HEALTH AND WELLBEING BOARD

Venue: **Voluntary Action, The Spectrum, Rotherham**

Date: **Wednesday, 1st June, 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 (Pages 1 - 13)
   Minutes of meeting held on 20th April, 2016

For Discussion

7. South Yorkshire and Bassetlaw Sustainability and Transformation Plan/Draft Integrated Health and Social Care Place Plan (Pages 14 - 228)
   Chris Edwards (Chief Officer, Rotherham Clinical Commissioning Group), Louise Barnett (Chief Executive, Rotherham Foundation Trust) and Sharon Kemp (Chief Executive Rotherham Council), to present

8. Joint Strategic Needs Assessment (JSNA) Update (Pages 229 - 232)
   Presentation by Miles Crompton, Policy and Partnership Officer, Rotherham MBC

9. Healthy Ageing Framework - A co-ordinated whole system approach to Healthy Ageing for Rotherham (Pages 233 - 242)
   Rebecca Atchinson, Public Health Specialist, Rotherham Public Health, Rotherham MBC

10. Better Care Fund (Pages 243 - 310)
Claire Smith (Rotherham Clinical Commissioning Group) and Nathan Atkinson (Assistant Director of Adults Commissioning, Rotherham MBC) to present

11. Better Care Fund Section 75 Agreement 2016-17 (Pages 311 - 370)
Claire Smith (Rotherham Clinical Commissioning Group) and Nathan Atkinson (Assistant Director of Adults Commissioning, Rotherham MBC) to present

12. Better Care Fund Quarter 4 Submission (Pages 371 - 393)
Claire Smith (Rotherham Clinical Commissioning Group) and Nathan Atkinson (Assistant Director of Adults Commissioning, Rotherham MBC) to present

13. Director of Public Health Annual Report 2015-16 (Pages 394 - 483)
Terri Roche, Director of Public Health, to present

14. Suicide Prevention and Self-Harm Action Plan Update 2015-16 (Pages 484 - 504)
Ruth Fletcher-Brown, Public Health Specialist, Rotherham Public Health, Rotherham MBC, to report

For Information

15. Date, Time and Venue of the Next Meeting
Wednesday, 13th July, 2016, at 9.00 a.m. Rotherham Town Hall

Future Dates
21st September, 2016
16th November, 2016
11th January, 2017
8th March, 2017

SHARON KEMP,
Chief Executive.

HEALTH AND WELLBEING BOARD
20th April, 2016

Present:-

Members

Councillor David Roche	Cabinet Member for Adult Social Care and Health **(in the Chair)**
Louise Barnett	Rotherham Foundation Trust
Graeme Betts	Acting Strategic Director, Adult Social Care and Housing
Karen Borthwick	Children and Young Peoples Services, RMBC
Tony Clabby	Healthwatch Rotherham
Richard Cullen	Governance Lead, Rotherham CCG
Chris Edwards	Chief Officer, Rotherham CCG
Sharon Kemp	Chief Executive, RMBC
Julie Kitlowski	Clinical Chair, Rotherham CCG
Rob Odell	South Yorkshire Police
Teresa Roche	Director of Public Health, RMBC
Debbie Smith	RDaSH
Janet Wheatley	Voluntary Action Rotherham
Councillor Taiba Yasseen	Cabinet Member, Neighbourhood Working and Cultural Services

Report Presenters:-

Steve Helps	South Yorkshire Fire and Rescue Service
Gill Harrison	Public Health, RMBC
Richard Hart	Public Health, RMBC
Sally Jenks	Public Health, RMBC

Officers

Dominic Blaydon	Rotherham CCG
Kate Green	Policy Officer, Chief Executive's Office
Gordon Laidlaw	Communications, Rotherham CCG
Dawn Mitchell	Democratic Services, Assistant Chief Executive

Observers

Chris Bland	Rotherham Pharmaceutical Committee
Councillor Mallinder	Vice-Chair, Health Select Commission

Apologies for absence were received from Carole Lavelles, Councillor Sansome, Kathryn Singh, Ian Thomas and Councillor Watson.

67. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

68. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

69. MINUTES OF THE PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 24th February, 2016, be approved as a correct record subject to the following clerical amendments:-

Minute No. 56 (Update on the Health and Wellbeing Strategy Implementation)
"It was noted that a lead officer from Voluntary Action Rotherham had now been identified for aim 2 by Ian Thomas as the Board sponsor and Janet Wheatley"

Arising from Minute No. 63 (Transforming Services for People with a Learning Disability and/or Autism), it was noted that discussions had taken place between the CCG and the Council. As from 1st April, 2016, the threshold had changed and the diagnostic tool adjusted the IQ to 70 rather than 50.

Arising from Minute No. 62 (Adult Safeguarding Strategy), Julie Kitlowski reported that GP practices were aligning themselves to care homes which would improve the Health input and be more alert to any possible issues.

A meeting had taken place to discuss the issue and ensure that the CCG had early warnings of any concerns.

Arising from Minute No. 65 (Rotherham Get Active Event), it was noted that so far 50 had registered for the event. There were 10 further places available and anyone interested should contact Kate Green as soon as possible.

Tony Clabby also raised the possibility of receiving the minutes as soon as possible following a Board meeting rather than waiting for the next agenda.

Resolved:- That the draft minutes be circulated to Board members as soon as possible after a meeting.
Action:- Democratic Services

70. SOUTH YORKSHIRE FIRE AND RESCUE

Steve Helps, Area Manager, gave a powerpoint presentation and a video of the work of the South Yorkshire Fire and Rescue Service Safe and Well initiative:-

Change of Fire and Rescue Service Business Model

- Change to Fire Service Act 2004 to introduce statutory duty to provide Community Fire Safety Advice
- UK Fire and Rescue Service business model amended from a reactive lead service to one of proactive

- The introduction of Home Safety Checks – approximately 670,000 completed annually across the United Kingdom – around 20,000 across South Yorkshire

Targeting the most vulnerable
- Are over 65 years of age
- Live alone
- Have a physical or learning disability
- Have a cognitive impairment including dementia or memory loss
- Have a mental health issue
- Have a substance or alcohol dependency
- Have Adult Social Care needs
- Are a smoker
- Are unable to protect themselves from harm for any reason

Safe and Well Visits
- In support of the 5 year forward plan CFOA, RSPH, NHS and Age UK published the consensus statement in 2015
- Move towards Safe and Well visits
- Doncaster pilot – Ageing Well, Falls questions, crime prevention, fire safety and crime private information
- Steering Group in Barnsley – work was progressing in Rotherham and Sheffield

Delivering a range of prevention initiatives
- Comprehensive schools educational programme
- Lifewise Centre introduced CPR awareness
- 7 Cadets Units routes4you
- Achieving Respect Confidence (ARC) courses
- Princes Trust Team Programme
- Eyesight tests RNIB Sheffield
- Boxing Clubs – Thorne and Moorend
- Age UK Barnsley and Rotherham
- Eastwood in Rotherham and Great Places in Sheffield – cooking courses
- Rotherham Hospice
- Hotspots referral scheme
- Over 100 Safe and Well Referral Partnerships
- Investment in £1.7m through SSCR across over 30 community-based projects
- Winter warm packs
- Midwife lead prevention work through SSCR project
- Troubled Families Programme
- Supporting food banks
- Dementia Alliance funding/project
- Alzheimer's Memory Café

Fire Health Conference 2016
Recommendations

- The introduction of Safe and Well visits across South Yorkshire
- Partnership supporting and becoming Safe and Well referral partners allowing the most vulnerable within our communities to receive early interventions
- A mature conversation with partners to identify opportunities for data sharing to ensure limited resources are targeted at the most vulnerable through early intervention activities
- South Yorkshire Fire and Rescue Service to support the priorities of the Health and Wellbeing Boards and for Boards to recognise the varied activities that the Service undertake in support of the Health and Wellbeing agenda
- Commissioners and South Yorkshire Fire and Rescue Service to identify activities which the Service's assets could contribute to support early intervention or reduce demand on existing services

Safe and Well Referral Partnership
How you can assist

- To sign up to become a Safe and Well Partner please follow the links below
  Website www.syfire.gov.uk/safe-well
  Email
  Safe&well@syfire.gov.uk
  Once you have made contact with us an Officer will follow up your enquiry to discuss further and process your application

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

- The fact that the Fire Service was a trusted service going into a property was very useful. For elderly people who were isolated and lonely, and by definition not engaging with services, the opportunity of Safe and Well visits linked up with social prescribing

- One of the biggest referrals from outside agencies was to the Fire Service
  We see the benefits of working with the 3rd sector agencies and Age UK with the engagement programme

- The Service was doing this work but most of the agencies did not see/aware of it; the challenge was how to make that connection. Was a Safe and Well visit communicated to partners?
  The referral pathway would enable the Service to report back the outcome and the number of visits made. If the visit resolved the issue that was the end of the matter but if it was more challenging and the resident was someone who had long term issues it would be escalated to a specialist Community Safety Officer. There would be a multi-agency approach with the right people around the table and

discuss the resident and every endeavour would be made to ensure that the resident was safe

- Were the red referral cards that a professional had to fill in still used? *The system had been found to be quite bureaucratic. A new simpler system was used for Safe and Well as well as a web portal*

- If the Service was able to find a way of looking at/achieving risk reduction it would be helpful to the Foundation Trust

- The Trust was to start its next stage of community setting work which would include the Fire Service so there would be an opportunity to educate the Health side

Steve was thanked for his very informative presentation.

71. HEALTH AND WELLBEING STRATEGY

Julie Kitlowski report on the workshop held on 16th March to address health inequalities and healthy life expectancy. Key themes that were felt to make a difference if all partners were aware of the commitments were pulled together:-

Making Every Contact Counts issues – which should include encouraging the most deprived and hard to reach to go for Healthchecks and have Champions in the community who would be able to give their stories about how they had managed to make significant life changes by personal testimony

Community Champions – there were some really good stories of people from hard to reach communities standing up and being prepared to say how they had made a difference. The aim was to have health champions/more health ambassadors

Keeping Active – All partners knew exactly what was available so it was incumbent on them to pass that information onto their clients and staff and attempt to try and link up the education of what was available

It was important that employers, businesses, volunteers etc. worked together with the Partnership Group and business community or it would not progress in the way needed to make a difference in health inequalities. It was key to engage better with partners and businesses

Measure Outcomes – the number of patients having Healthchecks could be measured as well as the number of Community Champions and those that signed up the various activity events

Terri Roche reflected that the notes from the workshop did not have a strong emphasis on NHS Healthcheck but agreed that it was important that harder to reach communities had support had access to the right

health care services in a timely manner. This could include improving the uptake of national screening and vaccinations programmes and early presentation of symptoms at Primary Care.

Discussion ensued on employment and business and linking in with the discussions taking place around the Sheffield City Region (SCR). The most effective way of tackling inequalities was money and that usually came from employment. There was a danger if the Board did not influence the SCR agenda, access to employment for those who experienced barriers could make the inequalities worse.

Terri Roche reported that the working group for Theme 5 had not met as yet. There was an outcome based accountability Safer Rotherham Partnership workshop taking place on 26th April, 2016, and it was felt that some of the actions that needed to be in Health and Wellbeing Strategy would "fall" out of that. The group would then look at the gaps and who else needed to be pulled in

Chris Edwards and Louise Barnett gave a brief report on the Sustainability and Transformation Plan (South Yorkshire and Bassetlaw Equality Plan). Chris, Louise and Sharon Kemp were meeting on a weekly basis to pull the Plan together. It covered health and wellbeing and had links through the whole Sheffield City Region. There were very tight timescales for its submission which would not coincide with the meetings of the Board. A submission had been made on 15th April with a further submission required by the end of June. There was to be an engagement event on 25th April.

Resolved:- (1) That the update on the Health and Wellbeing Strategy be noted.

(2) That an update on the Sustainability and Transformation Plan be submitted to the next meeting of the Board.
Action: Chris Edwards, CCG

72. THE HEALTH PROTECTION COMMITTEE'S ANNUAL REPORT

Richard Hart, Health Protection Principal, presented the Health Protection Committee's 2015 annual report.

The Committee had made considerable progress in seeking assurance from organisations across the Borough on a range of controls associated with health protection. The report outlined the responsibilities of the Council, NHS England, the Clinical Commissioning Group, Public Health England, Foundation Trust and RDaSH. It also highlighted the work that had been done over the year and areas where further development was needed.

