

HEALTH AND WELLBEING BOARD

Venue: Town Hall,
The Crofts, Moorgate
Street, Rotherham. S60
2TH

Date: Wednesday, 22nd January, 2014

Time: 9.30 a.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 and Matters Arising (Pages 1 - 5)
4. Communications
5. RMBC Budget - Meeting the Challenge (Pages 6 - 15)
 - Presentation by Pete Hudson, Chief Finance Manager
6. RMBC Commissioning Intentions for Adults and Children's Services (Pages 16 - 21)
 - presentation by Chrissy Wright, Strategic Commissioning Manager
7. Rotherham CCG Plan 2014/2015 (Pages 22 - 111)
 - Robin Carlisle, CCG, to present
8. Better Care Fund (Pages 112 - 123)
 - verbal update from the Task Group
9. Joint Protocol between Health and Wellbeing Board and Children's Safeguarding Board (Pages 124 - 131)
 - Phil Morris, Safeguarding Children and Families to report
10. Date of Next Meeting
 - Special Meeting – Tuesday, 11th February, 2014, commencing at 9.30 a.m.
 - Scheduled Meeting - Wednesday, 19th February, 2014, commencing at 1.00 p.m.

HEALTH AND WELLBEING BOARD
18th December, 2013

Present**Members:-**

| | |
|------------------------|---|
| Councillor Ken Wyatt | Cabinet Member, Health and Wellbeing (In the Chair) |
| Tom Cray | Strategic Director, Neighbourhoods and Adult Services |
| Councillor John Doyle | Cabinet Member, Adult Social Care |
| Chris Edwards | Chief Commissioning Officer, Rotherham CCG |
| Naveen Judah | Healthwatch Rotherham |
| Martin Kimber | Chief Executive, RMBC |
| Councillor Paul Lakin | Cabinet Member, Children, Young People and Families Services |
| Acting CI Paul McCurry | South Yorkshire Police (rep Jason Harwin) |
| Dr. David Polkinghorn | Rotherham CCG |
| Dr. John Radford | Director of Public Health |
| Joyce Thacker | Strategic Director, Children, Young People and Families |

Also in Attendance:-

| | |
|-----------------|--|
| Dr. Gunasekera | Rotherham CCG |
| David Hicks | RFT (rep Louise Barnett) |
| Brian Hughes | NHS England |
| Ian Jerrams | RDASH |
| Gordon Laidlaw | Communications, Rotherham CCG |
| Shona McFarlane | Director of Health and Wellbeing, RMBC |
| Janet Wheatley | VAR |
| Chrissy Wright | Strategic Commissioning Manager, RMBC |

Apologies for absence were submitted by Chris Bain, Louise Barnett, Karl Battersby, Jason Harwin and Tracy Holmes.

S59. MINUTES OF PREVIOUS MEETING AND MATTERS ARISING

Resolved:- That the minutes of the meeting held on 27th November, 2013, be approved as a true record.

Arising from Minute No. S55 (Flu Vaccination Programme), Dr. John Radford reported that he had attended a meeting regarding 2014's Flu Vaccination Programme. The JCVI was proposing that the United Kingdom be the first country in the world to stop the transmission of flu. Over the last 10-15 years flu vaccination uptake in the elderly had been running at 60-70% and 50% in the at risk group. Although best performing country, it was not sufficient to interrupt the transmission. It was proposed to vaccinate all secondary aged children from September-December, 2014.

This would be a logistical challenge in terms of commissioning and delivery across the network.

Arising from Minute No. 56 (Frequency and Format of Meetings), it was noted that the work programme and review would be submitted to the January meeting.

S60. COMMUNICATIONS

(a) Obesity Strategy Group

The minutes of the above Strategy Group, held on 23rd October, 2013, were noted.

(b) Winter Pressures Grant

Correspondence had been received from Sir David Nicholson, Chief Executive, NHS England, with regard to additional Winter Pressures monies that was being made available to the NHS to support effective delivery of Winter Plans. The Rotherham CCG would be receiving £1,228M.

The additional resources should be used to secure resilient delivery of the services to patients through the winter and would involve:-

- Schemes to minimise A&E attendance and hospital admissions
- Improvements to system flow through 7 day working across hospital, community, primary and social care with innovative solutions to tackle delayed discharges
- Specific plans to support high risk groups

It was noted that the Urgent Care Board had met that morning and considered bids submitted by the Local Authority, RFT and the Ambulance Service. All bids had been successful and funding secured.

(c) Yorkshire and the Humber Clinical Senate

An update was provided on the development of the above Senate. In accordance with the national guidance, it would need to provide a broad, strategic view on the totality of healthcare with Yorkshire and the Humber, bringing together experts to understand the impact of any 1 single initiative, or group of initiatives, upon the wider geographical area. The aim was for it to be a well-respected organisation whose judgements were trusted by commissioners who would call upon the Senate on issues ranging from quality standards and inconsistencies, the development of care pathways or reconfiguration proposals.

The Yorkshire and the Humber was following the national proposed structure of a Senate Council and a Senate Assembly; the Council being a core multi-disciplinary group to oversee Senate business, receive objective data/information and co-ordinate the formation of advice and the Assembly being a diverse multi-professional forum providing perspectives, ideas and expert opinions encompassing the birth to death spectrum and providing a source of experts for the Senate Council to draw upon.

Interviews for the Senate Chair had been held on 10th December, 2013 with the successful appointment being announced shortly.

A nursing representative and a clinical commissioner from within South Yorkshire and Bassetlaw was being sought and would be encouraged to apply for a position on the Senate Council.

It was felt that consideration should be given to a South Yorkshire-wide Health and Wellbeing Board meeting be held in 2014 once the Senate was established.

(d) Award

The Chair reported that Rotherham had been listed for an award by a national organisation.

(e) 111 Centre

The Chair reported that he was to visit to the 111 Centre the following day.

S61. JOINT STRATEGIC NEEDS ASSESSMENT - REFRESH

Chrissy Wright, Strategic Commissioning Manager, submitted the final draft of the JSNA Refresh which included sections on user perspective and a Directory of Assets consisting of community assets, physical infrastructure and individuals and met the latest Government guidance on JSNA content

A web-based approach had been adopted – www.rotherham.gov.uk/jsna/site - a presentation of which was given at the meeting. During 2014, as part of the Council's website refresh, the technology would be utilised to improve and enhance the JSNA website including the use of images.

There were 7 main headings, accessed via the tabs along the top of the page – People, Places, Economy, Staying Safe, Healthy Living, Ill Health and Services. In consultation with subject matter experts, analysis of the available information focussed on answering 3 key questions:-

- Why was this an issue?
- What was the local picture and how did we compare?
- What was the trend and what could we predict would happen over time?

This approach would enable the Board to easily identify and prioritise the key current and emerging issues affect health and wellbeing in the Borough.

If approved by the Board, there would then be a period of consultation with stakeholders from 30th December for 6 weeks. Any comments/amendments would be made with the final version submitted to the February Board meeting.

Discussion ensued on the document and the consultation that was to take place with the following issues raised/clarified:-

- Work would take place with the Communications Team with regard to the consultation
- The consultation questions would be appropriate to the audience concerned
- VAR was to help facilitate a consultation session with the voluntary and community sector
- The document needed to illustrate on the issues that now impacted on family life and how the population now presented with more complex needs

Resolved:- (1) That the draft JSNA be approved for consultation.

(2) That the final version be submitted to the February Board meeting.

S62. INTEGRATION TRANSFORMATION FUND

Kate Green, Policy Officer, submitted the proposed Terms of Reference for the Task Group established at Minute No. S53 of the meeting held on 27th November, 2013 and Risk Register.

Brian Hughes, NHS England, reported that the draft guidance was expected the following day containing the funding allocations. It was a very detailed document setting out the expectations of what was now known as the "Better Care Fund".

The proposed Terms of Reference appeared to be in accordance with the guidance.

The completed Better Care template, as an integral part of the CCG's Strategic and Operational Plans, should be submitted to NHS England by 14th February, 2014. They would be aggregated to provide a composite report and any areas identified where it had proved challenging to agree plans for the Fund. The revised version of the Plan should be submitted, as an integral part of the CCG's Strategic and Operational Plans, by 4th April, 2014.

The guidance was not clear as to what happened if the Local Authority and CCG could not agree on the joint plan and who would be the arbitrator.

It was noted that the guidance was very prescriptive in terms of approval and the timeline would be quite challenging.

Resolved:- (1) That a special Board meeting be held in February to approve the joint plan for submission to NHS England.

(2) That the Better Care Fund be included on the agenda for the January meeting.

S63. DATE OF NEXT MEETING

Resolved:- That further meetings of the Health and Wellbeing Board be held as follows:-

Wednesday, 22nd January, 2014, commencing at 9.30 a.m.

Wednesday, 19th February, 2014, commencing at 1.00 p.m.

Wednesday, 26th March, 2014, commencing at 9.30 a.m.

Wednesday, 23rd April, 2014, commencing at 1.00 p.m.

in the Rotherham Town Hall.

Health & Well Being Board

Meeting the Financial Challenge – An overview of the Council’s Budget Process for the 2014/15 Budget and beyond

Pete Hudson – Chief Finance Manager

22nd January 2014

The Financial Challenge

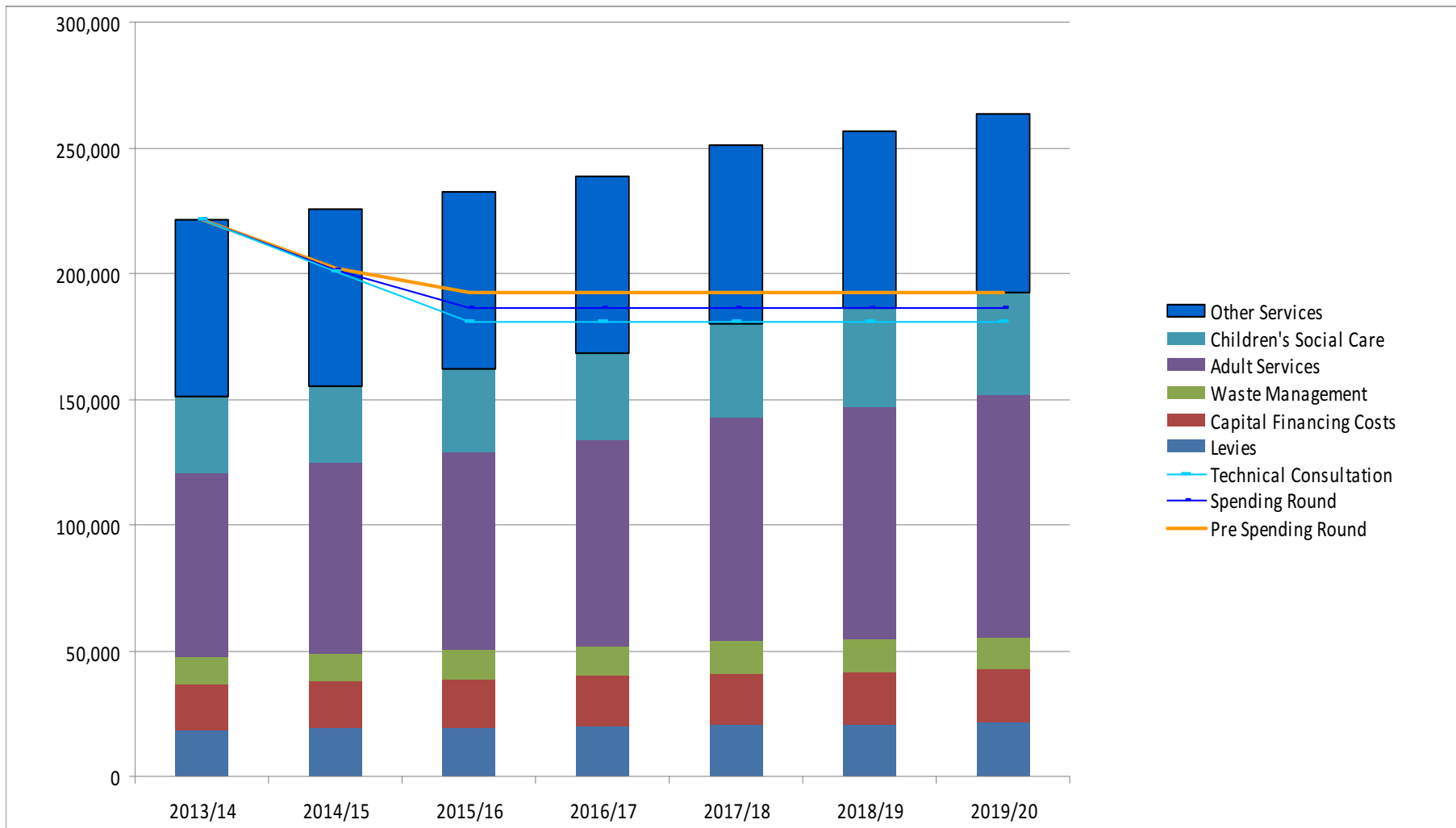
- The scale of financial challenges / risks facing local government is **set to continue at least until 2017 (possibly a decade)**.
- From 2013/14 there has been increased financial risk transferred to local councils through the local government finance and welfare reform changes and restrictions on finances eg CT Referenda.
- Sustainable medium/long term financial planning is **now even more critical!!**

What this means for Rotherham?

Never faced such financial challenges before...

- 2010/11 £5m (emergency budget)
- 2011/12 £30m
- 2012/13 £20m
- 2013/14 £20m
- 2014/15 £23m
- 2015/16 £23m (est)

Rotherham's Graph of Doom



Old Budget Principles

- Our previous Budget Principles served us well in the past, however, in the context of the Government's Finance and Welfare Reform changes a new approach is essential to meet future financial challenges;
 - Our Support Services have been pared to a minimum
 - Staff headcount has been reduced by over 1,000 and management posts reduced by 19%
 - We are a lean Council
 - We can no longer 'salami slice' services

New Budget Principles

The Council's Budget has been developed to:

- Focus on the things most important to local people
- Help people to help themselves wherever possible
- Provide early support to prevent needs becoming more serious
- Shift scarce resources to areas of greatest need, including targeting services and rationing services to a greater extent than at present.

What this means for Rotherham:

- Need to create an Investment Fund to focus on delivering Business Growth
- Not doing everything, providing fewer services directly and supporting more people needing help through forging partnerships with other Public Sector stakeholders, communities, businesses and citizens to help them to do more for themselves.
- Using our limited and shrinking resources to tackle the biggest problems for the most needy, focussing on our 11 most deprived areas, accepting some will need to get less or less frequently.
- Achieving the best quality, safest, most reliable outcome via the most affordable service delivery method.
- Direct provision of service only where we are the cheapest/best quality solution to meet the critical needs of our citizens

Rotherham's 2014/15 Budget Challenge

| | |
|---|---------------|
| Initial Funding Gap in MTFS | £19.1m |
| - June Spending Round adjustments | +1.0m |
| - July Technical Consultation adjustments | +0.4m |
| Additional Pressures: | |
| - New Govt. Announcements (Reduced HB Grant / reduced ESG) | +0.7m |
| - Pensions Triennial Revaluation | +1.5m |
| - Undelivered Savings Target 2013/14 | +0.3m |
| Revised Funding Gap | £23.0m |

Meeting the challenge: Savings Proposals 2014/15

Financial Challenge 2015/16

.... is currently estimated to be £17.5m

ROTHERHAM HEALTH AND WELLBEING BOARD

Adult Social Care & CYPS COMMISSIONING INTENTIONS 2014

The BIG things

Adult Social Care & CYPS

- Early Intervention & Prevention
- Dependence to Independence
- Joint Commissioning & Integration
- Achieving financial efficiencies

Alignment with Health & Wellbeing Strategic Priorities

- 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

ADULT SOCIAL CARE - Priority Activities

- **Early Intervention & Prevention**
 - Growth of CtS
- **Dependence to Independence**
 - Disinvest in residential care placements and invest in community-based services
- **Joint Commissioning & Integration**
 - BCF identify current joint work and opportunities for a pooled budget with alignment with RCCG
- **Achieving financial efficiencies**
 - Delivering the identified savings in the budget matrix

CYPS SOCIAL CARE - Priority Activities

- **Early Intervention & Prevention**
 - partnership with Public Health on breast feeding & smoking cessation in pregnancy
- **Dependence to Independence**
 - Deliver '*Support & Aspiration*' SEND reforms
- **Joint Commissioning & Integration**
 - Building transition into the BCF programme
- **Achieving financial efficiencies**
 - Deliver the strategic transformation intentions e.g., Reconfiguration of Children's Centres

NHS Rotherham Clinical Commissioning Governing Body

Operational Executive – Date

Strategic Clinical Executive – Date

GP Members Committee (GPMC) – Date

Rotherham Health and Well Being Board – 22 Jan 2014

Rotherham CCG 5 year Commissioning Plan

| | |
|-----------------|--|
| Lead Executive: | R Carlisle, Deputy Chief Officer |
| Lead Officer: | L George Planning and Assurance Manager |
| Lead GP: | J Kitlowski, Chair |

Purpose:

For members to endorse the CCG's 5 year commissioning plan prior to submission to NHS England on 14 February.

Background:

Attached is draft two of Rotherham CCG's 5 year commissioning plan.

The CCG has been developing the plan since September 2013, in discussion with member GP practices, other Rotherham commissioners (RMBC and NHS England) and providers of health services in Rotherham (including TRFT and RDASH).

The first draft of the plan was circulated to stakeholders in December and comments are incorporated in this draft.

The CCG is required to submit 4 documents based on this plan to NHS England on 14 February: a five year strategic plan, a two year operational plan, a financial plan and a Better Care Fund plan (previously known as the Integrated Transformation Fund, discussed further on page 20 & 21). NHS England Regional team will provide formal assurance on the five year strategic plan. NHS England's Area team will provide assurance on the operational and financial plans. Assurance on the Better Care Plan will be by ministers, NHS England Area team and the Local Government Association.

On 20 December NHS England published their Planning Guidance, 'Everyone Counts', Financial Allocations and a number of supporting documents.

Generally the planning guidance requires actions which are already well advanced in Rotherham such as urgent care redesign (a 15% decrease in elective admissions), transforming community services, transforming care pathways, GP case management and implementing the lessons on quality from the Francis, Berwick and Winterbourne View reports.

Specific implications of the national planning guidance include:

- Financial implications (see section below)
- The expectation that the CCG's strategic plan will include some details of other commissioners plans for the 'Rotherham unit of planning' (such as NHS England and RMBC Public Health)
- The importance of the Better Care Fund
- An emphasis on 'parity of esteem'. A term introduced in the guidance to ensure that patients with mental health problems receive the same standards of care as patients with physical health problems
- An emphasis on 7 day working
- The encouragement of CCG investment in primary care in addition to NHS England's investment, with a specific commitment to funding around £5/head to support patients aged 75 and above
- The emphasis on CCG actions to reduce premature mortality, avoidable deaths in hospital, health

related quality of life for people with long term conditions and the proportion of people living independently after hospital discharge.

- Reductions in running costs (management costs) for CCGs in 2015/16
- NHS England will publish further guidance in January a Vulnerable patients plan and also a planning tool 'any town', which can be used to model the impact of interventions.

Analysis of key issues and of risks

The second draft is considerable different to the first draft circulated in December, incorporating comments from members, stakeholders and the requirements of the planning guidance.

Members are asked to note in particular the executive summary and plan on a page, this includes a summary of the efficiency challenge facing the health community and a five year vision for health and social services in Rotherham, (page 5).

Substantive changes since the first draft include:

- The mental health section proposes the CCG will commission a fundamental review of CCG commissioning of mental health and learning disability services to ensure we are allocating funds proportionate to need and to ensure that we deliver the outcomes we require including parity of esteem (page 37).
- Revised Quality Innovation Prevention and Productivity (QIPP) structures, with 7 groups reporting to the QIPP Delivery group. In addition there will be a joint CCG and RMBC group responsible for producing reports on the Better Care Fund that will report direct to the Health & Well Being Board (page 74).
- Section 6.11 has been drafted which explains how the CCG meets the detailed requirements set out in the national planning guidance cross referenced to other sections of the commissioning plan (page 68).
- The section on risk has been amended to list the 7 highest risks on the current CCG risk register (page 83).
- More details of how the CCG will work with H&WBB partners to reduce Potential Years of life Lost to conditions amenable to healthcare (PYLL) and to reduce inequalities within Rotherham (page 67 & 68).

Some aspects of the plan are still being be finalised. These include:

- Detailed financial implications (see next section)
- Work is still to choose levels of ambition for outcome measures including those that will be used for CCG quality premiums. These measures include potential years of life lost from conditions amenable to healthcare, quality of life for people with long term conditions (EQ5D in the GP patient survey), reducing the amount of time people spend in hospital, increasing the proportion of people living independently post discharge, improving results from the friends and family test, increasing the number of people having a positive experience outside hospital, making progress to eliminating hospital deaths. Not all of these ambitions have a nationally available metrics yet.
- Work to agree Rotherham’s approach to the Better care fund (requires a separate submission to NHS England).

Financial implications:

The CCG is still working through the financial implications of the planning guidance. The financial allocations raise the possibility there will be some modest funding available for investments in additions to funding created from QIPP savings. In this second draft the sections on activity, efficiency and finance are in outline and in other places in the text financial values are still to be added these will be completed for CCG Members Committee on 29th of Jan and Governing Body on 5 Feb.

Patient, Public and Stakeholder Involvement

Everyone Counts stipulates a completely new approach to ensuring that citizens are fully included in all aspects of service design and patients are fully empowered in their own care.

The CCG discussed and then circulated the first draft of the plan to practice patient group

representatives in December and will discuss again at the 22 January meeting where one of the exercises will be to ask the patient groups to produce their own 5 year visions. Some patient group members have commented on draft one. Others have commented how difficult it is to align meaningful public engagement with NHS England's mandated timetable which releases financial allocations and guidance the week before Christmas to be agreed by all stakeholders by February. As soon as the 2014/15 plan is completed the CCG will produce a plain English version to encourage ongoing conversations with patients and the public about how best to deliver the plan during 14/15 and on ideas for the refresh of the plan in 15/16.

Human Resource Implications:

For the CCG these are covered in section 5.11. In section 4.4 we comment on the 5 year plans of TRFT and RDASH and the substantial efficiency challenges NHS providers face. The final version will have more details on the workforce implications of their plans including any staff reductions and also any areas where there may be difficulties in recruiting staff required to deliver this plan (such as GPs, practice nurses, community nurses and psychiatrists).

Approval history:

The plan has been produced by the CCG clinical and operational executives. GPMC commented on the first draft on 18 December and will receive the final version on 29th January.

Recommendations:

- Health and Well Being Board Members are asked to comment on the plan and endorse CCG officers to make submissions based on the plan to NHS England on 14 February.
- RMBC and NHS England as co-commissioners are asked to confirm that the plan is complementary with their own commissioning plans.
- TRFT and RDASH as substantial providers of health services within Rotherham are asked to confirm that the financial, activity and strategic vision in the plan triangulates with their 5 year organisational plans.

• **First Draft**
please see caveats on page 4

Key:

| | |
|------------------|---------------------------------|
| Add link | add a website link |
| Highlighted text | needs further work or checking. |



Commissioning Plan

2014 – 2019

Draft v2.0

Your life, Your health

Please send any feedback on the plan or any other issue relating to the CCG to:
rotherhamccg@rotherhamccg.nhs.uk



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1 Executive Summary

Introduction to 15 January Draft

This is the second draft of NHS Rotherham CCGs 5 year 2014 Commissioning Plan.

The first draft has been widely circulated to patient groups and stakeholders.

This draft has been amended in light of comments and of national planning guidance 'Everyone Counts' and 2 year financial allocations that were published on 20 December.

The plan will be discussed at CCG Governing Body on 15 Jan, Rotherham Health and Wellbeing Board on 22 January. It will then go for a final round of local agreement at GP Members Committee on 29 January, CCG Governing Body on 5 Feb, and an extraordinary meeting of the Health and Wellbeing Board in early February prior to being submitted to NHS England 14 February

- We apologise to members of the public that this version of our plan tends to be in technical language. This is because the plan has to be delivered to tight nationally set deadlines and needs to be sufficiently precise to be clear about our intentions for NHS providers during the forthcoming contract round. As soon as the final draft has been agreed in February we will produce a plain English version which will be used as part of our ongoing patient and public engagement throughout 2014.
- **Text highlighted in blue** shows where there will be hyperlinks to more detailed documents. The hyperlinks will not be enabled until the final version is submitted to NHS England and posted on the CCG website in February 2014. Please contact us if you wish to see any of the supporting documents in advance
- **Text in yellow are areas that in particular will be revised in subsequent drafts, for example where we are awaiting national guidance**
- In this draft there is no need to feedback on typos or inappropriate use of acronyms, the final draft will be proof read to remove these.
- It would be very helpful to have feedback by 22 January, feedback after that date will also be helpful and consider as we implement our plan throughout 14/15 but we can't guarantee that we will be able to include it in the version of the plan that is approved by our Members Committee.

This is NHS Rotherham Clinical Commissioning Group's (CCG) second Commissioning Plan. It builds on comments made by patients, GP members and stakeholders of our 2013/14 plan. This year for the first time, NHS England has made two year financial allocations therefore the plan gives detailed information on our commissioning intentions for the period from April 2014 to March 2016 as well as continuing to give an outline of our strategy up to March 2019. On page 9 we summarise the CCG's purpose, on page 10 we summarise this plan on a single page, the executive summary expands on the plan on a page.



The box below sets out our **five year vision** for health and social care in Rotherham in 2019.

