resources from inpatient services to community developments, which have off set the planned reductions and allowed for the redeployment of staff. Trust developments, together with TUPE transfers into the organisation from other health organisations, voluntary sector and the Local Authorities suggest an increase in some staff categories and mask the reductions to be achieved through the QIPP plans. Staff groups affected by reductions in staffing numbers include qualified nursing, allied health professionals and therapeutic posts, unqualified support staff, in both clinical and non clinical areas, managerial and administrative functions.

In 2012/13 additional investment has been targeted into Mental Health Intensive Community Therapies, and within Clinical Psychology services increases are anticipated linked to liaison with General Hospitals. The Trust is developing an Advanced Practitioner role in mental health which may have an impact on medical staff below consultant level in approx 2/3 years, but as yet the numbers are not known. Pharmacy services continue to develop with an expanding agenda relating to non medical prescribing.

Learning Disability Services in Rotherham are the subject of a joint review with RMBC to consider a number of options for this service in line with the developing commissioning strategy, and a new service model across the Trust is under consideration based on current national reports and NICE guidance.

# 11 IM&T

The CCG has developed its IT strategy through consultation with GPs, RMBC and providers and agreed it at the multiagency Rotherham IT strategy group. The strategy is needs based rather than technology driven. The priorities were chosen on the basis of electronic voting from Rotherham clinicians deciding the most important ways that effective, affordable, technology could help them with the challenges they face. The strategy group were mindful of the NHS Information Strategy: *The power of information*[18], with its commitments for much more online access for patients to records, appointments, feedback and trusted information services. Note that section 2 of the full strategy gives an overview of the responsibilities of the organisations involved with commissioning GP IT (the CCG, SY&B NHS CB and SY&B CSU). There are eight priorities for delivery:

- **Electronic discharge summaries and clinical letters**
- **Electronic End of Life Care register:** with common, sharable, templates to enable better co-ordination, communication and audit.
- **Summary Care Record:** to enable viewing of summary information from GP records by hospitals, GP Out of hours, the Walk in Centre and GP practices.
- **Text messaging:** to patients from GPs.
- **GP to GP transfers:** more efficient transfer of electronic information between practices when patients move practice.
- **Patient access to GP records:** including the ability to book appointments and order repeat prescriptions. There is a national expectation this will be available for all patients by 2015. The CCG will seek to pilot with interested practices.
- **Electronic prescription service:** all GP practices in Rotherham use compliant systems a pilot will start in February 2013, with planned roll out starting in July.
- **Paperlight GP practices:** working with the 11 Rotherham practices who are not yet paperlight accredited and the 25 who are to, improve their safety and effectiveness.

In addition there are four aspirations areas that we will actively explore and act, either when we are sure the technology gives value for money or when we are sure of there is a strong evidence base to solve problems that Rotherham clinicians are experiencing:

- **Remote working for GPs** this is highly desirable, we will explore its technical feasibility.
- **Portal technology:** this is the ability for health and social care workers to access appropriate patient information from multiple systems when required. The CCG with SY&B CSU will explore systems that are working elsewhere and consider them for Rotherham.
- **Telemedicine and e-referrals:** currently Rotherham has relatively small scale examples of telemedicine (for example stroke management) and e-referral (for example the virtual haematology clinic). The four clinical QIPP groups will keep investigating the potential of technology to help with key clinical challenges. This will include consideration of the Care Co-ordination Centre managing cohorts of people with specific conditions remotely, and participating in the South Yorkshire element of the national 3 million lives telemedicine project.

[18] Add link to NHS Information Strategy

# 12 Performance

## Accountability and outcomes

The Government has set a mandate to the NHS Commissioning Board[19], the NHS CB has published its annual planning guidance, 'Everyone Counts' which stipulates some outcomes the CCG must achieve[20].

**Figure 12.1 NHS CB thresholds for rights and pledges in the NHS Constitution**

| **Referral To Treatment waiting times for non-urgent consultant-led treatment** |
|---|
| Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% |
| Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% |
| Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% |
| **Diagnostic test waiting times** |
| Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral – 99% |
| **A&E waits** |
| Patients should be admitted, transferred or discharged within 4hours of their arrival at an A&E department – 95% |
| **Cancer waits – 2week wait** |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% |
| Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% |
| **Cancer waits – 31 days** |
| Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% |
| Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% |
| Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% |
| Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% |
| **Cancer waits – 62 days** |
| Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% |
| Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% |
| Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set |
| **Category A ambulance calls** |
| Category A calls resulting in an emergency response arriving within 8minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately) |
| Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95% |
| **Mixed Sex Accommodation Breaches** |
| Minimise breaches |

In addition to NHS constitution rights and pledges, the CCG will be expected to deliver trajectories for reducing health care acquired infections (zero tolerance for MRSA and a reduction from Rotherham's already low levels for C Difficile), increasing rates of dementia diagnosis and completing the roll out of the Improving Access to Psychological Therapies programme.