The following areas of progress were highlighted:-

- Clarifying health protection roles and responsibilities and the line of accountability between the Health Protection Committee and the Health and Wellbeing Board
- Maintaining effective working relationships and communications with Council staff, external agencies/professionals and the public
- Controlling the spread of TB and HIV through multi-agency incident meetings
- Providing local advice on national and local alerts on environmental hazards such as high level air pollution episodes
- Managing Health Care Associated Infections, MRSA bacteraemia and Clostridium Difficile Infections and engagement of the Hospital and Community Trusts
- Implementing the national childhood immunisation and seasonal flu programme across Rotherham
- Facilitation of training and simulation exercises run by the Emergency Planning Shared Service
- Local planning and response to Ebola and other emerging infections

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

- The CCG had employed an excellent Infection Prevention and Control Lead Nurse

- Was it appropriate to include issues that were pertinent to Rotherham e.g. poor air quality and how that impacted on respiratory indicators, the real improvements in antibiotic resistance and the supporting work carried out on Ebola

- Shade provision and reducing skin cancers – this did not come under the scope of Health Protection Committee but there was a need to revisit where that might fit particularly working with Children and Young Peoples Services

Resolved:- (1) That the Health Protection annual report be noted.

(2) That a report be submitted annually and exception reports as appropriate.

73. PHARMACEUTICAL NEEDS ASSESSMENT (PNA) UPDATE 2016-17

Sally Jenks, Public Health Specialist, presented the refresh of the Pharmaceutical Needs Assessment (PNA) which had been subject to consultation with all the key stakeholders involved in the process of developing the PNA.

Producing and publishing a PNA fulfilled the legal requirements laid down in National Health Service (NHS) (Pharmaceutical Services) (Amendment) Regulations 2010.

The PNA would guide the opportunities for pharmacists to make a significant contribution to the health of the population of Rotherham.

The document linked to a number of other key Borough-wide strategies and plans including the Rotherham Joint Needs Assessment which provided the local data set used for informing pharmacy applications and pharmaceutical service commissioning.

The document would be reviewed in a year or sooner if necessary to ensure progress was being taken or should there be any significant changes in Legislation or commissioning intentions.

Resolved:- (1) That the Pharmaceutical Needs Assessment be approved.

(2) That it be noted that the process had been conducted within the regulatory framework.

(3) That it be noted that the key stakeholders who contributed to the development of the PNA had been involved in the review process as per the regulatory framework.

(4) That, unless a significant change occurred locally which would trigger a re-write of the document, a new PNA would need to be published on 1st April, 2018.

74. ROTHERHAM SEXUAL HEALTH STRATEGY 2015-17 UPDATE

Gill Harrison, Public Health Specialist, presented a progress report on the multi-agency Sexual Health Strategy and action plan.

In May 2013 the Health and Wellbeing Board had recommended the reconvening of a multi-agency Sexual Health Strategy Group to produce an updated comprehensive Strategy for Rotherham. The final Strategy was agreed in December, 2014.

One year into the delivery phase of the Strategy the following had been achieved:-

- The mapping of the provision of Sex and Relationship Education across Rotherham
  An audit by the School Effectiveness Team had revealed that the provision varied but the majority of schools felt that it was an improving picture regarding time on the curriculum for Personal, Sexual and Health Education which was where relationships and Sexual Health Education would be taught

- CSE Theatre in Education (TiE)
  The TiE 'Chelsea's Choice' had been funded by the Clinical Commissioning Group and Public Health and aimed at Y8 or Y9 pupils. All secondary and special schools and Pupil Referral Units engaged and there were a further two evening sessions for vulnerable young people (60 capacity) and parents/carers and siblings of vulnerable young people (126 booked, 117 attended). All performances received excellent evaluations

- Review of Sexual Health for Looked After Children (LAC) and Children Leaving Care
  The multi-agency LAC Physical and Emotional Health Group now had a regular focus on sexual health with new training for carers being considered. A review of pathways into services was being undertaken

- Review of Youth Clinic Provision
  The Rotherham Foundation Trust and Early Help and Family Engagement had undertaken a comprehensive review of all youth clinic provision and there had been a realignment of services to provide consistent delivery of services to young people on sites that were accessible by all within the community/locality and extended beyond the restrictions of term time only. Staffing provision had improved in each clinic and the partners were marketing the services and had developed stronger links and pathways between other areas such as family Nurse Partnership and School Nursing. Where footfall was poor and the more vulnerable were not engaging with the services, plans had been put into place for outreach work. Embedded into the core of the clinics were robust assessments for CSE and Safeguard and partner notification or sexually transmitted infections such as Chlamydia

- Review of delivery of Emergency Hormonal Contraception in the Community
  Following a review, the CSE referral pathways had been updated and all pharmacists were undergoing extra training. An audit of activity had been undertaken and provision across Rotherham mapped. Data showed that the majority of women accessing this service were over the age of 20; this information would now help in the future commissioning processes

- Development of the Integrated Sexual Health Services
  In line with national recommendations, the Council had commissioned an Integrated Sexual Health Service from the Foundation Trust to provide a full range of STI testing, HIV testing (not treatment) and comprehensive contraceptive services. At present, NHS England also commissioned HIV treatment from the Trust. The Trust had been working to an integration plan and developing their services. CSE referral pathways had been strengthened and the Service would be going out to tender during 2016 which would further strengthen the

process of integration to offer Rotherham residents a comprehensive sexual health offer

- Review of Primary Care Sexual Health Services
  Existing provision had been mapped. Public Health and GP providers had been working towards ensuring that competencies were maintained and that there was a good service in place for all users. Audit of the Services had shown that they were mainly used by women over the age of 20

- New Service for HIV Prevention and Support
  +Me had been commissioned to provide HIV education, awareness raising and prevention in the community as well as support with a regular drop-in service for people living with HIV. The third sector was actively promoting HIV testing and working closely with the Trust to help people access services. Although Rotherham did not score well on the Public Health Outcomes Framework measure for late diagnosis of HIV, it did score highly on uptake of testing within the Sexual Health Services. The newly commissioned Service should help improve diagnosis by promoting the Services and HIV testing

Proposed future activity was:-

- Although the audit of schools was positive, it was felt that the promotion of good practice should be continued. Many schools were providing excellent Relationship and Sex Education and this should be the 'gold standard' for all Rotherham schools

- The audit of primary care contraception provision showed that a few young people were accessing these services. More work needs to be done to ensure that our young people had the best possible access to contraception. This is especially important as, there was an increase in teenage conception rate in 2014 taking Rotherham once again above the rate for England. However, Rotherham still has the lowest rate among its closest statistical neighbours and the last two quarters of 2014 had rates well below those in England

- Among NHS funded abortions in Rotherham, the proportion of those under 10 weeks gestation was considerably lower than in England. The earlier abortions were performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, was also cost effective and an indicator of service quality and increased choices around procedure. There was considerable room for improvement in earlier access to terminations in Rotherham. The commissioners (CCG), abortion providers and all referrers into the service needed to work to ensure earlier access

- Because of the complexity of the commissioning of Sexual Health Services, more work needed to be done to ensure that services provided were effective and provided services that were relevant to the needs of the population

Discussion ensued with the following issues raised/clarified:-

- The Group had felt there was a need to develop a specialist service to work with hard to reach vulnerable groups such as the Roma community and young people in care and adopt specific, evidence based targeted interventions but not necessarily to introduce a new service.

- Linking in with the locality theme work would be a good way of finding out what work was already taking place and ascertaining if there were any gaps

- There was a clearly defined action plan which was a living document used by the Strategy Group to monitor progress. This report was a summary of the things that had been achieved over the past year

- Teenage pregnancies had considerably decreased; the numbers had been slightly up at the beginning of last year but had reduced again and measured quite well with statistical neighbours. There were certain aspects of STI infection reports which were higher. However, the Chlamydia detection rate was good and providers of service were able to identify infection within the community

- In comparison with its statistical neighbours, Rotherham was the 3rd highest in Yorkshire and Humber with a tremendous difference between Rotherham and Wakefield and Doncaster

- How did diversity fit into the picture particularly in relation to commissioning?

- How was the work linked to deprivation particularly the effect of the Welfare Reforms?

- The Team participated in the work of the Health Protection Committee and did “deep dive” into infection. The Team tried to look at it from a Health Protection point of view of what was working well and how to address some of the issues

- The main provider of Sexual Health Services (Specialist Service) were required to report how many referrals they had made to the MASH

- Public Health England was looking at the early monitoring and early detection of STIs as a much earlier indication was required against what would normally be expected

- The report showed that there was progress of early testing of HIV but a high number of late diagnosis. HIV figures came out retrospectively so this was what had happened previously. Once patients were into the service, it was very good at offering the test and it being accepted. There was a need to get potential patients into the service and be tested earlier and was the reason why there was a group promoting HIV testing. A recent meeting had revealed that the measure of late diagnosis was reducing but more awareness raising was needed

Resolved:- (1) That the progress made against the suggested actions within the Sexual Health Strategy be endorsed.

(2) That the proposed future activity be endorsed.

75. ANY OTHER BUSINESS

(a) Self-Assessment
The Board would be undertaking a self-assessment which was being developed by the Local Government Association. A questionnaire would be sent to all Board members around 10th May with a return date of the end of May.

All responses would be anonymous and collated by the LGA. A facilitated session would be held on 13th July.

(b) Local Government Association Pilot
The LGA would be undertaking a pilot which would look at Health and Wellbeing Boards' transformation; Rotherham had been selected as a pilot area. The self-assessment (see (a) above) would take place and then look at how the Board could be best placed in terms of transformation. The LGA were looking at potentially holding workshops in September/October.

Resolved:- That a working group, consisting of the Chair, Terri Roche, Louise Barnett, Julie Kitlowski, meet to discuss integration.
Action: Kate Green

(c) Tony Clabby reported that he had recently attended the Health and Wellbeing Boards network event in York where the strategic transformation plans and devolution were discussed.

He has also attended the South Yorkshire and Bassetlaw Urgent and Emergency Care Network.

(d) Better Care Fund
Feedback on the recent BCF submission had been "assured with support" which was the best anyone had received in the South Yorkshire and Bassetlaw area.

76. 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.

NHS Rotherham Clinical Commissioning Group

Health & Wellbeing Board – Weds 1 June 2016

South Yorkshire & Bassetlaw Sustainability & Transformation Plan (STP)

Lead Executive:	**Chris Edwards**
Lead Officer:	
Lead GP:	**Julie Kitlowski**

Purpose:

To update the Health and Wellbeing Board on the South Yorkshire and Bassetlaw STP process.

Background:

The NHS Shared Planning Guidance asked every local health and care system in England to come together to create its own ambitious local plan for accelerating implementation of the Five Year Forward View (5YFV). These blueprints, called Sustainability and Transformation Plans (STPs), will be place-based, multi-year plans built around the needs of local populations.

To deliver STPs, local health and care systems have come together to form 44 footprints, which collectively cover the whole of England. These geographic footprints are of a scale which should enable transformative change and the implementation of the 'Five Year Forward View' vision of better health and wellbeing; improved quality of care, and stronger NHS finance and efficiency by 2020/21.

Rotherham sits within the South Yorkshire and Bassetlaw footprint which is led by Sir Andrew Cash (Chief Executive of Sheffield Teaching Hospitals).

Analysis of key issues and of risks

See attached stakeholder event summary.

Patient, Public and Stakeholder Involvement:

See attached stakeholder event summary.

Financial Implications:

NHS England has indicated that transformation funding will be made available plans which meet their criteria.

Recommendations:

- The Health and Well Being Board is asked to note progress and delegate responsibility to individual organisations to sign off the June submission.
- Note that it is proposed to bring the June submission to the next meeting.

South Yorkshire and Bassetlaw

Sustainability and Transformation Plan: Workshop

25 April 2016

SIR ANDREW CASH

Chief Executive, Sheffield Teaching Hospitals and South Yorkshire and Bassetlaw STP lead

JOHN MOTHERSOLE

Chief Executive, Sheffield City Council

LESLEY SMITH

Chief Officer, Barnsley Commissioning Group

Who is here today

- People who use NHS services
- Voluntary sector
- Patient and public champions
- Local Authorities

- NHS organisations from across South Yorkshire and Bassetlaw
- Research colleagues
- Education colleagues

What is today about?

