HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 24th February, 2016**

Time: **9.00 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. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Minutes of the previous meeting (herewith) (Pages 1 - 12)
   Minutes of meeting held on 13th January, 2016

For Discussion

7. Health and Wellbeing Strategy Implementation (Pages 13 - 15)
   - Update on Strategy implementation – Terri Roche, Director of Public Health
   - Feedback from Strategy workshops – Verbal Update by Kathryn Singh, RDaSH

8. Working towards Integration in Rotherham (Pages 16 - 18)
   Graeme Betts, Interim Director, Adult Social Care, to report

9. Better Care Fund Quarter 3 Submission. (Pages 19 - 34)

10. CCG Commissioning Plan. (Pages 35 - 178)
    Ian Atkinson, Rotherham CCG, to report

11. RDaSH Inspection Report. (Pages 179 - 199)
    Kathryn Singh, RDaSH, to report

The full inspection report for reference is available here at the following link:-

http://www.cqc.org.uk/provider/RXE

12. Adult Safeguarding Strategy (Pages 200 - 220)
Report by Graeme Betts, RMBC and Sandie Keene, Chair of Adult Safeguarding Board.

13. Transforming Services for People with a Learning Disability and/or Autism (Pages 221 - 234)
Report by Kate Tufnell, CCG

For Information

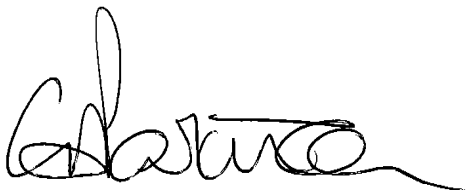
14. Rotherham Dementia Action Alliance Co-ordinator (Pages 235 - 253)

15. Rotherham Get Active Event (Page 254)

16. Date, Time and Venue of the Next Meeting and Future Dates for Agreement
Wednesday, 20th April, 2016, at 9.00 a.m. Oak House, Bramley

Future Dates for Agreement:-

2nd June, 2016
13th July, 2016
21st September, 2016
16th November, 2016
11th January, 2017
8th March, 2017



CATHERINE A. PARKINSON
Interim Director of Legal and Democratic Services.

HEALTH AND WELLBEING BOARD
13th January, 2016

Present:-

Councillor David Roche	Advisory Cabinet Member, (**in the Chair for Minute Nos. 41-45, 49-50)**
Dr. Julie Kitlowski	Vice-Chair, Rotherham CCG **(in the Chair for Minute Nos.48-48, 51)**
Tony Clabby	Healthwatch Rotherham
Miles Crompton	Policy, Improvement and Partnerships, RMBC
Dr. Richard Cullen	Governance Lead, Rotherham CCG
Chris Edwards	Chief Officer, Rotherham CCG
Kate Green	Policy Officer, RMBC
Alison Iliff	Public Health Specialist, RMBC
Gordon Laidlaw	Communications, Rotherham CCG
Carol Levelle	NHS England (representing Zena Robertson)
Councillor Jeanette Mallinder	Vice-Chair, Health Select Commission
Stella Manzie	Commissioner and Managing Director, RMBC
Paul McCurry	South Yorkshire Police (representing Jason Harwin)
Teresa Roche	Director of Public Health, RMBC
Councillor Stuart Sansome	Chair, Health Select Commission
Kathryn Singh	RDaSH
Ian Thomas	Strategic Director, Children and Young Peoples Services
Jon Tomlinson	Adult Care and Housing, RMBC
Janet Wheatley	Voluntary Action Rotherham

Apologies for absence were received from Jason Harwin, Zena Robertson, Councillors John Turner, Watson and Yasseen.

41. ROTHERHAM COUNCIL

The Chairman referred to the recent announcement regarding the potential restoration of some powers to the Council/Elected Members in February, 2016 as well as the appointment of Sharon Kemp as Chief Executive who would commence on 18th January, 2016 and attend future meetings of the Board.

He placed his thanks on record for the work of the Commissioners and in particular Commissioner Manzie for her efforts on behalf of the Health and Wellbeing Board.

42. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

43. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from members of the press and public present.

44. MINUTES OF THE PREVIOUS MEETING

Resolved:- That the minutes of the meetings held on 25th November, 2015, be approved as a correct record.

Arising from Minute No. 34 (Communications), it was noted that an update would be given at the next meeting regarding the refresh of the Board's website.

Arising from Minute No. 37 (Suicide Prevention and Self-Harm), it was noted that meetings had taken place with 2 individual Head Teachers but not at the collective Head Teachers meeting. Commissioner Manzie undertook to raise this issue with the Head of School Effectiveness Service.

It was also noted that 2 training programmes had been publicised. Firstly the Applied Suicide Intervention Skills training to be held on 10th and 11th March, 2016 and secondly the Safe Talk Training to be held on 12th and 26th February, 2015. Both programme were to be held at the Brinsworth Training Centre. They were open to the general public as well as employers.

An All Members seminar was to be held on 5th April, 2016, on this issue.

45. FOR INFORMATION

Physical Activity Event
The Chairman reported that the event would now take place in May, date to be confirmed, at the New York Stadium.

Network Event
An event was to be held in York on 11th March for Health and Wellbeing Board Members and Support Officers. The Chair and Vice would be attending. There were a further two places available. Anyone interested in attending should contact Kate Green.

Better Care Fund
A progress report would be submitted to the February meeting. A meeting had taken place between the Council, CCG and Foundation Trust to discuss assurance that there was a shared approach from the Hospital, CCG and Council. A report would be submitted to the March meeting focussing on locality and a named key person to all the services the three organisations offered.

Julie Kitlowski reported that the Trust had developed a ten minute soundbite which talked about what 2016 for Rotherham was going to look like, the transformation plans, getting people out of hospital and looked after closer to home in their home and the locality model. It would need to

be shared widely and hopefully would be presented to the next Board meeting. It was hoped to have a version that could be shared with the population of Rotherham.

(Julie Kitlowski assumed the Chair at this point in the meeting.)

46. UPDATE ON THE HEALTH AND WELLBEING STRATEGY IMPLEMENTATION

Further to Minute No. 35 of the meeting held on 25th November, 2015, Terri Roche, Director of Public Health, submitted an update on the progress made and the Board sponsors/lead officers as follows:-

Aim	**Proposed Board Sponsor**	**Lead Officer (to be nominated by Board sponsor – from different organisation)**
1. All children get the best start in life	Richard Cullen, CCG	Cara Milner, Matron, Children's Services, Rotherham Foundation Trust
2. Children and young people achieve their potential and have a healthy adolescence and early adulthood	Ian Thomas, CYPS	CCG to nominate representative (suggested Safeguarding lead)
3. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life	Kathryn Singh, RDASH	Ian Atkinson, CCG
4. Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing	Julie Kitlowski, CCG	Giles Ratcliffe, Public Health Consultant
5. Rotherham has healthy, safe and sustainable communities and places	Jason Harwin, SYP	Assistant Director of Community Safety and Neighbourhoods, RMBC (when appointed)

A series of development workshops would take place for aims 3, 4 and 5

to help identify where the Board can add value to specific actions and consider what was already in place locally.

Aims 1 and 2 would be led by the Children's Trust Board and was, therefore, suggested that the wider Children's Partnership be used to develop them rather than individual workshops.

Discussion ensued on the nomination of Lead Officers and the need to ensure a balance of organisations.

Resolved:- (1) That the Board sponsors and lead officers for each Strategy aim, as set out above, be approved.

(2) That a review of the nominated officers be reviewed as part of the LGA Peer Review.

(3) That discussions take place with Voluntary Action Rotherham with regard to possible nominated representation.

47. NHS PLANNING GUIDANCE 2016/17-20/21

The Chair drew the Board's attention to the recently published NHS Planning Guidance 2016/17-2020/21 which set out the steps to deliver a sustainable, transformed Health Service. It included the key priorities for the system, agreed by all national health and care bodies, plus the business rules and incentives that would support delivery.

The CCG would have to produce two plans as well as consult with the Board on the Rotherham Place Plan which was a five year plan and had to be produced by March, 2016. CCG's were also being instructed to produce a regional Sustainability and Transformation Plan which included sustainability across the hospital sector as well as the CCG. Debate was taking place as to whether this would include South Yorkshire and Bassetlaw or South Yorkshire, Bassetlaw and Derbyshire. Technical guidance was awaited and there would be timescale issues.

Discussion ensued with the following issues raised:-

- Possible alignment with the City Region – Health was not part of the South Yorkshire devolution
- It covered all ages and was all encompassing

Resolved:- That the report be noted and further updates be submitted as and when information becomes available.

48. INDICES OF MULTIPLE DEPRIVATION

Miles Crompton, Policy and Partnerships, gave the following presentation:-

Indices of Deprivation 2015

- Government measure produced by Oxford University
- Updates the previous ID2010
- 7 domains (37 Indicators) = Index of Multiple Deprivation (IMD) with 2013/14 baseline
- SOA Geography (167 in Rotherham and 32,844 in England)
- Average of SOA Scores measure – Rotherham increased from 53rd most deprived district in 2010 to 52nd in 2015 (326 districts)
- Minor changes to methodology

Rotherham Deprivation relative to England

% of Rotherham population within English IMD deciles	IMD 2004	IMD 2007	IMD 2010	IMD 2015
Most deprived 10%	12%	12%	18%	19.5%
Most deprived 20%	33%	32%	33%	31.5%
Most deprived 30%	49%	46%	46%	45%
Less deprived than national average	29%	35%	32%	37%

23.1% of children 0-15 live in 10% most deprived areas nationally (15.6% in 2007)

Rotherham's most deprived SOAs
All in top 2% of 32,844 English SOAs

SOA	Rank in 2010	Rank in 2015
Ferham	851	242 (+609)
East Herringthorpe North	230	257 (-27)
Eastwood Village	2,207	302 (+1,905)
Canklow North	434	315 (+119)
Eastwood East	641	323 (+318)
East Herringthorpe South	920	480 (+440)
Eastwood Central	1,089	500 (+589)
Maltby Birks Holt	1,207	597 (+610)
East Dene East	707	623 (+84)
Masbrough	847	634 (+213)

Deprivation by Domain

Domain	Top 10%	Change 2010-15	Top 20%	Top 50%
Education & Skills	24%	0	39%	69%
Employment	24%	+2%	42%	75%
Health & Disability	21%	-12%	40%	85%
Income	17%	+3%	33%	64%
Crime	15%	+4%	25%	65%
Living Environment	2%	-1%	4%	10%
"Barriers"	0%	0	2%	15%

40% of Rotherham is in the most deprived 20% nationally but none is in the least deprived 20%

Indices of Deprivation
Change in Health Indicators

Indicator	ID 2010	ID 2015	Change
Years of potential life lost	74.3	64.8	-9.5
Comparative illness & disability ratio (sickness & disability benefits)	147.1	142.5	-4.6
Acute morbidity (emergency admissions) 2006-8/2011-13	199.5	125.8	-73.7
Mood & anxiety disorders (Mental Health) 2006-8/2012-13	0.33	0.51	+0.18
Overall Health & Disability Score	0.84	0.64	-0.20

Average SOA scores (above) show improvement
Mental Health is worse – GP prescribing, hospital episodes, disability benefits and suicides
24.3% of children 0-15 are affected by low income

Income Deprivation affecting Children Index 2015

- Children 0-15 are 19% of population but 25% of those affected by low income
- 35% of children in low income families live in 10% most deprived nationally

Children and Young People's Attainment
Education Sub-Domain 2015

- 27% of children and young people live in 10% most deprived areas nationally
- 16% live in 5% most deprived areas

Comparison of Life Chances: Children

20 Contrasting Neighbourhoods	10 most deprived areas	10 least deprived areas
Total population (2013)	17,486	15,822
Children (aged 0-17)	5,870 (33.6%)	2,655 (16.8%)
Live in a family with 3+ dependent children	2,975 (50.7%)	470 (17.7%)
Good level of development at Foundation (2013)	117 (36.7%)	115 (73.2%)
Achieve Level 4 at Key Stage 2 (2011-13)	143 (56.7%)	135 (88.0%)
Achieve 5+ GSCEs A*-C inc English & maths (2011-13)	80 (32.7%)	141 (82.6%)
Be a Child in Need (Children Act 1989) (2014)	236 (4.0%)	21 (0.8%)
Be in contact with or supported by the CSE Team aged 13-16 (2012-14)	202 (20%)	31 (4.6%)

Comparison of Life Chances: Adults & General

20 Contrasting Neighbourhoods	10 most deprived areas	10 least deprived

		areas
Total population (2013)	17,486	15,822
Working Age Adults 18-64	9.732 (55.7%)	9,691 (61.3%)
Be unemployed, long term sick or FT carer	3,226 (33.1%)	505 (5.2%)
Be a disabled adult claiming DLA (2015)	1,460 (12.6%)	545 (4.1%)
Live in an overcrowded home (all households)	880 (12.6%)	114 (1.8%)
Recorded violent offences, burglary, theft and criminal damage (per 1,000 pop)	1,791 (102.4)	315 (19.9)
Older people aged 65+	1,884 (10.8%)	3,476 (22%)
Live in poverty as a pensioner	765 (40.6%)	222 (6.4%)
Male life expectancy	73.4	83
Female life expectancy	77.4	86.9

Key Messages

- Deprivation still top 20% nationally
- Employment and education deprivation most severe
- Improvements in health, crime and environment
- Most deprived areas getting worse
- Areas with average or low deprivation doing better
- Mental health getting worse
- Rising barriers to housing – affordability
- Polarisation on all domains except living environment
- 18.7% deprived of income
- 24.3% children v 16.5% working age adults
- Children more likely to be affected by deprivation

Policy Challenges

- Targeting the most deprived areas
  - Are we closing the gap? – no it is getting wider
  - Previous initiatives made little lasting impact
  - Welfare Reform exacerbating deprivation
  - Identify what works: evaluation and best practice
  - Joining-up services and targeting resources
- Improving education and skills in our most deprived areas
  - Raising school attainment and participation post-18
  - Higher adult qualifications and skills
  - Work readiness: basic life skills, welfare to work
  - Cultural shift towards learning and working

Discussion ensued with the following issues raised/highlighted:-

- Should the sub-groups target the top 10 most deprived areas rather trying to affect a change across the whole of the Borough? Or each

individual sub-group look at the issues that relate specifically to their area

- Need for the Local Strategic Partnership to link up activity – role of the Operational Chief Executive to draw up matrices of the different levels as well as the operational day-to-day co-ordination and deployment of resources both in terms of the partnership work and operationally

- Very good work was taking place in driving up the standard of education but what happened when a child left at the end of the school day? There was a whole raft of issues that needed to be pickup up given the complexities of neighbourhoods

- A challenge for Health would be do they target more of their budget to localities? Equity v equality

- Consistency was key and not constant time limited initiatives

- "So what Test" - in a year need to be able to a difference in the deprived areas for the resources that had been deployed

Resolved:- (1) That the presentation be noted.

(2) That the Health and Wellbeing Strategy workshops give consideration to equity and "closing the gap".

(3) That a discussion take place between the Chair and Vice, the newly appointed Chief Executive and Chris Edwards on the way forward.

(4) That an All Members Seminar be held on this issue.

(Councillor Roche assumed the Chair)

49. CHILDREN'S STRATEGIC PARTNERSHIP ARRANGEMENTS

Ian Thomas, Strategic Director, Children and Young People's Services, gave a verbal report on the Children's Strategic Partnership.

The Partnership was strongly related to Aims 1 and 2 of the Health and Wellbeing Strategy. There had been two development days held so far with the first meeting of the refreshed Partnership taking place on 10th February where the Chair and Vice would be agreed as well as the Terms of Reference. The Partnership's key workstreams were:-

Early Help
Workforce Development across the system
Development of a Children and Young People's Plan

with the key headline outcomes of keeping children safe and keeping children and families safe, children ready to learn and children and their

families ready for work.

The Partnership would meet bimonthly and report into the Health and Wellbeing Board.

Resolved:- That the update be noted.

50. EARLY HELP PROGRESS REPORT - SEPTEMBER TO DECEMBER, 2015

Ian Thomas, Strategic Director, Children and Young Peoples Services, presented an update on the progress made in developing Rotherham's Early Help Offer.

The report highlighted:-

- Appointment to the posts of Assistant Director for Early Help, Heads of Service, Team Managers and Children Centre Leaders
- Transfer of staff into the new locality team on 5th October, 2015 and major review of all property in the Borough that would provide Early Help office space and Service delivery points
- In excess of 30 different referral routes into Early Help each with its own criteria, assessment and evaluation and recorded across 8 databases
- Review of the Early Help Assessment Team within the MASH and reconfiguration to secure more efficient and effective processes
- 0-19 Pathway almost complete. It would be launched as an interactive online tool for all partners and practitioners as part of the Early Help Offer website
- Progress in developing an online Early Help Offer with over 76 services and agencies having completed a service synopsis of what they offered and how it could be accessed
- Monthly reporting of performance measures. However, until the Case Management System (Liquid Logic) was operational it would continue to be an inefficient process with 7 different databases and systems to interrogate in order to extract the required data
- Finalised Early Help Quality Standards and a new electronic Case Audit tool development and introduced. All Team Managers and Heads of Service were required to undertake 1 Case Audit per month as part of the wider Early Help QA Framework

It was also noted that in October, 2015, the best ever NEET figures had been reported. Rotherham's final (NCCIS validated) figures were:-

Y11 98% offers made (against a national average of 97%)
Y12 97% offers made (against a national average of 91%)
Combined – 97.6% offers made (against a national average of 94.1%)

The Offer would go live on Monday, 18th January, 2016.

Discussion ensued with the following issues raised/clarified:-

- There were six Police Officers within the Integrated Youth Support Service. A Sergeant had also been recruited and a Missing from Home Officer who would sit within the Early Help Office

- The new Barnardos' service, although not live until later in the month, was already taking referrals – there would be fifteen additional bodies out and about raising awareness around CSE working with schools and communities

Resolved:- That the report be noted.

51. JOINT COMMISSIONING UPDATE

Ian Thomas, Strategic Director, Children and Young Peoples Services, presented a report outlining the progress that had be made on the Rotherham Joint Commissioning Strategy

The Strategy had been developed in partnership with young people as well as extensive consultation with parents, carers and stakeholders in the development of the 7 priorities i.e. SEND, Child Sexual Exploitation Post-Abuse Support Services, Early Help, Transition, Looked After Children – our Sufficiency Strategy in relation to Residential Care and Fostering Placements, CAMHS and 0-5 Years including Best Start.

Rotherham had suffered in the past as there had been no partnership working to deliver better outcomes for its communities. The Joint Commissioning Strategy aimed to impact positively on children and young people through enhancement of current Mental Health Service provision. The priorities would bring about a positive contribution to promoting equality through improving access into service provision from disadvantaged and vulnerable groups.

Resolved:- That the report and progress made to date be noted.

(Julie Kitlowski assumed the Chair)

52. ROTHERHAM LOCAL SAFEGUARDING CHILDREN ANNUAL REPORT 2014-15

Christine Cassell, Independent Chair of the Rotherham Local Safeguarding Children Board, gave the following powerpoint presentation:-

Role of the Local Safeguarding Children Board

- Section 14 of the Children Act 2004 sets out the objectives of LSCBs which are:-
  - To co-ordinate 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
- To ensure the effectiveness of what is done by each such person or body for those purposes

Relationship to the Health and Wellbeing Board
LSCBs
- Do not commission or deliver direct frontline services though they may provide training
- Should also work with the Health and Wellbeing Board, informing and drawing on the Joint Strategic Needs Assessment

(Working Together 2015)

LSCB Annual Report
- The Chair must publish an annual report on the effectiveness of child safeguarding and promoting the welfare of children in the local area (Working Together 2015)
- The report should be submitted to the Chair of the Health and Wellbeing Board (Working Together 2015)
- Inspectorates expect to see evidence of LSCB influence on the Health and Wellbeing Board

Rotherham LSCB Report 2014-15
Commentary by previous Chair on priorities
- Importance of Early Help strategy being refreshed
- Neglect and Domestic Abuse – strengthening Families Framework being introduced
- CSE Strategy refresh

Commentary on LSCB Improvements
- Performance, challenge and improvement
- Co-ordination with strategic commissioning activity
- Hearing and acting on the experience of others
- Learning and Development

Priorities for 2015-16
- Effectiveness of Early Help
- Effectiveness of the response to neglect
- Experience of Looked After Children
- Effectiveness of the multi-agency response to child sexual exploitation
- Continuing to improve the effectiveness of the LSCB

Safeguarding is everybody's business
- Council
- Statutory and non-statutory partners
- Voluntary and community organisations
- The wider community

What should the Health and Wellbeing Board do?
- Ensure a safeguarding focus in commissioning decisions
- Support LSCB priorities through the implementation of the Health and

Wellbeing Strategy
- Undertake safeguarding impact assessments on major budget and organisational change
- Reports back to the LSCB on the impact of its work in support of LSCB priorities

Discussion ensued on the presentation with the following issues raised/clarified:-

- Further consideration was required to Impact Assessment in terms of the agencies' budgetary and organisational agendas

- To have an impact there had to be a baseline and once that discussion had been hade, how to get a collective view on what the impact was given agencies were driven by their own strategy and all measured outcomes differently; there had to be some commonality

Resolved:- (1) That the Health and Wellbeing Board:-

(a) Ensures a focus on safeguarding children in its commissioning decisions;

(b) Supports LSCB priorities through the implementation of the Health and Wellbeing Strategy

(3) That the issue of Impact Assessments be discussed at the Health and Wellbeing Board's Away Day and reported back to the Local Safeguarding Children Board.

53. DATE, TIME AND VENUE OF THE NEXT MEETING

Resolved:- That a further meeting be held on Wednesday, 24th February, 2016, commencing at 9.00 a.m. to be held at the Rotherham Town Hall.

Health and Wellbeing Board 24 February 2016 - Briefing Note

Health and Wellbeing Strategy implementation plan

1. Progress on board sponsors and lead officers

All board sponsors have now been confirmed.

Lead officers for the aims have been contacted where possible (some are new posts), but not all confirmed as yet.

Aim	Board sponsor	Lead officer
1. All children get the best start in life	CCG, Richard Cullen	Kara Milner, RFT
2. Children and young people achieve their potential and have a healthy adolescence and early adulthood	CYPS, Ian Thomas	TBC
3. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life	RDASH, Kathryn Singh	Ian Atkinson, CCG
4. Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing	CCG, Julie Kitlowski	Giles Ratcliffe, Public Health Consultant
5. Rotherham has healthy, safe and sustainable communities and places	SYP, Jason Harwin	Karen Hanson, RMBC (confirmed as lead but not in post until March 2016)

2. Progress on workshops

Aims 1 & 2: Best start and children and young people
A discussion is needed with the Children's Trust to establish how these aims, and their associated action plans, will be developed.

Aim 3: Mental health and wellbeing
The first strategy workshop took place on Monday 15 February at South Yorkshire Fire and Rescue Training Centre. A verbal update on the outcomes of this session will be provided at the meeting.

Aim 4: Life expectancy and health inequalities
The workshop will be held on Wednesday 16 March to develop the actions for this aim. A preparatory meeting with the Board Sponsor has been arranged for 22 February and work is underway to develop the workshop agenda and preparatory paperwork.

Aim 5: Healthy, safe and sustainable communities
Dates are being discussed for the workshop with the Board Sponsor and the nominated lead (starts in post on 14 March 2016).

3. Reporting to the Health and Wellbeing Board

The board will receive updates and progress reports on the outcomes of the workshops, and how the strategy action plans are being developed, through a series of presentations to future board meetings.

Presentations on the specific strategy aims are proposed to begin from September 2016, allowing for adequate time for progress to be made on the actions plans; working towards achieving the expected outcomes of the strategy.

The proposed schedule will be as follows (pending approval of the board meeting dates):

21 September – Presentation on aims 1 & 2 (children and young people)
16 November - Presentation on aim 3 (mental health)
11 January – presentation on aim 4 (life expectancy)
8 March – presentation on aim 5 (wider determinants)

An annual review of the whole strategy will be reported to the board, the first one to be taken April/May 2017. The annual report will include:

- An overview of any significant national and/or local changes relating to the HWS themes that may impact on prioritisation and/or delivery of actions
- A narrative update on progress against the agreed actions for each theme identifying achievements, barriers and solutions
- An update on the indicator bundles within the performance management framework
- Identification of any additional actions to be progressed over the coming twelve months

This full report is proposed annually due to the performance framework being based on indicators within the national outcomes frameworks, which are mostly collated on an annual basis. Therefore, reporting more frequently on the indicators would not provide much added value.

However, the board should be reassured that work is progressing on the strategy action plans and it is therefore proposed that a mid-year update to the board, which provides more of a narrative on progress on the whole strategy, picking up any issues or concerns and exception reporting in relation to any of the metrics, will take place September or November 2016 (although bearing in mind the specific aim presentations will only start from September, but this will be used to reassure the board that work is progressing on each of the strategy aims), then again around September 2017.

A template for strategy leads to submit their update 6 monthly will be developed.

4. Progress on Health and Wellbeing Steering Group

The steering group will be made up of each of the lead officers for the strategy, plus supporting officers and the Director of Public Health as chair.

Monthly meetings are being scheduled and once all lead officers have been agreed, they will be invited to attend.

The steering group will be the ‘engine room’ of the board, providing support on the strategy, horizon scanning and supporting development of the board’s work programme. The monthly meetings will feed into the board’s formal agenda setting process through the chair and supporting officer.

The Rotherham NHS Foundation Trust

Rotherham Metropolitan Borough Council Where Everyone Matters

NHS Rotherham Clinical Commissioning Group

Health and Well Being Board 24 February 2016

Discussion Paper
Working Towards Integration in Rotherham

Lead Executives:	**Chris Edwards:**	**Chief Operating Officer**	**Rotherham CCG**
	Graeme Betts:	**Interim Director of Adult Care and Housing**	**Rotherham MBC**
	Louise Barnett:	**Chief Executive**	**Rotherham FT**
Lead Officers:	**Jon Tomlinson:**	**Interim Assistant Director of Commissioning**	**Rotherham MBC**
	Dominic Blaydon:	**Head of LTC and UC**	**Rotherham CCG**

Purpose:

The purpose of this paper is to outline the future direction of travel for integrated health and social care services in Rotherham and update the board on proposals to develop an integrated team and hub approach.

Background:

There are a number of work programmes in place currently to promote and strengthen integrated working, the Better Care Fund (BCF) is predicated on this approach and will be an important vehicle for further integration. Alongside this, the lead Executives have identified the following priorities for further development of integrated services

- Development of integrated health and social care teams
- Development of a reablement hub incorporating intermediate care beds

Integrated Health and Social Care Teams

Evidence suggests that integrated health and social care teams achieve better outcomes than those that operate within individual organisational boundaries. The Kings Fund identifies some of the key characteristics of a successfully integrated team as:

- Community-based multi-professional teams based around practice populations.
- A focus on intermediate care, case management and support to home-based care.
- Joint care planning and co-ordinated assessment of care needs.
- Named care coordinators who retain responsibility throughout the patient journey.
- Clinical records that are shared across the multi-professional team.

Taking the Initiative Forward

Within one locality we propose that we develop a fully integrated health and social care team. The team will be co-located and will have a single line management structure and joint service specification. We propose that a combined outcome framework be developed which supports the strategic objectives of both the local authority and the CCG.

It is proposed that the integrated health and social care team will include a community physician, community nurses, a community matron, social workers, therapists and social

prescribers. The team will have a single point of access for all referrals. It will offer support with community rehabilitation, community nursing services, care coordination, supported discharge and admission prevention. It will carry out all social care assessments and reviews for the locality population. The team will develop integrated reablement plans for people at high risk of hospital admission. These plans will focus on optimisation, increasing levels of independence, promoting community integration and reducing reliance on formal care. The emphasis will be on providing support, care and advice when it is most needed and at the right time to enable resilience and minimise reliance on long term inputs to individuals, families and communities.

Key outcomes for the team will be; reductions in the cost of social care packages, reductions in hospital admissions, reduced length of stay in hospital, reductions in the number of care home residents admitted to hospital.

The process of integration will incorporate a programme of transformation that enhances inter-professional relationships and breaking down cultural/ organisational barriers.

It is proposed that the integrated team approach is introduced on a phased basis. During Phase 1 we propose that a fully integrated service is introduced in a single locality for one year. At this point we will carry out a full evaluation to establish whether the new service model can be rolled out across the borough.

A Reablement Hub Incorporating Intermediate Care

With an ageing population, people living longer with more long term conditions and a significant efficiency challenge we want to develop a more integrated approach to the provision of intermediate care services. This ambitious transformation of services will support our joint priorities of promoting independence, prevention of avoidable hospital admission and delayed discharges.

Our aim is to support recovery in a non-acute setting, enabling people to achieve optimum levels of independence. Building the right capacity and capability for an integrated intermediate care service is a key.

Taking the Initiative Forward

We propose that a fully integrated rehabilitation and reablement hub be developed, combining residential intermediate care, community rehabilitation, enabling services and specialist rehabilitation. It is proposed that the hub would offer extra care housing, incorporating access to both telecare and telehealth services.

The creation of a single rehabilitation/reablement hub enables both Rotherham CCG and Rotherham MBC to work together to transform intermediate care provision, supporting a broader range of people. Key outcomes of the hub would be to prevent hospital admissions, support discharge, reduce the cost of social care packages, increase levels of independence and promote community integration.

The emphasis would be on creating an environment to maximise multi-disciplinary team working, encouraging shared opportunities for developing links within Health and Social Care and with external partners. It is anticipated that there would be quality and cost efficiencies through economies of scale, access through a single point of contact, reduced travel time and less duplication. Contract monitoring and management would also be simpler.

Our Joint Strategic Needs Assessment (JSNA) projects a significant increase in the number of

adults with additional health and social care needs over the next five years. It is unlikely that either health or Social care budgets will be able to keep pace with the rising demand for services. Therefore, this strategy is important if the demographic challenge is to be met - it will require a joint approach to commissioning service delivery. Joint commissioning and Integrated working can remove duplication, increase economies of scale and through early prevention, reduce interventions further up the care pathway.

Recommendations:

It is recommended that the Health and well Being Board;

- Support in principle the plan to develop integrated health and social care teams
- Support in principle the plan to develop a rehabilitation and reablement hub
- Receive a detailed action plan on these two initiatives at a future meeting

Rotherham Metropolitan Borough Council
Neighbourhoods & Adult Services

NHS Rotherham Clinical Commissioning Group

1.	**Meeting:**	**HEALTH AND WELLBEING BOARD**
2.	**Date:**	**24th February 2016**
3.	**Title:**	**Better Care Fund Quarter 3 Submission**

4. Summary

The purpose of this report is to agree the content of the third quarterly report to NHS England regarding the performance of Rotherham's Better Care Fund

5. Recommendations

That the Health and Wellbeing Board approve the details for submission to NHS England by noon on Friday, 26th February, 2016.

6. Introduction/Background

6.1 Rotherham's BCF plan sets out key schemes and how each of these will be measured and managed.

6.2 A quarterly reporting template (attached as Appendix A) covers reporting on: income and expenditure, payment for performance, supporting metrics, integration measures and the national conditions.

6.3 Below is a summary of information included within the BCF submission:

7. Budget Arrangements

7.1 Confirmation that the BCF funds have been pooled by a Section 75 agreement signed by the Local Authority and the Clinical Commissioning Group.

8. National Conditions

The Spending Round established six national conditions for access to the Better Care Fund. In Quarter 2 of 2015/16, Rotherham reported fully meeting four of the six national conditions as follows:

- Plans are still jointly agreed between the Local Authority and the Clinical Commissioning Group.
- Social Care Services (not spending) are currently being protected.
- A joint approach to assessments and care planning are taking place and, where funding is being used for integrated packages of care, there is an accountable professional.
- An agreement on the consequential impact of changes in the acute sector is in place.

The two national conditions that Rotherham has now met during Quarter 3 of 2015/16 are as follows:

- 7 day services to support patients being discharged and prevent unnecessary admissions at weekends in place and delivering – Enabling and domiciliary services has been operating as the first phase of our 7 day services plan. We have now implemented a 7 day working hospital discharge pilot from 1st December, 2015, which will complete the intentions for 7 day working set out in the Rotherham BCF plan.

- NHS number being used as the primary identifier for health and care services –- work is well underway to ensure better sharing between health and social care. There are 5,495 adults who are in the scope of the NHS number matching project. By the end of February 2016 all in-scope BCF records will have an NHS number assigned. Training materials have been issued which demonstrate to practitioners in adult social care on how to use the NHS number field.

9. Performance Data

9.1 Our performance on most metrics is on target as follows:

9.2 Non-elective hospital admissions – Q3 data shows a reduction in admissions to 6,378, in comparison to 7,745 in Q1 of 7,745 and 7,503 in Q2 Rotherham CCG is aware of data quality issues relating to The Rotherham Foundation Trust's November admissions data, which have resulted in an understated position for Q3. The CCG believe this has been rectified for December. CCG also believe that the position for admissions, as per the BCF methodology, is slightly below plan for Q3 rather than significantly below plan as indicated.

9.3 Non-elective hospital re-admissions – Re-admissions for Q3 have reduced when comparing to Q1 and Q2. 11.9% for Q3 (Q1 13.4%, and Q2 13.36%).

9.4 Permanent admissions of older people (aged 65+) to residential and nursing care homes - Admissions as at Q3 shows 297 admissions, this equates to a rate per 100,000 of 607.0 and a projection of 396 admissions or rate of 809.3 by year end, representing an in year 15.6% reduction from 2014/15 of 958.5. We project that by year end the rate will be closer to target of 933.25 and represent a 2.6% reduction in change in rate, following estimated impact of seasonal adjustments i.e. expected higher rate of admissions over the winter period and year end quality assurance checks having been applied.

9.5 The proportion of older people (65+) still at home 91 days later after hospital discharge into rehabilitation –.This is an annual measure and collation of data is undertaken during Q3 by tracking service users 'offered' (ie. commence) the service during October to December 2015. Follow up actions to capture those who were still at home 91 days following discharge is completed during Q4 and finalised for submission during April/May. We will be able to provide an incremental cumulative estimate on progress from the data from analysis completed in the 3 sample months January to March 2016, from late February.

9.6 Delayed transfers of care from hospital (DTOC) – This measure continues to improve and there has been a marked reduction throughout the year in the number of days lost due to delayed transfers of care at both TRFT and RDaSH. This improvement is due, in part, to impact of changes made in relation to the 3 DTOC measures (BCF-whole year Total days, RMBC – ASCOF total people delays snapshots of effectiveness and offered) to operating practices with partners that were agreed during 2015/16.

9.7 NHS Family and Friends test - Annual measure using the National Inpatient Survey Results - latest published information shows a reduction in the rate of negative responses - 115.9 from a baseline position of 123.08. No further update from Q2.

10. New Integration Measures

10.1 Personal Health budgets, use and prevalence of multi-disciplinary and integrated care teams and use of integrated digital care records across and health and social care are new integration metrics that have been recently introduced. Rotherham can report favourably on the first two metrics.

11. Conclusion/Next Steps

11.1 The quarterly format, and the timetable for submitting the quarterly and annual returns have been included within the Section 75 Partnership Framework Agreement for the BCF, thus ensuring both the CCG and Local Authority are jointly responsible for compiling and submitting these reports to the HWB and NHS England.

12. Background Papers

12.1 Appendix A: BCF Quarterly Data Collection Quarter 3 2015/16

Contacts: Keely Firth, Chief Finance Officer, RCCG
E-Mail: keely.firth@rotherhamccg.nhs.uk, **Tel. No:** 01709 302025

Contacts: Jon Tomlinson, Interim Director of Commissioning, RMBC
E-Mail: jon.tomlinson@rotherham.gov.uk **Tel. No:** 01709 822270

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 26th February 2016.

The BCF Q3 Data Collection

This Excel data collection template for Q3 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 9 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.
8) New Integration metrics - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care
indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

template have been completed the cell will turn green. Only when all 9 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the Q1 and Q2 2015-16 submissions and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously the 2 further questions are not applicable and are not required to be answered.

they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be met through the delivery of your plan (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31st March
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4 - Q2. Two figures are required and one question needs to be answered:

Input actual Q3 2015-16 Non-Elective Admissions performance (i.e. number of NEAs for that period) - Cell O8
Input actual value of P4P payment agreed locally - Cell F19
If the actual payment locally agreed is different from the quarterly payment suggested by the automatic calculation in cell AR8 (which is based on your input to cell O8 as above) please explain in the comments box
Please confirm what any unreleased funds were used for in Q3 (if any) - Cell F34

5) Income and Expenditure

following information:

Forecasted income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1 to Q3
Forecasted expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure from the pooled fund in Q1 to Q3

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

6) Metrics

This tab tracks performance against the two national supporting metrics, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:
An update on indicative progress against the four metrics for Q3 2015-16
Commentary on progress against the metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

7) Understanding support needs

This tab re-asks the questions on support needs that were first set out in the BCF Readiness Survey in March 2015. These questions were then asked again during the Q1 2015-16 data collection in August. We are keen to collect this data every six months to chart changes in support needs. This is why the questions are included again in this Q3 2015-16 collection. The information collected will be used to inform plans for ongoign national and regional support in 2016-17.

The tab asks what the key barrier to integration is locally and what support might be required in putting in meeting the six key areas of integration set out previously. . HWBs are asked to:

Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan
support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) New Integration Metrics

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in the last BCF Quarterly Data Collection Template (Q2 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

9) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q3 2015/16

Data collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

3. National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. Non-Elective and P4P

Actual Q3 15/16	Actual payment locally agreed	Cumulative quarterly Actual Payments >= Cumulative suggested quarterly payments	If the actual payment locally agreed is <> suggested quarterly payment	Any unreleased funds were used for: Q3 15/16
Yes	Yes	Yes	Yes	Yes

5. I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the annual totals and the pooled fund
Income to	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes	Yes		
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Actual	Yes	Yes	Yes		
	Commentary	Yes				

6. Metrics

	Please provide an update on indicative progress against the metric?	Commentary on progress
Admissions to residential Care	Yes	Yes
Reablement	Yes	Yes
Local performance metric	Yes	Yes
If no metric, please specify	Yes	Yes
Patient experience metric	Yes	Yes

7. Understanding support needs

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan
Yes

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

8. New Integration Metrics

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Yes	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Yes	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?
Yes

Total number of PHBs in place at the beginning of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

9. Narrative

Brief Narrative	Yes

Cover

Q3 2015/16	
Health and Well Being Board	**Rotherham**
completed by:	Karen Smith
E-Mail:	karen-nas.smith@rotherham.gov.uk
Contact Number:	01709 254870
Who has signed off the report on behalf of the Health and Well Being Board:	Sharon Kemp and Chris Edwards

Question Completion - when all questions have been answered and the validation

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	17
6. Metrics	9
7. Understanding support needs	13
8. New Integration Metrics	67
9. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Rotherham

Have the funds been pooled via a s.75 pooled budget?	Yes
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q1/Q2 data collection previously filled in by the HWB.

National Conditions

Selected Health and Well Being Board: Rotherham

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Q4 Submission Response	Q1 Submission Response	Q2 Submission Response	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Commentary on progress
1) Are the plans still jointly agreed?	Yes	Yes	Yes	Yes		
2) Are Social Care Services (not spending) being protected?	Yes	Yes	Yes	Yes		
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	No - In Progress	No - In Progress	Yes		
4) In respect of data sharing - confirm that:						
i) Is the NHS Number being used as the primary identifier for health and care services?	No - In Progress	No - In Progress	No - In Progress	Yes		
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	Yes	Yes	Yes		
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	Yes	Yes	Yes	Yes		
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Yes	Yes	Yes		

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

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

Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously filled in by the HWB.

Better Care Fund: Revised Non-Election and Payment for Performance Calculations

Selected Health and Well Being Board: Rotherham

	Baseline				Plan				Actual						Planned cumulative reduction (cumulative) (negative values indicated the plan is larger than the baseline)			Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment							
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	No change (negative values indicate the plan is larger than the baseline)	Absolute reduction in non-election performance	Total Performance Fund Available	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Total Performance Fund	Total Performance and ringfenced funds	Q1 Payment locally agreed	Q2 Payment locally agreed	Q3 Payment locally agreed
1. REVALIDATED: HWB version of plan to be used for future monitoring	7,421	7,370	7,370	7,370	7,370	7,370	7,370	7,370	7,370	7,370	7,370	7,370	6,370	-1,000	-1,000	1,000	-1,000	-1,000	-1,000	1,000	370	370	370	370	370	370	370	370	370	370	370	1,480	1,480	370	370	370

Which data source are you using in section G? (NHIS, SUS, Other)	NHIS	If other please specify
Cost per non-elective activity	£1,200	

	Total Payment Made			
	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
Suggested quarterly payment (Taken from above)*	£0	£0	£0	£0
Actual payment locally agreed	£0	£0	£0	£0

If the actual payment locally agreed is different from the suggested quarterly payment (taken from above) please explain in the comments box (max. 140 characters)	

	Total Unreleased Funds			
	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
Suggested amount of unreleased funds**	£0	£0	£0	£0
Actual amount of locally agreed unreleased funds	£0	£0	£0	£0

	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select)	Acute Care	Acute Care	Acute care	Acute care

Footnotes:

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*Suggested quarterly payment (taken from above) has been calculated using the technical guidance provided here http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/. The key steps to calculating the quarterly payment are:
a. take the cumulative activity reduction against the baseline at quarter end and divide it by the cumulative Q4 2015/16 target reduction.
b. multiply that by the size of the performance pot available, and
c. subtract any performance payments made for the year to date.
The minimum payment in a quarter is £0 (there will not be a negative payment or "clawback" mechanism) and the maximum paid out by the end of each quarter cannot exceed the planned cumulative performance pot available for release each quarter.

**Unreleased funds refers to funds that are withheld by the CCG and not released into the pooled budget, due to a risk achieving a reduction in non-elective admissions as set out in your BCF plan. As payments are based on a cumulative quarter end value a negative(-) quarter actual value indicates the use of surplus funds from previous quarters.
HWBs should consider whether there is a need to make adjustments to Q3 payments where over or under payments may have occurred in Q2 2014/15, Q1 2015/16 or Q2 2015/16 due to changes made to NEA baselines and targets.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Rotherham

Income

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,829,000	£5,829,000	£5,829,000	£5,829,000	£23,316,000	£23,316,000
	Forecast	£5,829,000	£5,829,000	£5,829,000	£5,829,000	£23,316,000	
	Actual*	£5,829,000	£5,829,000				

Q3 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,829,000	£5,829,000	£5,829,000	£5,829,000	£23,316,000	£23,316,000
	Forecast	£5,829,000	£5,829,000	£5,829,000	£5,829,000	£23,316,000	
	Actual*	£5,829,000	£5,829,000	£5,829,000			

Please comment if there is a difference between either annual total and the pooled fund	

Expenditure

Previously returned data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,829,000	£5,829,000	£5,829,000	£5,829,000	£23,316,000	£23,316,000
	Forecast	£5,829,000	£5,829,000	£5,829,000	£5,829,000	£23,316,000	
	Actual*	£5,829,000	£5,829,000				

Q3 2015/16 Amended Data:

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,829,000	£5,829,000	£5,829,000	£5,829,000	£23,316,000	£23,316,000
	Forecast	£5,829,000	£5,829,000	£5,829,000	£5,829,000	£23,316,000	
	Actual*	£5,829,000	£5,829,000	£5,829,000			

Please comment if there is a difference between either annual total and the pooled fund	

Commentary on progress against financial plan:	Some of our budgets have changed against individual lines but the choreography between planning for 2015/16 and getting the original plan signed off was such that we took the judgement not to revisit the BCF budgets until 2016/17. This is intuitive to a piece of work currently being undertaken on the individual BCF objectives. It is likely that some of the schemes will change and budgerts realigned.

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Rotherham

Admissions to residential Care	% Change in rate of permanent admissions to residential care per 100,000
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	admissions or rate of 809.3 by year en, representing an in year 15.6% reduction from 2014/15 of 958.5. We project that by year end the rate will be closer to target of 933.25 and represent a 2.6% reduction in change in rate, following estimated impact of seasonal adjustments ie expected higher rate of admissions over the winter period and year end quality assurance checks having been applied.

Reablement	Change in annual percentage of people still at home after 91 days following discharge, baseline to 2015/16
Please provide an update on indicative progress against the metric?	Data not available to assess progress
Commentary on progress:	during Oct to Dec 2015. Follow up actions to capture those who were still at home 91 days following discharge is completed during Q4 and finalised for submission during April/May. We will be able to provide an incremental cumulative estimate on progress from the data from analysis completed in the 3 sample months January to March 2016.

Local performance metric as described in your approved BCF plan / Q1 / Q2 return	Emergency readmissions < 30 days of hospital discharge (all ages) PHOF4.11NHSOF3b - NB. local variation to national measure, using patients registered with a Rotherham GP, not LA population.
Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Readmissions for Q3 have reduced when comparing to Q1 and Q2. 11.9% for Q3 (Q1 13.4%, and Q2 13.36%).

Local defined patient experience metric as described in your approved BCF plan / Q1 /Q2 return	Inpatient Experience: The proportion of people reporting a poor patient experience of inpatient care. (Average number of negative responses per 100 patients)
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Annual measure using the National Inpatient Survey Results - latest published information shows a reduction in the rate of negative responses - 115.9 from a baseline position of 123.08. No further update from Q2.

Footnotes:

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board:	Rotherham

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	3.Developing underpinning integrated datasets and information systems

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	Yes	Central guidance or tools	
2. Delivering excellent on the ground care centred around the individual	Yes	Case studies or examples of good practice	
3. Developing underpinning integrated datasets and information systems	Yes	Central guidance or tools	
4. Aligning systems and sharing benefits and risks	Yes	Central guidance or tools	
5. Measuring success	Yes	Central guidance or tools	
6. Developing organisations to enable effective collaborative health and social care working relationships	No		

New Integration Metrics

Selected Health and Well Being Board: Rotherham

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	No	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Hospital	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via interim solution	Shared via interim solution	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution
From Mental Health	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Specialised Palliative	Shared via interim solution	Not currently shared digitally	Not currently shared digitally	Shared via interim solution	Not currently shared digitally	Shared via interim solution

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	Unavailable	In development
Projected 'go-live' date (dd/mm/yy)	31/01/17	31/01/17	31/01/17	31/01/17	31/01/18	31/01/17

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot currently underway

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the beginning of the quarter	97
Rate per 100,000 population	37

Number of new PHBs put in place during the quarter	0
Number of existing PHBs stopped during the quarter	0
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	100%

Population (Mid 2015)	260,782

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014).
http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/2012-based-projections/stb-2012-based-snpp.html

Narrative

Selected Health and Well Being Board: Rotherham

Remaining Characters	29,571

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time, please also make reference to performance on any metrics not directly reported on within this template (i.e. DTOCs).
Revised and strengthened governance is in place and working effectively for the BCF. BCF Governance continues to closely monitor specific BCF projects, to ensure full and accelerated implementation of the two remaining projects linked to the BCF national conditions within agreed timescales. These are: National Condition 3 - 7 day services to support patients being discharged at weekends has now been established and fully operational since 1st December, 2015. Two assessing officers and a team manager or principal social worker work on shift over the weekend. National Condition 4(i) - NHS Number being used as primary identifier for health and social care services - Work well underway to ensure better sharing between heath and social care. There are 5,495 adults who are in the scope of the NHS number matching project. By the end of February 2016 all in-scope BCF records will have an NHS number assigned. Training materials have been issued which demonstrate to practitioners in adult social care on how to use the NHS number field. A weekly report is issued to managers detailing the number of NHS numbers updated each week. The practice of checking NHS numbers with clients as part of 'business as usual' during contacts is bedding-in and NHS numbers are being updated by adult social care staff at the point of contact with customers. Our new social care system goes "live" later in 2016 and this includes the facility to integrate with the NHS 'Patient Demographic Service' (PDS) – which will deliver the ability to quickly look up NHS numbers on the NHS spine. Will begin using the NHS number on our correspondence when the new Liquidlogic system is "live" (Liquidlogic includes the facility to add NHS numbers to correspondence with little extra work). The newly formed BCF Strategic Group continues to take a lead in developing proposals for integration. The BCF service review has now been completed which examined all services that are currently funded through the local BCF programme. The report recommends a new structure for categorising BCF funded schemes into new themes e.g. mental health services, rehabilitation, reablement and intermediate care, social care purchasing, case management and integrated care planning, supporting carers and BCF infrastructure. Recommendations from the review included the creation of a BCF directory of services (work is now well underway) so that all clear stakeholders can see a clear map of provision. A series of individual service reviews will be carried out where there are funding or performance issues or where there are concerns regarding strategic relevance. Service reviews will take place between February and October 2016. Delayed Transfers of Care (DTOC) - This measure continues to improve and there has been a marked reduction throughout the year in the number of days lost due to delayed transfers of care at both TRFT and RDaSH. This improvement is due, in part, to impact of changes made in relation to the 3 DTOC measures (BCF-whole year Total days, RMBC – ASCOF total people delays snapshots of effectiveness and offered) to operating practices with partners that were agreed during 2015/16.

NHS Rotherham Clinical Commissioning

Strategic Clinical Executive –

GP Members Committee (GPMC) –

Clinical Commissioning Group Governing Body -

Health and Well Being Board 24 February 2016

CCG Commissioning Plan for 2016-20

Lead Executive:	**I Atkinson: Deputy Chief Officer**
Lead Officer:	**L George: Planning and Assurance Manager**
Lead GP:	**J Kitlowski: CCG Chair**

Purpose:

Members are asked to note Rotherham CCG's revised Commissioning Plan for 2016/17.

Background:

The CCG agreed a new four year commissioning plan in April 2015, as part of routine practice the CCG undertakes a review of the plan on an annual basis. The starting point for the review is for the CCG to reflect on the most up to date Joint Strategic Needs Assessment, Health and Wellbeing Strategy, GP member practices views, views of patients, public and stakeholders, CCG and NHS Constitutions, NHS England Guidance and the previous year's Commissioning Plan.

The process for producing the 2016/17 Commissioning Plan began in September 15 with a CCG Governing Body Development Session. The purpose of that session was to confirm / challenge the content of the current plan, to identify potential gaps, reflect on key elements of 2015/16 plan and suggest changes for 2016/17. The key themes identified for further specific discussion were:

- Approach to joint commissioning with RMBC including Better Care Fund,
- Commissioning of Children's Services
- Response to Child Sexual Exploitation (CSE)
- Hospital & Community Services
- Mental Health Services (including Learning Disability)
- Primary Care

The Chief Officer, Deputy Chief Officer and Chair of the GPMC attended all locality meetings during October and used the feedback from the development session to inform the discussions. The CCG has also shared plans with TRFT, RDASH, RMBC Public Health and Health Scrutiny.

The plan has draft sections that include some highlighted text or information to follow, much of this if predicated on further guidance from NHS England. The awaited NHS England guidance on contracts may require amendments to the financial assumptions, QIPP (quality, innovation, productivity and prevention) assumptions and affordable trajectories.

Ongoing intelligence from engagement activities is routinely gathered and used to inform commissioning; specifics can be found within the plan for each strategic priority (part 2).

Other key inputs to support the development of the plan are noted from the Annual General Meeting in July, the 'new face of GP services' event in November and the Patient Participation Group meeting in December

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Analysis of key issues and of risks

The CCG's GP Members Committee will received the final draft version of the CCG commissioning plan for 2016/17, at their meeting on the 24 February and will be asked to recommend its approval to the Governing Body on the March/April.

Members are asked to note the following key points associated with the draft plan:

The CCG has only <u>one plan</u>, the key difference for 2016/17 will be the separation of the plan in to two parts:

- **Part 1 'strategic plan'**
- **Part 2 'how we will deliver'**

<u>Part 1 - Key elements</u>

The separation means that the strategic content of the plan is covered within approximately 50 pages. The following describes the key sections of the plan:

- **Introduction** sets the scene of what a CCG is and its responsibilities, and then highlights our recent achievements.
- A description of the **National context**, followed by the local **vision for health and social** care set against the **assessment of need** for Rotherham.
- Articulation of the **challenges, solutions, <u>strategic priorities</u>**, and **measurements of success** - this was previously in the executive summary.
- **Relationships** with our key partners, partners' plans and the importance of joint work.
- Triangulation of **activity, finance and efficiency**.
- **Statutory responsibilities**, with an emphasis on Safeguarding, Child Sexual Exploitation and patient and public engagement.
- **Information Management and Technology** is expanded to explain the requirements of the digital roadmap.
- **Communication, performance management and assurance, risk** and **how we shared our plans** follow a similar format to previous years.

<u>Part 2</u>

15 key Strategic Priorities. The separation allows for the addition of further detail such as primary care (full strategy included) without compromising the 'strategic' flow of part 1 of the plan. Part 2 is the 'nuts and bolts' of how we will deliver the specific areas, and for each area we provide the following information:

- Why is this a strategic priority
- 5 year Strategic Direction
- Progress made in 2015/16
- How are we going to achieve our intentions
- Quality Improvements
- Innovation
- Alignment with the strategic aims of the Health & Wellbeing Strategy
- How will health inequalities be addressed
- What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?

<u>To note</u>

The separation means that we can add to the plan in the future, for example, the wider place based plan may become 'part 3'.