Plans and services of all commissioners and health and social service providers in Rotherham are prioritised by needs identified in our Joint Strategic Needs Assessment and the six Rotherham Health and Wellbeing Strategic Outcomes:

- Prevention and early intervention
- Expectations and aspiration
- Dependence to independence
- Healthy lifestyle
- Managing long term conditions
- Reducing poverty

They will be underpinned by NHS Rotherham CCG's solutions to the five year £80 million efficiency challenge:

- A stronger patient voice
- Clinical leadership in both primary and secondary care
- Supporting self care
- Delivering care as close to home as possible
- Better use of IT to improve communications
- Improved patient pathways

All local health and social care organisations will address collectively Rotherham's efficiency challenges, being mindful of the overall sustainability of health and social services and the impact of organisations on each others. The five year commissioning plans of NHS England, NHS Rotherham CCG, Rotherham Metropolitan Borough Council (RMBC) and Rotherham Doncaster and South Humber NHS Foundation Trust's (RDaSH) will all be aligned to maximise the use of the Rotherham public sector pound. We will prioritise delivery of these plans through the CCG led Rotherham system Quality Innovation Productivity and Prevention (QIPP) Delivery Group which feeds in to the Health and Wellbeing Board and individual organisations.

Patient outcomes, including safety and experience, will govern all that we do. Providing the right care in right place will mean that more people will receive care closer to their home. Some specialised services will have to be provided at a scale that makes them safe. This necessitates close collaboration with specialised providers outside Rotherham. Patients will receive diagnostic tests quicker so they will spend less time in hospitals. Better care pathways will mean that patients move smoothly between; supported self care, primary care, social care, community services, acute and mental health hospital care and specialised services.

Key measures of successful outcomes will include:

- additional years of life
- health related quality of life
- reduced avoidable time in hospital
- increase proportion of people living independently
- improved reported experience of care (Friends and Family Test hospital and GP)
- decreased avoidable deaths in hospital.



The health service, in common with the rest of the public sector, faces a major efficiency challenge, summarised below.

The Health Service Efficiency Challenge

Like all of the public sector the health sector faces a substantial efficiency challenge of £30 billion for the NHS overall over the next five years. NHS Rotherham CCG's share of this challenge is around **£80 million**.

It is very important that all our stakeholders understand the components of this challenge. In Health Service jargon efficiency is usually called QIPP (Quality, Innovation, Productivity and Prevention). QIPP has two components:

Provider QIPP: *efficiencies passed on to all providers.* For the last three years and for the foreseeable future, providers have been expected to provide the same services with less funding. For example in 2014/15 providers will be given a 2.1% uplift in funding but are then expected to make 4% funding efficiencies. This means they will receive 1.9% less in absolute terms for providing the same services. When QIPP was introduced in 2011 finding the first 4% efficiency saving was relatively straightforward, but finding each additional 4% efficiency every year is increasingly challenging.

System Wide QIPP: *efficiencies that are the direct responsibility of the CCG.* NHS financial allocations are expected to rise by around 0-1 % each year over the next five years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth would continue at around 6% a year because of the aging population, new medical technologies and rising expectations. System wide QIPP programmes are the actions required to keep overall growth at an affordable 0-1% level rather than the historical 6%. In Rotherham we split QIPP into four areas:

- unscheduled care
- clinical referrals
- mental health and learning disabilities
- medicines management

We face five substantial **challenges**:

1. Although Rotherham 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.**
2. There are unacceptable inequalities in health *within* Rotherham. **Life expectancy is eight years less in some parts of the Borough compared to others and people's perceptions are that health problems need to be dealt with by hospitals.**



3. 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.
4. **The health service efficiency challenge** (see box on previous page).
5. The population is living longer. This is good news in that most people are experiencing more years of good health, but it also means that there are **more people with multiple long term conditions**.

We suggest five **solutions**:

- **Clinical leadership, both in primary and secondary care.** The CCG is a successful GP led, members' organisation and has made substantial progress in 2013, working with clinicians across Rotherham to improve areas such as medicines management and the quality of clinical referrals. We have established strong relationships with hospital clinicians in local hospitals and in 2014 will be working to support them strengthen clinical leadership within their hospitals.
- **Supporting self care and delivering care as close to home as possible.** 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, RMBC, the voluntary sector and health providers on better prevention and earlier interventions.
- **Improving out of hospital care.** The Rotherham NHS Foundation Trust (TRFT) provides both hospital services and many community care services. In 2014, we will ensure that Rotherham patients benefit from this integration and in particular that there is a strong locality focussed community nursing service. We also commission £5 million of community pilot projects, from a range of providers, designed to reduce hospital admissions. We will re-evaluate these projects in 2014 and maintain investment in the projects that evidence reducing hospital admissions most effectively.
- **Better use of Information Technology.** IT systems that help patients to have more control over their health, help clinicians to access the information they need and to communicate it to patients and other clinicians are essential for the CCG to achieve its aims.
- **A stronger patient voice.** Our engagement strategy, *'From consulting room to governing body'* sets out how we will listen to patients across all areas of our work and ensure that what people tell us, informs how we commission and plan services. We will do this not only because it is best practice, but also because it is the best way to deliver our plans and meet our responsibilities. Being led by eight GPs and working with all our members who each hear over 100 patient stories a week gives us a head start in this area. In Section 6.1 we describe our full engagement strategy.



To continue to deliver high quality care and meet the efficiency challenge the local health service has to change radically. The plan prioritises 16 strategic aims in six areas:

1. **Unscheduled care.** By April 2015 we will transform how patients receive urgent care in Rotherham by integrating the current fragmented services provided by accident and emergency, walk in centre and GP out of hours into a single emergency centre where patients who need urgent treatment will get it from the most appropriate clinician directly without the need for onward referral. Patients who do not require urgent care will be signposted to routine services. We will continue to expand the GP led, multidisciplinary, case management of the 12,000 patients in Rotherham at highest risk of admission to hospital and expand Rotherham's successful Care Coordination Centre that offers options such as urgent assessments as alternatives to hospital admission.
2. **Clinical referrals:** The CCG will build on 2013 successes in improving care pathways and providing top tips advice to clinicians about planned and urgent referrals. We will reduce unnecessary hospital follow-ups down to national averages and aspire to be below. This will include the managed, funded transfer of some follow ups to general practice. We will also reduce waste from duplicated diagnostic tests.
3. **Mental health:** We will improve the quality of mental health services for both adults and children. We will continue to improve diagnosis, treatment and support for people and carers with dementia. We will also improve the mental health of people with long term conditions through the work of the case management pilot mentioned above and also through investments in older peoples, adults and alcohol liaison services.
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 redesign projects.
5. **Out of hospital care:** We will increase capacity and improve the locality focus of community nursing teams so that more people can be cared for in their own homes instead of being admitted to hospital and so that people who are admitted can return home as soon as possible. We will maintain £5 million of additional investment with a range of providers for additional out of hospital investments, including: GPs, a social prescribing pilot with Voluntary Action Rotherham and community end of life care delivered by Rotherham Hospice.
6. **Maximise partnerships:** We will improve health outcomes by delivering integrated out of hospital care through the Better Care Fund with RMBC. We will ensure the CCG's plans link and add value with other commissioners such as NHS England who are responsible for commissioning primary care and specialist services. Through the *Working Together Collaboration* (see page 16), we will encourage collaborations between local hospitals where these are in the best interest of Rotherham patients.



Priorities

For all our aims and priorities we will consider the four Health and Wellbeing Strategy (H&WBS) 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 2014/15 towards delivering the aims and priorities in this strategy. We will performance manage ourselves on delivering milestones and outcomes set out in 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 2014, but will refresh the 5 year strategy in 2015.

Assurance: At a time when health service providers are required to make year on year efficiency savings, we will be even more diligent in assuring that services are safe, of high quality and deliver effective safeguarding of children and vulnerable adults. In our assurance work we will communicate effectively with other commissioners and regulatory agencies.

Quality: As well as providing assurance for our patients we will work with all our providers to facilitate and incentivise quality improvements. We will work in partnership with NHS England to assist them to improve the quality of general practice in Rotherham.

Partnerships: 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.

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 deliver 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 four national and three local outcomes that will determine the CCG's quality premiums and the seven outcomes required for the Better Care Fund.



NHS 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 local 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 NHS England) or public health services (which are the responsibility of RMBC).

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. **Quality** - improving safety, patient experience and outcomes and reducing variations
2. **Delivery** – leading system wide efficiency programmes that consistently achieve measurable improvements whilst meeting our financial targets
3. **Assurance** - having robust internal constitutional and governance arrangements, ensuring that providers' services are safe and ensuring vulnerable people have effective safeguarding
4. **Partnerships** – listening and truly reflecting the wishes of patients, public and communities, maintaining strong relationships with all agencies in Rotherham, working collaboratively with other CCGs, NHS England and commissioning support services



NHS Rotherham CCG '5 year 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

- Life expectancy in Rotherham is one year less than the England average
- Life expectancy varies by eight years between different parts of Rotherham
- Too many people are in hospital who do not need to be
- NHS Rotherham CCG has an £80 million efficiency challenge over the next 5 years
- Increasing numbers of older people with long term conditions

Solutions

- Clinical leadership, both in primary and secondary care
- Delivery of effective out of hospital care
- Supporting self care and delivering care as close to home as possible
- A stronger patient voice
- Better use of IT to improve communications and enable care pathways

Strategic Aims

Health and Wellbeing 'Strategic Aims'

- Priority 1: Prevention and Early Intervention
- Priority 2: Expectations and aspirations
- Priority 3: Dependence to independence
- Priority 4: Healthy Lifestyles
- Priority 5: Long term conditions
- Priority 6: Poverty

Unscheduled Care

1. Urgent care redesign
2. Case management of 12,000 people with long term conditions
3. Care Coordination Centre

Mental Health

4. Parity of Esteem
5. Fundamental review of investment outcomes and role of providers
6. Improve Dementia services

Clinical Referrals

7. Improving care pathways
8. Efficient follow-ups

Medicines Management

9. Increase quality, efficiency and reduce variations across 36 practices
10. Six service redesign projects

Out of Hospital Care

11. Increase capacity and locally focused community nursing
12. Maintain £5 million additional investment for care out of hospital
13. Increase use of alternative levels of care to hospital

Maximise Partnerships

14. To deliver the Better Care Fund, with RMBC
15. To effectively align secondary and primary care plans, with NHS England
16. To deliver the 'Working Together Collaboration', with other CCG's

Corporate Priorities

Assurance

Delivery

Quality

Partnerships

Outcomes

National Priorities: including Constitution Rights and Pledges on waiting times

Health and Wellbeing Strategy outcomes:

- Dementia
- Smoking
- Alcohol
- Obesity
- NEETs (employment)
- Fuel Poverty

'Call to Action' 7 Key Outcome Areas:

1. Reduce no. of years of life lost from treatable conditions
2. Improve quality of life for people with long-term conditions
3. Reduce time spent in hospital through better and more integrated care in the community
4. Increase number of older people living independently following discharge from hospital
5. Reduce numbers reporting a very poor experience of inpatient care
6. Reduce numbers reporting a very poor experience of primary care
7. Progress towards eliminating avoidable deaths in 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



2 Introduction

CCG Chair, Chief Officer, GP Members Committee Chair and Lay Member

This is the CCG's second commissioning plan. For the first time in the NHS, financial allocations will be made for two years so the plan is specific for 2014/15 and 2015/16 but also sets out our intentions for the three subsequent years.

We are conscious that the language used in this version tends to be technical 'NHS language' but we will produce a plain English version that will be used as part of our ongoing patient and public engagement activities. There is a glossary in section 14.

The CCG is still a new organisation but we believe we have achieved a lot in our first year as a statutory organisation.

Achievements in 2013/14

Clinical leadership; An organisation run by its clinical executive, well developed locality and membership inputs and facilitation of the development of clinical leadership in our provider organisations. Programme of clinically led primary and secondary care quality visits and joint clinical education sessions for primary and secondary care clinicians.

Efficiency programmes; We have improved quality whilst keeping hospital admissions within affordable levels allowing us to maintain our increased investment in community projects.

Sustaining community investment; Successful evaluation of our £5 million investments in additional services in the community including case management of 6000 people at most risk of hospital admission

Innovation; care coordination centre, multi-award winning medicines management projects improving dietetics and stoma care, virtual clinics for haematology and prostate specific antigen results. Programme of top tips for primary and secondary care clinicians.

Developing partnerships; with other commissioners such as RMBC and NHS England and facilitating providers to work in partnership. Work in co-ordination with other CCGs.

The CCG is one of three health commissioners contributing to Rotherham's overall Health and Wellbeing Strategy (H&WBS). We are 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 RMBC) and primary care services (GPs, pharmacists, optometrists and dentists) are commissioned by the NHS England (South Yorkshire and Bassetlaw) (NHSE SY&B). The three health commissioners work with other organisations and communities to deliver the Rotherham's overall H&WBS (summarised in section 4 of this document).



Our 2014 plan builds on our 2013 plan. We have made changes in response to feedback from our member practices, public and patients or because of changes in national policy such as the Better Care Fund.

Areas of our 2013 plan we will continue and improve

- The work of the four clinically led efficiency programmes
- Redesigned urgent care services by the end of 2015
- Continuation of additional investments in community projects
- Award winning innovations in medicines management services
- Supporting clinical leadership in local hospitals

Key additions to our 2014-19 Commissioning Plan

- Additional investment and a locality focus for community nursing services
- Increased emphasis on quality for both adults and children's mental health services
- Improving out of hospital care through the Better Care Fund
- Better integration between CCG commissioned services and those of NHS England
- Increased public patient feedback to all our activities
- Major transformation of urgent care in Rotherham

In the executive summary we describe the challenges facing Rotherham, poor health outcomes, inequalities within Rotherham, high levels of emergency hospital admissions and our share of the NHS £30 billion efficiency challenge. Our solutions are; self care, a recognition that home care is the best care in most circumstances, improving community care, improving IT, strengthening clinical leadership and the patients voice.

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 and social 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.

The scale of the efficiency challenge makes it even more important that our quality assurance mechanisms are robust. At the end of the contract round each of our providers has to quality assure their Cost Improvement Plans. These plans, signed by their medical and nurse directors will then be considered by our Governing Body so we are assured that everything possible has been done to mitigate risks to clinical quality.

Although the CCG has a wide range of responsibilities and a £345 million commissioning budget, we are a small organisation. 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 we will keep focused on our agreed priorities which are the most important to continue to improve the quality of health care for the people of Rotherham.



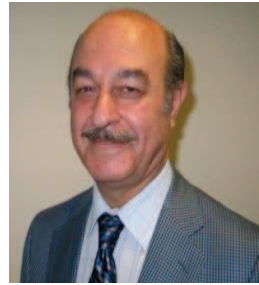
The CCG aims to improve services for patients, this can only be done on the basis of feedback from patients, public and clinician's, please send any comments on the plan or any other issue relating to the CCG to the following e-mail address rotherhamccg@rotherhamccg.nhs.uk .



Julie Kitlowski, GP
Chair CCG



Chris Edwards
Chief Officer CCG



Leonard Jacob, GP
Chair GP Members Committee



John Gomersall
CCG Lay Member



Phillip Moss
CCG Lay Member

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 CCG's 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 **CCG 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 CCG has well developed engagement processes with our GP members. The **GP Members Committee** is a strong advisory body to the CCG Governing Body and Strategic Clinical Executive with a responsibility to ensure member practices are linked into all the wider commissioning decisions. The GP Members Committee works through a locality structure using locality meetings, regular surveys, bi-annual Rotherham wide commissioning events and regular contacts with executive GPs to ensure that the views of all Rotherham GP practices contribute to our plans.

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 NHS **West and South Yorkshire and Bassetlaw Commissioning Support Unit** (NHS WSYB CSU) which supports the CCG in areas such as intelligence, IT, human resources and some clinical and financial services (see Section 5.11).

The links show the members of our three committees: Governing Body, GP Members Committee, and Strategic Clinical Executive [\(Add link\)](#).

CCG Statutory Responsibilities

The CCG's full responsibilities are detailed in its constitution [\(Add link\)](#). 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 England
- 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 NHS England and the NHS England's planning guidance, *'Everyone Counts'*
- Achieving financial balance



CCG Commissioning Responsibilities

The CCGs is responsible for commissioning health services to meet all the reasonable requirements of our local population, with the exception of: certain services commissioned directly by NHS England; health improvement services commissioned by RMBC; and health protection and promotion services provided by Public Health England. NHS England website sets out the full responsibilities for each agency [\[add link http://www.england.nhs.uk/wp-content/uploads/2012/09/fs-ccg-respon.pdf\]](http://www.england.nhs.uk/wp-content/uploads/2012/09/fs-ccg-respon.pdf)

Services commissioned by the CCG are:

- Urgent and emergency care (including 111, A&E and ambulance services) for anyone present in your geographic area
- Out of hours primary medical services (for everyone present in your area), except where this responsibility has been retained by practices under the GP contract
- Elective hospital care
- Community health services (such as rehabilitation services, speech and language therapy, continence services, wheelchair services, and home oxygen services, but not public health services such as health visiting and family nursing)
- Other community-based services, including (where appropriate) services provided by GP practices that go beyond the scope of the GP contract
- Rehabilitation services
- Maternity and newborn services (excluding neonatal intensive care)
- Children's healthcare services (mental and physical health)
- Services for people with learning disabilities
- Mental health services (including psychological therapies)
- NHS continuing healthcare
- Infertility services

Relationships

We work with individual practice patient user groups and have jointly developed with them our **CCG patient network** (see section 6.5). The CCG works closely with **Healthwatch**, for example they are helping the CCG with public consultation on this plan.

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

The CCG is accountable to **NHS England** for delivery of agreed outcomes. In addition the CCG works in partnership with NHS England in areas where the responsibilities of the two organisations overlap such as the interface between primary care commissioning (NHS England) , hospital and community service commissioning (CCG) and specialist commissioning (NHS England). The CCGs partnership with NHS England on GP quality is described in section 6.2. The CCG will work closely with **local professional networks** (for pharmacy, eye care and dentistry) and NHS England for relevant care pathways.

The CCG will work closely with **(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 important new development of the Better Care Fund is described in Section 4.3.



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 CCGs** 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 latest CCGCOM work plan. [\(Add link\)](#).

SYCOM is a group, reporting to the CCGs' Governing Body, where local CCGs and NHSE SY&B collaborate and take joint commissioning decisions in the areas where they have common interests. This includes care pathways which involve specialist, CCG and primary care commissioning.

'The Working together Collaboration' is an important collaboration between commissioners and Acute Hospitals in South Yorkshire, Mid Yorkshire and North Derbyshire to deliver safe and sustainable acute services through effective collaborative commissioning.

There are four commissioner led work programmes: cardiology and stroke, paediatrics and neonates, smaller specialties and out of hospital care.

There are also six provider workstreams: sharing information, consistency of care, smaller specialties, specialised services, locums and procurement. [\(Add link\)](#).

With regards to **Networks and Senates** we will work in partnership with NHS England to ensure that the CCG and Rotherham GPs are appropriately represented on these new structures.

4 Context

4.1 Joint Strategic Needs Assessment

The health of people in Rotherham is generally worse than the average for England, full details can be found in the Joint Strategic Needs Assessment [\(Add link\)](#). 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 Well-being Strategy.

People told us....

.... Older people have told us that they felt they had to be assertive to get a good service, and that experiences were very varied. People were also confused about what services were available and how some services could be accessed... Older people consultation in 2013, via Rotherham Older people's Forum

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.

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.

People told us...

.... that family carers need support too; if carers are not getting enough help and support, they may be using the hospital more than is clinically needed... Patient Participation Group meeting 29.10.13

In summary, health needs in Rotherham are significantly greater than the average for England and are associated with 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 benefit 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 health care from people with multiple comorbid long term conditions are likely to grow.

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. Key outcomes are dementia, smoking, alcohol, obesity, NEETs (not in employment, education and training) and fuel poverty.

4.3 Integrated Commissioning

The CCG and RMBC has been mandated to create a Better Care Fund plan. The plan for 2015/16 will start in 2014 with a two year operational plan that will be signed off through the Health and Wellbeing Board (H&WBB).

The CCG will work with partners at RMBC to ensure the Better Care Fund is invested in evidenced based services.

Where does the money come from?

The Rotherham wide fund is expected to be around £20 million and falls across both organisations' allocations. It is important to realise this is not new money. For both organisations it reflects around £10 million of resources that are currently committed to core activities. The intention is that pooling the resources into a single budget will create shared programmes which deliver improved outcomes.

What will it cover?

The funding will be used to support adult social care services in each locality, which also has a health benefit. However, beyond this broad condition the aim is to provide flexibility for local areas to determine how this investment in services is best used.

The CCG and RMBC will have regard to the JSNA for our local population and existing commissioning plans for both health and social care and agree with local health partners how the funding is best used within social care, and the outcomes expected from this investment.

Working with providers

The plan is for CCGs and local authorities to engage from the outset with providers, both NHS and social care, likely to be affected by the use of the fund and this will include:

1. Developing a shared view of the future shape of services.
2. Assessing future capacity requirements across the system.
3. Ensuring that the implications for local providers are set out clearly for H&WBB's prior to sign off.



Why are we making this investment?

A range of outcomes will be measured and improvements will need to be made as set out below:

1. Reducing years of life lost for (cancer, stroke, heart disease, respiratory disease, liver disease);
2. Improving quality of life for patients with 1 or more long term condition;
3. Reducing time in hospital through more integrated care in the community;
4. Increasing the amount of people living independently at home following discharge from hospital;
5. Reducing poor experience of inpatient care;
6. Reducing poor experience in primary care;
7. Eliminating avoidable death in hospital.

Measured by improvements to the following:

- Delayed transfers of care;
- Emergency admissions;
- Effectiveness of re-ablement;
- Admissions to residential and nursing care;
- Patient and service user experience.

What are the National Conditions?

There are six national conditions, with detailed the definitions [\(Add link\)](#):

1. Plans to be jointly agreed
2. Protection for social care services (not spending)
3. As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
4. Better data sharing between health and social care, based on the NHS number
5. Ensure a joint approach to assessments and care planning
6. Agreement on the consequential impact of changes in the acute sector

What is the process for 2014/15 and 2015/16?

The H&WBB will sign off the plan and will provide specific priorities and performance goals to be able to assure that the national conditions have been achieved. This will be submitted on 15th February 2014 to NHS England.

A draft template has been developed and is expected to be used in developing, agreeing and publishing integration plans. It sets out the key information and metrics that all H&WBB's will need to assure themselves that the plan addresses the conditions of the Better Care Fund.

The CCG and RMBC have established a Better Care Fund workstream and are identifying key members across all sectors for membership including considering a shared officer to lead the project.

Key initial actions include

1. Clear, simple vision from H&WBB with an initial plan/joint statement agreed
2. A single approach to obtaining Rotherham people's views;
3. Assessment of which existing services fall into the scope [\(Add link\)](#).
4. Completion of template and plans by early January;
5. Review services commissioned across both organisations to be prioritised for the £20 million fund;
6. Identify any current RMBC or CCG transformation schemes that should be prioritised for the fund.



4.4 Other Rotherham organisations' strategic plans

Commissioning plans

The CCG is only responsible for commissioning only one part of Rotherham's overall spend on health and social care. We will work closely with other commissioners to ensure that all commissioning plans are aligned so that together we deliver the maximum amount for each 'Rotherham pound'.

Rotherham will spend around £14.1 million on public health in 2014/15, commissioned by RMBC. The CCG as a Health and Wellbeing Board member expects to see that the following public health services continue to receive priority: NHS health checks, obesity, school nursing, sexual health services, drugs and alcohol services, tobacco control and public health support to NHS Commissioning. Plans for 2014/15 will be agreed at the Health and Wellbeing Board in [January 2014](#) [\(Add link\)](#).

Spending on social services is the responsibility of RMBC, plans for 2014/15 will be part of RMBC's 2014/15 Corporate Plan which will be agreed by Cabinet before 1 April 2014 [\(Add link\)](#). Primary care services (general practice, pharmacy, dentistry and optometrists), as well as specialised hospital services are all commissioned by NHS England. NHS England are consulting on their 2014 primary care strategy at both a South Yorkshire and National Level prior to publishing plans by April 2014 [\(Add link\)](#). NHS England will publish a national strategy for specialised commissioning in 2014 [\(Add link\)](#).

Local acute hospitals plans

In section 6.2 we describe how providers' Medical Director, Chief Nurse and Trust Board will perform quality impact assessments on the cost improvements plans required to deliver their efficiency savings. The CCG will then assure itself on these quality impact assessments. The cost improvements plans will be finalised by 24 February. In the sections below we describe current progress with cost improvement plans for our main providers of acute services and mental health.

The Rotherham NHS Foundation Trust

Local hospitals have the challenge of continuing to improve quality whilst delivering year on year efficiency savings (see section 8).