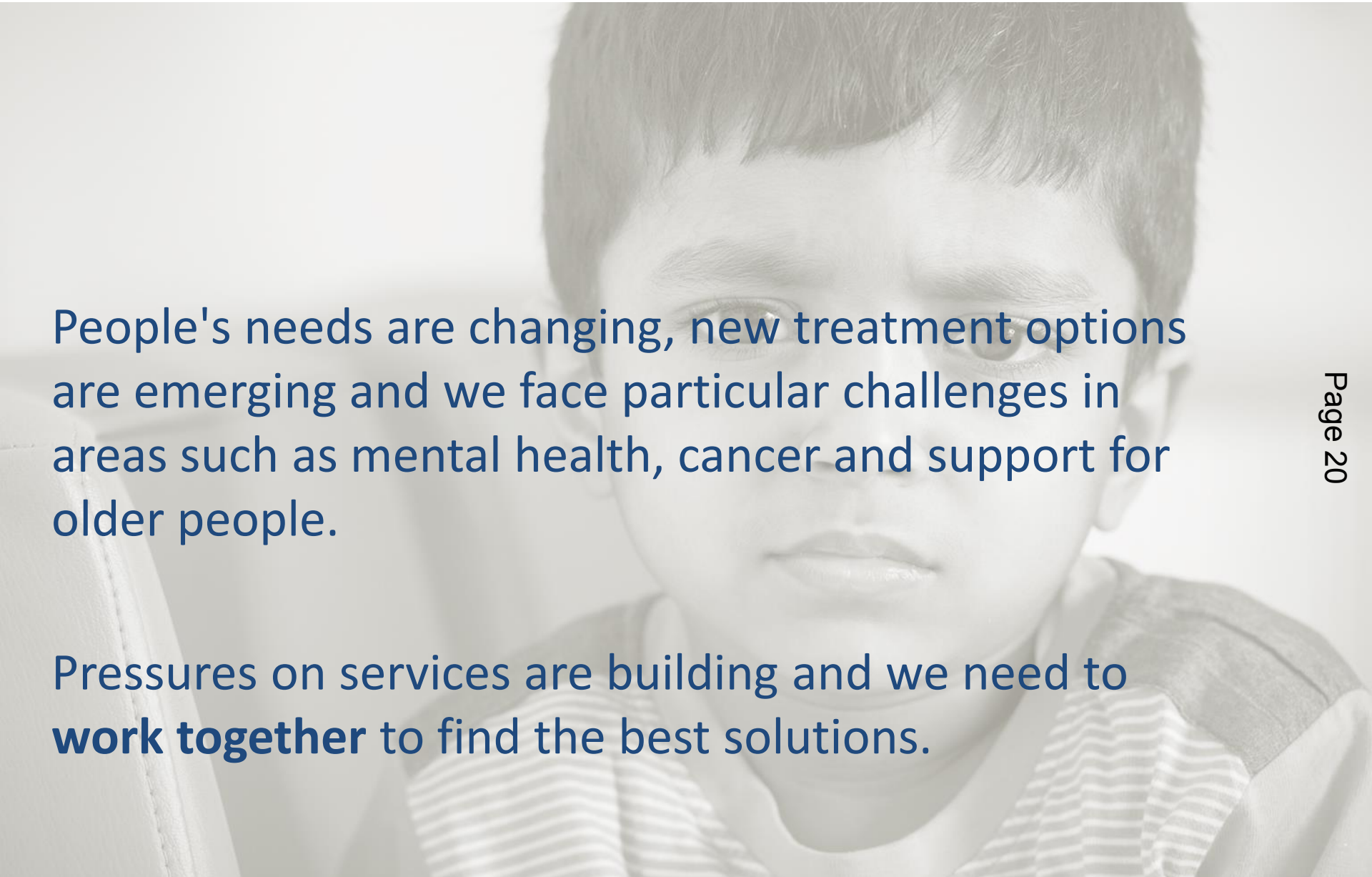
- **Bring you up to speed** with the South Yorkshire and Bassetlaw Sustainability and Transformation Plan process
- **Shape the plans** for our region
- Get **involved**

Why do we need an STP?

There have been some **big improvements** in healthcare in the last 15 years…

People with cancer and heart conditions are experiencing better care and living longer.

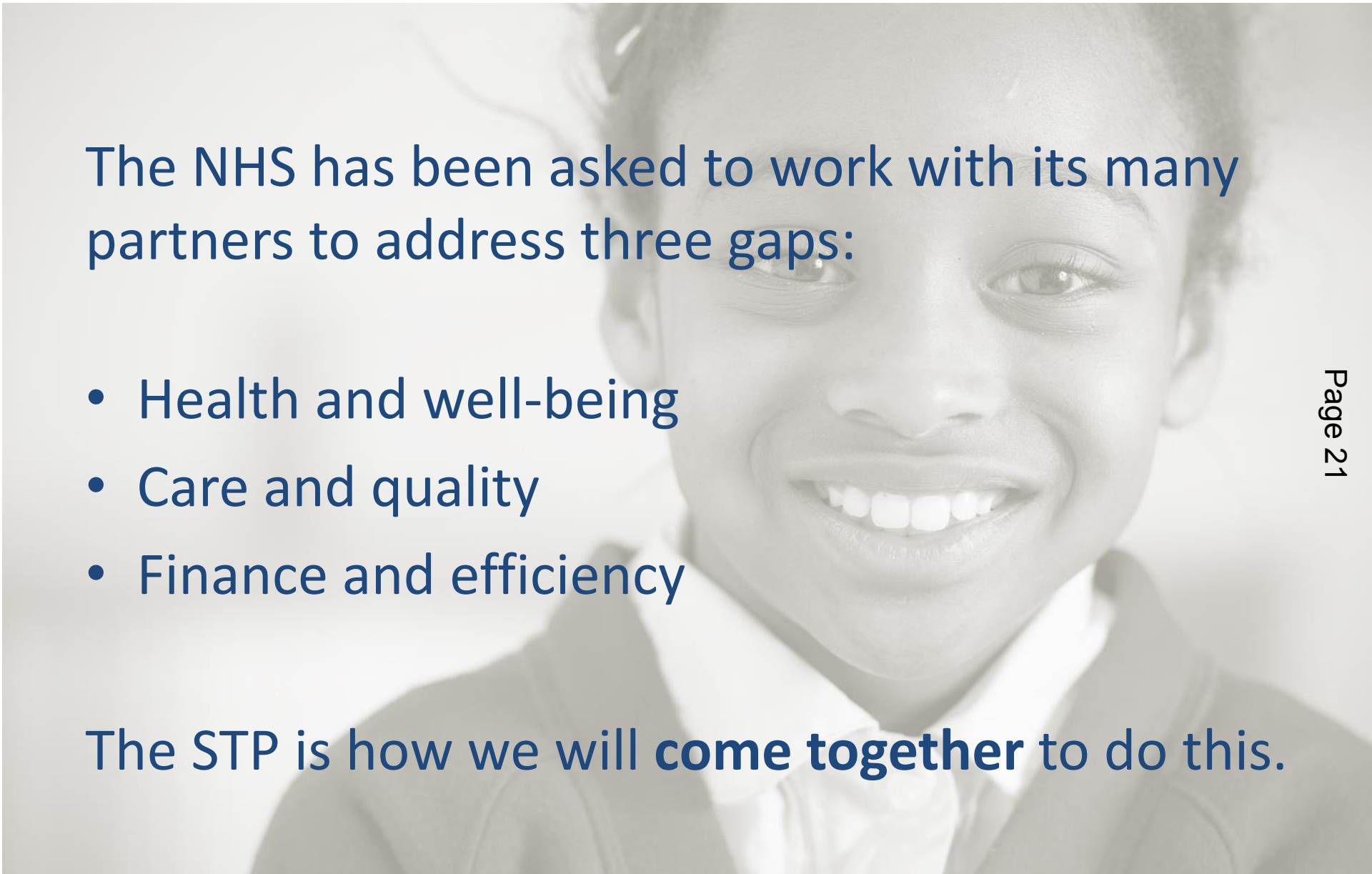
Waits are shorter and people are more satisfied – but the **quality of care** is **variable**, **preventable illness** is **widespread** and **health inequalities deep-rooted**.



People's needs are changing, new treatment options are emerging and we face particular challenges in areas such as mental health, cancer and support for older people.

Pressures on services are building and we need to **work together** to find the best solutions.

Three gaps



The NHS has been asked to work with its many partners to address three gaps:

- Health and well-being
- Care and quality
- Finance and efficiency

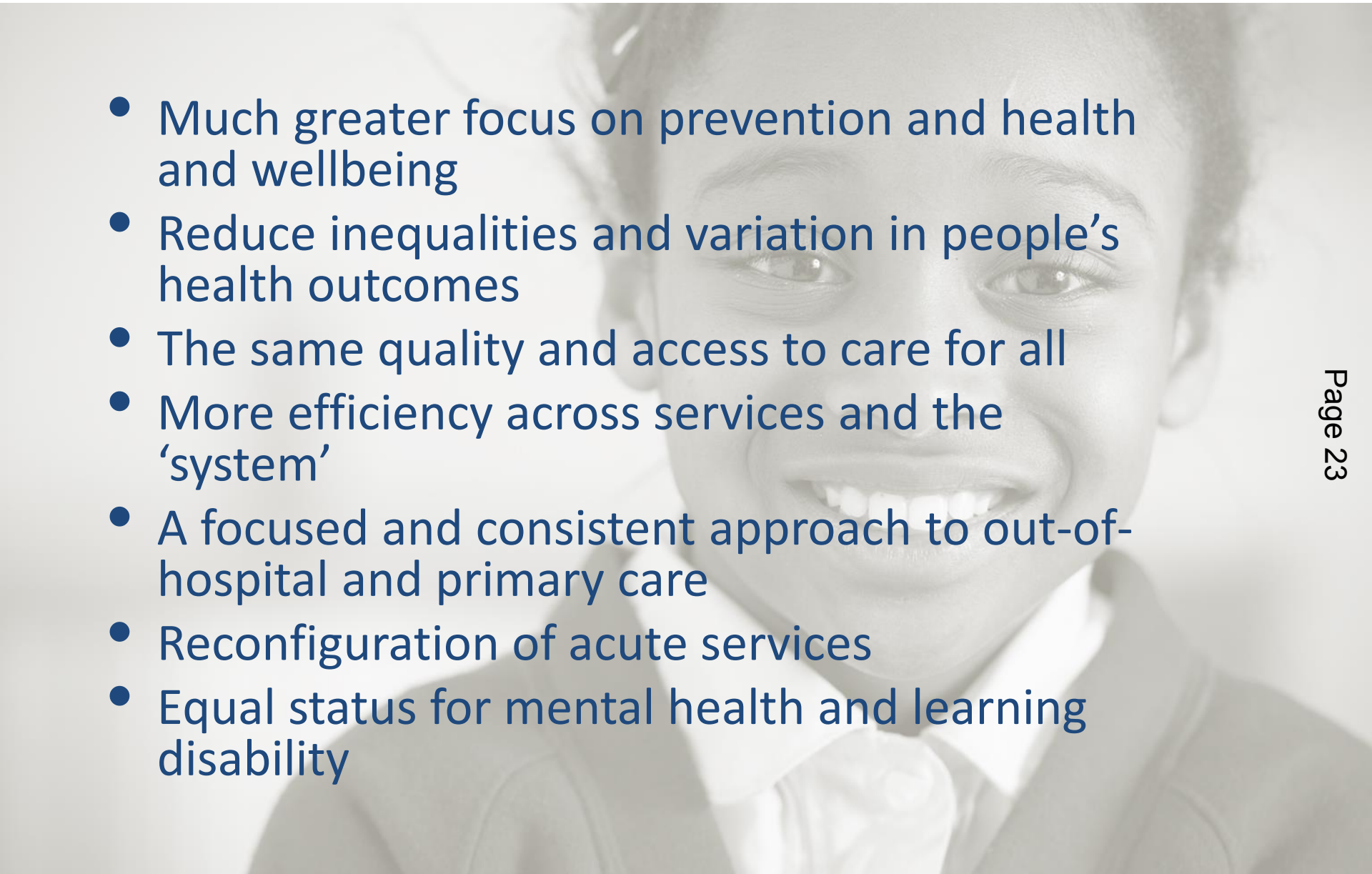
The STP is how we will **come together** to do this.

Our aim

We want to **work with you** to create plans that address and close the gaps.

This afternoon is just the start …

What is our focus?



- Much greater focus on prevention and health and wellbeing
- Reduce inequalities and variation in people's health outcomes
- The same quality and access to care for all
- More efficiency across services and the 'system'
- A focused and consistent approach to out-of-hospital and primary care
- Reconfiguration of acute services
- Equal status for mental health and learning disability

Engaging with the public

- **Engaging** and **listening** via our partners' networks online and in person
- **Matty** and **Lynne** are here today to keep us focused
- Our **voluntary** and **charity** sector partners are also here today

Engaging with our partners

- Regular **communications** to keep you updated and informed
- **Steering** group
- **Co-ordinating** group

Building on what we have

Our CCGs are already making good progress in a number of areas.

Our acute care hospitals are also making good progress with the Vanguard and clinical networks are coming together.

This combination of **local CCG** and **STP level** planning provides a top-down and bottom-up approach and ensures that:

- Localities are responsive to the needs of their local communities
- There is coordination across the footprint

There are also a number of themes that cut across the different levels of planning, and which will be relevant to all plans.

Whole system opportunity

It’s a fantastic opportunity to come together without boundaries, without walls.

If we are ambitious and joined up, we could attract significant investment to support our ideas.

This might be an NHS plan, but it’s a whole system opportunity. If we get this right, we can all make a real difference.