[19] Add link to mandate
[20] Add link to everyone counts

The CCG will be benchmarked against the NHS Outcomes frame work. The NHS CB has published a list of outcomes measures that are available at CCG outcomes level and in December 2012 published outcomes benchmarking support packs for both Rotherham CCG and Rotherham Council[21].

The Rotherham Health and Wellbeing Board will receive reports on joint outcomes. Six areas have been prioritized: dementia, smoking, alcohol, obesity, employment and fuel poverty.

Seven outcomes will be used to determine CCG quality premiums. Four set nationally and three locally (see Section 6.11).

The CCG will also be mindful of the impact of its actions on other performance frameworks applicable to Rotherham such as locally agreed measures for the Health and Wellbeing Strategy, the Public Health Outcomes Framework and the outcomes framework for Social Services (see figure 12.2).

## Performance reporting

SY&B CSU will produce a monthly integrated performance report for the CCG Governing Body that will cover the key elements of; the delivery of efficiency plans, outcome measures, contract management and financial performance. The current performance reports can be seen on the CCG website[22].

There will also be a range of "other" outcomes/standards that are monitored on a monthly basis by the SY&B CSU. Any issues of concern (as identified through the Performance Management Framework) will be reported to the CCG Governing Body.

Performance on quality metrics will be reported to the Governing Body in a separate quality report.
Until June 2013 the performance outcomes monitored, will include outcomes from 12/13 Operating Framework as well as new metrics from the NHS Outcomes Framework and NHS Mandate.

The Planning Guidance issued in December 2012 identifies the NHS Outcomes Measures that will be used by the NHSCB to track progress of CCG's (Table 1). It also identifies the rights and pledges from the NHS Constitution which the NHSCB will use to assess organisational delivery by CCG's (Table 2).

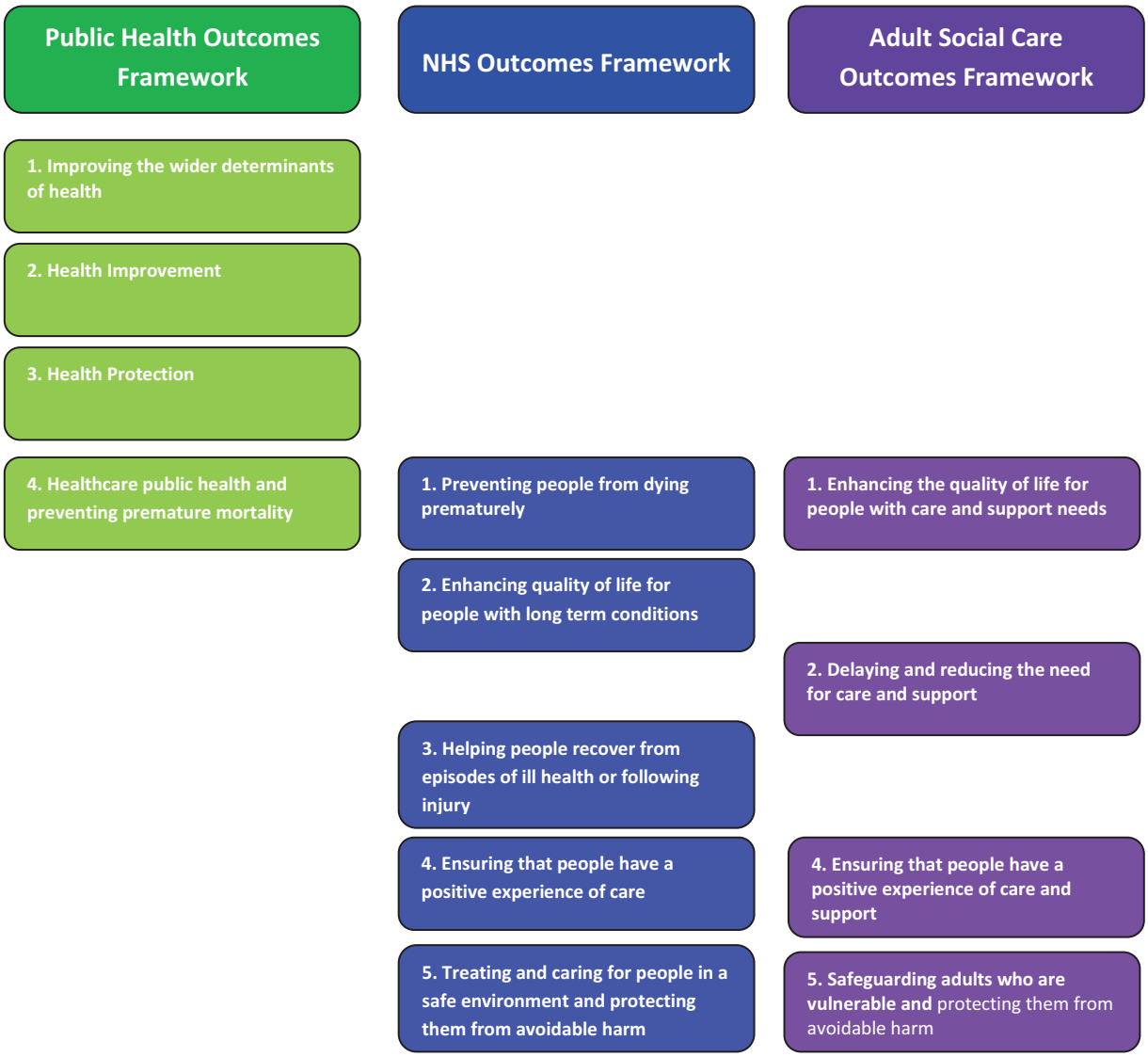
These measures plus any agreed local measures will be incorporated into performance management arrangements for 2013/14.