The Rotherham NHS Foundation Trust (TRFT) is required by Monitor to produce a 5 year plan including an options appraisal for collaboration with other hospitals. The CCG has the following views on the future of services acute hospital services in Rotherham:

- All services should be provided as close to the patient as possible, the only reason for services being provided outside Rotherham is where there is a compelling reason of clinical safety or improved patient experience.
- The CCG's first preference is for TRFT to remain as a stand alone organisation focussed on delivering high quality, safe, local hospital and community services to Rotherham patients.
- In 2013/14 the CCG supported TRFT by non recurrent investment for its efficiency plans. Further support will include support to provide state-of-the-art facilities for the Emergency Centre (see section 5.1)



- If a stand alone option is ever demonstrated not to be sustainable on safety or financial grounds the CCG would expect that any other organisational form would still continue to deliver Rotherham based hospital and community services. We would expect these services to be to our required standard with Rotherham based clinical and management teams. We would expect the organisation to work with the CCG to design and deliver high quality services for Rotherham patients. We would also require the organisation to contract with us on a Rotherham basis rather than a regional basis and to report Rotherham specific outcomes.
- If there is ever a merger of TRFT with another provider the CCG would reconsider its arrangements for commissioning community services (currently provided by TRFT).
- The CCG strongly encourages all local acute providers to work together where this will improve safety and sustainability. The CCG is mindful of clinical safety requirements in smaller specialties that will require collaborative working these include paediatrics and maternity services. The CCG is also mindful of national shortages in middle grade clinicians in Accident and Emergency which may require collaborative working between Accident and Emergency departments in South Yorkshire.
- The CCG strongly encourages collaborative working between acute hospitals where this will improve safety and sustainability (see the summary of Working Together Collaboration in Section 3).

TRFT have to make substantial efficiency savings in 2014/15 and in subsequent years. For December 2013 TRFT were required by Monitor to undertake an options appraisal as to whether to continue as an independent Foundation Trust or to consider merging with other Foundation Trusts. The options appraisal concluded to continue as an independent Trust which will involve increased collaboration with other trusts on some key care pathways. TRFT's options appraisal includes details of activity assumptions and efficiency plans including 6.8% savings in 2014/15. Every effort will be made to focus efficiency savings on back office functions rather than front line clinical services but efficiencies on this scale are challenging. The final draft of the CCG Commissioning Plan will include more details on implications on workforce and bed numbers and a link to TRFT communications issued following the submission of the options appraisal. [\(Add link\)](#)

Rotherham Doncaster and South Humber NHS Foundation Trust

Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) like all other providers has to deliver 4% efficiencies in both 2014/15 and 2015/16. In 2014/15 this will be £1.1 million on RDaSH's Rotherham contract. Efficiencies in adult mental health will include efficiencies in management costs, community occupational therapy, physiotherapy and psychology services. Older people's mental health efficiencies include drug expenditure, accommodation costs and redesigned day services. Efficiencies in child and adolescent mental health services include reductions in non pay expenditure and non clinical posts.



5 Commissioning Areas

5.1 Unscheduled Care

People told us.....

....that people are still confused about when to use A&E, and when to use other services despite national and local campaigns.....

Patient Participation Groups network, 29.10.13

| | |
|---------------------|---|
| Lead Officer | Chris Edwards – via Urgent Care Working Group (formerly Unscheduled Care Management Committee) |
| Lead GP | Ian Turner |

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 84% are to The Rotherham NHS Foundation Trust, 6% to Doncaster and Bassetlaw NHS Foundation Trust and 7% to Sheffield Teaching Hospitals NHS Foundation Trust.

Historically, Rotherham health community has been an outlier for emergency admissions to hospital. This is not fully explained by the higher than average levels of morbidity and there is 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 may seem like the safest and easiest way of dealing with an emergency, for many people high quality care at home or in a community setting could be 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. There are important links between this area and our plans to improve community services such as further developing the care coordination centre and providing alternative levels of care (see Section 5.6). The Better Care Fund is described in section 4.3.

In 2012/13 the CCG spent £59.2 million on unscheduled care and in 2013/14 £57.2million. Planned spend for 2014/15 is £57.2 million.

Key achievements in the last 12 months

In 2013/14 we set initiatives that, cumulatively, would reduce the number of emergency admissions. Current figures show that the impact of these initiatives is beginning to make a positive difference. Progress made includes:

- **Care Co-ordination Centre** in operation since November 2012, with significant reductions in GP admissions to the medical admissions unit seen in the first 12 months of operation

People told us....

..... that the trust people have in the services they use is important, as are the relationships they have with health staff and communication....

Patient Participation Groups network, 29.10.13

- 88% of GP practices engaged in the **Case Management Pilot** with 6,000 case management plans in place, anticipated to rise to 7500 by the end of March 2014. Plans receive input from GPs, social workers, social prescribing workers, community nursing and, if needed, other allied health professionals (see Section 5.10)
- Improved access to **Alternative Levels of Care** demonstrating high levels of utilisation and good patient flow. Services include Fast Response, Intermediate Care, Breathing Space, Oakwood Community Hospital,

enhanced Community Care Service and Care Home Support Service. Further information on these can be found in section 5.13.

- Patient level audit of **emergency admissions on elderly patients** (over 80s) undertaken and action plan developed to be jointly implemented between urgent care working group and clinical referrals. Progress made with the **self care** agenda, with agreement at H&WBB introduce organisational practitioner skills programmes and plans to deliver workshops in GP Practices
- **NHS 111** implemented with no significant issues at local level.
- Personalised budgets are nationally mandated, we have 31 patients currently in receipt of a **personal health budgets** (PHB) with up to 40 patients potentially offered a PHB during 2013/14.

In addition we carried out an extensive public consultation in Summer 2013 on the **Unscheduled Care Review**, resulting in broad support from stakeholders, groups and individuals for the creation of an integrated Emergency Centre at The Rotherham NHS Foundation Trust, linked to closure of the town centre based walk in centre.

What will we achieve for our investment including efficiencies?

The CCG will build on the successes of 2013/14 to transform the way patients with long term conditions, the frail elderly and others who access urgent care services are managed.

Emergency admissions will not increase by more than 1% over the next two 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.

People told us

...that they see A&E as safe and dependable... Patient Participation Group meeting, 29.10.13

In 2014/15 we will:

- Focus on driving forward the outcomes of the **urgent care review**. Work is underway to finalise the business case for a new emergency centre. Subject to final approval, current providers will work together under existing contractual arrangements whilst the capital development is completed in readiness for the new service and capital development to go live in April 2015. [\(add link\)](#)

People told us

... that ease of access and parking was as important to them as quality of care ...Unscheduled Care Review Consultation

- Embed and expand the use of the **care coordination centre**, see section 5.13
- Continue to implement and support practices to undertake the **case management pilot**
- Implement the findings from the **elderly acute admissions audit** [\(add link\)](#)
- Continue to implement the action plan to deliver **Rotherham's Joint Carers Charter**, in partnership with RMBC
- Continue to improve **acute alcohol services**, as described in the mental health (section 5.4)
- Continue to provide improved **children's services** (see sections 5.2 and 5.5)
- Improve acute services for **adult mental health, older peoples mental health** (including dementia) and ensure they are integrated with unscheduled care service

People told us....

.... That some older people have very limited contact with others and are isolated; more isolation possibly means more worry, more likely use of services...

....that respiratory (breathing) problems are scary, so people with these are likely to go to A&E; but perhaps wouldn't if there was somewhere they could go to or call for advice and reassurance....

.... there is a lot of support for self care, but people with long term conditions will need encouragement and support to live as healthily as possible; patient information needs to be accessible to everybody, and needs to be easy to understand, and there is a role for everyone in supporting family and friends in managing their health....

Patient Participation Group Network meeting, 29.10.13



The table below lists the four 2014/15 workstreams within the programme and the projects within these workstreams.

| | Workstream | Project |
|---|--------------------------------------|---|
| 1 | GP led integrated care | <ul style="list-style-type: none"> • Self Care • Case Management |
| 2 | Efficient access to unscheduled care | <ul style="list-style-type: none"> • Urgent Care redesign • Care Co-ordination Centre • Alternative levels of care |
| 3 | Personalisation | <ul style="list-style-type: none"> • Personal budgets for patients |
| 4 | Pathways | <p>Managed by CRMC: falls, frail elderly, end of life care, acutely ill child, COPD, cardiology/CVD</p> <p>Managed by MH/LD QIPP: adult and older peoples mental health including dementia, alcohol</p> |

How are we going to achieve our intentions?

In May 2013 as a result of the national A&E performance the Government determined that all CCGs should establish an Urgent Care Working Group to oversee the implementation of their A&E Recovery and Implementation Plan. The committee which oversees the unscheduled care programme (Unscheduled Care Management Committee) refreshed its membership to meet the requirements and was re-named. The Urgent Care Working Group meets every four weeks and is attended by the CCG urgent care GP lead, chief officer, two further GPs (one acting also as LMC representative), senior representatives from TRFT, RMBC, Care UK, YAS and RMBC Consultant in Public Health. The Urgent Care Working Group reports to the multi-agency Quality, Innovation, Productivity and Prevention (QIPP) Delivery group and then the CCG Strategic Clinical Executive (SCE).

In February, the Emergency Care Intensive Support Team (ECIST) will undertake a review of urgent and emergency care in Rotherham. They have had a major impact across the country by reducing performance variation, increasing and maintaining focus on key performance priorities and enhancing constructive working relationships across local health communities.

The **Urgent Care Redesign** is the CCC's major project for 2014-16, and is driven by an Urgent Care Steering Group which reports regularly to the Urgent Care Working Group. SCE GPs have been working on the redesign for over a year and there has been extensive consultation to inform the way forward for the service model, finance and capital development to support delivery. An extensive programme of organisational development work is planned to ensure the benefits of change are realised.

Our plan is highly consistent with Government intentions as set out in the recently published Keogh report [\(add link\)](#). In light of the report the CCG agreed at the Urgent Care Working Group to rename to it to the Emergency Centre.

Quality improvements

1. **GP led integrated care: Self care:** we will support patients to take more control over their condition and management. Our approach is described in detail at the [\(add link\)](#). Key elements of 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 hospital admission (as identified by the risk stratification tool). In 2014 the project will be expanded to include all patients in nursing and residential homes. Community nursing and social workers are refocused 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 a wide range of voluntary and community sector providers to help patients manage their own conditions. The care coordination centre, alternative levels of care and falls prevention link with social prescribing and the case management pilot.

People told us....

.... that patient groups at the practices could work with social prescribing to share local information and knowledge.... Patient Participation Group Network meeting, 29.10.13

2. **Efficient access to unscheduled care:** Rotherham care coordination 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. **Urgent care redesign;** in 2014 we will begin to implement proposals to redesign the way unscheduled care will be provided from 2015 by services such as GP out of hours
3. , the walk in centre and accident and emergency services.
4. **Personalisation:** this was piloted during 2013 and full roll out will be implemented from April 2014.
5. **Pathways:** redesigning care pathways initially focusing on those that account for the highest proportion of admissions.

Innovation

- GP Case Management Pilot – a major innovation at scale where Rotherham has invested substantially (£1.5 million in 2014/15) to fund additional community support
- Social prescribing – a significant investment (£0.5 million 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 12,000 people in Rotherham at most risk of hospital admission.
- Care Coordination Centre – a single access point for health professionals so that they can make informed choices about the most appropriate levels of care for patients.

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'. The 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 Urgent Care Working Group has an agreed set of principles that are derived from the H&WBS.

How will we address health inequalities?

Much of the spend in this area is focused on 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, and the personalisation agenda 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 people get access to appropriate urgent care.

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



5.2 Clinical Referrals

People told us....

.... They had to wait a long time for medication before they could be discharged from Rotherham hospital *Patient Participation Group Network meeting, 29.10.13*

| | |
|---------------------|--|
| Lead Officer | Robin Carlisle via Clinical Referrals Management Committee (CRMC) |
| Lead GP | Jason Page |

Why are we planning to invest in this area?

The CCG funds hospital inpatient and outpatient services. Services booked in advanced are known as scheduled care. The objective is to provide the right care at the right time and also to keep costs within affordable limits so that we maintain financial balance and can meet our obligations in other areas.

In some cases we wish to increase scheduled care particularly where more accessible services avoid the need for hospital admission, this includes successful fast track and one stop services. In other areas we are using an educational approach to reduce the need for hospital care by promoting self care, management in general practice and non face to face referrals such as virtual clinics.

In 2012/13 the CCG spent £69.0 million on scheduled care. Planned spend for 2013/14 is £68.9 million. For emergency care, the CCG will spend £37.7 million in 2013/14 rising to £38.0 million for 2014/15. Put in next year's figs when known.

Key achievements in the last 12 months

Taken overall growth in outpatients, electives, non-electives and diagnostics in Rotherham in 2013 has been within affordable limits. Given the continual rising demands on the system this represents a substantial achievement by all referring clinicians. Specific projects included the successful haematology virtual clinic, gynaecology fast track appointments and substantially reducing follow ups including transferring suture removal and Prostate Specific Antigen (PSA) monitoring to primary care.

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 all referring clinicians and providers to ensure that referrals, elective and non-elective procedures are kept within affordable limits. If the current consensual, educationally based approach continues to be successful it will mean that Rotherham can maintain short waiting times and avoid unnecessary restrictions on the numbers of types of procedures that are available to patients.

The 2014/15 planning guidance requires commissioners to consider providers' model of elective care to achieve a 20% productivity improvement within five years, so that existing activity levels can be delivered with better outcomes and 20% less resource.

- We will keep the annual growth in first outpatients and electives to X%.
- We will keep growth in diagnostics to 5% per year, because there will be more people requiring investigating in the community and guidance requiring diagnostics to be increased in some areas, these will mean considerable attention to reducing waste, particularly duplicate testing.
- 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 (a 12% reduction over two years).
- Rotherham is also an outlier in the number of emergency admissions to hospital – we will keep total non-elective growth to 0-1% per year, but increase the proportion of people receiving same day assessments and so reduce the number of hospital admissions (see Section 5.1).



- We will work with TRFT to benchmark the productivity of elective services by specialty and agree productivity improvements which will deliver these requirements over five years.

How are we going to achieve our intentions?

Policies and efficiency programmes for scheduled and unscheduled care pathways are agreed at the fortnightly Clinical Referral Management Committee (CRMC) which is attended by four GPs and TRFTs Medical Director, Clinical Directors and Director of Operations. 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, medicines management and mental health QIPP.

| | Workstream | Project |
|---|--|---|
| 1 | Benchmarking, trend analysis, and two way communication with all clinicians | <ol style="list-style-type: none"> 1. Regular review of trends in GP referrals, consultant referrals, A&E referrals, other referrals and elective activity. 2. Specialty specific discussion of areas identified by benchmarking or changing trends. 3. GP communication/education; bite size newsletter, SCE newsletter, protected learning time, top tips/map of medicine guidelines, GP peer led visits. 4. Communication with TRFT clinicians |
| 2 | Two way dialogue with all clinicians on benchmarking, trends and improved care pathways | <ol style="list-style-type: none"> 1. Better information on self care 2. More fast track services such as the successful fast track gynaecology service 3. More one stop services |
| 3 | Outpatient follow up reduction programme | <ol style="list-style-type: none"> 1. Reduction in Follow ups 2. Secondary to primary care Locally Enhanced Service |
| 4 | Diagnostics | <ol style="list-style-type: none"> 1. Reduction in duplicate and inappropriate diagnostic testing |
| 5 | Care Pathways (with Urgent Care Working Group and Mental Health QIPP Committee) | <ol style="list-style-type: none"> 1. COPD 2. Cardiology / CVD 3. Children's care pathways 4. A review of pain management services 5. Alcohol (with mental health QIPP group) 6. Falls (with UCWG) 7. Dementia (with Mental health QIPP group) |
| 6 | Safe effective non face to face 'referrals' | <ol style="list-style-type: none"> 1. Review of current virtual Haematology and consideration of extension to other specialties 2. Explore other ways of safe, effective non face to face contacts |

People told us....

.....people want reassurance about how virtual clinics work on a practical level, especially around issues such as accuracy, confidentiality and security...
 Patient Participation Group Network meeting, 29.10.13



Quality improvements

Patient experience will be improved by improving the quality of referral information to consultants, 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 will be more convenient for patients. The changes will ensure that patients receive care as close to home as possible.

People told us....

....that care close to home as possible is great for some things but not for all – people want to be able to discuss ideas for additional services delivered in primary care. Lots of people shared stories with us describing wasted afternoons at the hospital for an appointment of less than 5 minutesPatient Participation Group Network meeting, 29.10.13

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, emergency admissions rates and utilisation of diagnostics.

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

5.3 Medicines Management

| | |
|---------------------|--|
| Lead Officer | Stuart Lakin via Medicines Management Committee (MMC) |
| Lead GP | Avanti Gunasakera |

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 CCG's track record on effective medicines management is very strong. Cost growth has been below the national average for four of the last six years and compares favourably to neighbouring CCGs with similar demographics. NHS Rotherham CCG retained its prescribing incentive scheme, following the introduction of



the Quality and Outcomes Framework, this rewards practices for remaining within their allocated prescribing budget. This is considered to be a success where NHS Rotherham CCG has benefited from very competitive prescribing cost growth over the last 5 years compared to both neighbouring CCGs and England. It is planned to extend this practice incentive to reward improvements in the quality of prescribing.

The Medicines Management team have for the past four years produced a range of practice key prescribing indicators, these are a series 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 2013/14 the CCG will spend £43.5 million on prescriptions and on commissioned services (nutrition and continence). We plan to increase this by 2.5% net of efficiency savings in 2014/15. 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. A key element in managing prescribing cost growth is containing and reducing prescription waste, a number of ideas are to be trialled and evaluated in 2014/15.

Key achievements in the last 12 months

- Prescribing expenditure forecast to be -3.1% under spent at year end.
- The prescribing efficiency plan is being delivered on schedule.
- The stoma prescribing service has been commissioned and has delivered impressive savings and received excellent patient feedback
- A system for managing and auditing the prescribing on drugs outside of tariff will shortly be introduced.
- A project to identify prescribing waste has been started.

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 implement an audit tool for the prescribing of “drugs outside tariff” to ensure NHS 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 CCG’s 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 medicine 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 CCG’s medicines management 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 team receives very positive feedback from member practices and the strength of relationships is resulting in above expected efficiency savings in 2013/4.

2 Specific service redesign projects

The CCG has six specific prescribing projects where prescribing responsibility has been removed from GPs to either dietician’s or nurse led services. Nutritional supplements, specialist food stuffs and continence and

stoma equipment are now prescribed by specialist services. This has improved the service provision to patients and delivered financial efficiencies. Further work is ongoing with wound care.

| | Workstream | Project |
|---|--|--|
| 1 | Cost efficiency programmes | <ul style="list-style-type: none"> • An prescribing QIPP plan will operate throughout the financial year to help manage and contain prescribing cost growth. • The medicines management team (MMT) working with TRFT will introduce the Blueteq web bases process for managing the prescribing of “drugs outside of tariff” • Working with CSU procurement the MMT will undertake a procurement exercise for the direct purchase and supply of wound care products. • The successful introduction and management of a direct purchase and supply scheme for wound care products across Rotherham. • The continuation of the pharmaceutical waste audit project with the aim have having a clear understanding how to combat waste in the future. • The programming of GP practice systems with warning messages concerning the prescribing of a range of products are less cost effective that the alternatives. |
| 2 | Performance Benchmarking | Financial and quality benchmarking against other CCGs and agendas such as national QIPP reports. |
| 3 | Key Prescribing Indicators | Monitoring and helping practices to improve performance on a series of 14 evidenced based prescribing interventions. Additional Prescribing Key Performance Indicators are being developed The CCG has been requested to consider an incentive scheme to reward practices for improvements in the quality of their prescribing. |
| 4 | Prescribing Guidelines | Production and review of prescribing guidelines |
| 5 | RDASH prescribing pathways and share care agreements. | <ul style="list-style-type: none"> • Dementia prescribing pathway. • Better prescribing for Attention Deficit Hyperactivity Disorder • Addressing antidepressant prescribing in the community. • Ensure shared care protocols are in place and adhered too. |
| 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 wound care redesign project will improve the patient experience; significant unmet need has been discovered, whilst delivering real and potential cost savings. This project will ensure that dressing use is in line with the evidence base. It will also improve the timely access to dressings for patients and decrease the time spent by nurses obtaining dressings via prescriptions.
- The nutrition, continence, stoma and oxygen projects will continue to work with their patient service user groups to improve the customer focus of the services.

People told us....

....I am very happy with the prescription service. It is useful as it cuts visits to the surgery and chemist.

Products are delivered to my door, usually within 48 hours after ordering. The ladies who answer the phone are polite and helpful....

....although I have had a stoma for over 30 years I was unaware of the stoma prescription service until a recent spell in hospital. I was given the details about the service in preparation for discharge from hospital and found the service to be helpful and efficient. I know that there is someone to contact for help and advice....

.... Both my wife and I are in our 80s and about 12 years ago my wife started to have incontinence problems. She ... was given towels to use. These weren't really very good and we were told the only next step would be a catheter. This was when we were referred to the continence service. Since using the service we have had a better way of life. We have never met such friendly, helpful people. They have been absolutely magic. You only have to phone the up and they are always lovely..... Patient Opinion



Innovation

- The six service redesign projects are award winning examples that have improved service provision and addressed unmet need as well as resulting in substantial cost savings.
- The nutritional and continence procurements have created unique commercial partnerships that have released further efficiencies.
- Rotherham has an innovative practice budget setting mechanism, that ensures practice prescribing budgets are equitable. This is utilised by the prescribing incentive scheme to stimulate cost effective prescribing.
- Our key prescribing indicators described above.
- The medicines management team are increasingly participating in the redesign of clinical pathways, with the aim to produce referral and hospital admission efficiencies.

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.
- 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 service redesign project has demonstrated improvements in the patient experience.
- The wound care direct purchase and supply project will ensure patients in the community have prompt access to products and evidenced based care across Rotherham.

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.
- The service redesign projects ensures that there is equity in the provision of the redesigned services across Rotherham
- We will carry out equality impact assessments on all policies and procurements

5.4 Mental Health and Learning Disability

People told us....

.... They didn't think there were enough services in the community for people with mental health problems.... Patient Participation Group Network meeting, 29.10.13

| | |
|--------------|---|
| 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?

Mental Health

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 Rotherham. 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. We cannot be sure if the amount of overall investment we make in mental health services is proportionate to the needs set out in the JSNA and to the investments made by comparable health communities. We are not assured at present that our mental health and learning disability patients receive what NHS England term 'parity of esteem'. This inequality is manifest in at least three ways; we are not assured that equal attention is given across the whole system to people with mental health problems as to those with physical illnesses; we know that the physical health of people with severe mental health problems is much worse than average with their life expectancy being reduced by more than 10 years; we have particular



concerns about parity of out of hours mental health coverage, the current plans of our mental health providers for providing 24/7 coverage lag behind the plans of acute sector providers.

Mental Health Contractual arrangements:

The CCGs largest mental health contract is with Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) providing Children and Adolescent Mental Health Services (CAMHS), adults and older people's mental health services (around £28 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 £3.7 million on out of area mental health placements, of this £1.8 million was CCGs continuing care costs for mental health patients. We spend approximately £300K on mental health services through the voluntary sector.

People told us....

.... They don't know where to put him....

....we've been all over with her....

Carers Meeting, Autumn 2013

Rotherham GPs have raised significant concerns about all tiers of current CAMHS provision. The CCG is responsible for commissioning Tier 2 and Tier 3 services. Tier 1 services (universal provision such as general practitioners, school nursing and Youth Start) are mainly commissioned by RMBC and NHS England. Tier 4 services (inpatients and forensic beds are commissioned by NHS England. The CCG will work with the other two commissioners to better integrate services.

Rotherham GPs also have raised issues relating to the responsiveness of the RDaSH Adult psychiatric services following the introduction a Single Point of Access (SPA) 4 years ago.

Learning Disabilities

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.

Although the life expectancy is lower for people with learning disabilities, people are living longer and this means that the numbers of adults and older people with learning disabilities is increasing.

National publicity on abuse of patients at Winterbourne View near Bristol highlighted the importance of good quality commissioning for people whose behaviour challenges services, and those with complex needs. NHS 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.

The learning disability proportion of the CCG's mental health act with RDaSH is £700 K. We spent **£**X** million on out of area Learning Disability placements and some of the CCG's Continuing Care costs are for Learning Disability health patients. During 2013/14 we saw significant growth in the number of health funded Learning Disability out of area placements for patients requiring after care following their detention under the mental health act (Section 117).

Learning Disability Contractual arrangements

Currently learning disabilities are commissioned through our partnership arrangement with RMBC. The CCG is minded, in 2014, to commission its responsibilities directly through the mental health contract with RDASH but we will still work closely with RMBC to ensure that services for patients commissioned by the two organisations are closely aligned.



Key achievements in the last 12 months

Overall

Mental Health and Learning Disability Quality Innovation Productivity and Prevention group established with representation from CCG, RDaSH, RMBC and TRFT.

Children and Adolescent Mental Health Services

During 2013/4 the CCG has worked with GPs and key stakeholder to identify concerns around CAMHS services.

This work include:

- GPs CAMHS Survey monkey completed
- Universal Services CAMHS Survey monkey completed
- Developing a joint CAMHS action plan
- The development of the 'Top Tips for Children & Young people's Emotional Wellbeing Issues' and Directory of services in partnership with the CCG, RDaSH and RMBC
- Clinician meetings between the CCG SCE Mental Health Lead, GPMC Representative and RDaSH Clinicians
- The requirements of the Special Educational Needs and Disability (SEND) green paper which have implications for CAMHS services are described in Section 5.5.

People told us...

....they don't want to 'label' their children or loved ones, but need diagnosis to recognise and understand the person's needs, differences and behaviours.... *e-mail contact with CCG PPE Manager*

Adult

- An Acute Alcohol 7 day a week Service pilot provided by TRFT commenced in December 2013 this offers an immediate brief intervention for all patients presenting to TRFT with medical problems related to alcohol.
- In 2013 we planned to develop a 7 day a week acute and older peoples Mental Health Liaison service to offer a much better 7/7 service to people presenting with acute psychiatric problems and to older people presenting urgently with problems such as dementia. We have experienced delays developing these plans as clinical engagement has taken time to develop and workforce issues including models of care have also been a barrier to service development. In 2014, as set out later in this section, we will carry out a fundamental review of mental health and learning disability service funding prior to improving 7 day a week services.
- The CCG has worked in partnership with Public Health (RMBC) to produce GP top tips Information on suicide prevention and domestic abuse. The CCG has also worked with Public Health to deliver their 2013/14 suicide prevention and self harm action plan.