The public health perspective

Greg Fell

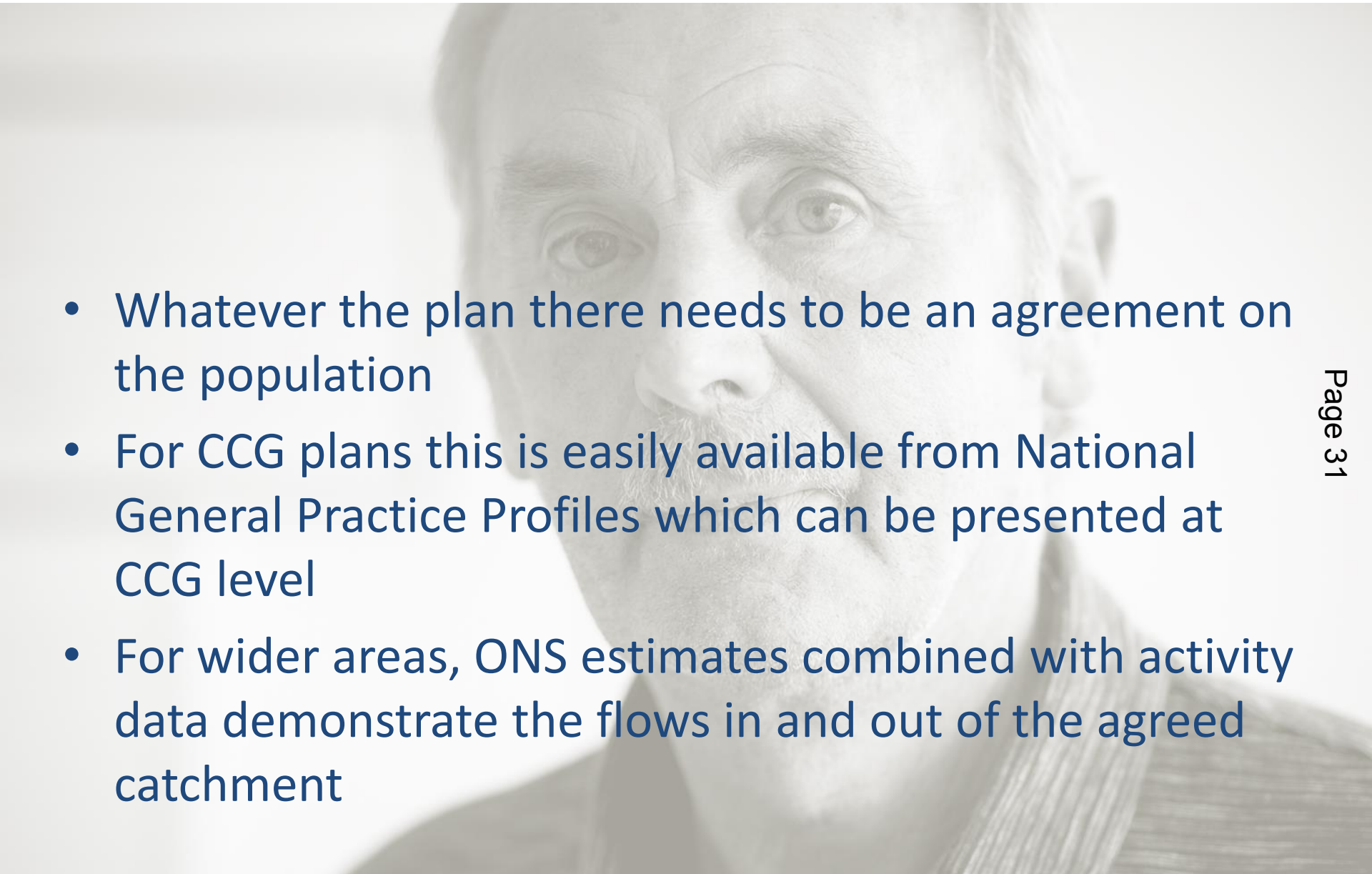
On behalf of all the directors of public health across South Yorkshire and Bassetlaw

And with thanks to Public Health England and the Yorkshire and Humber Academic Health Science Network

What is our focus?

The people of South Yorkshire and Bassetlaw

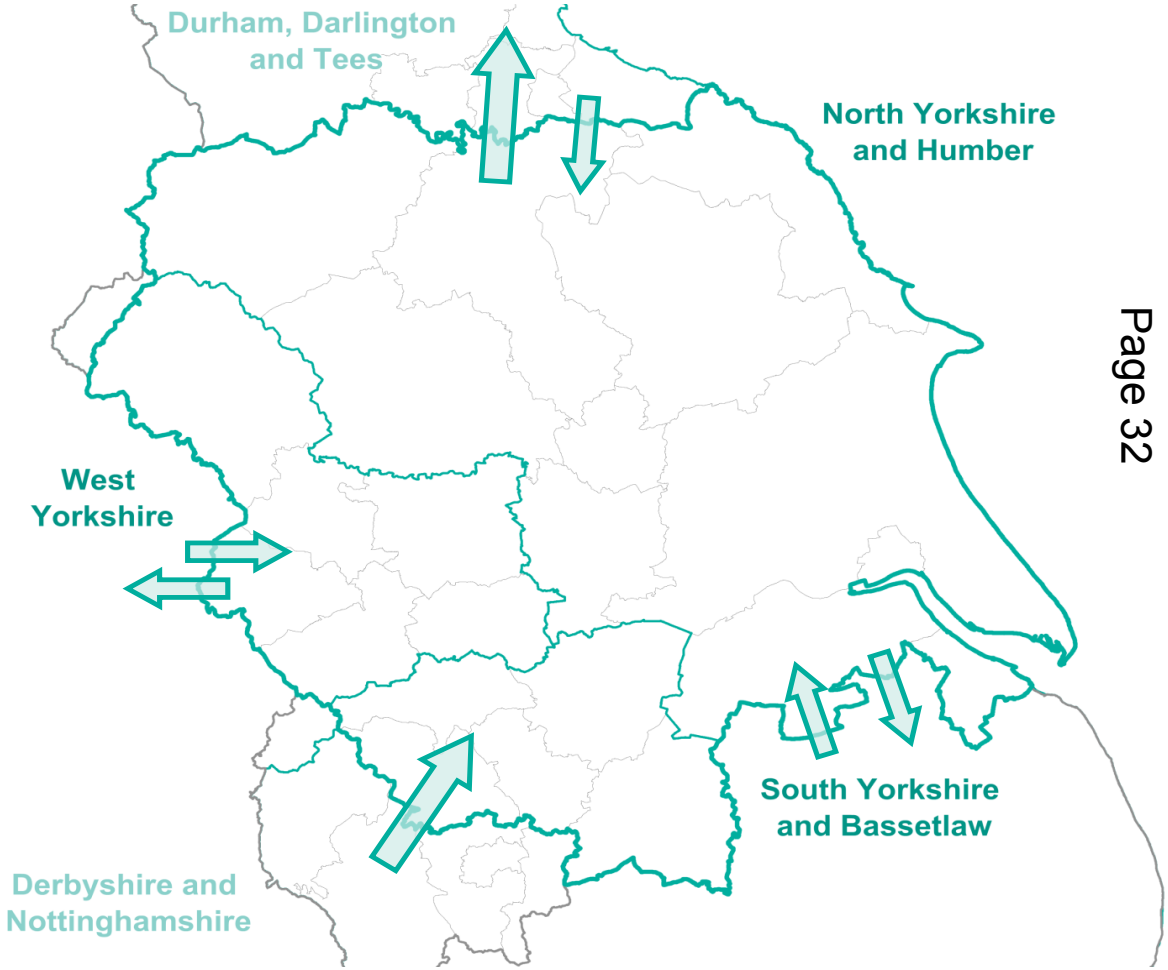
People



- Whatever the plan there needs to be an agreement on the population
- For CCG plans this is easily available from National General Practice Profiles which can be presented at CCG level
- For wider areas, ONS estimates combined with activity data demonstrate the flows in and out of the agreed catchment

For South Yorkshire and Bassetlaw the catchment population is 1.5m

- 1.5m population resident
- Health care flow wise – mostly self contained
- Some flow in from North Derbyshire



People

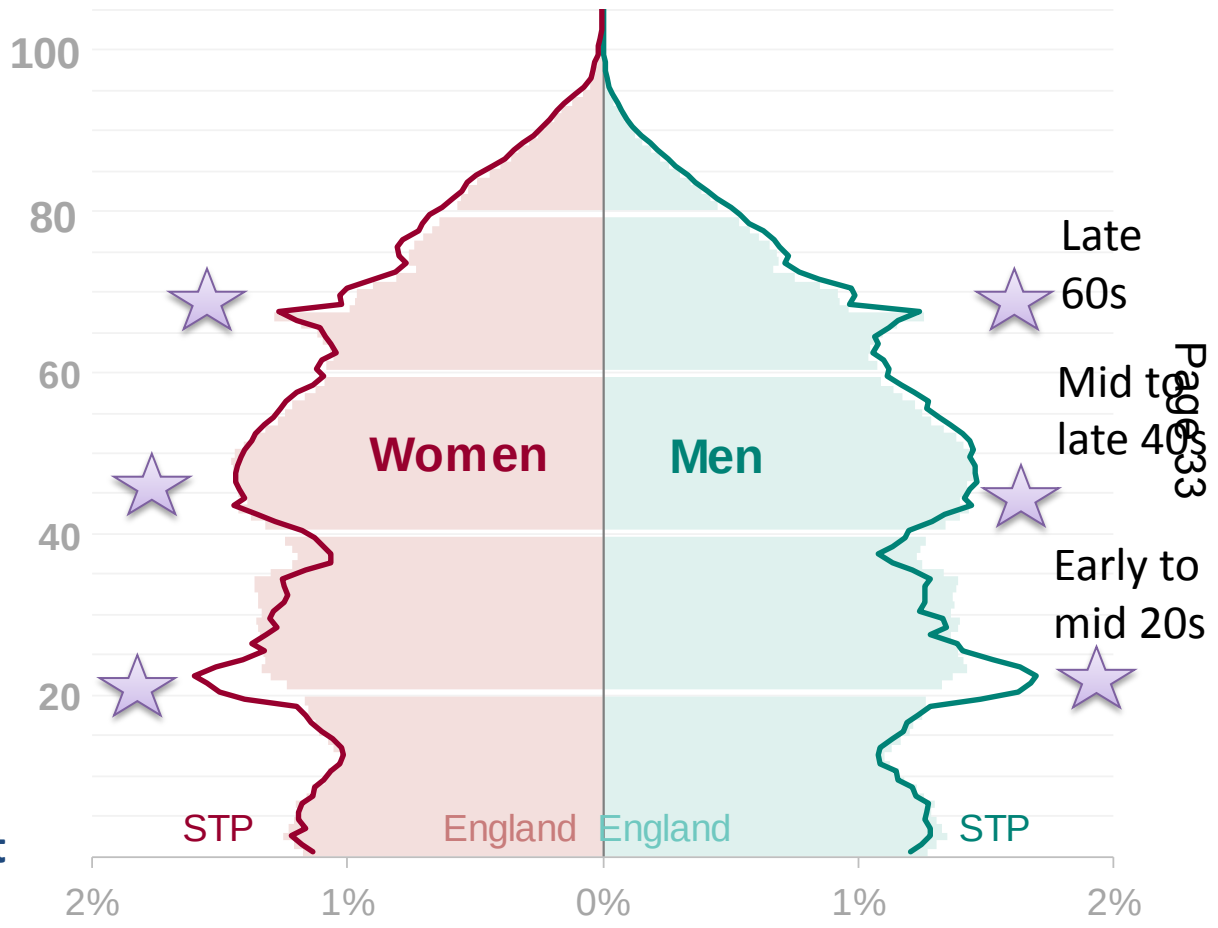
3 key peaks which will influence health service provision in the future.