At the end of the process audiences will have the choice of:

- A succinct executive summary
- A '50' page strategic plan (part 1)
- A '50-60' page detailed plan (part 2)
- And at the very end we will produce an easy read public facing version

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Patient, Public and Stakeholder Involvement:
This is covered in the plan in 3 ways: • throughout the plan are speech bubbles and CCG responses. • section 6.3 summarises what we do and has a link to the new CCG Communication and Engagement Plan '*Your Life, Your Health, Your Say*'. • section 14 describes how we shared this plan. Following completion of the plan we will also produce a shorter version and some illustrative patient stories to help on-going dialogue with the public.
Equality Impact:
Covered in the plan.
Financial Implications:
Covered in Sections 8 & 9.
Human Resource Implications:
Covered in the plan.
Procurement:
Covered in the plan.
Approval history:
Operational Executive, Strategic Clinical Executive, Senior Management Team and GP Members Committee have been engaged throughout the process.
Recommendations:
• The Health and Wellbeing Board are asked to note the draft plan and provide feedback. • Note that the plan will be submitted to NHS England in early April.

Enclosures:

- Cover paper
- Presentation
- Commissioning Plan part 1
- Commissioning plan part 2

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NHS
Rotherham
Clinical Commissioning Group

CCG Commissioning Plan

Health and Wellbeing Board
February 2016

Your life, Your health

Key changes

- Reminder to members that the CCG has only **one plan.**
- The key difference to our plan is that it has been separated into 2 parts
  - **Part 1 'strategic plan'**
  - **Part 2 'how we will deliver'**

Part 1

- The introduction sets the scene of what a CCG is and its responsibilities, and then highlights our recent achievements.
- After describing the National context, we set our vision for health and social care against the assessment of need for Rotherham.
- We then clearly articulate the challenges, solutions, strategic priorities, and measurements of success – this was previously in the executive summary but not in the main body of the plan.
- Next we describe our relationships with our key partners, their plans and joint working and the importance of joint work.
- By page 30 we have explained the role of the CCG, our key challenges, solutions and priorities and triangulated activity, finance and efficiency.
- The remainder of the plan follows similar to previous years covering all statutory responsibilities inc Safeguarding, CSE etc
- How our plan supports patients will be shown through patient characters, their stories and how our services support their particular needs.

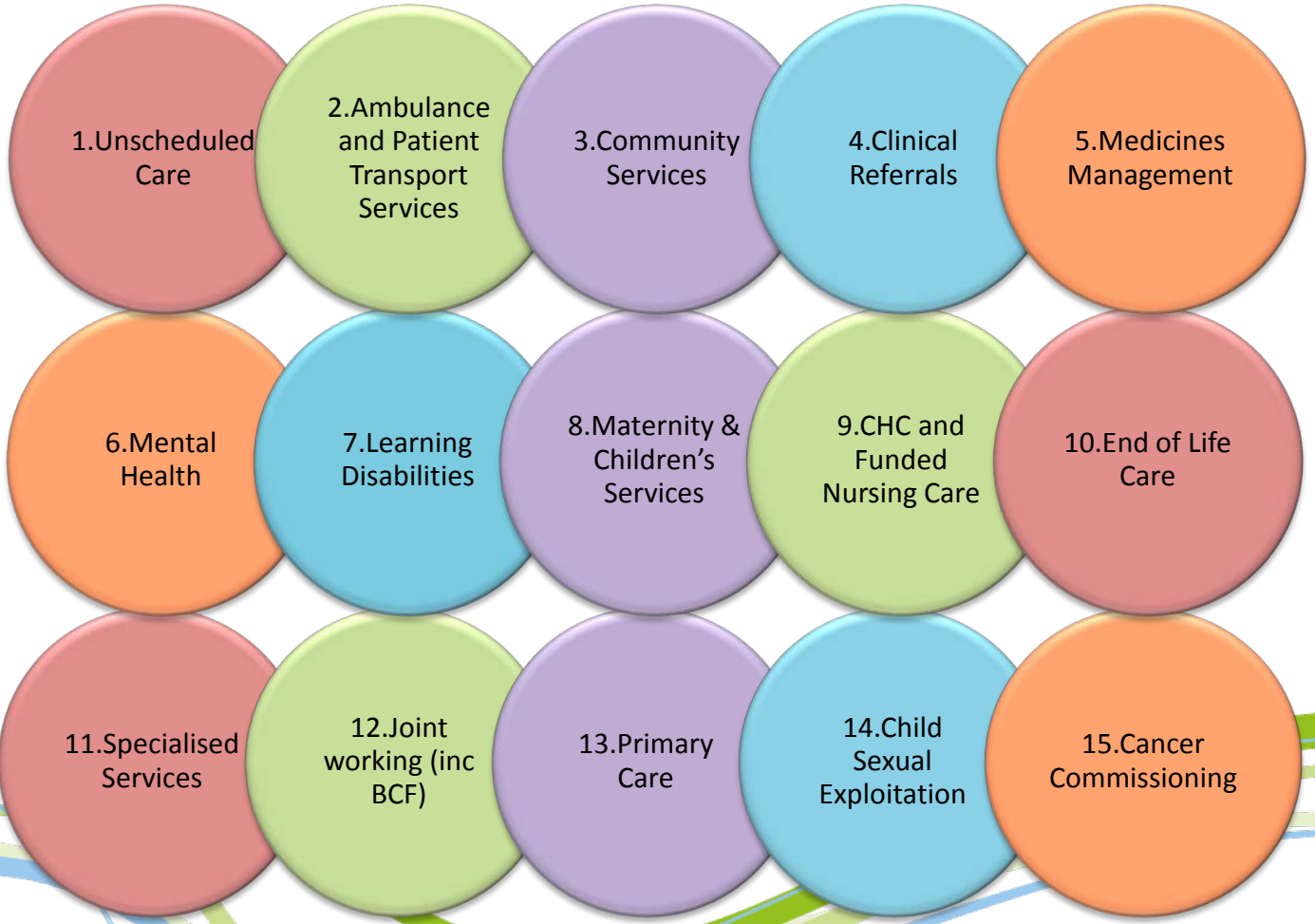
Part 2

- The Commissioning Areas (part 2) is the detailed 'nuts and bolts' of how we will deliver specific areas. The separation allows us to add in further detail such as primary care (full strategy included) without compromising the 'strategic' flow of the plan. It also enables us to add to the plan in the future, for example, the place based plan may become 'part 3'.

Flow of the Commissioning Plan

Your life, Your health

Part 2 - Delivering Strategic Priorities



Your life, Your health

For each identified Strategic Priority we describe:

- Why is this a strategic priority
- 5 year Strategic Direction
- Progress made in 2015/16
- How are we going to achieve our intentions
- Quality Improvements
- Innovation
- Alignment with the strategic aims of the Health & Wellbeing Strategy
- How will health inequalities be addressed
- What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?

The End product

In essence at the end of the process audiences will have the choice of:

- A succinct executive summary
- A '50' page strategic plan (part 1)
- A '50-60' page detailed plan (part 2)
- And at the very end we will produce an easy read public facing version

Timescales

- GPMC will receive the final draft version of the plan at its February meeting where they will be asked to recommend its approval to the Governing Body in March
- the final version will then be submitted to NHS England by 11 April.

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NHS
Rotherham
Clinical Commissioning Group

Commissioning Plan

DRAFT

2016-2020 V4.1 01 02 2016

Part One

Your life, Your health

http://www.rotherhamccg.nhs.uk/

Contents

Please note that the following applies to this version:

Text highlighted in yellow indicates that the content needs either further work, confirmation or update before submission.

Page numbers, signposting and hyperlinks (currently denoted in *orange italic text*) will be finalised in the March/April version

Exec summary to be inserted

1 Introduction

In April 2015 Rotherham CCG set a clear strategic direction and long term (5 years) commissioning vision. With the plan now one year into delivery it is important to reflect on progress in delivering the plan, take account of any in year strategic changes and to re-affirm the CCG strategic vision and commissioning priorities.

We are conscious that the language used in this plan tends to be technical 'NHS language' but once the refreshed plan is agreed we will produce a plain English version that will be used as part of our on-going patient and public engagement activities and also a set of patient stories to encourage dialogue about the difference the plan will make. There is a glossary in section 19.

2 About the Clinical Commissioning Group (CCG)

The CCG is a membership organisation, the 31 **GP practices** in Rotherham are its members, and they are grouped into eight localities. There are seven locality meetings (2 localities jointly meet) and link to the seven localities from a community service provision view. The CCG's main decision making body is the **CCG Governing Body**, five GPs, three executives, a nurse, a hospital consultant, and 3 lay members (for patient engagement, finance and audit and GP commissioning). The CCG ensures that 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 monthly 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 lead on the delivery of the CCG's strategic priorities. The eight GPs are supported by 106 (87wte) directly employed CCG staff. As well as the GP Members Committee another four GPs provide additional clinical advice on areas such as safeguarding, clinical referrals, medicines management and mental health. The CCG has a contract with eMBED which supports the CCG in areas which Include Business intelligence and Information Governance. We purchase other support services such as Human Resources from other local CCG's

The links show the members of our three committees: Governing Body, GP Members Committee, and Strategic Clinical Executive *CCG Governing Body and committees*. Further details of the CCGs governance structure are in Section 13.5.

2.1 List of CCG Statutory Responsibilities

The CCG's full responsibilities are detailed in its constitution. *RCCG Constitution.* The main responsibilities are listed below and in section 13 of this plan we set out how we meet these responsibilities:

- Upholding the NHS constitution, CCG constitution and governance standards. *NHS Constitution*
- 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
- Achieving financial balance

2.2 List of CCG Commissioning Responsibilities

The CCG 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. *CCG Commissioning Responsibilities*

Services commissioned by the CCG are:

- Urgent and emergency care (including 111, A&E and ambulance services) for anyone present in our geographic area
- Out of hours primary medical services (for everyone present in our 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
- Delegated authority for GP commissioning from 1 April 2015
- Specialist wheelchair services, outpatient neurology and neuro-surgery, renal dialysis and surgery for morbid obesity from 1 April 2016 subject to confirmation from NHS England.

2.3 Achievements in 2015-16

We continue to be a high achieving Clinical Commissioning Group, working proactively with partners and the wider public, some of our recent successes are highlighted below:

Clinical leadership; Run by our clinical executive, with well developed locality and membership inputs and with strong links with clinicians in our provider organisations. We have a programme of clinically led primary and secondary care quality visits and joint clinical education sessions for primary and secondary care clinicians.

Quality and Efficiency programmes; Signed off the business case for the Emergency Care centre that will open in 2017, achieved the first year of the Community Transformation Programme, begun the implementation of a comprehensive Mental Health Transformation plan.

Sustaining community investment; Undertaken a successful evaluation of our £5 million investments in additional services in the community, including the current case management of 9,600 people at most risk of hospital admission (15,000 plans in total over the last 4 years). Have substantially developed provision by the voluntary sector including national recognition of the Rotherham model of social prescribing.

Innovation; Care coordination centre, multi-award winning medicines management projects improving dietetics and stoma care, virtual clinics for haematology and prostate specific antigen results. Developed top tips for primary and secondary care clinicians. Invested over £800k in hospital Mental Health Liaison services in 2015.

CCG and staff development; In accordance with the CCG's constitution, Rotherham CCG undertakes a vote of confidence from its member's each year. In 2015 we asked two questions:

1. Do you have confidence in the direction of travel? **91%** 31 out of 34 practices said **'Yes'**

2. Do you have confidence in the executive teams of the CCG? **97%** 33 out of 34 practices said **'Yes'**.

We were the first CCG in the country to receive Investors in Excellence, in the top 6 CCGs nationally in the Health Service Journal Awards. All staff have twice yearly personal development reviews. Achieved the highest response rates to the national staff survey (100%) and with XX% positive feedback on; staff opportunities to show initiative, support from line managers and senior management commitment to patient care. Other achievements include being the runner-up for the in the CCG Workplace Award and runner-up in the HFMA Finance team of the year. Rotherham CCG has been chosen along with 11 other NHS Hospital Trusts to lead the way in the Healthy Workforce initiative, a commitment in the 'Forward View' to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy.

If you have any comments on the plan or would like further information relating to the CCG please contact us on rotherhamccg@rotherhamccg.nhs.uk, or by post to: Rotherham CCG, Oak House, Moorhead Way, Bramley, Rotherham, S661YY

Julie Kitlowski, GP
Chair CCG

Chris Edwards
Chief Officer /
Accountable Officer CCG

Leonard Jacob, GP
Chair GP Members Committee
(up to 31 March 2016)

John Barber
CCG Lay Member

Philip Moss
CCG Lay Member

Robin Carlisle
CCG Lay Member

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 admitted to hospital who do not need to be
- NHS Rotherham CCG has an £75 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 IT to improve communication, access to services and patient education

Strategic Aims

The CCG Strategic Aims seek to address all five H&WB Strategic Aims across all life stages and for all communities both geographical and communities of interest

1 Unscheduled Care
2 Transforming Community Services
3 Ambulance and Patient Transport
4 Clinical Referrals
5 Medicines Management
6 Mental Health
7 Learning Disabilities
8 Maternity and Children's Services
9 Continuing Health and Funded Nursing Care
10 Palliative Care
11 Specialised Services
12 Joint Working - local and Regional
13 Child Sexual Exploitation
14 Cancer
15 Primary Care

Corporate Priorities

Assurance | **Delivery**

Quality | **Safeguarding** (including Child Sexual Exploitation*)

Outcomes

24 National Pledges | 6 Better Care Fund Metrics | 6 Quality Premium Metrics | 7 NHS Ambitions

Key measures of successful outcomes will include:

- **Additional years of life** – 200 additional life years per year
- **Close the Rotherham Life Expectancy Gap towards the National Average**

- *To follow Key Metris associated with the 2016-17 CCG Assurance Framework

Better Health
Better Care

Health and Wellbeing 5 Strategic Aims

Aim 1: All children get the best start in life

Aims 2: Children and young people achieve their potential and have a healthy adolescence and early adulthood

Aim 3: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing

Priority 5: Rotherham has healthy, safe and sustainable communities and places

**** Prevention of Child Sexual Exploitation continues to be a priority in 2016/17. We will work with partners to address all issues that arise from the Jay and Casey reports into CSE and the Ofsted report into Children in need of help and protection.***

NHS Rotherham CCG 'Purpose on a Page'

NHS ROTHERHAM CLINICAL COMMISSIONING GROUP

Our Responsibilities

NHS Rotherham CCG is a membership organisation of 31 (as at 01.04.2016) 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, ambulance and hospice services. From April 2015 we also have delegated responsibility for commissioning GP services and some specialist services.

We do not currently commission pharmacy, optometry, dental and most 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. **Safeguarding** – ensuring all children and vulnerable adults are protected from harm, including implementing all actions on Child Sexual Exploitation from the Jay and Casey reports.

3 National Context

3.1 Government Mandate

NHS England is responsible for arranging the provision of health services in England. The annual mandate to NHS England sets the Government's objectives and any requirements for NHS England, as well as its budget. In doing so, the Mandate sets direction for the NHS, and helps ensure the NHS is accountable to Parliament and the public.

Every government department produces a plan setting out its objectives and how they will be achieved. For NHS England this therefore sets out its' contribution to the Government's goals for the health and care system as a whole. This year the objectives are underpinned by specific deliverables to be achieved in the short term (2016-17), and to be achieved in the long term (2020 or beyond).

3.2 Five Year Forward View / Planning Guidance for 2016/17 – 20/21

The ***NHS Five Year Forward View***, was published in October 2014, is a collaboration with six leading NHS groups including Monitor, Health Education England, the NHS Trust Development Authority, Public Health England, the Care Quality Commission and NHS England. It represents the first time the NHS has set out a clear sense of direction for the way services need to change and improve.

The Five Year Forward View includes **three key** messages for the future of the NHS:

- Firstly, to get serious about prevention and improving the health and wellbeing of the nation, by backing hard-hitting national action on obesity, smoking, alcohol and other major health risks, supporting people to take more control over their own care and improve partnerships with voluntary organisations and local communities.

- Secondly, support for the development of new models of care. Rrecognising there is not a 'one size fits all' care model for England, support the development of a number of new care models and a new deal for primary care. Nnational leaders will work together to provide meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied.

- Thirdly, a focus on efficiency and funding . There are viable options for sustaining and improving the NHS over the next five years. However, this will require the NHS to achieve the very demanding efficiency aspirations set out in the Five Year Forward View as well as investment from the next government.

Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21 sets out actions for delivering both the government's mandate and the *Five Year Forward View,* in light of the 2015 spending review settlement. The settlement provides a basis on which to achieve three the interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients. It includes an £8.4 billion real terms increase by 2020/21, aimed to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

CCGs are required to produce two separate but connected plans:

- a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging Sustainability and Transformation Plan (STP) (this plan).
- a five year STP, place-based and driving the Five Year Forward View. For Rotherham CCG this means being part of the South Yorkshire and Bassetlaw STP footprint, we will work collaboratively to engage fully in the development and submission of the STP which is expected to be completed by June 2016.

3.3 How Rotherham CCG will deliver the NHS Five Year Forward View

The table below summarises key points for the NHS 5 year forward view and identifies how these are addressed in our plan. On 23 December 2015 the 'F*orward view into action'* set out more specifics.

5 year Forward view	Rotherham CCG Commissioning Plan
A radical upgrade in prevention and public health	The Local Health and Well-being Board supported strongly by the CCG and Public Health supports are committed to ensuring maximal health gain from Rotherham's public health funding, we will refresh the existing Potential Years of Life Lost action plan and continue as a CCG to promote public health messages across Rotherham. The CCG's approach to Health Inequalities is in section 6.4 and includes quantifying ambitions for Potential Years of Life lost, smoking, alcohol and obesity. The CCG will continue to work closely with partners on the reforms for children with special educational needs and disabilities.
Patients will gain far greater control over their own care, joint budgets, carer support and partnerships with the voluntary sector	The CCG will look to maximise and expand projects in the Better Care Fund (21.12). Self care and personal budgets (sections 21.1 & 21.9). Carer support in sections 21.6 & 21.12. The Rotherham model of social prescribing in partnership with the voluntary sector is covered in sections 9.3, 21.1 & 21.15. Our partnership with Rotherham Hospice is described in section 21.10.
Breaking down barriers in how care is provided	This was also a key finding in our survey of the Rotherham public (Section 18). This is a key feature of Care Co-ordination (21.11), Social Prescribing (9.3) and our Better Care fund projects (21.12). The CCG will ensure that provider services prioritise the health needs of looked after children (21.8).
Integrated out of hospital care, multispecialty providers of community services, integrated primary and acute care systems and the importance of the list based primary care	Our plans to transform Emergency Care (21.1) were fully endorsed by the Keogh Urgent and Emergency Care review and is based on partnership between urgent care providers in Rotherham and best utilising the different skills of clinicians with primary and secondary care training. Our plans to transform community services are in section 21.2. The CCG encourages GPs to federate to increase commissioning options for a wider range of services within the community setting. The CCG's interest in innovative years of care models for areas such as diabetes, neurology and dermatology is flagged up in section 21.4. The importance of primary care, and the current risks in that area, is the reason why the CCG opted for wave 1 delegation of GP commissioning (21.15).
5 year ambition on quality	The CCG has a robust approach to secondary care quality improvement and assurance (section 13.1) and GP practice quality. The CCG will ensure that the voice of the child, young person and parent is fully engaged in the commissioning process (21.8).
Support for people with dementia	This is covered in Section 21.12, Better Care Fund project BCF 1 and the more detailed Rotherham Adult and Older Peoples Mental Health transformation Plan, see section 21.6.
Support for carers	See section 21.1 and also the Social Prescribing Service which support patients and carers (Section 21.12).
Enhanced health in nursing homes	The CCG will continue to facilitate GPs to move towards 1 GP practice providing patient services to residents of individual homes because we believe this improves quality of care. We will continue to work with Care Home to give them access clinical records.
5 year ambitions for mental health	This is summarised in section 21.6 and set out in detail in Rotherham Adult and Older Peoples Mental Health transformation Plan mentioned above.
Choice in maternity services	Set out in section 21.8.
Ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy	Rotherham CCG has undertaken a workplace wellbeing charter assessment and accreditation process, our commitment includes Board level leadership and engagement: championed by the Chief officer and GP Chair and commitment to achieve the 'Healthy Workforce' charter through a bottom up approach. We are the only CCG in the county to be piloting the national Healthy Workforce initiative.

3.4 Delivering the nine 'must dos' for 2016/17 within every local health economy

The 2016/17 planning guidance requires CCG's to work across local Health and Care economies to deliver nine key system priorities, these are:

1. Develop a high quality and agreed Sustainable Transformation Plan (STP), and subsequently achieve what you determine are the most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

Throughout this plan we identify how we deliver against **these 9 key areas.**

4 Vision for Health and Social Care in Rotherham

Commissioners of health and social services and the respective provider organisation delivering services in Rotherham are prioritised by needs identified in our Joint Strategic Needs Assessment, over the last 12 month Rotherham CCG has worked closely with partners to develop Rotherham's second Health and Wellbeing Strategy. The strategy for 2015-2018 sets out five key aims:

- All children get the best start in life
- Children and young people achieve their potential and have a healthy adolescence and early adulthood
- All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
- Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing
- Rotherham has healthy, safe and sustainable communities and places

The five year commissioning plans of NHS England, NHS Rotherham CCG, Rotherham Metropolitan Borough Council (RMBC), The Rotherham NHS Foundation Trust (TRFT) and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) will all be aligned to maximise the use of the Rotherham **public sector pound**. We will prioritise delivery of these plans through the System Resilience Group which feeds in to the Health and Wellbeing Board and individual organisations.

Patient outcomes, including safety, safeguarding and experience, will govern all that we do.

Providing the right care in the right place will mean that more people will receive care closer to their home. If as a local health economy we are going to achieve sustainable health care, the emphasis on commissioning community based primary care provision is paramount. The commissioning of primary care will be aligned to Rotherham's needs, where appropriate we will consider the targeting of resources in areas of highest need.

To continue to have a successful health system in Rotherham, substantial change is required. Rotherham's health system continues to be over-reliant on hospital admission as a solution to acute medical and social problems; our strategy will reduce this reliance. We will ensure that we commission **safe 7 day hospital services**, however through having a strong focus on **admission avoidance** and **reducing length of stay in hospital**, we will reduce the level of investment required in hospital services. This will allow the CCG to increase investment in community services and other alternatives to hospital admission.

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.

In 2015/16 non elective hospital activity has grown faster than is affordable. Our plans will address this in the long term but it is likely that we will have to take some short term actions to keep costs under control in 2016/17 while our longer term plans deliver.

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.

The CCG supports the direction of travel for Rotherham GPs to further develop the Limited Liability Federation to provide alternative models of care within the community setting. The CCG, through the Working Together partnership, supports increased collaborative working between acute providers and accepts the calls for increased pace of collaboration set out in the Dalton review.

The CCG will continue to maintain the principle of a **'Rotherham place'** base approach to commissioning health care services. However, as a CCG we fully accept that over the next 12 months we will have to work across the wider South Yorkshire and Bassetlaw footprint (STP footprint), to review existing services and develop plans for high quality safe sustainable hospital provision in the future.

All local health and social care organisations will address collectively Rotherham's £75m efficiency challenges, being mindful of the overall sustainability of health and social services and the impact of organisations on each other. NHS Rotherham Clinical Commissioning Group's (CCG) solutions to the efficiency challenge are:

- A stronger patient voice
- Clinical leadership and communication in both primary and secondary care
- Developing general practice
- Supporting self-care and delivering care as close to home as possible
- Transforming community care
- Improved patient pathway so patients are seen at the right place at the right time
- Better use of Information Technology to improve communications and provide information

5 Assessment of Need

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 JSNA. There is significantly higher than average deprivation (52nd out of 326 districts), unemployment and long term unemployment. **50,370** Rotherham residents (19.5%) live in the most deprived **10% of England**. Rotherham has **8,640** residents (3.3%) in Ferham, Eastwood, East Herringthorpe and Canklow living in the most deprived **1% of England**. The changing demographic will require the CCG and partners to consider where resources are allocated going forward.

Life expectancy at birth is 78.1 years for men and 81.4 years for women for 2011-13. Although this is below the National average it continues to improve for men but has recently been decreasing in women. Healthy life expectancy at birth is only 57.1 years for men and 59.0 years for women. This is 6.2 years less than the England average for men and 4.9 years less for women. This means that both men and women in Rotherham live over 20 years or a quarter of their lives with at least one long term health condition.

Another striking health issue 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 (1.3 males, 1.7 females) based on three years combined data for 2011-13. The gap in life expectancy between the most and least deprived parts of Rotherham for males is 9.0 years and females is 7.0 years (based on the same 2011-13 period).The gap has changed little for males since 2002-04 and has increased by 3.5 years for females.

Economic growth and getting people into employment remains a priority for the Borough. The links between poverty and ill health are well established and the pace of improvement in health is likely to be threatened if unemployment remains high or employment opportunities are low paid or insecure. 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.

The population of Rotherham continues to grow and is projected to reach 265,600 by 2020. The age profile will be increasingly dominated by the elderly; the number of people aged over 65 is projected to grow by 35% between 2012-2028 and by 70% for those aged over 85 in the same period. Increasingly these people will be living alone. This will be associated with an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. As at 2013/14 there were just under 13,500 people in Rotherham with diabetes, and 5,340 on GP stroke registers. By 2025 we project that there will be nearly 4,500 people in Rotherham living with dementia. 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.

Over the last decade, all-cause mortality rates have fallen. While early deaths from cancer, heart disease and stroke have fallen (cancer much less than heart disease), they remain worse than the England average. In contrast, premature deaths from liver disease have increased by 40%, particularly in females, although male rates have decreased recently. Further, respiratory disease mortality shows no net change over the last decade and has been increasing recently, more so in males.

Potential Years of Life Lost (PYLL) reflects deaths in people aged under 75. About 7,000 PYLL are lost each year in Rotherham through causes considered amenable to healthcare. This is over 1,600 years more than might be expected based on the England average. This CCG will aim to reduce this by 200 years per year over the next 5 years.

The main disease areas behind excess PYLL in Rotherham are the same as those creating inequalities in life expectancy; namely, circulatory disease, cancer and respiratory disease.

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.

We understand that the consequences of sexual exploitation for the victims of abuse and their families will be significant and will be lifelong. Mental health support and understanding will require continued investment both in professional awareness and increased multi-agency working in services for those who have been abused.

In response to the growth in long term conditions and care needs, the number of informal carers has increased and is currently estimated at 31,000 at 2011 Census. 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.

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. The health of EU migrants from Eastern Europe is generally poorer because of the poor social conditions in their native country. High levels of smoking and alcohol use are likely to pose significant threats to the health of these communities.

Staying healthy remains a significant challenge for many people in Rotherham.

5.1 Children and Young People's Health

Child poverty is the biggest barrier to improving outcomes for children and young people. In Rotherham about 11,320 children under 16 (22.8%) live in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is <60% median income), this poses an immense challenge to give those children the best start in life.

The proportion of 16-18 year olds not in education, employment or training (NEET) is 5.9% (2014), higher than the England average of 4.7% Disengagement at this time can have a significant and lasting impact on the young person's health and wellbeing.

Rates of sexually transmitted infections are high, measured using chlamydia diagnoses as a marker condition, and indicate high levels of unprotected sexual activity in 15-24 year olds. Under 18 conceptions have improved significantly since 2008 with rates for 2013 now the same as England.

5.2 Maternal and infant health

Infant mortality, the rate of deaths in infants aged under 1 year per 1,000 live births, is 5.1 in Rotherham (2011-13), not significantly different from the England rate of 4.0. Further, 3.1% of babies at term are of low birth weight, again not significantly different from the England average of 2.8 (2012). Both infant mortality and low birth weight are key markers of child and maternal health in a local population.

Significant inroads have been made in reducing smoking in pregnancy, the main avoidable cause of low birth weight and infant mortality. Rates of smoking at delivery in Rotherham have dropped from 22.4% (in 2010/11) to 19.9% in 2013/14. While this rate is still significantly higher than the national average it demonstrates the impact intensive local interventions are making.

Breastfeeding initiation and maintenance are continuing challenges for us to give children the best start in life. Both are significantly worse than the England average. Teenage pregnancy rates have fallen dramatically and were the same as England in 2013.

5.3 Obesity and physical activity

In 2013/14 23.1% of children at Reception were classed as obese or overweight which is slightly higher than the national average; however, 36.0% of children at Year 6 were classified as obese/overweight and significantly worse than the national average. Adult obesity (obese or overweight) prevalence was estimated to be 65% (for 2012) which is similar to England.

Only 52.1% of Rotherham adults are physically active with 31.5% inactive according to data from Sport England's Active People Survey for 2014. Smoking prevalence is estimated via the Integrated Household Survey to be 18.9% (2013) in Rotherham. This is a significant decrease over 2012 and is now similar to the England average. This rises to 26.5% for those in routine & manual occupations.

Levels of substance misuse (opiate/crack use) are significantly higher than the England average (2011/12) whereas admissions to hospital due to alcohol related harm have reduced over recent years and are now similar to the national average (2013/14)

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 (obesity and lack of physical activity) and poverty. 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 significantly as the population ages.

Source of data: Public Health England using data principally from the Office for National Statistics and the Health and Social Care Information Centre (Data available under the Open Government Licence)

6 Key Challenges

As a CCG we therefore 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.**
3. At the moment **too many health problems are dealt with by hospital admission.** Rotherham's health and care services needs to be reshaped to meet the needs of its population more effectively and to enable more resources to be invested earlier to prevent problems as well as treat them.
4. **The health service efficiency challenge.**
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** and people in Rotherham are experiencing more years of ill health than the national average.

7 Solutions to our challenges

We suggest five **solutions:**

1. **Clinical leadership, both in primary and secondary care.** The CCG is a successful GP led, members' organisation and has made substantial progress working with other clinicians across Rotherham.
2. **Supporting self-care and improving quality of care at home.** 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.
3. **Transforming out of hospital care.** To prevent admission to hospital we need to ensure that as a CCG, we commission high quality, safe community based (out of hospital) provision from across the Health and Care economy.
4. **Better use of Information Technology.** Expand the use of IT systems that help patients to have more control over their health and information when they require it. Ensure interoperability of I.T systems through the implementation of 'Digital Roadmaps'. Effective interoperability will help clinicians to access the information they need, and have options in addition to face to face consultations.
5. **A stronger patient voice.** Our new joint communication and engagement plan, 'Your Life, Your Health, Your Say' 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 13.4 we describe our full engagement strategy.

8 Strategic Priorities

To allow us to deliver the vision outlined within section 4 and taking account of our local needs and key challenges, we will prioritise the following 15 strategic developments:

1. ***Transforming Unscheduled Care.*** By Spring 2017 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 clinical advice first time without the need for onward referral. Patients who do not require urgent care will be signposted to other appropriate services. As a CCG we will fully engage in the development of and delivery of the South Yorkshire wide Urgent and Emergency Care network.

   We will continue to expand the GP led, multidisciplinary, case management of patients in Rotherham at highest risk of admission to hospital, maximising the visibility of case management plans to other clinicians, we will also consider extending case management to patients on the palliative care pathway.

   We will further expand Rotherham's successful Care Coordination Centre that offers options such as urgent assessments and out- patient clinics as alternatives to hospital admission. Consideration will be given to the utilisation of the Care Coordination Centre by other parts of the Health and Care economy.

2. ***Transforming Community Services:*** We will continue to invest in increased community 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 project with Voluntary Action Rotherham and community palliative care provision.

3. ***Ambulance and Patient Transport Services:*** The CCG commissions 999 Ambulance provision from Yorkshire Ambulance Services (YAS), we will continue to work with YAS to commission high quality services that are delivered in a timely manner and in line with national targets. Linked to our wider discussions with partners regarding urgent care we will continue to improve commissioned ambulance pathways to provide alternatives to hospital attendance where appropriate.

   Our drive to move increased levels of elective activity out of hospital settings and to work more collaboratively across the wider South Yorkshire footprint, will undoubtedly impact on the way that 'traditional' (non-urgent) patient transport services are delivered. In 2016 we will review across the South Yorkshire footprint the most appropriate way of delivering routine patient transport services.

4. ***Clinical Referrals (Managing Elective Care):*** The CCG will build on successes in improving care pathways and providing top tips advice to clinicians about planned and urgent referrals. We will continue to focus on reducing unnecessary hospital attendance and follow-ups down with a continued drive to align with national averages. This will include the managed, funded transfer of some follow ups to general practice. We will also reduce waste from duplicated diagnostic tests. As a Health economy we will continue to evaluate both the thresholds and effectiveness of certain procedures currently undertaken within secondary care, where there is limited evidence of improved clinical outcome the CCG will consider future commissioning options.

5. ***Medicines Management:*** We will continue to build on our award-winning successes in medicines management, working with all practices quality, efficiency and delivering six specific service redesign projects. In the context of increased drugs costs we will continue to focus on innovative ways of managing costs growth and maintain a strong focus on reducing medicine waste.

6. ***Transforming Mental Health:*** In 2015 we successfully re-commissioned hospital liaison services, we will continue to prioritise improvements in dementia diagnosis and treatment care pathways with the aim of providing care in the community prior to hospital assessment. We will focus on improving waiting times and ensuring equitable access to mental health services, focusing initially on Improving Access to Psychological Therapies and Early Intervention in Psychosis services. We will continue to engage voluntary sector support for people with long term mental health problems and dementia. We will also look to work with existing providers to reconfigure 'adult' mental health services. Priority will be given to the delivery of the Child and Adolescent Mental Health Services reconfiguration and transformational plan.

7. ***Learning Disabilities:*** Over recent years the CCG has focused efforts on ensuring that patients with Learning Disabilities are placed in the most appropriate setting to meet their needs. The outcome of this work has seen increasing numbers of patients moving from hospital based settings to placements within the community. As a CCG we continue to prioritise this work in collaboration with our Local Authority partners and wider South Yorkshire commissioners. In 2016 we will work to deliver the requirements of the national 'Transforming Care' programme.

8. ***Health and Wellbeing of Children and Young People:*** Commissioning high quality services that support the Health and Wellbeing of Children and Young People is a key priority, we can only achieve this through joint commissioning with our Local Authority colleagues. In key areas of commissioning such as the Special Educational Need (SEND) and Child and Adolescent Mental Health Services we are already working jointly to commission services and this will continue. The CCG will work closely with Public Health colleagues to support commissioning of School Nursing and Health Visiting services.

   In terms of hospital based paediatric services, the CCG is working across the wider South Yorkshire footprint to review the current arrangements for the delivery of safe, sustainable paediatric surgery provision. We expect this review to conclude in 2016.

9. ***Continuing Health Care:*** The provision of Continuing Health Care is statutory requirement for the CCG, we will continue to ensure that ensuring the timely assessment and review of patients that are entitled to CHC will be a priority. Within section 21.9 we describe the priority areas for CHC moving forward.

10. ***Palliative Care (including EOLC):*** The CCG aspiration is to commission clear joined up palliative pathways of care, these pathways will embrace all elements of Palliative care including: Hospice services for adults and children, Palliative Care and end of life care in acute settings, palliative care and end of life care in community settings (including primary care).

    Priority will be given to ensuring that the key aspects of the Nice Guideline 'Care of dying adults in the last days of life' (December 15) is delivered across commissioned services.

11. ***Specialised Services:*** The commissioning of specialised services remains the responsibility of NHS England, however if we are to achieve high quality sustainable specialised services there is a wide recognition that CCG commissioners need to work in a more collaborative way with NHS England to review and were appropriate re-commission pathways of care.

12. ***Maximise partnerships working:*** We will continue to work closely with RMBC to deliver maximum value for the Rotherham pound. This will include delivering the aims of the refreshed Rotherham Health and Well Being Strategy, delivering the outcomes of the Better Care Fund, jointly commissioning services where appropriate to do so and working with public health to improve public health outcomes in Rotherham.

Maximise partnerships with other CCGs and Foundation Trusts across South Yorkshire and Bassetlaw (STP): To improve both quality of service provision and to support the delivery of the significant efficiency challenges and sustainability of services due to efficiency and workforce challenges that face all South Yorkshire health economies , we will continue to proactively engage in local commissioning developments across the South Yorkshire 'foot print' and work with providers to ensure the success of the South Yorkshire wide scheme 'Vanguard' . Further detail can be found in section 3.

13. ***Response to Child Sexual Exploitation (CSE)****:* The CCG's will continue to work closely with partners to prevent future child sexual exploitation and providing victim support. Our actions associated with this key priority are in the introduction to this plan and in section 13.3. The CCG will routinely review the services that it has commissioned to support victims of CSE and work with partners to identify any unmet need in provision.

14. ***Commissioning of Cancer Services:*** Commissioning high quality cancer pathways that deliver treatment within the required national waiting times is an absolute priority for the CCG. We will work with our local primary care and hospital providers to ensure that assessment and treatment targets are delivered. Where Rotherham residents require highly specialist treatment in 'tertiary centres' we will work at a sub- regional level to improve existing pathways, this work will reduce the risk of breaching the key 62 day cancer treatment standards. By ensuring delivery of these standards we will be optimising the opportunity to deliver improvements in our one year cancer survival rates across the borough.

15. ***Commissioning General Practice Services*****:** From 1 April 2015 the CCG received delegated authority for commissioning General Practice services, we have over the last 12 months developed our local primary care strategy (see section 21.15) . This means that decisions affecting general practice can be made locally in Rotherham and enable local GPs to have influence in commissioning decisions around Primary Care work in Rotherham.

In Part 2 of our plan we detail the delivery of each strategic priority.

8.1 Measuring success

Each of our strategic aims will have individual measures of success, however we have identified the following key measures:

Key measures of successful outcomes will include:

- **Additional years of life** – 200 additional life years per year
- **Close the Rotherham Life Expectancy Gap towards the National Average**

- *To follow Key Metrics associated with the CCG Assurance Framework

Better Health
Better Care

9 Relationships with key partners and stakeholders

The success in delivering our strategy is underpinned and dependent on working with key partners and stakeholders.

9.1 NHS England

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 13.1. The CCG will work closely with **local professional networks** (for pharmacy, eye care and dentistry) and NHS England for relevant care pathways.

9.1.1) Working Together 'Commissioners'

Commissioners Working Together is a collaborative of eight clinical commissioning groups and NHS England across South and Mid Yorkshire, Bassetlaw and North Derbyshire. Our ambition is to develop excellent healthcare together by reconsidering how services are delivered, redefining how we work together as commissioners and coming together with partners to find the best solutions for our populations.

Planning and commissioning on a bigger geography is becoming increasingly urgent as more and more people use NHS services, live longer and technology and how care is delivered improves. For some services, there will not be enough trained and experienced staff in the future if we continue to provide services in the way we do today.

We know that many people are treated in hospital when their needs could be better met elsewhere and that there is variation in people's experiences of services across our region, with some people getting better access and outcomes than others. At the same time, costs are rising. If we do not act now more people will suffer from poor health and we could face a funding shortfall in the region of £852 million in healthcare alone by 2021. It all adds up to needing to do things very differently if we are to continue providing high quality, sustainable NHS services for everyone.

As Commissioners Working Together, we want everyone to experience the highest quality and safest service possible and we are ready to make it happen. We have already made good progress in some areas; urgent and emergency care, children's services, critical care for people who have had a stroke and cancer services.

High Level Plans for 2016/17 to be implemented in 2016/17

- Cancer: 1 Living with and beyond cancer
- Children's Surgery
- Urgent & Emergency Care
- Hyper-acute Stroke

But we want to do more, faster. We want to develop excellent healthcare together through our **Sustainability and Transformation Plan (STP)** and NHS Clinical Commissioning Groups in South Yorkshire and Bassetlaw have agreed that they will work jointly to develop the STP.

Rotherham CCG is committed to maintaining strong relationships with **other CCGs** across the region to ensure that we can act collectively to commission high, quality safe service for the public of Rotherham

9.1.2) 'Working Together' Providers

The CCG agrees with the **Dalton Review** that more pace is required towards delivering increased efficiency and quality from collaborative working between NHS providers. In 2016-17 the CCG will working closely with our local acute providers to understand the opportunities that will be identified from the recent successful 'Vanguard' application.

We work in partnership with the **Local Education and Training Board** on the important issues of workforce planning, particularly in the list of specialities that are challenging for Rotherham flagged up in Section 9.3.

Working in Partnership with the Clinical Networks across Yorkshire and the Humber.

With regards to **Networks and Senates**, our aim is to work in partnership with NHS England to ensure that the CCG and Rotherham GPs are appropriately represented on these structures, we will engage with Strategic Clinical networks, Operational Delivery Networks and the Urgent Care Network.

9.2 Joint Working in Rotherham

The CCG is an active member of the **Rotherham Health and Wellbeing (H&WB) Board** and the newly formed **Rotherham Together Partnership.** The CCG will work closely with **RMBC** to ensure that Rotherham's H&WB Strategy is delivered.

In 2015 the Rotherham Health and Wellbeing Board took the opportunity to update and refresh the 'Rotherham Health and Wellbeing Strategy'. The 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. We all aspire to reducing health inequalities and providing better care outside hospital. The CCG's Commissioning Plan aligns with the H&WBS and sets out, as a key partner, how we will support its delivery.

Throughout 2015 the CCG and RMBC have proactively engaged in the development and delivery of the 'Better Care Fund'. Where appropriate and in the best interest of patients, the CCG will continue to develop joint commissioning arrangements with RMBC. Key areas of service provision that the CCG (with agreement from our members) will further explore with RMBC include:

- Children' Services
- Adult Social Care
- Continuing Health Care
- Mental Health
- Learning Disability

The CCG will continue to work in partnership with **Rotherham Public Health to understand the changing demographics and health need of the population allowing the CCG to target resources where appropriate.**

We work with individual practice patient user groups and have jointly developed with them our **CCG patient network** (see section 13.4). The CCG works closely with **Healthwatch,** for example they are helping the CCG with public consultation on this plan.

The CCG will also work in partnership with **RMBC and the Police** to ensure appropriate services for the victims of Child Sex Exploitation are delivered and maximise joint working to improve prevention and detection.

We have developed a **carers action plan** jointly with RMBC and voluntary sector organisations. The plan has been implemented in Rotherham and includes identifying and working with young carers, elderly carers, dementia carers and working alongside GP practices and supporting staff by providing flexible working arrangements'. The additional responsibilities for local authorities and CCGs to access carers needs are summarised in Section 21.1.

9.3 Other Rotherham organisations' strategic plans

9.3.1 Commissioning plans

The CCG is responsible for commissioning only one part of Rotherham's overall spend on health and social care. We will work closely with other commissioners (NHSE, RMBC) 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 2015/16, commissioned by RMBC. The CCG as a H&WB 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.

Spending on social services is the responsibility of RMBC, plans will be part of RMBC's 2016/17 Corporate Plan which will be agreed by Cabinet before 1 April 2016.

NHS England's commissioning intentions for specialised services are attached. *NHSE Commissioning Intentions*

9.3.2 Local Secondary Care Provider Plans

The CCG continue to have strong relationships with our main secondary care Acute and Mental Health providers (TRFT and RDASH), both parties have been consulted and agree with the CCG's strategic commissioning direction.

In section 13.1 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 implications are also discussed at twice yearly Board to Board meetings with our two biggest providers. In the sections below we describe current progress with cost improvement plans for our main providers of acute services and mental health. TRFT and RDASH will submit their plans to their regulator Monitor in March 2016 and these will then be linked to this document.

Local hospitals have the challenge of continuing to improve quality whilst delivering year on year efficiency savings (see section 11). The activity trajectories described in Section 10 of this document have been jointly agreed by clinicians in both primary and secondary care. The activity trajectories in the CCG's plan and TRFT's Monitor plan are consistent with each other.

In December 2013 TRFT submitted an options appraisal to Monitor on whether to continue as an independent Trust or to consider merging with other Foundation Trusts. The conclusion was to continue as an independent Trust but to increase collaboration with other trusts on some key care pathways.

The CCG support the collaboration between the hospitals and expect it to increase sustainability and maintain or increase clinical quality.

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.
- If a standalone 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 for local services and on a regional basis for services which cover a wider footprint. We would also require the provider to report Rotherham specific outcomes and play an active part in delivering the Rotherham CCG strategy and the Rotherham Health and Well – being Strategy.
- 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 (see the summary of Working Together Collaboration in Section 3). 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.

TRFT, like all provider trusts, have to make substantial efficiency savings in 2016/17 and in subsequent years, driven mainly by the national efficiency requirement and the subsequent reduction to prices through the national tariff. For 2016/17 the efficiency rate within the national tariff is 2%.

9.3.3 Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)

RDaSH like other providers has to deliver 2% efficiencies in 2016/17. The CCG has made a commitment that these efficiencies will be re-invested in mental health services for example with the voluntary sector and GP providers to improve services to people with dementia. Efficiency plans will be discussed through the MH QIPP group and the CCG will scrutinise the quality impact assessments.

9.3.4 Voluntary Sector and Social Prescribing

The NHS five year forward view published in October 2014, quoted the Rotherham Social prescribing service as an 'emerging model for the future'. The CCG has an excellent relationship with the Voluntary Sector. We recognised two years ago that *'doing the same'* was not an option and wanted to find a different innovative way to commission services for people with Long Term Conditions who were in danger of hospital admissions.

There are over 1600 Voluntary and community groups in Rotherham all of whom were keen to work with us. Together we came up with the Rotherham model of social prescribing.

An annual investment of £547,000 into the third sector has funded the infrastructure and commissioned extra services across the sector. There are five voluntary sector health advisers who link to all GP practices and are equal partners around the table when discussing the case management of patients with long term conditions.

They act as a link to all the Voluntary & community Services and work with patients to find a service or activity that meets the patient's needs. In 2016 we will continue to extend the social prescribing model for mental health patients (see section 21.6). NHS England and its national partners have announced a new programme to focus on the acceleration of the design and implementation of new models of care in the

NHS, to promote health and wellbeing and provide care that can then be replicated more easily in other parts of the system.

The service has been independently evaluated, see table below:

All patients included in evaluation. (939 patients)	When patients over the age of 80 were excluded from the analysis - reductions are greater. (513 patients remaining)	When patients continue to access VCS services after initial service has ended much larger reductions are now seen to be evident
Non-elective Inpatient Admissions: • Finished Consultant Episodes (FCEs): **7%** reduction • Inpatient Spells: **11%** reduction **A&E Attendance:** • All patients: **17%** reduction This data is for all patients and does not tell the whole story: more detailed analysis shows marked differences between different types of patients, in particular: • By age • By level of engagement with SPS	**Non-elective Inpatient Admissions:** • Finished Consultant Episodes (FCEs): **19%** reduction • Inpatient Spells: **20%** reduction **A&E Attendance:** • All patients: **23%** reduction Highlights importance of ensuring SPS is appropriate for patients who are referred Impact of SPS on older (80+) patient's needs to be understood through other measures	**Non-elective Inpatient Admissions:** • Finished Consultant Episodes (FCEs): **53%** reduction • Inpatient Spells: **51%** reduction • Bed Days: **43%** cent reduction **A&E Attendance**: • All patients: **35%** reduction Highlights the importance of sustained engagement with VCS services

The award winning Social Prescribing service is a Win/Win for everyone:

- The public sector and the GP's benefits, as it addresses inappropriate admissions into hospital and reduces attendance at GP practices.
- The voluntary and community sector benefits as it supports their sustainability

And most importantly...

- The patients and carers benefit as it improves quality of life, reduces social isolation and moves the patient from dependence to independence.

9.4 Workforce Capacity

There are several areas where recruitment of clinicians presents risks to our transformation plans; general practitioners (see section 17 on key risks) accident and emergency specialists, community and general practice nurses and psychiatrists especially older people and children's psychiatrists).

District nurse recruitment and retention is a key theme of our community services transformation plan (Section 21.2) and significant work has taken place in 2015-16 to improve district nurse staffing levels, mental health workforce both recruitment and modern models of care are key themes in our Mental Health transformation plan (Section 21.6). New ways of providing emergency care are discussed in section 21.1.

One of the reasons the CCG accepted delegated authority for GP commissioning so it can better address the challenges of recruitment to the general practice workforce (section 21.15). We are working with the local GP training scheme to understand the aspirations of current GP registrars, working with the Local Education and Training Board on increasing practice nurse training and investigating new models such as physicians assistants.

10 Activity

For both electives and non electives TRFT is the main provider of services to Rotherham CCG patients. Percentages of CCG activity by main providers are as follows: non electives; TRFT 83%, DBH 6% STHT 7%: for electives, TRFT 72%, STHT 20% DBH 6%.

Rotherham clinicians agreed trajectories for keeping growth within affordable limits for 2015/16. There has been over-performance against these trajectories in the first half of 2015/16 against non-elective admissions and follow up outpatients. Forecast out-turn for non-electives in 15/16 is a x% increase compared to the 15/16 plan which was to reduce slightly from 2014/15 outturn (non-elective activity in Rotherham is still 15% below its 10/11 peak and Rotherham's non elective growth in 15/16 is expected to be below the national average). There was a 0.4% decrease in A&E attendances in 15/16, whereas A&E attendances rose sharply in the previous year. The CCG believes the plans set out in this document will achieve a long term flat line in non-electives, however as discussed in the introductory section the CCG is considering a list of least worst options to curb activity if either non electives or electives were above plan in 16/17.

The trajectories from March 2016 out-turn are:

- **first outpatients** 1.9% growth
- **electives**; 1.6% annual growth
- **follow up appointments**; will be reduced by x% from contracted activity (to peer average follow up ratios) and then remain flat
- **emergency admissions**. In 2016/17 we will reduce non electives from 2015/16 outturn and then hold them at this level for the foreseeable future. This is extremely challenging because Rotherham's activity is already 15% below the 2010/11 peak, however primary and secondary care clinicians have agreed that the combination of initiatives in this commissioning plan will deliver this challenge
- **lab diagnostics**: 2.5% increase per year to enable the early diagnosis required to maintain increasing numbers of people with multiple conditions in community rather than hospital care
- **accident and emergency:** maintain at 2015/16 outturn levels
- There has been a reduction of over 25% in excess hospital lengths of stay in 2015/16 therefore the plan is to maintain this position going into 2016/17.

11 Efficiency

11.1 The Health Service Efficiency Challenge

Like all of the public sector the health sector faces a substantial efficiency challenge amounting to £30 billion for the NHS overall over the five years starting 2014-15. NHS Rotherham CCG's share of this challenge is around £75 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

E*fficiencies passed on to all providers*. For the last five years and for the foreseeable future, providers have been expected to provide the same services with less funding. For the first time in 2016/17, providers will be given a 3.1% uplift in funding and are then expected to make 2% efficiency savings. This means they will receive a net increase of 1.1% in absolute terms. When QIPP was introduced in 2011 finding the first 4% efficiency saving was relatively straightforward, and although in 2016/17 the requirement is lower there has inevitably been a build-up of unmet savings in providers as finding each additional annual efficiency saving is increasingly challenging.

System Wide QIPP

E*fficiencies that are the direct responsibility of the CCG*. NHS financial allocations are expected to rise by around 1-2% each year over the five years starting 2014-15. 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 1-2% level rather than the historical 6%. We have 5 CCG QIPP areas (numbered below), which will enable QIPP to be delivered across the system and the Better Care Fund which reports directly to the Health and Wellbeing Board:

QIPP Areas/Committees	QIPP Enablers
1 Systems resilience group	Information Technology
2 Clinical Referrals	Working Together (with SY hospitals and CCGs)
3 Mental Health and Learning Disabilities	Better Care Fund
4 Medicines Management	
5 Transforming Community Services	

11.2 Provider efficiency savings

Figure 11.1: Summary of Provider Efficiency Challenges for Rotherham 2014/15 -2018/19

Table to follow

11.3 System wide efficiency savings

Figure 11.2: Breakdown of System Efficiency Challenges for Rotherham 2014/15 -2018/19

Table to follow

The schemes are summarised as follows:

- **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.
- **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;
- **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.
- **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.
- **Corporate Services** – a reduction of 10% was achieved in 2015/16 in line with the planning guidance and the working assumption is that there will be no more cuts to the target but it must be highlighted that capacity will need to be made available to take on the new areas of commissioning port folios being transferred back to CCGs from NHSE.

The combined Provider and System Wide Efficiency savings is set out in the table below and totals £xm.

Table to follow

11.4 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%. Running costs allocated to the CCG was £6.2 million in 2014-15 and in 2015-16 reduced by a further 10% to £5.5m.

11.5 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 governance arrangements are as follows:

- The System Resilience Group is a chief executive level group that meets monthly with partners in Rotherham, NHS England and the Yorkshire and Humber Ambulance service to oversee quality and efficiency across the whole system with a particular focus on unscheduled care.
- Four other QIPP groups report to the System Resilience Group; Clinical Referrals Management Committee, Medicines Management Committee, Community Transformation Committee and the Mental Health and Learning Disability QIPP Group.
- Two other groups with a role in enabling QIPP report direct to the Strategic Clinical Executive; the IT Strategy Group and Working Together.
- The Better Care Fund Task Group reports directly to the Health and Well Being Board.
- All QIPP groups are shown on the diagram in Section 13.5.

11.6 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. Our approach to efficiencies is described in detail in section 11.

12 Finance

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

12.1 Financial Planning Assumptions

The NHS planning guidance prescribes that CCGs must achieve the following:

- 1% Operating Surplus £3.9m
- 1% recurrent headroom £3.9m
- 0.5% Contingency £1.9m

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

1. Published growth in financial allocations in 2016-17 of 2% (£8m) before taking out national obligations from previous years @ £2m and other national price changes of £5.5m.
2. **First outpatients:** we are planning for an increase of x% in 2016/17 against 2015-16 outturn.
3. **Follow-up outpatients:** we plan to move to national average ratios which is a reduction of x% against 2015-16 outturn.
4. **Planned admissions:** we plan to increase by x% against 2015-16 outturn in 2016/17.
5. **Urgent admissions:** we plan to reduce admissions from 2015-16 outturn back to the 2014/15 planned levels.
6. The costs of continuing care are forecast to be at similar levels to 2015/16 in 2016/17.