[21] Add links to benchmarking support packs
[22] Add links to performance reports

## Performance management

The CCG has a performance management framework that sets out its vision, methods of reporting, data quality, partnership arrangements, accountabilities and escalation polices[23]. This performance framework will be reviewed in July 2013 when the performance frameworks of other organisations that affect health in Rotherham will be clear.

***Figure 12.2: the three outcomes frameworks***




[23] Add link to performance management framework

# 13 Risks

Rotherham's JSNA (section 4.1) shows that the number of people with long term conditions, especially dementia, will rise quicker than NHS funding. The current economic downturn will affect peoples' health directly and also cause pressures on partner organisations that will impact on the CCG. Growth in NHS funding will not be sufficient to afford all new technologies unless the CCG successfully delivers its efficiency plans. The CCG is an organisation with new clinical leadership and with 50% lower management costs than previous NHS commissioning organisations. To operate effectively we have to work with partners, this includes developing effective relationships with other new organisations such as the NHS Commissioning Board, South Yorkshire and Bassetlaw Commissioning Support Unit and RMBC Public Health Team. The requirement of 4% year-on-year efficiency will be increasingly difficult for NHS providers to deliver without impacting on clinical quality and safety, ambitious but robust cost improvement plans from our providers will be key (section 6.1).

## Risk Management Framework

The CCG will ensure that the organisation is properly governed in accordance with best practice corporate, clinical and financial governance. The **Integrated Risk Management Policy**[24] gives the CCG a clear view of the risks affecting each area of its activity; how risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of the CCGs objectives. Risks are identified and managed by all teams across the CCG, the CCG **Risk Register**[25] captures all the operational risks to the organisation. If a risk scores in excess of 11 and is 'strategic' then it is escalated to the **Assurance Framework**[26]. The CCG Assurance Framework captures the high strategic potential risks to the organisations strategic objectives. As at November there were 54 entries on our Risk Register, with 15 scoring in excess of 11, and there were 18 entries on our Assurance Framework, with 12 scoring in excess of 11.

**The six highest risks on the CCG Risk Assurance Framework are:**

1. Failure of acute provider Electronic Patient Record System potentially leading to patient harm
2. Failure to deliver efficiency savings in Unscheduled Care
3. Financial viability of our main acute provider
4. Impacts on quality and safety of the cost improvement plans of our key providers
5. Failure to deliver efficiency savings in Planned Care
6. New NHS commissioning organisations not successfully picking up all important responsibilities that were previously NHS Rotherham's .

[24] Add link to Risk Management Policy
[25] Add link to Risk Register
[26] Add link to Assurance Framework

# 14 How we shared our plans

Numerous stakeholders have been engaged in the development of our Annual Commissioning Plan and figure 14.1 below describes the inputs into its development. Feedback from the Rotherham-wide consultation on the H&WB Strategy and feedback from GP members, the GP Reference Committee (GPRC), the Patient Forum and the Stakeholder Forum have been especially important in its development. The consultation table lists some of the meetings and events at which the ACP has been discussed at and the comments received[27][28].