Early twenties is the only one larger than the national average (universities & colleges)

The is also a dip for people in their late thirties that is greater than the national average

Don't forget early years – best value investment for health outcomes

Age pyramid for South Yorkshire and Bassetlaw



Source: ONS 2014 population estimates

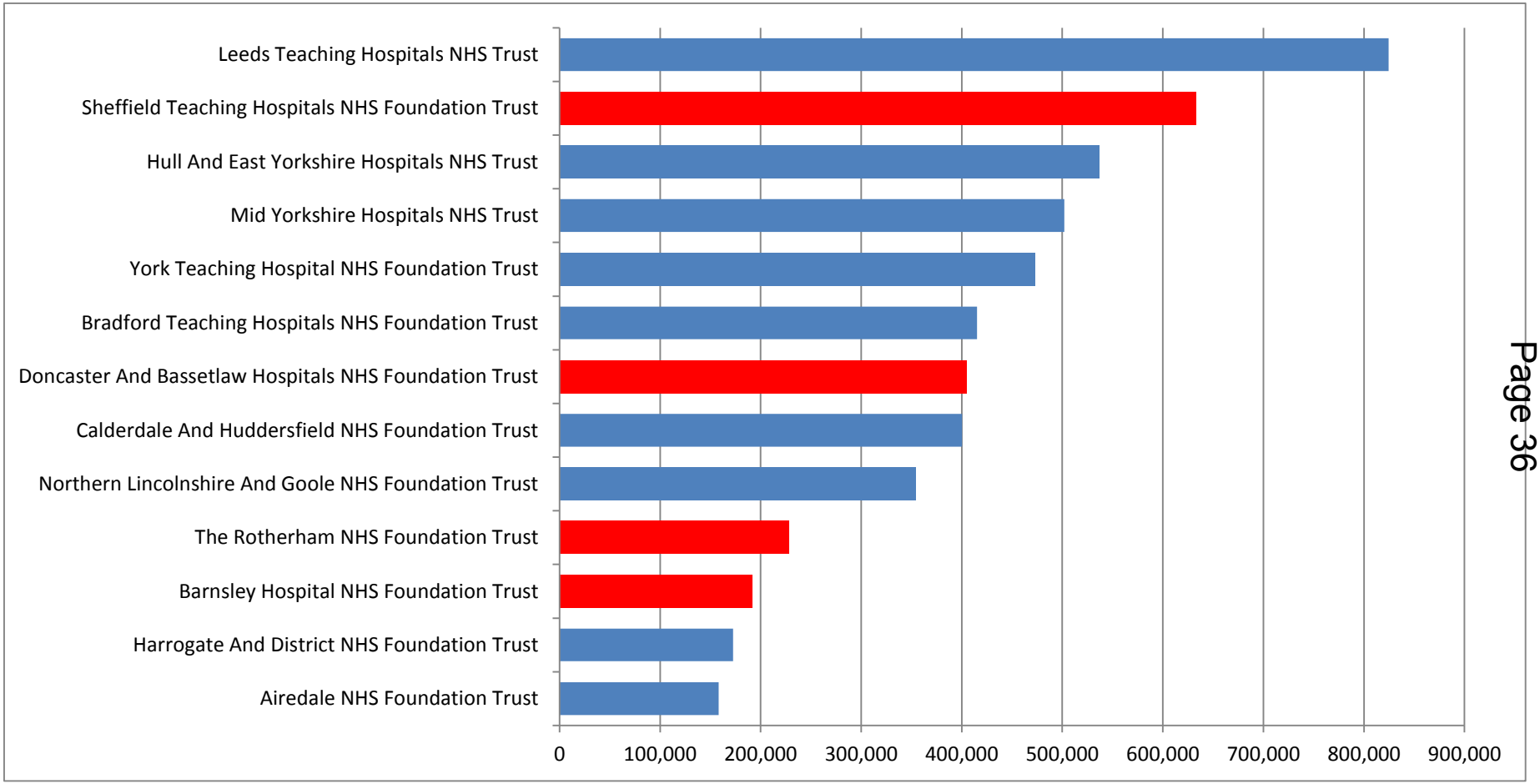
People - children

- The marked increase in live birth rate up to 2012, the birth rate has dropped since
- Overall, we expect around an increase of about 5,000 children under 16 between 2014 and 2018

People – older adults

- Currently over 230,000 people are aged 65-84 (approximately 16% of the total population)
- Over 37,000 are aged 85 and over (approximately 2% of the total population)
- The 65 and over population is predicted to increase by about 20% over the next twenty years
- Big implications
- Generally most of the spend on health is in the first year and last few years of life. An important **but** to this…

People – provider catchments
(district general hospital level)



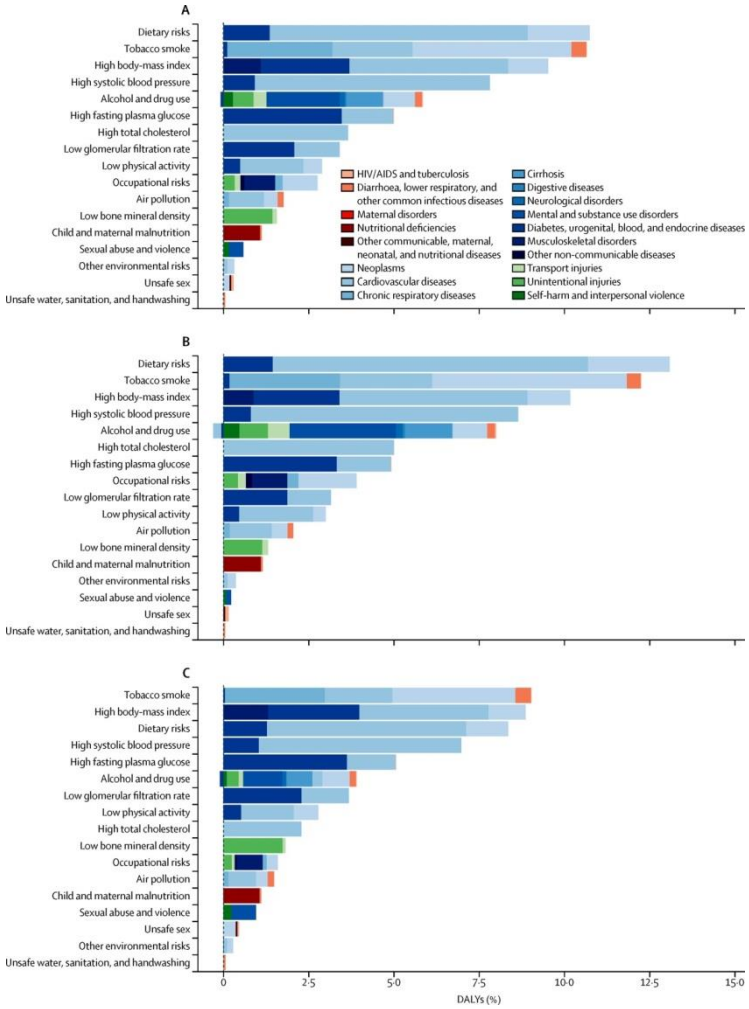
Getting the flow and footprint right for different models

People - children

- Continued rises in need for children and young adults
- Early years represent best value investment
- Increasing need for the ‘middle-aged’ cohort as they move into older age – healthy ageing
- Local services need to be planned in partnership to maintain viable and sustainable provider catchments

Need, risks, outcomes JSNA forms the basis

Risks – behavioural risks to England burden of disease



The usual list

Fat, cigs, booze, lack of sweat, too many pies

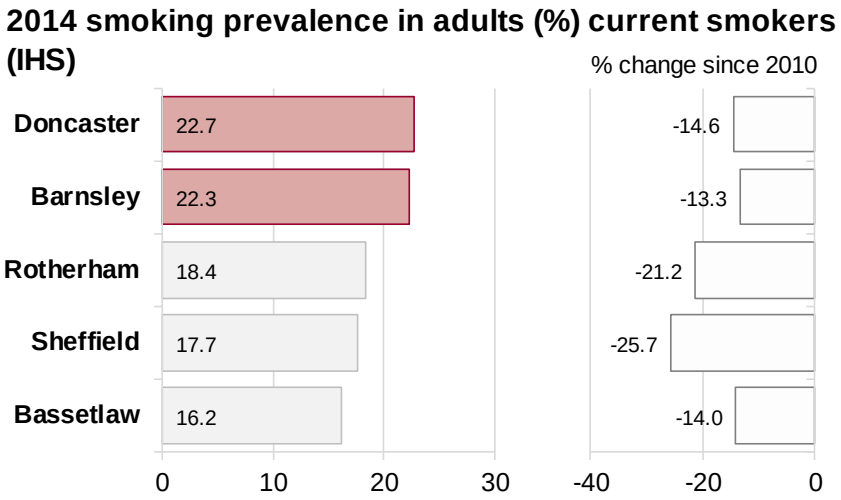
The downstream consequences of these things

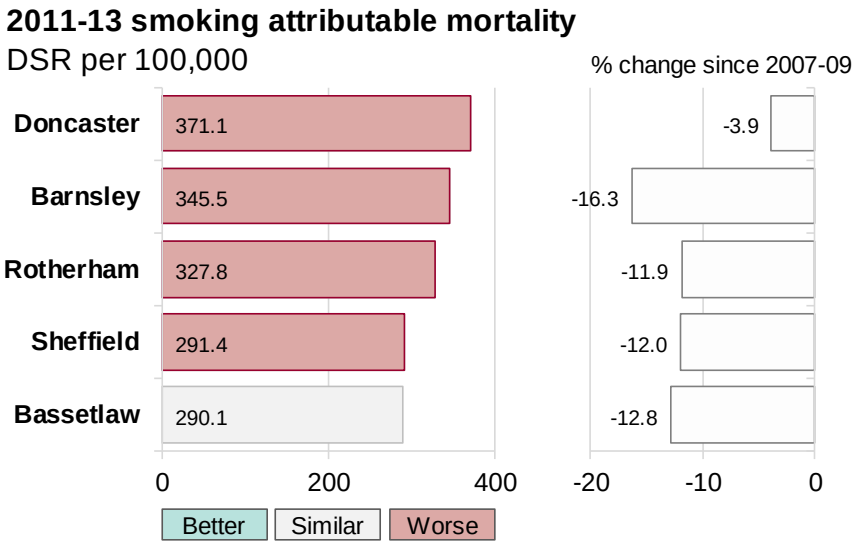
Disability-adjusted life-years (DALYs) attributed to level 2 risk factors in 2013 in England for both sexes combined (A), men (B), and women (C)

Tobacco

- Smoking prevalence is going down
- Faster in some areas than others
- It remains the most important risk factor
- Between 16% and 23% of the population smoke
- Not evenly spread

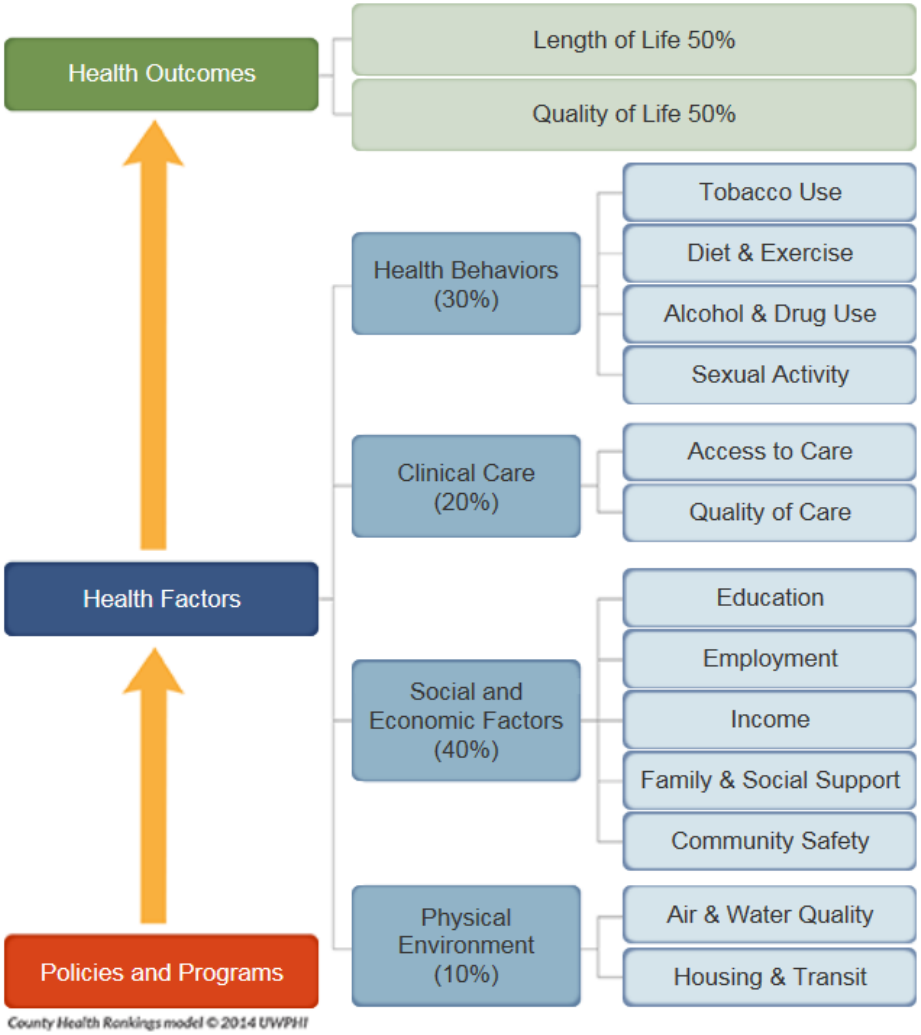
2011-13 smoking attributable mortality is significantly higher than England in all local authorities except Bassetlaw. Rates have been decreasing since 2007-09