Older Peoples

- NHS Rotherham CCG benchmarks well in terms of accurately identifying people with dementia in General Practice (1800 people in March 2013).
- We have improved the dementia care by:
 - The GP Memory Clinic referral pathway
 - GP Guidance on referral Memory Clinic produced. 95% of GPs surveyed reported the guidance to be either quite useful or very useful.
 - Case Finding – As part of the 2013/14 NHS Standard Contract NHS Rotherham Clinical Commissioning Group and The Rotherham Foundation Trust (TRFT) have agreed a programme to screen those over 65 in hospital for Dementia. TRFT / RDaSH have agreed a Dementia referral pathway for those individuals identified.
 - The Social Prescribing Project has awarded the Alzheimer Society some additional funding for a part time Dementia Support Worker
 - Review and redesign of the Crossroads contract resulting in the reduction in waiting times and improved the quality of support to Carers



Learning Disability

- Completed the Phase 1 review of Rhymers court Assessment and Treatment Unit. This aligns the number of beds with patient needs and now means we can carry out our plans to increase the number of people with learning disability being cared for in the community.
- Rotherham benchmarks well for the number of people with LD receiving an annual health check at 75.14% (the figure rises to 84.91% when adjusted for the number of people who chose **not** to have an annual health check)

What will we achieve for our investment including efficiencies?

Mental Health Investment / efficiencies:

Like all providers mental health services will be expected to deliver 4% efficiency savings for at least the next two years. This means that real income will reduce by 1.9% (2.1% allowance for inflation with 4% efficiency). A major theme in 2014 will be increased clinician to clinician discussions between CCG GPs and mental health service clinicians to ensure that quality improvements can still be made in the increasingly challenging financial situation. An action log was produced in December 2013 setting out details of this. In 2013/14 mental health was the only area in which the CCG made substantial additional investments. Although we will require the 4% efficiency requirements we may consider some re-investment of these savings in priority areas such as Older and Adult Mental Health liaison services, 7/7 working and CAMHS.

- An increased focus on quality for Rotherham residents in both adult services and CAMHS (see next section)
- Older and Adult Mental Health Liaison Services and Alcohol Services. These services which started in 2013 will be evaluated and enhanced if they provide value for money and deliver the required outcomes (service improved care and savings in acute hospital spend)
- An increased focus on the mental health of people with other long term conditions. The Older people, Adults and Alcohol liaison services mentioned above will be part of an increased emphasis on the mental health needs of people accessing acute hospital services. The GP case management and social prescribing schemes (section 5.10) describe the increased multiagency and voluntary sector inputs we will deliver to 12,000 people with long term conditions and who are at risk of hospital admission.
- Dementia
 - Achieving timely diagnosis and improving the care pathway, and reviewing scanner capacity.
 - Develop a one-stop clinic for dementia diagnosis
 - With increasing numbers of diagnoses dementia waiting times are a significant concern. We will consider commissioning a locally enhanced service (LES) in this area if waiting time remains an issue.
 - Improving support to carers
 - Work with partners to review dementia day care service provision across health and social care
 - Social prescribing support is improving support to carers, it is helping more hidden carers to be identified and get support earlier.
- Establish an adult autism diagnosis process.
- Work to implement Mental Health Payment by results. This will include keeping referrals within affordable limits which will include primary and secondary care clinicians working together on benchmarking and care pathways.

Learning Disability investment / efficiencies:

- Investment in services for people with learning disabilities will ensure the provision of high quality, cost effective services for people with learning disabilities.
- Review and service redesign of Rotherham Assessment and Treatment Unit and community services reducing the number of beds in line with Winterbourne Report recommendations.
- Ensure equitable access for people with learning disabilities to mainstream services.
- 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?

Strategic

The CCG will commission a fundamental review of CCG commissioned mental health services. This is required in the run up to the implementation of mental health payments by results. The review will focus on the following areas; whether the CCGs overall investments in mental health and learning disability services is proportionate to the health needs of Rotherham patients, how to ensure parity of esteem, how to strengthen clinical leadership of the efficiency and quality assurance agendas, and how to improve the reporting of outcome and activity measures. The review will include a market analysis, whether the CCG should be using a greater plurality of providers (including voluntary sector providers, a greater variety of mental health foundation trust providers, GP providers and more facilitation of self help such as computerised CBT). If the review concludes there is a case for increasing the overall investment in mental health services the review will consider the relative priorities of investing in identified unmet needs areas of; dementia services (including scans, diagnosis and support), acute (24/7) services for adult mental health and older mental health services, improved CAMHS services (including increased medical capacity), services for autism and attention deficit disorder, community services for learning disability patients and making recurrent current non recurrent investments in preventing alcohol re-admissions.

Operational Mental health

- Establish a Rotherham Mental Health Quality Group, this will include three GPs (two from the GP Member Committee) to meet with RDaSH colleagues at least quarterly to ensure that Rotherham's specific concerns are being addressed. This includes the CAMHS action plans and responses to concerns on Single Point of Access
- The Mental Health and Learning Disability QIPP group will continue to drive the delivery of system wide efficiencies and improvements including improved communication between clinicians. In order to continue delivering efficiencies this group will have increasing clinical representation.
- Monitor the delivery of the CAMHS action plan through the contract process.
- Work with mental health providers and with the GP case management pilot to improve the quality of care of people with long term conditions. This includes increasing the support given to people with physical long term conditions to prevent them developing mental health problems and paying greater attention to the physical health problems of people with long term mental health problems.
- Work with partners to ensure that CCG commissioned Tier 2 and Tier 3 services are integrated with universal (tier 1) and specialised services (tier 4). This will be achieved by working with partners CAMHS Partnership Group and developing a Joint CAMHS Strategy (RMBC, CCG and NHS England)
- Ensure that the requirements to deliver mental health choice are effectively delivered
- Evaluate and develop the adult mental health liaison service and the alcohol service.

Operational Learning disability

- Undertake a review and redesign of the Rotherham Learning disability services in partnership with RMBC, Service users, carers and Provider services.
- 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.

Quality improvements

Children and Adolescent Mental Health Services

- Delivery of the 8 point CAMHS plan as set out in the quality query in October 2013.
- Improved patient/user and stakeholder experience
- Improve the identification and support for young people with mental health problems
- improve waiting times

Adults



- improve the quality of patient and GPs satisfaction of services in particularly the Single Point of Access
- Improve the uptake of Improving Access to Psychological Therapies (IAPT)

Older people

- Improve diagnosis rates
- Improve waiting times

Learning Disability

- Improved community support for service users and carers. This will mean there are less residential beds for Rotherham residents.
- More people with a Learning Disability will have equitable access to mainstream services.
- 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)

Innovation

Mental Health - 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.

Learning Disability – NHS 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 and treatment, community services and out of area placement provision. This work will review good practice from across health care system and will include lessons 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 mental health illness and people with learning disability will increasing identify their own needs and choose solutions that are best suited to their personal circumstances.
- **Aspiration & Expectation** - The expectations of Rotherham people with mental health illness and people with learning disability will be understood and matched by services that are delivered according to their needs and where they live
- **Healthy Lifestyles** - People with mental health illness and people with learning disability 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.
- 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.
- 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.
- We will carry out equality impact assessments on all policies and procurements
- Improving communication through the development of 'easy read' information and materials, such as 'easy read' questionnaires, menus, disease specific booklets etc.
- 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.



5.5 Maternity and Children Services

People told us....

.....all midwives have been helpful and approachable on all visits. Really informative, made me feel at ease with everything....

....the friendly staff were always available and had advice when needed. With this being our first child, helpful tips were always appreciated. Thank you....*Friends and Family Test Comments*

| | |
|---------------------|--------------------------|
| Lead Officer | Sarah Whittle |
| Lead GP | David Polkinghorn |

Why are we planning to invest in this area?

Pregnancy, birth and the weeks and months beyond, are a key time of change and development for parents, as well as for their baby and supporting children to get the best start in life is a key priority for NHS Rotherham CCG and the H&WBB.

The development of children's health will impact greatly on the future provision of health services and NHS Rotherham CCG are committed to investing in children and young people's services, working together with key partners to ensure that children and young people grow to live, safe healthy lives and achieve.

Health commissioning for children in 2014/15 will involve close partnership between the CCG, RMBC (including Public health) and NHS England (SY&B). The table over page outlines the responsibilities of the CCG and the new arrangements for commissioning by NHS England and Public Health.

| The CCG is formally responsible for the commissioning of: | NHS England responsible for commissioning of: |
|--|--|
| Maternity Services | General Practice Services for children – transferred to NHS England April 2013 |
| Hospital Acute Provision | Health Visiting – transferred from NHS Rotherham to NHS England April 2013 |
| Community Provision for complex needs | Family Nurse Partnership – transferred from NHS Rotherham to NHS England April 2013 |
| | RMBC responsible for commissioning of: |
| Community provision for Long term conditions e.g.; Asthma, Diabetes, Epilepsy, Cystic Fibrosis | School Nursing – Transferred from NHS Rotherham to Rotherham Public Health April 2013 |
| Services for children with continuing health care needs | Public Health initiatives e.g. Obesity, Smoking – transferred from NHS Rotherham to Rotherham Public Health April 2013 |
| Safeguarding children and young people and looked after children – see section 6.4. | |

While the CCG does not commission some of the services above, it will work in partnership to enable our partners to meet their objectives, ensuring a joined up approach to commissioning across Rotherham.

People told us....

.....that it is less clear for children than for adults about what services to access...
antenatal/postnatal consultation 2013

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

Key achievements in the last 12 months

- Piloted SystmOne to improve communication between midwives and GPs in the south of the borough
- Developed plans for service reconfiguration of community midwifery
- Relocated and redesigned the ante-natal and post-natal ward, based on patient feedback
- Implemented the new maternity Tariff.



- Worked in partnership with RMBC on the development of the Special Educational Needs & Disability agenda, to establish key principles to deliver the changes outlined in the green paper.
- Developed a pathway to reduce 0-5yr A&E attendances. Piloted and tested the model for roll out 14/15
- Reconfiguration of the child development centre into a community setting
- Developed a discharge planning process in collaboration with TRFT to reduce length of stay.
- Increased the capacity of the community nursing team to support care closer to home.
- Developed and implemented the clinical pathways commencing from Primary Care through to acute and after care
- Developed ways to engage with general practice to inform planning e.g. protected learning time events, top tips and visits to practices.
- Implemented the looked after children's best practice tariff

What will we achieve for our investment including efficiencies?

Maternity services and Early Years

- NHS Rotherham CCG will work with providers to develop a consistent approach within the early years setting for antenatal education, through the piloting of 'birth and beyond' programme to support the increase in breastfeeding, early development in baby and identification of maternal mental health issues amongst other key outcome areas.
- Through the implementation of an electronic system we will work with partners to ensure that maternity services are aligned with primary care, health visitor services and with the family nurse partnership, avoiding duplication.

People told us...

.....it's instinct, you want to see someone quick, so people go to the place they know and trust, and know it's always open...

....we spend ages trying to decide whether or not to come here or not, but better safe than sorry..... *A&E interviews*

The Unwell Child

- We aim to support patients to access the **right** service, **first time** by educating patients about where to take their child when they are poorly with the aim to reduce unnecessary attendances at A&E and to enable parents to access timely care within an appropriate setting.
- In conjunction with Rotherham paediatricians we will roll out developed pathways to support primary care in managing some conditions which do not require emergency care, with the aim to support general practice to manage some urgent conditions within a primary care setting
- For those children who do need acute care, we understand that staying in hospital can be quite unsettling and are looking to develop pathways which enable children to be cared for at home when their condition no longer required acute care, with the same expertise as they would receive on the ward. This will support a reduction in length of stay as care is provided in a community setting.

Long Term Conditions and Care Closer to Home

- We are currently working with partners to redesign the following pathways asthma, diabetes and epilepsy, with a view to developing care plans across primary and secondary care, improving patients ability to self manage their conditions and improve transition from children's to adult services.

Special Educational Needs and Disabilities (SEND)

- To ensure that we are commissioning effective SEND services we will review existing provision against the SEND Green Paper, and work with key stakeholders to ensure that children are identified early, with joint assessments and care plans.
- We will explore how to give those parents who would like control, personal budgets and look at ensuring that transition from children into adult services is smooth

How are we going to achieve our intentions?

Delivering the commissioning intentions outlined in section 3 above can only be achieved through working with key partners across Rotherham, ensuring a consistent approach to delivering joint aims and objectives.

Service redesign and changes in policies will be written into newly designed service specification, with clear performance indicators which we will use to robustly monitor commissioned services.



Quality improvements

- Through 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 seek to transform community service provision, engaging with patients and public to agree how we can meet their needs better and develop a service which is flexible to meet those needs and meet the increasing birth rate.
- Listening to children, young people and their families/carers we will ensure that commissioning for SEND provision is aligned to patient needs, dovetails with RMBC priorities and meets the new policy changes.
- Through implementation of the diabetes best practice tariff, we will ensure that children who have diabetes receive the best standard of care.
- NHS Rotherham CCG are keen to implement the best practice tariff for epilepsy once published which will ensure that children with epilepsy receive the best standard of care.

Innovation

Midwifery and Early Years (Planned Care)

- Birth and beyond programmes of care, will enable services to work together to deliver a core service provision to all parents to be in a way Rotherham has not seen previously.
- The roll out of community midwifery onto SystemOne from a paper system will enable better information to travel across service provision, such as directly with health visiting and the family nurse partnership. An electronic record system will also support commissioners to use timely data when developing commissioning plans, to better meet the needs of Rotherham residents.

Care Closer to Home (Planned Care)

- 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.

Unscheduled Care

- 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 and the Children and Young people Plan 2013 - 2016

- Signed up to working with partners to deliver the children plan
- Early intervention and prevention
- Best start in life – a child who is healthy, safe and supported, is more likely to learn and thrive.
- Improved aspirations and expectations, and giving new families the confidence to be good parents
- In partnership with public health, we will support children and young people to lead healthy lifestyles
- Through exploring personalised budgets (SEND workstream) we will support children and young people with complex needs to live independent lives.

How will we address health inequalities?

We will carry out equality impact assessments on all policies and procurements and service specifications. 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 through a reduction in smoking during and after pregnancy and ensuring the delivery of the safe sleeping policies
- Through working with children centre's 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.



5.6 Community Services

| | |
|---------------------|------------------------|
| Lead Officer | Dominic Blaydon |
| Lead GP | Phil Birks |

Why are we planning to invest in this area?

NHS Rotherham CCG commissions a range of community health services which support vulnerable patients in their own home. Table 1 sets out the current spending profile.

Table 1: Spending Profile for Community Services

| SUMMARY OF COMMUNITY SERVICES | £000s |
|--|---------------|
| Children & Young People's Services | 4,296 |
| Planned Care | 4,151 |
| Long Term Conditions, Intermediate and Urgent Care | 13,794 |
| CQUIN | 559 |
| Pilots | 3,425 |
| Reablement | 631 |
| TOTAL | 26,855 |

People told us....

.....if we can help prevent people from becoming lonely, isolated and anxious, people may be more likely to feel well and adopt a healthy lifestyle.... Patient Participation Group meeting 29.10.13

A portion of this funding will transfer to RMBC as part of the Better Care Fund discussed in section 4.3.

NHS Rotherham CCG is committed to moving care closer to home where it is clinically appropriate to do so. We believe that more community investment is needed to facilitate this shift. Investing in community services will help to deliver positive health outcomes and free hospitals to focus on acute care.

Moving care away from hospital and into the community requires a whole-system approach. Hospital restructuring cannot happen in isolation but must be accompanied by a strategy for investment into community services. There has to be a greater focus on integration so that we can improve continuity and reduce fragmentation between the health and social care systems.

NHS Rotherham CCG will adopt the following principles when transferring services to the community:

- Integrating care and encouraging partnership working between health and social care providers
- Investing in initiatives to reduce hospital readmissions
- Developing a strong, knowledgeable, compassionate and skilled workforce
- Reducing bureaucracy, strengthening governance and developing clear lines of accountability

Key achievements in the last 12 months

NHS Rotherham CCG has already introduced initiatives which will increase the amount of care delivered in the community. Key achievements within the last 12 months include;

Development of The Oakwood Community Unit

The Oakwood Community Unit is a 20 bedded nurse-led unit intended to meet the need for step-up care from the community and step-down care from the hospital. The Unit supports patients who are medically stable but unable to return home. 66% of all admissions are direct from A&E. The service has prevented 657 admissions since it started in September 2012. The CCG evaluated the Unit's first year of operation in October 2013. A further evaluation will be held in October 2014 this will establish the contribution the unit is making to reducing hospital admissions, nursing levels on the unit, arrangements for medical cover and the ability of the unit to accept step up as well as step down patients.



Introduction of the Care Coordination Centre (CCC)

The Care Coordination Centre has three key functions

- Access point for GPs and other health professionals into alternative levels of care
- Supported discharge planning for patients at risk of readmission
- Single Point of Contact for NHS 111 patients who require community health services

The service has already had a significant impact on the number of GP admission. 11.5% of all referrals are diverted to alternative levels of care.

Reductions in Falls Related Admissions

NHS Rotherham CCG has worked closely with TRFT to develop an integrated falls and bone health service that works across acute and community. We have made significant investment in our falls service at a time when other CCGs have decommissioned services. As a result, during the last year the number of falls related admissions for people over 55 years dropped by 19%. The number of fragility fracture admissions for people over 75 years also reduced by 16%. Finally the number of people with a fractured neck of femur reduced by 8%.

GP case management, Social Prescribing and Community Hospice Pilots

These important projects with different providers are described in Sections 5.10 and 5.8

What will we achieve for our investment including efficiencies?

NHS Rotherham CCG is aiming to achieve the following outcomes

- Greater integration across health and social care
- The development of a single point of access into all community health services
- A better quality and more relevant community nursing service
- Increased utilisation of alternative levels of care

How are we going to achieve our intentions?

Workstream 1: A better quality and more relevant community nursing service

NHS Rotherham CCG will carry out a full review of community nursing services to produce a new service specification that will clearly define the role of the service and identify expected outcomes. The review will consider new emerging national priorities relating to the management of long term conditions identifying the contribution that the community nursing service can make to this agenda.

The Review will focus on the district nursing and community matrons but it will also consider the role of the Fast Response Team and how they connect with the broader community nursing services. The CCG requires a locality focus and vision for community services such as district nurses, the vision has to emphasise accessibility to GPs. There will be better communication about personnel changes, both internally within community services and with GPs, to ensure continuity of services to patients.

The CCG will consider investing in additional district nursing capacity if the current provider can provide a service that has a locality focus and will provide additional capacity to look after the additional numbers of people who will be cared for outside of hospital. Whilst the CCG will require 4% efficiency savings (1.9% absolute reduction for community services as a whole), district nursing services will be considered as an area for additional investment.

Workstream 2: Greater integration across health and social care

The Better Care Fund is a key driver in developing integrated health and social care services and is described in detail in section 4.3.

NHS Rotherham CCG will be negotiating with RMBC on the development of integrated care pathways, commissioning joint health and social care teams and extending intermediate care services. We will integrate



condition specific care pathways which straddle acute and community care. Specifically we will focus on falls/bone health, neurological conditions, cardiac rehabilitation and respiratory conditions. Finally we will promote an ethos of self-management as part of the integration agenda. We will deliver joint workforce development plans on self-management and develop patient skills programmes that are easily accessible.

Workstream 3: The development of a Single Point Access into community health services

This year NHS Rotherham CCG will extend the role of the Care Coordination Centre (CCC) so that becomes a single point of access into all community services that offer alternative levels of care. The CCC will support GPs on case management and ensure that care plans are available to CCC staff. The CCC will be a hub for telehealth locally and provide tele-coaching services for patients on the case management programme. We will explore the potential for extending the hours of the service so that it can support health professionals and patients 24/7. We will strengthen care pathways from NHS 111. Finally we will ensure full utilisation of the care pathway from YAS (999) to the CCC.

Workstream 4: Increased Utilisation of Alternative Levels of Care (ALOC)

Rotherham has a range of ALOC services that are easily accessible, well utilised and which have a proven track record in admission avoidance. We will make sure that commissioning arrangements ensure that the needs of patients with respiratory illness are addressed and that Rotherham patients get maximum value from the Breathing Space facility. We will reconfigure The Oakwood Community Unit so that it takes a greater proportion of step-up beds. We will also increase utilisation of those beds. We will explore the potential for integrating the falls service into intermediate care and we will look at the interface between generic therapy services and intermediate care.

Quality improvements

The key quality outcomes that will be achieved if we successfully implement this strategy are;

- The CCG will require monthly reporting on community nurse staffing levels in a comparable way to ward reporting as required in the Government response to the Francis Report.
- Increased levels of self-management for people with long term conditions
- Greater continuity between health and social care services
- A clear access point to services when people have an urgent health needs
- A GP facing, high quality community nursing service

People told us....

.....that both patients and GPs need information and education about self care and why its important....

Patient Participation Group meeting 29.10.13

Innovation

Rotherham has a track record of delivering innovative community health services. As well as The Community Unit, Care Coordination Centre and ALOC Services Rotherham has supported a range of leading edge initiatives. We have a fully integrated stroke care pathway, which incorporates specialist psychological support, a community stroke team and carer support workers. NHS Rotherham CCG recently commissioned a Community Buddy and Communication Partnership scheme that uses volunteers to support community integration after hospital discharge. We have also introduced an urgent response equipment transport service which ensures that patients in hospital get equipment supplied within 48 hours.

Alignment with H&WB strategy?

All the workstreams identified in this part of the Commissioning Plan are aligned with Priority 5 of The Health and Wellbeing Strategy - long term conditions. The strategy states that 'Rotherham people will be able to manage long term conditions so that they are able to enjoy the best quality of life'. The CCG leads this priority and supports its partners in delivery.

How will we address health inequalities?

Much of the spend in this area is focused on caring for people from disadvantaged groups because the JSNA shows that they are the groups who suffer more morbidity. Currently most of the CCGs spend is on acute hospital treatment for conditions that have already become emergencies. Investment and realignment of community health services will promote earlier intervention, individualised care and self care to help people live and work well. The redesign of care pathways will flow through the system and enable more care to be provided at home or close to home.



5.7 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 patient's 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 domiciliary care providers. There are 20 nursing homes in Rotherham.

The spend for 2011/12 and 2012/13 on Continuing Healthcare (CHC) and funded nursing care (FNC) was £12.6 million and £14.4 million, respectively. In 2013/14, we expect this to rise to £ 15.3 million. Based on the trend, we expect expenditure in 2014/15 to reach £ 16.6 million.

Key achievements in the last 12 months

The CCG has piloted personal health budgets (PHB) for 40 patients in receipt of CHC in a domiciliary care setting. This is to ensure our readiness to respond to patients who will have the right to request a PHB from 1 April 2014. A provider event was held for all care homes and plans are in place to implement the NHS Standard Contract with full performance monitoring arrangements from 1 April 2014. The CHC service is now provided by the CSU and full transition to the new organisational structure has taken place.

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 a domiciliary or residential care setting. 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
- We will benchmark ourselves against other CCGs to understand how we compare on CHC costs and activity – the CCG current is 50 out of 211 CCGs nationally and has higher activity and costs per 10,000 population than the England and North of England average
- Work in partnership with the RMBC, TRFT, Rotherham Hospice, primary care, domiciliary providers, care homes and the voluntary sector
- Work in partnership with the NHS West South Yorkshire and Bassetlaw Commissioning Support Unit to ensure the delivery of a high quality CHC service.
- Continue to commission individualised services for children with complex health needs
- Roll out the right to request personal health budgets to patients in receipt of domiciliary CHC from 1 April 2014.
- 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
- The community EOLC pilot (section 5.8) will provide additional specialist support for fast track CHC patients



Quality improvements

Quality improvements will be driven through robust contracting arrangements. 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

In April 2014, the CCG will roll out the right to request a personal health budgets to all patients with receiving CHC in their own home.

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.
- The personalisation agenda will put recipients of CHC in control of their care and that opportunities for self care and the use of alternatives to acute hospital admission maximised.
- Opportunities for self care 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.

5.8 End of Life Care

People told us....

.....that it's vital for people to be able to talk about how and where they spend their last days, but wondered who starts these difficult but important conversations.....

.....that everyone in Rotherham should be able to choose where they spend their last days and how they are care for... Patient Participation Groups network, 29.10.13

| | |
|--------------|----------------|
| 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 £2.75 million in specialist End of Life Care from Rotherham Hospice. This provides a multidisciplinary service for patients with complex problems and provides specialist educational and practical support to other primary and secondary care staff. Around £2 million of this is recurrent funding, £750, 000 is for an additional hospice community care pilot that commenced in 2012, this service will be re-evaluated in October 2014.

In view of the importance of the area and the fact that the Hospice generates a considerable proportion of its own funding the CCG will fund the Hospice's recurrent funding in 14/15 will be unchanged and so not subject to the -1.9% efficiency requirements of other providers.

Key achievements in the last 12 months

Put in deaths not in hospital data when this becomes available.

The Hospice community pilot has delivered increased capacity allowing an additional 300 people to receive community EOLC. The pilot also provides a 24 hour helpline and an educational programme to health professionals in Rotherham.



We have agreed a care pathway with Yorkshire Ambulance Service so that EOLC patients who deteriorate can be transferred directly to hospice services without the need for A&E assessment.