7. Running costs will not exceed the allocation which reduced by 10% in 2015/16 but is expected to remain static in the next three years. The portfolio for the CCG will continue to expand as more commissioning is transferred from NHSE.
8. The plan maintains 1% recurrent headroom as per the planning guidance.
9. A contingency of £1.9 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 2015-16 to 2016/17.
12. The asset base transferred to NHS Property Services in 2013-14 so limited or no capital expenditure in 2016/17.
13. The CCG's Maximum Cash Drawings limit will be adhered to for CCG operational activities in 2016/17.

The I & E assumptions up to 2018/19 are set out below:

Table to follow

12.2 Source and Application of Funds

There are a number of priorities detailed in the planning guidance which have been considered by our GP members. The main source of funding is from QIPP savings (which therefore must be achieved) and growth funding. The planned use of the funds is set out in the table below:

Table to follow

There is increased focus on system resilience which has been embedded throughout 2015/16. There will be continued focus on 7 day working in acute, community and Mental Health services and better care for people requiring integrated health and social care services including support to GP practices in transforming the care of patients aged over 75.

12.3 Better Care Fund

This is a pooled budget of £23 million for health and social care services to work more closely together. The plans were developed and implemented throughout 2014/15 and all services reviewed and refined in 2015/16. The fund is supported by a Section 75 agreement.

The fund includes expenditure on reablement services e.g. intermediate care, stroke and emergency response services, community services and adult social care. The national objectives include avoiding emergency admissions and delayed transfers of care and enhancing patient/service user experience. More details are given in Section 5.14.

The plan for 2016/17 is to build upon the review work undertaken and focus on areas that are key to ensuring that the national conditions will be achieved against a range of performance metrics. Beyond 2016/17, it is anticipated that the areas of joint commissioning will expand where there are clear benefits to patients and citizens.

12.4 Non Recurrent Initiatives

The key area of non-recurrent expenditure planned in the next few years is the completion of the Emergency Centre and implementation of new and innovative ways of working which is in step with national thinking around emergency care. The Centre will be functional from Summer 2017 and the capital development is progressing well.

Mental Health, Learning Disabilities, Voluntary Sector and Better Care Fund services are also being supported non recurrently and will be evaluated at the end of 2016.

12.5 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 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 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. More will be known in early 2016 when allocations and the distance from the new target are published.
4. Prescribing risks:
   - 2015/16 saw a significant increase in prices and there is nothing to suggest that this is not going to continue. This is exacerbated by shortages in the pharmaceutical supply chain which can occur at any time forcing category M prices to suddenly increase.
   - NICE guidance can have an adverse effect on cost growth forecasts.
   - Failure to agree therapeutic guidelines with secondary/tertiary care providers can also have an adverse impact on the prescribing bill.
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 but a revised version of the HRG grouper is expected in 2017/18.
6. Services providing “after-care” for Section 117 patients are creating new pressures in 2016/17 and beyond. The overall risk to our financial plan is likely to increase over the next few years.
7. Continuing health care continues to be an area with increasing demand as people are supported at home or in a community setting plus there are potential unquantifiable risks from the retrospective caseload.

12.6 Further Actions Required

1. Sustained and intensive clinical leadership is required to ensure the delivery of the efficiency programmes set out in section 8 (prescribing, mental health, community transformation, 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 shown on page 75).
2. Monitoring of other financial risks not including the current efficiency programmes which could impact upon financial balance.
3. To support the repatriated Continuing Healthcare Team to continue to develop the end to end service required to ensure that all packages of care are appropriately assessed and reviewed.
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.

12.7 ‘Least Worst Options’

In 2015/16 non elective hospital activity have grown faster than is affordable. Our plans will address this in the long term but it is likely that we will have to take some short term actions to keep costs under control in 2016/17 while our longer term plans deliver. A commissioning event held in December 2014 produced a list of ‘least worst’ options, for managing activity within affordable levels, in 2015-16 the CCG managed to avoid implementing any of the Group B1 and B2 options identified below. However as we move into 16-17 the CCG will need to re-visit and consider the options identified, if other efficiency plans are not delivered. In the event of further consideration we will discuss these further with the public and clinicians before implementing them.

'Least worst' options for keeping activity within affordable levels

- Group A: uncontroversial options that are included in this plan.
- B1: Options that could be implemented quickly e.g. by June 2016.
- B2: Options that could be implemented after June 2016.

We will discuss these options further with patients, clinicians and stakeholders before making final decisions

Group A

- Patient Education
- More virtual clinics
- More attention given to getting people to the right clinic first time
- Increase ease of access to diagnostic tests
- Increase the number of rapid access clinics
- Education of secondary care clinicians about what community services can deliver

Group B1

- Implement clinical threshold for surgery to exceptional cases for specific conditions
  - Varicose Veins grades 1-3
  - Minor skin lesions
  - Tonsillectomy (adults and children)
  - Grommets
  - Hysterectomy for heavy menstrual bleeding
- Implement thresholds prior to surgery for specific conditions
  - Knee replacements
  - Hip replacements
  - Cataracts
- Thresholds for consultant to consultant referrals
- Focussed work on frequent service users

Group B2

- Cuts to block contracts such as the contract for community services
- Restrict procedures given to smokers and the obese
- Invite proposals for different models of care for:
  - Diabetes
  - Neurology (e.g. headache)
  - Dermatology
  - Heart Failure & cardiology
  - Orthopaedics
  - Pain services
- Use primary care winter resilience moneys more flexibly to reduce A&E attendances
- Commission a referral triage service for specific conditions
- Move to using generic Avastin rather than Lucentis for Wet Acute Macular Degeneration

13 Statutory Responsibilities

13.1 Quality Assurance and Quality Improvement of Commissioned Services

The CCG's Chief Nurse works with the GPs responsible for the integrated acute and community contract, mental health, primary care and governance 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 (see sections 13.1 and 13.4).

The CCG's Head of Clinical Quality supports the Chief Nurse in the clinical quality agenda with regards to supporting quality assurance of provider services across Rotherham, and supports the Chief Nurse with assurance of quality with regards to all quality issues. Additionally the role leads on Continuing Healthcare for Adults and Children, Personal Heath Budgets and representing the CCG at the regional quality leads meeting.

The Functions of a Clinical Commissioning Group (March 2013) states that it is the duty of a CCG to 'assist the NHS England with securing continuous improvement in the quality of primary medical services'. The CCG's Head of Primary Care Quality supports the Chief Nurse in the primary care quality agenda. Additionally, the roles lead on development of long term conditions case management, the commissioning local incentive scheme and the protected learning time events.

The CCG works with our commissioned 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 improvement 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 the agenda is set around the three main domains of quality, safety and patient experience in line with the NHS Outcomes Framework. Discussions include the review and monitoring of national and local quality standards set out in the main contracts hospital mortality rates, providers' Cost Improvement Plans, Commissioning for Quality and Innovation (CQUIN) and other Local Incentive Schemes, Serious Incidents, patient safety agenda, complaints and compliments, inspections, clinical audit, safeguarding, friends & family test (FFT), patient survey reports and staff surveys and staff FFT, Care Quality Commission (CQC inspections of TRFT and of Rotherham's Safeguarding and Looked after Children services were carried out in February 2015, the CCG ensures that any actions are addressed).
- The CCG has worked closely with TRFT to understand and put in place a process of continued improvement with regard to hospital mortality data. In 2013 this included patient level audit and a revision of TRFT's procedure for hospital mortality assurance. In 2014 TRFT worked with other Foundation Trusts in Yorkshire and Humber and the Improvement Foundation to have a continuous process of mortality review including peer comparison. In 2015 mortality remains a strong focus for the CCG and TRFT and is monitored through a new mortality report fed into contract quality meetings and LOFI. Areas of improvement were identified including review of all deaths within 28 days, implementation of the 'Hospital at Night' initiative and improved 'Admit to Die' analysis. These help to provide intelligence to continuously improve process to assure the CCG and TRFT that hospital mortality is managed appropriately.
- Agreement and monitoring of action plans developed due to underachievement against contractual quality standards and holds the provider to account for delivery through formal contract meetings.
- Holds all our providers to account to make further substantial reductions in clostridium difficile with a route 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 with agreed action plans for improvements in quality where appropriate.
- 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 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 information on quality with other commissioners to pool intelligence.
- All our main providers are signed up to the 'sign up to safety campaign'
- 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 *Appreciative enquiry*
- GP Peer Review is the process, whereby each practice is visited every 3 years. The GP Primary Care Lead and the Head of Primary Care Quality have an open discussion with practices about their performance in comparison to other Rotherham practices with regard to prescribing indicators, elective and non-elective activity and enhanced services. Every year the performance of each practice is reviewed as part of a table-top exercise so that visits can be prioritised if needed. Actions identified as part of the visit are logged and followed up. This is intended to be a supportive process and part of the on-going dialogue between practices and the CCG.
- Protected learning time is a series of 6 meetings, held bimonthly which have a strong focus on clinical quality and strong engagement from secondary care clinicians. Key focuses have been on appropriate referrals and the use of clinical pathways.
- The advent of co-commissioning brings responsibility for GP workforce planning to the CCG, however maintenance of the Performers list and GP accreditation and validation remains with NHS England.
- The CCG will continue to support Rotherham practice managers forum and the Rotherham practice nurse development forum.

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 Winterbourne 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 which is supported by an ongoing action plan *Key Reports Diagram*.

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 CQUIN is monitored through contract meetings and 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.

We make full use of Commissioning for Quality and Innovation (CQUIN) incentives with our providers of healthcare services. These are additional payments for providers who deliver improvements above the baseline requirements of the NHS Standard Contract. In 2016/17 the maximum value of the CQUIN is set at 2.5% of the full contract value. Detailed guidance on the 2016/17 national CQUIN scheme is due to be published in early 2016.

- Add the list of agreed CQUINS agreed with contracts and value

In addition to CQUIN incentives, the CCG works with TRFT to 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 2016/17 will focus on those priority areas in both the CCGs Commissioning Plan and the NHS Outcomes Framework. Details to following once the Planning Guidance is released.

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RDaSH

National mental health CQUINs are:

- Improving Physical Healthcare for patients with severe mental illness (SMI)
- Urgent & Emergency Care (UEC) – Improving diagnosis and re-attendance rates of patients with mental health needs in A & E.

Local mental health CQUINs are:

- Outcomes in CAMHS, Personality Disorder & Learning Disability
- Risk Assessment
- Safeguarding

In part 2 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 though 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 16 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.

13.2 Safeguarding

NHS Rotherham CCG fully endorse that safeguarding is **a responsibility for all of us**. Regarding **children and young people** the Clinical Commissioning Group fully accepts its statutory duty to safeguard and promote the welfare of children; ensuring that robust governance arrangements are in place and welcomes being an active member of the Rotherham Local Safeguarding Children Board. The Care Act 2014 highlights that the responsibility for coordinating adult safeguarding arrangements lies with Rotherham Metropolitan Borough Council (RMBC). NHS Rotherham CCG is a willing multi-agency safeguarding partner and has robust governance arrangements in place to ensure that its own safeguarding structures and processes are effective and that the agencies from which NHS Rotherham CCG commission services meet the required standards. NHS Rotherham CCG will ensure that integrated working between Health and Social Care is at the fore front of providing Rotherham residents with safe effective care, this includes being an active partner on the Safeguarding Boards.

13.3 Child Sexual Exploitation in Rotherham

The Alexis Jay report was published in August 2014; this was an Independent Inquiry into Child Sexual Exploitation in Rotherham 1997 - 2013. *Jay Report* NHS Rotherham CCG like all other partners was shocked by the extent of the exploitation and continues to work with partners to deliver on a comprehensive multi-agency action plan.

This action plan includes the need for all services to recognise that once a child has been affected by CSE they are likely to require support and therapeutic intervention for an extended period of time. This may necessitate the on-going commissioning of additional support for victims. As part of that multi-agency response NHS Rotherham CCG is working with RMBC and Public Health to support the long term commissioning of effective therapeutic services.

NHS Rotherham CCG has reviewed and is assured of its own internal approach to addressing Child Sexual Exploitation. The CCG has worked closely with partner health organisations to provide a 'health' specific action plan based on the CSE National Working Group Recommendations. In February 2015 the Care Quality Commission inspected the health economy's Children Looked After and Safeguarding arrangements. The report was published in July 2015 and contained recommendations for the health economy to consider. NHS Rotherham CCG accepted all the recommendations and alongside providers of health care are progressing the work.

NHS Rotherham CCG is assured by the steps that are being taken by providers such as TRFT and RDaSH to raise awareness and address Child Sexual Exploitation and to support the victims of historical abuse. In June 2015 TRFT and RDaSH shared their action plan returns to Monitor regarding the Department of Health investigation into the abuse undertaken on NHS Premises by Jimmy Savile.

NHS Rotherham CCG facilitated a national CSE Conference in September 2014 with nationally acclaimed speakers. Further CSE training was commissioned for over 800 delegates to help them understand the neuroscience around victim behaviour and plans to provide further training on this in March 2016 to coincide with the national CSE awareness raising day.

NHS Rotherham CCG has agreed that safeguarding including CSE is one of its four priorities within its Commissioning Plan 2015 – 2019.

The Casey report *Casey Report* in February 2015 concluded that Rotherham Council was not fit for purpose and failed in its duty to protect vulnerable children and young people from harm. NHS Rotherham CCG will proactively work with the nationally appointed commissioners and other partners to implement all aspects of the Casey report and the requirements of the multi-agency Improvement Board.

For **looked after children (LAC**) Rotherham CCG takes its Responsible Commissioner role seriously for all its LAC and Care Leavers. This responsibility includes providing Looked After Children with regular planned

health assessments, upon placement and an annual/bi-annual review thereafter. NHS Rotherham CCG will ensure that their identified health and welfare needs are prioritised, ensuring that our LAC receive a quality seamless health service. For our Rotherham LAC who live outside of the borough we will endeavour to ensure that the healthcare they receive is appropriate and meets their needs. Data on achieving regular planned health assessments will be monitored by the commissioner and provider of services, results will be shared with RMBC and at the Corporate Parenting Panel to provide external assurance.

NHS Rotherham CCG has an expectation that all services it commissions will work with statutory and voluntary partners to reduce **domestic abuse**; this includes participating in Multi Agency Public Protection Arrangements (MAPPA) and Multi Agency Risk Assessment Conferences (MARAC).
NHS Rotherham CCG is committed to:

- proactively work in partnership with Local Safeguarding Boards
- ensure that identified clinicians have the seniority and capacity to lead on safeguarding agendas
- support the expected increase in the health visiting workforce by 24 by 2015 to ensure that early help is provided in a timely manner
- support the delivery and quality assurance of the Family Nurse Partnership to support vulnerable families
- monitor health providers work with the healthy child programme and the early identification of health and welfare needs
- work 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.
- Continue to monitor safeguarding standards in contracts, service specifications and compliance with Section 11 children Act expectations
- ensure 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.
- establish and publish 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.
- support the development of the safeguarding adult's agenda, including, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards legislation.

NHS Rotherham CCG produces and publishes annually a "Safeguarding in Rotherham" report which incorporates children, young people and adults. This report provides assurance that all vulnerable clients in Rotherham are given significant consideration at all levels of service delivery 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 NHS Rotherham CCG's Safeguarding Vulnerable Clients Policy for commissioners.
Whilst the responsibility for coordinating safeguarding arrangements lies with Rotherham Metropolitan Borough Council (RMBC), effective safeguarding is based on a multi-agency approach. NHS Rotherham CCG is a willing multi-agency but challenging safeguarding partner and will continue to commission services that meet robust safeguarding standards, remaining committed to working together to ensure that safeguarding vulnerable clients is at the core of all that we do. In addition to the eight SCE GP members, the CCG employs a Named GP for safeguarding at 2 sessions per week.

The Prevent strategy is part of the Governments counter terrorism strategy CONTEST which is led by the Home Office. The health sector approach to Prevent is within pre criminal space and is to focus on stopping vulnerable individuals becoming exploited and radicalised towards or have an involvement in terrorism. RCCG monitors providers working with the Prevent agenda via the Safeguarding standards

13.4 Public Involvement in CCG and Promotion of Choice

13.4.1 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. CCG's 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 lay members, with a specific remit for public and patient involvement.

13.4.2 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 communications and engagement strategy. *Communication and Engagement Plan*. 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 Patient and Public Engagement and Experience report is received at each of our governing body meetings, describing current activity, outcomes and plans. Our aim is that in all that we do we can demonstrate that the patient or their voice is at the table, that it is heard effectively and impacts on our decision making. It is important to us that we continually improve our engagement with patients and the public, and ensure that this work actively contributes to service improvement. To this end, we have established a governing body sub-group to oversee engagement and communications, and to ensure that we are carrying out the right activity, with the right people, at the right time to inform our work.

We continue to strengthen our engagement work, and to map activity systematically across all our workstreams, to evaluate, share information and identify gaps. This also helps us to demonstrate how we listen to patients across all our areas of work and how what people tell us informs how we commission and plan services. Over the last year, we have trialled innovative ways of involving people in large events, this ensured over 150 people attending our AGM, which was based around information stalls and a community song.

We also continue to work with stakeholders and partners, in a number of ways, including:-

- work with Rotherham Healthwatch on consultation events, and to access the wealth of experience data that Healthwatch collect
- with the voluntary and community sector to reach overlooked communities
- with providers, to ensure we hear the voice of both clinicians and patients

Section 18 has more details on how we are sharing this commissioning plan with the public and with stakeholders.

13.4.3 What this means, and what we will do

Individual participation

We will ensure that patients and carers can participate as far as they want to in planning, managing and deciding about their care through:

- extending the use of personal health budgets in continuing care
- promoting case management for people with long term conditions
- supporting providers to consider tools such as 'Ask 3 Questions' and Patient Decision Aids
- continuing our third sector commissioned social prescribing programme, aiming to:
    - Improve outcomes for patients in terms of health, wellbeing, self-care and independence
    - Increase resilience of individuals and communities
    - Support dependence to independence
    - Reduce social isolation.

Public participation

We will routinely engage with patients, carers and the public when redesigning or reconfiguring healthcare services, including

- 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,
- reaching out to diverse communities

- Ensure that the public, patients and carers continue to be involved in the development of the new urgent care facility, working with local providers
- Continue to support and work with our 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 new mechanism for collecting and analysing patient experiences to identify emergent themes across health, and act responsively on this data.

Using patient experience, insight and feedback

We aim to listen to and use patient experience to inform our commissioning and also to ensure that our providers use patient experience to improve the quality of the services that they deliver and that we commission.

- The 'Friends and Family Test (FFT)' identifies whether patients would recommend a health service to others needing a similar service. From March 2015, the FFT has been extended to cover all health services. We will continue to work with all our providers to monitor the results, feedback and outcomes. We will share the information with the public, congratulate and challenge providers where appropriate and see how the information triangulates with other insights and feedback
- The CCG's ambition for the GP access survey can be found in section 16.
- We will continue to systematically feedback to individuals where possible and to the community in general, telling people how what they have told us has informed our decisions. We will do this using electronic mechanisms, local press and community networks, where possible our 'you said, we did' format
- We continue to use a variety of mechanisms for listening to patient voice including social media, FFT, Healthwatch reports and comments from engagement activity, triangulating this feedback for possible and reporting on any emergent themes
- We will continue to develop our website and the use of social media to feedback to the community .

13.4.4 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 Department of Health 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. *Complaints/concerns*

13.4.5 Assure that our providers make good use of insight and feedback

- The 'Friends and Family Test (FFT)' identifies whether patients would recommend a hospital or service to others. Following full roll out, we will continue to work with all our providers to monitor the results, feedback and outcomes. We will share the information with the public, congratulate and challenge providers where appropriate and see how the information triangulates with other insights and feedback.
- The CCG's ambition for the GP access survey can be found in section 16.
- Publish evidence of what 'patient and public voice' activity has been conducted, its impact and the difference it has made. We will continue to systematically feedback to individuals where possible and to the community in general, telling people how what they have told us has informed our decisions. we will do this using electronic mechanisms, local press and community networks
- 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, where they are 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

13.5 NHS Constitution, CCG Constitution and Governance

The National Health Service (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.

The constitution brings together in one place details of what staff, patients and the public can expect from the NHS. 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. The CCG has regular Board to Board meetings with our key providers where any under-performance against the NHS Constitution Standards can be escalated. Through the System Resilience Group we forward plan so constitutional rights and pledges are maintained through busy periods.

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

13.5.1 The CCG Constitution

NHS Rotherham CCG is a membership organisation of 31 practices who are responsible for commissioning a range of health services on behalf of people in Rotherham.

The CCG constitution sets out the 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 is reviewed on a regular basis by the GP Members and the CCG Governing Body.

13.5.2 Governance

Apart from the Better Care Fund where the H&WB Board exercise formal decision making powers, ultimate accountability for decision making remains with the CCG Governing Body.

The CCG Governing Body

- Ensuring the CCG delivers on its statutory duties through good governance
- Holding the organisation to account for performance and delivery
- Seek assurance that the CCG systems of control are robust and reliable

The following sub committees have been established by the Group:

GP Members Committee

To be a strong advisory group to the Strategic Clinical Executive (SCE) and CCG Governing Body and to ensure that the member practices are linked into all of the wider commissioning decisions of the CCG. It is representative of all of the GP Practices in Rotherham and is mandated by them. The chair of the GPMC receives minutes from the OE, SCE and SRG in order to decide on the agenda items that need discussion and challenge by members.

The committee's key role is to support the GPs on the SCE and to hold the SCE to account for its commissioning activities. It should provide a 'reference' point for all commissioning developments.
Responsibilities:

- Approval of applications to change the CCG constitution
- Appointing clinical leaders
- Appointments of members of the governing body
- Agreeing the annual commissioning plan before it is submitted to the governing body

Strategic Clinical Executive

To be the 'engine house' of the governing body, with regards to producing its plans and leading on delivery. SCE GPs are expected to bring strong clinical leadership and share and develop innovative ideas.
Specific functions include:

- Operational delivery of individual GPs" lead areas
- Preparing strategic plans for Board
- Approving changes to clinical pathways
- Seeking the views of the Member's committee on all strategic matters and receive its recommendations

Operational Executive

To receive information and to manage actions on specified areas.

- Operational delivery for the Group
- support of the governing body
- Corporate policy and strategy
- corporate assurance and risk management
- oversight of progress with vision, strategy and operating plan
- performance review and improvement
- partner and market relations/management
- preparation for meetings of the CCG Governing Board and SCE
- To agree which issues should be escalated to SCE or Members

Audit and Quality Assurance Committee

To obtain assurance that:

- There is an effective and consistent process in commissioning for quality and safety across the CCG
- High standards of care and treatment are delivered. This will include areas regarding patient safety, effectiveness of care and patient experience.
- An effective system of integrated governance, risk management and assurance across the Board activities is established and maintained.
- Risks to the achievement of Board objectives are identified and assurances obtained that appropriate mitigating action is being taken.

Remuneration Committee

Has delegated authority on behalf of the governing Body to:

- Determine appropriate terms of service for the Chief Officer and any other senior managers placed within its remit.
- Determine all aspects of salary - including any performance related payments, pensionable pay and car entitlements, as applicable.
- Determine arrangements for termination of employment and other contractual terms for those staff.
- Determine allowances payable to members of the Governing Body, SCE and Members Committee.

Primary care Sub-committee

To ensure the effective commissioning of high quality, safe and sustainable primary medical care services for the population of Rotherham

- To oversee the development of an operational plan for safe and sustainable Primary Care Commissioning
- To oversee the development and agreement of primary care contracts for 2016/17
- To consider and act on the 'conflict of interest' of General Practitioners with reference to Primary care Commissioning.

Patient and Public Engagement & Communications Sub Committee

Provides strategic and operational leadership, for the development of effective public and patient engagement.

- To oversee the development & implementation of the communications & engagement strategies and action plans.
- Ensure that Patient and Public Engagement is central to the business of the CCG, and that is embedded in all decision making processes adopted by the CCG
- Advise the Governing Body on all matters relating to engagement and the process of formal consultation.
- Ensure that the CCG (and the services it commissions) engage in meaningful dialogue with its public, patients and Partners

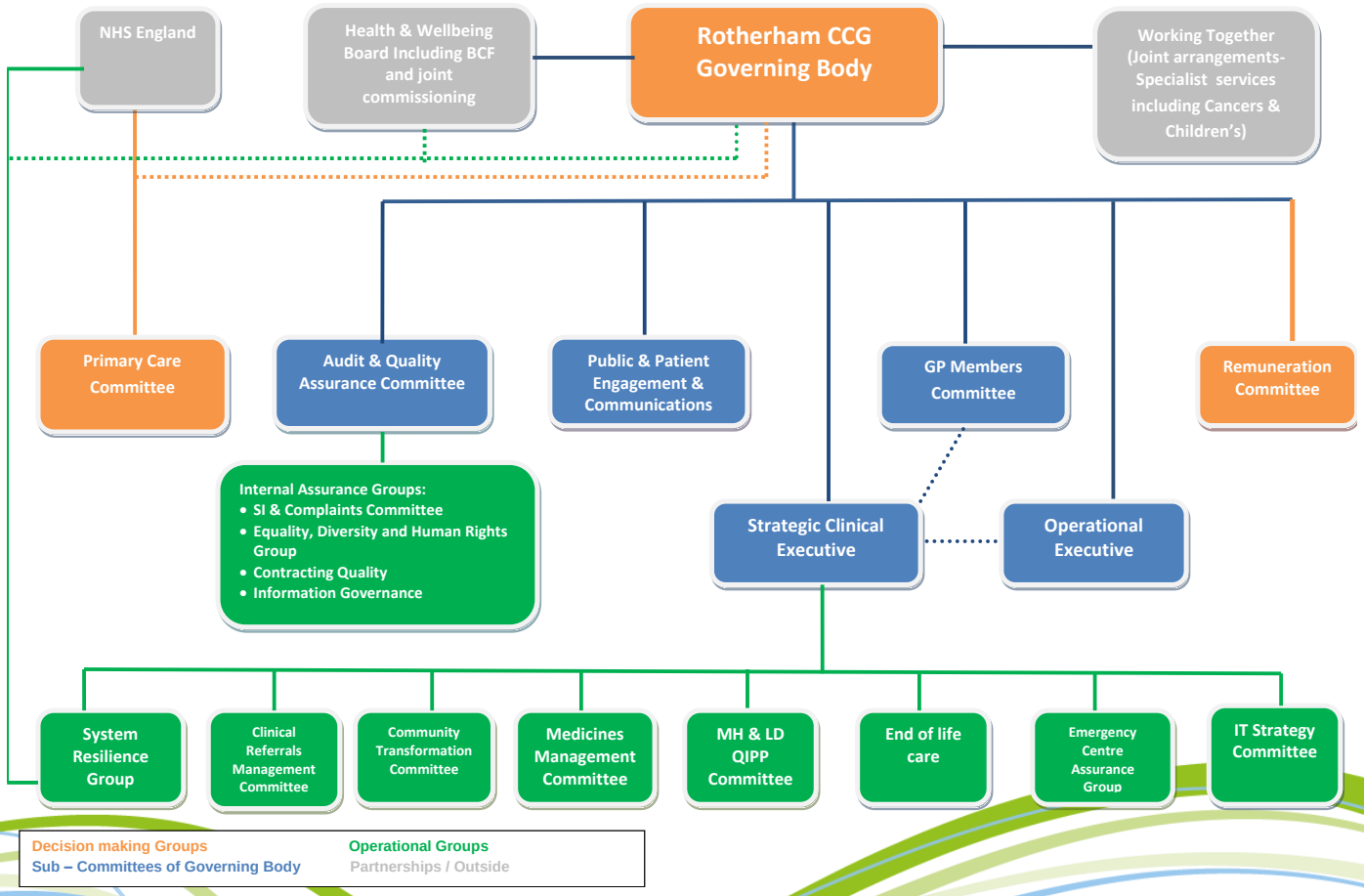
Health and Wellbeing (H&WB) Board

The H&WB Board is a statutory, sub-committee of the council. Locally, it will be the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing in order to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The board brings together key decision makers to address issues of local significance and to seek solutions through integrated and collaborative working, whilst being an advocate and ambassador for Rotherham collectively on regional, national and international forums.

The structure below details the interdependencies between each of the sub-committees and also the H&WB Board.

NHS Rotherham Clinical Commissioning Group – High level - Governance Structure



13.6 Public Sector Equality

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 Equality Act 2010 and 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.

The CCG is committed to advancing equality and diversity for patients, communities and the NHS workforce. NHS Rotherham Clinical Commissioning Group welcomes the introduction of the NHS Workforce Race Equality Standard (WRES) as a useful tool to identify and reduce any disparities in experience and outcomes for NHS employees and job applicants of different ethnicities. The WRES baseline data and an action plan were published on 1st July 2015 in line with national guidance.

We have used the Refreshed NHS Equality Delivery System (EDS 2) to develop and prepare our four equality objectives which are:

The revised objectives will be agreed at the next Equality Steering Group in January 2016

13.7 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 measureable 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. Having a strong research programme is beneficial to the Rotherham economy and increases the attractiveness of Rotherham providers to new recruits. We will discuss with partners whether this funding should be continued in 2015/16 and which organisations 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 CGG's IT strategy is summarised in section 10 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 part 2 we describe specific innovations in each of the areas we commission these include:

- The case management project, risk stratification and social prescribing schemes
- The haematology virtual clinic and use of technology to improve communication between GPs and consultants, such as video top tips programme for clinical referrals
- The award winning nutrition and continence procurement projects and the set of key prescribing indicators
- 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
- Secondary to primary care local enhanced service that enables movement of services from hospital to community setting

13.8 Education and Training

The CCG is committed to maintaining the education and training of the NHS workforce. The CCG has links with **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 which is detailed in the CCGs organisational development plan. The CCG has developed plans for organisational sustainability and succession planning.

Rotherham CCG was the first CCG to achieve the national 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 has a team of Investors in Excellence Practioners, these work with all staff and the national Investors in Excellence team to regularly review that excellent working practices are fully spread throughout the workforce and in its engagement with stakeholders.

The CCG's response rate for the annual national NHS survey was 100%, compared to 75% nationally. The outcomes were overwhelmingly positive, examples being such as 98% of staff would recommend working at the CCG, 100% of staff feel that their senior managers are committed to patient care and 98% of staff feel that their line managers support them with difficult work tasks and are supportive in a personal crisis.

13.9 Environmental Sustainability

NHS Rotherham CCG is a socially and environmentally responsible organisation.

The Sustainable Development Strategy for the Health and Care System 2014 - 2021, the Social Value Act 2012 and the Climate Change Act 2008 requires public bodies 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 on-going focus to reduce the CCG's direct impact, including our: building related greenhouse gas emissions, business travel and waste going to landfill.

We also understand that the vast majority of our impact is embedded in our commissioning and procurement activities and we have a duty to both support and challenge our providers and suppliers to also reduce their own impact; while continually improving the social value of our activities.

We endeavour to work closely with our staff, clients, patients, suppliers, providers and local communities in all aspects of sustainability.

We aim to integrate economic, environmental and social considerations into our strategic decision making and we are open-minded and transparent in our engagement with those who may be affected as a result. In order for Sustainability to exist in an organisation, it needs to be embedded within it too. To help us to do this we have taken the approach to engage our whole staff team to develop the activities within our Sustainability Development Management Plan, which has four components.

<table>
<tr><td>1. Corporate leadership
'The NHS has the potential to touch almost every person in this country. By demonstrating how to reduce carbon emissions and promoting healthy, sustainable lifestyles, the NHS can lead the way to a healthier, happier society.' – Neil McKay.</td><td>2. Staff health and wellbeing and community engagement
The CCG as an employer will enhance the health and wellbeing of staff, patients, the public and suppliers. We will improve the wellbeing of local communities, the economy and the environment through building relationships and minimising negative impacts.</td></tr>
<tr><td colspan="2">3. Reducing our internal impact
We will support the government target to reduce the NHS Carbon Footprint by 80% by 2050. This will involve measuring our baseline and setting targets for;
a. Energy Management
b. Travel Reduction & Greener Travel
c. Material management and the waste hierarchy.</td></tr>
<tr><td colspan="2">4. Sustainable commissioning and procurement
Sustainable procurement means purchasing goods and services in a way that maximises positive benefits and minimizes negative impacts on society, the economy and the environment through the full life-cycle of the product. The NHS spends around £11 billion a year. It contributes enormously to local economies and has the significant market power needed to drive innovation. The NHS contributes up to 10% of regional GDP, and in more deprived areas an NHS Trust can have an even greater economic impact. The majority of our impact comes from our commissioning and procurement activities. While we intend to focus on our internal impact, health and wellbeing of staff and embedding sustainability into the organisation as a priority this year, we must begin to put measures in place to challenge and support our providers to reduce their impact too.</td></tr>
</table>

14 Information Management and Technology

14.1 Introduction and Context

The CCG has developed an I.T strategy to ensure that Rotherham CCG and partners have the IT capabilities to fully support the delivery of key priorities identified within Commissioning Plan for 2016/17 and beyond and also reflects the goal of the new national information framework to support the delivery of technology enabled, personalised care services.

Given the significant financial challenge faced by the NHS there is an absolute need for enabling programmes linked to improved Information Technology to drive the QIPP agenda to deliver increased Quality, Innovation, Productivity and Prevention.

Our strategic direction for I.T developments have been identified and developed through engagement with GPs and partners across the Rotherham Health and Social Care community. Consequently our priorities impacts across primary, secondary and community care as well as commissioners and will require the engagement and support of all partners to be fully realised.

The main clinical systems that are currently in use in the Rotherham Health and Social Care community are:

- General Practices - use a mix of systems supplied by TPP (SystmOne GP) and EMIS (Web)
- Rotherham Foundation Trust – Meditech and SystmOne Community
- RDaSH – use a mix of Silverlink and SystmOne Community
- Rotherham Hospice – SystmOne Palliative
- RMBC Childrens and Young Peoples Services and Neighbourhoods and Adult Services – SWIFT (moving to Liquid Logic in 2016)
- Care UK – a mix of Adastra and SystmOne OOH

14.2 IT Delivery

The current responsibilities and configuration for the delivery of IT services to the CCG and Rotherham's General Practices are as follows. 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.

During 2014 the CCG appointed a Head of IT, jointly with Doncaster CCG, to lead on the development and delivery of local IT strategy and manage the contract for delivery of IT services to the CCG and GPs. In April 2015 the IT programme and project management, data quality and GP system support services which were formally procured from NHS Yorkshire and Humber Commissioning Support (YHCU) were taken back in house and are now provided by a joint team working directly for Doncaster and Rotherham CCGs. IT and RA services for the CCG and GPs are procured from The Rotherham NHS Foundation Trust (TRFT).

14.3 Review of Rotherham IT Strategy 2015/16

Rotherham CCG approved an IT Strategy for 2015/16 in December 2014. The strategy identified nineteen priorities for delivery over the period April 2015 to March 2016 and the implementation of this has been overseen by the Rotherham IT Strategy Group.

Key deliverables from the 2015/16 IT strategy that have been or will be met by March 2015 are:

- Development of a local clinical portal, available to all GPs, which shares data from TRFT and primary care to support the care of patients identified at high risk of hospital admission
- Deployment of
- Rollout of electronic discharge messages from TRFT to all General Practices
- Implementation of the MIG with the local clinical portal.
- Implementation of ITK messaging for NHS 111
- Implemented Hospice EMIS Web EPR viewer allowing hospice staff access to patient records from EMIS practices EMIS Web viewer for community teams.
- GP Training Needs Analysis completed
- SMS solution implemented with EE.
- Implementation of Wi-fi access at all general practice sites
- Implementation of Wi-fi access at identified Care Home sites
- EPS deployments to seven practices (Total 19 EPS deployments in Rotherham)
- Supporting practices with Patient Online requirements to allow patients access to their coded data held within the GP practice.

This document provides a refresh of the 2015/16 strategy, identifying those priorities that need to be carried forward into 2016/17 and a set of new priorities for the next year.

14.4 NHS Information Strategy

The new NHS Information framework titled "Personalised Health and Care 2020: Using data and Technology to transform Outcomes for Patients and Citizens" was published on the 13th November 2014. The framework sets out a programme for transforming information for health and care so that services can achieve higher quality care and improve outcomes for patients and service users. It makes a commitment to delivering improved digital access for people to healthcare services, their clinical records and other healthcare information and to improving the sharing of information between health and care professionals.

The framework proposes a locally driven approach to decisions on systems, programmes, interfaces and applications, which will be supported by a set of nationally defined standards and definitions and clear expectations regarding interoperability. It identifies that generally the IT systems currently used in health and care lack the capacity to share information and that this lack of interoperability is a major and fundamental problem that has not been addressed successfully by previous national strategies. The framework's key commitments, relevant to this strategy, are:

- Citizens will be able to view GP records by 2015
- The SNOMED CT clinical coding system is to be adopted by all primary Care systems by December 2016
- Citizens will be able to access and write into all their health and care records by 2018
- By 2018 clinicians in primary, urgent and emergency care will be operating without paper records
- All patient care records will be digital, interoperable and accessible in real time by 2020
- Citizens will be offered a single point of access, through NHS Choices, to common digital transactions like booking appointments
- Patients will increasingly be offered mobile care records that they control the access to. A proof of concept focusing on End of Life Care and Maternity records will be carried out to test this

The framework identifies that local health economies are to produce local digital roadmaps detailing the actions they will take to deliver the ambitions above.

14.5 The Rotherham Digital Roadmap

In September 2015 NHS England released further guidance on the development of the digital roadmaps titled "Paper-free at the Point of Care - Preparing to Develop Local Digital Roadmaps." The guidance required CCGs to identify the footprint for their local digital roadmap, the digital roadmap partners, and the proposed Governance structure by 31st October 2015. In response to this Rotherham CCG proposed that it will develop a digital roadmap within the CCG footprint in partnership with The Rotherham Foundation Trust, Rotherham Doncaster and South Humber NHS Foundation Trust, Rotherham Hospice, Rotherham Metropolitan Borough Council and the CCG's 34 member practices. The rationale for this footprint selection was that the health and social care organisations in Rotherham have long established working relationships, including working together on the delivery of information and technology initiatives over many years.

Rotherham has an IT Strategy Group, that includes members from all key providers and the local authority, which oversees the delivery of a co-ordinated approach to IT and has met for many years. We have recently established a new borough wide Interoperability Group to lead on the development of our digital roadmap and initiatives that support collaborative working and the improved sharing of information across our organisations. In support of this agenda, since 2013, we have been working together to develop a Rotherham Clinical Portal system to improve data sharing across organisational boundaries.

Our chosen footprint fits with the primary flow of patients and service users within our geographic area and with the footprint of Rotherham Health and Wellbeing Board and Better Care Fund. It is envisaged that all key providers will align their own IT strategies to support and develop the local roadmap and will generate momentum and drive transformation across the local health economies and inform local investment priorities.

We recognise that there is a flow of patients outside of these boundaries, particularly into the neighbouring CCG areas in South Yorkshire and Bassetlaw, and intend to share and cooperate with these areas as we develop and implement our digital roadmap. We have already discussed and shared our intended footprint boundaries with Bassetlaw, Doncaster and Sheffield CCGs and a South Yorkshire and Bassetlaw forum is being established for digital roadmap leads to discuss how we might progress with a collaborative approach to the development of our Digital Roadmaps. This will ensure that roadmaps and the technologies they will deploy are aligned and compatible for future integration. There also is recognition that where we can share learning and support future joint efforts, such as on areas including communications and engagement, it makes sense to do so.

The Rotherham footprint has been endorsed by the Director of Commissioning Operations (DCO), Moira Dumma (Yorkshire and the Humber) for the North of England region and logged with the NHS England Digital Technology Team.

Full guidance on the content and requirements of the local digital roadmaps will be published with the CCG planning guidance for 2016/17 in December 2015. Following publication of this guidance Rotherham CCG, working with our partners on the Interoperability Group, will develop a full local digital roadmap, which will be published in April 2016. In addition to this during the period November 2015 – January 2016 providers will complete a digital maturity self-assessment that will be used to baseline and benchmark local progress towards achieving digital care records. It is expected that the output from these self-assessments will be available to support development of the local roadmap.

This strategy sets out how locally in Rotherham we will take forward the aims of the new framework. As the additional guidance, standards and definitions are introduced we will need to review how they impact upon our plan and take action to amend them as necessary.

14.6 Rotherham CCG IT Strategy

This strategy has been developed by consultation across the Rotherham Local Health Community. Several areas of work will be carried forward into this year's strategy which has been identified in the table below as they were unable to be completed during the last financial year.

Priorities carried forward
Electronic Clinical Letters and Discharge Summaries
Emergency Care Centre Solution
Business Intelligence Systems
IT Infrastructure • Connect GP practices to TRFT WAN
Clinical System Interoperability • EMIS Web and TPP Interoperability
GP Practice Systems Optimisation • Paper-light status • GP Practice system optimisation programme • Digitisation of Referral Forms • GP IT Training

A survey was sent out in November 2015 to the identified IT leads of each GP practice to prioritise new key areas of work to take forward within this strategy and to establish any other areas which should be considered. The final set of new key strategic priorities is listed in the table below:

New Priorities identified
Community Pharmacy access to patient summary information (SCR, Clinical Portal)
GP Trainee Assessment
GP Practice Systems Optimisation • Medicine screening tools • e-Consultations • Video Consultations • Patient Electronic Health Monitoring • Clinical System User Groups
Clinical System Interoperability • Clinical Portal Development (Safeguarding, end of life) • Patient Portal

The strategy also acknowledges the national project requirements and will support practices to achieve these as and when necessary.

National Projects
National E-referral service (Advice and Guidance)
Patient Online Service
Electronic Prescription Service
GP2GP

This strategy is aligned to the Commissioning Plan and sets the strategic direction for IT developments over the next year. A high level programme plan for delivery of this strategy is provided in section six of this document. Rotherham CCG will ensure when delivering this strategy that information and new technology is equally accessible across vulnerable groups. At the point of implementation of each project a full Equality Impact Assessment will be carried out and this will be subject to regular monitoring. Rotherham CCG's partners will also be required to share evidence that they have carried out Equality Impact Assessments on their developments

15 Communication 'Plan on a Page'

EVALUATION & MONITORING

Our Priorities

- Effective 2-way communication with all our stakeholders and the people of Rotherham to listen, inform, support, shape and plan health services.
- Make sure that all stakeholders have easy access to the information they need; from GPs and member practices to stakeholders and the public, including accessing the right care, first time.
- Build trust and credibility in Rotherham CCG, making sure that the CCG is easily recognisable
- Manage and develop the reputation of Rotherham CCG as the local leader of the NHS
- Make sure that patients, their views and experiences are at the heart of local health commissioning.

Key Messages

- We are a membership organisation of local clinicians working together to secure the best possible healthcare
- We will commission services that provide the right care in the right place. at the right time
- We are committed to working together with our partners, patients and the public to achieve the best health outcomes
- We are a listening organisation that actively seeks out and values the views of staff, members, partners, patients and the public
- We act on feedback to shape and improve services.
- We make sure that decisions about services are based on evidence of local need and outcomes.

Target Audience

Patients and the public

Provider/partner organisations

Key influencers/political figures

Media

Clinicians

Our staff and members

Health and Wellbeing Board

Voluntary and Community sector

Our Principles

Accessible & Inclusive	**Flexible & Innovative**	**Proactive**
Clear & Concise	**Consistent & Accountable**	**Two-way & Timely**
Open, Honest & Transparent	**Targeted & Responsive**	**Cost effective & Proportionate**

Tactics

Working closely with Local Strategic Partners

(Not an exhaustive list)

Internal – staff and members

- E-newsletters
- Intranet
- E-mail
- Briefings
- Protected Learning Time
- Meetings and committees
- Blogs
- GP Commissioning Events
- Practice Managers Commissioning forum
- Engagement and Communications Sub Committee

External

- Media Relations – print and broadcast
- Website
- Social and Digital Media
- Events
- Printed materials
- Advertising & Branding
- Blogs & Social Media
- Networks and patient groups
- Surveys & Consultations
- Focus groups

16 Performance and Assurance

This section will need to be updated in line with the new CCG Improvement and Assessment Framework – Awaiting release from NHSE

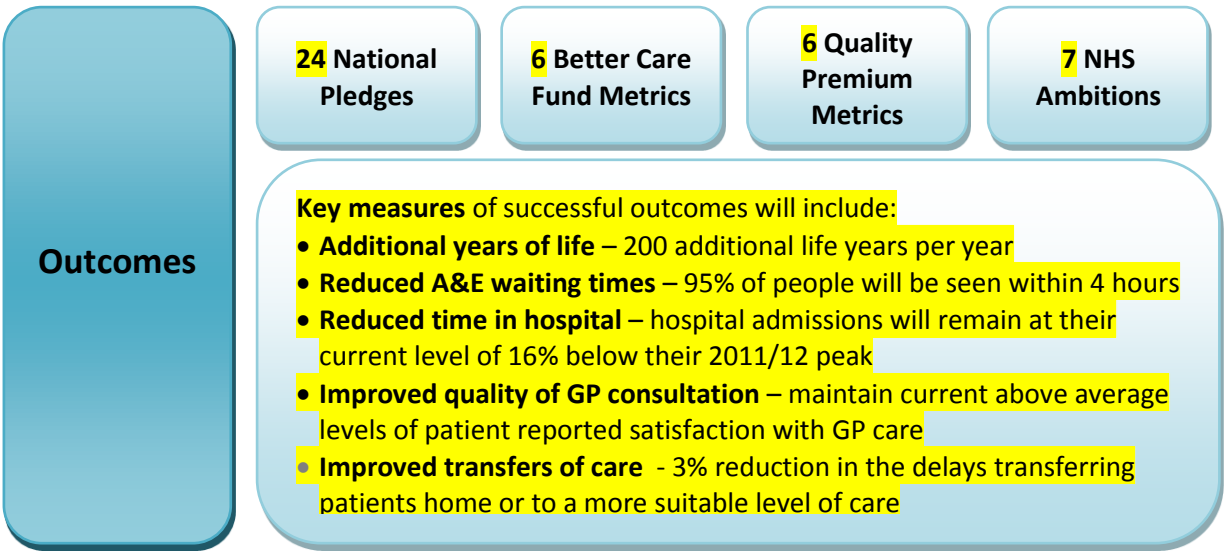
16.1 Outcomes

This section confirms the assurances and quantifiable improvements we will deliver over the next 5 years.

Self assurance of our plan confirms that:

- We will deliver the NHS Pledges and the standards in the NHS Constitution
- The CCG will undertake assurance that Provider Cost Improvement Programmes are deliverable and safe by April 2016
- Management of health care acquired infections results in no cases of MRSA.

NHS England has set a total of 79 metrics. In order to give emphasis to a smaller set, the CCG has chosen the five key measures below for the plan on a page:



The CCG keeps under surveillance all NHS Pledges and Constitution indicators and measures on the **NHS Outcome Framework** and reports exceptions to the CCG Governing Body.

1. Referral to treat time (admitted, non-admitted and incomplete) & diagnostics waits
2. Cancer Waiting Times Standards: 2 week wait, 2 week (breast symptoms), 31 Day First Treatment, 31 Day Surgery, 31 Day Drugs, 31 Day Radiotherapy, 62 Day GP Referral, 62 Day Upgrade & 62 Day Screening
3. Ambulance Performance Red 1 Cat A calls, Red 2 Cat A calls & Cat A 19 calls
4. A&E Performance
5. C.Difficile
6. Mental Health: Dementia, IAPT Access, IAPT Recovery & Mental Health Access - 18 Weeks & 6 Week
7. Patient Satisfaction at a GP Practice, Patient Satisfaction at a Surgery & Patient Satisfaction with access to primary care

The CCG is also works with partners on the two other outcomes frameworks relevant to the Health and Well Being Board, the **Social Care outcomes framework** and the **Public Health outcomes framework.** From the wide range of metrics, three sets of outcome are relevant for the CCG's external performance. Metrics in bold are in more than one outcome set.

Better Care Fund performance metrics. The BCF metrics will be reviewed with RMBC and NHS England in light of 2014 / 15 Performance. One quarter of the total £20 million Better Care fund is dependent on delivery against the following outcomes. The first five are chosen nationally the 6th locally chosen.

1. Number of admissions to residential and nursing homes (12% reduction)
2. **Proportion of over 65s at home 3 months after discharge** (to be confirmed)
3. Delayed transfers of care from hospital (to be confirmed)
4. **Avoidable emergency admissions (15% reduction over 5 years)**
5. New national patient experience measure currently under development
6. Emergency admissions within 30 days of discharge from hospital (reduce by 1.2% over 5 years)

Quality Premiums: The indicators making up the 2015/16 CCG Quality Premium are:

1. **Potential Years of Life Lost (PYLL) (10%).** 7000 years of life are lost in Rotherham each year by people dying before their time, we will reduce this by an average of 200 life years each year over the next five years (3.2% decrease).
2. **Urgent and Emergency Care Menu (30%)**
3. **Mental Health Menu (30%)**
4. **Improving antibiotic prescribing in primary and secondary care (10%)**
5. **Local Measure One: Alcohol Related Hospital Admissions and Readmissions (10%)** – ensure there is no increase in hospital admissions
6. **Local Measure Two: People who have had a stroke who are admitted to acute stroke unit with 4 hours of arrival to hospital (10%)**

In addition to the above list, the following NHS Constitution Measures will reduce the Quality Premium payment if these are not achieved:

1. 18 Weeks Referral To Treatment – Admitted, Non Admitted and Incomplete Pathways (30%)
2. A&E 4 Hour Wait (30%)
3. Cancer Two Week Wait (20%)

GP Access: as a CCG accepting delegated responsibility for primary care commissioning, the CCG will agree trajectories for patient survey results with NHS England, for the following three outcomes:

1. ED1 Satisfaction with the quality of consultation at the GP practice
2. ED2 Satisfaction with the Overall Care received at the Surgery
3. ED3 Satisfaction with Accessing Primary Care

The following list of Ambition metrics were set in the 2014/15 planning round and still apply for 2015/16.

Five year ambitions for six key NHS objectives. The CCG will be held accountable for delivery against these ambitions by NHS England at quarterly assurance meetings. An additional national metric on reducing avoidable mortality is being developed.

1. **Potential Years of Life Lost will be reduced by 3.2% each year**
2. We will meet the current England average for quality of life of people with long term conditions by 2019
3. We will maintain **emergency admissions** at current level (16% below the 2011/12 peak)
4. We will maintain Rotherham's current excellent performance on the **proportion of over 65's** at home 3 months following hospital discharge for the next 5 years.
5. We will improve the proportion of people having a positive experience of hospital care in Rotherham to the current national England average by 2019
6. We will improve the proportion of people having a positive experience of care outside of hospital in Rotherham to the current England average by 2019

16.2 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. This framework will be reviewed in the early part of 2015 to ensure that it reflects the planning Guidance "The Forward View Into Action: Planning for 2015/16" and meets the Governing Body requirements.

NY&H CSU Business Intelligence team produce a monthly performance report for the CCG Governing Body that will cover the performance against key outcomes required by NHS England *Delivery Dashboard* shows as an example the April 2015 Governing Body performance report. The current reports concentrate on a limited number of key metrics and then exception reporting against the full range of the NHS Outcomes framework.

The CCGs monthly scorecard includes the metrics and assurance statements that are also used for quarterly assurance meetings with NHS England. After each quarterly meeting NHS England produces a letter surmising discussions on performance and this letter together with the quarterly score card is published on the CCGs website. *CCG Assurance*

In addition to reporting on national outcomes the CCG will produce three reports a year on the delivery of this commissioning plan. The Commissioning Plan Performance Report sets out the process and outcome measures we will report on *Commissioning Plan Performance Report*

17 Risks

17.1 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** 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** 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**. The CCG Assurance Framework captures the high strategic potential risks to the organisations strategic objectives. As at January there were 63 entries on our Risk Register, with 32 scoring in excess of 11, and there were 33 entries on our Assurance Framework, with 26 scoring in excess of 11.

Key risks to delivering this plan are:

- Adverse impact on patient care from leadership change, liquidity pressures issues at acute provider trust
- Subcontracted commissioning services fail to deliver outcomes as a result of CSU not being on lead provider framework
- NHS Efficiency challenge
- Quality implications – cumulative impact of year on year efficiency requirements causing a negative impact on patient safety
- CCG affordable trajectories – CCG not able to keep non-elective and elective activity within affordable trajectories.
- Providers not being able to deliver efficiency plans
- Viability of local services could be affected by efficiency plans.
- Failure to meet key performance targets for
    - A&E 4 hour target
    - Ambulance 8 minute target
    - National Improving Access to Psychological Therapies waiting times
- GP recruitment and retention affecting pathways provided by GPs and the availability of GPs to take part in commissioning
- Implications in terms of patient safety and finance from the the 'who pays' Section 117 guidance and complex patient transfers
- Specialist commissioning - risk of the CCG not being able to address its new specialist responsibilities effectively and risks that over spends in areas of NHS England responsibility could be transferred to the CCG
- Inability to reconfigure and re-organise CAMHS successfully
- Impact of taking on new services and hosting shared services on corporate running costs

18 How we shared our plans

Numerous stakeholders have been engaged in the development of our Commissioning Plan and figure 18.1 below describes the inputs into its development.

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. *Sharing our Intentions.* In addition, the CCG undertakes a breadth of consultation with members, patients and partners on areas within the commissioning plan. *CCG Events 14/15*

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 10) 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.