Source: Local Tobacco Control Profiles for England

But it's not just care or behaviour that determines health

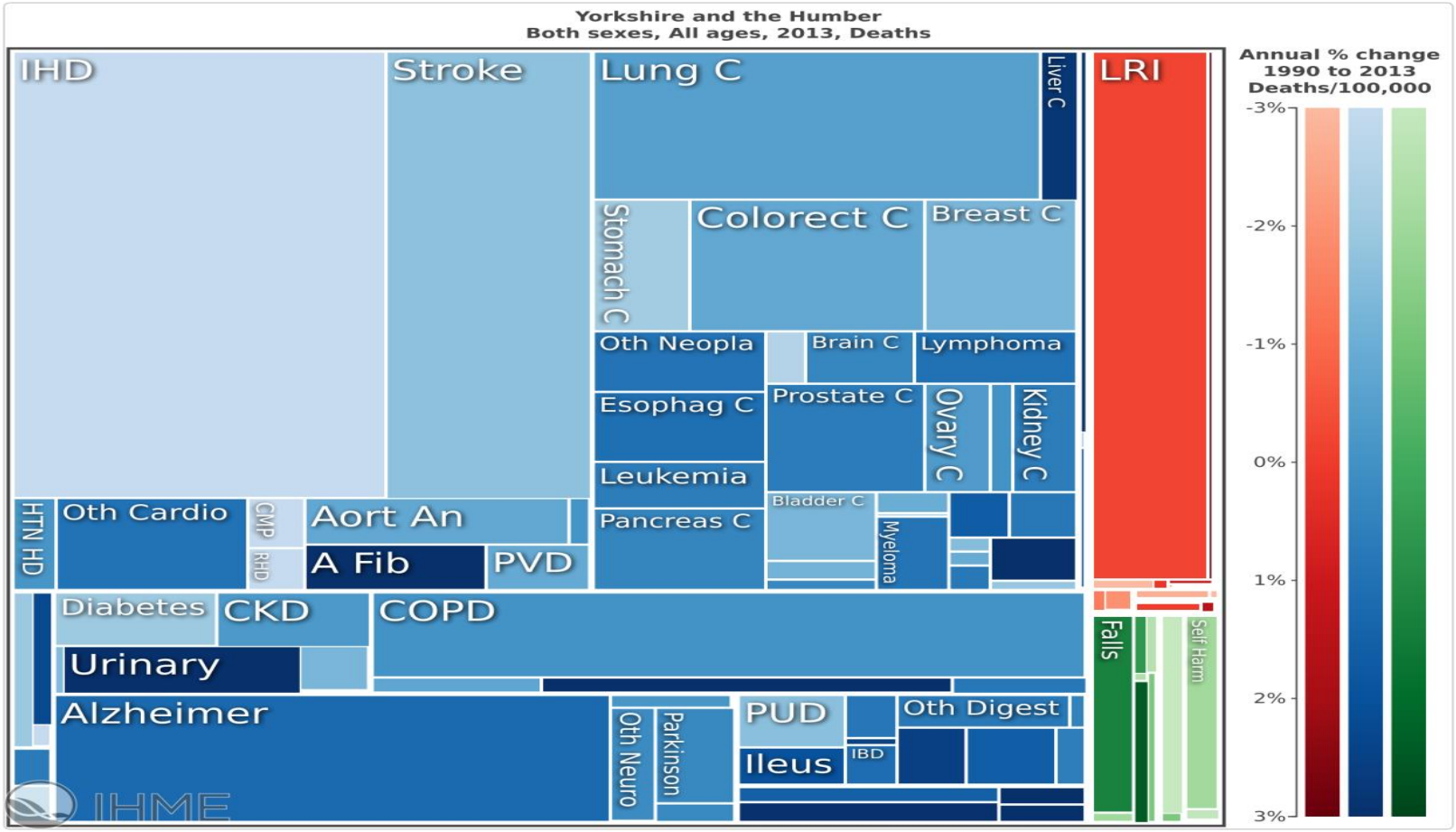


http://www.countyhealthrankings.org/Our-Approach

This has a bearing on how we plan the broad model of care and well being

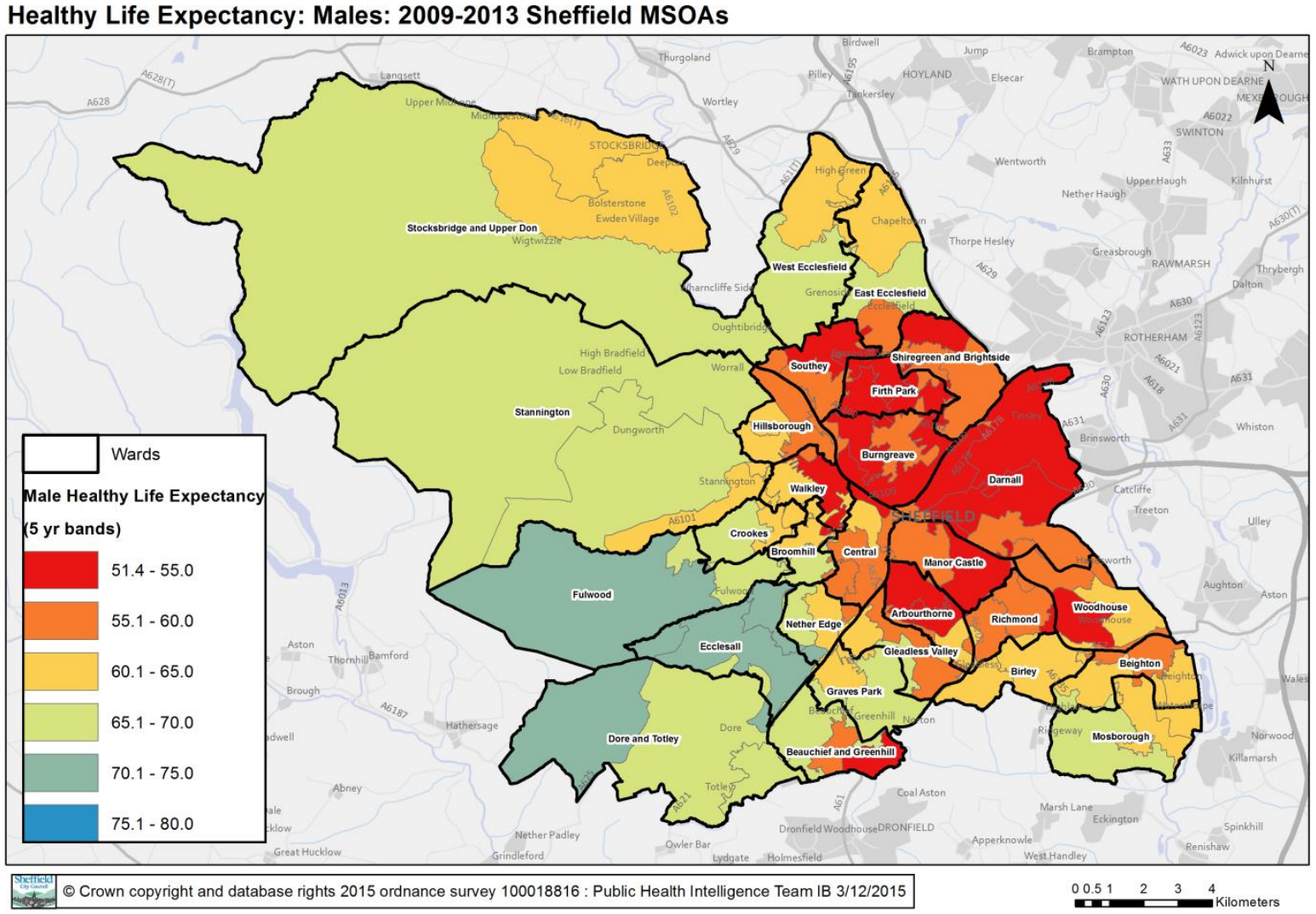
What kills us in Yorkshire and the Humber?
In a single picture

2013



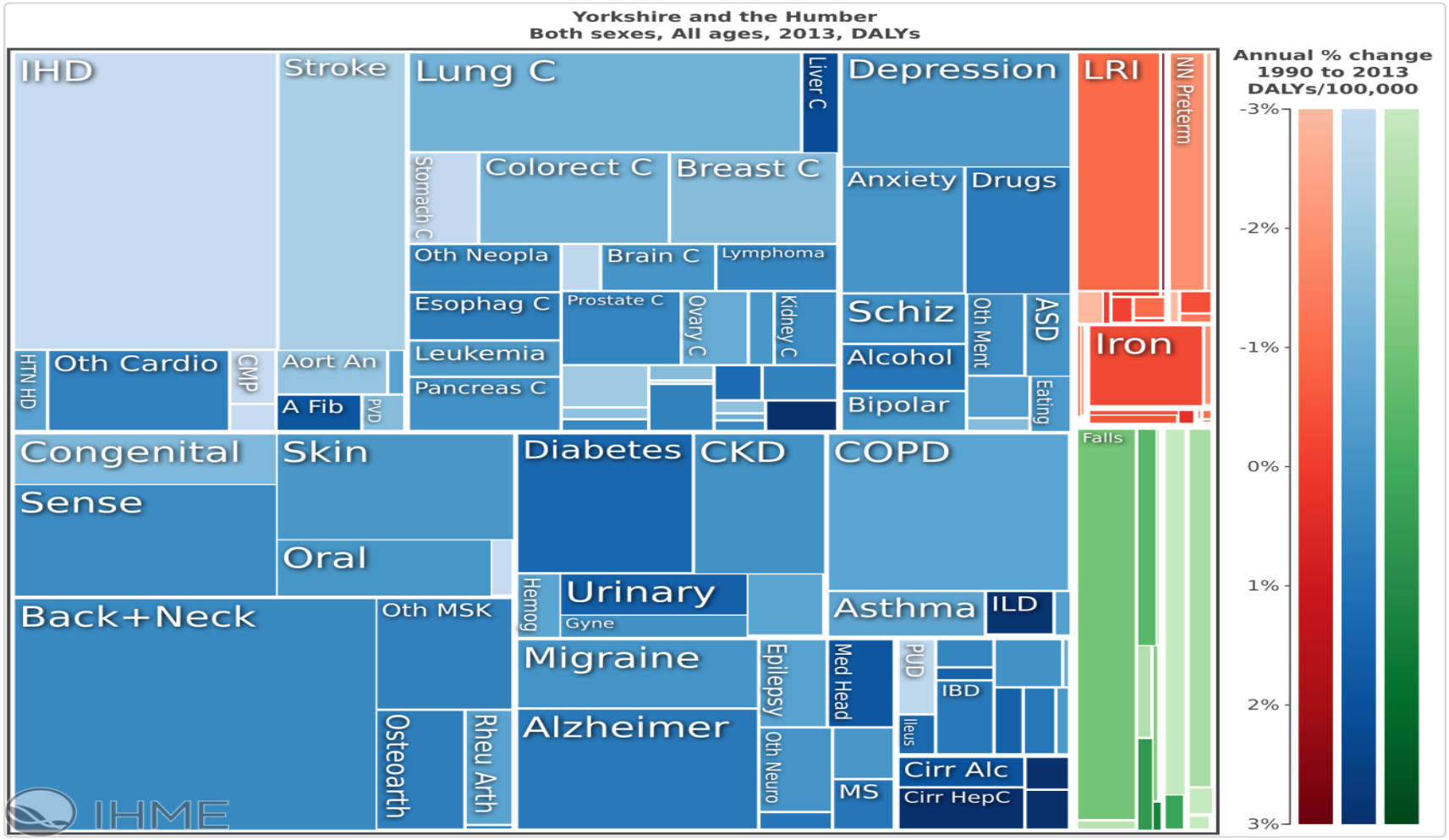
Newton et al
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00195-6/abstract
http://vizhub.healthdata.org/gbd-compare/

Metrics that matter – healthy life expectancy – the 20 year gap in males



What causes us to be poorly in Yorkshire and Humber – DALYS? In a single picture

2013



Newton et al
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00195-6/abstract
http://vizhub.healthdata.org/gbd-compare/

The ageing population myth
Multi morbidity – it is NOT all about the ageing population
It is not age per se that drives health care use, but morbidity
Age is a poor proxy for morbidity.