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.

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 ensure that TRFT actively recruits to district nurse vacancies so that the numbers of district nurses in the community match contracted numbers (see section 5.6).

Rotherham Hospice and TRFT care coordination centre will further develop protocols and working arrangements so that more EOLC patients who deteriorate can be offered the option of community services rather than hospital assessment (see section 5.1).

The CCG will ensure that crucial conversations about EOLC care take place at the appropriate time for patients with long term conditions, the Case Management Pilot (see Section 5.10) will be a major enabler of this. The CCG has extended the eligibility for funding of the GP case management pilot to all patients in nursing and residential homes, this funds additional GP time which will be important to better coordinate EOLC in nursing and residential homes.

The CCG, RDaSH and Rotherham Hospice will further develop care pathways for EOLC patients with dementia. In 2014, following the expected publication of further national guidance the CCG will work with TRFT and Rotherham Hospice to phase out the Liverpool Care Pathway without reducing the quality of care for people on EOLC pathways. The emphasis will be on the *Preferred Priorities of Care Tool*, decision making, consent and changing language to facilitate the concept of a good death.

The CCG will work with Rotherham Hospice to review the hospice's current services (which are recurrently funded by the CCG and from the hospices' own fund raising). The review will include how the hospice delivers community services, arrangements for medical cover and increasing the ability of the hospice to admit patients to community or inpatient care 7 days a week.

The CCG will invest an additional sum in 2014/15 to continue the current community EOLC pilot. This service will continue to provide community EOLC services, a 24 hour helpline, better record sharing and an electronic register to enable better case management between patients. The CCG will review the educational aspect of this pilot. The pilot will be required to deliver a consistent level of communication to all practices across Rotherham. The key deliverable to ensure continued funding will be to continue the demonstrable reduction in hospital admissions for EOLC patients. The pilot will be evaluated in October 2014.

Quality improvements

- More patients will have better conversations about the fact that they need end of life care
- More patients and families will have advanced directives.
- Patients care will be better co-ordinated.
- More patients will die in the setting of their choice.

Innovation

Rotherham customised the Leeds electronic end of life care register project in 2013, in 2014 we will ensure that this is fully rolled out.



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. The community EOLC pilot will work with individual practices to reduce this inequality.
- 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.
- We will monitor the ethnicity of people receiving specialist EOLC services and ensure that this is representative of the Rotherham population.

5.9 Ambulance and Patient Transport Service

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|--------------|-----------------|
| Lead Officer | Dominic Blaydon |
| Lead GP | Ian Turner |

Why are we planning to invest in this area?

NHS Rotherham CCG is committed to delivering an effective 999 service which 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

We are also committed to delivering a non-urgent Patient Transport Service (PTS) which 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

The time taken to pick up 999 patients in Rotherham was consistently below the rate for other CCGs across South Yorkshire. NHS Rotherham CCG is continuing to show improvement through 2013/14 and we intend to continue this trend. We will work with our main provider, the Yorkshire Ambulance Service to ensure that paramedics and ambulance crews seek alternatives to A&E when transporting patients. We will establish close links with the Care Coordination Centre so that senior nurses can advise ambulance crews on the most appropriate service destination. Finally we will broaden the range of community facilities that ambulance crews can use when transporting patients.

People told us....

.....Patients who used Yorkshire Ambulance Service Patient Transport in September 2013 told us that only 1/3 of them (35%) would recommend the service to family and friends in a similar circumstance... survey in September 2013

Key achievements in the last 12 months

Patient Transport Services

Activity with YAS is continuing to reduce with an in year reduction of 8.6%. This continues the trend of previous years. PTS performance continues to provide challenges. The Renal transport contracts continue to provide a high level of service provision and patient satisfaction. The flexible service model is being reviewed with a view to share the learning and success with other PTS providers.



YAS 999 contract

The over-performance on the 999 contract continues and ways to reduce this demand are being explored with some success. NHS Rotherham CCG has recently commissioned a pilot transport service which undertakes urgent GP admissions. We are supporting YAS with the introduction of their Pilot Paramedic Pathfinder in the Rotherham area. Training local paramedics to undertake routine non trauma examinations of patients will reduce conveyance rates to A&E.

What will we achieve for our investment including efficiencies?

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

Patient Transport

NHS Rotherham CCG will progress the work on 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 relaunch the eligibility criteria and promote a better understanding of the costs involved. We will 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 the eligibility criteria.

We will review all the current service specification, so that it is aligned with the general aims of the Commissioning Plan. 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 explore the potential to pilot a Patient Transport Service providing journey's into and out of GP practices for housebound patients.

A new transport provider will be procured to ensure all journeys for NHS Rotherham CCG patients outside the South Yorkshire boundary are undertaken in the most cost effective way. This will remove the need to place journey's with arms length private providers at a significant cost.

We will work closely with staff at the acute trust to ensure the transport for discharge is an integral part of their discharge planning, therefore ensuring it is undertaken in the most cost effective way and reducing the demand on the more costly on the day discharge transport service.

Pilot to extend eligibility to patients seeing GPs

The CCG will do an audit and then a pilot to investigate the value of providing a transport service for housebound patients who need to see their GP. This would improve quality of care for people with long term conditions and also reduce GP time in travelling which can be used to the benefit of other patients. In 2014/15 following an audit to establish baseline information, proof of concept and evaluation criteria we intend to pilot a service which will have clear outcomes linked to the CCGs area of responsibilities. The results of the evaluation will determine whether to roll this out to all patients in 2015/16. Following the audit there would need to be a business case demonstrating likely outcomes and efficiencies. The governing body would then need to consider whether it would offer a pilot to a member practice to further gather evidence of outcomes and efficiencies. The business case would need to note conflicts of interest where appropriate.

Emergency Ambulance Service

YAS are required to meet Yorkshire wide targets including the time to respond to urgent calls, during 2013/14 they have been able to meet their wider targets but sometimes without meeting Rotherham specific targets so ensuring that standards for Rotherham patients are the same as the YAS average is very important for the CCG. 999 activity continued to increase in 2013/14 and we will work with YAS and the public to decrease this trend. NHS 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. We will improve the patient flow from 999 calls through to the 111 system.



NHS Rotherham CCG will work with individual GP practices who are referring a higher number of patients to YAS for transport than their peers to fully understand the requests and to ensure that their referrals are appropriate.

Currently most patients conveyed by ambulance are taken straight to A&E. We will put in place protocols to transfer patients to other services such as Breathing Space, Fast Response or Rotherham Hospice. By developing strong partnership arrangements between the Care Coordination Centre and YAS, we will introduce targeted clinical support so that ambulance crews can make an informed choice about the most appropriate level of care. We will support YAS with the introduction of the Paramedic Pathfinder to increase their non-conveyance rates. .

The care coordination 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. We will introduce local performance measures to monitor the use of alternative levels of care.

We will work with local care and residential homes to understand the demand they place on YAS to ensure this is appropriate and work to ensure they are aware of alternatives services for the patient.

How are we going to achieve our intentions?

The CCG will streamline the commissioning of Ambulance and PTS services. Sheffield CCG will represent South Yorkshire CCGs with regards to the commissioning of NHS 111 and YAS (including the YAS PTS contract). NHS Rotherham CCG will continue to directly commission the four other PTS contracts.

Quality improvements

NHS Rotherham CCG will improve the quality of emergency and planned patient transport services by delivering

- A broader range of service destinations for emergency or planned transport services
- Better integration between the ambulance service, primary care and community services
- Transport for patients to the most appropriate care setting

Innovation

Key innovations delivered as part of this year's Commissioning Plan include;

- Partnership working with the CCC to support on identification of appropriate level of care
- Use of an alternative provider to deliver GP urgent transport
- 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

HWB Strategy - Priority 3: Dependence to Independence. Clear eligibility criteria will encourage patients who are not housebound to utilise alternative transport.

HWB Strategy - Priority 5: Long-term Conditions. The hub and spoke approach to patient transport will mean that people with long term conditions can receive treatment in the community, nearer to home.

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.



5.10 CCG Commissioned Primary Care

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

Why are we planning to invest in this area?

The CCG will commission primary care services in addition to those commissioned by other commissioners where they are necessary to address our responsibilities and achieve our priorities.

Commissioning core primary care services is currently the responsibility of NHS England but high quality primary care is essential for the CCG to commission effective hospital services. NHS England are responsible for the vast majority of NHS Commissioning from primary care. This includes the core contract, all GP directly enhanced services and most locally enhanced services. The CCG will however commission some locally enhanced services from primary care providers, in addition some services will be commissioned by public health.

In our approach to commissioning in this area we will be mindful of services commissioned by other commissioners and ensure that as far as possible our services are complementary and additional to those from other commissioners.

Overall the CCG will commission from primary care in the following areas:

1. A Local Incentive Scheme (LIS) to ensure the CCG has GP engagement/member engagement. This is likely to include a clinical audit programme and a prescribing incentive scheme to ensure that GPs prioritise high quality and costs effective prescribing.
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 plans (section 5.2). Currently the two main areas covered by this scheme are post operative wound management and the management of people with prostate specific antigen, but it is likely that other areas will arise as part of a managed shift of the management of follow ups from secondary to primary care.
3. The Case Management Pilot LES to improve the case management of 12,000 patients at risk of hospitalisation which is key to our unscheduled care efficiency plan (see also section 5.1). In 2013/14 the pilot was solely for patients identified by a computer tool as being at the highest risk of admission to hospital. In 2014/15 the tool will still be used to identify the first 3% of patients eligible to be on the scheme. An additional 2% of each practices population will be eligible for the scheme this will also include all patients in nursing and residential homes and other patients selected on the basis of clinical judgment.
4. The Case Management Pilot will be re-evaluated in October 2014. It is one of the areas whose future commissioning will be via the Better Care Fund (see section 4.3) so the evaluation will be used to assist the Health & Wellbeing Board make decisions on the future commissioning of the pilot.
5. CCG commissioned Locally Enhanced Services with GPs (LES); including anticoagulation and disease modifying agents. On an annual basis the CCG will review its LES to ensure they are still fit for purpose. In 2014/15 we will no longer commission an acupuncture LES but we will commission a local pain management service (see section 5.2).
6. CCG commissioned LES with optometrists. In 2014/15 the CCG will commission two LES; for cataracts and the detection of intraocular hypertension. These are intended to reduce the number of people who need to see hospital specialists. Currently less patients than expected use these services and in October 2014 we will review whether to continue these LES in 15/16.
7. CCG pharmacy LES's for minor ailments and palliative care.



In 2013/14 spend in this area includes £0.7 million for the LIS and £1.3 million for the Case Management Pilot, plus funding for the CCG commissioned LESs.

The CCG will consult about potentially moving to a situation where GP services to nursing homes are provided by one practice per nursing home in most cases. The CCG believes that this would lead to increased quality of care and to more effective safeguarding. There are however concerns about patient choice and practice autonomy so consultation and learning lessons from other health communities that have made this change will be important.

In addition to services commissioned from primary care the CCG supports NHS England in its role of developing primary care in the following ways:

- Joint work on GP quality (see section 6.2)
- Running protecting learning time events for General Practices
- Supporting a Rotherham practice managers forum
- Developing and implementing a Rotherham GP IT strategy (see section 11)

Key achievements in the last 12 months

Rotherham Practices are well engaged with the CCG through a successful locality structure and a GP Members Committee that works very constructively with the executive GPs. Rotherham GPs gave a 100% vote of confidence in their executive in October 2013.

30 out of 36 practices are engaged with the case management pilot, at evaluation this was judged to have made an important contribution to keeping Rotherham's emergency admission rates within affordable levels in 2013.

All practices have collectively signed up to the secondary to primary care LES which makes the managed transfer of follow up patients much simpler and safer.

Referral and admission rates have kept within affordable levels. This has been as the result of commitment by all 36 practices in responding to benchmarking, education events and guidance. More details are given in sections 5.1 and 5.2.

The CCG practices have improved prescribing quality whilst having the second lowest prescribing costs growth in Yorkshire and the Humber see section 5.3.

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?

- The CCG will make a proposal to NHS England to manage GP general medical service and personal medical service contracts if sufficient management resources were transferred and governance arrangements for managing conflict of interest were robust. We believe this would be in the interest of Rotherham patients and make it easier to develop the system wide care pathways required to deliver efficiency programmes. This proposal could only come into being if NHS England agreed to delegate this responsibility, there would then have to be a change to the constitution and so if the proposal becomes a realistic opportunity the CCG would evaluate the benefits and risks and consult extensively with the membership before making a final decision.
- 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



- The urgent care redesign project (section 5.1), has considerable implications for both out of hours and day time general practice services and should lead to a situation where over time more patients with general practice problems get seen in a general practice setting

People told us....

.....they came to A&E and to the Walk in Centre when they could not see their doctor at the time they felt appropriate ' its easier to come here than to go to the GP'.... Survey in A&E 2013

- We will support NHS England with 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
- The CCG will keep under review the services that it commissions from GPs and will avoid any duplication that might arise from future changes to national NHS England contracts.

Quality Improvements

- The CCGs Memorandum of Understanding with NHS England on GP quality is described in Section 6.2
- The CCG runs a well regarded programme of protected learning time events aimed mainly at general practice staff, which has strong involvement of community and secondary care clinicians
- 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 will enable the CCG to move appropriate services out of a hospital setting and into the community

Alignment with Health & Wellbeing 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 care closer to home and self care

How will we address health inequalities?

- Secondary to primary care LES ensures universal coverage of provision
- All previous LES's will be reviewed and either decommissioned 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 and is linked to social prescribing which addresses health inequalities
- We will work with NHS England to reduce unexplained historical funding variations to GPs so that all practices have equal opportunity to provide the best services to patients.

5.11 Commissioning Support/Intelligent Commissioning

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|--------------|-----------------|
| Lead Officer | Robin Carlisle |
| Lead GP | Julie Kitlowski |

Why are we planning to invest in this area?

The CCG has to deliver all its responsibilities effectively but also keep its running costs as low as possible so the maximum amount of funding is allocated to front line patient services. It is also likely that the current national maximum allowable spend of £25/head may be reduced in future years.



In 2013/14 the CCG spent £6 million on internal costs, £5.47 million were classed as running costs and £500K (mainly medicines management CCG costs that are not included in running costs).

Of the £6 million costs of supporting commissioning £3.9 million (65%) is spent directly by the CCG on its GP leaders, supporting officers and associated costs. £2.1 million (35%) is spent on a contract with South Yorkshire and Bassetlaw Commissioning Support Unit (CSU). CCG running costs (£22/head) are currently below the NHS England set threshold of £25/head for 14/15 but the threshold will be reduced further in 15/16

Key achievements in the last 12 months

The CCG has established itself as a new organisation which was authorised in the first wave with no conditions and is fit for purpose to deliver its responsibilities. We have specified the service level agreement (SLA) and key performance indicators for the services that we require to be delivered by an external CSU.

What will we achieve for our investment including efficiencies?

The CCG will continue to improve as an organisation by learning from our experiences and deliver our functions in an increasingly efficient way.

The CCG will continue to monitor and listen to staff feedback and staff satisfaction.

In 2013 we moved the communications service back in house because it was felt that this service would provide better value if the communications manager were full time in Rotherham in order to work more effectively in partnership with the communications leads of our local Rotherham based partner organisations.

Currently 9 services are provided by the CSU; continuing health care, business intelligence, individual funding requests, choose and book, human resources, organisational development, equality and diversity, aspects of financial management, procurement and information technology.

How are we going to achieve our intentions?

The CCG's operational executive will review the CCG's structure each 6 months to ensure that it is fit for purpose to deliver our strategy and statutory functions and also provides value for money. This review will involve considering whether current in house services could be more efficiently provided externally.

The CCG manages its contract with the CSU through monthly SLA meetings and contributes to the development of CSU services together with other CCGs through the SY & B leadership forum. The CSU expects to be able to deliver 10% efficiency savings on the CCG's SLA during the 2 year period starting from April 14.

In 2014 NHS England will support a process through which the CCG will procure commissioning support for a four year period through a lead provider model for those areas of support that the CCG chooses to outsource. The CCG will review its make/share/buy decisions on all its services as part of this process.

Quality improvements

This section is about improving and making more efficient support services to improve commissioning to improve the quality of services providers offer to patients.

The CCG is working with Investors in Excellence to develop all of its workforce and its organisational competence.

Innovation

The CCG expects to see substantial improvements in business intelligence through the CSU developing a data warehouse with the front end ability to present information on hospital activity to general practice members, more easily, more accurately and in a more timely fashion.

How will we address health inequalities?

The CSU SLA includes the equality and diversity function.



6 Statutory Responsibilities

6.1 Public Involvement, Promotion of Choice and Complaints

Why Public Involvement and Choice are vital to NHS Rotherham CCG

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, maintaining one strong legal duty around patient and public engagement, and introducing a new legal duty for individual engagement. Clinical Commissioning Groups (CCGs) therefore have a duty to enable:

- patients and carers to participate in planning, managing and making decisions about their care and treatment, through the services they commission;
- the effective participation of the public in the commissioning process itself, so that services provided reflect the needs of local people.

In addition, NHS England has set out clear expectations of how participation is central to helping local clinicians to deliver more responsive health services in *'Everyone counts: planning for patients 2014/15'*; these duties are also further clarified in publication of *'Transforming Participation in Health and Care'*

However, in Rotherham, the CCG recognises that participation is not only about legal requirements. It underpins everything that we do. NHS Rotherham CCG has a real commitment to patient, public and stakeholder engagement; this is led by one of our two lay members, with a specific remit for public and patient involvement.

NHS Rotherham CCG's vision for involvement

NHS Rotherham CCG has comprehensive plans to extend our existing engagement across the key areas of individual participation, public participation, and using insight and feedback, while ensuring that engagement and participation is strongly allied to our organisational priorities.

Our vision is described in more detail in our patient and public engagement strategy *'From Consulting Room to Governing Body'* [\(add link\)](#). The strategy has informed this section of our plan, as have *'Transforming Participation in Health and Care'*, NHS England 2013, and the reports of Berwick, Keogh and Francis.

Driven by these three reports a detailed Patient, Public Engagement and Experience report is received at each of our governing body meetings. The report includes information, from *'Patient Opinion'*, feedback from the *'Friends and Family Test'* and details other specific patient and public engagement activity across the borough.

Our aim is to ensure that engagement informs all our work; we have developed a systematic process to map, monitor and evaluate engagement across all our workstreams and to identify gaps. We started this process during 2013, opening the evaluation to key stakeholders, and intend to continue and refine this process, to enable us to record engagement activity and to systematically identify any gaps and priority areas.

We also want to be able to demonstrate openly two things:

- how we listen to patients across all our areas of work
- and how what people tell us informs how we commissioning and plan services



In this annual plan, we are taking steps towards this, and our aim is to improve this year on year.

In addition, patients, the public and stakeholders have been influential in developing this commissioning plan, further details of this is in section 14.

What this means, and what we plan to do

Individual participation, we will

- Evaluate the success of our existing programme for personal health budgets in continuing care and use the data in extending this programme
- We will ensure that patients and carers can participate as far as they want to in planning, managing and deciding about their care through a variety of commissioned services, including continue to commission our social prescribing programme from the third sector, in order to:
 - Improve outcomes for patients in terms of health, wellbeing, self-care and independence
 - Increase resilience of individuals and communities
 - Support dependence to independence
 - Reduces social isolation.
- Self-management for life programme (commissioned to end March)
- Ensure that providers are involving patients in all aspects of service redesign
- Commissioning for involvement in own health pathway is key
- Continue to build public awareness on shared decision making using tools such as “Ask three Questions”

Public participation, we will

- Build on the techniques used in our ‘Right Care, First Time’ consultation on the future shape of urgent care services in Rotherham, to ensure that we routinely engage with patients, carers and the public when redesigning or reconfiguring healthcare services,
 - Using tools such as the ladder of engagement and the engagement cycle to plan and measure public participation
 - Providing good information, and raising health literacy
 - Providing a range of opportunities and mechanisms for engagement, using both electronic media and community networks
 - Reaching out to diverse communities
- Ensure that during 2014/15 that the public, patients and carers continue to be involved in the development of the new urgent care facility, working together with local providers in this
- Continue to support and work with the established Network of Patient Participation Groups; facilitating the development of strong practice based participation groups, and offering a forum to consider cross cutting issues
- Continue to work with Healthwatch, seeking to add value and avoid duplication in both our work and roles. We will build on the emergent mechanisms for sharing information and identifying emergent themes across health.
- Look at using different ways – throughout the life of the plan – to make sure that we listen to patient voices,
 - Through direct conversations with patients and the public
 - Through ensuring that the services we commission also seek patient views; use this information to improve services; and share the information with us as commissioners.
- We will also ensure that we will involve people in new and emergent pieces of work, including



- Community nursing services
- Ensuring quality in both children and adults mental health services
- Improving out of hospital care

Ensure that we capture insights from patient stories from all our 150 member GPs

- Our 150 together see thousands of patients each week, and therefore provide fast and timely feedback and reflection on current patient need
- We will establish mechanisms to capture and use this soft intelligence to identify common themes and priorities

Assure that our providers make good use of Insight & feedback

- Listen and act upon patient and carer feedback at all stages of the commissioning cycle – from needs assessment to contract management.
- Publish evidence of what ‘patient and public voice’ activity has been conducted, its impact and the difference it has made.
- Publish any feedback from Rotherham Healthwatch about health and care services in their locality, and other data, in a way that patients and the public understand.
- We will continue to systematically feedback both to individuals where possible and to the community in general, how engagement has informed decisions, using both electronic mechanisms, local press and community networks
- During 2014/15, the Government aims to see the ‘Friends and Family Test’ (this identifies whether patients would recommend a hospital or service to others) extended to all services. We will work with all relevant providers to support this and to use any data from this exercise in commissioning and monitoring of services. The FFT is already giving both service providers and commissioners more real time patient views of services than ever before, and NHS Rotherham CCG welcomes the extension of this rich data stream
 - As information from FFT becomes available, we will ensure that we share this data with the public.
- We continue to use a variety of mechanisms for listening to patient voice - including ‘the whispers’. We will triangulate data coming from these, for example
 - Comments from FFT as above, shared openly by providers
 - Online comments and stories via Patient Opinion and NHS Choices, for example
 - Data shared by Healthwatch
 - Informal information from community meetings and contacts
- We will continue to develop our website and the use of social media to feedback to the community
- We will continue to work with Healthwatch and RMBC to get views from patients and carers around complex care to support the Special Educational Needs and Disabilities (SEND) agenda

How to feedback comments on the CCG Commissioning Plan

The CCG aims to improve services for patients, this can only be done on the basis of feedback from patients, public and clinician’s, please send any comments on the plan or any other issue relating to the CCG to the following e-mail address rotherhamccg@rotherhamccg.nhs.uk .



Complaints

Complaints are another mechanism for listening to patient's views and concerns, and an opportunity to improve the services that we commission.

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 provider's services. We will do everything possible to try and resolve complaints. Complaint letters should be addressed to the Chief Officer or the Governance and Complaints Officer, detailed information about how to make a complaint is available on our website [\(add link\)](#)

6.2 Quality Assurance and Quality Improvement of Commissioned Services

The CCG's Chief 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 6.3, 6.1 and 6.4).

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 is integrated with health related or social care services, where it would improve quality or reduce inequalities.

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

- Assurance that providers' cost improvements plans (CIPs) have robust quality impact assessments and can be delivered without compromising quality and safety. It is requisite that CIPs be signed off by providers' medical and nurse directors and provide a 'line of sight' to ensure the commissioner is aware of any risks to clinical safety resulting from the requirements to make efficiencies.
- Monthly contract quality meetings with main providers where discussions include outcomes, experience, hospital mortality rates, CIPs, Commissioning for Quality and Innovation (CQUIN), Serious Incidents, patient safety agenda, Care Quality Commission inspections, audit, and safeguarding.
- At our contract meetings providers report compliance with National Institute for Clinical Excellence (NICE) technology appraisals. We track local formularies to ensure they are consistent with guidance from NICE.
- Monitoring of national and local quality standards set out in the contracts the CCG holds with providers and application of financial sanctions for underachievement as appropriate.
- Monitoring of action plans developed due to underachievement against contractual quality standards and holding the provider to account for delivery through contract meetings.
- Healthcare associated infections; we hold all our providers to account to make further substantial reductions in clostridium difficile with a root cause analysis of all cases. We have a zero tolerance approach to MRSA.
- Monthly quality reports to both open and closed sections of the CCG Governing Body covering issues, compliments, incidents, and complaints.
- Serious Incident 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 and Chief Nurse walk rounds, both of these unannounced and at varying times during the day and night.



- 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.
- Obtaining assurance from providers regarding the “Compassion in Practice Vision and Strategy” for Nurses and Midwives and implementation of the 6 C’s across services (Compassion, Courage, Competency, Commitment, Care and Communication).
- 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, developed to collate evidence relating to quality of commissioned services, gaining assurance, assessing risk, and undertaking in depth assessment where appropriate [\(add link\)](#)

The CCG seeks additional assurance whenever required. For example we have sought assurance following the nationally publicised abuse of patients at the Winterbourne View near Bristol, and the CCG actively case manages and visits regularly all patients who are placed out of area with mental health or learning disabilities.

In line with the recommendations made in the second Francis Report, the Keogh Review, and the Berwick Report, and the Winterbournes Report, the CCG carefully monitors quality and standards in all providers through a framework of reporting, monitoring, assessment and visits. To ensure that the CCG responds fully and takes account of these four reports and the Government responses we have mapped the key points and recommendations in a diagram [\(add link\)](#) which is supported by an ongoing action plan.