From the consultation during October 2015 with localities we have confirmed that members are supportive overall for the direction of travel. Whilst the main themes were **CAMHS and Primary Care**, below are areas that were highlighted by more than one practice:

Primary care

- Concerns over primary care capacity (and of moving services from secondary care to primary care)
- Increase self-care and patient education
- Supportive of plans for estates
- Agree we need to make Rotherham an attractive place to work
- Support development of LLP

Children's

- Further work needed on CAMHS
- Clarity on pathways
- Single point of access for children's services

Mental Health

- Agree direction of travel for Dementia LES but further work needed
- Concern with IAPT

Hospital and Community

- Very supportive of CCC and of potentially extending the services
- Support for community transformation work, recognising it will continue to develop

CSE

- Supportive of CCGs response, positive comments re: MASH

Joint Commissioning + BCF

- Agree with plans for BCF and supportive of joint work

All supportive of work on **IT interoperability**

Input from patients and the public

The Patient Participation Group Network considered the 2016/17 Commissioning Plan and provided feedback on several specific areas. This work led to the production of a short and simple, public facing version of the plan, which has been well received by the public, partners and stakeholders alike.

The 2016/17 plan has been informed through engagement in our workstreams and projects throughout the year, this is demonstrated within individual sections of the plan which show where engagement has informed our work, and how we are acting on what people have told us.

However 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.

During the last year we have, as promised, used a variety of different ways to engage with the public and patients of Rotherham, these have included:

- social media and extended the use of our website
- electronic and paper surveys
- formal consultations
- targeted events, meetings, workshops and focus groups
- attendance at community events
- a stakeholder and community conference in July 2015
- a stakeholder event focussing on primary care in November 2015
- continued work with Rotherham PPG Network
- attendance at community meetings to both share information and hear people's concerns
- work with voluntary and community organisations to make sure we hear from potentially overlooked communities

The early drafts of the 2016/17 Commissioning Plan will be circulated to key stakeholders and partner organisations, and comments received will be addressed in the final version.

We used several of these mechanisms to share priorities and principles, and asked for comments and feedback on these, including:

- electronic survey on our website, distributed widely and through social media sites
- paper versions distributed to local organisations
- a 'hands on version taken to community events (such as Fairs Fayre)
- Conversations with people, enabling young people, and people with disabilities and limited English to share their views and concerns with us.

From this, it was clear that people prioritised several elements that were similar:

- 'treat me as a person, not a number'
- Co-ordinate care round me (this related to hospitals working together, health and social care working together, and primary care working with secondary care)
- Make sure that services are safe and trustworthy, and that emergency care works well for me
- 'Not repeating my story more than once'

Throughout this plan, we have therefore sought to reflect how important this is, and to ensure that all our work puts patients at the heart, making sure services work well for the patient first and foremost. This work will continue during the next year, and the continued contributions of patients and the public will be vital if we are to succeed in ensuring that the services we commission are truly centred around the patient.

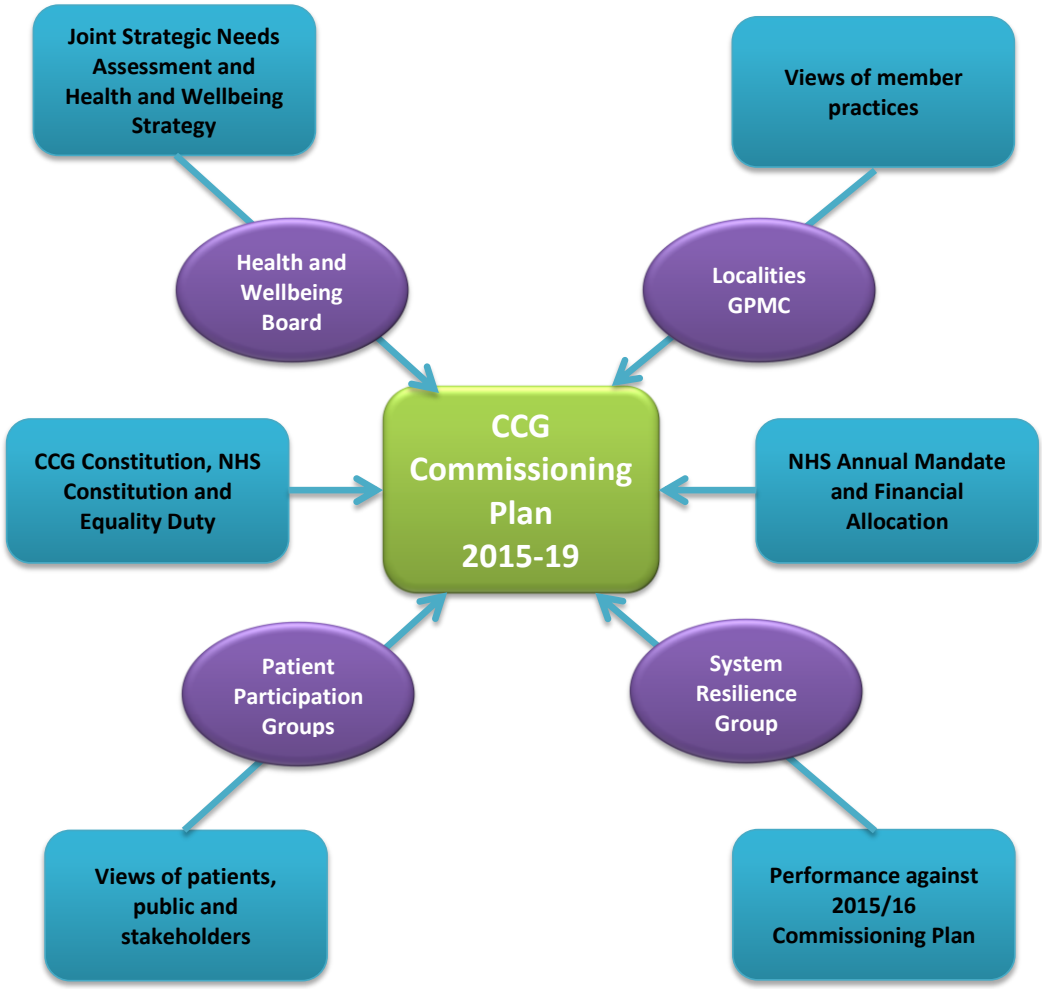
How to feedback comments on the CCG Commissioning Plan

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 . Or by post to: Rotherham CCG, Oak House, Moorhead Way, Bramley, Rotherham S66 1YY

Acknowledgement

We would like to thank all CCG staff, executive GPs, member practices and Health and Wellbeing partners for their contributions to and feedback on the development of this plan. We would also like to thank Patient Participation Groups and members of Healthwatch for their important contributions.

Figure 18.1: Inputs into the development of our Commissioning Plan



19 Glossary – update

A&E	Accident and Emergency
APC	Area Prescribing Committee
BCF	Better Care Fund
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CCGCOM	A group of the 5 South Yorkshire and Bassetlaw CCGs to commission jointly on agreed areas
CHC	Continuing Health Care
CP	Commissioning plan
CIP	Cost Improvement Plans
CRMC	Clinical Referrals Management Committee
CSE	Child Sexual Exploitation
NY&H CSU	North Yorkshire and Humber Commissioning Support Unit
CQUIN	Commissioning for Quality and Innovation
DBH	Doncaster and Bassetlaw NHS Foundation Trust
DH	Department of Health
EDS	Equality Delivery System
EU	European Union
FFT	Friends and Family Test
FNC	Free Nursing Care
GPRC	GP Members Committee
HAP	Health Action Plan
H&WBB	Health and Wellbeing Board
H&WBS	Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
IT	Information technology
KPI	Key Performance Indicator
LAC	Looked After Children
LMC	Local Medical Committee
LES	Local Enhanced Service
LIS	Local Incentive Scheme
LOS	Length of Stay
LTC	Long Term Conditions
MHQC	Mental Health QIPP Committee
MMC	Medicines Management Committee
MRSA	Methicillin Resistant Staphylococcus Aureus
NHSE (SY&B)	NHS England (South Yorkshire and Bassetlaw)
OE	Operational Executive
Parity of Esteem	Ensuring that all mental health patients receive attention that is equal to acute patients
PbR	Payment by Results
PPG	Patient Participation Group
PTS	Patient Transport Services
PYLL	Potential Years of Life Lost
QIPP	Quality, Innovation, Productivity and Prevention
RAIDR	Reporting Analysis & Intelligence Delivering results
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust
RMBC	Rotherham Metropolitan Borough Council
SCE	Strategic Clinical Executive
SEND	Special Educational Needs and Disabilities
SHSC	Sheffield Care and Social Care Trust
SLA	Service Level Agreement
SRG	System Resilience Group
STH	Sheffield Teaching Hospitals NHS Foundation Trust
SYCOM	South Yorkshire CCG Collaboration
TRFT	The Rotherham NHS Foundation Trust
YAS	Yorkshire Ambulance Service

20 List of hyperlinked documents – update

Document hyperlinked	Page Number
Communication and Engagement Plan	
CCG Governing Body structure	
NHS Rotherham CCG Constitution	
NHS Constitution	
CCG Commissioning Responsibilities	
Rotherham Joint Strategic Needs Assessment	
H&WB Strategy	
NHSE Commissioning Intentions	
Children's and Adolescent Mental Health Services Strategy	
Children's and Adolescent Mental Health Services Needs Analysis	
Adults and Older Peoples Mental Health Transformation Plan	
Primary Care Co-Commissioning Guidance	
NHSE Commissioning Intentions for Specialised Commissioning	
Care Act Implications for Rotherham	
Commissioning for quality policy/procedure on gaining assurance and identifying failing services using an appreciative enquiry approach	
Diagram of four key quality reports	
The Jay Report	
The Casey Report	
Communication and Engagement Plan	
Complaints Information	
Equality and Diversity	
Five year forward view and Forward View Into Action	
IT Strategy	
Communication and Engagement Plan	
NHS Rotherham CCG Delivery Dashboard	
NHS Rotherham CCG Assurance	
Commissioning Plan Performance Report	
Commissioning Plan 'sharing our intentions'	
Consultation Events 2014/15	

investor in excellence

NHS
Rotherham
Clinical Commissioning Group

Commissioning Plan

2016-2020 V4.1 01 02 2016

DRAFT

Part Two

Your life, Your health

http://www.rotherhamccg.nhs.uk/

This section provides further specific detail regarding how the CCG will deliver the long term vision and previously highlighted strategic aims.

Please note that the following applies to this version:

Text highlighted in yellow indicates that the content needs either further work, confirmation or update before submission.

Page numbers, signposting and hyperlinks (currently denoted in *orange italic text*) will be finalised in the March/April version

Contents

21.1 Unscheduled Care

Lead GP	David Clitherow
Executive Lead	Chris Edwards
Officer Lead	Dominic Blaydon
Key Meeting	System Resilience Group

Why is this a strategic priority?

Historically, the 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 is a better, safer option.

A corner stone of our strategy is to commission alternative services to hospital admission, and to 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 Co-ordination Centre and providing alternative levels of care (see Section 21.2). The Better Care Fund is described in section 21.12

In 2015/16, the CCG spent £x million on unscheduled care. Planned spend for 2015/16 is £x million.

5 year Strategic Direction

Managing Acute Emergency Care:

A new state-of-the-art Emergency Centre is being built at Rotherham Hospital and is due to open its doors fully in 2017. Our aspiration is that the centre will provide a world class service for patients. A new service model of Emergency Care will be delivered using a skill mix of existing A&E and primary care staff working to provide a multi-skilled workforce fully equipped to meet the patients' needs.

Primary Care out of out of hours' services and the already successful care co-ordination centre will be based at the Centre so all urgent care services are together on one sight. There will be excellent links with mental health services as the recently commissioned enhanced Crisis and Liaison service as well as Social care services, will be integrated within the centre.

Managing out of Hospital Urgent Care:

Rotherham CCG will continue to work with Primary Care to ensure that we are able to optimise access for patients with urgent care needs. We will work with other Primary Care colleagues such as pharmacists and dentists, to ensure that they are pivotal to the delivery of urgent care services. We will also work collaboratively with other key stakeholders through our System Resilience Group to ensure that the services developed work in synergy.

Managing Urgent and Emergency Care across the wider South Yorkshire 'Working Together' footprint.

The CCG will fully engage in the development and delivery of the South Yorkshire Wide Urgent and Emergency Care network to ensure improved co-ordination and delivery of urgent care provision across South Yorkshire.

We will strive to commission a system that supports patients to return home safely through our supported discharge pathways. We will work with local stakeholders to develop more integrated, responsive and co-ordinated care pathways.

We will work with local providers to ensure that where appropriate and secure, we can have IT systems that help health professionals to share information in a manner that supports care pathways and upholds patient confidentiality.

One of our main goals is to have a central point of access to Urgent Care. We will work with partners to develop NHS 111 so that it becomes the first port of call for anyone with an urgent health care need. This will reduce pressure on emergency services and ensure that patients receive the right care in the right place.

The CCG will continue to build on the successes of previous years to embed the changes we have made in 2015/16. Our community transformation programme will continue to transform the way patients with long term conditions, the frail elderly and others who access urgent care services are managed.

Progress made in 2015/16

During 2015/16 demand for Accident & Emergency Services in Rotherham has slightly reduced overall, however there have been some significant periods of volatility with unprecedented high levels of demand in short periods of time. This has culminated in some extremely challenging times for the management of the unscheduled care system in Rotherham. 2015/16 has also seen an increase in emergency admissions of x%. Specific progress has been made in the following areas to meet demand in the urgent care system:

- £12m Emergency Centre development on track to be delivered to plan by Spring 2017
- Further Enhancement of the **Care Co-ordination** centre allowing 24/7 day working (quote number of telephone calls per month XX)
- Further Enhancement of the Case Management Programme with XXX case management plans in place.
- Clinically led patient level audits of emergency admissions on patients in the over 70s through both A&E and the Medical Assessment Unit**.** Action plans have been developed and will be implemented between the System Resilience Group and Clinical Referrals Management Committee.
- Support the implementation of year 2 of the transformation programme which focuses on the transformation of unscheduled healthcare services in Rotherham through the achievement of three key aims:
    - Achievement of the 4 hour A&E quality standard
    - Reduction in the acute bed base
    - Reduction in the number of emergency admissions
- Development of plans to extend and reconfigure the current medical assessment unit to provide enhanced ambulatory care, recruitment of additional consultants to meet the clinical standards for seven day working and ensuring seven day availability and development of frail and elderly pathways to avoid unnecessary emergency admissions for this cohort of patients.
- Following the CCG's investment of £4.1m in 2014-15, further progress on the implementation of the seven day working agenda.

Plans for 2016/17 and 2017/18

In 2016/17 we will continue in our drive to reduce non electives from 2015/16 out-turn and then hold them at this level for the foreseeable future. This is extremely challenging. However primary and secondary care clinicians have agreed that the combination of initiatives in this commissioning plan will deliver this challenge. A full description of planned activity for both unscheduled and clinical referrals is identified in section 21.4.

TRFT and partners will drive forward work to ensure the new Emergency Centre is fully operational for Spring 2017. Key programmes of work include capital development, workforce development, IT and change management. The Emergency Centre is the CCG's major project up to 2017, and is driven through the Emergency Centre governance structure providing assurance to the Emergency Centre Assurance Group which reports regularly to the SRG. The business case was approved by the CCG and TRFT Board in October 2014 and the Capital Development scheme commenced in March 2015. This service transformation is clinically led with an executive director sponsor from TRFT, Care UK and Rotherham CCG. An extensive programme of organisational development work is planned to ensure the benefits of change are realised.

Rotherham CCG will also lead on a local Transformation Programme. This will focus on two urgent care priorities

Priority 1: Emergency and Urgent Care

- The development of a frail elderly care pathway service aimed at reducing hospital admissions
- Realignment of the GP service at A&E so that it makes a greater contribution to the 4 hour A&E target

- The redesigning of the structure of acute intake, speeding up patient flow and taking pressure off A&E
- Redefining the role of A&E clinicians so that they are better able to manage risk and redirect patients.

The key outcomes associated with this priority are;

- Increase in the number of patients seen by the GP in A&E service
- Reduction in admissions of patients > 65 years
- Increase in the number of ambulatory patients

Priority 2: Structured Management of Acute Bed Base

- Aspiring to be a Perfect Ward, which will operate robust systems of discharge planning and patient flow
- A clear system for management of long stay patients
- Developing coherent system for managing outliers
- Introducing weekend working for consultants on medical wards and the Medical Assessment
- Site coordination service becoming fully operational, acting as a hub for managing patient flow
- Expanding role of the Care Coordination Centre so that it manages the interface between acute and community
- Consider the use of the Care Co-ordination Centre for other Health and Social Care services
- Continue to commission acute alcohol services to reduce alcohol related emergency admissions.
- Continue to focus improvements for adult and older people's mental health services

How are we going to achieve our intentions?

In May 2014 as a result of the national drive, NHS England determined that all CCGs should establish a system resilience group (SRG) to oversee the delivery of A&E performance, urgent and emergency care efficiency programmes and delivery of the 18 week referral to treatment standard. The SRG 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 SRG reports to the CCG Strategic Clinical Executive (SCE) and the Health & Well Being Board.

The Emergency Centre is the CCC's major project up to 2017. The business case was approved by the CCG and TRFT Board in October 2014. This service transformation is clinically led with an executive director sponsor from TRFT, Care UK and Rotherham CCG. An extensive programme of organisational development work is planned to ensure the benefits of change are realised.

Quality Improvements

Reduce unnecessary hospital attendances and admission ensure right place right times.

- **GP led integrated care: Self care:** we will support patients to take more control over their condition and management. 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 21.9. **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 2015 the risk tool will be reviewed and resources targeted at the most complex patients and those most at risk of admission. Community nursing and social workers are refocused to provide input into patient reviews. There is a direct link with the **social prescribing** project 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 programme.
- Better quality community nursing services which offer 7 day services including during the out of hours period will reduce overall and weekend mortality rates
- **Enhanced care co-ordination centre:** 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.
- **Emergency Centre;** this is a full redesign of emergency and urgent care services which will ensure that

patients receive the right care, first time. We will incentivise quality improvements in line with the Keogh Review of Urgent and Emergency care through the national CQUIN and local quality premium.

- **Personalisation:** Continuing Health Care patients have a right to have a personal health budget giving them more control over their care.
- **Pathways:** redesigning care pathways initially focusing on those that account for the highest proportion of admissions.

Innovation

The following initiatives have been put in place this year to support patients with an urgent health care need.

- GP Case Management Programme – a major innovation at scale where Rotherham has invested substantially (£1.4 million in 2015/16) to fund additional community support. There are currently 9,600 plans in place with 15,000 plans in total over the last 4 years.
- Nationally recognised award winning social prescribing – a significant investment (£547,000 in 2015/16) 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 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.
- A £12 million purpose built facility to house a nationally recognised emergency centre at the TRFT site with an innovative approach to staffing and seeing patients quickly.
    - Robust GP and GP OOHs Services – Work is underway to ensure that there is a robust service from GP practices during core hours, together with a comprehensive GP Out of Hours service. GP practices will flex their capacity to ensure patients who telephone urgently before 4.00pm are seen the same day. Rotherham is also promoting the Pharmacy First scheme which offers a minor ailments service. A DES (Directed Enhanced Service) is being reviewed for Rotherham GPs to provide extended access to patients.
    - Up-to-date and Accurate Directory of Services for 111 – South Yorkshire and Bassetlaw CCGs employ a full-time member of staff to oversee, update and amend the 111 Directory of Services. This ensures that the Directory of Services is continually updated and that a wider range of agreed dispositions can be made.
    - Rapid Assessment and Treatment in A&E – One of the key priorities within TRFT's Transformation of Unscheduled Care Programme is to redesign the acute intake of the hospital, speeding up patient flow, reducing pressure in A&E. This includes the development of an effective Ambulatory Care Unit and Frail and Elderly Assessment Unit. Due to space constraints, A&E does not currently have the capacity to provide a Rapid Assessment and Treatment (RAT) model, however construction has recently started for the new Emergency Centre at TRFT and within this development there is provision for a 4 bedded RAT assessment area.
    - Consultant Led Ward Rounds 7 Days a Week to Support Discharges, Patient Flow and A&E Performance – Daily ward rounds take place on all wards Monday to Friday. Consultant-led ward rounds take place on weekends with the main focus on MAU. A weekend plan identified those patients for review for weekend discharge. There has been investment in diagnostic and clinical support services across to embed a more comprehensive 7 day working model of care delivery. A dedicated site management team supports patient flow and reconciles admissions and discharges at the end of each day. Hospital social work staff also attend MDT meetings (Monday to Friday) and are working towards 7 day social care assessments. Hospital Discharge Management and Alternative Capacity – Discharge to Assess beds have been commissioned at 2 bases; Oakwood Community Unit and a private care home. These beds have full therapy capacity and are fully utilised. In addition, Step-Up and Step-Down beds are available in Intermediate Care, Breathing Space and at Oakwood Community Unit. The need for additional Discharge to Assess beds, and in particular, EMI beds, will be considered.

Alignment with the strategic aims of the Health & Wellbeing Strategy

The Urgent Care Strategy addresses the following H&WB strategic objectives:

Aim 4: Healthy life expectancy is improved for all Rotherham people

Aim 5: Rotherham has healthy, safe and sustainable communities and places

How will health inequalities be addressed
The nature of commissioning and delivering urgent care services provides challenges in terms of addressing health inequalities. We work closely with providers to ensure their service delivery is equitable.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
Extensive pre-consultation work followed by a formal consultation process informed the plans for the Emergency Centre. This process created substantial interest in the project, and as a result a number of community groups asked for, and receive regular updates. As the plans have developed, we have continued to both engage with and keep patients and the public informed, through information stands, attendance at community events, and an information stand at our AGM in 2015. Patients have told us that they want a system that is integrated and that does not ask for the same information twice. They want an urgent care system that responds to their needs without referring to another service. Through integration, we would like to create a seamless patient pathway into urgent care, whether patients access the service by walk in, telephone or via the ambulance service. Greater patient engagement and awareness is crucial and is one of the core messages that came out of our patient engagement work. Our patients have told us that they are not aware of all of the services that are available to them and therefore they access services at the local Accident and Emergency Department. We will ensure that along with our GP colleagues we raise awareness of what services patients can access and when they can access them. Working with the voluntary sector, we have established a number of community ambassadors who help us to deliver the 'Right Care First Time' message, reaching into communities. During the summer of 2015, we also worked with Rotherham Older People's Forum, who spoke to a number of older people about crises, and the use of A & E, we will use this to inform future work, including the information we provide for older people about the services available

21.2 Transforming Community Services

Lead GP	Phil Birks
Executive Lead	Keely Firth
Officer Lead	Dominic Blaydon
Key Meeting	Community Transformation Board

Why is this a strategic priority?

The majority of this section describes the important projects that the CCG is leading to transform the services provided by Rotherham NHS Foundation Trust's (TRFT). The CCG also makes important investments in community services from other providers, such as the Walk in Centre (Care UK), Rotherham Hospice (see section 21.10), general practice for example the case management programme (see section 21.1) and the voluntary sector including the award winning social prescribing scheme (see section 21.1). The table shows the spending profile of services commissioned to support vulnerable patients in their own home from TRFT. Some of the services are jointly commissioned through the Better care Fund (see section 21.12)

Table 1: Spending Profile for Community Services

Summary of Community Services	£000s
Children and Young People's Services	**3,680**
Planned Care	**5,523**
Long Term Conditions, Intermediate Care and Urgent Care	**14,121**
CQUIN	**579**
Pilots	**3,165**
Reablement	**631**
Total	**27,699**

The CCG is committed to moving care closer to home where it is clinically appropriate to do so. We believe that 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

5 year Strategic Direction and key priorities

The 5 year strategic vision for community health services reflects the objectives set out in The King Fund publication on transforming our health care system.

- Active support for self-management
- Primary and secondary prevention interventions aimed at reducing demand for formal health services
- Developing an integrated response to people with both mental and physical health problems
- Care co-ordination through integrated health and social care teams and a single point of access
- Improving identification of patients who are at the end of life, and providing appropriate support
- Developing an integrated approach to admission prevention supported discharge

Progress made in 2015/16

Rotherham's Community Transformation Programme has made significant progress over the last year.

A Better Community Nursing Service

The community nursing service has been reconfigured so that there are locality teams serving GP practice populations. The service has better leadership, clinical supervision and systems of governance. There has been significant additional investment delivering an additional 14 nurses against 2014/15 establishment. Bureaucracy has been taken out, increasing the amount of face-to-face time with patients. All community matrons and district nurses have been provided with new IT equipment that includes full connectivity with electronic recording systems. Rotherham CCG also coordinate regular bilateral performance meeting between community nursing teams and GP localities.

Integrating Services

A new Integrated Rapid Response Service, merging the functions of Fast Response Advanced Nurse Practitioners and OOH community nursing, is being developed. Community Transformation Board has endorsed an integrated respiratory care pathway which incorporates community support. There is additional investment in the integrated falls and bone health care pathway incorporating a reinvigorated fracture liaison service. Finally, there has been recent agreement on a new service model for neuro rehabilitation which includes community support for patients with degenerative conditions.

An Enhanced Care Coordination Centre (CCC)

A new service model has been agreed that delivers additional functionality. The CCC has now been resourced to provide 24/7 cover for patients who have an urgent health need. The CCC will act as a hub for new supported discharge and admission prevention care pathways. It will maintain a register of patients who are medically fit for discharge and ensure that they are placed on the correct care pathway. This year the CCC will act as a single point of access for community nursing referrals. It will also start to support GPs in the case management of patients with long term conditions.

Utilisation of Alternative Levels of Care

Significant progress has been made in developing new care pathways that can act as an alternative to hospital. Community Transformation Board has approved a new service model for The Community Unit, realigning provision so that it targets the frail elderly. Rotherham CCG has commissioned 6 Discharge to Assess beds at Waterside Grange to reduce winter pressure and assist patient flow. The Trust has now introduced 3 supported discharge and admission prevention care pathways which should start to impact on pressures in secondary care this year.

Plans for 2016/17 and 2017/18

The Community Transformation Programme is now focusing on the following priorities;

1: Prevention of Admission and Discharge Pathways

Rotherham CCG will embed the 3 supported discharge and admission prevention pathways for patients who are medically fit for discharge. .

Pathway 1: Patients who can be cared for at home with intensive support package
Pathway 2: Patients who cannot return home and require a period of rehabilitation/recovery
Pathway 3: Patients who have 24/7 nursing needs

We will develop ring-fenced commissioning arrangements for relevant services. We will fully implement the Integrated Rapid Response Service. We will explore the potential for development of EMI step-down provision. We will review the current intermediate care service model with a view to improving its effectiveness in admission prevention and supporting discharge. We will ensure that there are community-based alternatives for all patients who are medically stable but do not need to be admitted to hospital.

The key outcomes associated with this priority are:

- Reduction in GP admissions to the Medical Assessment Unit
- Full utilisation of the Alternative Level of Care bed base
- Reduction in A&E attendances by care home residents

2. Integration of Acute and Community Care Pathways

Rotherham CCG will embed the 7 locality community physicians, ensuring that there is medical support for patients. We will support patients already at a high risk of hospital admission through the case management programme. We will work with Rotherham MBC to develop integrated health and social care teams, with a single line management structure and single point of access. We will develop proposals for a pilot health and social care team to operate within one of our localities known as the 'perfect locality'. We will then use practice based evidence to support the roll out of a fully integrated model across the borough. We will also align locality community nursing teams and practices with care homes, setting clear performance targets on emergency admissions and quality. As part of our work on community transformation we will also undertake a full review of acute and community respiratory pathways, which will include the provision at Breathing Space.

We will develop portal technology, allowing locality teams to have full visibility of hospital patients who live in their area. Technology will play an important part in delivering this priority. We will develop local protocols for social care assessments in our community beds, specifically improving the process of managing Section 2 and Section 5 referrals. We will develop closer working arrangement on the management of EMI patients with RDASH.

The key outcomes associated with this priority are:

- Reduction in unscheduled admissions for patients within localities
- Reduction in length of stay for patients
- Reduction in the number of delayed transfers of care

How are we going to achieve our intentions?

The Community Transformation Board has been working on four key initiatives which will be fully operational within the life of this commissioning plan. These initiatives will deliver the vision for a community health service that prevents admission and supports hospital discharge. The new service model will be future proof,

meeting the demographic challenges faced by the local health economy. It will support primary care in the case management of people with long term conditions and deliver a sustainable health service outside the boundaries of hospital care. Figure 1 describes the four initiatives on community transformation

Figure 1: Summary of Key Initiatives

A Better Quality Community Nursing Service

The Community Nursing Service serves GP practice populations. Focuses on episodic support for housebound patients and the case management of people with long term conditions.

Supported Discharge and Admission Prevention

Pathway 1	Supporting patients in their own home
Pathway 2	Rehabilitation support within a residential setting
Pathway 3	Nurse led care for adults with complex care needs

An Enhanced Care Coordination Centre

Routes patients to the most appropriate level of care. Access point for GPs who require an alternative level of care for a patient. Advises on available range of services. Makes referrals, arranges placements and co-ordinates transport.

An Integrated Out of Hours Service

Takes responsibility for all community nursing activity out of hours. The service will support patients at risk of hospital admission. It will respond to issues for patients on the supported discharge and End of Life care pathways. The service will also carry out district nursing activities until locality teams are back on line

Quality Improvements

During the last year Rotherham CCG has conducted surveys of local GPs to assess levels of satisfaction with services. We have seen considerable improvement in satisfaction rates for community nursing services. The Care Coordination Service has a GP approval rate of over 90%. All services continue score highly on patient satisfaction rates.

Community health services are now subject to r a rigorous performance framework. RCCG actively monitors services on a range of indicators. In general, our community health services score well on initial response rates and waiting times.

Innovation

There are significant areas of innovation within Rotherham's current community services strategy.
The introduction of a locality structure for community nursing based on practice populations

- The development of a Care Coordination Centre which acts as a portal into community health services
- Three supported discharge pathways which can be commissioned separately
- A range of alternative levels of care targeted at patients who can be cared for away from hospital

Alignment with the strategic aims of the Health & Wellbeing Strategy

The current community health service strategy contributes to the following strategic aims identified in the Health and Well Being Strategy.

Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing ***Aim 5: Rotherham has healthy, safe and sustainable communities and places***
How will health inequalities be addressed
Rotherham CCG has recently completed a Health Equality Audit of community based rehabilitation services. It shows some inequity between localities. We are currently working with TRFT, public health and the Health and Wellbeing Board to address this and ensure that patients from areas of deprivation receive an equitable service.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
Ongoing work with a wide variety of patient groups and public consultations has reinforced the basic premise that patients want to receive care as close to home, and as conveniently as possible, as long as this is safe, and quality care is provided. This has included feedback on our plans from the Rotherham PPG network; from a focus group on case management, and informal discussions with a variety of community groups. As part of the performance framework for community health services, RCCG receives feedback from patients on the service they receive, feedback is also obtained through the patient experience tracker and via the Friends and Family Test. In addition, the feedback of carers is vital in supporting patients with long term condition, the CCG is working with carers to re-invigorate a local carers forum, it is hoped this group will contribute to discussions going forward. This year the Community Transformation Board will be developing a Patient Engagement Strategy to ensure that, as services change, we receive feedback from patients on impact. The strategy will also consider ways in which we can involve patients and carers in the planning process.

21.3 Ambulance and Patient Transport Services

Lead GP	David Clitherow
Executive Lead	Keely Firth
Lead Officer	Julia Massey
Key Meeting	TBC

Why is this a strategic priority?
NHS Rotherham CCG is committed to commissioning 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 target during 2015/16. We will work with the Yorkshire Ambulance Service (YAS) to improve Red 1 and Red 2 response times so that they hit the target of 75% by the end of 2015/16. We will work with YAS 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.

5 year Strategic Direction and key priorities

We are working closely with YAS to commission in a new and innovative way to support an effective 999 service which will:

- Respond quickly and appropriately 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 in a timely manner

Commissioning of ambulance services has become much more complex. There are multiple dependencies between the services offered by YAS and the wider provision of urgent and emergency care. This requires Rotherham CCG to have much greater sophistication in commissioning, including a greater alignment of ambulance commissioning with the plans of our Urgent Care Network and alignment with national policy's imperative to provide a 24/7 healthcare service.

The time taken to pick up 999 patients in Rotherham was consistently below target during 2015. We will work with the Yorkshire Ambulance Service (YAS) to improve Red 1 and Red 2 response times so that they can improve and work towards achieving the 75% target in Rotherham by the end of 2016/17. We will work with YAS to ensure that paramedics and ambulance crews seek alternatives to A&E when transporting patients. Finally we will broaden the range of community facilities that ambulance crews can use when transporting patients.

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

There are a number of transport providers commissioned to meet patients transport needs, working with a small number of providers delivers opportunities for transport to be focused on and meeting patient's needs. Improvements have been achieved by YAS as the primary provider with strong performance year to date. Other providers continue to deliver strong performance in specific areas of service delivery.

Progress made in 2015/16

Emergency Ambulance Service

The CCG commissioned Urgent Care Practitioner Scheme has been re commissioned through 2015/16. The scheme is reducing the number of patients conveyed to ED, with 63% of patients being managed at home or through a referral to an Alternative Level of Care.

We have continued our support for residential and nursing homes to access alternative community support before phoning 999. The Care Home Support Service and Advanced Nurse Practitioners have both contributed to better outcomes for patients in residential care. This year we are working with Care homes to align GP practices with Care Homes across Rotherham. This will improve access to GP's and other Health Care Professionals reducing the need to call an Ambulance to attend.

Commissioners, invested in three schemes were to support reduction in demand; Frequent Callers, Mental Health Triage in EOC and Increased Clinical Advisors in NHS 111. The Frequent Callers projects identifies frequent callers to the service and works with their GP and other health services to ensure their needs are met in a more appropriate way. Commissioners invested in Mental Health Nurses within the 999 call centre to triage call and refer patients to the most appropriate Mental Health intervention. These initiatives have delivered a reduction in activity and small improvements in performance.

Patient Transport Services

Activity with YAS is continuing to reduce with an in year reduction of 8.7%, this continues the trend of previous years. The Renal transport contracts continue to provide a high level of service provision and patient satisfaction.

We have been working closely with transport providers and 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. We will commission additional transport support during periods of high demand to ensure the acute trust bed flow is managed efficiently

We have successfully moved existing activity from the hospital, extending Patient Transport Services so that it is able to transport eligible patients to Intermediate Care, Breathing Space, Community Rehabilitation Services, Residential Care and community based outpatient clinics. Rotherham Fast Response service has access to transport services through UK Event Medical, which mean that patients with an urgent health need can be transported to alternative levels of care without delay.

A new transport provider has been commissioned to ensure journeys for NHS Rotherham CCG patients outside the South Yorkshire boundary are undertaken in the most cost effective way. This has, in accordance with last year's plan, removed the need to place journeys with arms-length private providers at significant cost. The CCG working with other South Yorkshire CCG's have commissioned a review of existing PTS services, which will report in early 2016.

Plans for 2016/17 and 2017/18

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

Emergency Ambulance Service

There is scope for ambulance service providers to develop in a way which affords them greater opportunity to deliver planned as well as unplanned care. We will work with our commissioning colleagues to review the current commissioning arrangements and work towards a more coherent approach to specifying services through a vision for ambulances which potentially places them in the heart of a whole system response to urgent and emergency care

Whilst activity within the 999 contract has reduced during the first two quarters of 2015/16 we will partake in a Yorkshire & Humber wide review of Urgent Transport to ensure future services are cost effective and support the provider in achieving RED 1 performance

The CCG will continue to work with other CCG's from across Yorkshire and the Humber to develop effective ways of commissioning ambulance service across the identified geographical areas of the Yorkshire and Humber.

Patient Transport Service

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 review and re launch 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 evaluate the GP Urgent Transport Pilot currently delivered by UK Event Medical and make a decision about whether to embed this in the urgent care pathway.

The CCG will consider the need to procure the current PTS service. The decision on whether to test the market on this service area will depend on:

- Legal framework relating to procurement of clinical services
- Current performance challenges relating to the current service
- Strategic relevance and potential impact on commissioning plan priorities

How are we going to achieve our intentions?

The CCG will streamline the commissioning of Ambulance and PTS services. Sheffield CCG will continue to

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.

NHS Rotherham will develop a local performance framework which oversees local performance, service development and implementation of the local commissioning plan

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

Emergency Ambulance Service

The Ambulance Quality Indicators (AQIs) were introduced in April 2011 for all ambulance services in England and look at the quality of care provided as well as the speed of response to patients. The AQIs are ambulance specific and are concerned with patient safety and outcomes. YAS continue to deliver a strong performance in AQI's and commissioner will continue to work with YAS to ensure the correct Patient Pathways are accessible to ensure a smooth transition of care.

Patient Transport Services

In order to deliver a high quality efficient service we worked with the main provider to implement a new complex patient algorithm. The algorithm will improve the booking process for clinicians and ensure the correct mobility and therefore transport is booked. This will reduce the number of cancelled and abort journeys due to incorrect mobility assessment by the end of 2015-16.

We have undertaken real time studies which provided recommendations on what improvements can be made to reduce the delays on wards when collecting patients for discharge transport. The provider is working collaboratively with our colleagues within the Acute Trust settings to implement any changes which can bring about the improvement to the patient experience.

Innovation

Rotherham CCG will be working in collaboration with Sheffield CCG, Doncaster CCG and Barnsley CCG to undertake a wide review of Patient Transport Services. The review will produce a map of existing provision and develop a needs analysis for the next five years. The review will ensure that specifications for services going forward include clear evidence based clinical standards to support the required patient outcomes. The review will result in a specification for future services reflecting changes in models of provision, patient choice, clinical standards and logistical issues relating to patient needs, hospitals and community settings, geography and patient mobility. This will enable commissioners to have a clear understanding of current and future requirements for patient transport services when designing and procuring the service.

<u>Calls to 999 and 111 will undergo Clinical Triage Before an Ambulance or A&E Disposition is made</u> – YAS has a strategic vision to develop an integrated call centre, and clinical advice integration is part of the YAS Transformation Programme for 2015/16. Currently YAS provides NHS 111 and 999 clinical advice through both services through a) Clinicians in the 999 Emergency Operations Centre working 24/7 and b) NHS 111 has successfully piloted a variety of clinical intervention models to support clinical triage of ambulance referrals.

<u>See and Treat in Ambulance Service</u> – The Paramedic Pathfinder scheme provides paramedics with an algorithm base assessment tool for them to use to support non-conveyance decision making. The tool allows Paramedics to see and treat patients on scene with confidence, to refer to alternative levels of care and to admit patients directly to surgical/medical wards. This is now embedded in the 999 service provision from YAS in Rotherham.

<u>Reduction in Conveyance for Falls from Care Homes</u> – The following steps are underway to support the management of falls in care homes so that people are not conveyed by ambulance to hospital when

appropriate. The Rotherham Care Home Support Service has developed a system to support all care homes with the necessary interventions and protocol following a fall; immediately following a fall care home staff will contact 111 or an Advanced Medical Practitioner in the first instance. Follow up support for people who have fallen includes a multi-factorial falls assessment, bone density assessment and interventions and exercise regimes to prevent falls. YAS also provide education and advice to care homes to offer alternatives to calling 999 for falls.
Alignment with the strategic aims of the Health & Wellbeing Strategy
Aim 3: Health and Wellbeing Priority - All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life The Mental Health nurses in the 999 call centre will support the population of Rotherham access the correct mental health services in a timely manner. Reducing the need to attend ED inappropriately. For those patients whom attendance at a care facility is appropriate we have pathways in place to ensure they are transported to the most appropriate acre setting. ***Aim 4: Health and Wellbeing Priority - Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing*** 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. The innovative work with Frequent Callers to the 999 service will ensure that s patients access the most appropriate treatment in a timely manner to improve their patient outcomes.
How will health inequalities be addressed
The nature of commissioning and delivering transport services provides challenges in terms of addressing health inequalities. The eligibility criteria used by providers ensures patients have equitable access to services. We work closely with providers to ensure their service delivery is equitable within the framework of the criteria.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
We receive some, but limited feedback on both ambulance and patient transport services. Little data is collected through the Friends and Family Test; however some patient feedback is received through Healthwatch, which demonstrates both positive experiences, and some that could be improved. The joint review of Patient Transport Services will have a strong focus on patient needs. It will require meaningful engagement with patients in order to be clear about the factors which are important to people. We will plan targeted engagement with service users to provide commissioners across South Yorkshire with a clear understanding of current and future requirements for patient transport services to enable us to design and procure an innovative service, planning work on this is due to start in January 2015

21.4 Clinical Referrals

Lead GP	Anand Barmade
Executive Lead	Ian Atkinson
Lead Officer	Janet Sinclair-Pinder
Key Meeting	Clinical Referrals Management Committee (CRMC)

Why is this a strategic priority?
The CCG funds hospital inpatient and outpatient services. 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. Services planned in advance are called scheduled care. Keeping within affordable limits requires a step change in the efficiency of unscheduled care, 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.

Rotherham's health service bench marks favourably in the use of one stop shops and day case procedures and historically has had relatively short waiting times. The system benchmarks less favourably in terms of admission and re-admission rates. Lengths of stay have substantially reduced over the last decade in line with national trends. Upward pressure on referral rates comes mainly from 'other' referrals, referrals from A&E, between consultants and from other clinicians, GP referrals are more stable.

In 2016/16 the CCG spent £XX million on scheduled care. Planned spend for 2016/17 is £XX million.

5 year Strategic Direction

One of the key deliverables to enable Rotherham CCG to transform elective care over the next five is to ensure that all clinical pathways are efficient, offer high quality services and provide patients with the best possible experience. It is recognised that too many health problems are dealt with by hospital admission; coupled with an ageing population in Rotherham who are experiencing more years of ill health with multiple long term conditions, Rotherham's health service needs to be reshaped to meet the needs of its population more effectively.

Building on the successful use of clinical referrals management as a vehicle for change, the CCG will continue to develop the most appropriate and efficient clinical management of patients whose condition requires elective referral to hospital or result in emergency admission or assessment. 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. Keeping within affordable limits requires a step change in the efficiency of non-elective care, to achieve this in some cases we wish to increase elective care particularly where more accessible services avoid the need for hospital admission; this includes the development of one stop services and the development of new ways of working/pathways.

In other areas we are using an educational approach to reduce the need for hospital inpatient care by promoting self-care, management in general practice and non-face to face referrals such as virtual clinics.

The work of CRMC will also continue to focus on ensuring the evidence base is fully utilised to gain assure that the appropriate thresholds for treatment are being applied across commissioned services. Where pathways are identified which do not meet the evidence base for clinical threshold or patient outcomes then the CCG will consider re-commissioning.

Progress made in 2015/16

Throughout 2015/16, the CCG has continued its approach on clinical leadership and peer influence with both primary and secondary care clinicians. Work has progressed with all referring and receiving clinicians to emphasise the importance of ensuring outpatient, elective and non-elective activity is kept within affordable limits and provides mechanisms to enable this to be achieved through the Clinical Referrals Management Committee.

Principal achievements of the CCGs approach to referrals management during 2015/16 include the following:

1. Focus on the follow up reduction programme with The Rotherham Foundation Trust where contracted ratios at peer average have been agreed at which any activity over these levels will not be financially supported. The programme includes the managed transfer of a proportion of follow ups into Primary Care;
2. Continuation of the haematology virtual clinic,
3. Development and implementation of an IV Therapy pathway to manage patients within the community who require IV antibiotics and other medication to prevent the need for admission to hospital or to allow earlier discharge from hospital.
4. Successful transfer of anticoagulation management to Primary Care for stable patients.
5. Continued educational approach taken with GP Practices through the use of top tips advice and targeted support to those GP Practices with the highest referral rates for non-elective and elective pathways.
6. Embedding the outcomes of joint clinical audits to support The Rotherham Foundation Trust to change

clinical practice through increased support for Junior Doctors when making discharge decisions, reductions in Consultant to Consultant referrals and encouraging clinicians to look at alternative methods of delivery to reduce follow up appointment and emergency admissions.

7. Development and implementation of a prior approval process applicable to particular procedures within certain specialities. Exceptional cases/procedures included tonsillectomy, grommets, varicose veins and hysterectomy for heavy menstrual bleeding which are recognised procedures of limited clinical value (PLCV).
8. In order to improve outcomes for people with Diabetes and to increase and standardize quality of care, RCCG has looked at a number of best practices which have evolved nationally and which indicate what good diabetes care looks like. The RCCG has decided to base the Rotherham Diabetes Care model around the Portsmouth care model which focuses around "super six" care.

Plans for 2016/17 and 2017/18

The CCG will continue to build on successes in improving care pathways and providing top tips advice to clinicians about elective and non-elective referrals. We will continue to ensure the avoidance of unnecessary hospital follow-ups by continuing to set challenging but achievable new to follow up ratios and further develop the use of virtual clinics. Where pathways are identified which do not meet the evidence base for clinical threshold or patient outcomes then the CCG will consider re-commissioning.

The CCG will continue to strive to achieve maximum patient outcome and quality of care for patients requiring elective care services that are commissioned by the CCG. To achieve this aim going forward the CCG may require the introduction of a range of required pre-habilitation prior to surgery on some specific pathways.

The proposed 2016/17 changes in activity and to 2018/19 in key programme areas are:

- We will increase annual growth in outpatient firsts to 2.9% in line with the assumed forecast outturn for 2015/16 plus 1% growth (1%/year to 2018/19)
- We will hold follow up ratios at the peer average set in 2015/16 (0%/year to 2018/19)
- We will keep the annual growth in electives to 1.5% (1.5%/ year to 2018/19)
- We will increase annual growth in direct access diagnostics to 13.4% line with the assumed forecast outturn for 2015/16 plus 2.5% growth (2.5%/year to 2018/19)
- We will reduce non-elective admissions from 2015/16 forecast outturn in line with 0% growth and hold this level for the foreseeable future (0%/year to 2018/19)
- We will keep the annual growth in non-elective assessments to 1% (1%/year to 2018/19).
- We will reduce the annual growth for non-elective excess bed days by 28% in line with the assumed forecast outturn position
- We will reduce the A&E activity by 0.4% in line with the forecast outturn position (0%/year to 2018/19)

Key priorities will include:

1. Referral analysis, alternative ways of working and two way communication with all clinicians
   a. Monthly programme of clinical audits concentrating on the specialities and modes of referral that are experiencing most growth.
   b. Specialty specific discussion of areas identified by benchmarking or changing trends.
   c. GP communication/education; bite size newsletter, protected learning time, top tips, GP peer led visits.
   d. Communication with TRFT clinicians
   e. Extension of one stop services and virtual clinics
2. Care Pathways (including some with System Resilience Group and Mental Health QIPP Committee)
   a. Priority areas to be jointly agreed
3. Explore long term potential for radical changes to specific elective pathways
   a. Explore different models of delivery for specific pathways, possible examples being single point of access for MSK/Physio/T&O, diabetes and pain services.
   b. In order to improve outcomes for people with Diabetes and to increase and standardize quality of

care, RCCG has looked at a number of best practices which have evolved nationally and which indicate what good diabetes care looks like. The RCCG has decided to base the Rotherham Diabetes Care model around the Portsmouth care model which focuses around "super six" care.

4. Consider commissioning options keep activity within affordable levels
   a. Development of 'least worst' commissioning options if non-elective and elective activity does not keep within affordable levels. We will discuss these options further with patients, clinicians and stakeholders before deciding.

How are we going to achieve our intentions?

Policies and efficiency programmes for scheduled and unscheduled care pathways are agreed at the 4 weekly Clinical Referral Management Committee (CRMC) which is attended by four GPs, TRFTs Clinical Directors and Head of Contracts and Business Development. The CRMC reports to the multiagency System Resilience 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.

1	**Benchmarking, trend analysis, and two way communication with all clinicians**	1. Regular review of trends in GP referrals, consultant referrals, A&E referrals, other referrals and elective activity. 2. Programme of clinical audits concentrating on the specialities that have been identified as having the largest scale opportunities for change as a result of increasing demand, potential for different ways of working and have all been identified as priority areas for CRMC. 3. Specialty specific discussion of areas identified by benchmarking or changing trends. 4. GP communication/education; bite size newsletter, SCE newsletter, protected learning time, top tips/map of medicine guidelines, GP peer led visits. 5. Communication with TRFT clinicians	
2	**Two way dialogue with all clinicians on benchmarking, trends and improved care pathways**	1. Better information on self care 2. More fast track services such as the successful fast track gynaecology service 3. More one stop services including continuing Paediatric rapid access. 4. Potential restrictions to elective procedures such as minor skin surgery, varicose veins, tonsillectomy, hysterectomy and thresholds for hip and cataract surgery 5. Potential for 'other referrals' to be redirected via back to GPs 6. Strengthened educational approach through return of poor quality and inappropriate referrals	
3	**Outpatient follow up reduction programme**	1. Reduction in Follow ups 2. Secondary to primary care Locally Enhanced Service	
4	**Diagnostics**	1. Reduction in duplicate and inappropriate diagnostic testing	
5	**Care Pathways (including some with System Resilience Group and Mental Health QIPP Committee)**	1. COPD 2. Cardiology / CVD 3. Children's care pathways 4.	5. T&O/MSK 6. Dermatology 7. Dementia (with Mental Health QIPP group)
6	**Safe effective non face to face**	1. Review of current virtual Haematology and consideration of extension to other specialties, e.g. Fracture clinic and thyroid virtual clinics	

	'referrals'	2. Explore ways of making it much easier for GPs and consultants to communicate speedily with each other including the best electronic and management systems to make this possible and ways of funding consultants to provide more advice and less face to face contacts
7	**Explore long term potential for radical changes to specific elective pathways**	Explore the market with regard to the possibility of some elective pathways being provided by providers using GP expertise and funded outside of PBR mechanisms. Possible examples to be explored are year of care funding for diabetes or alternative ways of providing some neurology, dermatology, heart failure, cardiology, orthopaedics and pain services.
8	**Consider restricting some services to keep activity within affordable levels**	On page 11 we set out a list of 'least worst' options for restricting services that we will consider if non-elective and elective activity does not keep within affordable levels. We will discuss these options further with patients, clinicians and stakeholders before deciding.

Quality Improvements

Patient experience will be improved by enhancing the quality of referral information to consultants, avoidance of unnecessary follow ups and delivery of the right care at the right time in the right place by emphasising the need to avoid hospital admission and/or keep patients under hospital care management for prolonged periods of time.

Innovation

Areas of innovation include the development of a virtual Fracture Clinic and virtual Endocrinology Clinic. These clinics prevent patients from having to attend unnecessary outpatient clinic appointments, direct patients to the right place at the right time and provide a specialist advice facility to GPs to be able to safely care for patients in the community without the need for referral to hospital.

We are also working to develop a Diabetes Care Model with an emphasis on care closer to home which should be ready for implementation by 2017.

Alignment with the strategic aims of the Health & Wellbeing Strategy

Aim 5: Rotherham has healthy, safe and sustainable communities and places **-** Quick access to high quality, evidenced based health care interventions are essential to ensure people start, develop, live, work and age well. Ensuring people are cared for at the right time in the right place by emphasising the need to avoid hospital admission will support increased life expectancy.

How will health inequalities be addressed

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.

What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?

Many changes the CRMC group makes are rapid educational changes designed to resolve issues that patients have flagged up to clinicians that are not working optimally, other changes are positive quality improvements through the use of clinical benchmarking.

We will continue to explore the use of decision support tools and materials so that patients can be better informed of the factors to take into account when they considering whether they need to see a specialist, and ensuring that patients play an active part in decision making and their own care pathway

When we make substantial service re-designs we will ensure that providers and the CCG have involved patients in the initial decision making and subsequent evaluation, and that we consult with or inform patients as appropriate, and in line with national guidance and best practice.

If our current consensual educational approach to referrals management fails to keep referrals within affordable levels, we will have to make more restrictions to referrals. In this case we would consult proportionately to the scale of the restriction that was being introduced.

21.5 Medicines Management

Lead GP	Dr Avanti Gunasekera
Executive Lead	Ian Atkinson
Lead Officer	Stuart Lakin
Key Meeting	Medicines Management Committee

Why is this a strategic priority?

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 is, 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 2014/15 the CCG will spend £45.2 million on prescriptions and on commissioned services (nutrition and continence). The 2014/15 uplift was 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.

5 year Strategic Direction

We aim to improve the health and wellbeing of Rotherham by ensuring pharmacological interventions evidenced to improve mortality and reduce morbidity are applied with equity across all practices. Prescribing costs will be maintained within affordable limits and we will maximise benefits to patients from the appropriate use of medicines.

Medicines Waste has been highlighted as a significant area of concern by patients and carers across Rotherham, and we will work across all elements of the prescribing chain to decrease medicines waste, this includes our recently launched Medicines Waste campaign.

We will continue to work with Rotherham practices to deliver six medicines management service redesign projects that improve services to patients and produce efficiency savings, these are:

1. Nutritional Supplements
2. Nutritional Gluten Free and Specialist Feeds
3. Wound Care
4. Stoma Care

5. Continence
6. Oxygen

	Workstream	Project
1	**Cost efficiency programmes**	• A 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" • The CCG is undertaking a procurement for the direct purchase and supply of wound care products this will be completed by January 2015. This direct purchase of dressings will enable ▪ Wound care products to be available whenever the patient requires them ▪ Encourage evidence base wound care management ▪ Increase District Nurse Patient contact time ▪ Facilitate discharge into the community ▪ Contain wound care prescribing costs • The CCG is launching a prescribing waste scheme direct to the public in collaboration with Doncaster CCG in February 2015.
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 intends to continue the current prescribing incentive scheme which rewards practices for improving the quality of their prescribing and also for cost effective prescribing.
4	**Prescribing Guidelines**	Key priorities include supporting practices with the implications of the NICE guidance on atrial fibrillation and lipid management
5	**RDASH prescribing pathways and share care agreements**.	• 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.