Aged 50-54 **18.3%** have >1 morbidity in **most affluent**.
36.8% in most deprived
10-15 year difference in age at onset of MM

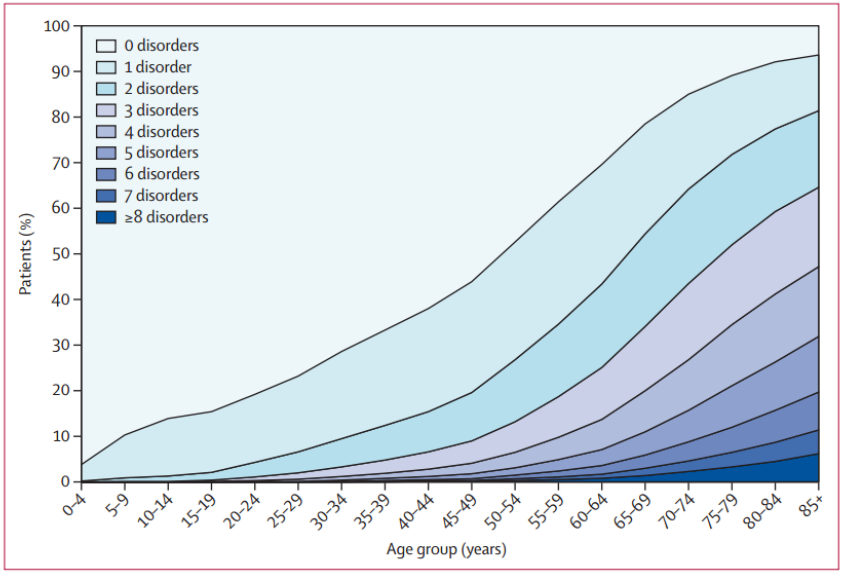


Figure 1: Number of chronic disorders by age-group

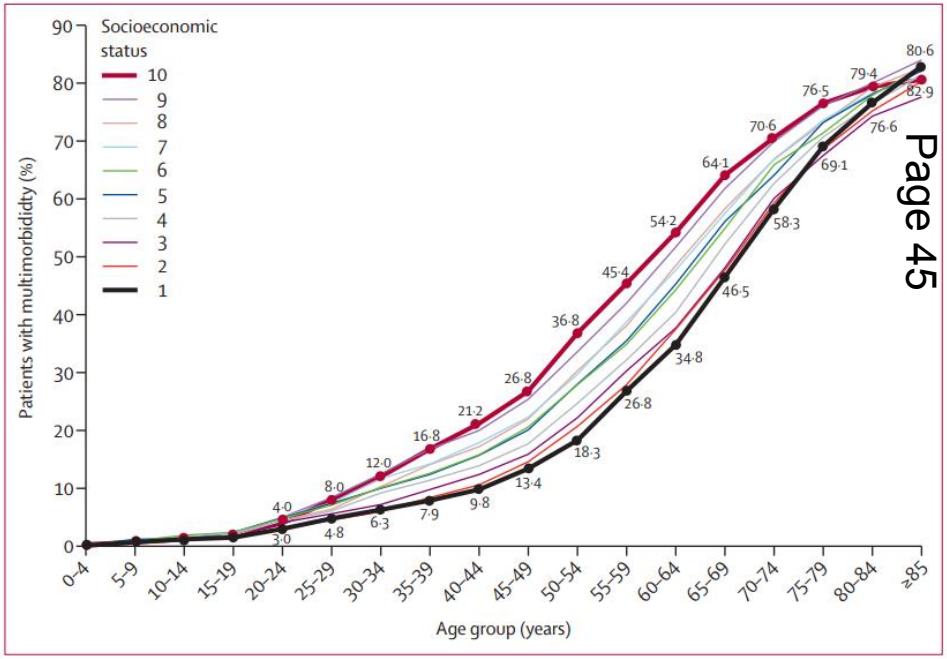


Figure 2: Prevalence of multimorbidity by age and socioeconomic status
On socioeconomic status scale, 1=most affluent and 10=most deprived.

Lancet 2012; 380: 37–43

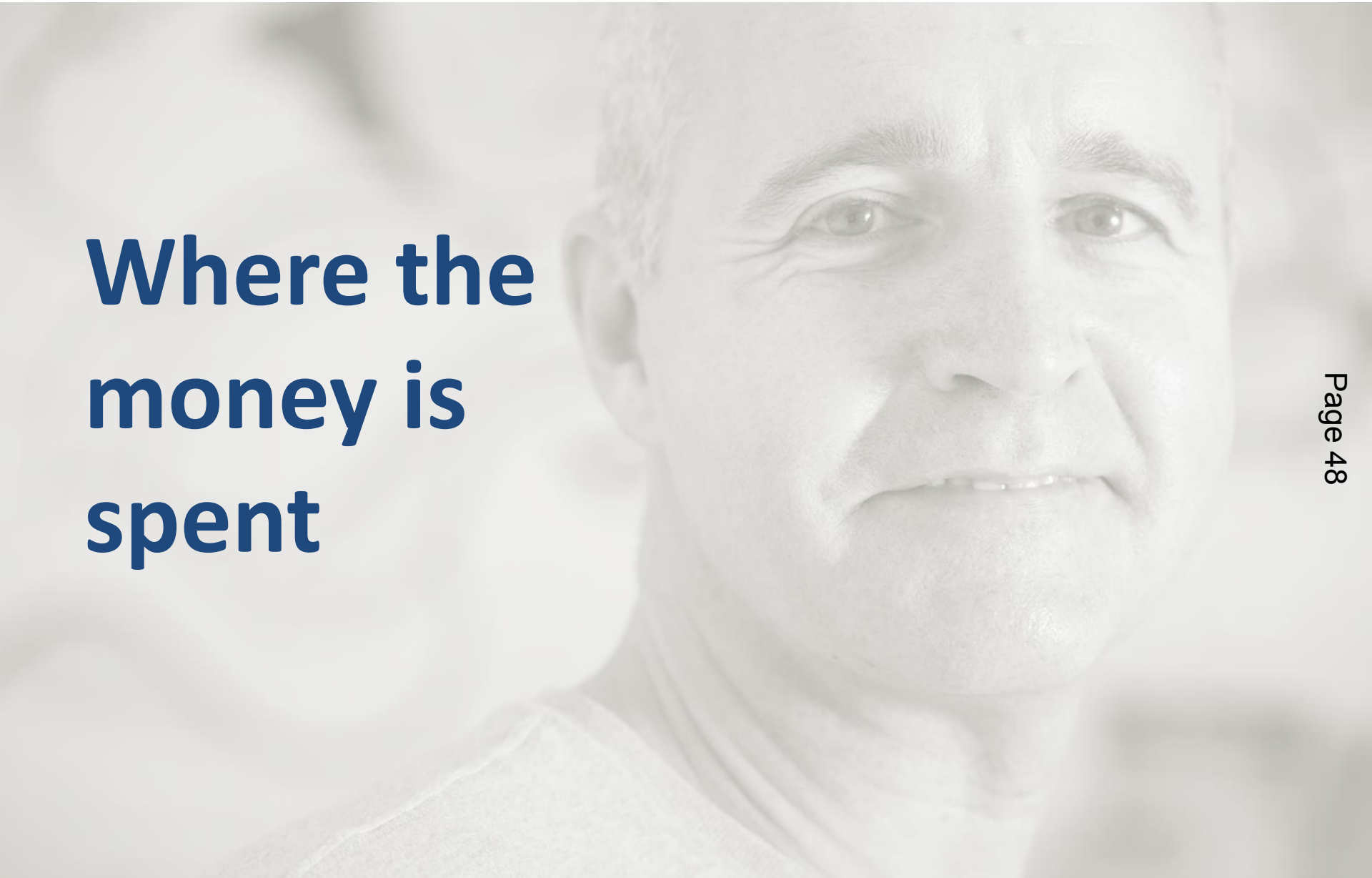
Services for population outcomes

Cancer, mental health and learning disabilities, urgent and emergency care, maternity and children, elective

I haven’t put the data up

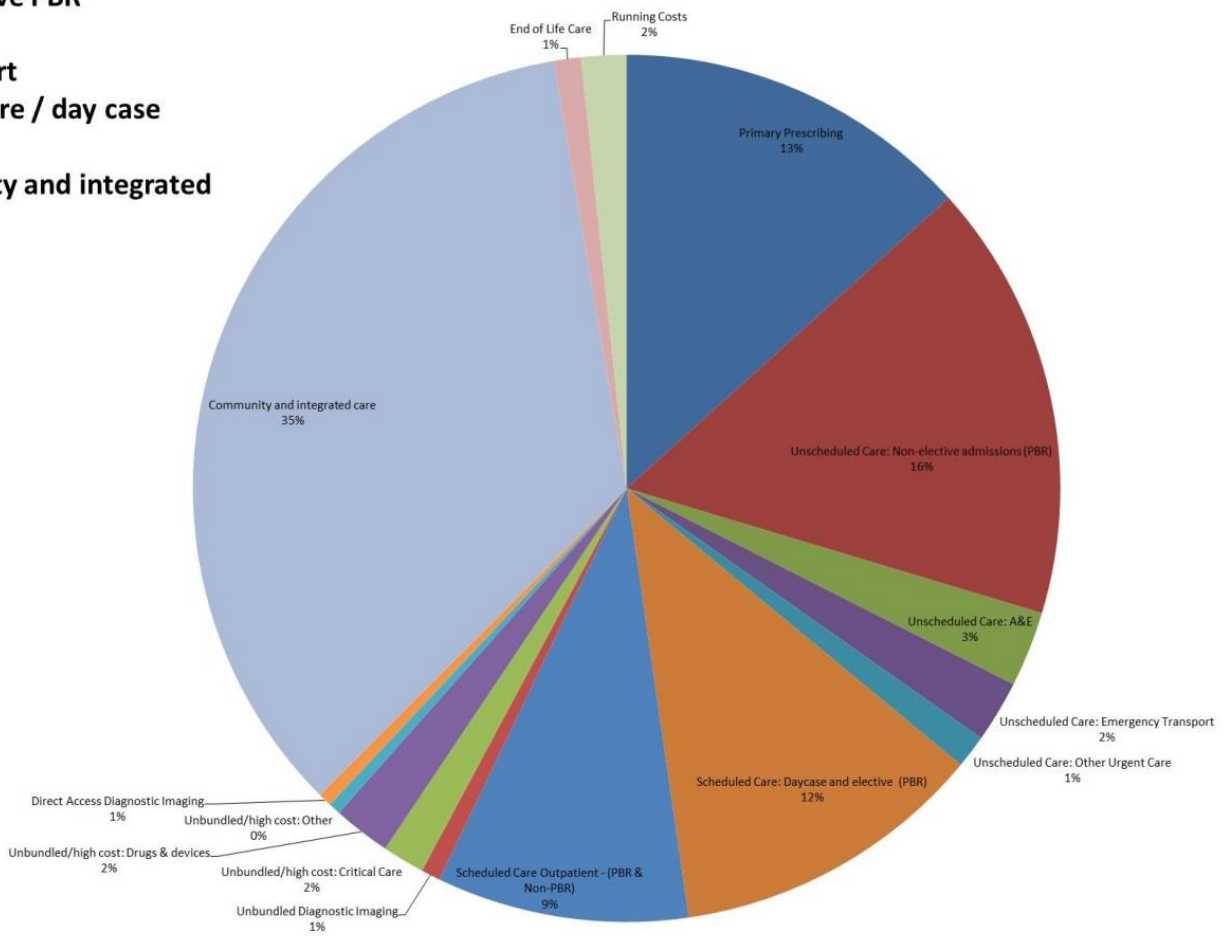
- The data doesn’t matter?
- **Systems** of care for **populations** focus on **outcomes, and equality of access / care** / **institutionally blind** – addressing fragmentation and the archipelago
- Focus on where the **value** is (and isn't)
- **Focused effort on prevention** at **every level**
- Primary, to tertiary prevention. Across large population, over a long time period matters
- **Moving upstream at every opportunity**
- **Population level management of large risk factors**
- Our biggest killers share the **same risk factors**

Where the money is spent

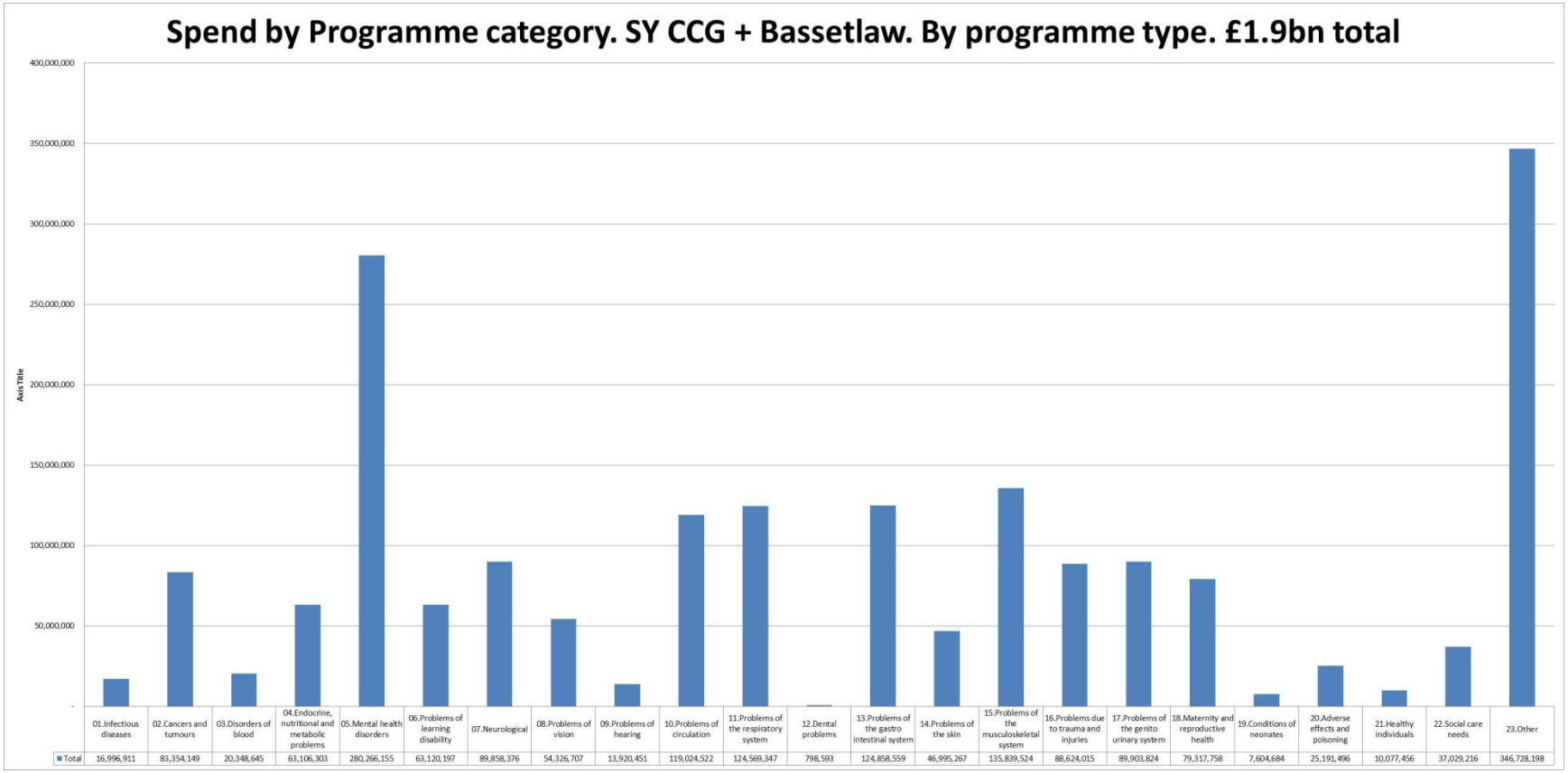


Where the money is spent

£1.923bn on health care in SYB.
£256m Px
£313m Non Elective PBR
£54m ED
£44m Em Transport
£224m elective care / day case
£180m OP care
£669m COmmunity and integrated