With the increased emphasis on assurance driven by Francis, Keogh, Berwick and Winterbourne, the CCG Governing Body recognised the need for increased information and discussion. In response, a detailed Quality and Safety report, which includes safeguarding, patient safety, mortality rates, incidents and CQUINs is received at each governing body meeting. Going forward the report will be refreshed to ensure contract quality information is adequately reflected.

The CCG is a member of the South Yorkshire and Bassetlaw Quality Surveillance Group which brings together all commissioners and regulators to co-ordinate their assurance. Where the CCG has concerns over assurance we gather further information and escalate concerns according to our Appreciative Inquiry Policy [\(add link\)](#).

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 2014/15 the maximum value of the CQUIN is set at 2.5% of the full contract value.

To achieve CQUINS providers have to meet pre-qualification requirements of compliance with the national High Impact Innovations. The pre-qualification criteria for 2014/15 have not been published to date, but are due for release in January 2014. It is anticipated that the pre-qualification requirements will relate to the following areas: dementia, telehealth and digital, NICE technology guidance and service transformation, although the specifics of these areas have not been released.

The guidance for the 2014/15 CQUIN scheme has yet to be published but is due for release in January 2014. Early indications are that the national indicators will continue to focus on the Friends and Family Test, NHS Safety Thermometer, Dementia. Venous Thromboembolism is expected to be removed although there has been no formal communication to date. Currently, the national CQUIN goals are 0.5% of the full contract value.



The CCG will be shortly entering into the contract negotiations process whereby the agreement on inclusions for the local CQUINs will be discussed. Local CQUINs account for 2% of contract value and early discussions have highlighted the following areas as priorities for inclusion in the 2014/15 local scheme [\(add link\)](#):

TRFT

- Improving Quality and Timeliness of Clinic Letters from Secondary Care to Primary Care
- Improving Quality and Timeliness of Discharge Letters from Secondary Care to Primary Care including Handover Plans
- Safeguarding (Francis and Winterbourne)
- Community Patient Experience
- Engagement in CRMC including Audits
- Engagement in UCMC including Audits
- Nurse Leadership/Key Nurses – acute and community staffing ratios
- 24/7 working

RDaSH

- Patient experience
- Learning Disabilities and Dementia
- Dementia
- Care Planning
- Recovery
- Carers
- Safeguarding

Our proposals for 2014/15 are being developed in collaboration with our membership and provider. [Add link](#)

In addition to the CQUIN incentives, the CCG make full use of the Local Incentive Schemes that are included in the NHS Standard Contract to ensure the delivery of quality services and promote innovative practice. The Local Incentive Scheme for 2014/15 will focus on those priority areas in both the CCGs Commissioning Plan and the NHS Outcomes Framework.

In section 5 we list quality improvement initiatives in each of the CCG's 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 the management of people with long term conditions through GP Case Management, and increased self-management levels
- Reduction in waiting times for psychological therapy services
- Improved quality and standards in comparison to National and Local priorities for health and social care
- An increase in the number of patients able to access treatment locally at their GP practice
- Annual prescribing efficiency plan and redesign projects such as wound care, nutrition and continence
- Improved service in children and adolescent mental health services
- Ensure the special educational needs and disabilities (SEND) agenda is aligned to patient needs
- Improved high quality community nursing service
- Improving outcomes for babies born to teenage parents
- Increasing the number of people with a learning disability who are 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.

Working with the CCGs largest provider of secondary care, the CCG Quality Assurance Team supports and actively engages with a programme of clinical audit and effectiveness activity that is designed to improve standards and quality in the delivery of services, and at the interface of primary and secondary care. The CCG remains committed to its involvement in the Yorkshire group for quality professionals, sharing and learning from best practice across the region, as well as feeding into the national bodies of the Healthcare Quality Improvement Partnership and the National Audit and Governance Group.

6.3 Role in GP Quality

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

A Memorandum of Understanding between the CCG and NHS England sets out how the two organisations, will respect each other's responsibilities, share information and work together on "Improving Quality in Primary Medical Services" [\(add link\)](#).

The CCGs Quality Assurance Team manages the majority of enhanced service contracts in primary care relating to general practice and optometry. They provide oversight of performance against contract parameters, and routinely collect information that assures the CCG that commissioned enhanced services are safe and good value for money.

The CCG has agreed a programme of peer review visits with all GP practices in Rotherham, with each practice receiving a visit at least once every three years in a rolling programme. SCE GP members will undertake the visits. The CCG will make available to GP practices information regarding the practices achievement across an identified set of quality indicators including medicines management, local enhanced services, referrals, unscheduled admissions. Practices are able to benchmark themselves against other Rotherham practices. The peer review discussion will focus on area of good practice and those where it has been identified the practice could make changes to improve the quality of the services they provide.

The CCG provides benchmarking information to member practices as set out in sections 5.1 and 5.2 and supports successful 'protected learning time' events for general practitioners and incentives practice managers to meet together in the practice manager forum.

6.4 Safeguarding

NHS Rotherham CCG fully acknowledges that safeguarding is **all our responsibility**. With regard to **children and young people** the CCG endorses its statutory duty to safeguard and promote the welfare of children; ensure robust governance arrangements are in place and to be active members of the Rotherham Local Safeguarding Children Board. It is anticipated that the safeguarding **vulnerable adults** Care and Support Bill, once given assent, will set out comparable requirements. This includes the expectation that CCGs will be active partners in Safeguarding Adults Boards.

For **looked after children (LAC)** CCGs are to retain the Responsible Commissioner status for all Rotherham LAC. This responsibility includes providing looked after Children with regular planned health assessments, upon placement and an annual/bi-annual review thereafter; identified health and welfare needs will be given



additional priority ensuring that our LAC receive a quality seamless health service for those Rotherham LAC living in or out of area. The CCG has an expectation that the CCG and the services it commissions will work with statutory and voluntary partners to reduce **domestic abuse**, this includes 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
- ensuring that identified clinicians have the seniority and capacity to lead on safeguarding agendas
- supporting the expected increase in the health visiting workforce by 24 by 2015 to ensure that early help is provided in a timely manner
- supporting the delivery and quality assurance of the Family Nurse Partnership to support vulnerable families
- monitoring health providers work with the healthy child programme and the early identification of health and welfare needs
- working with central government, partner organisations and RMBC to ensure that LAC receive timely and effective health care. Achieved through active membership of the RMBC's Corporate Parenting Group.
- continuing to monitor safeguarding standards in contracts, service specifications and compliance with Section 11 children Act expectations
- ensuring that the safeguarding agenda takes into consideration emerging national and local trends, for example work around child sexual exploitation and increase in self harm and suicides in young people.
- establishing and publishing a safeguarding dashboard of key performance indicators that will be shared with local partners and partners across South Yorkshire and Bassetlaw to allow for transparency and challenge in the system.
- supporting the development of the safeguarding adult's agenda, including, the Mental Capacity Act (2005) and Deprivation of Liberties legislation.

The CCG will produce and publish an Annual Safeguarding Children and Adult report [\(add link\)](#) 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 Children'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 Vulnerable Clients Policy [\(add link\)](#).

6.5 NHS Constitution and NHS Rotherham CCG Constitution

NHS Constitution '.....The NHS belongs to the people.....'

The NHS is there for us from the moment we are born. It takes care of us and our family members when we need it most.

The NHS Constitution has been created to protect the NHS and make sure it will always do the things it was set up to do in 1948 – to provide high-quality healthcare that's free and for everyone.

No government can change the Constitution without the full involvement of staff, patients and the public. The Constitution is a promise that the NHS will always be there for you.



For the first time in the history of the NHS, the constitution brings together in one place details of what staff, patients and the public can expect from the National Health Service. It also explains what you can do to help support the NHS, help it work effectively, and help ensure that its resources are used responsibly.

The Constitution sets out your rights as an NHS patient. These rights cover how patients access health services, the quality of care you will receive, the treatments and programmes available to you, confidentiality, information and your right to complain if things go wrong.

One of the primary aims of the Constitution is to set out clearly what patients, the public and staff can expect from the NHS and what the NHS expects from them in return.

The CCG has a strong record of achievement in the delivery of the standards enshrined in the NHS Constitution. The standards are a requirement of the NHS Standard Contracts we hold with all providers and we monitor these through monthly performance meetings. Where performance concerns arise, the CCG holds extraordinary meetings to discuss in detail performance concerns and develop robust action plans. Where the CCG has encountered performance concerns our approach has led to significant improvements e.g. performance against the 95% 4 hour A&E standard. The CCG has regular Board to Board meetings with our key providers where any under-performance against the NHS Constitution Standards can be escalated.

The CCG abides by the NHS constitution and promotes its awareness among patients, staff and the public.

The CCG Constitution

NHS Rotherham CCG is a membership organisation of 36 practices who are responsible for commissioning a range of health services on behalf of people in Rotherham.

The constitution sets out the CCGs arrangements to meet these responsibilities to ensure that decisions are made in an open and transparent way and that the interests of patients and the public are central.

The constitution covers the responsibilities of individual member practices, the GP Members Committee and the CCG Governing Body and committees of the CCG Governing Body.

It includes the CCG's duties to manage conflicts of interest and maintain a register of interests of its members and employees.

The Constitution will be reviewed on a regular basis by the GP Members and the CCG Governing Body.

6.6 Public Sector Equality Duty

The CCG is committed to equality of opportunity for all, regardless of race, gender, gender reassignment, religion or belief, sexual orientation, age, disability, maternity and pregnancy, marriage and civil partnership and we will strive to uphold the human rights of all staff and service users in accordance with the Human Rights Act 1998.

As a commissioner of health services:

- We will work with the people of Rotherham to continually assess and understand their changing needs.
- We will use the insight they give us to plan and deliver the right health services, and provide support and information to increase accessibility and choice.



As an employer:

- We will recruit, develop and retain a workforce that reflects the diversity of Rotherham.
- We will work to remove any unintended barriers that prevent equal opportunities for all staff.

Equality is central to the work of the CCG to ensure there is equality of access and treatment within the services that are commissioned. The promotion of equality, diversity and human rights is central to the NHS Constitution and 'Your life, Your health' and other drivers to reduce health inequalities and increase the health and well-being of the population.

We have used the NHS Equality Delivery System (EDS) to develop and prepare our four equality objectives which are:

- Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within Provider contracts.
- Ensure appropriate and accessible targeted communication with local communities to facilitate improved access and patient experience.
- Develop consistency of equality approaches across the South Yorkshire and Bassetlaw CCG's in respect of equality leadership, staff empowerment and access to development opportunities.
- 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.

We will use the NHS Equality Delivery System (EDS) 2 to further develop our equality objectives.

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 also collaborates with **Yorkshire and Humber Academic Health Science Network** a collaboration of patients, health services, industry, and academia to achieve a significant measurable improvement in the health and wealth of the population. One branch of the academy is the **Yorkshire and Humber Improvement Academy** which is concerned with speeding up the widespread adoption of proven ideas particularly in the area of clinical safety.

In 2014/15 the CCG will contribute £40,000 to the **Rotherham Research Alliance**. This alliance of the CCG and TRFT promotes health research in Rotherham and manages local governance for health organisations including general practice. The CCG will continue this funding in 2014/15 because having strong research programmes is beneficial to the Rotherham economy and increases the attractiveness of Rotherham providers to new recruits, however during 2014/15 we will discuss with other commissioners about whether this funding should be continued in 2015/16 and which commissioners should contribute to it.

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 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 CCG's IT strategy is summarised in section 11 and is informed by Digital First. 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 use of technology to improve communication between GPs and consultants, such as 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)
- Early adapter of payment by results for mental health and clinical engagement on pathways and referrals.
- Acutely ill child pathway, education of parents to reduce unnecessary A&E attendances with children
- The Community Unit, Care Co-ordination Centre and alternative levels of care, fully integrated stroke care pathway which incorporates specialist psychological support, community stroke team and carer support workers
- Development of 'hub and spoke' approach to patient transport
- Secondary to primary care local enhanced service that enables movement of services from hospital to community setting

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 NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSY&B CSU) and detailed in the CCGs organisational development plan [\(add link\)](#). The CCG has developed plans for organisational sustainability and succession planning [\(add link\)](#). The CCG has developed plans for organisational sustainability and succession planning [\(add link\)](#).

In December the CCG made a commitment to the Investors in Excellence standard. The standard covers all activities within the organisation and is focussed on achieving what matters the most for the CCG, for its local public and patients and for its stakeholders. The CCG is working with Investors in Excellence to ensure that excellent working practices are fully spread throughout the workforce and in its engagement with stakeholders.

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 there is an ongoing focus to reduce the CCG's 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

Overall Approach

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.

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 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 **NHS England** 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:

- **Urgent Care:** the urgent care redesign will enable more care to be provided closer to home and the care co-ordination centre will ensure vulnerable people get access to appropriate urgent care.
- **Children and Maternity:** work in partnership with RMBC and the voluntary sector to support actions on infant mortality (smoking during and after pregnancy and safe sleeping policies), breast feeding and teenage pregnancy. Work with RMBC to take forward the Special Educational Needs agenda.
- **Long term conditions:** the case management pilot is targeted at the 12,500 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. Work with partners to tackle the inequalities that result from poor mental health, such as lower employment rates, poor housing, education and poorer physical health.
- **Learning disabilities:** ensure equitable access to services for all condition, working with all providers to be sensitive to the needs on minority populations and ensuring that people with learning disability have good access to preventative healthcare.
- **Community Services:** investment and realignment of community health services will promote early intervention, individualised care and self care.
- **Continuing Care:** engage hard to reach groups to increase awareness.
- **Ambulance and patient transport:** vulnerable groups will receive a more responsive service to their needs and be assessed to enable the most appropriate care pathway.
- **Primary Care:** benchmarking with all practices to reduce unexplained variations in treatment, referrals and admissions.
- **Prescribing:** Key Prescribing Indicators promote equal access to key medications that are vital for long term condition management.

How we will deliver additional years of life for the people with treatable mental and physical health conditions

CCG:

- a) **Medicine management** – the CCG has a range of 14 prescribing interventions that are proven to improve mortality, prevent a serious health event or a hospital admission
- b) **Care pathways** – improved pathways ensure quick access to high quality, evidence based healthcare interventions, which are essential to ensure people start, develop, live, work and age well
- c) **Hospital mortality** – a recent hospital mortality review has highlighted improvements that can be made.
- d) **Case management** – facilitates improved quality and co-ordination of care in the community setting using a multi-disciplinary approach. Targets people who are most at risk of hospital admission.
- e) **Social prescribing** - improves outcomes for patients with reference to health, wellbeing, self-care and independence. Increases resilience of individuals and communities. It increases years to life and life to years.

Public health – securing additional life to years is measured in the Public Health Outcomes Framework. The CCG will ensure all patients have the opportunity to Public Health interventions.

Under 75 mortality rate from:

- a) **All causes** - support and signpost to all lifestyle and behaviour change activities (Obesity, physical activity, health trainers, stop smoking, alcohol support, NHS Health checks).
- b) **cardiovascular diseases considered preventable** - ensure 100% uptake of the NHS Health check
- c) **cancer considered preventable** - refer and support patients to stop smoking and to lead healthy lifestyles
- d) **liver disease diseases considered preventable** - refer to weight management services and alcohol support services to help people make lifestyle changes

Health & Wellbeing Strategy

- a) **Prevention and early intervention** - Rotherham people will get help early to stay healthy and increase their independence.



- b) **Expectations and aspirations** - All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances
- c) **Dependence to independence** - Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances
- d) **Healthy lifestyles** - People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.
- a) **Poverty** – reduce poverty in disadvantaged areas.

How we will deliver improved services for the most vulnerable people in Rotherham

- a) **Case management and social prescribing** – targeted at people most at risk of hospital admissions
- b) **Parity of esteem** – in section 5.4 we describe how we will commission a review of our investments in mental health services and use the additional resources to deliver parity of esteem and a range of other improvements in mental health and learning disability services
- c) **Community Transformation Committee** – ensuring that community services and staff are distributed proportionately to need across the most disadvantaged areas
- d) **Better Care Fund** – This will provide an opportunity to improve the lives of some of the most vulnerable people in Rotherham, giving them control, placing them at the centre of their own care and support and in doing so providing them with better service and better quality of life.

6.11 How we will deliver our mandated areas

The Government published a revision of the NHS mandate in November 2013 [Add link](#). In December NHS England published planning guidance to CCGs *Everyone Counts*. [Add link](#) which is based on the mandate. CCGs are required to submit four plans to NHS England by February 2014:; A 5 year strategic plan which includes a vision for the desired state of the health and social care economy in 2018/19; a detailed two year operational plan with details of ambitions against seven specific outcomes and trajectories for key activity measures; a financial plan and a Better Care Fund plan.

As NHS Rotherham CCG is already part way through consulting with the public and member practices on its plan the CCG has chosen to retain the structure of the first draft of its commissioning plan and once the plan is agreed with stakeholders will use it to populate NHS England's templates. The table below sets out how NHS England fundamental requirements of commissioning plans are addressed in our plan.

| Fundamental | | Key features to be demonstrated in plans |
|-------------|----------|--|
| 1 | Outcomes | Delivery across the five domains and seven outcome measures |
| 2 | | Improving health |
| 3 | | Reducing health inequalities |
| 4 | | Parity of esteem |
| | | <p>The domains and outcome measures are described in section 13. The actions needed to improve the measures are described in Section 5 and their governance in Section 8.</p> <p>In section 6.10 we set out how we will work with our Health and Wellbeing Board partners to improve health including the 5 steps in the '<i>Commission for Prevention</i>' report.</p> <p>In section 6.10 we set out how we will work with our Health and Wellbeing Board partners to identify and close the gap for Rotherham residents who have poor health outcomes, how we will implement the 5 National audit Office recommendations on health inequalities and implement Equality delivery system 2.</p> <p>In section 5.4 we describe how we will commission a review of our investments in mental health services and use the additional resources to deliver parity of esteem and a range of other improvements in mental health and learning disability services.</p> |



| Fundamental | | Key features to be demonstrated in plans | |
|-------------|-------------------------|---|---|
| 5 | Patient services | New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care | In section 6.1 we explain how we put patients and citizens voices at the heart of decision making. In section 14 we explain who we engaged with patients and the public in the development of this plan. |
| 6 | | Wider primary care, provided at scale | In Section 5.10 we set out how we will invest in primary care services to achieve our priorities, including a GP case management pilot, a secondary to primary care Locally Enhanced Service and quality incentives in our Local Incentive Scheme. In section 5.6 we set our plans to make additional investments and transform community services provided by TRFT in the first 6 months of 2014/15. We also describe how we will continue to invest and improve £5M investments in additional community services made by a variety of providers. Together with the changes made to the national GP contract made by NHS England these plans will transform primary and community care in Rotherham. |
| 7 | | A modern model of integrated care | The process for integrating care through the Better care fund is described in Section 4.3 |
| 8 | | Access to the highest quality of urgent and emergency care | This is described in Section 5.1 and includes our major Emergency Care redesign project. |
| 9 | | A step-change in the productivity of elective care | This is described on section 5.2 |
| 10 | | Specialised services concentrated in centres of excellence | In section 4.4 we describe the CCGs approach to the future configuration of acute services. As part of quality assurance we will ensure that specialist and low volume procedures are carried out by teams who carry out sufficient procedures to provide a demonstrably high quality service. |
| 11 | Access | Convenient access for everyone | CCG commissioned GP services are covered in section 5.10, community services in section 5.6 and mental health services in section 5.4. |
| 12 | | Meeting the NHS constitution standards | Covered in sections 5.1, 5.2 and 5.4 |
| 13 | Quality | Response to Francis, Berwick and Winterbourne View | This is set out in section 6.2 |
| 14 | | Patient safety | This is set out in section 6.2 |
| 15 | | Patient experience | This is set out in section 6.2 |
| 16 | | Compassion in practice | This is set out in section 6.2 |
| 17 | | Staff satisfaction | Staff satisfaction for CCG staff is covered in section 5.11. How the CCG will monitor and respond to staff satisfaction in local Foundation trusts is in section 4.4. |
| 18 | | Seven day services | For acute trusts this is covered in section 5.1 for mental health in section 5.4 |
| 19 | Safeguarding | Set out in section 6.4 | |
| 20 | Innovation | Research and innovation | Set out in section 6.7 |
| 21 | Delivering value | Financial resilience; delivering value for money for taxpayers and patients and procurement | This is set out in the CCGs financial plan and summarised in Section 9 |



7 Activity

7.1 Introduction to First Draft

Rotherham clinicians have discussed different scenarios for keeping growth within affordable limits. Based on these discussions, the CCG's benchmarking position and the work programmes of the Clinical Referral Management Committee and Urgent Care Working Group, affordable trajectories for the next 5 years are expected to be:

- first outpatients and electives to 1-2% annual growth;
- diagnostics 5% increase per year
- follow up appointments will reduce by 12% reduction over two years and then remain flat
- we will keep non-elective growth to 0-1% per year

During December we will work through detailed QIPP assumptions, this will include revisiting the 2011 base line 'do nothing' assumptions (see Section 8) and looking at growth predictions and QIPP programmes for each clinical area. The figures above may well change as we work through the detail and discuss the implications in contract discussions.

The remainder of this draft section sets out the tables that will be in the final version of the Commissioning Plan.

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

Statement about triangulation with local acute providers plans.

Figure 7.1 Changes in trajectories from previous Commissioning Plan

Table with historical activity data from 2011 forward, 2013/14 plan and forecast out turn, and plans for the next 5 years for:

- Electives
- Non Electives
- Emergency Assessments
- Community unit admissions
- First outpatients
- Follow up outpatients
- Diagnostic tests
- Accident and Emergency, Walk in Centre, Go Out of Hours activity
- Prescribing costs



7.2 Changes in Trajectories from Previous Commissioning Plan

A narrative explaining where the CCG is an outlier particularly for hospital admissions and follow up attendance and how our planned trajectories are achievable in the context of benchmarking from elsewhere.

Figure 7.2 The following graphs set out visually the CCG affordable trajectories

Graphs of historical and planned:

- First outpatients
- Follow up outpatients
- Electives
- Non electives and Emergency Assesmen



8 Efficiency

8.1 Introduction

The Health Service Efficiency Challenge

Like all of the public sector the health sector faces a substantial efficiency challenge of £30 Billion for the NHS overall over the next 5 years. NHS Rotherham CCG's share of this challenge is around £80 million.

It is very important that all our stakeholders understand the components of this challenge. In Health Service jargon efficiency is usually called QIPP (Quality, Innovation, Productivity and Prevention). QIPP has two components:

Provider QIPP; Efficiencies passed onto health service providers. For the last three years and for the foreseeable future, providers have been expected to provide the same services with less funding. For example in 2014/15 providers will be given 2.1% uplift for inflation but are then expected to make 4% efficiencies. This means they will receive 1.9% less for providing the same services. When QIPP was introduced in 2011 finding the first 4% efficiency saving was relatively straightforward, but finding additional 4% efficiencies every year is increasing challenging.

System Wide QIPP; This is the direct responsibility of the CCG. NHS financial allocations are expected to rise by around 1-2% each year over the next 5 years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth would continue at around 6% a year because of the ageing population, rising expectations and new medical technologies. System wide QIPP programmes are the actions required to keep overall growth at an affordable 1-2% level rather than the historical 6%. In Rotherham we split QIPP into four 4 areas: unscheduled care, elective care, mental health & learning disabilities and medicines management (our approach to efficiencies is described in detail in section 7).

8.2 Provider efficiency savings

Figure 8.1 Breakdown of £8 million Provider Efficiency Challenges for Rotherham 2014/15 -2018/19

| QIPP Plans 2013/14 | 2013/14 Forecast | 2014/15 £000 | 2015/16 £000 | 2016/17 £000 | 2017/18 £000 | 2018/19 £000 |
|----------------------|---------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Medicines Management | (8,300) | (8,503) | (8,975) | (8,975) | (8,975) | (8,975) |



8.3 System wide efficiency savings

Figure 8.2 Breakdown of £8 million System Efficiency Challenges for Rotherham 2014/15 -2018/19

| QIPP Plans 2013/14 | 2013/14 Plan | 2013/14 Forecast | 2014/15 £000 | 2015/16 £000 | 2016/17 £000 | 2017/18 £000 | 2018/19 £000 |
|----------------------|-----------------|---------------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Medicines Management | (800) | (800) | (1,932) | (1,980) | (2,030) | (2,081) | (2,133) |
| Unscheduled Care | (1,558) | (2,517) | (1,097) | (1,079) | (1,079) | (1,079) | (1,079) |
| Clinical Referrals | (1,898) | (1,531) | (3,626) | (3,609) | (3,609) | (3,123) | (3,123) |
| Mental Health | (527) | (527) | (350) | (350) | (350) | (350) | (350) |
| Corporate Services | (250) | (250) | (99) | (250) | 0 | 0 | 0 |
| TOTAL | (5,033) | (5,625) | (7,105) | (7,269) | (7,068) | (6,634) | (6,686) |

The schemes are summarised as follows:

- (i) Medicines Management - has six prescribing projects where prescribing responsibility for nutritional supplements, specialist food stuffs and continence and stoma equipment are now prescribed by specialists. This has improved the service provision to patients and delivered financial efficiencies.
- (ii) Unscheduled Care - our plan 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;
- (iii) Clinical Referrals – seeks to innovate scheduled care particularly where more accessible services avoid the need for hospital admission, this includes successful fast track and one stop services. In other areas we are using an educational approach to reduce the need for hospital care by promoting self care, management in general practice and non face to face referrals such as virtual clinics.
- (iv) Mental Health - redesigning Rotherham Assessment and Treatment Unit and community services in line with Winterbourne Report recommendations and case management of out of area services.
- (v) Corporate Services – a reduction of 10% will be achieved by 2015/16 in line with the planning guidance.