Prescribing guidelines will be incorporated into clinical pathways and pathway\service redesign initiatives and we will work closely with Secondary care collages on the introduction of biosimilars and specialist drugs.

We will improve prescribing benchmarking against other CCGs with regard to cost and quality

Progress made in 2015/16

- Deliverance of the 2015/16 prescribing QIPP programme.
- Consistent progress has been made against the antibiotics quality premium.
- The awarding of a contract for wound care products and the implementation of a wound care direct purchase scheme across Rotherham (District nurses, nursing Homes, GP Practices)
- Introduction of the Blu-teq system for managing the prescribing of drugs outside of tariff.
- A medicines waste campaign has recently been launched.

Plans for 2016/17 and 2017/18

As above note:

- Improving the health and wellbeing of Rotherham by ensuring pharmacological interventions evidenced to improve mortality and reduce morbidity are applied with equity across all practices.
- To maintain prescribing costs to within affordable limits.
- To facilitate and mentor the introduction of practice employed pharmacists to work in practices.
- To ensure that the service redesign initiatives continue to deliver both patient and financial benefits.
- To improve the management of "drugs outside of tariff" and specialist drugs.

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, the Local Pharmacy Committee Chair and the CCG's medicines management team. The MMC reports to the multi-agency system resilience 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:

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.

Quality Improvements

- The Key Prescribing Indicators 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.
- Evidence that the waste campaign has been effective.
- The antibiotic quality premium has been achieved.
- Completion of the wound care direct purchase scheme. This project improves patient experience by identifying significant unmet need, it has improved timely access to dressings for patients and decreased the time spent by nurses obtaining dressings via prescriptions.
- The nutrition, continence, stoma and oxygen projects continue to work with their patient service user groups to improve the customer focus of the service.

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, continence and wound care 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.
- The medicines waste campaign focused on obtaining the patients experience and seeing waste from the patient's experience. The campaign is designed to gather intelligence as to why waste occurs and as a result a range of bespoke interventions will be implemented to address these issues.
- The CCGs Medicines management Team will work with practices to help recruit mentor and train pharmacists to work directly in practices to address the potential workforce issues going forward due to GP retirements.

Alignment with the strategic aims of the Health & Wellbeing Strategy

Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing **-** The key prescribing indicators which are actively monitored and incorporated into the practices prescribing action plans. These indicators are based a series of prescribing interventions proven to improve mortality reduce hospital admissions.

How will health inequalities be addressed

- 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
- Practice prescribing budgets incorporate deprivation into the budget setting mechanisms, therefore practices with a relative high deprivation scores are not penalised financially.

What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
An extensive patient engagement exercise was undertaken in designing the medicines waste campaign. It is intended that this level of patient engagement will continue to discuss the impact of the campaign and how it should develop. The service redesign projects have all established a patient/service user group provide feedback and inform on future developments. Additional engagement have included: • work with carers of people with mental health problems, to identify areas of concern and solutions; • using links through Rotherham Participation Group Network to disseminate information via community channels

21.6 Mental Health

Lead GP	Russell Brynes - Adults Mental Health including Older People Richard Cullen – Children and Adolescence in Mental Health (CAMHS)
Executive Lead	Ian Atkinson
Lead Officer	Kate Tufnell
Key Meeting	Mental Health / Learning Disability QIPP Group

Why is this a strategic priority?
One in four adults experience mental illness at some point during their lifetime. Mental ill health is the single largest cause of disability in 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. The overarching priority is to deliver 'parity of esteem' - ensuring that people with mental health problems are treated with the same priority and urgency as people with physical health problems. The CCG carried out a fundamental review of mental health services in 2014 which showed there is still some way to go with regards to full delivery of parity of esteem hence the needs for transformation plans described below. The fundamental review showed that Rotherham benchmarks favourably with regards to the overall proportion of the budget that is allocated to mental health. In addition the CCG made £1.5 million of additional recurrent mental health investments in 2014/15, mainly through the Better Care Fund. The CCG will ensure that in 2015/16 its total spend on mental health (with all providers including general practice and the voluntary sector) will grow in line with the CCGs overall allocation increase. In 2014/15 the CCG spent £33.5 million on mental health, planned spend for 2015/16 is £34 million.
5 year Strategic Direction
Children and young people mental health (CAMHS) The national 'Future in Mind' (2015) strategy for Child and Adolescent mental health services, outlined the government's plans for transforming the 'design and delivery of a local offer of services for children & young people with mental health needs'. The key themes of the report were: • Promoting resilience, prevention and early intervention. • Improving access to effective support – a system without tiers. • Care for the most vulnerable. • Accountability & transparency. • Developing the workforce.

The national strategy extends to 2020 and the CCG has developed our CAMHS Local Transformation Plan (LTP) in response, this plan outlines the key priority areas for service development in Rotherham. These are:

- Enhanced Crisis Service
- Enhanced Community Support Service
- ASD Support
- Prevention/Early Intervention
- Family Support
- Workforce Development
- Services for 'Hard to Reach Groups'
- Looked After Children
- Development of services through input from Children & Young People
- Child Sexual Exploitation
- Transition to adult services

These key priority areas were identified in consultation with all stakeholders across Rotherham and in particular from work specifically with children & young people.

Adults and Older people

In 2015 the CCG developed an Adult and Older Peoples Transformation Plan LINK has eight key priorities:

- Improving data, pathways and outcomes
- Improved strategic and partnership working including workforce
- A newly commissioned Adult and Older Peoples Mental Liaison service that will ensure that mental health provision is a central component of the new Rotherham Emergency Care model.
- A more primary care focussed model
- Improved dementia Care pathway (including the delivery of % of patients diagnosed per expected population)
- Improved transfers between RDASH and community services
- Improving access to psychological treatments (IAPT) (6ww and 18ww targets)
- Improved acute and rehabilitation pathway

In addition to the initiatives identified in the Mental Health Transformation plans the CCG will ensure that the following are delivered through the 2015/16 contract.

- Mental Health Choice - working with GPs and providers to ensure that patients are aware of their rights and are offered choice in mental health services and supported to make meaningful choice
- Greater parity for mental health by working to implement the new access and waiting times standards for mental health including psychological treatment waiting time standards and ensuring that by April 2016 50% of Rotherham people experiencing a first episode of psychosis will receive treatment within two weeks.

This will also help the CCG to work with partners to deliver the Crisis Care Concordat (http://www.crisiscareconcordat.org.uk/areas/rotherham/) – improving outcomes for people experiencing a mental health crisis. Working with NHS England and RDASH the CCG will develop health provision for local offenders as part of the NHS England Wave 2 Liaison and Diversion Pilot.

The CCG has commissioned additional support for historic victims of child sexual abuse and will respond further as recommendations emerge from the multiagency needs assessment described in section 6.2.

The first year evaluation of the Acute Alcohol Liaison service showed some success in reducing length of stay as the service develops in 2014/15 we expect to see it start to reduce admissions.

Progress made in 2015/16
CAMHS During 2015/16 the CCG invested an additional £200k in RDaSH CAMHS services. This included £80k in additional therapy and general capacity, £55k in a CAMHS liaison post, £30k in the out of hours service and £35k in a single point of access (SPA). The new CAMHS liaison post has worked with TRFT to agree new mental health pathways through A & E and has worked with NHS England on CAMHS Tier 4 step-up and step-down. The CCG has worked closely with RDaSH on the CAMHS re-configuration which will provide a more locality focus and enhanced SPA and Crisis Response. Additional general capacity has re-enforced the CAMHS Duty Team and this will further develop as a SPA. The CCG has forged better links with children & young people (and their families) through interface with the Youth Cabinet and Youth Parliament and indirectly through work with the Rotherham Parents Forum and Healthwatch. The CCG also worked with RMBC to develop a CAMHS website – www.mymindmatters.org.uk – for Children & Young people, families and professionals. This is regularly updated. Adult and Older People Over the last 12 month progress has been made in the implementation of the Adult Transformation plan with key achievements including: • Dementia Carer resilience Service – established in April 2015 this service is designed to work with GP practices to support those caring for people with dementia. Already this new approach to supporting carers has been successful in being put forward as a regional finalist for the Putting People First / personalisation category of the Great British Care Awards • Mental Health Social Prescribing - building on the success of the social prescribing programme an additional mental health social prescribing pilot was established in 2015/16. To date **awaiting data people have been referred to the new mental health social prescribing path with ** people successful being discharge from secondary care service. • Adult Mental Health Liaison (7 day working) and Police Street triage both of which are key parts of the work the CCG is doing with partners to deliver the Crisis Care Concordat within the borough http://www.crisiscareconcordat.org.uk/areas/rotherham/) . In 2016/17 further work will be undertaken to expand this service to include Children and young people to create an all age service More details needed. • Dementia Diagnosis rates – The CCG currently achieves higher than expected (compared to the expected population diagnostic rate) Dementia Diagnosis rates, in 2016-17 we will continue to build on this positive position as well as work to ensure the delivery of high quality post diagnostic health support. • Dementia LES – In 2015-16 the CCG developed a Dementia Diagnosis LES, in 2016-17 we will look Work is ongoing to agree the implementation with Primary Care colleagues across the borough with the expectation that this will be rolled out during 2016/17 • During 2015/16 the CCG worked with RDaSH to ensure the reduction in DNAs across adult services
Plans for 2016/17 and 2017/18
CAMHS During 2016/17 and 2017/18, work will continue on the key elements of the CAMHS LTP. These area:- • An enhanced crisis service – which will link to the Adult Liaison service at TRFT in-hours and the Crisis/Access service out of hours. This will also link to the local Crisis Care Concordat and the change by South Yorkshire Police to not detain children or Young people in a police cell. • An enhanced community support services (Tier 3+) - which will support Children & Young People to either avoid an inpatient admission or step down more quickly back into community services. This will aim to reduce the costs of inpatient activity for Rotherham patients and enable them to remain locally based and

supported in the community.

- Enhanced ASD support, particularly family (rather than school) based and will complement the service provided to school by the Autism Communication Team at RMBC. This is a recognised gap in provision.
- Support work with schools (through the CAMHS locality workers) to provide early intervention work. The CAMHS re-configuration identifies specific CAMHS Locality Workers who will link with local schools and support working with mental health issues. This should help to provide more focused early intervention services.
- Further development of a Family Support Service, through the Rotherham Parents Forum. This will focus on supporting families of children with emotional wellbeing and mental health issues before and once they access services. Such work will enable families to cope better with their children's emotional wellbeing and mental health conditions and avoid more severe issues.
- Further ongoing support for Children & Young people affected by CSE. This will supplement the established investment by the CCG.
- Provision of advocacy services for children through Healthwatch. This service previously has been provided on a non-commissioned 'ad-hoc' basis. This work will provide a resilient and ongoing service and enable the voice of children to be heard.
- Ongoing development of the CAMHS website – www.mymindmatters.org.uk – to include potential Apps, self-help elements, training (for professionals, etc.).
- Implementing a CAMHS Transition specification, to ensure that patients have a smooth journey when transitioning from CAMHS to Adult services (including also Learning Disability patients) and undertaking work to ensure how this process can be improved.

Adults and Older People

- Delivery of Adult transformation plan – phase one and two
- Working with partners to ensure the delivery of the Crisis Care Concordat (http://www.crisiscareconcordat.org.uk/areas/rotherham/) across the borough. The aim of which is to iimprove the outcomes for people experiencing a mental health crisis through the delivery of services / initiatives, such as – Adult Mental Health Liaison Services, improvements in the crisis care pathway, development of crisis care plans etc.
- Improve access and waiting times for both the early intervention in psychosis and IAPT services to ensure the delivery of the national waiting times targets
- Improve the delivery of the Eating disorders pathway by working with colleagues from Doncaster and North Lincolnshire CCG to enhance the current provision.
- Working with colleagues from TRFT, RDaSH, primary care, Voluntary sector and patients to develop a new Perinatal pathway
- Works with primary care and RDaSH to implement the delivery of the Dementia diagnostic local enhanced service (LES)
- SMI registers and physical health
- Support people towards recovery through delivery of the mental health social care pathway.
- Review of existing inpatient provision at Woodlands to ensure that capacity matches demand.

How are we going to achieve our intentions?

The CCG has strategic commissioning forums well established for both CAMHS and Adult Mental Health Services. This involves CCG clinicians, RDASH and key stakeholders from RMBC and TRFT.

Quality Improvements

CAMHS:

Quality improvements link to the plans outlined above and include:-

- More focused and timely response to Children & Young People (C&YP) in Crisis. The Key Performance Indicator (KPI) will be that all C & YP will be seen within 1 hour of presenting in A & E.
- C&YP will be able to be better supported in the community and if they have to be admitted to an inpatient bed, they will be able to be discharged sooner.
- Families will have better support in general when C&YP are entering services and more specific support where their children have ASD.
- Schools, colleges, GP practices and RMBC Early Help centres will have clear direct links to the RDaSH

CAMHS service through CAMHS Locality Workers, enabling C&YP to be directed to the most appropriate services for their situation.
- A dedicated advocacy service for C&YP.

Adults and Older Peoples Mental Health Services:
- Improve the quality of patient and GPs satisfaction of services (15/16 target)
- Improved patient experience measured by the Friends and Family test
- Increase the number of people moving to recovery X % of people referred to the mental health social prescribing pathway will be discharged from secondary care services
- Improve access and waiting time for mental health services including Psychological Therapies (IAPT) (15/16 target) replaced with 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral
- Improving the access times for people experiencing a first episode of psychosis replaced with 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral (national target for April 2016)
- Improving the outcomes of care for people experiencing a mental health crisis (15/16 target) replace with either Reduction in the number of patients attending an A&E department for a mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E (2015/16 quality premium) – or could modify this to % of people seen within 1 hour – current local target / or use the new psychiatric liaison target – we are expecting)
- Improve dementia diagnosis rates – 74% now – suggest we replace with post-diagnosis we don't really measure this / I guess we could link to the dementia carer resilience project
- Improve the support to practices and those caring for someone with dementia by ensuring that 100% GP practices will have an allocated GP carers Dementia Link worker
- Improve memory clinic waiting times for diagnosis and treatment – need to review in light of current debate
- improve dementia pathways with a more primary care focus – as above

Innovation

CAMHS
RDaSH have employed a Family Support Worker on a non-recurrent basis, but the commissioning of the Family Support service through the Rotherham Parents Forum is a new approach that will really focus on providing families with practical help, advice and support.
The further development of the liaison and crisis services will be a move closer towards a true 'all-ages' service which will eliminate the need for transition between services.

Adult and Older People
In phase one of the Adult Transformation Plan phase one the CCG has established a number of pilot projects which include:
- Dementia Carer Resilience service
- Mental Health Social Prescribing
- Adult Mental Health Liaison
- Street triage – a project to support South Yorkshire Police

All of the pilots are being externally evaluated by Sheffield Hallam University with the final evaluation reports expected in 2016.

Dementia Carer Resilience?

In phase two of the transformation plan work has commenced with partners to develop a new improved gateway into services as well as looking at how the adults and older peoples mental health teams can work to provide a locality focused all age service (Need to check language used here is ok with everyone).

Alignment with the strategic aims of the Health & Wellbeing Strategy
The Rotherham CAMHS LTP aligns with the aims of the Health & Wellbeing Strategy in that it focuses on supporting children through their adolescence and early adulthood, which can be a time when some mental health issues manifest themselves, and provides support to the whole family when dealing with such issues. Adult and Older People Aim 3: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life. This will be achieved by improving support for people with enduring mental health needs, including dementia by: • Helping them live healthier lives through initiatives, such as Dementia Carer Resilience, Mental Health Social Prescribing , supporting RDaSH to go Smoke free and commissioning a model of mental health that promotes recovery • Reduce the occurrence of common mental health problems , such as providing support, advice and training to people with dementia and their carers, working with RMBC to develop the website mymindmatters.org.uk • Reduce social isolation through initiatives, such as mental health social prescribing Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing. This will be achieved for people with mental health problems by: • Reducing the number of early deaths from cardiovascular disease and cancer by working to improve the access to physical health check for those individual's on the SMI registers • Improving support for people with long term health ,such as dementia and disability needs to live healthier lives through developments by delivering a recovery model approach to mental health • Increasing the opportunities for participation in physical activity seen in the recent investment of additional gym equipment on the Swallow nest wards. • Reducing levels of alcohol-related harm through initiatives, such as the TRFT Alcohol Liaison service • Reducing levels of tobacco use through initiatives, such as the RDaSH SmokeFree programme launched 1st March 2016
How will health inequalities be addressed
CAMHS The further development of CAMHS locality workers will ensure that all geographical areas of Rotherham are afforded equal status. A family support service which is independent of the service providers will also help to break down communication barriers with families and ensure that families' voices are heard. The commissioning of a dedicated children's advocacy service will ensure that children who might not otherwise be able to understand their situation and the services that they are supported by, will be better informed. The overarching aim of the adult mental health transformation plans are to deliver parity of esteem with the expectation that this will also include the delivery of quality physical health services and improve Health outcomes for people with mental health problems. To achieve this the CCG will: • Work with RDaSH and primary care to align the health promotion data in secondary and primary care databases for patients with severe mental illness. This is an important step in ensuring parity of esteem for health promotion for this patient group so reducing the 20 year gap in life expectancy. • Using the contract process to ensure that providers comply with the Equality Act 2010, reasonable adjustment standards, autism statutory requirement etc. • Work with partners to tackle stigma and the inequalities that result from poor mental health, such as lower employment rates, poor housing, education and poorer physical health
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
Patient feedback is received through a number of mechanisms, all are used to inform service plans, and individual issues are addressed wherever possible; • A low amount though Friends and Family Test (actions are in train to increase this) • Other data collected by providers • Directly to the CCG via patients and patient groups, and through engagement events

- Collected by Healthwatch and shared with the CCG
- Issues are raised through the Dementia Forum

CAMHS engagement
Patient engagement was a significant part of the original Emotional Wellbeing & Mental Health Strategy and the CAMHS LTP. The Youth Cabinet were involved in the development of the Strategy, the CAMHS website and LTP and the conclusions of the Youth Parliament report 'Mind The Gap', fed into the LTP. The Health Select Commission scrutinised CAMHS services in April 2015, working closely and informed by young people; the outcomes from this continue to be actioned and to feed into a variety of workstreams. Representatives of the Youth Parliament continue to be part of the Quarterly CAMHS Strategy & Partnership meetings.
Non-recurrent funding will be used during 2015/16 to support a 'self-help' conference to be hosted by the Rotherham Youth Cabinet.

Worked with partners and young people to design and establish a young people's mental health website (My Mind Matters).

The Family Support Service will enable constant patient/family engagement and feedback to commissioners and service providers.

Young people have been involved in (visiting/inspecting) inpatient accommodation and suggesting ways that services could better meet the needs of young people. Between January and March 2016 an independent assessment will be undertaken around engagement, which will identify good practice, and areas for improvement. Work with Rotherham Parents Forum and Healthwatch highlighted issues faced by both young people and their families in accessing services, and has also informed a number of workstreams including patient & family engagement, communication and Autism post diagnosis support.

Adult and Older People

Over the past year both the CCG and RDaSH has worked with people with mental health problems, families/carers and other key stakeholder to inform the development of adult services / packages of care and future planning of services, such as:

- Mental health and Learning Disability QIPP Group
- Extensive engagement from summer 2015 to Jan 2016, led by RDaSH, and including all stakeholders, focused on and informing transformational change; this pre-consultation work will inform a subsequent consultation on service changes during 2016.

Carers have told us (PPG Network and dedicated workshop) about the issues in caring for people with mental health problems, and in particular people with dementia; this has informed the Carer's Resilience Project.

We have worked with medicines management in listening to the concerns of carers of people with enduring mental health problems, and ways that these issues could be addressed.
We have commissioned REMA to explore Access to Mental Health Crisis Care by BME groups

In addition, we have user and carer representation on a number of our key planning and working groups:-

- Mental Health Social Prescribing Group
- Dementia Carer Resilience Group (monthly meetings)
- Membership by the CCG at the Dementia Action Alliance meeting (monthly meetings)
- Community and service user representation on the MH Social Prescribing Group

21.7 Learning Disabilities

Lead GP	Russell Brynes / Richard Cullen
Executive Lead	Ian Atkinson
Lead Officer	Kate Tufnell
Key Meeting	Mental Health / Learning Disability QIPP Group

Why is this a strategic priority?

In Rotherham there are 1104 people with a learning disability (311 – aged 17 and under, 793 aged 18 and over).

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. National requirements which the CCG fully supports are set out in the Winterbourne concordat.

5 year Strategic Direction

The overarching priority is the delivery of the new Learning Disability enhanced community and inpatient model. The aim of which is to improve community services for people with learning disability and their carers thus reducing the need for admission to an Assessment and Treatment Unit. The CCG is fully committed to the 'Transforming Care' agenda and will work with colleagues from across both Doncaster and Sheffield (NHS and Local Authority) to continue to drive improvement in this area of provision.

- Government Response to No Voice Unheard, No Right Ignored published November 2015
- Hidden Voices of maternity: parents with a learning disabilities speak out
- The Learning Disabilities Mortality Review (Ledger programme)
- CTR National Policy
- The National Transformation Plan & National Service Model
- Attain Review 2 recommendations – awaiting final document

Progress made in 2015/16

Over the last 12 month significant progress has been made in the implementation of the Adult Learning Disability Transformation plan with key achievements including:

- **Provision of an enhanced community team providing a seven day service across the borough**. The implementation of this new team has increased the support available to people with learning disability and their family to enable them to continue to live within the community. Need to state how many patients have move from hospital to community
- **Delivering Winterbourne requirements** – In 2015/16 the CCG has continued to work with partners to deliver the national Winterbourne standards with the introduction of Care and Treatment Review (CTR) and "at risk register" process. During this period the number of Rotherham people with a learning disability in a hospital placement has remained low, with only X admissions during this period.
- **Peer Support** - Feedback as part of the 2014/15 Public Consultation highlighted that people felt the

introduction of a peer support role as part of the Learning Disability Service would be beneficial. Working with RDaSH and Speak UP the CCG has recruited a Peer Support to work as part of the local LD team to support them to deliver training, to work as part of the Care and Treatment Review (CTRs) team and develop communication information

- **Working with Expert by Experiences** - Over the past 12 months the CCG has worked with SpeakUP a self-advocacy organisation run by and for people with learning disabilities and/or autism on a wide range of issues. These include the completion of Community Treatment Reviews (CTRs) by their Expert by Experience team and recruitment of the peer support worker
- **Supporting people to access mainstream NHS Services** – Work has continued to support people to access mainstream health services with the introduction of a Learning Disability Liaison Nurse in TRFT and supporting GP practices to extend the Annual Health Check LES to include those aged 14 – 17
- **The Joint Health and Social Care Learning Disability Self-Assessment Framework (SAF)** is an annual review process which provides people with learning disability and family carers the opportunity to review and quality assure local services against national standards. In 2015 Rotherham achieved 6 Green and 1 Amber rating against the 7 Staying Healthy Indicators. (https://www.improvinghealthandlives.org.uk/securefiles/151110_1714//Rotherham.pdf)

Plans for 2016/17 and 2017/18

Learning Disability – CAMHS & transition elements – to be confirmed

Learning Disability – Adults

- Work with partners from across the Transforming Care Partnership planning area to ensure delivery of the South Yorkshire and North Lincolnshire TCP Plan
- Move toward joint commissioning with RMBC
- Continue to review local inpatient requirements to support delivery of the nation bed planning assumptions across the SY & NL TCP footprint. Continue to develop the enhanced community team established in 2015/16
- Delivery of national Plan Targets
- Develop a Rotherham Care and Treatment Review (CTR) and 'at risk of admission' Policy
- Work with partners to ensure the delivering of the requirements of the new maternity guidance

How are we going to achieve our intentions?

The CCG will contract for community services and ATU with RDASH in 2015/16 whilst evaluating the impact of the changes made in 2014 and monitoring the bed requirements of the new service. We will require on going quality improvements. The two evaluations of the Assessment and Treatment unit will be used to inform our commissioning intentions for the 2016/17 contract.

We will continue a case management approach to individual bespoke personalised care packages to ensure patients require the services they require and that overall costs are kept in line with CCG allocations.

We will closely align our plans with RMBC's commissioning intentions for wider services for learning disabilities through a partnership agreement with RMBC, sharing commissioning intentions at the Joint LD Commissioning Executive and the LD Partnership Board (LDPB) meeting. The CCG will also work with partners from across the footprint to deliver the South Yorkshire and North Lincolnshire TCP delivery plan which is a three plan which will commence in April 2016.

The CCG will continue to explore the option of fully integrated commissioning of LD services for example with a shared budget for the whole of LD services commissioned by RMBC and the CCG. The issues we wish to address through integrated commissioning are: improved outcomes for patients; delivery against NHS England mandated outcomes; QIPP; financial transparency across the whole shared budget; and CCG running cost capacity.

Quality Improvements

- Improve patient and carer experience of services expecting national targets on this
- Increase support and quality of care – expecting national targets on this
- Reduce inappropriate admissions by ensuring that **X %** of people receive a CTR prior to a planned

admission to an Assessment and Treatment Unit or mental health inpatients

- Reduce length of stay in hospital by ensuring that **X %** of people in an Assessment and Treatment Unit receive a CTR every 6 months
- Improve access for people with a learning disability to mainstream services by ensuring that **X %** of people have a hospital passport in place

Innovation

Key innovations delivered as part of the 2016/17 Commissioning Plan include:

- Commissioning an adults service model which is less reliance on inpatient services by strengthen support in the community with the provision of a service which operated 8am –6pm, 7 days a week.
- Working with people with a learning disability and /or autism to develop and improve the quality of LD services across the borough.
- The employment of an Expert by Experience to work as a Peer Support worker with the adults Learning Disability Team

Alignment with the strategic aims of the Health & Wellbeing Strategy

Aim 3: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life. This will be achieved by improving support for people with enduring mental health needs, by:

- Improving support for people with enduring mental health needs, including dementia, to help those live healthier lives.
- Reducing the occurrence of common mental health problems
- Reducing social isolation

Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing. This will be achieved for people with learning disabilities by:

- Reducing the number of early deaths from cardiovascular disease and cancer
- Improving support for people with long term health and disability needs to live healthier lives through developments, such as the enhanced community LD team
- Increasing the opportunities for participation in physical activity

How will health inequalities be addressed

The CCG will work with partners to address health inequalities by:

- Ensuring that people with learning disabilities get good care and support from mainstream NHS services, have access to information in in formats that they can understand and they receive appropriate support to help them to communicate, in line with the Accessible Information Standards .
- Ensuring that people with learning disabilities have good access to physical health care and preventative services
- Issuing contracts that require the providers comply with the Equality Act 2010, reasonable adjustment standards, autism statutory requirements etc.

What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?

Over the past year the CCG has continued to work with people with a learning disability and their families to inform the development of adult services / packages of care and future planning of services. This is done an in variety of ways:

- Through meetings ,such as the Learning Disability Partnership Board (LDPB) and Learning Disability Partnership Board Health Sub-group
- Consultation with people with Learning Disability, their carers/families and key stakeholder as part of the Two Attain Reviews undertaken in 2015/16.
- New posts/services established (LD liaison at TRFT and Peer Support) as a result of this consultation have ongoing engagement embedded with and continuing to inform these roles.
- Working with Experts by Experience to inform the development and delivery of services, such as the Peer Support, Care and Treatment Reviews and specific piece of work completed to support service development, and including site visits.
- Working with NHS England to undertake a Health Needs Assessment to support the development of the South Yorkshire and North Lincolnshire TCP submission.

21.8 Maternity and Children's Services

Lead GP	Dr Richard Cullen
Executive Lead	Sarah Whittle
Lead Officer	Emma Royle
Key Meeting	Rotherham Children and Young People's Strategic Partnership Board

Why is this a strategic priority?

Pregnancy, birth and the weeks and months beyond, are a key time of change and development for parents, as well as for their baby. 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 developing 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.

The future of Health commissioning for children will involve much closer partnership between NHS Rotherham CCG and RMBC ensuring that the voice of the child, young person and parent is fully engaged in the commissioning process.

The important joint responsibility of RMBC and the NHS Rotherham CCG under the Care Act, such as transition assessments for 18 year olds, are summarised in section 21.12.

5 year Strategic Direction

Pregnancy, birth and the weeks and months beyond, are a key time of change and development for parents, as well as for their baby. There is overwhelming evidence that conception through to the early years is a crucial phase of human development. The mental and physical health of mothers during and immediately after pregnancy can have lifelong impacts on the child. 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 developing 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.

A number of specific priorities have been agreed through consultation with the GP Localities, for the coming years. These will focus on:

- Integration of TRFT Acute & Community Children's Services
- Potential for locality working
- Develop Children's Joint Commissioning Strategies
- Efficiency agenda (number of hospital paediatrics beds, assessment beds & rapid assessments)
- Collaboration between South & Mid Yorkshire, Bassetlaw and Mid Derbyshire hospitals children's surgery and anaesthetic services (Working Together workstream)

Health commissioning for children in 2016/17 will involve more public participation to help influence our work and we will ensure that the voice of the child, young person and parent is fully engaged in the commissioning process.

The NHS Rotherham CCG has important responsibilities to work with partners to safeguard children. These responsibilities and the specific actions the CCG is undertaking with partners regarding child sexual exploitation are described in Section 13.3. The NHS Rotherham CCG is committed to ensuring that we commission the highest quality paediatric surgical pathways for Children and Young People, we will therefore work across South Yorkshire to review current surgical pathways of care.

Progress made in 2015/16

Some of the progress made during 2015/16 is outlined below:

- Engaged in the first phase of the South & Mid Yorkshire, Bassetlaw and Mid Derbyshire hospitals children's surgery and anaesthetic services review.
- A Children's Joint Commissioning Strategy has been developed in collaboration with RMBC identifying potential areas to be commissioned jointly.
- To support joint commissioning in the future, NHS Rotherham CCG and RMBC have jointly funded a new post - Joint Assistant Director – Commissioning, Performance and Quality.
- Implementation of the Special Educational Needs & Disabilities (SEND) Code of Practice has moved forward, and a SEND Joint Commissioning Strategy with nine priorities, is out to consultation.
- Smoother transition to adult services was identified as an area of need, and we have been working with partner organisations to map the current position in Rotherham, with the aim of implementing a consistent approach across all services.
- Progress has been made on production of pathways of care to help move care into community settings, reducing unnecessary attendances and admissions to hospital.
- Continued to support the work of Public Health by contributing to work on public health priorities, including infant feeding, teenage pregnancy, foetal alcohol syndrome and obesity.
- The development and piloting of a revised antenatal parenting programme provided jointly by midwives, health visitors and children's centre staff.
- A pilot for new children's asthma plans has been undertaken in three GP practices. The results of the pilot will determine next steps. Further work will be around asthma plans in schools.

Plans for 2016/17 and 2017/18

During the next two years, we will give particular focus to ensuring that care pathways across primary and secondary care are reviewed, agreed and in place, along with 'top tips' for GPs.

The main aim of this work is to ensure 'right care, first time', prevent inappropriate attendance at A&E and inappropriate admissions to hospital. This will involve looking to increasing the number of children with complex, acute and long term health conditions being managed in community settings, closer to home. Care plans will be developed across primary and secondary care, improving patients ability to self-manage their conditions and improve transition from children's to adult services. This work has already been undertaken for asthma - diabetes and epilepsy are to follow. Communication between primary and secondary care will improve as a result of this work, giving a better experience of care for children, young people and their families.

We aim to support patients to access the 'right service, first time' by raising awareness for parents and carers 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. A revised children's acute care pathway will be implemented in time for the opening of the new emergency centre.

A review of paediatric community services will take place to assist with the updating of the service specifications and refreshing of the key performance indicators and ensure that services deliver measurable outcomes for children and young people.
Implementation of the recommendations, where possible, within Facing the Future for Paediatric Health (2015) will support this work. This will also look at the potential for locality working (paediatricians working more closely with GP localities) and improved integration of The Rotherham Foundation Trusts Acute & Community Children's Services.

Work will continue regarding the efficiency agenda (number of hospital paediatrics beds, assessment beds & rapid assessments).

Continued implementation of the SEND reforms and the Rotherham SEND Joint Commissioning Strategy will take place, working closely with RMBC and providers, including:

- Ensuring that systems are in place to ensure that children are identified early, with joint assessments and

joint Education, Health and Care Plans.

- Parents and young people who would like more control are able to apply for a personal health budget
- We will also work jointly with RMBC and other organisations to ensure that transition to adult services for children with complex needs and long term condition, is a smooth as possible.
- A review of the Child Development Centre model of working will take place.

Maternity

- We will review the choices that are locally available for women accessing maternity services. We will work with service users and the public, to consider what more can be done to offer meaningful choice. This may include choice of how to access maternity care, the type of care women receive, where they give birth and where they receive their antenatal and postnatal care.
- We will work with partners to ensure that a robust Perinatal Mental Health Pathway is in place.
- We will publish a Rotherham Maternity Strategy.
- We will continue to support the work of Public Health regarding issues such as low birth weight, infant mortality, maternal health including mental health, and teenage pregnancy.
- During 2017/18 we will carry out a review of the new maternity service specification.
- We await the results and of the national Maternity Review carried out by NHS England and accompanying recommendations.

Delivering the commissioning intentions outlined 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 polices will be written into newly designed service specifications, with clear performance indicators which we will use to robustly monitor commissioned services to help ensure positive outcomes for children and young people.

How are we going to achieve our intentions?

Delivering the commissioning intentions outlined 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 polices will be written into newly designed service specifications, with clear performance indicators which we will use to robustly monitor commissioned services to help ensure positive outcomes for children and young people.

Quality Improvements

Current service specifications are being reviewed and new key performance indicators will be agreed.

Paediatric care pathways and 'top tips' for GPs will continue to be revised and developed to improve the continuity and co-ordination of care, clinical effectiveness and communication giving a better experience of care for the patient.

The NHS England review of Paediatric Asthma Services across Yorkshire and Humber has been completed and Rotherham contributed to this. Revised asthma plans are currently being piloted in three GP practices with the aim of rolling this out across Rotherham practices and then school asthma plans within schools.

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. We will also work with NHS England and TRFT on the regional review of Epilepsy Services.

Listening to children, young people and their families/carers and new mothers and their families, will ensure that commissioning for children's and maternity services is aligned to patient needs, dovetails with RMBC priorities and meets new policy changes.

Innovation

Joint work has taken place with RMBC to produce a children's joint commissioning strategy for Rotherham. This covers a number of areas including Early Years, CAMHS and Special Educational Needs and Disabilities (SEND). From this, sub strategies are to be developed – the first of which is the SEND Joint Commissioning Strategy. The strategies will include priority areas to be implemented and monitored jointly between NHS

Rotherham CCG and RMBC.

We will work in partnership with TRFT to implement the recommendations within Facing the Future for Paediatric Health. This will involve looking at new ways of working and improved communication between primary and secondary care.

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

Alignment with the strategic aims of the Health & Wellbeing Strategy

Aim 1: All children get the best start in life. We will continue to work with RMBC and TRFT on early intervention and prevention and will contribute to the review of early help services.

Aim 2: Children and young people achieve their potential and have a healthy adolescence and early adulthood. *We are working jointly with RMBC and other organisations to ensure that transition to adulthood is as smooth as possible. Through the introduction of personal health budgets (SEND workstream) we will support children and young people with complex needs to live independent lives.*

Aim 3: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life. We are working with TRFT and RDASH to produce and updated Perinatal Mental Health Pathway that is NICE compliant and meets the needs of the women of Rotherham. Child and adolescent mental health is discussed in section *21.6*

Aim 5: Rotherham has healthy, safe and sustainable communities and places. In partnership with Public Health, we will support children and young people to lead healthy lifestyles.

How will health inequalities be addressed

Children and young people under the age of 20 years make up 24% of the population of Rotherham. The health and wellbeing of Rotherham children is mixed. Infant and child mortality rates are similar to the England average. Approximately 10% of children aged 4-5 years and 23.5% of children aged 10-11 years are classed as obese (significantly worse that the England average).

Smoking in pregnancy is known to increase the risk of a baby having a low birth weight. The percentage of babies being born with a low birth weight is higher than the England average. Whilst rates are improving, numbers of women smoking during pregnancy are particularly high. Breast feeding initiation and rates at 6-8 weeks are some of the lowest across Yorkshire and the Humber region.
Such issues have a significant effect on the future health of children. We will continue to work with Public Health to help reduce these inequalities and others, through programmes of work such as a revised antenatal parenting programme, the Infant Feeding Group and the Foetal Alcohol Syndrome Group.

Equality Impact Assessments will be carried out on all new and revised services specifications.

What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?

The Rotherham Parent Carers Forum has undertaken consultation on behalf of the CCG regarding experiences of health care, and have attended Governing Body to present this. This work has been used to inform the (currently draft) joint commissioning strategy for children and young people with special educational needs and disabilities, as well as the work taking place on new service specifications for paediatric community services. It also informed a Health event in March 2015, with around 150 people attending; and which was led by parents.

In addition, the partnership SEND 'In it Together' event took place on July 3rd 2015, with the aims of both engaging with and informing parents and young people.

A draft SEND joint commissioning strategy has been developed taking into consideration comments from the Parent Carers Forum consultation (July 2015). A stakeholder consultation strategy has been drafted (Aug 15).

Comments from the Friends and Family Test are also received on a monthly basis, which gives an overview of how people are experiencing using the services; there are specific forms for young people and parents to encourage feedback.

Work with the Youth Cabinet and Looked After Children Council has also directed work in producing a health information booklet for young people.

We have greed a new model of working for the Maternity Services Liaison Committee which involves GROW visiting Bumps and Babies Groups in Children's Centres across Rotherham to obtain comments regarding experience of all aspects of maternal care in Rotherham. A substantial amount of feedback is received on maternity services through the Friends and Family Test, which is shared with GROW and the MSLC; GROW also provide feedback via the Bumps and Babies Groups. Engagement will also be built into the work to inform a new strategy for maternity services.

The CCG is working on consulting in other ways, with children, young people and their families. This involves, for example, working with the Rotherham Young Ambassadors through Healthwatch, and also through the Integrated Youth Support Service. Much of the consultation will be undertaken in partnership with RMBC.

We will work with The Rotherham Foundation Trust to develop questionnaires and other methods of consultation for children and young people using paediatric community services, to inform development of the new paediatric service specifications.

21.9 Continuing Care and Funded Nursing Care

Lead GP	Richard Cullen
Executive Lead	Sue Cassin
Lead Officer	Alun Windle
Key Meeting	TBC

Why is this a strategic priority?

The CCG has a statutory obligation and duty to fund Healthcare for clients who are assessed as meeting NHS Continuing Healthcare need via an in-depth assessment.

NHS Continuing Healthcare can be delivered in any setting, including the patient's own home or nursing home. However the majority of NHS Continuing Healthcare funded patients are delivered in specialised homes, where the NHS is responsible for the care home fees, including board and accommodation.

If provision of NHS Continuing Healthcare is assessed as being safe to be delivered in a domiciliary settings, then NHS pays for healthcare through mainstream services such as community nursing or specialist therapists, and is responsible for supplementing care from contracted domiciliary care providers, however is not responsible for 'board and accommodation' fees.

5 year Strategic Direction and key priorities

The CCG has a statutory obligation and duty to fund Healthcare for people who are assessed against eligibility criteria for NHS Continuing Healthcare, NHS Funded care and Children's Continuing Care.

Therefore the CCG has to build upon the extensive quality work undertaken to continue to deliver specialist assessment of needs and effective decision making on eligibility against contemporary frameworks published by the Department of Health.

The CCG will with local partners continue to develop and extend the personalisation agenda for patients eligibly for Continuing healthcare, joint assessments and decision making.

Progress made in 2015/16

Key delivery changes undertaken have streamlined the service and reduced timescales within the process.

The community 'End to End' service ensures that each patient receives a dedicated nurse who leads and supports the patient from a referral to completion; any further review is undertaken by the same dedicated nurse.

The 'End to End' process commenced in the community has developed to include patients in the acute setting, significantly reducing the time spent in acute beds and facilitating early discharge.

National recording data for Continuing Healthcare has resulted in Rotherham significantly improving its position against other CCGs nationally. The current position is 103 out of 211 CCGs which indicates that Rotherham has moved to a more positive average position of activity and costs per 10,000 population in England.

Plans for 2016/17 and 2017/18

To continue to assess, fund and commission reasonable care packages that meet patient's needs with a focus on personalisation and commissioning for both eligible adults and children.

To assess patients for CHC eligibility in line with the requirements of the national framework for NHS Continuing Healthcare, NHS Funded Care and Children's Continuing Cares changing frameworks and that care packages are commensurate with patients' needs.

Further develop and maximise the use of mainstream services in delivering NHS Continuing Healthcare

We will continue to benchmark ourselves against other CCGs to understand how we compare on NHS Continuing Healthcare costs and activity with the aim of maintaining a position of between 90 and 110

To further develop Working partnership's with the RMBC, TRFT, Rotherham Hospice, Primary Care, domiciliary providers, care homes and the voluntary sector

To explore with partner organisations the possibilities of joint commissioning of social and healthcare budgets. And to continue to develop the personalisation agenda, and promotion of Personal Health Budgets.

Consider the opportunity to deliver an 'End to End' Continuing Healthcare Assessment service, for Learning Disabilities and Mental Health patients.

How are we going to achieve our intentions?

- Assess patients for CHC eligibility in line with the requirements of the national framework for NHS Continuing Healthcare and FNC and that care packages are commensurate with patients' needs
- Maximise the use of mainstream services in delivering NHS Continuing Healthcare
- We will benchmark ourselves against other CCGs to understand how we compare on NHS Continuing Healthcare costs and activity – the CCG current position is 103 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
- Continue to commission individualised services for children with complex health needs

Quality Improvements

Quality improvements will be driven through robust audit of the application of current National frameworks for adults and children with a focus on utilisation of multiple locally commissioned services. 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
Further develop the right to request a personal health budget to all patients who receive NHS Continuing Healthcare in their own home and support the choice of Notional, Third Party and Direct Payments. To improve patient engagement and feedback opportunities through the use of systems such as patient opinion and direct CCG feedback opportunities.
Alignment with the strategic aims of the Health & Wellbeing Strategy
Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing - The JSNA highlights the changing population demographics and the impact this will have on the number of elderly people with complex care needs: Many of these patients will possibly be eligible for CHC. CHC aims to deliver high quality aftercare for patients in their own home or care home setting. ***Aim 1: All children get the best start in life and Aim 2: Children and young people achieve their potential and have a healthy adolescence and early adulthood -*** Equally children with complex care needs are also able to be assessed for continuing care to support needs that are not supplied by universal or complex commissioned services. It is recognised that many children with the Special Educational Need (SEN) reforms will also be eligible for Personal Health Budgets and have a right to request. ***Aim 5: Rotherham has healthy, safe and sustainable communities and places -*** the personalisation agenda will put recipients of NHS Continuing Healthcare in control of their care and those opportunities for self-care and the use of alternatives to acute hospital admission maximised.
How will health inequalities be addressed
We will ensure that all patients are assessed for NHS Continuing Healthcare 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.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
Patient and relative feedback is sought on each assessment that is undertaken, and patients have the opportunity to record feedback on the process and assessment that is undertaken. The CSU have additionally commissioned the Patient Opinion service as a measure to record feedback from service users and responsible individuals. A communication strategy has been developed, ensuring people receiving Continuing Healthcare receive appropriate information, and have the opportunity to feedback their experience.

21.10 Palliative Care

Lead GP	Avanthi Gunasekera
Executive Lead	Ian Atkinson
Lead Officer	Nigel Parkes
Key Meeting	End of Life Care Strategy Group

Why is this a strategic priority?
Commissioning high quality palliative care services for the residents of Rotherham is an absolute priority for the CCG, within the Rotherham Health and Social Care economy, Palliative Care (inc end of life care EOLC) is provided across a range of core commissioned services for example, Primary Care, Acute and Community Services Community, Residential Care and Nursing Homes. In addition to this the CCG invests around £3m million in specialist palliative care provision from Rotherham Hospice. The Hospice provision provides a multidisciplinary service for patients with complex problems and provides specialist educational and practical support to other primary and secondary care staff. Around £2.24 million

of this is from the CCGs core budget and £788,000 for the community end of life care service through Better Care Fund.

5 year Strategic Direction and key priorities

The CCG aspiration is to work closely with local Health and Care providers to commission clear joined up Palliative pathways of care, these pathways will embrace all elements of Palliative care including:

- Hospice services for adults and children.
- Palliative Care & EOLC in Acute settings.
- Palliative Care & EOLC in community settings.

Priority will be given to ensuring that the key aspects of the Nice Guideline 'Care of dying adults in the last days of life' (December 15) is delivered across commissioned services:

The CCG will continue to support the five 'Priorities of care' identified in the report 'One Chance To Get It Right':

- Clear communication following recognition that a person may die in the next few days or hours.
- Sensitive communication with the dying person and those identified as important to them.
- The dying person and those identified as important to them are involved in treatment & care decisions.
- The needs of families and those identified as important to the dying person are explored, respected & met.
- An individual plan of care is agreed, co-ordinated and delivered.

The CCG will also follow the six ambitions laid out in the document 'Ambitions for Palliative and End of Life Care':

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help.

Progress made in 2015/16

In 2015-16 Rotherham Hospice continued with the roll-out of its re-design, implementing the out of hours element of the Hospice at home, in collaboration with Marie Curie, to provide a 24/7 service.

The CCG funded two posts, one based at the Hospice and the other at TRFT to provide training around 'One Chance To Get It Right'.

The CCG ensuring that crucial conversations about EOLC take place at the appropriate time for patients with long term conditions, the Case Management Project will be a major enabler of this. The CCG extended the eligibility for funding of the Case Management Project to all patients in nursing and residential homes, to fund additional GP time which will be important to better co-ordinate EOLC in nursing and residential homes.

Work continued around the roll-out of the EPaCCs electronic EOLC register, with the template being updated in line with reporting changes. Whilst uptake continues to be slow, the work undertaken has eliminated any IT issues and promotion to GPs continues. This development remains a priority for the CCG.

The Hospice@Home service continues to provide significant benefits in terms of reduced admissions to TRFT and these are expected to total XX in 2015/16, giving estimated savings of £XXX,XXX.

Further work has continued relating to EOLC patients with dementia.

The Rotherham Foundation Trust has prioritised improvements in EOLC pathways within the hospital setting, evidence of senior clinical staff attending advanced communications training and reduction in complaints

around communication issues at the end of life., reduction in readmission rates of patients in the last years of life, evidence of appropriate use of care plan for the last days of life, delivery of a 7 day palliative care team.

Plans for 2016/17 and 2017/18

1. Continue to review Hospital Mortality to understand opportunity for improvements in existing palliative care pathways
2. Further work will be undertaken to ensure the roll-out of the EPaCCs system and this may include the option to incentive up-take through the PMS premium in 2016/17.
3. Work with partners to embed into service provision requirements of the 'Care of dying adults in the last days of life' (Nice Guideline December 15)
4. Routinely commission the Hospice at Home model of delivery across the Rotherham area.
5. The CCG will work with The Hospice and TRFT to ensure that the Care Co-ordination Centre (CCC) is an active part of the EOLC pathway.
6. The CCG will also formalise the commissioning arrangements for Children's Hospice services.
7. The CCG will ensure that it is aware of and involved in any further developments towards a palliative care and EOLC payment system.
8. The CCG will as part of the locality model of care, look at how best palliative care patients can be more proactively managed, before the very end of their life

How are we going to achieve our intentions?

- The CCG is investing in additional nursing capacity through the transforming community services project (see section 5.7) and will consider using some of this funding to expand 24/7 coverage by the community EOLC service.
- 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 Project (see Section 5.11) will be a major enabler of this.

The CCG has extended the eligibility for funding of the GP case management project 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. The CCG will continue to work with TRFT and Rotherham Hospice to implement the five key priorities which make up the new EOLC model as outlined in the 'One chance to get it right' publication.

The CCG will continue to invest in the community EOLC service through the 'Better Care Fund'. 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.

Quality Improvements

- Over the last 2 years the proportion of people in Rotherham dying in setting other than acute hospitals has increased from below 40% to above 50%
- 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

The Hospice has continued to provide innovative solutions to EOLC in Rotherham through the recent re-design and enhanced services such as psychological support.

All stakeholders will continue to work together on innovative solutions to specialist palliative and EOLC including, for example, the Amber Care Bundle.

Alignment with the strategic aims of the Health & Wellbeing Strategy
In line with the aims of the Health & Wellbeing Strategy, the CCG will ensure that people approaching the end of their life get high quality care, wherever that care is delivered. Continuing to implement the five priorities of 'One Chance To Get It Right', outlined above, will ensure that care is planned with the individual and the people close to them and tailored to their needs and wishes and includes management of symptoms, as well as provision of psychological, social, spiritual and practical support. Work will continue to ensure that more people in Rotherham are able to exercise choice over their end of life care and the place of their death.
How will health inequalities be addressed
Work is ongoing at the hospice to increase the percentage of patients who receive EOLC and who don't have cancer, but some other condition. • 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.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
Patients and their families continue to have a vital input into determining the type of care and support provided in the last stages of life and this is integral to good EOLC. Work will continue to improve the quality of conversations with patients and their families who are approaching the end of life so that care is tailored to their individual needs.

21.11 Specialised Commissioning

Lead GP	Richard Cullen
Executive Lead	Chris Edwards
Lead Officer	Jacqui Tuffnell
Key meeting	Specialised Commissioning Oversight Group

Why is this a strategic priority?
Responsibility for commissioning a wide range of very specialist services lies with NHS England. Such areas include specialist cardiac surgery, specialist paediatric and neonatal critical care, adult critical care, specialist cancer drugs and radiotherapy and specialist mental health services (such as forensic services). Although NHS England has responsibility for commissioning specialised services the CCG needs to work collaboratively to ensure quality safe pathways of care are commissioned across secondary and tertiary services.
5 year Strategic Direction and key priorities
Responsibility for commissioning a wide range of very specialist services lies with NHS England. NHS England's have published commissioning intentions for these services. H:\Specialised commissioning\Commissioning Intentions 2016-2017 for Prescribed Specialised Services GW04131 final.pdf The CCG works with NHS England to ensure co-ordinated care pathways across areas of CCG and specialised commissioning and to ensure there is local input into specialist commissioning decisions.
Progress made in 2015/16
Two areas that were the responsibility of NHS England in 2014/15 were transferred to CCGs in 2015/16: • Specialist wheelchair services • Outpatient neurology (GP referred)

All CCGs were asked to identify their key priorities for specialised service improvements. In Yorkshire and the Humber the following services were identified as priorities: Vascular – a service review has been conducted and an early options appraisal is being progressed Cardiac devices – a service review has been conducted with an overall recommendation to increase implantation across Yorkshire and Humber. Rotherham was identified as within the expected range for implantation. CAMHs – Tier 4 – a national procurement is in progress however this is intertwined with a review of Tier 3 services to enhance community availability to enable children to remain within their own homes with appropriate wraparound services. A plan for Rotherham has been submitted.
Plans for 2016/17 and 2017/18
It is likely following ministerial confirmation that the following services will be commissioned by CCGs from 2016/17 • Surgery for morbid obesity • Some highly specialised male urological procedures • Some highly specialised adult haematology procedures • Primary ciliary dyskinesia management services for adults In addition to these formal transfers NHS England has set up Specialised Commissioning Oversight Groups to develop collaborative commissioning arrangements with CCGs to enable better aligned decision making to help restore pathway integrity and improve transition for patients between specialised and non-specialised services.
Quality Improvements
Opportunity for improving pathways – co-ordination across non-specialised and specialised pathways are expected to improve health outcomes for service specific patients Cardiac devices review – will ensure all patients appropriate for implantation receive their device CAMHS Tier 3 plus service will enable children to receive appropriate care in their home setting and avoid, where possible an inpatient stay.
Alignment with the strategic aims of the Health & Wellbeing Strategy
Aim 5: Rotherham has healthy, safe and sustainable communities and places - The ability to work across the pathway aligns with this aim.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
To date, specialised services have engaged patients via involvement in clinical reference groups. These will continue for services remaining with NHS England however regional specific conditions will also have direct patient engagement and involvement.

21.12 Joint Commissioning with RMBC (inc.) Better Care Fund

Lead GP	Julie Kitlowski
Executive Lead	Keely Firth
Lead Officer	Dominic Blaydon
Key meeting	Better Care Fund Operational Group

The Better Care Fund (BCF) is an important Government Initiative to create a single joint budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. The fund does not in itself create any new money but bringing existing budgets under joint commissioning responsibility is expected to lead to better outcomes.

Public sector commissioners in Rotherham already align their commissioning strategies as much as possible to achieve best outcomes for each Rotherham pound through the Health and Wellbeing Board. The Health and Wellbeing Strategy 2015-19 places particular emphasis on a shared vision and leadership for improving health and care services and it provides the framework for the Better Care Fund proposals to ensure seamless, effective and efficient service delivery.

In particular the BCF aligns with the Health and Wellbeing Strategy Aim 3: *All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life* and Aim 4: *Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing.* Part of the priority is the need to ensure that people who have a long-term condition or disability and those with mental health problems receive the right care in the right place at the right time. It is evident that too many people are admitted to hospital unnecessarily and are kept in hospital for too long due to inconsistences in discharge. The BCF supports this aim by integrating and increasing access to health services in the community and supporting the reduction of care that occurs in hospital. The BCF also ensures that services are in place across the health and social care economy to support the most vulnerable to remain independent for as long as possible, and to support those friends and family who provide unpaid care.