## Input from Joint Strategic Needs Assessment and Health and Wellbeing Board

The JSNA and H&WBS have been the key starting points for our plan. In the 'plan on a page' (page 6) we reference how the CCG's strategic aims are aligned with the strategic aims of the H&WBS.

## Input from GP members, locality groups and GP reference Committee

The consultation table documents the extensive dialogue the CCG executive has had with its member practices in drawing up the strategy. This has been directly from individual GPs, via the 6 monthly all practice commissioning events, from locality groups and from the GPRC. Some of the most important priorities chosen were initially advocated by individual GPs; the proposal for improving services for acute alcohol (section 5.2) was first suggested by an individual GP, the idea to put a major emphasis on emergency admission conversion rates and feedback from the Care Co-ordination Centre came from the GPRC (section 5.1), the dementia strategy (section 5.4) results from a multiagency 'summit' with input from both the GP mental health executive lead and GPRC mental health representative.

## Input from the Patient and Stakeholder Forums

We are very grateful for the feedback given by the patient and stakeholder forums. Participants at these forums have noted how difficult it has been for patients to input meaningfully into this our first strategy within the nationally imposed timetable.

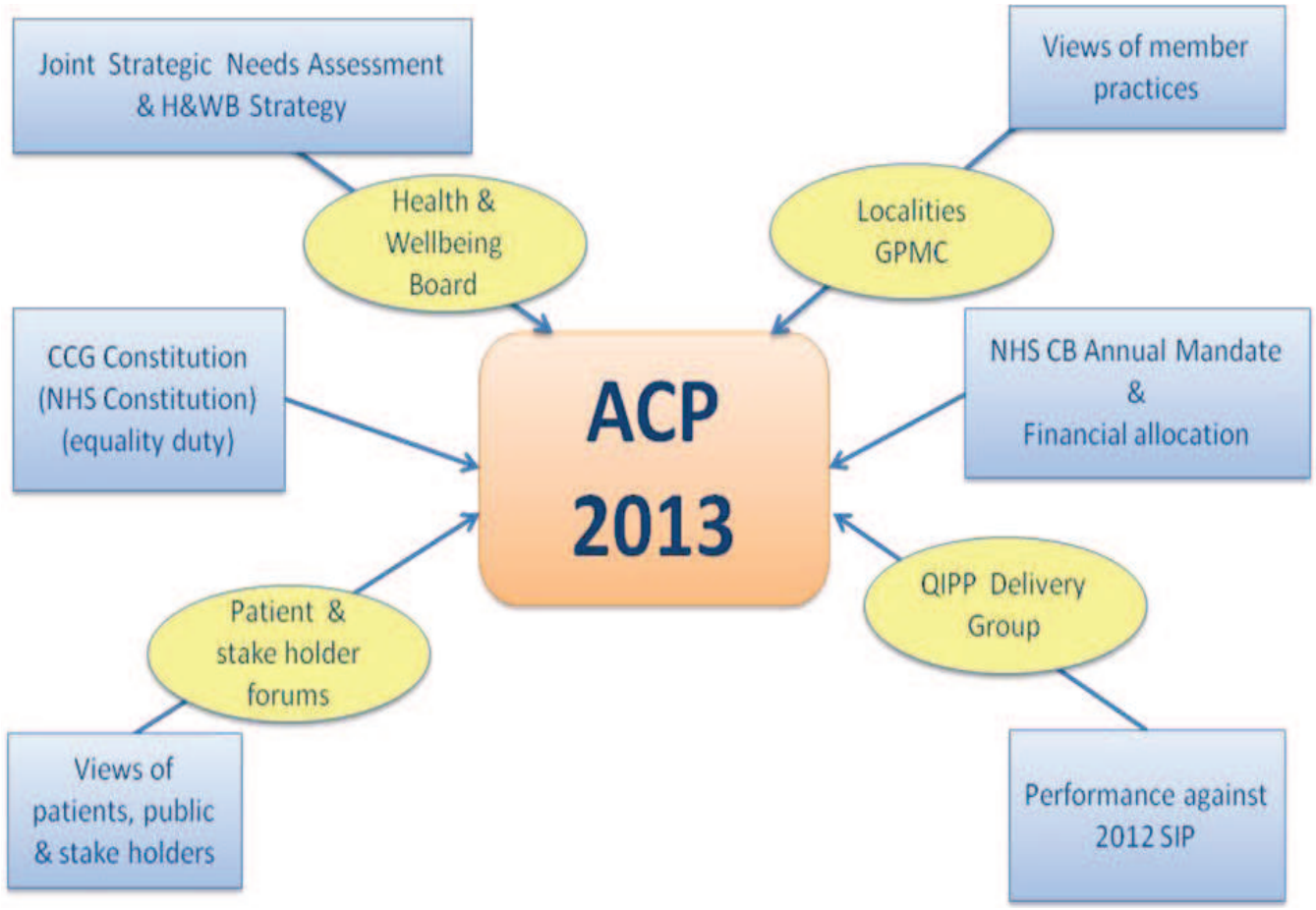
There are substantial challenges in having high quality discussions with public, patients, stakeholders and clinicians:

- the current NHS re-organisation is complicated and confusing to many; it will take time for people to understand the roles and responsibilities of the new organisations
- 'big picture' conversations about the whole of our £340 million portfolio sometimes struggle to do justice to important individual details and concerns
- there are nationally imposed constraints on our planning timetable. We do not receive financial allocations and important payment rules until mid December but our providers require clear intentions from us in time to negotiate contracts well before the 31 March.

[27] Add links to comments documents – up to first draft and after first draft
[28] As above

Although we will have to stick closely to the agreed priorities in this plan during 2013/14, we will be refreshing the plan for subsequent years and we intent to have full dialogue with the public of Rotherham throughout 2013 to develop out 2014 plan. Figure 14.1 summarises the multiple sources of input into the plan.

***Figure 14.1: Inputs into the development of our Annual Commissioning Plan***



# 15 Glossary

| | |
|---|---|
| **ACP** | *Annual commissioning plan* |
| **APC** | *Area Prescribing Committee* |
| **CAMHS** | *Child and Adolescent Mental Health Services* |
| **CCG** | *Clinical Commissioning Group* |
| **CCGCOM** | *A group of the 5 South Yorkshire and Bassetlaw CCGs to commission jointly on agreed areas* |
| **CHC** | *Continuing Health Care* |
| **CIP** | *Cost Improvement Plans* |
| **CRMC** | *Clinical Referrals Management Committee* |
| **CQUIN** | *Commissioning for Quality and Innovation* |
| **DBH** | *Doncaster and Bassetlaw NHS Foundation Trust* |
| **DH** | *Department of Health* |
| **EDS** | *Equality Delivery System* |
| **EOLC** | *End of Life Care* |
| **FNC** | *Free Nursing Care* |
| **GPRC** | *GP Reference Committee (to be re-named GP Members Committee on 1April 2013)* |
| **HAP** | *Health Action Plan* |
| **H&WB** | *Health and Wellbeing Board* |
| **H&WBS** | *Health and Wellbeing Strategy* |
| **JSNA** | *Joint Strategic Needs Assessment* |
| **KPI** | *Key Performance Indicator* |
| **LAC** | *Looked After Children* |
| **LMC** | *Local Medical Committee* |
| **LES** | *Local Enhanced Service* |
| **LIS** | *Local Incentive Scheme* |
| **LTC** | *Long Term Conditions* |
| **MHQC** | *Mental health QIPP Committee* |
| **MIND** | |
| **MMC** | *Medicines Management Committee* |
| **MRSA** | *Methicillin Resistant Staphylococcus Aureus* |
| **NHS CB** | *NHS Commissioning Board* |
| **OE** | *Operational Executive* |
| **PCT** | *Primary Care Trust* |
| **PTS** | *Patient Transport Services* |
| **QIPP** | *Quality, Innovation, Productivity and Prevention* |
| **RDaSH** | *Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust* |
| **RMBC** | *Rotherham Metropolitan Borough Council* |
| **SCE** | *Strategic Clinical Executive* |
| **SHSC** | *Sheffield Care and Social Care Trust* |
| **STH** | *Sheffield Teaching Hospitals NHS Foundation Trust* |
| **SWYPFT** | *South West Yorkshire Partnership Foundation Trust* |
| **SY&B AT** | *South Yorkshire and Bassetlaw Area Team* |
| **SY&B CSU** | *South Yorkshire and Bassetlaw Commissioning Support Unit* |
| **SYCLAHRC** | *South Yorkshire Collaboration for Leadership in Applied Health Research and Care* |
| **TRFT** | *The Rotherham NHS Foundation Trust* |
| **UCMC** | *Unscheduled Care Management Committee* |
| **YAS** | *Yorkshire Ambulance Service* |