8.4 Commissioning costs

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 2013 NHS reforms total commissioning costs for the former PCTs were reduced by 50%. The running cost of the CCG is now £6.2 million. Of this £4 million are direct costs (support to commissioning GPs by directly employed staff) and £2.2 million are the costs of services from NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit. (see section 5.11). In 2015/16 CSU costs will reduce by a further 10% bringing the amount spent per head of population in Rotherham to £22.50.

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.

Four clinically led, multi-agency delivery groups meet every two to four weeks with the responsibility for the detailed delivery of the QIPP programmes; Clinical Referral Management Committee and Medicines Management Committee meet every two weeks. The Urgent Care Working Group meets every four weeks,

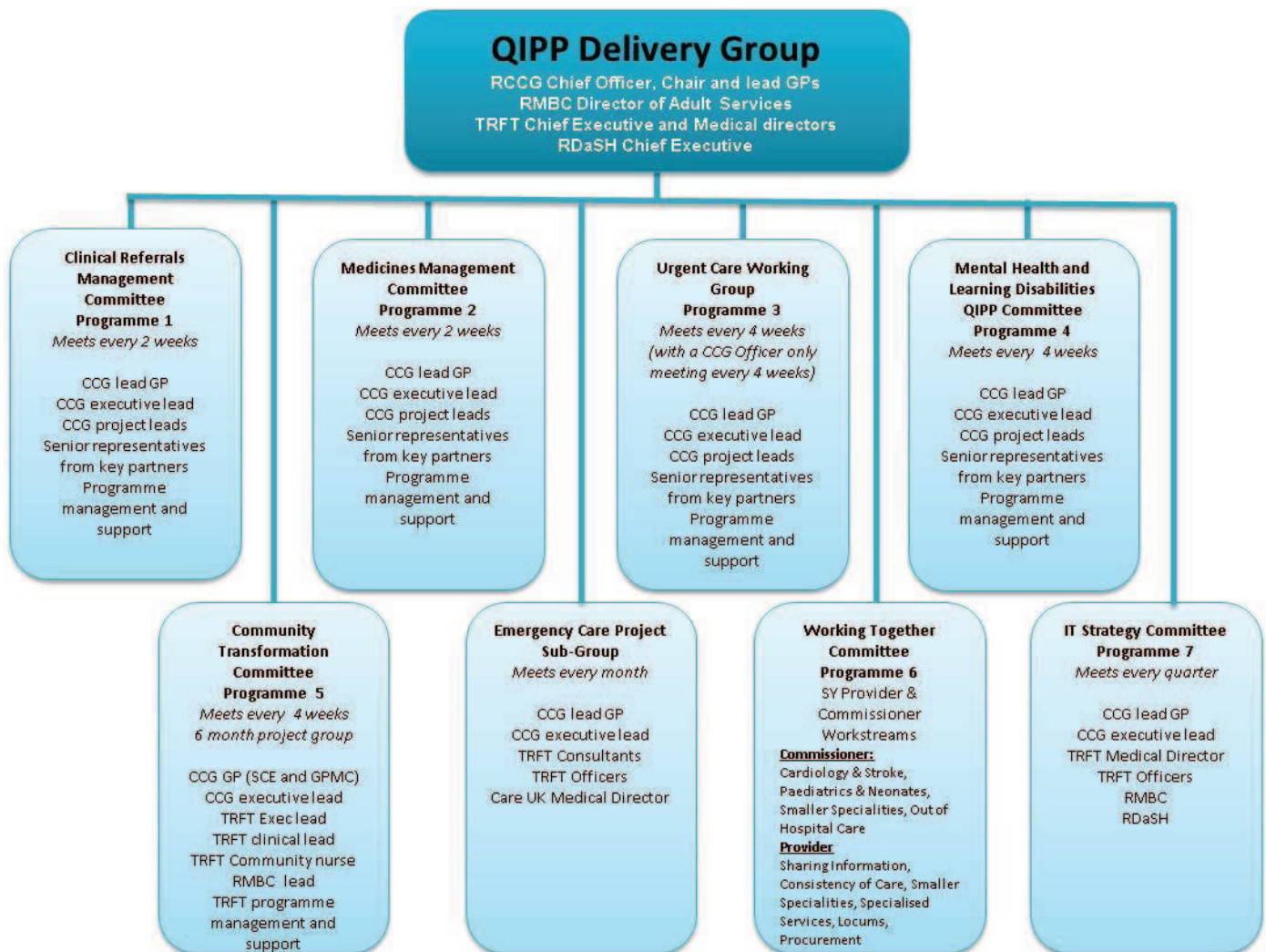


with a CCG officer only meeting every four weeks. The Mental Health and Learning Disabilities QIPP Group meets monthly.

8.6 Commissioner Requested Services

The CCG will review Commissioner Requested Services (services that remain available if providers go into services financial difficulty). The CCG has a Board level commitment from its major acute provider that it will be consulted early in any plans to reduce services for efficiency reasons.

Figure 8.3: 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 NHS planning guidance prescribes that CCGs must achieve the following:

- 1% Operating Surplus £3.4m
- 1.5% recurrent headroom £5.1m
- 0.5% Contingency £1.7m
- 1% Call to Action fund £3.4m

In addition – the financial factors inherent within the plan are as follows:-

1. A 2% growth in financial allocations in 2014/15 (£7m) and 1.7% in subsequent years.
2. **First outpatients:** we are on plan to achieve the 2014/15 trajectories.
3. **Follow-up outpatients:** we are on plan to achieve the reduction from 2013/14 to 2014/15 which will progress the activity towards national average ratios.
4. **Planned admissions:** we are on plan to achieve the 2014/15 trajectories.
5. **Urgent admissions:** the assumption is that the 2014/15 trajectories will be achieved - this includes accelerating the rate of progress made in 2013/14.
6. The costs of continuing care are estimated to rise by £1.0 million in 2014/15.
7. The plan assumes that running cost reductions of 10% will be achieved by 2015/16.
8. The plan maintains the 1.5% recurrent headroom as per the planning guidance.
9. A contingency of £1.6 million (0.5%) is built into the plan.
10. Prescribing growth is 7% **before** efficiency gains of 4.5%.
11. Tariff rules remain stable from 2014/15 to 2016/17.

The four year I & E is set out below

| Income and Expenditure (including non recurrent) | 2013/14 £000 | 2014/15 £000 | 2015/16 £000 | 2016/17 £000 | 2017/18 £000 | 2018/19 £000 |
|---|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Income | 335,232 | 344,904 | 347,952 | 354,244 | 360,175 | 366,202 |
| Expenditure | 329,941 | 341,613 | 344,472 | 350,701 | 356,573 | 362,540 |
| Surplus | 5,291 | 3,291 | 3,480 | 3,542 | 3,602 | 3,662 |



9.2 Source and Application of Funds

There are a number of priorities detailed in the planning guidance which have been considered by our GP members. There are two sources of funding available; QIPP savings and growth funding. These are forecast to total £14 million. The planned use of the funds is set out in the table below:-

Table to follow

There is increased focus on 7 day working in all parts of the health service, parity of esteem for people living with Mental Health issues and better care for people requiring integrated health and social care services. There is also a requirement for the CCG to support GP practices in transforming the care of patients aged over 75. This will be developed in year to compliment our strategy for vulnerable people which is included in our plan.

9.3 Better Care Fund

This is a single pooled budget for health and social care services to work more closely together in the Rotherham area. The outline plans will be agreed by our Health and Wellbeing Board and will demonstrate how the national conditions will be achieved against national and local metrics. The total fund is likely to be £20 million combined.

It will include expenditure on reablement services e.g. intermediate care, stroke and emergency response services, community services and adult social care. The national metrics will include avoiding emergency admissions and delayed transfers of care and enhancing patient/service user experience.

9.4 Non Recurrent Initiatives

There are a number of non recurrent initiatives which are designed to enable the enhancement and transformation of services in a community setting to avoid unnecessary admissions. Services will be invested in recurrently if the reviews in October 2014 can evidence that the objective of avoiding admissions has been achieved.

The key schemes include:-

- Community Hospital, Falls service, Fast Response;
- Care Coordination Centre
- End of Life Care
- Case Management
- Social Prescribing

In addition, a range of reablement schemes have been commissioned for the last two years – this funding has now transferred to the better care fund and will be reviewed as part of the pooled arrangements with RMBC colleagues.



9.5 Risks to Recurrent Balance

1. The continued focus 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 reductions in spending across a range of services will be inevitable.
2. Failure of local providers to achieve the required efficiencies of 20% over five years (as per the planning guidance) may affect viability leading to the interruption or cessation of service provision and failure to achieve the contract.
3. The recent national review of allocations formula has resulted in the CCG being £21million over its target allocation. The plan to reduce funding levels to the target requirement does not present an immediate financial risk but limits the amount of investment that can be made to support the growing demands inherent in an ageing population.
4. Prescribing risks:
 - Shortages in the pharmaceutical supply chain can occur at any time forcing category M prices to suddenly increase.
 - NICE guidance can at any time have an adverse effect on cost growth forecasts.
 - Failure to agree therapeutic guidelines with secondary/tertiary care providers
5. Changes to the structure of the tariff could generate unplanned financial pressures - our plan is predicated upon a neutral impact of any changes to tariff.
6. Continuing health care continues to be an area with increasing demand and the growth assumption of £1million may be compromised in the current climate with additional risks from the retrospective caseload.

9.5 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 with GP leadership and engagement essential to drive 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. A range of additional actions with timescales and values would be implemented if required but the CCG considers these far less preferable than successfully implementing the actions set out in this plan.

9.6 Capital

There is no capital expenditure in 2014/15 due to the asset base transferring to NHS Property Services.

9.7 Cash

Cash limits will be achieved for CCG operational activities. There is a risk to cash regarding the uncertainty around the legacy retrospective claims to clients and further clarity is awaited from NHS England.



10 Information Management and Technology

10.1 IT Strategy

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 has been further developed by workshops held with the GP membership to ensure that their needs and priorities are fully reflected within it. Through this engagement additional priorities have been identified for the development of GP clinical system optimisation, data sharing, remote working solutions and the implementation of a clinical portal. To maintain on-going engagement in the development and implementation of the IT strategy we have reviewed the way in which the GP members are consulted on IT issues and established a consultation group with representation from all member practices.

Following completion of the NHS transition in April 2013 the responsibilities and configuration for the delivery of IT services have been changed, particularly with regard to GP IT Services. NHS England is responsible for primary care information services. It delegates the responsibility for operational management of GP IT services to CCGs. In NHS Rotherham CCG Dr Richard Cullen the GP IT lead, supported by the Deputy Chief Operating Officer, is the responsible officer for IT services to the CCG and its GPs. These duties are discharged through NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYB CSU). The CSU have an Information Services function that manages the delivery of IT services to the CCG and GPs, supports the development and delivery of the local IT strategy and provides data quality and GP system support services. The CSU currently procures IT services for the CCG and GPs from The Rotherham NHS Foundation Trust. During 2014/15 the CCG will review its provision of IT services and decide how services should be provided from 2015/16 onwards.

There is a full NHS Rotherham CCG IT Strategy [\(add link\)](#), which will deliver on the ambitions identified sections 25 to 30 of 'Everyone Counts: Planning for Patients 2014/15 to 2018/19.' A summary of the nine priorities for delivery in the IT strategy is below:

- **IT service provision:** review of service requirements and establishment of a contract for IT service provision for 2015/16 onwards.
- **Electronic discharge summaries and clinical records:** implementation of the receipt of messaging from The Rotherham NHS Foundation Trust and Rotherham Doncaster and South Humber NHS Foundation Trust.
- **Data sharing:** implementation of the SystmOne enhanced data sharing model, EMIS Web viewer and Summary Care Record viewing.
- **Data sharing in Key Clinical Areas (EOLC, Pregnancy and Case Management Pilot):** implementation of data sharing across clinical systems to support the delivery of services.
- **GP Clinical System Optimisation:** implementation of greater use of clinical system features including GP to GP data transfers, SMS messaging to patients, online access to patient records including repeat prescribing and appointment booking and development of call and recall systems.
- **EPS (Electronic Prescription Service) Release 2 Implementation:** completion of the rollout of EPS to all Rotherham practices.
- **Data Quality:** implementation of standardised clinical coding and paper light ways of working.



- **Remote working for GPs:** review of remote working options and how these can be implemented to support General Practices.
- **Clinical portal:** development of the capability to integrate patient data from systems across the health and social care community and the provision of appropriate levels of secure access for patients and clinicians to this information. A pilot project to test a platform for the integration of data from Rotherham's GP, acute and risk stratification systems will be completed by March 2014. Rollout of a full clinical portal to all general practices is expected by the end of 2014/15.

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

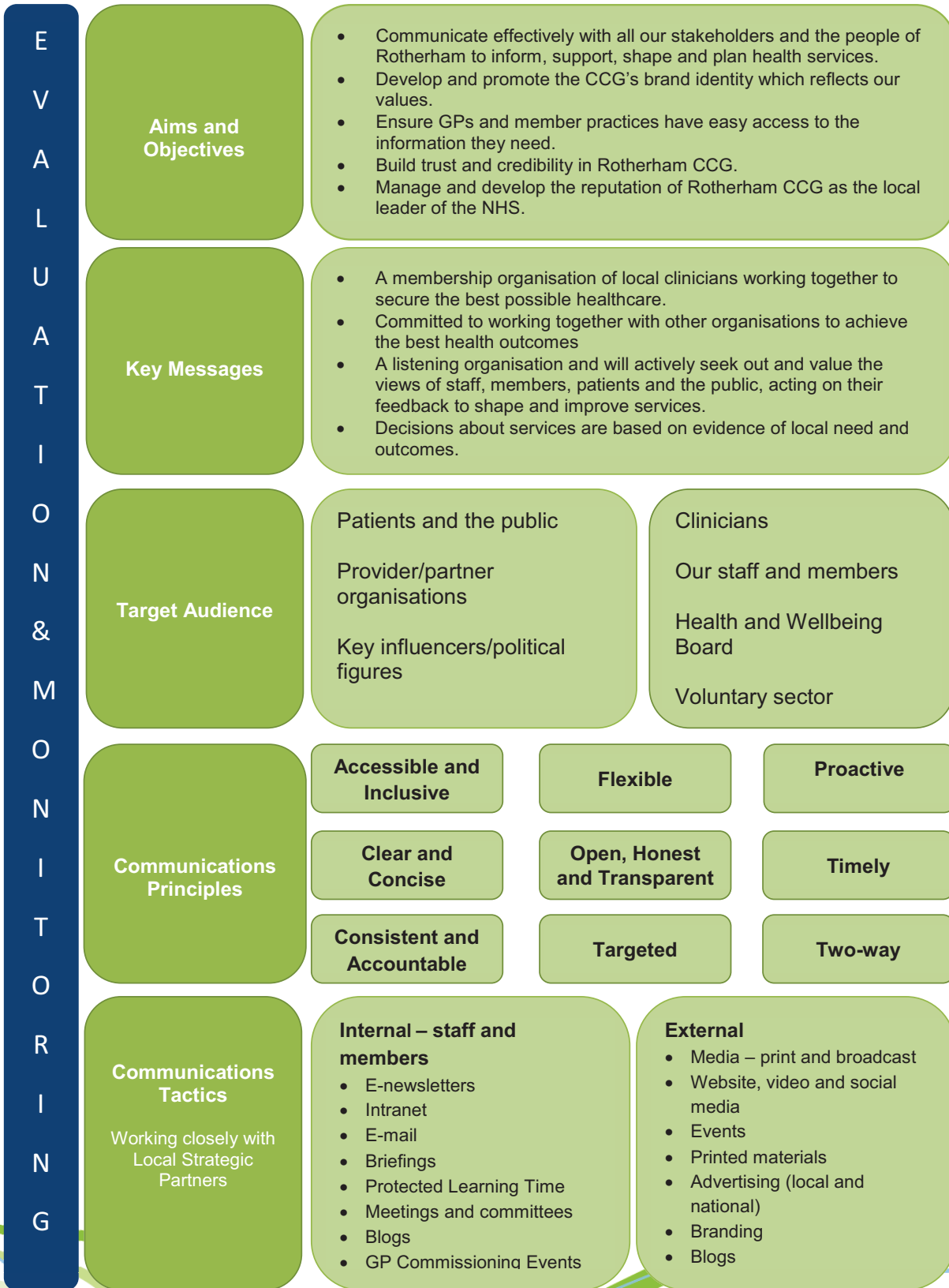
- **e-Referrals:** review the potential of using EMIS Web and SystmOne to support e-consultations with hospital consultants which could help to reduce the number of unnecessary referrals to secondary care. In addition we will review and implement the benefits of the NHS e-Referral Service when it replaces the Choose and Book Service.
- **Tele consultations:** identify what telehealth solutions can be developed to enable GPs to carry out remote consultations with patients in nursing homes.

10.2 Information Governance

In 2013 there have been major challenges around information governance resulting from the conditions of CCG authorisation (CCGs have less statutory permissions to hold data than PCTs) and also from Caldecott's second review of NHS Information Governance. Caldecott's report sets out what NHS organisations can and can't do with patient's data. Whilst the report contains important safeguards for the public it is also potentially adds risks for the tax payer as the right of CCGs to use patient identifiable information, for functions such as financial invoice checking, is unclear. The CCG will implement the requirements of Caldecott 2 together with the CSU, who are both our source of expert information governance advice and also handle patient identifiable information on our behalf by being an Accredited Safe Haven under Section 251 of the NHS Act. The implementation will involve communicating with the public about what the NHS will and won't do with their information.



11 Communication 'Plan on a Page'



[Add link to full Communication Plan and Digital Media plan](#)



12 Performance and Assurance

Outcomes

The December planning guidance for 2014/15 to 2018/19 'Everyone Counts' [\(add link\)](#) set out the Outcome Measures and objectives for CCGs to achieve over the planning period. They include:

- **Outcome Measures** - seven key measures identified from the CCG Outcome Indicator Set
- **Benchmarking against outcomes in the NHS Constitution**
- **Patient Activity (elective, non-elective, outpatients, A&E) and Referral levels**
- **Quality Premiums** – based upon five key outcomes from the Planning Guidance:
 1. Potential Years of Life Lost (PYLL)
 2. Reduction in avoidable Emergency Admissions
 3. The proportion of people who enter IAPT against the level of need
 4. Family and Friends Objectives
 5. Improving the reporting of Medication errors.

The levels of ambition for improvement will be set and monitored on a quarterly basis for the first 3 outcomes and self assessments /plans will be put in place for achievement of the last 2 objectives. In addition NHS Rotherham CCG will need to gather agreement to planned levels of improvement/ambition for the key Outcomes with the Health and Wellbeing Board in Rotherham and with the NHS England Area Team for South Yorkshire and Bassetlaw.

One local priority will also be chosen from the CCG Outcome Indicator Set of measures, or if necessary a locally determined measure that better reflects a major planning area for NHS Rotherham CCG.

- There will be a number of outcomes identified within the **Better Care Fund** guidance which will need agreement across the Health and Social Care community during 2014/15 in anticipation for the fund to be managed and monitored in 2015/16

In addition to the CCGs responsibilities to NHS England there are four other sets of performance outcomes relevant to the CCG as a member of Rotherham Health and Wellbeing Board:

- **Health and Wellbeing Board outcome priorities** - dementia, smoking, alcohol, obesity, employment and fuel poverty.
- **The public health outcomes framework** – key outcome measures of which are found within 'Everyone Counts'
- **The outcomes framework for Social Services**



- **Supporting NHS England with the specialist commissioning outcome measures identified within 'Everyone Counts'**

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 [\(Add link\)](#). This framework will be reviewed in the early part of 2014 to ensure that it reflects the planning Guidance 'Everyone Counts' and meets the Governing Body requirements.

SY&B CSU produce a monthly performance report for the CCG Governing Body that covers the performance against key outcomes required by NHS England. [\(add link\)](#) The current reports concentrate on a limited number of key metrics and then exception reporting against the full range of the NHS Outcomes framework, which is monitored by the Operational Executive.

NHS England produce a balanced scorecard which is used for quarterly assurance meetings. The CCG is moving towards having its own performance report that closely replicates the NHS England format but the governing body has to balance concentrating solely on the limited subset of metrics chosen by NHS England for assurance reporting, its responsibility to manage performance against the full range of the NHS outcomes framework and to be aware of the wider set of metrics relevant to Rotherham Health and Wellbeing Board.

In addition to reporting on national outcomes the CCG will produce four reports a year on the delivery of this commissioning plan. The Commissioning Plan Performance Report [\(add link\)](#) sets out the process and outcome measures we will report on.

Quarterly Assurance meetings

The CCG meets NHS England each quarter. Prior to this NHS England produces a balanced scorecard based on key quality, outcome and financial outcomes. The CCG and NHS England discuss any issues which NHS England summarise in a letter which is published alongside the balanced scorecard.

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 NHS England, NHS West and 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** [\(add link\)](#) 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** [\(add link\)](#) 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** [\(add link\)](#). The CCG Assurance Framework captures the high strategic potential risks to the organisations strategic objectives. As at November there were 63 entries on our Risk Register, with 19 scoring in excess of 11, and there were 24 entries on our Assurance Framework, with 15 scoring in excess of 11.

The seven highest risks on the CCG Risk Assurance Framework are:

1. Financial, leadership and IT challenges at our main acute provider (TRFT)
2. Shortage of GP capacity impacting on clinical care and also on the capacity of GPs to prioritise clinical commissioning work
3. Risks to patient safety and quality resulting from providers cost improvement plans
4. Failure to deliver CCG and provider efficiency plans
5. Long term funding of the NHS in Rotherham and the impact of NHS funding allocations
6. Impact to areas of CCG responsibility from the efficiency programmes of other commissioners in Rotherham (NHS England, RMBC and public health)
7. Impact to services commissioned from funding being transferred to the Better Care Fund

14 How we shared our plans

Numerous stakeholders have been engaged in the development of our 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 Members Committee (GPMC) and the Patient Participation Groups have been especially important in its development. The consultation table lists some of the meetings and events at which the Commissioning Plan has been discussed at and the comments received [\(add link\)](#).

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 Members 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 six monthly all practice commissioning events, from locality groups and from the GPMC. Some of the most important priorities chosen were initially advocated by individual GPs. Examples of these that were in last year's plan and will be taken forward into the 2014-19 plan are; 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 GPMC (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.

Key additions to the 2014-19 Commissioning Plan as a result of strong feedback and support from members are; additional investment and locality focus for community nursing services (section 5.6); increased emphasis on quality for both adults and children's mental health services (section 5.4) and better integration between CCG commissioned services and those of NHS England (section 5.10).

Input from patients and the public

We are very grateful for the feedback given by the patient participation group network; which this year focused on several specific areas and feedback on the earliest drafts. However our commissioning plans have been informed through engagement in our workstreams and projects throughout the year. Early drafts of the plan will also be circulated to key stakeholders and partner organisations, and will be available on our website.

In addition, we are working with Healthwatch Rotherham, and intend to identify and circulate key questions to Healthwatch members, and use the feedback to inform the plan.

The challenges in making sure that people have the opportunity to influence our planning remain;

- the NHS re-organisation was 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.

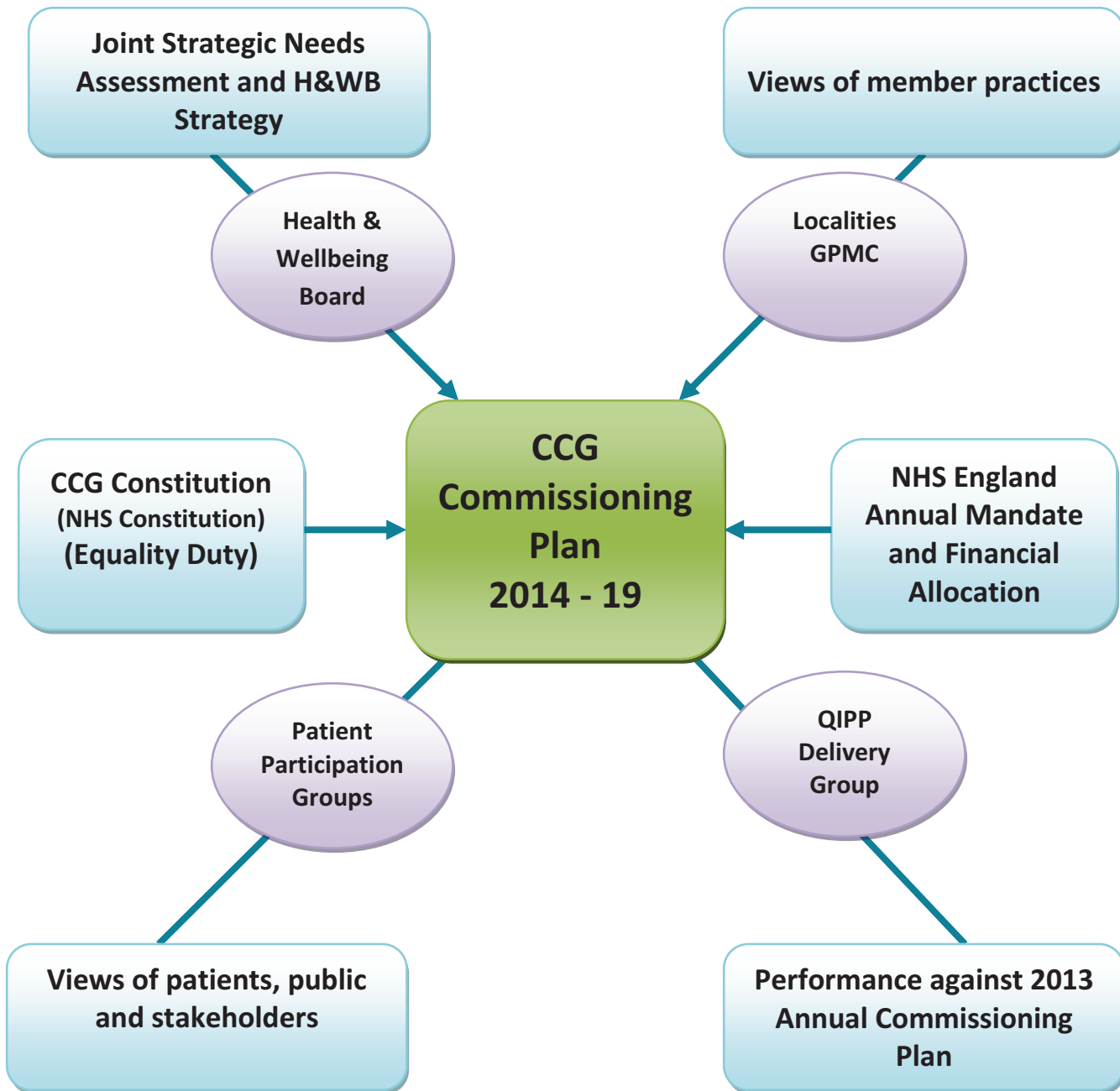
Although we will have to stick closely to the agreed priorities in this plan during 2014/15, we will be refreshing the plan for subsequent years. We intend to have full dialogue with the public of Rotherham throughout 2014 to develop future plans, using a variety of different mechanisms. Figure 14.1 summarises the multiple sources of input into the plan.