The Rotherham Better Care Fund brings together 16 schemes that are particularly important for joint working into a single jointly owned budget of £23.3 million. There are six national conditions that have to be addressed.

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

The plans have to achieve specific outcomes in seven areas:

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.

Rotherham Better Care Fund Schemes	Description of Better Care Fund Schemes
Mental Health Liaison Service	Development of an Adult and Older Mental Peoples Mental Health Liaison Service to improve care, reduce admissions and length of stay and ensure that mental health is a fully integrated in the new Rotherham Emergency Care Model. See Section 21.1.
Falls Prevention	Ensure older people are aware of the risks of falls and have opportunities to remain active and healthy in their community. Where a person is more at risk of a fall, they are provided with the right advice and guidance.
Integrated rapid response team	Integrate the current Fast Response Service, Advanced Nurse Practitioner and District Nursing Twilight Service. The main aim of the service is to assess patients who are medically stable but need additional support to remain at or return home. The service will co-ordinate and deliver care for patients for a time limited period.

7 day community, social care and mental health provision to support discharge and reduce delays	Extend current provision so that appropriate services are available 7 days a week, to enable timely discharge from hospital and avoid unnecessary admissions to hospital or residential care.
Social Prescribing	A portal for health professionals to access voluntary and community support services, to enable existing third sector providers and groups to complement the formal support that people with long term conditions receive. They are able to provide flexible, appropriate services that help people to self-manage.
Joint residential and nursing care commissioning, quality and assurance team	Approximately 1,700 people live in care homes in Rotherham, this workstream is to develop a joint approach towards quality assurance of residential and nursing care homes. CCG and RMBC will work closely to develop an integrated quality assurance service
Review existing jointly commissioned integrated services	All jointly commissioned services have been reviewed to establish if they provide value for money and are aligned with the BCF vision and principles. If services are not efficient and effective, services will be reconfigured or decommissioned.
Data sharing between health and social care	All Rotherham NHS correspondence uses the NHS number as primary identifier. RMBC has a plan already in development to enable this to be used on social care systems. The NHS number has been used as a unique identifier creating a starting point for the development of shared IT capacity locally. So far RMBC have successfully attached NHS numbers to 22,000 service users.
End of Life Care	Investment in enhanced community end of life care services by Rotherham Hospice to augment the current day hospice /Inpatient Patient Unit services with hospice at home provision.
Adaptations	Investment in minor and major adaptations to help people live independently within their own homes for longer. The aim is to improve health and wellbeing of individuals, reduce admissions to residential care and hospital and reduce the use/reliance on home care packages.

The fund will improve outcomes in the following areas:

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

The plan is overseen by BCF Executive Group which includes senior representatives from both the CCG and RMBC and reports to the Health and Well Being Board. The Executive Group is supported by an Operational Group which is made up of the identified leads for each of the BCF Schemes. In additional to local reporting plans and outcomes have to be assured by and report to NHS England.

£23.3 million represents only a small proportion of the total budgets that could potentially be shared between the CCG and RMBC, the CCG will review the potential for increased shared budgets on an annual basis. Table 1 sets out the key schemes that RCCG and RMBC have worked on this year.

In the first year of operation significant steps have been taken to improve integration, strengthen community services in the health and social care economy and reduce unnecessary non elective admissions to hospital and premature admission to long term residential care.

Highlights of Progress to Date

- BCF01: Fully operational and is now operating extended hours from 9am-8pm. (further update/clarity required)
- BCF04: Extensive work has been completed to ensure a fully operational service is in place by January 2016.
- BCF06: social prescribing services are well established across the Rotherham Borough, events have enabled patients to share success stories and Sheffield Hallam was commissioned to evaluate the provision. There is now a mental health social prescribing pilot in development.
- BCF09: Continuing Healthcare adults and children are being offered information regarding Personal Health Budget's at the point of assessments. A work plan for PHB's is being developed for 15/16 including local PHB network involving PHB recipients and the voluntary sectors.
- BCF 14: Currently 57% of people receiving social care services having an NHS number recorded. An active and current project plan is capturing the NHS number for all new referrals in our social care database. Culture and process changes have been made to embed the maintenance and usage of NHS number in RMBC's day to day activities. The deadline for matching all NHS numbers with social care records is April 2016.
- BCF15: Fully operational and the number of deaths outside hospital is being kept at its current positive position. Strong links are established with the Care Co-ordination Centre to maximise admission avoidance.

A new BCF plan will be proposed in 2016-17 that follows our customer journeys along the continuum of care, to ensure that BCF services are realigned so that they deliver the following key projects;

1. A single point of access into health and social care services
2. Integrated health and social care teams
3. A multi-disciplinary carers support service
4. A multi-disciplinary integrated rapid response service
5. A joint approach to care home support
6. Implementation of personal health and social care budgets
7. Development of a reablement hub incorporating intermediate care beds
8. Reconfiguration of the local authority residential bed base

21.13 Child Sexual Exploitation

See section 13.3 further narrative to be inserted re: specific invetsments made by the CCG in this area.

21.14 Cancer

- Awaiting further national guidance on Cancer Targets at which point this section will be drafted in full and cover the following:

Lead GP	Richard Cullen
Executive Lead	Ian Atkinson?
Lead Officer	Janet Sinclair-Pinder
Key meeting	???

21.15 CCG Commissioned Primary Care

Lead GP	Jason Page
Executive Lead	Chris Edwards
Lead Officer	Jacqui Tuffnell
Key Meeting	Primary Care Committee

5 year Strategic Direction and key priorities

The CCG received delegated responsibility for commissioning all general practice services on 1 April 2015. NHS England continues to commission pharmacy, optometry and dental services and we continue to work with them on these areas. The responsibility for GP workforce planning is now part of CCG responsibilities, but the maintenance of the Performers List and GP Accreditation and validation still remain with NHS England. Since taking responsibility, the CCG has developed an interim GP strategy, the full version is at the end of this section.

The CCGs approach to GP quality is described in Section 6.1. The CCG's IT strategy is important in supporting general practice and this is described in Section 10.

The CCG is working with practices to transform services over the next five years to achieve the following key outcomes:

- Improved consistency in access to general practice – aspiring to within 24 hours for an urgent appointment and within 5 days for routine appointments
- A combined, collaborative workforce across primary, secondary and community care providing a seamless pathway for patients with GPs as the linchpin for care
- Patients able to self manage their conditions from home utilising technology to connect with healthcare professionals
- 200 additional years of life
- All patients will be able to access equivalent services
- We will increase the wider workforce within general practice to improve consistency in patient experience

The interim strategy describes the 10 key strategic aims for general practice which have been devised from engagement events with patients, carers and clinicians:

- Quality Driven Services – benchmarking to ensure all services are high quality and sustainable
- Services as local as possible – developing new ways of managing patients and providing care closer to home
- Equality of service provision – ensuring equity of service provision across Rotherham and therefore equality of access for patients.
- Increasing appropriate capacity and capability – ensuring a sustainable, well trained workforce
- Primary care access arrangements – ensuring services meet demand
- New models of care – collaborating to deliver equity and sufficient capacity and capability
- Self care – empowering patients to have confidence to manage their condition(s)
- Robust performance management – to support practices to improve and ensure consistency
- Continued improvements to medicines management – 6 service redesign projects to improve prescribing
- Engaging patients to ensure patient pathways are optimised – empowering Patient Participation Groups

Progress made in 2015/16

Since taking on delegated commissioning good progress has been made on devising and implementing the GP strategy. The following actions have been taken to date:

- A Primary Care Committee has been established to govern primary care (GP) commissioning. The

committee is chaired by a Lay Member with specific responsibility for primary care with a further lay member and officers of the CCG providing a decision making role. The committee also has GP, NHS England, Health and Wellbeing Board and Healthwatch representatives. The committee meets in public on a monthly basis and papers for each meeting are uploaded onto the CCG website 7 days prior to the meeting. Since April, the committee has approved the following actions:

- An interim strategy for General Practice – setting the direction of travel for general practice in Rotherham
- Merger of Brinsworth and Surgery of Light practices – these are now known as Brinsworth and Whiston medical practices
- Approved the merger of Thrybergh and Magna practices
- A managed dispersal of Chantry bridge patients following a re-procurement exercise
- Approval to proceed with the building of new healthcare premises on the Waverley site
- Reprocurement of the current Gateway services provided from 3 practices: The Gate, Rosehill and Canklow
- Rotherham Strategic Estates plan
- General Practice Workforce plan
- Practices have also actively engaged in the extension of services to bring them closer to home:
  - Minor dermatology procedures
  - Joint injections
  - Phlebotomy
- The CCG has also supported the active alignment of GP Practices to their nearest Care Home which should be completed by 31st March 2016 . There are approximately 1500 patients in care homes and these are some of the most vulnerable patients. The alignment is anticipated to improve the care for these patients by improving communication between practices and care homes. In 2016-17 we will build on this alignment by putting in place a new enhanced service for care homes which will offer a proactive service for these patients.
- A practice dashboard has been developed to focus the primary care committee on the key quality and contracting areas and also support practices with the provision of benchmarking information on areas such as workforce.
- A waste campaign has commenced with focus on medication reviews and repeat prescribing
- Commenced a review of available technology to support patients to self care
- Working on a pilot of Saturday opening for routine appointments to support patients who struggle to attend weekday appointments
- Continued progress has also been made in the following areas:
  1. A Local Incentive Scheme (LIS) to ensure the CCG has GP engagement/member engagement into the commissioning and quality agenda.
  2. This scheme commissions GP commissioning audits; a prescribing incentive scheme to ensure that GPs prioritise both high quality and cost effective prescribing and time for GPs (in addition to the 8 Executive GPs) to take part in commissioning. GPs continue to be well engaged with all practices taking part.
  3. A Secondary to Primary Care Local Enhanced Service (LES) to enable care to be moved out of a hospital setting and into primary care and deliver our clinical referrals efficiency plans (section 5.2). Currently, this includes post operative wound management, the management of people with prostate specific antigen and anticoagulation, but there are proposals for other areas to be included as part of a managed shift of the management of follow ups from secondary to primary care
  4. The Long Term Conditions Case Management LES to improve the care of 12,000 patients at risk of readmission to hospital, which is key to our unscheduled care efficiency plan (see also section 5.1). This service will continue to focus upon those patients (up to 5% of the practice list size) who have been identified as being at the highest risk of admission to hospital either via the risk stratification tool or clinical judgement. In 2014, the CCG also responded to the national planning guidance and added an additional component to provide an annual health review for those 20,000 patients over the age of 75. It is planned to continue with this initiative. The funding for this scheme was made

recurrent and the uptake of the scheme is now close to the maximum level.

5. CCG commissioned Locally Enhanced Services with GPs on an annual basis. The CCG will review its LES to ensure they are still fit for purpose.
6. CCG commissioned LES with optometrists. In 2016/17 the CCG will continue to 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. CCG pharmacy LES's for minor ailments and palliative care.

In 2016/17 spend in this area includes £0.7 million for the LIS and £1.2 million for the Case Management LES, plus funding for the CCG commissioned LESs.

Plans for 2016/17 and 2017/18

Review of capacity and demand and proposals to support practices to meet rising demand

- Reviewing telephone infrastructure and ensuring it is fit for purpose to meet demand and facilitate increased telephone consultations
- Working with practices to implement new workforce models
- An agreed funded transfer of some outpatient services from hospital to general practice if appropriate

Optimising care pathways to enable patients to remain out of hospital

- Improved management in primary care of patients with Type 2 diabetes
- Reviewing opportunities for delivering care pathways within the community

Implementing education and technology to enable patients to self care

- Promoting use of the minor ailment scheme
- Supporting patients by providing more information about their condition and opportunities to discuss issues e.g. condition 'cafes'
- Piloting the use of telehealth – which enables patients to test themselves at home e.g. blood pressure monitoring and text their result to the practice who would then take action if the result is out of range

Review of current reimbursement arrangements eg. Quality and Outcomes Framework to ensure that they meet the needs of Rotherham patients

Progress the Community Provider Model

- Continued high quality engagement with member practices to enable us to deliver our QIPP plans via the Commissioning LIS.
- Continued case management of people at risk of hospital admission

Quality Improvements

Care home alignment- the rationalisation of practices to care homes will improve communication between homes and practices and provide the basis for care to be delivered in an efficient and proactive way.

- The CCGs approach to primary care quality including peer visits, supporting protected learning time and practice manager meetings is described in Section 6.1.
  The secondary to primary care LES will allow patients to be treated locally at their GP practice. Examples are shown below:
- Minor dermatology procedures and joint injections are now being provided by the majority of GP practices minimising the requirement to attend hospital for these procedures.

The CCG is working with GPs to develop quality standards in relation to primary care to ensure that quality improvement is continuous and a focus within all practices.
Phlebotomy is now part of the CCG secondary to primary care LES and therefore GP bloods are now required to be provided by the practice or sub-contracted to be provided on behalf of each practice within 24 hours for urgent bloods and within 5 working days for routine bloods.

The CCG is working with practices to review their workforce and develop a sustainable workforce by using

clinical pharmacists to support medication reviews, manage patients with complicated long term conditions and provide quality review of prescribing across practices. The CCG also supports the development of Healthcare Assistant roles and facilitating the training places for new roles in primary care e.g. Associate Practitioners as it is acknowledged that there will be insufficient nurses as well as GPs to deliver in future.

Innovation

Self care technology – We are piloting a system to enable patients to self test and notify practices of their results to enable patients to self manage their conditions and reduce the requirement for patients to attend practices. This is particularly helpful for working patients and those away from home for long periods.

Telephone infrastructure – Work is taking place to improve patient telephone access to practices by ensuring there is sufficient line and capacity to manage initial calls and the scope for telephone consultations.

Primary care dashboard – Rotherham CCG has internally developed a dashboard to bring together publically available data in relation to general practice to benchmark and support practice improvements

Alignment with the strategic aims of the Health & Wellbeing Strategy

The GP strategy aligns with the health and wellbeing strategy as it plans the following:

- Greater collaboration with public health colleagues in relation to prevention
- Optimising pathways to improve life expectancy
- Community provider model to not only focus on those who are unwell but keeping communities well

How will health inequalities be addressed

- Ensuring universal coverage of service provision by increasing the 'basket' of services which are required not a choice of practices.
- Case management- promotes prevention, early intervention and self-care and is undertaken by all practices. Patients are selected by clinical need and this is linked to social prescribing which addresses health inequalities.
- Care home alignment- Covers all care homes for elderly and EMI (Elderly Mentally Impaired)
- Local Enhanced services are reviewed and either decommissioned or rolled out to ensure universal coverage
- Closer working with public health to prevent ill health

What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?

We receive feedback on primary services through a number of mechanisms; through the Friends and Family Test, through the PPGs and the PPG Network, via Healthwatch Rotherham, and individually raised issues at community meetings and events.

The primary care team have engaged patients and carers via the Healthy balance event in June 2015 and through the Rotherham Patient Participation Group Network. A further primary care specific event took place in November to provide a more in-depth opportunity to participate in planning the delivery of the strategy alongside ensuring we are meeting the needs of patients.

Each of the local enhanced services now has an element of patient feedback built in and this is planned for when any new services are considered.

Appendix 1: Interim Strategy for General Practice within Rotherham

1. Our vision for general practice within Rotherham

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 (H & WB) Strategic outcomes(due to be reviewed in September 2015:

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

The CCG will work with practices to transform services over the next 5 years to achieve the following key outcomes:

- Improved consistency in access to general practice – aspiring to within 24 hours for an urgent appointment and within 5 days for routine appointments
- A combined, collaborative workforce across primary, secondary and community care providing a seamless pathway for patients with GPs as the linchpin for care
- Patients able to self manage their conditions from home utilising technology to connect with healthcare professionals
- 200 additional years of life
- All patients will be able to access equivalent services
- We will increase the wider workforce within general practice to improve consistency in patient experience

2. Introduction

Rotherham Clinical Commissioning Group (CCG) is responsible for commissioning the majority of health services for Rotherham patients as detailed in section 2.2 of the Commissioning Plan.

Primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing ongoing mental and physical health conditions and helping recovery from episodes of ill health and injury (Ref: NHS mandate 2013). General practice plays a significant part in primary care and Rotherham CCG is committed to adhering to the principles of the NHS and how these are applied locally to best meet the needs of our population.

The CCG has an overall vision of working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities. Primary care, defined for this purpose as care that can be provided out of hospital by GPs and the teams they employ, is at the heart of the NHS

and will play a central role in achieving this aim by ensuring a co-ordinated service for patients, centred on the needs of the people that we serve and not silo organisations.
We have fantastic examples of care in Rotherham but as our population increases and ages, it is critical that we respond by providing services in different ways to ensure we continue to sustain and improve during challenging times. Our key challenges within GP services include our own ageing workforce. Over 33% of GPs in Rotherham are due to retire in the next 5 years with limited availability of trainees to fill vacancies. In addition there are significant changes to funding arrangements for GP practices potentially destabilising investment and pressure to improve access.

Rotherham CCG believe a significant step forward in this journey included bringing back, the commissioning of primary care (GP services) to Rotherham, this was achieved in April 2015. We are already seeing the benefits of being able to respond to local issues with local knowledge as often it is difficult to understand and respond to our population from afar but with our dedicated resources we are able to ensure this is achieved. To ensure good governance is maintained, the CCG has created an additional committee, Primary Care Sub-Committee which is chaired by a Lay member of the CCG and meets monthly in public to discuss all issues affecting general practice. Healthwatch, NHSE and a representative from the Health and Wellbeing Board are all committee members. The CCG will continue to work with NHSE who commission other primary care services i.e. pharmacy, optometry and dental to ensure these services complement each other however this strategy is focused on GP services.

This strategy is a key component to ensure we continue to mould our journey to deliver our priorities and what we will do to make the vision a reality. The strategy aligns with the Health & Wellbeing board priorities and the CCG's commissioning plan which has a specific strategic aim of developing general practice. The strategy should also be considered as an enabler for, and read in conjunction with the RCCG Better Care Fund (BCF) plan which is a pooled budget of £23 million for health and social care.

There are some considerable challenges to be overcome as we move towards delivery of our vision. 56.8% of our population live with health-related problems. More people are living longer with more chronic diseases and medical treatments are getting more complex and expensive. We have to deliver healthcare differently as funds are not growing to deliver in its current format which could increase inequity in funding if it is not managed effectively.

We have developed our strategy by reflecting on feedback from our patients and the wider primary healthcare teams at market place and development events held in June 2015, as well as considering the challenges facing general practice. The following ten key principles have been identified to form the main elements of the general practice strategy:

1. **Quality driven services** – providing high quality, cost effective, responsive and safe services
2. **Services as local as possible** - teams working in community in conjunction with GPs, in-reaching into secondary care where possible
3. **Equality of uniform service provision** - addressing inequalities in Rotherham's life expectancy – we will focus on health prevention and education to support these areas along with 'baskets' of services to ensure equality across Rotherham
4. **Increasing appropriate capacity & capability** – as well as continuing to recruit to our workforce, we will develop new roles to support the GP and nursing workforces to ensure patients are well managed along with innovative models to manage patients conditions e.g. telephone support and extended use of pharmacists. We will also educate the public to feel confident in using different health professionals for their care.
5. **Primary care access arrangements** – ensuring our access to general practices meets the needs of our population
6. **Maximised use of integrated / aligned care pathways** – new models of care, taking a lead from the new Vanguard models and other good practice across the NHS
7. **Self care** – improved information including patient health portals, ability to monitor conditions at home/link to appropriate service when 'abnormal'

8. **Robust performance management** to provide assurance that safe and cost effective care is being delivered
9. Continuing our programme to **improve medicines management** with appropriate prescribing and reducing waste
10. **Engaging patients** to ensure patient pathways are optimised – to date engagement has been varied and the CCG is committed to finding alternative ways to ensure the patient voice is heard

We have developed our strategy for general practice, which was agreed at the Governing Body in XX.

Engagement with local professional, patients and the public will continue as we develop more detailed operational plans. There will be continued opportunities for people to influence how we make our vision a reality. This strategy will be incorporated during 15/16 into the CCG overall commissioning plan to ensure that delivery and review remain high priority.

Vision				
	Priority Area	Challenges	Solutions	Outcome
1	Quality Driven Services	Financial Uncertainty	• 4 year reinvestment plan • Benchmarking • Comparing practice quality and productivity • Delegated responsibility for general practice • New models of delivery	• Improved patient experience – ED1-3 • Improved efficiency
2	**Services as local as possible**	Capacity to deliver	• New ways of managing patients: ➢ Telephone consultations, skype video consultations ➢ Utilising our wider workforce ➢ Integrating out of hours and urgent care	• % reduction in patient attendances at GPs
		Care closer to home	Seamless services	• Improved efficiency • Improved patient experience
3	**Equality of service provision**	Inequalities in life expectancy equity of services	• 'Baskets' of services • Providers working together • Focused health prevention measures ➢ Working with public health	• 200 years of life per year • All patients able to access equivalent services
4	**Increasing appropriate capacity and capability**	Recruitment and retention	• Workforce plan ➢ Sufficient capacity and an appropriately skilled workforce • Effective succession planning • New workforce models ➢ More effective use of different professions ➢ Engaged and empowered workforce • Recruitment strategy ➢ Improved profile of Rotherham as a place to work ➢ Improved fill rates	• Improved workforce numbers • Improved workforce retention • Improved patient experience
5	**Primary care access arrangements**	Public expectation GP facilities Contract arrangements	• Review of arrangements and to pilot extended opening • Provision of wrap-around services to support GPs	• % reduction in patient attendances at A & E • Improved patient experience
6	**New models of care**	Contractual complexity	• Collaborating groups of practices to deliver care in the community • New emergency centre ➢ Secondary and primary care clinicians working together	• Improved efficiency • Improved patient experience
7	**Self care**	Increasing demand	• Education ➢ Patients confident to manage their condition(s) • Social prescribing ➢ Signposting & support to manage their condition(s) • Technology ➢ Proactive monitoring to enable fast response • Case management ➢ Clear plans of care	• % reduction in attendances – all services
8	**Robust performance management**	Different systems in place	• Performance dashboard to collate data • RAIDR to ensure consistency	• Ability to define & manage performance issues • Improved performance ED1-3
9	**Continued improvements to medicines management**	Reducing medicines waste	• 6 service redesign projects to improve prescribing • Prescribing Local Incentive Scheme	• Improved efficiency - QUILT • Safer medicines management
10	**Engaging patients to ensure patient pathways are optimised**	Improving patient involvement	• Effective Patient Participation Groups • Condition specific focus groups	• Services which meet the needs of the population

Steps to Make the Vision a Reality

There are the key enabling strands of work that underpin the strategy. These tackle the main issues and challenges facing general practice and will allow the CCG to turn the vision into reality. More detailed consideration of them is required in the short term to translate them into an implementation plan.

4. Context

4.1 Profile of Primary Medical Care in Rotherham

90% of all NHS contacts are with general practice.

There are around 1.5M GP consultations every year in Rotherham with each patient seeing their general practice 6 times per year on average.

Rotherham's resident population is estimated at 259,800 who are cared for by a total of 36 GP practices (as at April 2015) alongside a centrally based walk-in centre providing 24/7 access. At the present time, five GP practices in Rotherham are singlehanded compared to 31 practices with multiple GP partners or which are alternative providers.

National average list size	6287
Rotherham average list size	7182

The CCG currently has 15 training practices. This is important as training practices play a significant role in supporting new GPs and encouraging them to stay in the area once they are qualified.

With regard to type of contract there are:

- 24 Personal Medical Services (PMS) practices
- 8 General Medical Services (GMS) practices
- 2 Alternative Provider Medical Services (APMS) practices (covering 4 practices)

A Limited Liability Partnership (LLP) is currently being formed by an appointed GP lead to enable practices to work collectively and be able to respond to the demands facing general practice. These demands are identified more extensively within this strategy.

4.2 Current General Practice

Whilst media attention is often focused on the challenges facing the heath service , it must be acknowledged that there is excellent work taking place in general practice, day in, day out to ensure patients receive high quality care. As a principle, it was agreed that these should be protected and preserved when thinking about any future model of care. They included:-

- GPs holding longer term contracts that build real commitment to the local community
- Registered list that leads to continuity of relationships and care•
- GP acting as the coordinator of care between other health and social care settings
- Appetite for innovative ways of working
- Keen to learn new skills through educational programmes designed by local GPs

- Practices beginning to work together to share good practice and learning
- Secondary to primary care Local Enhanced Service agreement where practices have agreed to work together to provide services for all patients when individual practices have not got capacity
- The delivery of high quality care e.g. anticoagulation, where the increased service quality being delivered is outstanding.

General practice incorporates the essential values of personal care, continuity of care, generalist skills and a holistic approach to patients. Prevention and the treatment of ill health both have equal priority.

It is also important to acknowledge the teams that support the clinical professionals such as practice managers, reception staff and apprentices without whom our services would not be fully functional.

4.3 Changes to Contractual Arrangements

NHS England are nationally leading changes to the payment arrangements for general practice to apply the principles of equitable funding. The aim of which is to by move to a position where all practices (whether GMS, PMS or APMS) receive the same core funding for providing the core services expected of all GP practice. The review of PMS funding, determined that any additional funding above this must be clearly linked to enhanced quality of services or the specific needs of a local population. Also that practices should have an equal opportunity to earn premium funding if they meet the necessary criteria. NHSE have determined that over the next four years commencing 2015/16 financial year, the current PMS premium paid to PMS practices will be reduced by ¼ each year and reinvested across Rotherham GP practices to enhance the quality of services. All practices will have equal access to the payment as detailed above. A decision regarding the phasing out of MPIG for GMS had already been determined with correction factor payments reduced by 1/7th over 7 years commencing 2014/15.

On a positive note, the funding released from the PMS review will remain within Rotherham and will be reinvested back into Rotherham primary care over the 4 year period described to achieve the following:

- Reflect joint area team/CCG strategic plans for primary care – supporting an integrated approach to delivering community based services
- Secure services or outcomes that go beyond what is expected of core general practice – ensuring premium funding is tangibly linked to providing a wider range of services or providing services to higher quality standards
- Help reduce health inequalities
- Give equality of opportunity to all GP practices
- Support fairer distribution of funding at a locality level

The GMS monies released from MPIG removal will not remain within Rotherham and it is understood that they will be reinvested into the 'global sum' for general practice (equitable funding level).

5. Our Key Priority Areas

5.1 Quality Driven Services

A high-quality service can only be delivered if there is a focus on three key quality dimensions: clinical effectiveness, safety and patient experience. It is crucial that the economic challenge does not change this focus. We will, therefore continue to support innovation in clinical practice and develop pathways that improve effectiveness and that enhance the patient experience as well as providing value for money. The CCG already supports protected learning time every 2 months, for all GP practices and sufficient time for localities to ensure they are clinically and professionally updated. There are four core components to this focus: quality, innovation, prevention and productivity. The CCG will continue to review benchmarking and learning from peers to support this agenda.

Funding for all practices should be equitable for delivery of service and also demonstrate value for money. Core contract activities will be remunerated in line with national agreements. Benchmarking information, comparing practice quality and productivity within our area and externally, will be used to ensure value for money.

We will look to achieve best value for money, driving efficiencies in the way general practice is delivered. Local practices have already embraced the opportunities to be more efficient in medicines management and prescribing with £1.8m savings in 2014/15.

The CCG already undertakes quality peer review visits to all GP practices and has developed a framework to support practices where there are quality concerns co-commissioning principles. The Care Quality Commission (CQC) have advised the CCG that they will be undertaking quality visits of all GP practices during 2015/16 commencing with 8 practices in June 2015. The CCG will work collaboratively with practices where any required improvements are identified.

5.2 Services as Local as possible

Our main aim is for general practice to sit at the heart of a patients care. Currently, when a patient requires secondary care intervention, care is handed over to the 'specialist' and handed back once treatment is complete or where protocols exist for care to continue in the community. Often patients could be more appropriately managed by their GP who has a holistic understanding of the patient and therefore increasing used of shared care protocols is a key aim of this strategy. This is difficult to achieve when there are capacity issues therefore patient management will take on a variety of forms e.g. skype and telephone consultations and utilising our upskilled nursing workforce.

Three important local plans which will impact on general practice are the community transformation plan (which will improve and expand out of hospital care provided by teams from Rotherham NHS Foundation Trust), Rotherham Mental Health Transformation plan which will increase the locality focus of mental health services provided by RDASH and the Emergency Centre.

Integration with GP out-of-hours providers and other urgent care services will help to reduce duplication and confusion about how best to access urgent care. Rotherham CCG has committed to capital funding to build a new emergency centre on the Rotherham Hospital Foundation Trust site. Building work has commenced with a completion date in 2017, along with significant pathway work between primary and secondary care clinicians to ensure pathways are as seamless and effective as possible.

The CCG has also committed to the provision of 'social prescribing' to support patients requiring healthcare

5.3 Equality of Service Provision – Enhanced Services

GPs are contracted to provide "core services" (essential and additional) to their patients. The extra services they can provide on top of these are called „enhanced services" which are voluntary but, if taken up, often add to the quality of care. The CCG is committed to maximizing the uptake of enhanced services and will look to practices to collaborate with each other to ensure that patients have equitable access.

There are three types of enhanced service:

1. National enhanced services (NES) - services to meet local needs, commissioned to national specifications and benchmark pricing. The CCG is unable to influence these.
2. Directed enhanced services (DES) – must be commissioned by NHS England (optional for GPs to provide). The CCG will work with NHS England to ensure these arrangements are congruent with CCG aspirations.
3. Local enhanced services (LES) – locally developed and commissioned services designed to meet local health needs. These are now commissioned by the Local Authority and CCG.

Enhanced services address gaps in essential services or deliver higher than specified standards, with the aim of helping the CCG to reduce demand on secondary care and other health services. Enhanced services expand the range of services to meet local need, improve convenience and extend choice. The total investment by the CCG in 2014/15 was £3.4m. The number and variety of schemes has increased over the years as local enhanced services have been developed and the local enhanced services are currently:

- Case management
- Anticoagulation
- Aural care
- DMARDs (Rheumatology monitoring)
- PSA
- Suture removal
- Acupuncture

In addition to this the CCG also has Local Incentive Scheme (LIS) which ensure that practices remain up to date with current practice. Rotherham CCG spends on average £4 per head of population, which is at the lower end of the national range

The CCG is responsible for providing services for all Rotherham patients so developing the capacity to help all eligible patients will be an important consideration when planning future expansions of general practice services.

5.4 Increasing Appropriate Capacity and Capability

Fewer trainees are choosing general practice when they qualify and more GPs are choosing to retire earlier than normal retirement age. Rotherham has a good track record of attracting trainees, predominantly due to a good reputation for education but also the proximity to Sheffield.

Until fairly recently, practices were almost exclusively run on a GP partner basis, with occasional use of locums to cover study, sickness or holiday absence. More recently, there has been a significant growth in locum and salaried GPs, with fewer being attracted to the partnership model. The primary care workforce is changing. An increasing number of GPs are working outside the traditional model with more sessional and locum GPs and utilisation of different professions, more typically nursing to undertake traditionally GP roles. The gender balance between male and female doctors is also changing which is also impacting on workforce availability as traditionally female GPs have chosen to work part-time. The success of the CCG will be dependent on its ability to embrace, utilise and develop potential across its whole clinical and non-clinical workforce. It will also work with provider organisations and the local authority to harness the skills of the wider primary care health and social care teams including district nursing, social work, pharmacy, podiatry, physiotherapy and others. A workforce plan is under development and will also incorporate the national 10 point plan – Building the workforce – new deal for GPs.

Practice size and sustainability is an important consideration. Rotherham has historically benefitted from having high quality services provided by practices of different sizes. In May 2015 the CCG Governing Body took the view that as opportunities arise the CCG will work to encourage small practices to work closer together in order to provide more sustainable services.

5.5 Primary Care Access Arrangements

Primary care access arrangements are set out in the GMS contract. This defines core hours as the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday, except Bank holidays. The contractor must provide essential services at such times within core hours, as are appropriate to meet the reasonable needs of its patients. Practices offer a variety of systems for walk in access, telephone triage, same day and pre-booked appointments. Some practices close for one afternoon a month in order to have protected learning time however many increase their capacity during that week to ensure the

same number of appointments are offered. Where practices are closed, arrangements are in place for patients to access the out of hour's service during this period.

It is acknowledged that access is one of the most significant concerns for the general public. As detailed below, the area requiring most focus is patient experience of making an appointment. From triangulating this data, we have commenced work with practices about their capacity for patients contacting their surgeries along with the service received once their call has been answered.

	ED 1										ED 2	ED3			
	Last GP/N they saw /spoke to was good at giving them enough time		Last GP/N they saw/spoke to was good at listening to them		Last GP/N they saw /spoke to was good at exp' tests / treatment		Last GP/N they saw/ spoke to was good at involving them in decisions about their care		Last GP/N was good at treating them with care & concern		Describe overall exp of surgery as good	Exp of making an appt as good			
	GP	Nurse	GP	Nurse	GP	Nurse	GP	Nurse	GP	Nurse			ED 1	ED 2	ED 3
Roth	87	83	88	82	83	79	76	69	83	80	86	74	81	86	74
Eng Av	86	81	88	79	82	75	74	67	82	78	86	77	79.2	86	77

The CCG will also work with practices to examine the options for extended hours to support access and redesigned service provision. At present, no GPs open on Saturdays with the known increase in impact on secondary care which is no longer sustainable. We will therefore review this evidence and pilot extended working arrangements to meet Rotherham population needs. This ambition will also support the new urgent care pathways which culminate with a new Emergency Centre opening in 2017.

5.6 New Models of Care

In October 2014, an alliance of NHS organisations published the Five Year Forward view. A significant element of this strategy is to review the local healthcare system to consider different models of delivering healthcare. Different variations of the models are emerging and NHSE announced in March the first wave of 29 Vanguard sites which will lead the way for piloting new operating models. It was also recently announced that Greater Manchester health and social care budgets will be devolved to the region's councils and health groups by April 2016 enabling local control over how budgets are allocated and with a main purpose to pool resources to improve out of hospital care.

As outlined in 4.2, the CCG has already committed to a new emergency centre which is based on a partnership between urgent care providers in Rotherham and best utilising the different skills of clinicians with primary and secondary care training. The CCG has also committed to transforming community services and already seen significant improvement to out of hospital care, focus is currently on the following:

- Better quality community nursing services
- Supported discharge and admission prevention
- Enhancing the Care Co-ordination Centre
- An integrated out of hours service

We will consider facilitating the availability of specialists and community teams in primary care settings. Consultants may work with federated groups of practices to provide integrated care, defaulting to primary and community settings rather than hospitals. This enhanced care will be provided in the home setting regardless of place of residence meaning those people who live in care homes will be able to access enhanced community and home based care. An effective case management Local Enhanced Service is already in place providing effective management of more than 12,000 patients who are at highest risk of hospital admission.

5.7 Self Care

The aim of self care is to prevent patient's conditions from deteriorating to facilitate them being able to remain at home, in familiar surroundings but with the knowledge that their condition is well managed. As well as the changes outlined above, which facilitate the most effective arrangements for long term care, patients and carers will be supported to take control of their long-term conditions through a variety of different ways. Case management and social prescribing are already in place to support patients. Community transformation projects will also refocus community nursing and social work time to input into patient reviews so all the patients needs are considered.

The CCG will also be considering the use of technology to assist patients to manage their conditions for example blood pressure monitoring at home with results reported directly into the GP to take action where results are abnormal.

Education will be a key component to self care, to empower patients and their carers to manage their conditions and to take a more active role in consultations and decisions about their care. . We know that to date, success in improving patient attendance and adherence has been patchy e.g. uptake for cardiac rehabilitation and we must work harder to devise innovative ways of reaching our population.

5.8 Robust Performance Management

As a CCG with delegated responsibility for GP commissioning, we have agreed trajectories for patient survey results with NHS England for the following three outcomes:

1. ED1 Satisfaction with quality of consultation at the GP practices
2. ED2 Satisfaction with the overall care received at the surgery
3. ED3 Satisfaction with accessing primary care

2014/15 performance is included within the primary care access arrangements section of this strategy. In addition to this, the CCG has developed a performance dashboard that provides the primary care sub-committee with an effective tool for high level monitoring of general practice key performance indicators. Data alone is not an indication of poor service provision however this enables the primary care sub-committee to focus attention on practices that are outlying to ensure that the primary care team are triangulating with other local intelligence to take the necessary steps and provide the committee with an appropriate level of assurance.

This also supports the published commissioning and quality principles for primary care. These identify the processes which will be followed in circumstances where the key performance indicators are not being achieved.

5.9 Continued Improvements to Medicines Management

The CCG is responsible for all GP prescriptions issued by its member practices. In 2014/15, the CCG spent £45.2 million on prescriptions and on commissioned services (nutrition and continence). The CCG is focused on ensuring all patients are receiving the right medications, at the right time, to date efficiency savings of over £1.8m have been achieved. A Prescribing Local Incentive Scheme commenced in 2014/15 and is reviewed regularly to ensure more effective practice is achieved. More info required from Stuart

5.10 Engaging Patients to Ensure Patient Pathways are Optimised

Rotherham CCG is committed to active and meaningful engagement with all its patients and potential patients Link to engagement and communications plan.

Patient Participation Groups have been in existence for several years; the changes to primary care commissioning will mean that the CCG can more effectively:

- Work with practices to ensure that wherever possible, practices have an active PPG, operating to acknowledged good practice (Link to NAPP website)
- That PPGs are supported through the PPG Network with information, shared good practice, and the opportunity to consider wider, cross Rotherham issues

However, PPGs are only one mechanism for patient and public engagement and experience. The CCG also aims to extend engagement, and work with a variety of organisations to improve the patient voice for specific communities, both geographical and communities of interest, for example people with specific long term conditions. If the CCG is to develop new ways of working; it will be vital to ensure that patient experience actively and meaningfully informs new systems and processes. This cannot be done in one way, and may involve any of the following:

- Condition specific focus groups
- Patient interviews and/or diaries
- Patient experience – from survey work, consultations, and other feedback (ie social media, complaints and issues raised with other bodies such as Healthwatch)

6. Enablers to Delivering our Strategy

6.1 Primary Care Estates and Premises

The CQC has a mandate for ensuring that essential standards of quality and safety are met.

However, the CCG undertakes quality visits which encourage practices to offer premises that:

- Deliver care in the right place with the right access
- Provide the patient with an environment that is fit for purpose
- Ensures easy access with clear sign posting
- Meets all statutory and mandatory requirements including compliance with all relevant disability, fire, health and safety legislation

Rotherham Metropolitan Borough Council are currently reviewing all 'government' estate to ensure it is fit for purpose and utilised appropriately across all services. Whilst this is welcomed by the CCG, many general practices are privately owned by partners in the practice and will not therefore be captured under this review. The CCG will therefore undertake an assessment of the current estate suitability for primary care in Rotherham. The strategic direction is towards larger practices, able to provide a range of general medical services, enhanced services and community based healthcare.

6.2 Information Management and Technology

The CCG has developed its IT strategy through consultation with GPs, RMBC and providers and the following identified the key areas where IT development will support the general practice agenda

Practices should be able to access electronic information relating to their patients when they are treated in other parts of the health system. This particularly includes discharge and out patient summaries, pathology, diagnostics and care delivered in community settings.

The CCG is supporting the roll-out of SystmOne to practices as the system of choice. At present 8 practices use a different system, EMIS web which to date has caused a barrier to linking practices. EMIS web and SystmOne have now agreed to facilitate interoperability between the 2 systems which will significantly support the CCG's strategy to facilitate the exchange of information between practices and other local providers, dissemination of guidelines, audit etc. whilst ensuring patient confidentiality is maintained, there are appropriate levels of data protection and access will be undertaken only on a need to know basis.

The CCG is also supporting practices to utilise the Electronic Palliative Care Co-ordination Systems (EPaCCS) which enables the recording and sharing of patient's preferences and key details about their care with those delivering their care. The systems support co-ordination of care and the delivery of the right care, in the right place, by the right person, at the right time. EPaCCS is the most effective way of providing an EOLC register for patients in Rotherham, enabling information to be seen and shared by all parties involved in a patient's care. A template has been developed and IT solutions put in place to enable the sharing of this information across primary care. GPs have a key part in the roll-out of an electronic EOLC register in Rotherham and linking this to the PMS premium will provide an excellent incentive for the EPaCCS to be fully implemented and for patients to get real benefits from a co-ordinated and well informed approach to their care

The CCG is committed to ensuring that all patients have equal access to internet based services, in particular the ability to book appointments online and order repeat prescriptions which are then automatically forward to pharmacies for collection. 33% of practices are now live with EPS Release 2 functionality and 82% of pharmacies. Many general practices in Rotherham already offer the facility to online book but it is not well publicised and websites are not easy to navigate so a key aim will be

- The CCG is also committed to exploring best practice in relation to IT solutions for self care, it will therefore commission and IT workstream to review the following:
- Monitor and review telehealth solutions that can be used to support the elective referral programme
- Monitor and review telehealth solutions that can be used as part of Long Term Conditions management
- Observe the work ongoing in other health communities and the whole system demonstrator programme to identify opportunities for local telehealth implementations in particular, there is strong support across the NHS for Flohealth with positive feedback from where it has been implemented to date

Implementing (RAIDR) Reporting Analysis & Intelligence Delivering Results. The CCG is required to provider member practices with high quality information on patient activity and costs. In summer, 15/16 the CCG will pilot RAIDR which is a GP developed tool initially from the North East of England. It is expected that this tool will help practices better understand their patient flows and compare their activity with their peers. The tool has a range of Dashboard covering areas such as emergency admissions, patients who regularly attend hospital, risk stratification, linkages between prescribing and activity data. There are also screens that will help practices with tasks such as flu vaccination, dementia diagnosis and data quality. Over time it will be possible to develop screens that will make reporting for Locally Enhanced Services to become less onerous. If the tool pilots well the CCG will procure RAIDR for all practice in autumn 15/16.

Appendix 2: Estates Strategy for General Practice within Rotherham

NHS Rotherham CCG

Strategic Estates Plan

August 2015

Contents

Executive Summary

Rotherham CCG Estate Strategy (2015-20*)*

This paper provides a summary of the CCG local estate strategy review process and the proposals to support the NHS 5 Year Forward View:

1. Scope Overview:

- Review only covers NHS PS Primary Care buildings
- The CCG has a new General Practice Strategy that is being developed which this Strategic Estates Plan (SEP) is a key enabler for delivery

2. The CCG drivers and challenges:

- Care closer to home in order to reduce hospital admissions and tackle the health inequalities.
- CCG has had delegated authority for commissioning general practice services and requires an effective SEP

3. The estate overview:

- 20 properties, comprising 15,200 sq. m
- Costs of £5.2m p/a
- Very few Leasehold opportunities.

4. Key themes emerging from the review:

- Overall the estate is in a good condition.
- The health infrastructure impact of a new 20,000 person residential development at Waverly.
- There are challenges around vacant space and looking to bring two modern good quality properties to full utilisation.

5. Property Opportunities and savings:

- Disposals opportunities totalling receipts of £265k
- Cumulative running cost saving of £867k over the 5 year period.
- Address the void space at 2 purpose built clinical facilities at Rawmarsh Customer Service Centre and the PDL Bungalows

6. Other property considerations:

- A new health care facility will be delivered in the Waverly area as this new settlement builds out. NHS PS will support the CCG in the delivery of this facility. NHS PS would likely become the new owner of this property but this is to be confirmed

7. Recommendations

- The strategy and opportunities are endorsed by CCG and NHS Property Services

1 Scope overview

- The CCG has an overall vision of working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities.
- This strategy reviewed the CCG clinical strategy and NHS PS property in the CCG's area – a summary of the key themes is included in Section 4 of this report.
- Rotherham's resident population is estimated at 259,800 who are cared for by a total of 36 GP practices (as at April 2015) alongside a centrally based walk-in centre providing 24/7 access.
- The CCG has a new General Practice Strategy that is being developed which this SEP is a key enabler for delivery. Since April 2015 the CCG has had full delegated authority for commissioning general practice services
- Many general practices are privately owned by partners in the practice, this is starting to become more of an issue as GPs are now more likely to choose to become a salaried GP rather than take on a partnership.
- Dialogue with other NHS stakeholders and the Council has taken place in the development of this strategy and will continue as the opportunities are developed.

2 The CCG drivers and challenges

Health Inequalities and increase in Elderly care needs

- 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 admitted to hospital who do not need to be, which results in high costs of treatment.
- Increasing numbers of older people with long term conditions which has a direct impact of health needs.

Clinical Strategy and Financial Implications

- Transforming community care and Care closer to home in order to reduce hospital admissions and tackle the issues listed above.
- Improved patient pathway so that patients are seen at the right place at the right time.
- Since April 2015 the CCG has had delegated authority for commissioning general practice services and this is a driver for a clear and effective Strategic Estates Plan.
- Maximising the partnership with RMBC to deliver optimum value for the Rotherham pound
- £75 million efficiency challenge over the next 5 years

3 The Estate Overview

Overall the estate is in a good condition as the former PCT invested heavily in the buildings with the council on joint medical centres.

20 Holdings / 15.2k sqm NIA / x Ha

13 Holdings - 7510sqm NIA

Health Centres

3 Holdings - 3502sqm NIA

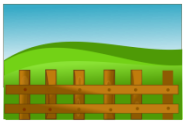
Hospitals

0 Holdings

Nursing/Care Home

3 Holdings - 4201 sq. NIA

Offices



1 Holdings (Car Park)

Land without buildings

0 Holdings

Other / Unknown

Top 5 properties (by size - NIA)

- **Rotherham Community HC** (Health Centre) 2914
- **Oak House** (Offices), 2461
- **220 BML (Badsley Moor Lane Hospital)** (Offices), 1740
- **Breathing Space** (Hospital), 1231
- **Aston Joint Service Centre** (Health Centre), 998

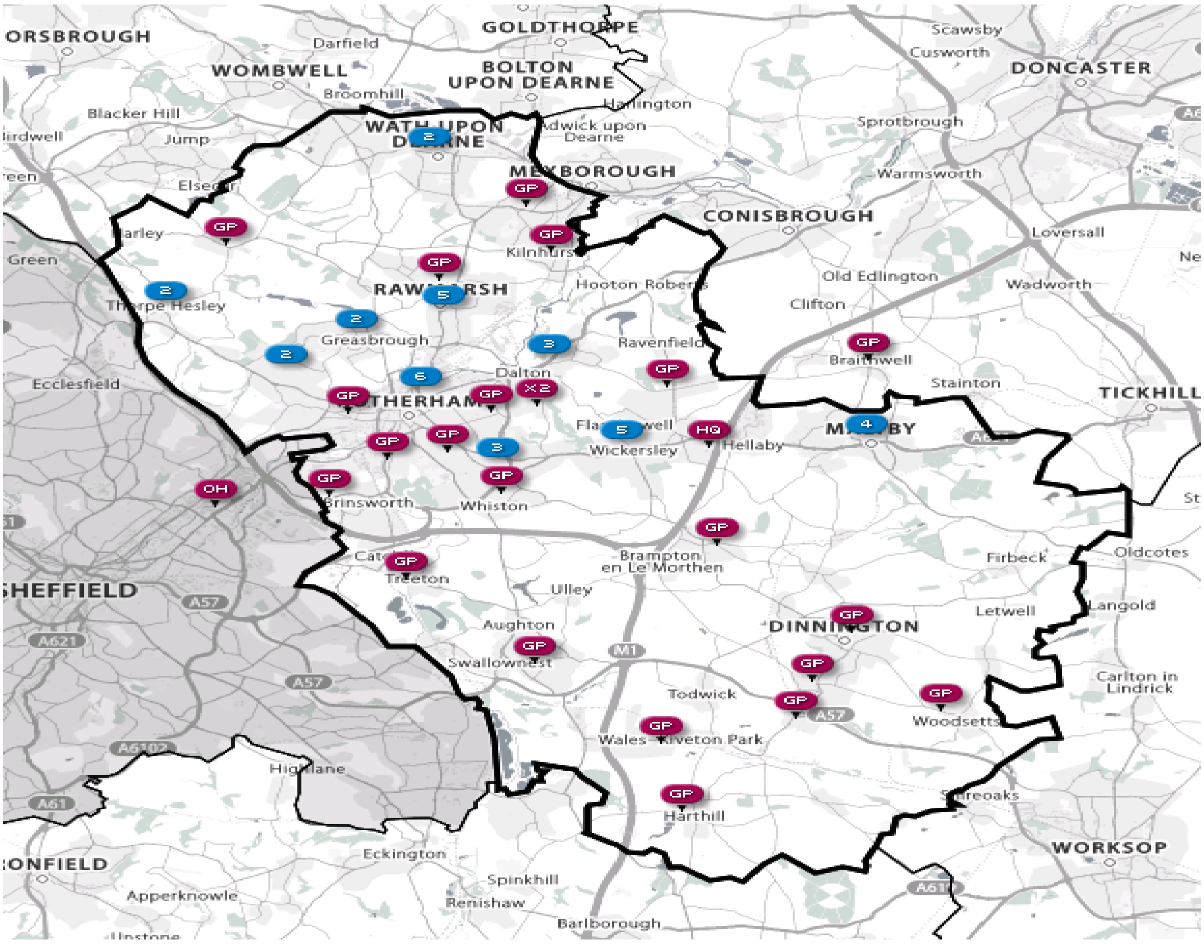
Total Cost of Estate

- **Based on 15/16 costs: £5.2m p.a.**

Top 5 Properties by Cost

Property	Running Cost £ p/a	Running Cost £ per m2
Rotherham Community HC (Health Centre)	£2,381,324	£817
Oak House (Offices)	£848,280	£345
220 BML (Badsley Moor Lane Hospital) (Offices)	£505.133	£292.61
Maltby Service centre (Health Centre)	£444,177	£779
Aston Joint Service Centre (Health Centre)	£280,324	£281

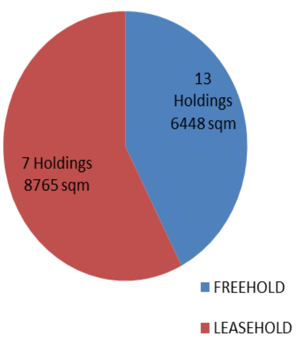
The Estate Overview – Estate Map



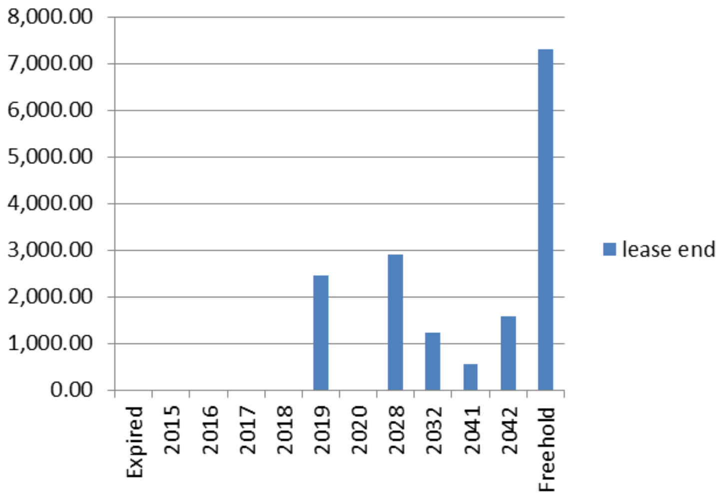
The Estate Overview

- Very few lease break opportunities and Oak house is a purpose built health admin building which is in an excellent location and popular with tenants.
- **Leasehold Opportunities (5 Years)**
- Oak house (CCG HQ and main admin base) end of lease 29.9.19

14.8K NIA sq m (20 Holdings)



Lease End + Break Profile (NIA sq. m)



4 Key themes emerging from the review

1. **Immediate Priorities:**

- Clinical leadership, both in primary and secondary care
- Delivery of effective out of hospital care to reduce admissions
- Supporting self-care and delivering care as close to home as possible and therefore a fit for purpose local estate
- Better IT to improve communication, access to services and patient education

2. Healthcare planning and Challenges:

The JSNA and Health and wellbeing objectives are:

- Prevention and early intervention
- Expectations and aspiration
- Dependence to independence - to tackle the marked health I equalities in Rotherham
- Healthy lifestyle – to tackle the marked health I equalities in Rotherham
- Managing long term condition- Rotherham has increasing number of elderly with these
- Reducing poverty -to tackle the marked health I equalities in Rotherham

3. Service Model Developments /Changes:

- Care closer to Home to reduce hospital admissions and tackle the above challenges
- Improved consistency in access to general practice – aspiring to within 24 hours for an urgent appointment and within 5 days for routine appointments

4. Financial considerations:

- The CCG has a £75 million efficiency challenge over the next 5 years
- Efficiencies passed on to all providers who must make 3.5% saving a year
- Finding each additional annual efficiency saving is increasingly challenging
- Rotherham will spend around £14.1 million on public health in 2014/15, commissioned by RMBC

5. Existing strategies and plans:

- Rotherham Health and Well Being Strategy that will be refreshed by September 2015 delivering the outcomes of the Better Care Fund and working with partners to improve public health outcomes in Rotherham.
- A new General Practice Strategy is being developed which this SEP is a key enabler for delivery.