How to feedback comments on the CCG Commissioning Plan

The CCG aims to improve services for patients, this can only be done on the basis of feedback from patients, public and clinician's, please send any comments on the plan or any other issue relating to the CCG to the following e-mail address rotherhamccg@rotherhamccg.nhs.uk .



Figure 14.1: Inputs into the development of our Commissioning Plan





15 Glossary (to be updated)

| | |
|------------------|---|
| CP | <i>Commissioning plan</i> |
| APC | <i>Area Prescribing Committee</i> |
| AQP | <i>Any Qualified Provider</i> |
| CAMHS | <i>Child and Adolescent Mental Health Services</i> |
| CCG | <i>Clinical Commissioning Group</i> |
| CCGCOM | <i>A group of the 5 South Yorkshire and Bassetlaw CCGs to commission jointly on agreed areas</i> |
| CHC | <i>Continuing Health Care</i> |
| CIP | <i>Cost Improvement Plans</i> |
| CRMC | <i>Clinical Referrals Management Committee</i> |
| CQUIN | <i>Commissioning for Quality and Innovation</i> |
| DBH | <i>Doncaster and Bassetlaw NHS Foundation Trust</i> |
| DH | <i>Department of Health</i> |
| EDS | <i>Equality Delivery System</i> |
| EOLC | <i>End of Life Care</i> |
| FNC | <i>Free Nursing Care</i> |
| GPRC | <i>GP Members Committee</i> |
| HAP | <i>Health Action Plan</i> |
| H&WBB | <i>Health and Wellbeing Board</i> |
| H&WBS | <i>Health and Wellbeing Strategy</i> |
| JSNA | <i>Joint Strategic Needs Assessment</i> |
| KPI | <i>Key Performance Indicator</i> |
| LAC | <i>Looked After Children</i> |
| LMC | <i>Local Medical Committee</i> |
| LES | <i>Local Enhanced Service</i> |
| LIS | <i>Local Incentive Scheme</i> |
| LTC | <i>Long Term Conditions</i> |
| MHQC | <i>Mental health QIPP Committee</i> |
| MMC | <i>Medicines Management Committee</i> |
| MRSA | <i>Methicillin Resistant Staphylococcus Aureus</i> |
| NHSE (SY&B) | <i>NHS England (South Yorkshire and Bassetlaw)</i> |
| OE | <i>Operational Executive</i> |
| PCT | <i>Primary Care Trust</i> |
| Parity of Esteem | <i>Ensuring that all mental health patients receive attention that is equal to acute patients</i> |
| PTS | <i>Patient Transport Services</i> |
| QIPP | <i>Quality, Innovation, Productivity and Prevention</i> |
| RDaSH | <i>Rotherham Doncaster and South Humber NHS Foundation Trust</i> |
| RMBC | <i>Rotherham Metropolitan Borough Council</i> |
| SCE | <i>Strategic Clinical Executive</i> |
| SHSC | <i>Sheffield Care and Social Care Trust</i> |
| STH | <i>Sheffield Teaching Hospitals NHS Foundation Trust</i> |
| SWYPFT | <i>South West Yorkshire Partnership Foundation Trust</i> |
| SY&B AT | <i>South Yorkshire and Bassetlaw Area Team</i> |
| WSY&B CSU | <i>West and South Yorkshire & Bassetlaw Commissioning Support Unit</i> |
| SYCLAHRC | <i>South Yorkshire Collaboration for Leadership in Applied Health Research and Care</i> |
| TRFT | <i>The Rotherham NHS Foundation Trust</i> |
| UCWG | <i>Urgent Care Working Group</i> |
| YAS | <i>Yorkshire Ambulance Service</i> |



16 List of hyperlinked documents (to be updated)

| Footnote Number | Document hyperlinked | Page Number |
|-----------------|---|-------------|
| 1 | CCG committee structure | |
| 2 | NHS Rotherham CCG Constitution | |
| 3 | Rotherham Joint Strategic Needs Assessment | |
| 4 | Carers Charter | |
| 5 | Rotherham Self Care Document | |
| 6 | Rotherham Dementia Strategy | |
| 7 | Commissioning for quality policy/procedure on gaining assurance and identifying failing services using an appreciative enquiry approach | |
| 8 | NHS Constitution | |
| 9 | NHS Rotherham CCG Constitution | |
| 10 | Equality and Diversity Strategy (including EDS) | |
| 11 | Communication and Engagement strategy | |
| 12 | Complaints and Concerns | |
| 13 | Commissioning Safeguarding Vulnerable Clients Annual Report 2011/12 | |
| 14 | Commissioning Safeguarding Vulnerable Clients Policy | |
| 15 | Organisational Development Plan | |
| 16 | Sustainability and Succession plan | |
| 17 | Government Mandate to NHS England | |
| 18 | NHSCB Planning guidance 'everyone counts' | |
| 19 | NHS Information Strategy | |
| 20 | Government Mandate to NHS England | |
| 21 | NHSCB Planning guidance 'everyone counts' | |
| 22 | LA Benchmarking support packs | |
| 23 | CCG Benchmarking support packs | |
| 24 | NHS Rotherham CCG Integrated Performance Report | |
| 25 | NHS Rotherham CCG Performance Management Framework | |
| 26 | Integrated Risk Management Policy | |
| 27 | NHS Rotherham CCG Risk Register | |
| 28 | NHS Rotherham CCG Assurance Framework | |
| 29 | Commissioning Plan 'sharing our intentions' | |

Rotherham Better Care Fund: Definition, vision and outcomes

Task Group Meeting
17 January 2014

Task Group Terms of Reference

- To work with members of the HWB, to understand and interpret the requirements of the BCF
- To develop a local jointly agreed vision for integration
- To develop a plan to be signed-off by the HWBB and submitted to NHS England by 14 February
- To do any necessary further work to ensure the plan is adopted and being monitored by April 2014

We are here...

- HWB developed good relationships across the new health and care landscape
- Already agreed the joint priorities through Health and Wellbeing Strategy, informed by the JSNA
- HWB has made a commitment to integration through the local strategy;
- With clear links to what needs to be delivered as part of BCF
- Genuine enthusiasm for integration
- **BCF Plan will help us deliver the Health and Wellbeing Strategy**

Definition of integration

Adopt the nationally recognised definition of Integration:

'I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me' ('National Voices')

Vision

Overarching vision of Health and Wellbeing Board: *To improve health and reduce health inequalities across the whole of Rotherham*

The Better Care Fund plan will contribute to 4 of the strategic outcomes of the Health and Wellbeing Strategy:

- **Prevention and early intervention:** Rotherham people will get help early to stay healthy and increase their independence
- **Expectations and aspirations:** All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community
- **Dependence to independence:** Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances
- **Long-term conditions:** Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

Measuring Success

- Develop 'I statements' as a common narrative to help us:
 - keep the voice of Rotherham people at the heart
 - understand what integration feels like for service users/patients/carers
- Based on what people tell us – way of 'making it real'
- Influencing change through people's experiences
- Adopt this as a principle with aim to implement at a later date (*drawing on lessons learned from national consultation*)

National Outcome Measures

| Measure | Baseline 12/13 | Y&H Rank (of 15) | National Rank (of 152) | BCF % Imp. Target | BCF Target | Comment |
|---|--|---------------------|------------------------------|-------------------------|---------------|--|
| Admissions to Res/Nursing Care (ASCOF) | 345 | 11th | 85th | -13% | 276 | Existing ASCOF measure |
| Effectiveness of Re-ablement (ASCOF) | 86.70% | 7th | 46th | 6% | 91.90% | Existing ASCOF measure |
| Delayed Transfers from Hospitals (NEW) | 4.1 | 5th | 21st | -4% | 3.9 | Note: The definition for this measure will change to 'total number of delays' (not ASCOF) |
| Avoidable Admissions (NHSOF) | Data not available until end January 2014 | | | | | Note: The definition for this measure is currently being revised |
| Patient/Service User Experience (NEW) | Data not available | | | | | New National Measure not yet developed |
| LOCAL MEASURE | One to be selected from menu of 9 <u>or</u> develop our own local measure | | | | | |

Criteria for selection of one local measure

Must have:

- a clear, demonstrable link with the Joint Health and Wellbeing Strategy
- data which is robust and reliable with no major data quality issues (e.g. not subject to small numbers – see “statistical significance” in next section)
- an established, reliable (ideally published) source
- timely data available, in line with requirements for pay for performance – this means that baseline data must be available in 2013-14 and that the data must be collected more frequently than annually
- a numerator and a meaningful denominator available to allow the metric to be produced as a meaningful proportion or a rate
- a challenging locally set plan for achievement and
- A metric which creates the right incentives

(Extract from the BCF Technical Guidance)

Local Measure (choose 1 from 9 or select own)

| Measure | Baseline | Y&H Rank (of 15) | National Rank (of 152) | Comment |
|---|---|------------------|------------------------|--|
| NHS Outcome Framework | | | | |
| Proportion of people feeling supported to manage their (long term) condition | 69.70% | Not Available | Not Available | In line with England average |
| Diagnosis rate for people with dementia | 62.60% | Not Available | Not Available | Upper quartile England |
| Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days | Data not currently available at Rotherham level | | | |
| Adult Social Care Outcomes Framework | | | | |
| Social care related quality of life | 19.2 | 3rd | 27th | Annual survey, would require additional surveys – currently top quartile nationally. Difficult to improve further |
| Carer reported quality of life | 8.8 | 1st | 8th | Survey every 2 years – would require more frequent surveys currently Top 10 nationally. Difficult to improve further |
| Proportion of adults in contact with secondary mental health services living independently, with or without support | 78.5 | 2nd | 34th | Currently Top Quartile Reliant on MH data which is nationally recognised as difficult to collect. Difficult to significantly improve further. |
| Public Health Outcomes Framework | | | | |
| Proportion of adult social care users who have as much social contact as they would like | 39.5 | 14th | 125th | Annual Survey, would require additional surveys – bottom Quartile. |
| Proportion of adults classified as inactive | 33.6 2012 data | 12th | Not Available | Data not available for 2013 |
| Injuries due to falls in people aged 65 or over (Persons) | 1833 2011/12 | 11th | Not Available | Data not available for 2013 |

Does the local measure meet the BCF criteria?

| Measure | Link to HWBS | Data Quality | Est. Source | Timely Data | Frequency | Meaningful | Challenging | Right Incentive |
|---|--------------|--------------|-------------|-------------|-----------|------------|-------------|-----------------|
| NHS Outcome Framework | | | | | | | | |
| Proportion of people feeling supported to manage their (long term) condition | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Diagnosis rate for people with dementia | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Adult Social Care Outcomes Framework | | | | | | | | |
| Social care related quality of life | Yes | Yes | Yes | NO | NO | Yes | Yes | Yes |
| Carer reported quality of life | Yes | Yes | Yes | NO | NO | Yes | Yes | Yes |
| Proportion of adults in contact with secondary mental health services living independently, with or without support | Yes | NO | Yes | Yes | Yes | Yes | NO | Yes |
| Public Health Outcomes Framework | | | | | | | | |
| Proportion of adult social care users who have as much social contact as they would like | Yes | Yes | Yes | NO | NO | Yes | Yes | Yes |
| Proportion of adults classified as inactive | Yes | Yes | Yes | NO | NO | Yes | Yes | Yes |
| Injuries due to falls in people aged 65 or over (Persons) | Yes | Yes | Yes | NO | NO | Yes | Yes | Yes |

Local Measure – suggested option

| Measure | Baseline | Y&H Rank (of 15) | National Rank (of 152) | Comment |
|---|-------------------|---------------------|---------------------------|---|
| NHS Outcome Framework | | | | |
| <p>Possible NEW local measure</p> <p>Health Related Quality of life for people with long term conditions. indicator E.A.2 from the “Everyone Counts”</p> | 69.60% | Not Available | Not Available | <p>England average of 73.1. RCCG are proposing setting an ambition over the coming 5 years of meeting the England average of 73.1 The data for this is also drawn from the GP survey.</p> |
| <p>Proportion of people feeling supported to manage their (long term) condition</p> | 69.70% 2012-13 | Not Available | Not Available | <p>NOTE: HSCIC website states this measure is under review and may change – but back data to be supplied</p> |

Next steps

- To have a clear commitment from all partners to provide data and information as and when required
- To agree the local measure for pay-for-performance element
- Joint officer working group (LA/CCG/NHSE) to ensure we are meeting all national conditions
- Consultation with users/patients/providers
- Next 'Task Group' meeting 31 Jan to look at:
 - What is currently commissioned that does not improve BCF measures
 - What needs to be commissioned to meet the BCF measures and estimated costs
 - First draft of BCF Plan

| |
|---|
| ROTHERHAM BOROUGH COUNCIL – REPORT |
|---|

| | | |
|-----------|---------------------|--|
| 1. | Meeting: | Health and Wellbeing Board |
| 2. | Date: | 22nd January 2014 |
| 3. | Title: | Protocol between Health and Wellbeing Board and Rotherham Local Safeguarding Children Board |
| 4. | Directorate: | Rotherham Local Safeguarding Children Board |

5. Summary

The protocol will outline and confirm the functions and responsibilities of Rotherham's key strategic partnerships;

- Health and Wellbeing Board;
- Children, Young People and Families Partnership;
- Rotherham Local Safeguarding Children Board;.

and the relationship between them, providing clarity, and ensuring that the needs of children and young people in the borough are identified and addressed at a strategic level.

6. Recommendations

That the Health and Well-Being Board approve the protocol and that it is effective with immediate effect.

7. Proposals and Details

The revised statutory guidance on interagency working to safeguard and promote the welfare of children (Working Together 2013) states that

'all local agencies need to have a clear understanding of the collective needs of children locally when commissioning effective services. As part of that process, the Director of Public Health should ensure that the needs of vulnerable children are a key part of the Joint Strategic Needs Assessment that is developed by the health and wellbeing board.' (WT 2013 para 16)

The statutory guidance also states that LSCBs should work with Health and Wellbeing Boards informing and drawing upon the JSNA. The LSCB submits its annual report to the Health and Wellbeing Board and other strategic partnerships and the protocol is the agreement that formalises this mechanism.

8. Finance

The LSCB has its own budget financed by member agencies, the key agencies for such financing being Children's Social Care Services, Children's Health Economy, and the Police. A budget statement is included in the RLSCB Annual Report.

9. Risks and uncertainties

The requirement to collaborate effectively at a strategic level is more important at this time than it has ever been; the changes to the NHS and the impact of budget reductions in local authorities and other organisations require partnerships to be more effective in achieving their aims.

10. Policy and performance information

The revised Ofsted framework for the inspection of services for children in need of help and protection, children looked after and care leavers is due to be implemented nationally from November 2013. Amongst other areas the framework will evaluate the effectiveness of partnership and governance arrangements at a strategic level.

11. Background Papers and Consultation

Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children: HM Government 2013

Ofsted framework for the inspection of services for children in need of help and protection, children looked after and care leavers: Ofsted 2013

Contact Name:

Steve Ashley, Independent Chair of Rotherham LSCB

Phil Morris, Business Manager, Rotherham LSCB
01709 254925 phil.morris@rotherham.gov.uk

ROTHERHAM

January 2014

Protocol

between

Rotherham Local Safeguarding Children Board

and

Rotherham Health and Wellbeing Board; including the Children, Young People and Families Strategic Partnership

1 PURPOSE

This protocol will outline and confirm the functions and responsibilities of Rotherham's key strategic partnerships; Health and Wellbeing Board; Children, Young People and Families Partnership; Rotherham Local Safeguarding Children Board; and the relationship between them.

2 OBJECTIVE

To provide clarity in terms of the relationships between the Rotherham Local Safeguarding Children Board and the Rotherham Health and Wellbeing Board, including the Rotherham Children Young People and Families Strategic Partnership; and articulate the specific links and reporting arrangements between them.

3 BACKGROUND

- 3.1 Rotherham Local Safeguarding Children Board (RLSCB) is a statutory partnership board and the Children Young People and Families Strategic Partnership (CYPFSP) is a key leadership forum for services provided to children and their families. Both have important, complimentary but distinctive roles in ensuring that the strategic planning needs for children and young people in the borough are understood and met. This includes keeping children safe and promoting their welfare.
- 3.2 There is not a hierarchical relationship between the Rotherham Local Safeguarding Children Board and Children Young People and Families Strategic Partnership but a joint responsibility to ensure that the needs of

children and young people in Rotherham are prioritised at a strategic level and delivered effectively at an operational level.

- 3.3 The Children Young People and Families Strategic Partnership contributes to the local Joint Strategic Needs Assessment (JSNA) developed by the Health and Wellbeing Board (HWBB). RMBC Children and Young People's Services on behalf of the CYPFSP reports the Children and Young People's Commissioning Plan into the Health and Wellbeing Board in order to take account of and contribute to the Health and Wellbeing Strategy for the borough. This ensures that local priorities and improved outcomes for children and young people are aligned and identified through the JSNA.

4 ROTHERHAM LOCAL SAFEGUARDING CHILDREN BOARD

- 4.1 The RLSCB is not a service delivery body; it is the scrutiny and decision making body for multi-agency safeguarding responsibilities within Rotherham. It is a statutory partnership board; its work is directed by statutory guidance.

- 4.2 Safeguarding and promoting the welfare of children is defined as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

- 4.3 The Chief Executive of the Local Authority has a statutory responsibility for ensuring that an effective Local Safeguarding Children Board is in place for the Local Authority area.

- 4.4 The core objectives of Rotherham Local Safeguarding Children Board which are set out in Section 14 of the Children Act 2004 are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and

(b) to ensure the effectiveness of what is done by each such person or body for those purposes.

- 4.5 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 and Working Together 2013 further prescribes the functions in relation to these objectives as:

- developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority.

- communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

participating in the planning of services for children in the area of the authority;
and

- undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

Regulation 5 (3) provides that an LSCB may also engage in any other activity that facilitates, or is conducive to, the achievement of its objectives.

4.6 The Rotherham Local Safeguarding Children Board is responsible for challenging each relevant partner, as defined by the Children Act (2006)¹ on their effectiveness in safeguarding children and ensuring their welfare.

4.7 LSCBs do not commission or deliver direct frontline services though they may provide training. While LSCBs do not have the power to direct other organisations they do have a role in making clear where improvement is needed. Each Board partner retains their own existing line of accountability for safeguarding children.

4.8 Rotherham LSCB will publish an annual report and business plan

- RLSCB is chaired by an independent chairperson appointed by the Council Chief Executive in conjunction with Board partners. The RLSCB Chair sits on the CYPFSP.
- The Strategic Director for Children and Young People's Services and the Director of Public Health are RLSCB Members
- The Cabinet Member for Children Young People and Families Services is a participating observer on the RLSCB.

5 ROTHERHAM HEALTH AND WELLBEING BOARD

5.1 The Health and Wellbeing Board, a statutory sub-committee of the council established under the Health and Social Care Act 2012, is the single strategic forum to ensure coordinated commissioning and delivery across the Rotherham Clinical Commissioning Group (RCCG), NHS England, RMBC , social care, RMBC public health and other services directly related to health

¹ 'The Local Safeguarding Children Boards Regulations 2006 (Statutory Instrument 2006 No.90)

and wellbeing in order to secure better health and wellbeing outcomes for the whole Rotherham population.

5.2 The functions of the Health and Wellbeing Board include:

- To oversee the development of local commissioning plans, to ensure that all commissioning plans take account of the Health and Wellbeing Strategy and are aligned to other policies and plans that have an effect on health and wellbeing.
- Assess the needs of the local population and lead on the Joint Strategic Needs Analysis (JSNA)

To hold relevant partners to account for the quality and effectiveness of their commissioning plans

To enable, advise and support organisations that arrange for the provision of health or social care services to work in an integrated way.

- To ensure that public health functions are discharged in a way that help partner agencies to fully contribute to reducing health inequalities.
- To ensure that there are arrangements in place to provide assurance that the standards of service provided and quality of service are safe, meet national standards and local expectations
- The Cabinet Member for Children Young People and Families Services is a member of the Health and Wellbeing Board

The Strategic Director for Children and Young Peoples Services is a member of the Health and Wellbeing Board

- The Director of Public Health, who is also a member of the Health and Wellbeing Board is responsible for ensuring that vulnerable children's issues feature in the JSNA (WT 2013)

6 ROTHERHAM CHILDREN, YOUNG PEOPLE AND FAMILIES STRATEGIC PARTNERSHIP

6.1 The Children, Young People and Families Strategic Partnership² is the local partnership that brings together the organisations responsible for strategic planning and commissioning of services for children, young people and families with a shared commitment to improving children's lives.

6.2 The functions of the CYPFSP are to³:

² Determined as a statutory obligation under the Apprenticeships, Skills, Children and Learning Act 2009

³ Extract from consultation of 'Statutory Guidance on co-operation arrangements' para 1.7

- a) develop and promote a local vision – set out in the CYP Commissioning Plan – to drive improved outcomes for local children, young people and their families
- b) have in place robust arrangements for inter-agency co-operation
- c) develop integrated strategies, sharing data and workforce development
- d) support those strategies via more integrated processes, including effective joint working
- e) develop and promote integrated front line delivery, organised around the child in a setting which supports family life rather than statutory intervention, professional or institutional barriers.
- f) develop the Children and Young People’s Plan, keeping it under review and revising it as necessary
- g) monitor progress and produce a report on the extent to which the CYPFSP partners are delivering their commitments in the Children and Young Peoples Plan and its Commissioning Plan
- h) feedback progress to the Rotherham Health and Well Being Board against delivery of the Children and Young People’s Plan and the overarching Health and Wellbeing Strategy priorities.
 - The CYPFSP is chaired by the Cabinet Member for Children Young People and Families Services
 - The Strategic Director for Children and Young People’s Services is a member of the CYPFSP.
 - The Director of Public Health is a member of the CYPSP

7. THE RELATIONSHIP BETWEEN THE RLSCB AND CYPFSP

- 7.1 The Independent Chair of the RLSCB is a member of the CYPFSP and the Chair of the CYPFSP is a participating observer on RSLCB.
- 7.2 CYPFSP expects that RLSCB will fulfil its statutory functions and duties under 4.4 – 4.8 of this protocol.
- 7.3 The RLSCB produces an Annual Report which is presented to the CYPFSP. The Annual Report follows a format which accords with statutory guidance and should be completed by September each year.
- 7.4 The Board minutes for both the CYPFSP & RLSCB are shared in a timely manner.
- 7.5 The RLSCB will be formally consulted by the CYPFSP when the Children’s Commissioning Plan is being refreshed. The consultation phase will be sufficiently long to allow a thorough debate to support the RLSCB response to

the consultation. The Children’s Commissioning Plan will draw on the ‘support and challenge’⁴ from the RLSCB Annual Report and other on-going work.

8 THE RELATIONSHIP AND COMMITMENTS BETWEEN ROTHERHAM HEALTH AND WELL BEING BOARD, RLSCB AND ROTHERHAM CYPFSP

8.1 The CYPFSP will formally report to the HWBB on the progress update against the relevant priorities (in line with the Health and Wellbeing Strategy) of both the CYPFSP and the key milestones and targets within the Children and Young People’s Commissioning Plan.

8.2 The RLSCB will submit its Annual Report to the Health and Wellbeing Board.

8.3 The Health and Wellbeing Board will ensure that:

- The Joint Strategic Needs Assessment takes account of key areas for vulnerable children identified via the RLSCB Annual Report and the CYPFSP key priorities. The Director of Public Health has specific responsibility for this.

8.4 The Health and Wellbeing Board may also request that the CYPFSP and/or the RLSCB to consider issues for development, action or scrutiny.

9 SIGNATURES

Name.....

Date.....

Independent Chair Rotherham Local Safeguarding Children Board

Name.....

Date.....

Chair Rotherham Health and Wellbeing Board

Name.....

Date.....

Chair Rotherham Children, Young People and Families Strategic Partnership

⁴ See ‘Working Together...’ para 3.63