6. Key site requirements:

Overall the estate is in a good condition as the former PCT invested heavily in the buildings with the council on joint medical centres. However the following are the key challenges the SEP must tackle:

i) Waverly

- The impact of the Waverly residential development (circa 20,000 new patients) and the subsequent new Primary Care provision needed for which the capital finance will be provided by S106 developer contributions.
- Linking to the Waverly development the future of nearby Treeton medical centre (NHS PS owned).
- NHS PS can provide assistance to the CCG regarding these issues and the path to future delivery.

ii) Rawmarsh Customer Service Centre (RMBC owned, NHS PS long lease)

- Rawmarsh Customer Service Centre – The building is currently underutilised with a high vacancy

rate (42%) but is an excellent modern purpose built building. A co-location opportunity exists with a cluster of GP practices and/or the vacant space could be marketed. (Options paper needed).

iii) PLD Bungalows (NHS PS owned)

- Are part of the 220 Badley Moor Lane site (NHS PS owned) have recently become vacant (100%). There were purpose built as a residential/day care for learning difficulties. They are part of and central to a large integrated wider health complex at BML that was built on a former hospital site. Given this they will have to retained for some kind of health or health related use and an options paper and/or a planning appraisal will need to be conducted to determine their future use.

iv) GP Estates Issues

- The future of Broom Valley GP (privately owned) which is in a poor condition. (Options paper needed)
- Canklow Road (NHS PS owned) poor quality building, potential to dispose and move to private premises.
- Rosehill medical centre (NHS PS owned) is small and in a poor condition.(options paper needed).
- A new health facility has opened at Dalton and the former Dalton MC (NHS PS owned) can be disposed.

5 Property Strategy Forward View

 **Clinical Estate**	Overall the estate is in a good condition and most sites have had recent investment. NHS PS have identified with the CCG some sites that are in a poor condition and need replacement or surplus to requirement. Need to tackle the key void space at Rawmarsh. A new facility is needed to meet planned growth at Waverly. This will funded by developers as part of a S106 agreement.	→	Dispose of surplus sites at Dalton Health Centre (new build complete) and review of the poorer quality sites at Rosehill and Canklow Road (options papers needed). Assess the future of Broom Valley GP (options paper needed). Fully utilise the Rawmarsh Centre through co-location of nearly by GP practices or sub letting. Help deliver the new facility at Waverly linked to the existing GP facility in Treeton.
 **Admin Estate**	Oak house (CCG HQ) has a lease end opportunity, however the CCG have confirmed the property is ideal for them. The 220 BML is 100% occupied by the council and forms the Learning Disability Service. PLD Bungalows were purpose built for a service that didn't develop the numbers required to make it viable. They are part of the above complex/site and are vacant and need to be found a new use.	→	Retain Oak house and 220 BML. Fully utilise the PLD Bungalows. An options paper and potentially a planning assessment would be required. Then marketing.

 **Estate Metrics**	Running costs: NHS PS estate £5.2m p/a Estate footprint: 11,012sq. m of clinical space across 16 property holdings. 4,201sq. m of back office space across 3 property holdings.	→	Running costs: Target to reduce the ongoing running cost to less than £5m p/a Around a 4% saving. A cumulative saving of £857k over the 5 year period. Estate footprint by March 2020: - 10,612sq. m. of clinical space across 13 properties. - 4,201sq. m of back office space across 3 property holdings. - Reduction of void.

6 Summary of Property opportunities

Summary of financial benefits:

Opportunity Area	15/16	16/17	17/18	18/19	19/20	Totals	One-off capital receipts	One-off maintenance avoidance
Consolidation and disposal opportunities	63	12	0	0	0	**75**	£265k	TBC
Improved utilisation and sub/let savings / maintenance avoidance Marketing of surplus (void) space	0	126	0	0	0	**126**	0	TBC
Leasehold opportunities – - Exits - Regears	0	0	0	0	0	**0**	0	TBC
Totals	**63**	**138**	**0**	**0**	**0**	**201**	**£265**	**TBC**

Summary of non-financial benefits:

- Reconfiguration of the estate to better meet the commissioners needs
- Disposal of property that is surplus to need or is not fit for purpose.
- Full utilisation of quality modern purpose-built estate at Rawmarsh Service Centre and PDL Bungalows at Badsley Moor Lane.

Consolidation and disposal opportunities:

Opportunity	Estimated Running Cost savings £k pa	Estimated disposal proceeds £k	Target Financial Year of savings
Disposal of Canklow Road GP Surgery (NHS PS Owned)	£4k	£48k	16/17
Disposal of Dalton Health Centre + Land (NHS PS Owned)	£63k	£125k	15/16
Disposal of Rosehill Medical Centre (NHS PS Owned)	£8k	£92k	16/17
Totals	£75k	£265K	

Canklow Road

Rosehill Medical Centre

Improved utilisation and sublet savings:

Opportunity	Estimated Running Cost savings £k pa	Maintenance Avoidance £m pa	Target Financial Year
Option 1 Rawmarsh Service Centre. Improve utilisation by facilitating with the CCG the co location of 3 x privately owned GP practices	£85k	Tbc	16/17
Option 2 Rawmarsh Service Centre. Market the vacant space (or residual space if 1 or more of the GP relocate)	£85k	tbc	16/17
Market the 4 PLD Bungalows at 220 Badsley Moor Lane (offices/residential other)	£41k	TBC	16/17
Totals	£126k	£TBA	

Rawmarsh Customer Service Centre

Leasehold exit opportunities

Opportunity	Estimated Running Cost savings £ p/a	Estimated disposal proceeds £ p/a	Target Financial Year
None (Oak house is the only opportunity, it was purpose built as the PCT HQ and the CCG and other tenants want to remain)	0	0	N/A
Other property considerations: A new health care facility will be delivered in the Waverly area as this new settlement builds out. A facility of al least 1300 sq. m is agreed in the S106. NHS PS will support the CCG in the delivery of this facility. NHS PS would likely become the new owner of this property but this is to be confirmed			

Oak House current CCG HQ

7 Investment considerations

Investment considerations:

- NHS PS to offer support to deliver the health care element of the Waverly development where a health care centre of at least 1300 sq. m is stipulated in the S106 signed on 03/03/2011. Negotiations with the Local Planning Authority and developer will take place and a delivery route would be worked up in due course. It is envisaged that this would be a NHS PS asset but developed using capital from developer contributions.
- Currently there is land held by NHS PS adjacent to the Treeton Medical Centre for a new build scheme to replace the ageing building. The practice has so far not indicated that they would like NHS PS to pursue this new build through a customer capital scheme. There is potential to link this with the new build at Waverly. Options need to be discussed with the CCG and practice and agreed by the Primary Care sub-committee

8 Financial Analysis

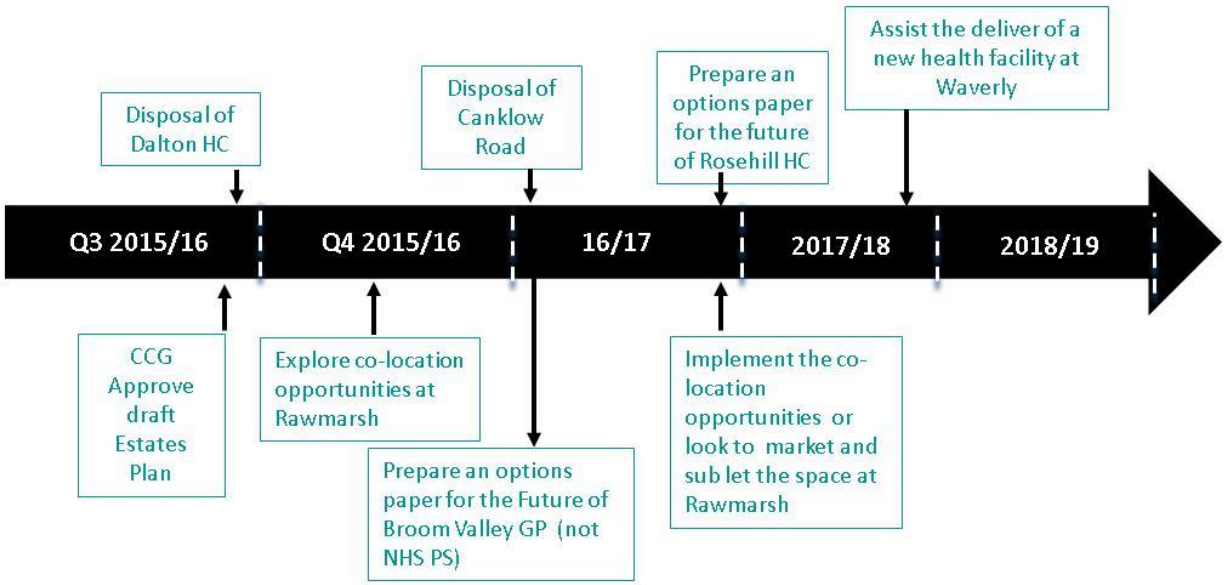
Indicative profile of running costs savings:

- **Cost savings profile based on full year benefit from the year of the event with cumulative benefit.**
- **Disposal proceeds shown in year of receipt**

Target financial Year	15/16	16/17	17/18	18/19	20/21	5 Year Total
- 15/16 savings	63	63	63	63	63	315
- 16/17 savings		138	138	138	138	552
- 17-18 savings			0	0	0	0
- 18/19 savings				0	0	0
- 19/20 savings					0	0
Total 5 Year Running Cost savings	63	201	201	201	201	867
Disposal Proceeds £k	125	140	0	0	0	265
Net Benefit £k	187	341	201	201	201	1132

9 Work Plan

- NHS PS is working with the CCG to deliver the strategy.
- Timeline of work programmes and planned disposals



10 Recommendations

Example CCG Estate Strategy (2015 -19): Recommendations for CCG approval:

1. Implementing priority healthcare changes
   - The CCG has a new General Practice Strategy that is being developed. This Strategic Estates Plan is a key enabler for delivery.
   -
2. Cost reduction opportunities
   - The review has identified costs savings of £200K.
   - These costs saving can be made with little impact on service delivery
   - The disposals identified will be added to E-Pims and offered to all priority purchasers including the local councils. If no interest is received NHS PS will openly market the properties

- The capital receipts are based on estimates, market valuations will be carried out to ensure the disposals receive best value.

3. Dealing with void space
   - NHS PS will look at co-location opportunities with the CCG and individual GPs focused on the Rawmarsh Service Centre in Q4 of 2015/16.
   - If this doesn't produce results then NHS PS will actively market the space in 2016/17.
   - Following an options appraisal NHS PS will actively market the vacant space at the PDL Bungalows in 2016/17.

4. Improving estate utilisation
   - The actions listed in the above section are the key to improving estate utilisation in Rotherham.
   - The utilisation will continue to be monitored and reviewed and any significant changes will be addressed by the CCG and NHS PS in line with this strategy.

6. Work Plan
   - The plan at section 9 outlines a number of key projects that will need to be progressed to realise the savings.
   - These projects need to be worked through utilising NHS PS Asset management teams, Capital and Facilities teams.
   - NHS PS and the CCG will work together to drive forward the opportunities and optimise the benefits.

Rotherham Doncaster and South Humber NHS Foundation Trust

CQC Inspection

Kathryn Singh

Chief Executive

Sign up to SAFETY LISTEN LEARN ACT

RDaSH leading the way with care

Rotherham Doncaster and South Humber NHS Foundation Trust

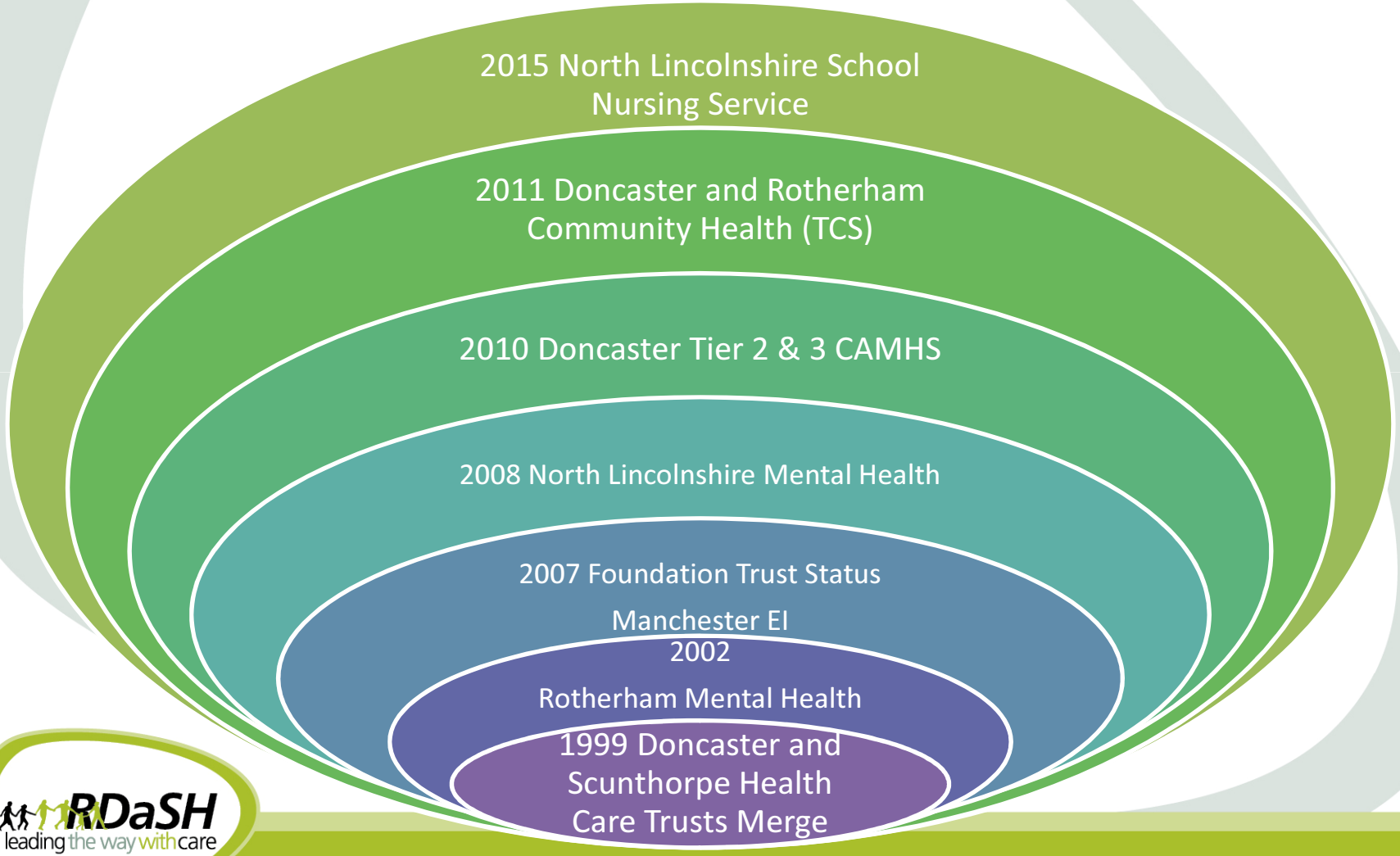
What I will cover

- Understanding our history & our services
- Our ratings
- What the CQC said we do well
- What the CQC said we must improve
- Our approach and response
- Our governance arrangements
- Support with our action plan

RDaSH leading the way with care

Understanding our history …

Rotherham Doncaster and South Humber NHS Foundation Trust



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Our services in 2016 …

Rotherham Doncaster and South Humber NHS Foundation Trust

The services we provide in the different localities are presented in this map.

RDaSH leading the way with care

Facts about RDaSH …

Rotherham Doncaster and South Humber NHS Foundation Trust

Employees	Circa 4,300 (3,700 WTE)
Volunteers	Circa 200
Annual budget	£155 Million
Commissioners	• Clinical Commissioning Groups (CCGs) • Local Authorities • Others, e.g. Drug Treatment Agency • NHS England

RDaSH leading the way with care

RDaSH facts continued…

Rotherham Doncaster and South Humber NHS Foundation Trust

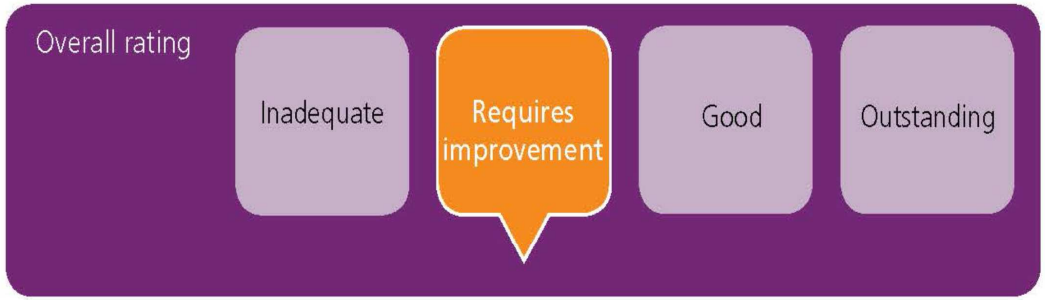
Locations	240 across 5 regional areas
Number of beds	347 beds on 21 wards
Community Teams	89 across 5 localities
Adult Social Care	Learning Disability Domiciliary Services in Doncaster and Rotherham Learning Disability Registered Homes: 88 Travis Gardens, Danes Court and Station Road
Patient contacts	In 2014/15 • 82,356 people accessed our services • 912,409 face to face contacts • A further 143,363 non face to face patient contacts

RDaSH leading the way with care

Care Quality Commission

Last rated - 19 January 2016

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

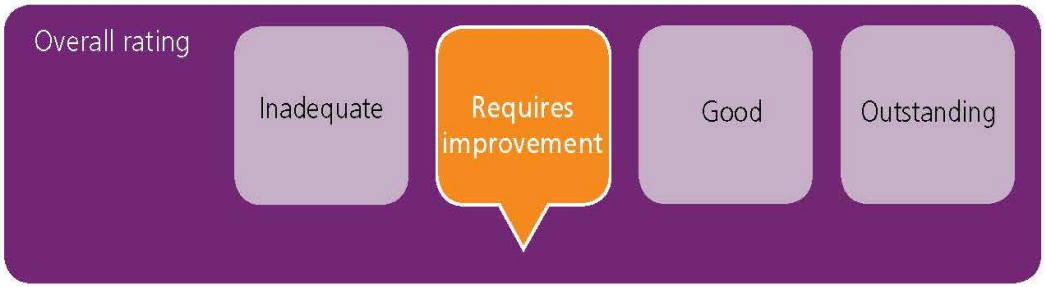


	Safe	Effective	Caring	Responsive	Well -led	Overall
10a/10b Station Road	Good	Good	Good	Good	Good	Good
88 Travis Gardens	Good	Good	Outstanding ☆	Good	Good	Good
Domicilliary Care	Good	Good	Good	Good	Good	Good
Substance misuse services	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Community health services for children, young people and families	Good	Good	Good	Outstanding ☆	Outstanding ☆	Outstanding ☆
Community health inpatient services	Requires improvement	Good	Good	Good	Good	Good
Forensic inpatient/secure wards	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Good	Outstanding ☆	Good	Outstanding ☆	Good	Outstanding ☆

Care Quality Commission

Rotherham Doncaster and South Humber NHS Foundation Trust

Last rated - 19 January 2016



	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Good	Requires improvement	Good	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Outstanding ☆	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Community health services for adults	Requires improvement	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Specialist community mental health services for children and young people	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good

Our overall rating …

Rotherham Doncaster and South Humber NHS Foundation Trust

Overall Requires improvement

Read overall summary

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Good

RDaSH leading the way with care

What the CQC said we do well …

Rotherham Doncaster and South Humber NHS Foundation Trust

Learning Disability Services	• Solar Centre - commended by patients and carers • 88 Travis Gardens – Outstanding for Caring
Adult Mental Health Services	• Mental Health Crisis Teams – Rated Outstanding Overall by CQC • Mulberry House – Introduction of the 'Perfect Week' • Doncaster Perinatal Service • Rotherham dedicated service for deaf patients with mental health problems
Children & Young People's Mental Health Services	• Safeguarding Advisor in post and training at a high level across all services • Out of hours duty system provides excellent coverage of emergency/crisis calls • Peer Support Workers assist with transition to adult mental health services
Drug & Alcohol Services	• Peer Mentor Scheme developed, including training packages to provide service users with the skills and knowledge to become Peer Mentors • Peer Mentors from New Beginnings worked across the services in Doncaster and three had progressed into paid employment
Adult Community Services	• Telehealth Services developed to respond to the needs of patients with long term conditions • Specialist Falls Service facilitates a Falls and Balance Group that has received positive patient feedback • Dietetics Service innovative use of the MUST Tool to support community nurses offering 'Food First' advice

RDaSH leading the way with care

What the CQC said we do well …

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

End of Life Services	• Caring and compassionate staff • Patients and relatives were empowered and supported to manage their own health • Evidence of Lessons Learnt
Community Inpatient Services	• Implemented Fall Safe • Care records are comprehensive • Staff were caring and respectful of patients privacy and dignity, patients were involved in decision making
Community Health for Children, Young People and Families	• Rated Overall by CQC as Outstanding • Development of local education and health aids • Development of 'Roots of Empathy' to prevent bullying, funded by NHS England
Forensics	• Reducing Restrictive Interventions training introduced to assist patients to develop positive ways to manage their aggression, resulting in a 50% reduction in physical interventions
Older People's Mental Health Services	• Community-based services for Older People rated as Outstanding for Caring • Young Onset Dementia Day Care offering carer respite and patient engagement • Male Carers Support Group for patients with Huntingdon's Disease • Cognitive Stimulation Programme – support patients with cognitive functioning • Kings Fund advice and guidance to make wards Dementia Friendly

RDaSH leading the way with care

Rotherham Doncaster and South Humber NHS Foundation Trust

Our approach and response…

September 2015 - Immediate actions were taken and action plan drafted following initial feedback from CQC

November 2015 - Trust Quality Improvement Plan developed following receipt of draft CQC reports

December 2015 - Executive director leads identified for all quality improvement actions

December 2015 - New Governance structure agreed (part of Well Led)

January 2016 - Executive Director of Health Informatics post approved

- BoD approved our Listening into Action application (next cohort will start April 2016)

RDaSH leading the way with care

Our action plan …

Rotherham Doncaster and South Humber NHS Foundation Trust

Safe: Community mental health services for people with learning disability or autism

Action already underway:

- **Ironstone Centre -** our Trust has provided non-recurrent funding for additional staff and a business case has been submitted to North Lincolnshire CCG to request additional staff resource. An external review of community LD services has been commissioned.
- **Learning Disability Services –** we have undertaken a review of the completion of risk assessments across all learning disability community services and have implemented a revised monitoring, escalation and audit process.
- **Rotherham Community Learning Disability Team -** clinical environment assessed and actions taken to ensure the safety of people who use services and staff. Psychiatry consulting rooms made safe by removing non-essential equipment and a clinical consulting room has been identified.
- **Learning Disability Services –** personal audible alarms provided to all staff working in learning disability consulting rooms in Doncaster, Rotherham and North Lincolnshire.

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Safe: Community based mental health services for working age adults

Action already taken:

- **Mandatory/statutory training compliance –** fortnightly monitoring of training compliance by team implemented and monitored by Assistant Director
- **Access to Patient Information –** training needs analysis underway to provide targeted focused training based on individual staff competencies using IT Systems. Training to be completed during March/April 2016.
- **Medication Management –** implementation of standard operating procedures across adult mental health services to standardise recording of medication in relation to storage, prescribing, administration and recording of medicines.

- **Physical Health Monitoring –** A Trust wide Physical Health and Wellbeing Strategy is in development and will continue to deliver physical health and wellbeing clinics in Early Intervention in Psychosis services and also introduce as part of the Nurse Led Clinics in all localities.
- **Risk assessments –** immediate action taken to review and identify patients without a current risk assessment and complete risk assessments. A Community Managers Group to develop, implement and embed risk assessment and service specific care planning templates has been established.

Actions already underway …

Rotherham Doncaster and South Humber NHS Foundation Trust

- **Patient Engagement –** Our Trust is committed to working and engaging with patients, carers and the public in a wide range of ways. However, we recognise that our current approaches to ensuring that people's views are heard needs reviewing. This will be a CEO led piece of work and our partners will be encouraged to participate in the development of our **NEW** Patient & Public Engagement Strategy
- **Mandatory/Statutory Training Compliance –** continues to be reported monthly to the Board of Directors. Compliance as at 28 January 2016 is 88.06%. The Trust has implemented a robust system of monitoring compliance by individual staff, by business division and Trust wide in order to achieve 90% compliance by 31 March 2016.
- **Duty of Candour –** DoC Action plan implemented in September 2015 to improve documentation, recording, medical involvement and reporting. An Internal Audit will be completed by 31 March 2016

RDaSH leading the way with care

Actions already underway …

Rotherham Doncaster and South Humber NHS Foundation Trust

- **Clinical Environment -** Trust to re-define the terms of reference for the Environment Risk Group and provide clear guidance to encompass all aspects of risk related to the clinical environments area
- **Risk Assessment/care planning –** Immediate action taken to review patient risk assessments in identified services, complete risk assessments and monitor compliance locally. In addition, a Trust wide FACE Risk Assessment audit to be undertaken during quarter 2, 2016/17
- **Medicines Management –** Reviewing Trust wide Safe and Secure Handling of Medicines Policy, including the revision of medicines management forms. Audits regarding omitted/unsigned prescriptions, dosage and fridge and room temperatures strengthened
- **Venous Thromboemolism (VTE) –** All patients are now risk assessed on admission or transfer to community health inpatient wards for VTE. VTE is recorded as part of the monthly Patient Safety Thermometer.

RDaSH leading the way with care

Our governance arrangements …

Rotherham Doncaster and South Humber NHS Foundation Trust

- Published CQC Reports to the Board of Directors meeting on 28 January 2016
- Integrated CQC Improvement plan (progress report) to Board of Directors (monthly)
- Overall monitoring and oversight undertaken by Executive Management Team (EMT)
- Must do action plans monitored through Board of Directors Sub Committee Structure
- Divisional-level action plans to address local issues and share learning

RDaSH leading the way with care

Support with our action plan …

Rotherham Doncaster and South Humber NHS Foundation Trust

- Ironstone Centre Staffing – temporary funding required whilst service is reviewed
- Electronic Patient Record – our Unity Programme
- Developing an RDaSH approach to PPE
- Recognition of partnership priorities and joint working

RDaSH leading the way with care

Finally …

Rotherham Doncaster and South Humber NHS Foundation Trust

- We have reviewed our vision, values and strategic objectives
- We will continue to focus on our patients
- Our services were rated as Good for being Caring, Responsive and Well-led
- 13 out of 17 services rated Good or Outstanding
- We have listened to the CQC feedback and recognise the areas where we are required to make improvements:
  - **Safe**
  - **Effective**
- We are sharing CQC findings with our staff and will ensure that we taken action and learn.

RDaSH leading the way with care

Thank you

Rotherham Doncaster and South Humber NHS Foundation Trust

Any questions?

RDaSH leading the way with care

ROTHERHAM SAFEGUARDING ADULTS BOARD

STRATEGY 2016-19

CONTENTS

1. FOREWORD

It gives me very great pleasure to welcome and introduce this document which has been developed by agencies and community representatives in Rotherham to take forward the vital work in safeguarding adults in need of care and support in the town.

Around the country there have been many stories of care which has not achieved the standards we would all expect and want for our loved ones. There is an increasing understanding of the factors which lead to poor and sometimes abusive situations whether they be in the home of an individual or a care setting. We are also developing an understanding of what interventions are helpful to reduce or avoid such incidents. In response to this, new legislation has been introduced this year to guide local areas in their practice and to raise the profile of this important subject.

We recognise that the way agencies and the people of Rotherham work together is vital in preventing abuse, identifying risky situations and responding appropriately when abuse has occurred. This strategy will help us to continue to improve and commits us to working together with common objectives and commitments.

The strategy builds on the excellent work previously undertaken and sets out the vision and priorities for future work. The vision that people should be able to live a life free from harm and our culture should not tolerate abuse is championed by everyone on the Board and I look forward to joining the team to provide leadership, support and challenge to the shared endeavour to create a safer Rotherham.

Sandie Keene
Independent Chair Rotherham Safeguarding Adults Board

2. WHAT WE WANT FOR ROTHERHAM

The Safeguarding Adults Board is committed to achieving this vision

People of Rotherham are able to live a life free from harm where all organisations and communities

- **have a culture that does not tolerate abuse**
- **work together to prevent abuse**
- **knows what to do when abuse happens**

It's the Board's job to make the vision real by ensuring that agencies who support people at risk of harm are able to prevent abuse happening, act swiftly when it does and are competent in achieving good outcomes for people. We will know we have achieved it when:

- *People are aware that protecting them is taken seriously and their concerns will be responded to sympathetically.*
- *People know where to go to when they have a concern.*
- *People will be supported to report a concern.*
- *People's desired outcomes are always taken into consideration.*

  Services always work with individuals to make them feel safer.

  After reporting a concern they will be told what has been done about it.
- *People will know what to expect from the safeguarding system.*
- *People will know what the Safeguarding Board is and what it does.*

3. WHY DO WE NEED A STRATEGY?

Unfortunately adults who need some form of care can be subjected to varying forms of abuse and neglect**. Last year there were 1,669 reports of adult abuse in Rotherham**. Like child abuse it needs all relevant agencies to work together to tackle it and, as far as possible, to prevent it happening.

The process of working with people to stop abuse, make them safer and prevent abuse is termed **safeguarding**. The abuse can take many forms such as: physical, sexual, psychological, financial, exploitation, neglect (including deliberate acts of omission), discrimination, institutional, hate crime, domestic, organised crime, slavery and trafficking.

To deal with this complex area the various agencies need an overall strategy so that they can coordinate their resources and planning. The strategy consists of a set of **principles and objectives that everyone believes in** and works to. It also tells the public what they can expect and forms the blueprint for the more detailed work plans that are developed from the strategy and gives a means of measuring how well we are doing to make people safer.

4. WHAT IS THE SAFEGUARDING BOARD AND WHAT DOES IT DO?

It's a **legal duty** for each local authority to set up a Safeguarding Adults Board. Its objective must be "to help and protect adults who have needs for care and support, who are experiencing or are at risk of abuse or neglect, and as a result of their needs are unable to protect themselves from abuse or neglect." This is whether or not the adult is having their needs met or they meet the local authority's eligibility criteria for care and support services.

As well as its main objective the Care Act 2014 sets out the board's specific functions:

1. **It must publish a strategic plan** for each financial year that sets how it will met its main objective and what the members will do to achieve these objectives. The plan must be developed with local community involvement, and the Board must consult the Local Healthwatch organisation.

2. **It must publish an annual report** detailing what the Board has done during the year to achieve its main objective and implement its strategic plan, and what each member has done to implement the strategy as well as detailing the findings of any Safeguarding Adults Reviews or any on-going reviews.

3. **It must conduct a Safeguarding Adults Review where it believes that agencies did not work together well enough and someone was seriously harmed.**

The Board can only achieve its objective through its members by co-ordinating and ensuring the effectiveness of what each of them does. Every Board must have three **statutory members the police, the NHS and the local authority**

but it has wide-ranging discretion to include whatever other organisations that will help it achieve its objective. The Board has a group of members who are all active in protecting adults at risk of harm in various ways. The partner organisations are:

- Independent Chair of the Board
- Rotherham Metropolitan Borough Council
- NHS Rotherham Clinical Commissioning Group
- South Yorkshire Police
- South Yorkshire Fire and Rescue Service
- Healthwatch Rotherham
- The Voluntary Sector
- Rotherham Safeguarding Children Board
- NHS England
- Rotherham NHS Foundation Trust
- Rotherham Doncaster and South Humber NHS Foundation Trust

Each of these organisations has a representative on the board who has a thorough understanding of abuse and neglect and its impact and can make sure their organisation can carry out the relevant parts of the Board's strategy. The board is chaired by an independent person (not employed by any of the members) who has good experience of adult safeguarding, partnership working and is able to challenge and hold the members to account.

The board work to the six principles set out in the **Care Act 2014** and through this strategy make them relevant to Rotherham:

Empowerment - presumption of person led decisions and informed consent

Prevention - it is better to take action before harm occurs

Proportionality - proportionate and least intrusive response appropriate to the risk presented

Protection - support and representation for those in greatest need

Partnerships - local solutions through services working with their communities

Accountability - accountability and transparency in delivering safeguarding.

The national statutory guidance six principles of safeguarding

The Rotherham Safeguarding Adults Board holds full board meetings every two months. It runs a number of sub-groups who carry out the board's work such as: developing multi-agency policies and procedures; promoting training that ensures a common understanding of abuse and neglect; making sure the public know about adult abuse and what to do if they suspect it is happening, etc. It has a relatively small budget which is made up of contributions from the core partners.

The table below is not exhaustive but will help to clarify what the board does and doesn't do.

RSAB responsible for	**RSAB not responsible for**
Assuring service coordination	Provision of services
Production of multi-agency safeguarding procedures	Provision of advocates
Quality assurance of safeguarding	Quality assurance of providers
Promoting access to justice	The Multi Agency Safeguarding Hub
Safeguarding Adult Reviews	Referrals and casework
Production of an adult safeguarding strategy and annual reports	Inspecting services and residential homes
Assuring safeguarding for people aged 18 and over.	Children and young people up to the age of 18
Raising public awareness about adult abuse	Criminal investigations and proceedings
Coordination of adult safeguarding training	
Holding member organisations and people to account	

5. WHAT ARE OUR PRIORITIES?

The board members have given a lot of thought about what we can deliver for Rotherham and how we can do it. Much has been achieved in the past but there is a lot more work to do. And we can only do it by working together on a plan that is relevant and realistic. We want to reach our vision for Rotherham as soon as possible but can't do everything at once. Therefore we have set ourselves **five main priorities for the next three years**.

a) **Review and update the Board's organisation to give it the capacity to deliver its strategic objectives and promote a constructive and challenging culture.**

b) **Review and update the Board's constitution to maximise partnerships and establish its identity.**

c) **Involve the public in planning, quality assurance, service provision and communication.**

d) **Promote a culture change within all the organisations to embed a person-centred approach.**

e) **Establish a user-friendly reporting framework which measures and assures the Board's work and its impact on safeguarding.**

This strategy sets out how we intend to achieve each of the priorities and will be the board's blueprint for the next three years. It will ensure everyone - board members, staff, and the public - are clear about what we want to do and can work together to make it happen.

While the strategy gives a broad sweep it will be delivered through a **work plan**. Each year board members will agree on exactly what they need to do to achieve the agreed strategic priorities. The work plan will be published alongside the strategy and the board will implement the plan.

We will measure how well we are helping to keep people safer and hold partners to account to ensure they meet their work plan commitments. At the end of each year we will publish an annual report that says what and how we have done to deliver that year's work plan and agree a new work plan for the following year. The Board will also do its bit to support partners, listen and learn from people who have been abused and work actively with other boards and public bodies.

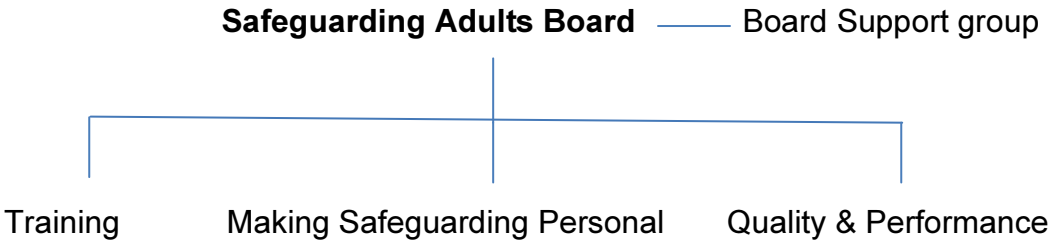
6. HOW ARE WE GOING TO DELIVER THIS STRATEGY?

a) Review and update the Board's organisation to give it the capacity to deliver its strategic objectives and promote a constructive and challenging culture.

Since the Board was established there have been many changes - increased demand, widening of responsibilities, re-organisations in partner organisations and cuts in public service funding. So we have looked at the Board and decided what must be done to make sure that it can meet its aims.

Structure

In order to manage the delivery of this strategy and work plans we will revise the current sub-group structure to create three standing sub-groups and a Board Support Group. Other task and finish sub-groups will be agreed as required. Each of the sub-groups will be led by a chair accountable to the Board and be members of the Board Support Group which will coordinate the overall work as shown in the diagram below.



A group to oversee the conduct of any SAR's will be convened when required.

Capacity

The board needs to increase its capacity in order to meet **new statutory responsibilities, increases in safeguarding work and to deliver this strategy**. We will increase our resources by agreeing funding from the three core partners for the life of this strategy. Appoint a board manager, establish a contingency fund for any independent safeguarding reviews that may arise and to allow greater involvement of the public. We will also ensure that relevant organisations have identified an officer who will manage concerns about any staff who abuse or neglect their service users.

We already work with other boards in the region to share learning and ensure we all take a consistent approach and use the South Yorkshire Safeguarding Procedures. We will continue to learn and implement good practice both regionally and nationally.

We will review board membership to ensure all bodies are represented and at the right level of seniority. Partners are committed to work with the Board by committing practical involvement to implement this strategy, contributing time to run the sub-groups and a proportional sharing out of the work plan tasks.

Learning

While the Board's members are committed to delivering this strategy they also want to be **open to learning** encouraging trust, sharing and constructive challenge between members. There will be regular development sessions for the Board and its members to ensure everyone is clear on what is happening and are able to freely share their views with each other.

We will promote a **non-blame culture** - it is not the Board's job to apportion blame, there are other ways of doing that eg. the courts, disciplinary processes, complaints management, etc. It is the Board's job to ensure that people do have access to justice and to **learn how to make improvements when things go wrong.**

The new Review and Audit sub-group will consider what lessons can be learned from practice, professional and procedural issues. It will adopt a range of review methods to examine cases as effectively as possible up to and including a full independently-led Safeguarding Adults Review. There will be a review protocol so that partners will know what will happen when a review takes place and what will be expected of them.

Managing risk

The Board will develop a **strategic risk management framework** that measures and reports threats and risks to the implementation of the strategy and work plan. It will be reported to and updated by the Board at each of its quarterly meetings.

We will also build and constantly update a detailed picture of **local needs and issues** which all members can access and add to. In this way we will be able to pinpoint possible vulnerable areas and ensure early action to prevent abuse or neglect.

We will update the **multi-agency procedures** so that everyone is clear about the pathway for handling reported concerns and alerts. It will take into account the new duties on local authorities to make enquiries under section 42 of the Care Act and explain alternative ways of helping where an alert does not fit the section 42 definition.

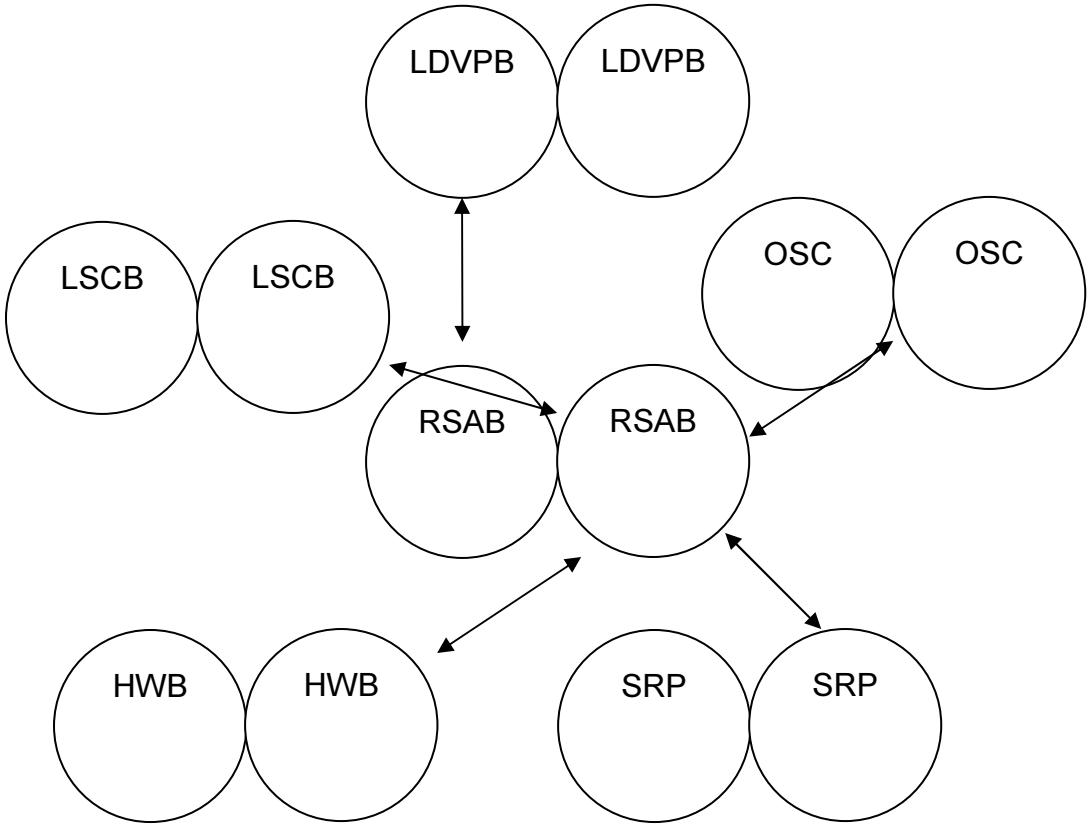
Workforce

It is vital that all workers in care and health understand adult safeguarding and know what to do when they work with people who are at risk. The Board will develop its **training and development strategy** to ensure that all staff keep up to date with developments in practice, policy changes and understand what is available to support their work. It will include awareness-raising for staff in all sectors who are in contact with adults at risk of harm so that they are be able to recognise abuse and know what to do if they have concerns.

b) Review and update the Board's constitution to maximise partnerships and establish its identity.

The Board can only make things happen through its member organisations and by **working in partnership** with other boards and committees. We will therefore draw up a constitution to make it clear to members, other organisations and the public how we will work together. It will set out an operating framework, the responsibilities and accountabilities of Board members and how we will link to other relevant bodies. The work will include a review of terms of reference, protocols, procedures, etc in order to update them in line with new statutory duties and most up-to-date practice.

We will effectively link the Board into other bodies where there is overlap of provision or responsibility. The current picture will look like this but it will be regularly updated as organisations change:



KEY

SRP Safer Rotherham Partnership.
LSCB Local Safeguarding Children Board.
LDVPB Learning Disability Valuing People Board.
OSC Health and Social Care Overview and Scrutiny Committee.
HWB Health and Wellbeing Board.

Ensuring a **free and open flow of information** between organisations and workers is an absolute necessity for good safeguarding to take place. The board will always support people who pass on information to relevant others where it will help to make people safer. All staff, in all partner agencies, should understand the importance of sharing safeguarding information and the potential risks of not sharing it. Therefore we will work with the organisations to draw up an information-sharing protocol which ensures that vital information is passed on and boundaries to confidentiality are clear for everyone.

If the partnerships are working well then **people will see the following outcomes**:

- The Board and its members are fully compliant with the Care and Mental Capacity Acts.
- Members report good progress on implementing the work plan at Board meetings.
- We publish an annual report that details what members have done to implement the Board's strategy.
- Annual self-assessments and peer reviews show how well the Board and its members are meeting our responsibilities.
- Board members are aware of the levels of safeguarding activity and are assured about the quality of intervention, including audits of casework.
- Member organisations report details of any inspections that have examined their ability to safeguard adults.
- There is a free-flow of information between workers and organisations within realistic confidentiality boundaries.
- There is a smooth transition of young people to adult safeguarding when they become 18.
- There is a good working relationship between the Safeguarding Adults Board and other boards and committees.
- Service users, family carers and the public have a real say in how we carry out safeguarding in Rotherham.

c) Involve the public in planning, quality assurance, service provision and communication.

The Board recognises that it has not involved service users, carers or the public sufficiently in its work; therefore we are making a new commitment to **increase involvement of individuals and communities** in developing our understanding of their expectations and needs. We will

1. Develop a partnership public involvement strategy that will consider current engagement networks and identify any gaps, to ensure a fully inclusive strategy.

2. Develop a partnership communications strategy that highlights the Board's purpose and priorities and provides a two-way flow of communication.

3. We will look at evidence and learning from across the country to find the best ways of achieving meaningful public engagement.

More specifically we want to:

- Raise public awareness of abuse, neglect, health and wellbeing. Make sure it is easy to report concerns and publicise how to do so.
- Create a new and dedicated Board website (independent of the council's web site). Among other information it will provide access to the Board's documents, explanations of what safeguarding means and hyperlinks to other helpful sites.
- Facilitate discussions on how to improve safeguarding, with the public and representative bodies eg Age UK, Healthwatch, Adult Survivors Group, etc.
- Agree and coordinate public messages and press statements.
- Raise the public profile of the Board so people will know what it can do for them.
- Issue regular newsletters and target them at people who could be at risk eg. people in receipt of direct payments.
- Open up access to Board meeting minutes and other key documents.
- Conduct wide consultation on the Board's strategy, annual reports and other projects.
- Update and make relevant the public face of safeguarding eg posters, leaflets, etc.

d) Promote a culture change within all the organisations to embed a person-centred approach.

We want to develop a culture within care and health organisations that puts the service user at the centre of everything that happens to them **"no decision about me without me."** It means that the adult, their families and carers are working together with agencies to find the right solutions to keep people safe and support them in making informed choices.

The Board has already adopted the **Making Safeguarding Personal** programme and organisations are working to embed it through changing systems and their staff culture from process-driven to outcome-led. We want to see it fully embedded across the care and health system and are setting up a sub-group to lead it with the following objectives:

- People are safeguarded in a way that supports them in making choices and having control in how they choose to live their lives.
- People are empowered to speak out, saying what they want and taking a full part in their care planning.
- Appropriate independent advocacy is provided to individuals when they are unable to speak for themselves without support or do not have the mental capacity to do so.
- Risk management seeks a proportionate balance of acceptable risks, in the words of Lord Justice Munby "what good is it making someone safer if it merely makes them miserable?"
- Care planning starts from the outcomes that people want, understands that these can change through the intervention and keeps them involved throughout it.
- Resulting personal safeguarding plans are realistic, practical and acceptable to the Individual.
- Making Safeguarding Personal is built into training at all levels.
- Policies, procedures and systems are revised to embody a person-centred approach.

The person-centred approach will also extend to **carers**. We recognise that caring for a relative or friend is extremely demanding requiring utmost dedication and patience. Therefore when carers needs are assessed workers will take into account that by providing support and breaks, they are at the same time preventing possible breakdown in the relationship. If abuse or neglect does happen then it will be dealt with compassionately.

e) Establish a user-friendly reporting framework which measures and assures the Board's work and its impact on safeguarding.

The aim of the strategy is to improve safety for adults at risk of harm so we need to know if the strategy is working, how well and in what areas it is not. Otherwise we are working in the dark. There are a number of ways to find the answers to those questions and we intend to use them all.

There is a lot of data available and the board have set itself the job of making sense of it in a **performance reporting framework** that is easy to understand and only report the things that will make a real difference to people. We will take data from:

- Existing performance indicators from member organisations that show how quickly and effectively they responded to concerns.
- Outcome data from casework and service users that says if they felt any safer following safeguarding intervention.
- Analysis of what happened to reported concerns that were not progressed to a statutory safeguarding enquiry.
- Surveys of service users' and carers' views eg. "would you report a similar concern again?"
- Results of annual self-assessments and peer reviews.
- Mapping of shared concerns and agreed actions with other boards and bodies.
- Case file audits.
- Safeguarding reviews.
- Healthwatch case studies
- The Care Quality Commission's judgements of Rotherham's services.

The performance framework will be widely available, updated and presented to the full Board at each of its regular meetings. It will feed into improving practice and to hold people to account where they are not achieving what they should be. It will address issues of quality as well as quantity, particularly from the perspective of those who have experienced safeguarding services.

RELATED DOCUMENTS

Single page version of this strategy.

The Board's Work Plan 2015/6.

The Board's constitution including its terms of reference.

Rotherham Multi-agency Safeguarding Adults Procedures.

Sign-up document for all partners (include logos).

ROTHERHAM SAFEGUARDING ADULTS BOARD

STRATEGY-ON-A-PAGE

OUR VISION

People of Rotherham are able to live a life free from harm where all organisations and communities

- have a culture that does not tolerate abuse
- work together to prevent abuse
- knows what to do when abuse happens

It's the Board's job to make the vision real by ensuring that agencies who support people at risk of harm are able to prevent abuse happening, act swiftly when it does and are competent in achieving good outcomes for people.

We will know we have achieved it when:

People are aware that protecting them is taken seriously and their concerns will be responded to sympathetically.

People know where to go to when they have a concern.

People will be supported to report a concern.

People's desired outcomes are always taken into consideration.

Services always work with individuals to make them feel safer.

After reporting a concern they will be told what has been done about it.

People will know what to expect from the safeguarding system.

People will know what the Safeguarding Board is and what it does.

OUR PRIORITIES 2015/18

a) Review and update the Board's organisation to give it the capacity to deliver its strategic objectives and promote a constructive and challenging culture.

b) Review and update the Board's constitution to maximise partnerships and establish its identity.

c) Involve the public in planning, quality assurance, service provision and communication.

d) Promote a culture change within all the organisations to embed a person-centred approach.

e) Establish a user-friendly reporting framework which measures and assures the Board's work and its impact on safeguarding.

BACK PAGE

What to do if you suspect somebody is being abused.

Contact numbers, etc.

Rotherham Metropolitan Borough Council

Rotherham Health and Wellbeing Board

Council Report

Title: The Safeguarding Adults Strategy

To Be Presented to: The Health and Wellbeing Board 24th February 2016

Is this a Key Decision and has it been included on the Forward Plan?
Yes

Strategic Director Approving Submission of the Report

Professor Graeme Betts (Interim Director of Adult Care and Housing for Rotherham Metropolitan Borough Council)

Report Author(s)

The Safeguarding lead for ADASS (Association of Directors of Adult Social Services), Mike Briggs

Ward(s) Affected

All

Summary

A Briefing for the Health and Wellbeing Board on the Safeguarding Strategy

In June 2015 Professor Graeme Betts commissioned a peer review to be completed by Dr Adi Cooper (Chair for ADASS) and Stephen Forbes (Executive Head of Adult Social Care at the London Borough of Sutton). The review highlighted the need for the Rotherham Safeguarding Adult Board (RSAB) to have a comprehensive and detailed Safeguarding Adults Strategy. Mike Briggs was commissioned to develop and write The Safeguarding Adults Strategy which was developed with partner agencies and community representatives of Rotherham to help RSAB to continue to improve Safeguarding practices by working together with shared objectives and goals. The document explains in plain language what a Safeguarding Adult Board is, why it is required and what its responsibilities are. The Strategy is a three year plan and clearly details priorities and how the Safeguarding Adults Strategy can be delivered. The Strategy builds on excellent work previously undertaken and sets out the vision and priorities for future work; a vision that people should be able to live a life free from harm.

1. Recommendations

1.1 To publish The Safeguarding Strategy.

1.2 With a published Strategy the residents of Rotherham will have a clear message that Rotherham Safeguarding Adults is transparent in its practice, its vision and its promises, increasing public confidence.

1.3 To develop a multi-agency working party to develop an action plan to deliver the Strategy.

1.4 To roll out the action plan to deliver the Strategy.

2. List of Appendices Included

2.1 The Safeguarding Strategy final draft

3. Background Papers

3.1 Safeguarding Review June 2015 by Dr Adi Cooper and Stephen Forbes
3.2 RSAB work plan 2015/16
3.3 The Boards constitution including its terms of reference
3.4 South Yorkshire Safeguarding Adults Procedures

Consideration by any other Council Committee, Scrutiny or Advisory Panel:

Presented to Rotherham Safeguarding Adults Board on 11.01.2016

Council Approval Required

Yes

Exempt from the Press and Public

No

NHS Rotherham Clinical Commissioning Governing Body

Health and Wellbeing Board – 24th February 2016

Delivery of the Learning Disability Transforming Care Partnership across the Rotherham, Doncaster, Sheffield and North Lincolnshire Footprint

Lead Executive:	Ian Atkinson , Deputy Chief Officer
Lead Officer:	Kate Tufnell, Head of Contracts and Service Improvement – MH, LD and EOLC
Lead GP:	Russell Brynes, SCE lead Mental Health and Learning Disability

Purpose:

The purpose of this paper is to provide the Rotherham Health and Wellbeing Board with an update briefing on the NHS England Learning Disability Transforming Care Partnership Programme and the implications for Rotherham CCG, RMBC and wider partners.

Background:

National Transforming Care Partnership Programme:
Following the publication of the guidance 'Building the right support - a national programme to develop community services and close inpatient facilities' NHS England first developed a fast track pilot programme and more recently the Transforming Care Partnership Programme. The expectation of the TCP programme is that health and social care commissioners will build up community capacity and close some inpatient services in order to shift the investment into high quality, personalised support.

An overview of the programme can be seen in the attached presentation refer to **appendix 1**.

Key things to note about the programme are:

- It is a population based approach which expects CCGs, LAs and NHS England specialised hubs to work together to look at what services are needed for the local population with a learning disability and/or autism across a TCP footprint area.
- It is a three year programme that focuses on the provision of services to children, young people and adults.
- It is essential that as part of the TCP plans that the CCGs identify how they intend to extend their offer of Personal Health Budgets (PHB) for people with a Learning Disability beyond the current offer within CHC.
- It needs to be about service transformation and pathway re-design (investing in preventative services/early intervention in the community) – not just 'resettlement' of current inpatients into the community.
- Rotherham is included in the Doncaster, Rotherham, North Lincolnshire and Sheffield TCP footprint in which Chris Stainforth; Doncaster CCG has been identified as the Senior Responsible Officer (SRO) and Phil Homes, Director of Adult Services Communities Portfolio, Sheffield City Council

Submission documentation to be completed:
Each of the following documents has to be completed at a local level and then collated to provide a Doncaster, North Lincolnshire, Rotherham and Sheffield Transforming Care Partnership submission which has to be submitted to NHS England by 8th February 2016.

This submission will require the completion of a range of documents which includes the following:

- Joint Transforming Planning template
- Finance and Activity Template

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- Transforming care Route map

Transforming Care Partnership delivery timescale (known to date):

25th January 2016	Finance & Activity template submission to Doncaster CCG (local milestone)
26th January 2016	External Consultant Health Needs Assessment Workshops – funded by NHS England
8th February 2016	First Transforming Care Partnership (TCP) Plan submission – **Completed appendix 2 Plan on a Page submission**
9th February 2016	NHS England Expert panel reviews against the assessment framework
11th February 2016	NHS England feedback collated to be shared with local TCPs
15th & 16th February 2016	NHS England will facilitate a discussion with the local panel for clarification, request further information etc.
22nd February 2016	Revised TCPs to be resubmitted to the NHS England Regional office
24th February 2016	Local TCP Plans to be reviewed for by NHS England Regional panel for sign-off. Potential outcomes – approved, approved with required revisions, not approved (it will then be escalated to the national team)
24th March 2016	NHS Contract signature date
11th April 2016	Implementation to commence (3 year programme from this date)

Further work is needed to agree Local TCP timescales to enable the document to be collated and then circulated back out to Health and Wellbeing Boards for sign-off.

Analysis of key issues and of risks

- **Delivery timescale and capacity** – as highlighted in the above section the delivery timescale is very tight, complex and will require some significant input at both local level and across the footprint to ensure the successful completion of the documentation.
- **NHS England risk share proposals** – NHS England is keen to work with CCGs to develop a number of risk share agreements for the more complex patients.
- **CCG / Health & Wellbeing Board Approval** -The CCG and RMBC need to agree a process for sign-off of the TCP plan by the CCG and the Rotherham Health and Wellbeing Board.
- **Local Governance arrangements** – The CCG and RMBC needs to agree a local governance process to align with the proposed TCP Board structure. This will be agreed through the LD Commissioning Executive Group.
- **Performance management** – NHS England have indicated that a set of performance indicators will be developed against which the programme will be monitored. Early suggestions indicate that this set of performance indicators will include the monthly Winterbourne submission data and SAF performance indicators.

Patient, Public and Stakeholder Involvement:

Future Stakeholder Involvement

As part of the work commissioned by NHS England to support CCGs to develop their Transforming

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Care Partnership submission an external consultant has been commissioned to work with local areas to undertake a Health Needs Assessment. The Rotherham workshops were held on the 26th January 2016.

The TCP plan will require a stakeholder engagement plan to be developed as part of the 3 year delivery plan – to be developed

Submission stakeholder involvement:

A key component of the submission is to demonstrate what local stakeholder engagement has been completed. Co-production of the programme with service users, carers and families is a central expectation of its delivery.

Equality Impact:

Not applicable at this stage.

Financial Implications:

Transforming care Partnership Programme:

To support local areas with transitional costs, NHS England has indicated that it will make available up to £30 million of transformation funding over three years, with national funding conditional on ***match-funding*** from local commissioners. In addition to this, £15 million capital funding will be made available over three years.

Financial / Activity Submission Requirements:

As part of the LD Doncaster, North Lincolnshire, Rotherham and Sheffield LD Transforming Care Partnership submission a finance / activity template detailing both health social care funding will be produced.

Human Resource Implications:

It has been agreed by the CCGs that Chris Stainforth from Doncaster CCG will act as the Senior Responsible Officer (SRO) for this programme. In view of this it has been agreed by the CCG's that the NHS England funding allocation of @ £25K for the Doncaster, Rotherham, North Lincolnshire and Sheffield footprint should be used to fund project management support to co-ordinate the production of the submission.

Each of the CCGs has identified concerns about their capacity to achieve the programme requirements within the very tight timescale prescribed, as illustrated in the background section.

Procurement:

Not applicable at this stage.

Approval history:

Not applicable at this stage

Recommendations:

The Health and Wellbeing Board is asked to:

- Note the work that has to be completed to by the timescale highlighted.
- Agree to delegate the Health and Wellbeing Board sign-off of the final plan to the Chair and Co-Chair of the Health and Wellbeing Board.

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Transforming services for people with a learning disability and/or autism

Planning guidance and support

December 2015

NHS England Gateway Ref: 04477

Contents

1. Introduction

- Transforming care for children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, is a national priority.

- This means improving the independence, well-being and health of people with learning disabilities and/or autism, closing some inpatient services, and strengthening services in the community.

- Over the summer of 2015, six ‘fast track areas’ (collaborations of CCGs, local authorities and NHS England (NHSE) specialised commissioners) drew up plans to make that transformation a reality.

- Learning from that process, NHS England, the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS), will now support areas across England to draw up and deliver on transformation plans.

- This guidance is focused on supporting local areas to develop comprehensive and deliverable plans by guiding them through a planning framework that can be tailored to the individual needs of each area. It is designed to empower local leaders to lead and control the change whilst ensuring a consistent standard of delivery.

2.1 What we are asking

- We are asking commissioners (CCGs, LAs, NHS England specialised commissioners) to formulate a **joint transformation plan to radically change services for people with learning disabilities and/or autism.** Guidance on joint governance arrangements are in the delivery pack.
- **We expect commissioners to build up community capacity and close some inpatient services in order to shift the investment into high quality, personalised support.**
- This needs to be based on a **population approach** – CCGs, LAs and NHS England specialised hubs looking at what services are needed for the local population with a learning disability and/or autism in their area.
- It needs to be about service transformation and pathway re-design (investing in preventative services/early intervention in the community) **– not just 'resettlement' of current inpatients** into the community.
- That will involve changing relationships with **the whole provider market in this field**. There are some large providers who will be particularly impacted and commissioners need to work closely with them but plans should *not* simply be about one provider.
- Joint transformation plans in some areas will impact on commissioners elsewhere (e.g. because of the impact they have on local providers). So **commissioners in such areas will need to liaise with other commissioners** as appropriate. Where two plans impact on one provider in a significant way, plans will need to be clearly consistent.

2.2 What we are asking

While plans will be tailored to local areas to take into account the key differences in the health economy, provider landscape and demographics, there are three consistent national **outcome improvements** that should be incorporated in all local plans:

1. **Improved quality of care**
2. **Improved quality of life**
3. **Reduced reliance on inpatient care**

There are also three **national principles** that will underpin all local planning and delivery activity:

- **Plans should be consistent** with **Building the right support** and the **national service model** developed by NHS England, the LGA and ADASS, published on Friday 30th October 2015.
- **This is about a shift in power.** People with a learning disability and/or autism are citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. We need to build the right community based services to support them to lead those lives, thereby enabling us to close all but the essential inpatient provision.
- **Strong stakeholder engagement:** providers of all types (inpatient and community-based; public, education, private and voluntary sector) should be involved in the development of the plan, and there should be one coherent plan across both providers and commissioners. Stakeholders beyond health and social care should be engaged in the process (e.g. public protection unit, probation, housing) including people with direct experience of using inpatient services.

A **national plan template,** along side a **finance and activity plan template**, set this out in more detail (see delivery pack).

3. Financial underpinnings

The costs of the future model of care

- Will need to be met from the total current envelope of spend on health and social care services for this population, across the geographical footprint.
- That may involve shifting spend from some services along the pathway to others. A range of financial mechanisms may need to be used to do this, including pooled budgets where appropriate and NHS-funded dowries for people being discharged after very long spells in hospital (see below).
- Where agreed as part of a relocation package, dowries will be available to local authorities for people leaving hospital after spells in inpatient care of 5 years or more. Dowries will be recurrent, will be linked to individual patients, and will cease on the death of the individual.

The costs of transitioning to the future model of care

- Will need to be funded out of existing allocations, through additional investment in learning disability/autism services and/or efficiency savings.
- To help, NHS England will make available up to £30 million of transformation funding over 3 years, to be matched by CCGs. NHS England will also make available £15 million capital funding over 3 years.

4. Support

A package of support will be made available, including:

During the planning phase (2015/16):

- Independently-facilitated workshop for commissioners in the Transforming Care Partnership to help develop a shared understanding of where they are now,
- Independently-facilitated workshop for commissioners in the Transforming Care Partnership to help develop a shared vision for the future
- Regional events on implementing personalisation / PHBs

During delivery (2016/17 onwards):

- Potential collaborative improvement programme
- Potential intensive support offer – focus on trouble shooting discharge / commissioning blocks

5. Planning methodology / timeline

- We are suggesting the following stages for the development and delivery of transformation plans:

- These stages describe the journey that each area will need to go on in developing a coherent, and supported plan.
- We understand that every local area is different, and so this methodology and the support that underpins it is designed to be flexed and adapted to ensure the delivery of a model that is right for your area and also meet national standards.

5. Planning methodology / timeline

December 2015:

- Agree and confirm organisational / governance arrangements (mobilise ‘partnerships’)
- Appoint Senior Responsible Officer SRO and deputy from health and social care.
- Agree Lead CCG (for host finance arrangements)
- Agree involvement and engagement with NHS England specialised commissioners;
- Agree launch or ‘go-live’ date for partnership (where not already working together formally)
- Transformation planning approach formalised, including workforce and financial modelling and the approach to workforce development especially in relation to positive behavioural support and leadership of change across the system
- Agree outline scope of transformation plan and timescale for local delivery (includes publishing meeting dates for governing board)

January to March 2016:

- First governing board meeting (if not already in train)
- Drafting of transformation plans
- First cut transformation plan by 8th February 2016
- Local assurance of plan coordinated through NHS England with stakeholders (see delivery pack for more detail of how assurance will work)
- Finalise plan following regional and national moderation and feedback within March 2016

April 2016

- Final plan due 11th April
- Begin to implement plans

Our vision is…

South Yorkshire and North Lincolnshire (SY& NL) LD TCP plan

We serve…

To create a health and social care system across the footprint that places less of a reliance on inpatient beds by providing support to people with a LD and/or autism to enable them to lead a good and meaningful everyday life within their community.

Learning disability populations across the SY & NL TCP foot print

Doncaster – 1443, North Lincolnshire – 704, Rotherham – 1435 & Sheffield - 3380

We are succeeding when…

- ☑ Reduction in the number people with a learning disability +/or in hospital across the SY & NL area
- ☑ 95% of crisis referrals managed safely within a community setting
- ☑ Improve patient/ carer experience
- ☑ Proportion of young people with a joint transition plan

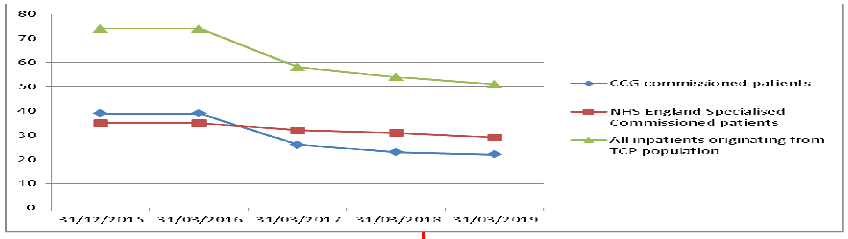
The journey we need to take…

Our transformational journey

In 2015 we spent £XXm on the following service model

Describe the current model

- 143 people are in specialist Commissioned services
- 30 people in hospital services commissioned by the CCGs
- Across the SY & NL TCP footprint we have a variety of different community LD models operating



Priority changes today

Changes to be made in the next year

- Establish SY & NL TCP Operational board and work themes
- Develop an Engagement & communication / workforce development plan
- Complete a Hospital provision / patient profile review
- Develop and agree New hospital / community model of care

Long-term enablers

Long-term changes to deliver plan

- Establish a strong SY & NL TCP partnership
- Good service user and carer/family engagement
- Workforce development
- A shift of resources from hospital provision to community
- Building community capacity and capability

In 2020 we will spend £XXm on the following service model

Describe the future model

- Less reliance on specialist and CCG commissioned hospital provision
- A stronger community assets to support people to live good and meaningful lives within their communities
- Good access to mainstream services

This needs to change because…

Explain the case for change:

- Too many people with LD +/ autism are in still in hospital placements
- Not enough people with LD +/autism are supported to live with in their communities

This is beneficial because…

Explain the benefits of this model

People will have:

- the choice of where they live and who they live with
- Good and meaningful lives
- Good access to mainstream services and specialist
- Good access to community services

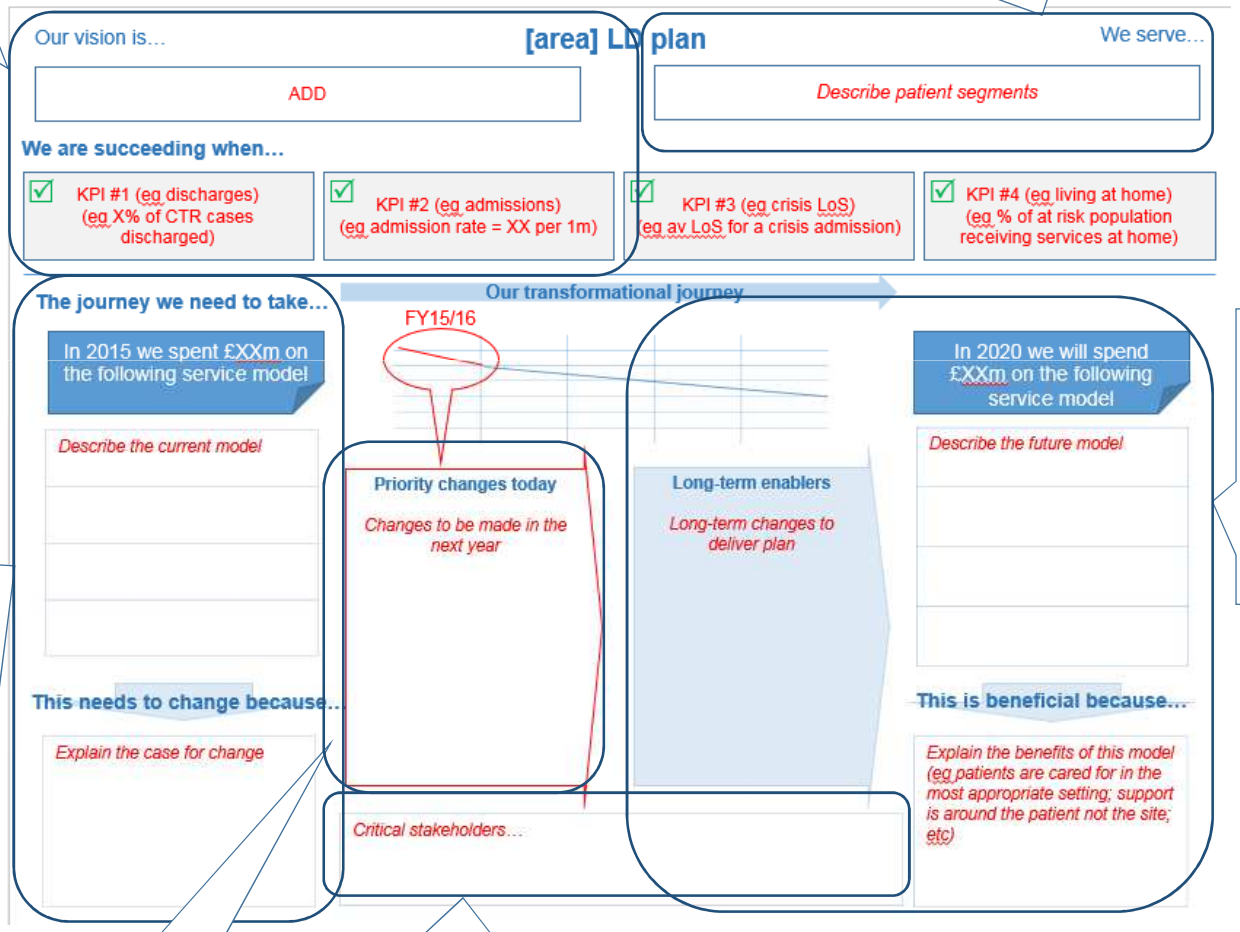
Critical stakeholders*… people with a learning disability +/or autism, carers /families /parents , GP and primary care, LDPBs, health and social care commissioners, children's services, housing providers, advocates, NHS England , providers , acute hospitals and mental health services*

This should describe what success looks like both from a vision perspective but also KPIs / measurable changes

This should describe a summary of the needs analysis

This should summarise the current model and where it is failing patients.

This should be supported by evidence, including testimony of service users



Key features of the model and the critical requirements for success (long-term enablers).

Plan of action

Governance / engt model

DAA
Rotherham Dementia Action Alliance

Rotherham Dementia Action Alliance Coordinator's Post

A Proposal for Continued Funding

Alzheimer's Society | Leading the fight against dementia

DAA
Rotherham Dementia Action Alliance

Keynote Introduction and Overview by the RDAA Chair

The Effectiveness of the Rotherham Dementia Action Alliance

The work of the *Rotherham Dementia Action Alliance* **(**RDAA) has already proven that it is possible to achieve wider local social benefits beyond those of the development and implementation of the individual organisational Action Plans it helps establish, develop and monitor. The RDAA has enabled organisations from within and, more crucially *outside* traditional health and social care planning to help deliver specific community building projects as well as general awareness.

Some practical results so far include the free local *Legal and Financial Services Guide* and free local *What's on Where Guide* for older people. By engaging local private businesses other areas of signposting and advisory initiatives will also develop over time. RDAA is a neutral platform which helps consolidate and cascade information between as many organizations and agencies as possible.

RDAA involvement helps *Members* become aware of and then flag up the need for early diagnosis and intervention. So effectively private organisations, and other *Member* organisations, become involved in improving the health and well-being of the community in a very practical way - helping secure the positive outcome of early intervention and crisis prevention in a highly cost effective manner.

The same applies to explaining how RDAA Members can signpost people on to appropriate social support such as their GPs and the Alzheimer's Society. For example the *Memory Cafes* have grown partially as the result of integrating a wider group of organisations than public health and social care structures into their awareness and support networks. This is part of local de-stigmatisation in action.

There are also substantial local campaigns evolving in specialist areas; For example establishing *Dinnington High School,* Rotherham, as a flagship for the roll out of the dementia friendly communities' agenda in schools. That has had a tremendous impact amongst pupils, staff and clearly benefits local families who are affected or think they may be affected by dementia. That campaign also involves all the private, public and third sectors in one form or another.

There is a clear local cascade effect evident in Rotherham. That is derived from the leadership, motivation and organisation provided by the volunteers in the *RDAA Steering Group* (and its sub-groups) working in conjunction with the paid Co-ordinator. This means that the RDAA is confident that it can continue to deliver great results at nil or much reduced cost to the public purse.

The RDAA is a significant structural part of not only the dementia friendly communities' agenda but also of cost effective local community building. Given the focus of the personalisation agenda for Health and Social Care on peer support, integration of all local sectors and value for money it would seem logical to ensure that the good work which has been begun is supported sufficiently to ensure it continues to deepen and broaden.

In Short the work of the RDAA to date could not have been achieved without a paid Co-ordinator. This is further explored in this report.

David Coldrick – Chair RDAA. November 2015

DAA
Rotherham Dementia Action Alliance

What are Dementia Action Alliances?

Dementia Action Alliances are a national initiative and operate throughout the country. The Action Alliances were created in line with the World Health Organisation's (WHO)[1] directive that the way forward to help people with dementia live well, out of the health care system for as long as possible, was to create dementia societies.

They are social movements with a simple aim – to change society's attitudes towards dementia and cascade knowledge, support and guidance to enable companies, organisations, faith groups, schools, colleges and community groups become dementia friendly.

Dementia Action Alliances and The Dementia Friends initiatives are supported and regulated by the Alzheimer's Society (Annex 1).

Rotherham Dementia Action Alliance

Rotherham Demetria Action Alliance (RDAA) was formed late 2013 and was the officially launched in May 2014; a Chair (David Coldrick – Managing D*irector Home Instead Rotherham*) and Vice Chair (Liz Hopkinson - Rotherham & Doncaster Service Manager - *Alzheimer's Society*) were elected.

During the period up to launch (November 2013 and Feb 2015) the Chair and Vice Chair created local 'sub-groups' and made other links to key organisations within the private, statutory and third sectors. The list of Member organisations has been has broadened since the appointment of Kathryn Rawlings as RDAA Co-Ordinator in early 2015.

Organisations and companies sign up to become members of the RDAA and gain knowledge, via the Coordinator, on how to become Dementia Friendly, creating meaningful action plans that will help people with dementia live well in society. The long term vision within Rotherham is to be recognised as a dementia friendly town. This can only be achieved with high levels of involvement within Rotherham.

The more dementia knowledge within the communities the more we can help to create a community spirit - this is done by cascading dementia awareness. This knowledge gives people a true insight into the world of a person with dementia and help's to encourage care and tolerance into our communities.

In addition the Alliance looks at dementia friendly physical environments; how a building /area can be designed to help a person with dementia feel more at ease (this work has wider society benefits

[1] WHO http://apps.who.int/iris/bitstream/10665/75263/1/9789241564458_eng.pdf?ua=1

DAA
Rotherham Dementia Action Alliance

RDAA is a neutral platform which helps consolidate and cascade information between as many organizations and agencies as possible.

In the first 18 months *Rotherham Dementia Action Alliance* membership totalled 26 organisations including *South Yorkshire Fire and Rescue*, *South Yorkshire Police* and the *Rotherham, Doncaster and South Humber NHS Foundation Trust*...

Once the Dementia Action Alliance Coordinator was in post, from the 23rd February 2015, RDAA membership grew rapidly. There are currently 72 members with up to 121 organisations being worked with to create meaningful action plans.

Summary of work:

- 72 Organisation (or individuals) signed up
- 10 action plans developed or completed
- 23 newly committed organisations
- 16 organisations shown an interest (new)New interest 16
- 121 total Rotherham Dementia Action Alliance new members

There have been 95 additional members since 23rd February 2015.

Review of Adult Services

Local Authority Adult Services Directorates, across the country, are reviewing how they deliver services with regard to considering how they can provide a better service with outcomes focusing on personalisation in the ever more difficult fiscal climate of local government funding.

There is an acknowledgment, and research evidences, that when people can are supported within their communities they will stay independent and have increased wellbeing for longer and avoid the decline and dependency that long term residential and traditional outdated day care bring.

Dementia Alliances support this concept and look for ways for people with dementia to be kept safe and remain integrated within their communities for as long as possible by taking a preventative approach and exploring inclusive ways to help people with dementia live well for as long as possible.

DAA
Rotherham Dementia Action Alliance

Work generated from Rotherham Demetria Action Alliance

Case Study 1

RDAA Membership: South Yorkshire Police

South Yorkshire Police (SYP), in Rotherham, raised the issue that when people with dementia go missing it can be very concerning for offices and very distressing for the person with dementias carers. This opened up discussions and work began to consider how to manage these incidents more affectively.

The *Herbert Protocol* (Annex 2) was created through partnership and co-production working.

The *Herbert Protocol* is a risk management and information gathering tool for use when a person is reported as missing; when someone is reported as missing, it is vital that the police get information as soon as possible. The *Herbert Protocol* tool provides carers and family members with a method to gather relevant information so that it is available to pass to police officers when a person is reported as missing.

Since it was adopted, in Rotherham, the protocol has and is being cascaded as good practice throughout the country - a credit to Rotherham Demetria Action Alliance

Note: *average cost of a missing person is £1325 – £2415: CMPS 2012)*[2] *depending on the length of time a person is missing and the resources used.*

Case Study 2

RDAA Membership: Solicitors and Financial Advisors

The need for families to sort their financial arrangements is of high importance. It is a distressing additional issue to contend with and that is not helped due to the variety of information available being vast and varied in quality which can be confusing for families.

At their own cost the *Rotherham Dementia Action Alliance* professional sub group produced a *Financial Guide* (Annex 3) which gives clear guidance on financial advice for families who are affected by dementia. Those involved in the group gained knowledge about dementia to ensure they were equipped to handle and understand the issues that arise when a family is caring for someone with dementia and in the longer term considering the issues surrounding residential /nursing care.

These guides are distributed by many Alliance organisations including *Alzheimer's Society*, *Age UK*, care providers, General Practitioners (GP's) and *RDaSH*.

[2] Centre for Missing Person; University of Portsmouth http://www.port.ac.uk/uopnews/2012/08/06/cost-of-missing-persons-investigation-revealed/

DAA
Rotherham Dementia Action Alliance

Case Study 3

RDAA Membership: South Yorkshire Fire and Rescue

South Yorkshire Fire and Rescue (SYFR) have recognised the potential for the beneficial joint working within the Alliances across South Yorkshire and the inroads into other agencies that this enables- the *Alliance* has a combined membership of 300 including public sector, retail, voluntary sector, private companies and faith communities.

SYFR have provided £149,000.00 funding to *Dementia Action Alliances* in South Yorkshire over 2 years from the *Rescue Safer Communities Reserve* for *Home Safety Checks*. The *Homes Safety Check* project is important as it allows people with dementia to stay safely in their own homes longer – a person with dementia becomes a far greater risk to themselves and their families' and neighbours

Fire Safety and *Community Safety* are feature in the establishment of each of the four South Yorkshire areas seeking to become *Dementia Friendly.* Dementia awareness will become embedded in the training programmes of all fire fighters assisting in the recruitment of *Dementia Friends* in each area.

Note: *The average cost of a house fire in the Yorkshire & Humber is £46,000.00*[3] *whilst an accidental death including a house fire is £1,800,000.00.*

Case Study 4

RDAA Membership: *Rotherham NHS Foundation Trust District General Hospital*

Rotherham Dementia Action Alliance supports the dementia lead nurse of the *Rotherham NHS Foundation Trust District General Hospital* to consider how to reduce the incidents of people with dementia being admitted to hospital and reduce the time spent in hospital.

With the move to integration and the advent of the *Better Care Fund* health provision has moved from a service of 'cure' to one of 'prevention'. Prevention is key to people living well in society – in their own communities – as they are less likely to have a crisis, which could result in a hospital admission.

The *Rotherham Dementia Action Alliance* believe that the work already undertaken can be built on, through partnership working, to achieve the aims of health and social care statutory organisations.

Note: A Hospital bed costs approximately £250 per day (NHS England[4] *2014). Research shows that a person with dementia, once admitted, is far more likely to have a longer stay in hospital and is more likely go into full time residential care prematurely on discharge.*

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3 http://webarchive.nationalarchives.gov.uk/20121108165934/http:/www.communities.gov.uk/documents/corporate/pdf/1838338.pdf

4 NHS England http://www.england.nhs.uk/

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Case Study 5

RDAA Membership: Dinnington High School

Dementia Action Alliances, throughout the country, are working to create a *Dementia Friendly Next Generation;* schools, colleges, youth groups, scouts and guides are signing up as *Dementia Friends*.

Dinnington High School, Rotherham (a coeducational secondary school for pupils aged 11 to 18 years) is a perfect example of how the *Rotherham Dementia Action Alliance* is creating the next generation of *Dementia Friends. Dementia Friends* has been built into the Health and Social curriculum and has been well received – the work of the pupils is a credit to the school.

The model used by, *Rotherham Dementia Action Alliance,* to cascade knowledge and interest about dementia to pupils at Dinnginton High School is one that the Alliance aims to roll out to schools throughout Rotherham, this is a planned area of work for 2016.

Case Study 6

RDAA Membership: Rotherfed and Rotherham Metropolitan Borough Council's 7Areas Assemblies

The *Rotherham Dementia Action Alliance* is working with Rotherfed[5], Area Assemblies and Town Councils to maximise the work of the Alliance within the local communities.

By working in partnership with local communities the Alliance can cascade the concept of *Dementia Friendly Communities* to local business and community groups. By communicating and working with communities the benefits of the Alliances work can be wide reaching.

Case Study 7

RDAA Membership Rotherham GP practices

The *Rotherham Dementia Action Alliance* is working with over 18 General Practice practices in the NHS Rotherham CCG locality; the Alliance cascade dementia knowledge to staff groups and information about local services.

General Practice staff are encouraged to look at their environments to see if practice layout and signage can be improved to become more dementia friendly. This support has been very well received amongst the GP's themselves and has made an impact on the teams.

[5] Rotherfed http://rotherfed.org.uk/

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Rotherham Dementia Action Alliance

Additional Information and Benefits: *Dementia Action Alliance Coordinator*

Rotherham Dementia Action Alliance have been successful in becoming a finalist in the *Voluntary Action Rotherham Community Awards* for 2015 helping to mark a very successful year since the coordinators post has been in place .

In addition to signing up new members *Rotherham Dementia Action Alliance* delivers *Dementia Awareness* and *Dementia Friends* sessions across the borough – the post has generated over 750 *Dementia Friends* for Rotherham.

The *Dementia Action Alliance Coordinator* post is a proven successful way of cascading service information about social outlets, educational tools and resources and information GP's and *Dementia Action Alliance* members.

The *Dementia Action Alliance Coordinator cascades* good practice in care home and amongst care providers. The Alliance is currently working with *Rotherham Metropolitan Borough Council* and interested residential homes and care providers to form a group to promote good practice and generate interest in new initiatives.

Evidence of need: *Dementia Action Alliance Coordinator*

It is estimated that there are 815,000 people living with dementia in the UK (Alzheimer's Society[6] 2014).

In the *Rotherham Metropolitan Borough Council* geographical area 3165[7] people are currently predicted to be living with dementia and this is set to rise to 5115 by 2030[8]. Those with a '*Dementia Diagnosis'* currently registered with a General Practice (GP) in the NHS Rotherham Clinical Commissioning Group (03L) geographical area total 2165 (HSIC[9] January 2015)

Alzheimer's Society is a well-established local provider in the *Rotherham Metropolitan Borough Council* and *NHS Rotherham Clinical Commissioning Group's* geographical area. The Society provides a number of services which are person centred and are based on the needs of people with dementia and of the local community.

[6] Alzheimer's Society http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=412
[7] Projecting Older People Population Information (www.poppi.org.uk).
[8] Projecting Older People Population Information (www.poppi.org.uk).
[9] Quality and Outcomes Framework (QOF) Recorded Dementia Diagnoses – April 2014 to January 2015 (Health and Social care Information Centre) http://www.hscic.gov.uk/catalogue/PUB16910/qual-outc-fram-rec-dem-diag-Jan-2015-anx1.xlsx

DAA
Rotherham Dementia Action Alliance

Conclusion

The Alzheimer's Society are currently looking to our partners in Health, Social Care, Voluntary and local Business sectors to secure funding for the *Rotherham Dementia Action Alliance Coordinators* post for a further 12 or 24 months.

The Alzheimer's Society is requesting the *Rotherham Health and Wellbeing Board* to contribute to funding the *Rotherham Dementia Action Alliance Coordinator* post; costings are attached in Annex 4.

South Yorkshire Fire and Rescue have provided an annual contribution of:

- 1st February 2016 – 31st January 2017 **£9,600.00**
- 1st February 2017 – 31st January 2018 **£9,600.00**

Alzheimer's Society is committed to contribute an annual contribution to host the post of *Rotherham Dementia Action Alliance Coordinator*

Alzheimer's Society will make a contribution towards costs of:

- 1st February 2016 – 31st January 2017 **£1,586.00**
- 1st February 2017 – 31st January 2018 **£1,598.00**

NHS Rotherham Clinic Commissioning Group has committed to contribute:

- 1st February 2016 – 31st January 2017 **£5,000.000**

Alzheimer's Society is therefore requesting that the *Rotherham Health and Wellbeing Board*, and its constituent partner organisations, consider the Society's request to allow for the current work streams to continue. The Society is seeking the following for each 12 month period:

- 1st February 2016 – 31st January 2017 **£20,873.00**
- 1st February 2017 – 31st January 2018 **£26,239.00**

Annexes

Annex 1

Alzheimer's Society

Alzheimer's Society is the UK's leading support and research charity for people with dementia, their families and carers. Dementia currently affects over 800,000 people in the UK.

The Society provides information and support to people with any form of dementia and their carers through publications, a '*National Dementia Helpline'*, our website and more than 2,900 local services throughout England, Wales and Northern Ireland.

The Society supports health and social care professionals by delivering high quality education, resources and training. Our work also includes the influencing of politicians (local and national) and policy-makers and we campaign for a better quality of life for people living with dementia and their carers and for greater understanding of dementia in the wider society.

We also fund innovative research in the areas of cause, cure, care and prevention. The Society works with scientists and people affected by dementia to ensure that the medical and social research programmes that we fund have a positive impact on people's lives. We were a founder member of the 'National Dementia Action Alliance' which launched the national 'Dementia Declaration for England'. The Society also launched the high profile 'Dementia Friends' campaign which aims to recruit 'Dementia Friends' who will commit to take action to improve the life for people with dementia.

Alzheimer's Society believes people with dementia are experts on living with dementia and we those who use the Society's service in recruitment, training, service development, quality assurance and evaluation.

As detailed within the Alzheimer's Society's 2013 Report '*Dementia: The Hidden Voice of Loneliness'*[10], the Society worked with partner organisations to launch a *National Dementia Declaration for England*. In this declaration people with dementia and carers described the seven outcomes that were most important to their quality of life:

- I have personal choice and control or influence over decisions about me.
- I know that services are designed around me and my needs.
- I have support that helps me live my life.
- I have the knowledge and know-how to get what I need.
- I live in an enabling and supportive environment where I feel valued and understood.
- I have a sense of belonging and of being a valued part of family, community and civic life.
- I know there is research going on which delivers a better life for now and hope for the future.

These seven core principles underpin the Society's work and are central to the *Rotherham Dementia Action Alliance* service.

[10] http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1677

Annex 2

Herbert Protocol (text)

An initiative supported by Alzheimer's Society

T: 0845 3000336 (Mon-Fri 0830 – 1830) Web: www.alzheimers.org.uk

The Herbert Protocol - *A risk reduction tool for people and families living with dementia (Version for a person living at home)*

What is this for?

These forms are designed to make sure that, if someone goes missing, the police can get access to important information about that person as soon as possible.

If a relative cannot be found, then this is a deeply distressing and upsetting time for their family and friends. Being asked by a police officer to remember all sort of different information can add to this stress, and these forms are designed to remove some of that worry.

When should I complete them?

As soon as possible! These forms can be completed at your leisure, with no time pressure or urgency. That said, the sooner they are ready, the quicker they can be used if they are needed.

When you have completed the form, keep it safe – make copies and keep them in a handy place, such as next to your phone, in a handbag or day bag. Consider giving them to family & neighbours.

Consider whether it would be a good idea to take a photograph of the form to store it on your mobile phone or email it to yourself and save email with the attached document on your mobile phone .Both these options give you easy access to the information.

How much detail is needed?

Whilst sometimes more information is better, police officers want an overview rather than in depth detail. So while we need to know, we don't need to know everything! If you are writing the information by hand, please try to make sure that it is easily readable for someone perhaps not used to your handwriting.

What will happen to this information when I have completed the form?

There is no need for the police or anyone else to have access to this information unless the person to whom it refers goes missing. You keep the information and hand it over when the police need it – it will be used to help the police to find your loved one as soon as possible, and nothing more!

With your permission, we will create what is called a 'location tag' on your home address. This is just a note on the police systems, which lets us know that you have this information sheet available. We may also ask some of our community officers to come and pay you a visit, to make sure you are ok, to offer some crime prevention advice and just to make contact with you and your family. The Alzheimer's Society will also ask to speak with you and yours.

We will never share your information with anyone else, unless as a part of a live investigation where there is sufficient justification in the interests of a person's safety.

What should I do when I find out that my relative / friend is missing?

This is vital – if you can't find a person after a couple of minutes looking, then you MUST call the police on 999.

It is quite normal to worry about calling 999. Some people are worried that they will be criticised for calling the police – if you are worried about a person's safety, then this will not happen!

Minutes saved can mean lives saved! The sooner the police know that someone is missing, then the sooner officers can start looking for them.

What will the police need to know?

When you ring 999, the operator will ask you which service you want – tell them 'POLICE'

The police operator will then answer the call. When the police operator speaks to you, it is important that you tell them exactly what the concern is, for example, "I cannot find my husband / wife. They may have gone missing and they have dementia"

Tell the police operator that you have the Herbert Protocol document for officers

The operator will then ask you several questions. One of the first questions will be about your address, or where you are calling from.

Do not worry that talking to the operator will slow down the police response!

The systems are in place to allow them to talk to you at the same time as officers are being sent to find your loved one.

They will ask:

- When was the person last seen? How long ago, and where – be as specific as you can.

- What were they wearing? They will ask for a description of the clothes the person was last seen wearing, and anything they might be carrying, such as a bag or walking stick etc.

If you are away from home, and don't have the information sheet with you – don't worry!

The information contained will be of great use for being able to coordinate the search for your loved one. You will be feeling upset and worried for their safety. This is completely natural, and the police officers will make sure that you are supported throughout the process.

PLEASE REMEMBER– this form, and the information it contains should be regarded as an additional measure to help ensure a person's safety. It should NOT be the only approach taken. Looking after someone with degenerative conditions is one of the most difficult and upsetting things anyone has to deal with – support is available through the NHS, various charities and other groups local to you. They can officer advice, support and guidance.

Vulnerable Person Profile

Fill in these sections and keep it in a safe place, where it can easily be located if the person it refers to goes missing. You may want to make several copies, which can be kept safe by neighbours or relatives.

The checklists below are indicative – do not worry if you do not have or cannot get all of the information it asks for- some of it will not apply to everyone.

Name of Vulnerable person:	**Date of Birth**

Medical Information	
- *Current Diagnosis?* - *Medical Conditions?* - *Any particular fears or phobias (such as fear of water / heights etc)?* - *How easily can the person walk? How far could they get before becoming tired? Do they need a stick or other aid? Can they move between furniture without help?* - *How may they react to being upset or scared?* - *If they don't have their medicine – are there any short term risks?*	
Places or addresses of note	
- *Previous home address?* - *Childhood address?* - *Family addresses?* - *Places of interest or significance – could be old school, a favourite walk or place to visit, a cemetery, former place of work or a childhood home*	
Jobs, Interests and Hobbies	
- *Where did / do they work? Most recent AND historic* - *Favourite pub / club / sports ground / allotment etc* - *Favourite outdoor activities? Bowling? Cricket? Fishing? Library? Cinema?* - *Regular holiday destinations*	

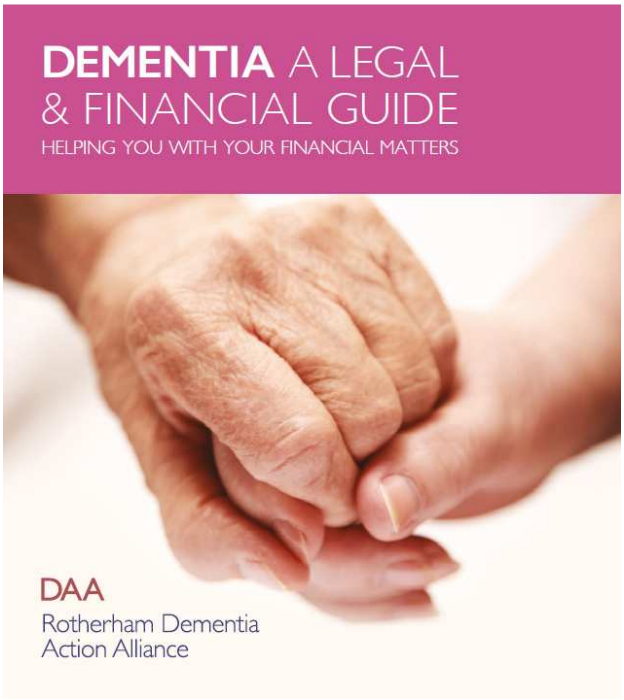
- *Any particular or special interests?*	
Weekly habits	
- *Which shops are used?* - *Favourite cafe?* - *GP / Nurse / Clinic / Group* - *Church/ Mosque / Synagogue / Temple?* - *Houses / friends to visit (now and historic)* - *Chemists?* - *Hospital?*	
- *Bus Pass?* - *Access to money – cash card, cheque book, cash usually carried* - *Mobile phone? Number?* - *Local transport – nearest bus stop: to where?* - *Nearest train station?* - *Car? Able to drive? Previously driven?*	
Anything else?	

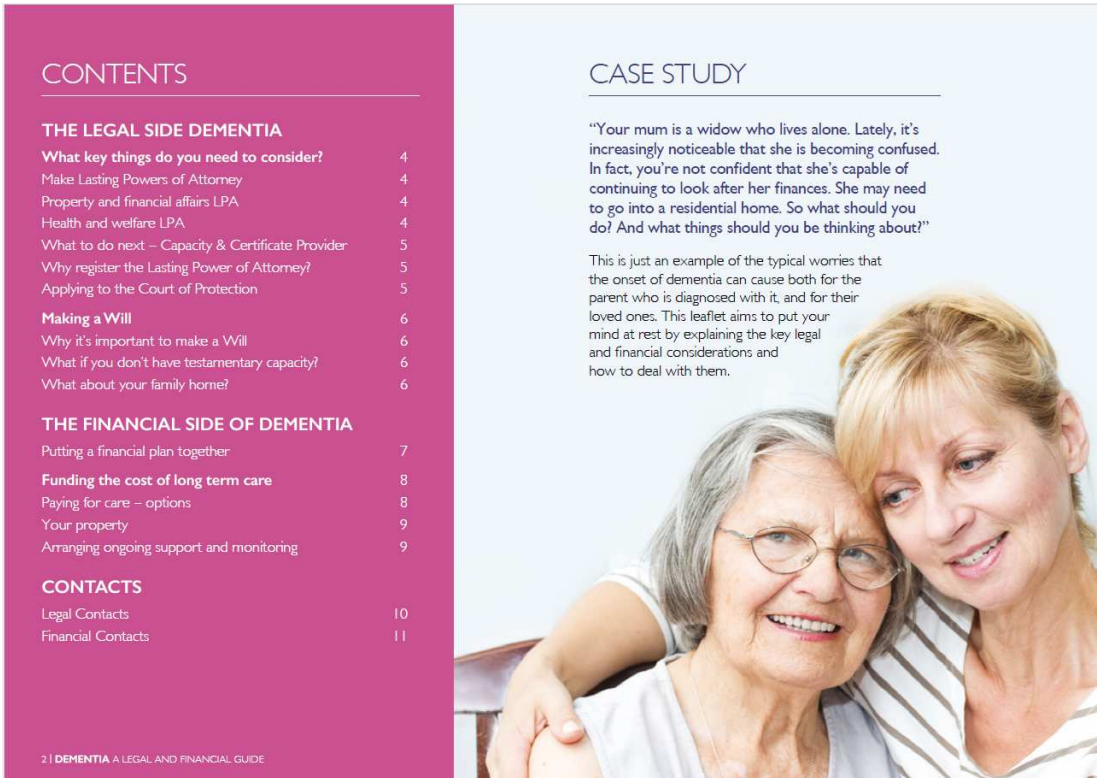
Do you have a recent photograph? Is it readily available, and a good likeness?

Photo

Annex 3

Financial guide (attached PDF)



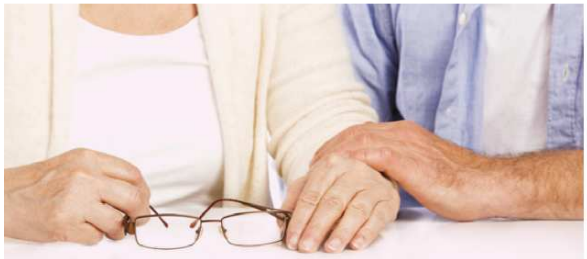


CONTENTS

CASE STUDY

"Your mum is a widow who lives alone. Lately, it's increasingly noticeable that she is becoming confused. In fact, you're not confident that she's capable of continuing to look after her finances. She may need to go into a residential home. So what should you do? And what things should you be thinking about?"

This is just an example of the typical worries that the onset of dementia can cause both for the parent who is diagnosed with it, and for their loved ones. This leaflet aims to put your mind at rest by explaining the key legal and financial considerations and how to deal with them.



THE LEGAL SIDE DEMENTIA
WHAT KEY THINGS DO YOU NEED TO CONSIDER?

When someone you care about is increasingly unable to make decisions about their finances or health you may need to consider a Lasting Power of Attorney (LPA). An LPA is a way of nominating a trusted friend or relative to look after their affairs.

MAKE LASTING POWERS OF ATTORNEY

There are two types of Lasting Powers of Attorney (LPA) that you can apply for:

PROPERTY AND FINANCIAL AFFAIRS LPA

This allows for the appointment of someone (an Attorney) to deal with financial affairs including paying bills and applying for benefits on behalf of the person (the Donor) who is having difficulty managing those financial affairs for themselves. This can be used as soon as it's registered.

HEALTH AND WELFARE LPA

This allows for the appointment of someone (an Attorney) to deal with decisions about health and welfare. It can include decisions about medication and treatment, where they will live and who will visit them.

An attorney can only use this LPA when the Donor has lost the capacity to make these decisions for themselves.

WHAT TO DO NEXT – CAPACITY & CERTIFICATE PROVIDER

An LPA can only be made when the Donor has the mental capacity to understand the document, the powers they are giving to the Attorneys and the implications.

In order to put an LPA in place, someone known as a Certificate Provider must confirm that the Donor has the necessary capacity to make an LPA. The Certificate Provider is quite often the treating consultant at the Memory Clinic.

It is often the case that the Memory Clinic will suggest an LPA be put in place once a diagnosis has been given.

WHY REGISTER THE LASTING POWER OF ATTORNEY?

Please bear in mind that an LPA must be registered with the Court before it can be used by the Attorney. This means you'll need to factor in the time it takes to deal with registration, which is typically 10 – 12 weeks. However, the timescale will vary depending upon each Court's workload.

APPLYING TO THE COURT OF PROTECTION

If the Certificate Provider is unable to confirm that the Donor has the necessary capacity to put in place an LPA then steps needs to be taken in order to appoint a Deputy.

An application will need to be made to the Court of Protection before any financial decisions can be taken. The Court of Protection is the Court that has the power to make decisions relating to people who have lost their mental capacity.

If a person lacks capacity to make an LPA, family members or friends can apply to be appointed as a Deputy on their behalf. Once appointed, the Deputy will be able to make financial decisions on behalf of the person who lacks capacity, subject to the overall control of the Court. For example, the Deputy would have the legal authority to sign papers relating to the sale of the property and to then look after the proceeds of sale.

If something needs to be completed quickly such as selling the house, special directions might be needed from the Court.

As with registering for an LPA, it takes time to appoint a Deputy. This is typically 4 – 6 months, although it can take longer.

MAKING A WILL

WHY IT'S IMPORTANT TO MAKE A WILL

The next thing to consider is to ensure a Will is in place. A Will ensures that when you die, your money and possessions go to the people you choose. If you do not have a Will, the law will dictate who will benefit from your estate.

This means it is important to make a Will whilst you still have testamentary capacity. If you have dementia, you may still have testamentary capacity to make or change a Will.

WHAT IF YOU DON'T HAVE TESTAMENTARY CAPACITY?

In this situation, only the Court of Protection can make a Statutory Will on your behalf.

Partners/relatives of the person with dementia may also wish to consider making or changing a Will.

If you wish to leave your estate to the person with dementia, you should consider setting up a Trust to ensure their income is protected. This will also help to prevent their eligibility for means tested benefits being affected by the inheritance they are due to receive.

WHAT ABOUT YOUR FAMILY HOME?

You can make provision for your property in your Will. Leaving your share of your property in your Will to your children for example, can ensure that they inherit what you have worked hard for.

As you get older you may require advice on a number of property transactions in addition to the above. You may also need to consider moving home to find accommodation that's more suitable for you.

THE FINANCIAL SIDE OF DEMENTIA

Following a diagnosis of dementia one of the most daunting things to consider can be ensuring that the financial side of things is taken care of.

This can range from planning a monthly budget, to understanding how to fund care fees, applying for state benefits and ensuring that assets are properly managed and protected. With the right support and advice this can all be taken care of.

PUTTING A FINANCIAL PLAN TOGETHER

The financial consequences of dementia may begin to be felt well before you need to consider funding the cost of care. If your parent or loved one has always managed their own finances (or that of the family) they will probably need help very quickly.

By seeking advice about financial support, you can create a plan to make sure that things continue as normal during what may well be a difficult time. A professional adviser will help you to work with the person affected by dementia, starting from the immediate need to manage their income through to the potential need for care or assistance. They will guide you through the options and remove many of the uncertainties and concerns about the future.

FUNDING THE COST OF LONG TERM CARE

One of the biggest concerns for those with dementia, and their families, is how to fund the cost of both immediate and longer-term care. Although state benefits such as Attendance Allowance are available, it can be difficult to find out about the wider range of support that local authorities and the NHS can offer. This is especially true when trying to understand the impact of means testing and the likely implications of self-funding.

The average cost of residential care in the UK is currently estimated at £550 per week. If nursing care is also required, this can rise to £758 per week. The average cost of care in your home is £15 per hour (source: Laing & Buisson Care of Older People, UK market report 2013/14).

It is therefore not surprising that one in four people who fund their own care run out of money (source: Partnership 2013), leading to potential compromises regarding their future care. Most commonly, this is because they do not consider all the options or take proper advice.

With financial planning it may be possible to fund care for as long as required, whilst safeguarding as much capital as possible. For this reason, consulting with a specialist financial adviser is essential from both a health and financial perspective.

PAYING FOR CARE – OPTIONS

For those required to pay for their own care, there are a number of different ways this may be done, depending upon your circumstances:

1. **Own income**
2. **Family contribution**
3. **Savings accounts**
4. **Investments**
5. **Care Fees Plan**

1. Own income: You may receive sufficient income to pay for care in full, or as a "top up". This income could be from a number of possible sources:

- Pensions
- Investment income
- Rental property
- Attendance Allowance
- Nursing Care contribution (if applicable)
- Funding from other family members

Details of state benefits can be found at **www.gov.uk/browse/benefits**

Even if your income appears to be enough to cover the cost of care in full, take advice. It is likely that improvements can be made.

2. Family contribution: Your family may be able to cover some or all of the cost, or difference in cost, as a "top-up". If neither of these are an option, you will need to raise money either by accessing savings or investments, releasing money from your home via an equity release plan, or selling the home.

3. Savings accounts: This includes money held in deposit accounts, Cash, Individual Savings Accounts (ISAs) and National Savings. Very low risk, but with current rates of interest being so low you will need to ensure your capital is not eroded too quickly.

4. Investments: There are many possibilities here, from investment bonds and unit trusts to shares. However, the most profitable are usually the highest risk therefore a balance may need to be struck. There is no guarantee that values will not fall and put your capital at risk.

Again, this is where advice from a professional can be invaluable by helping to ensure your savings and investments provide you with a predictable and consistent income for funding care costs.

5. Care Fees Plans (also known as Immediate Needs Annuities): These are specialist insurance plans designed to convert capital into income to help meet care fees. In return for a one-off lump sum you receive a guaranteed tax free income for life.

YOUR PROPERTY

The proceeds of a house sale can be used to support any of these options if other assets on their own are insufficient.

ARRANGING ONGOING SUPPORT AND MONITORING

It's also a good idea for partners or family members to meet regularly with a Financial Adviser to monitor and understand any changes in circumstances as they develop and to adapt their financial arrangements to take account of them. This can provide genuine peace of mind for everyone when it really matters.

Looking after your finances can have a dramatic effect on your ability to pay for the type of care or care home that you require. Seeking professional advice from a regulated financial adviser will help you achieve this.

LEGAL CONTACTS

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Annex 4

Rotherham Dementia Action Alliance Coordinator	**Year 1** **01/02/2016 to 31/01/2017**	**Year 2** **01/02/2017 to 31/01/2018**
Salaries plus on costs Dementia Action Alliance Coordinator 35 hrs. pw Services Manager 1.75 hrs. pw	£26,337.00	£26,612.00
Learning & Development	£423.00	£428.00
Volunteer costs	£822.00	£831.00
Mileage	£1210.00	£1222.00
Office costs e.g. rent printing, stationery, postage etc.	£1,586.00	£1,598.00
IT costs	£1,195.00	£1,205.00
Other essential & local support costs including Finance, HR, Health & Safety, Safeguarding & risk, evaluation and support from the Regional Dementia Action Alliance	£5,486.00	£5.540.00
Sub-total	**£37,059.00**	**£37,437.00**
NHS Rotherham Clinical Commissioning Group	£5,000.00	n/a
South Yorkshire Fire & Rescue contribution to total cost	£ 9,600.00	£ 9,600.00
Alzheimer's Society contribution	£1,586.00	£1,598.00
Balance: Rotherham Health and Wellbeing Board and constituent partners	**£20,873.00**	**£26,239.00**

Call to action – "Rotherham get active"

Draft Agenda
11 May 2016
9:15 – 2:30pm

8.45 – 9.15 am	Registration
9.15 am	Welcome and introduction Cllr David Roche/Terri Roche, Chair of the Health and Wellbeing Board
9.30 am	Keynote speaker Karen Creavin, Birmingham City Council
10.00 am	Sport England (TBC)
10.15 am	Sport and Physical Activity in Rotherham – local context Rebecca Atchinson & Chris Siddall
10.35 am	Rotherham Active Partnership
10.45 am	Break and refreshments
	Local good practice presentations:
11.00 am	Rotherham United Community Sports Trust
11.20 am	Active for Health
11.40 am	Leisure centres / parks & green spaces (TBC)
12.00 pm	Question and Answer – panel of speakers Chaired by Karen Creavin
12.20 pm	Networking and light lunch
1.05 pm	Welcome back – purpose of afternoon session/workshops
1.20 pm	Workshops To be confirmed.
2.10 pm	Launch the call to action – "Rotherham Get Active" website
2.20 pm	Closing remarks – what happens next