Where the money is spent



GPs at the deep end
The steep slope of need and the flat slope in funding

Gary McLean, Bruce Guthrie, Stewart W Mercer and Graham CM Watt

General practice funding underpins the persistence of the inverse care law:

cross-sectional study in Scotland

Abstract

Background
Universal access to health care, as provided in the NHS, does not ensure that patients' needs are met.

Aim
To explore the relationships between multimorbidity, general practice funding, and workload by deprivation in a national healthcare system.

INTRODUCTION

Although the principal social determinants of health operate outside health care, health care can mitigate the effects of poor health, by reducing the severity and delaying the progression of conditions.[1] Whether health care reduces or increases health inequalities depends on the extent to which it is delivered in proportion to need across the socioeconomic spectrum.[2]

The inverse care law states that the group and then applied to general practice populations in 2011–2012.

Deprivation was measured using the 2009 version of the Scottish Index of Multiple Deprivation. Practice deprivation scores were obtained from the Information Services Division (ISD) of NHS Scotland, based on an aggregates of patient postcodes within practices.[8,9] Practice scores were then used to divide practice populations into deciles (10 groups of similar population

GP funding & consultations not matched to clinical need as measured by different measures of multi morbidity

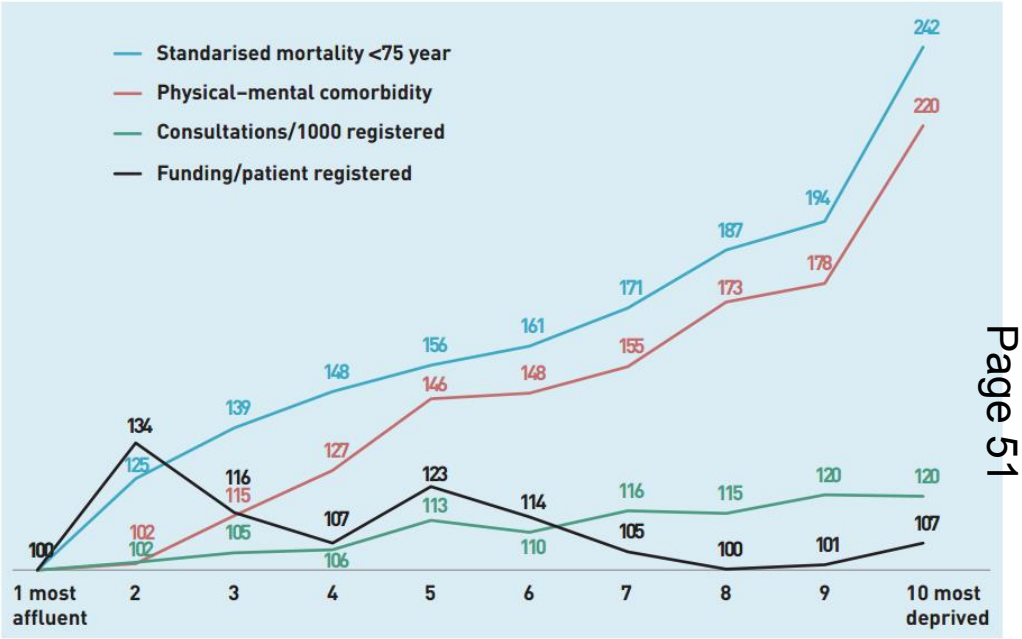


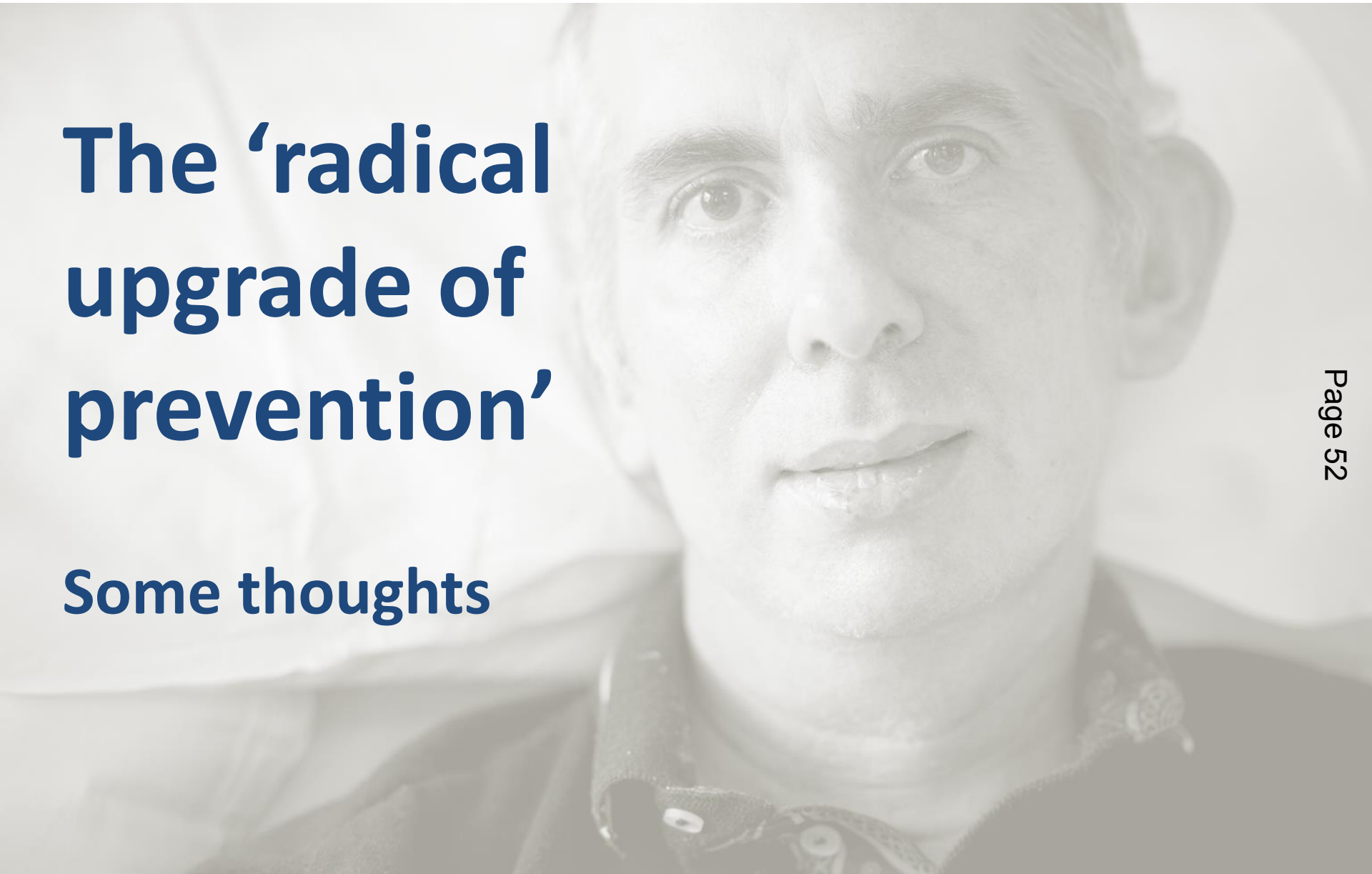
Figure 1. % Differences from least deprived decile for mortality, comorbidity, consultations, and funding. Least deprived decile = 100.

(£0.03 per patient increase in funding with every unit increase in consultations), with the weakest association found for mortality.

Br J Gen Pract 2015; DOI: 10.3399/bjgp15X687829

The ‘radical upgrade of prevention’

Some thoughts

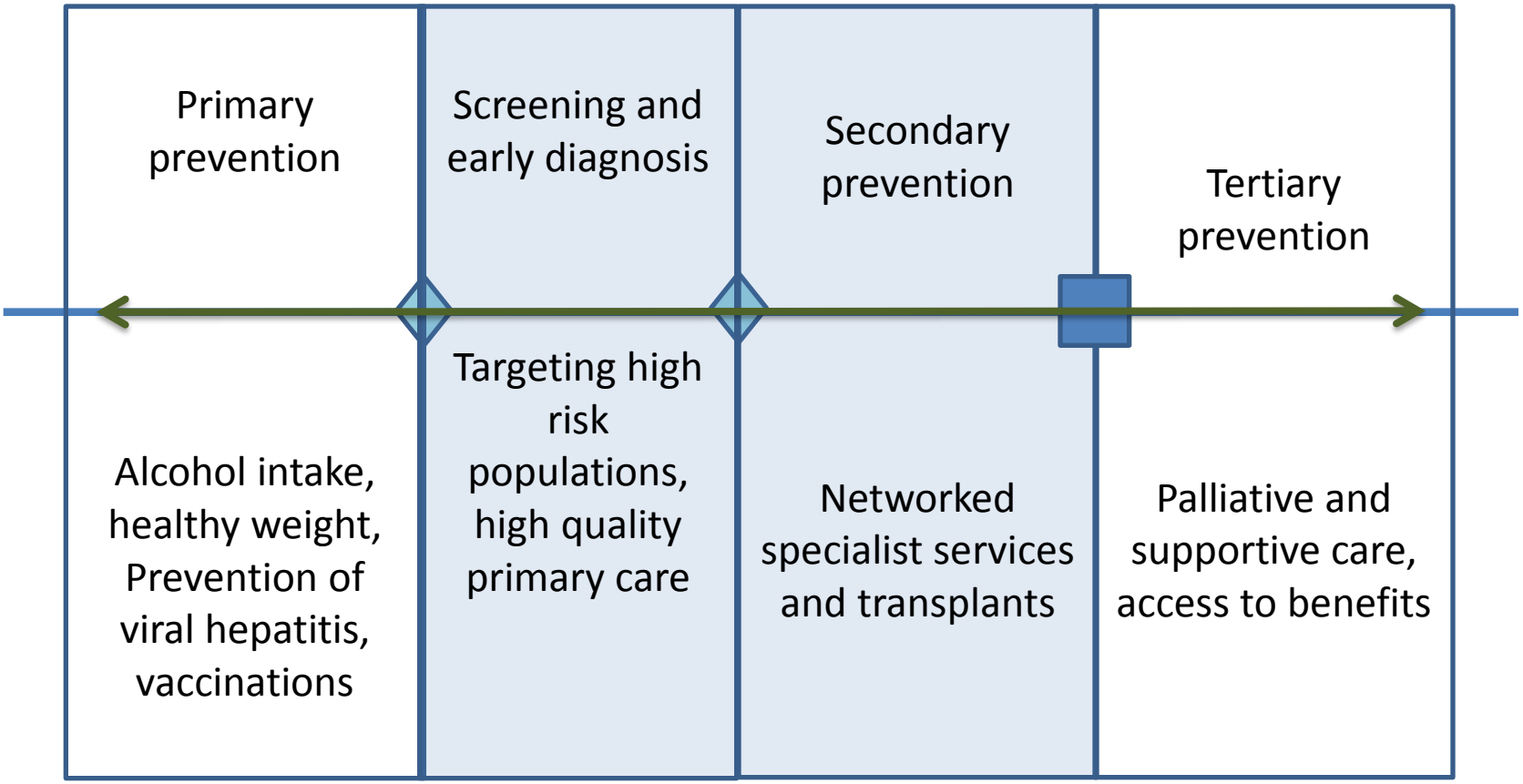


Some perspectives on prevention

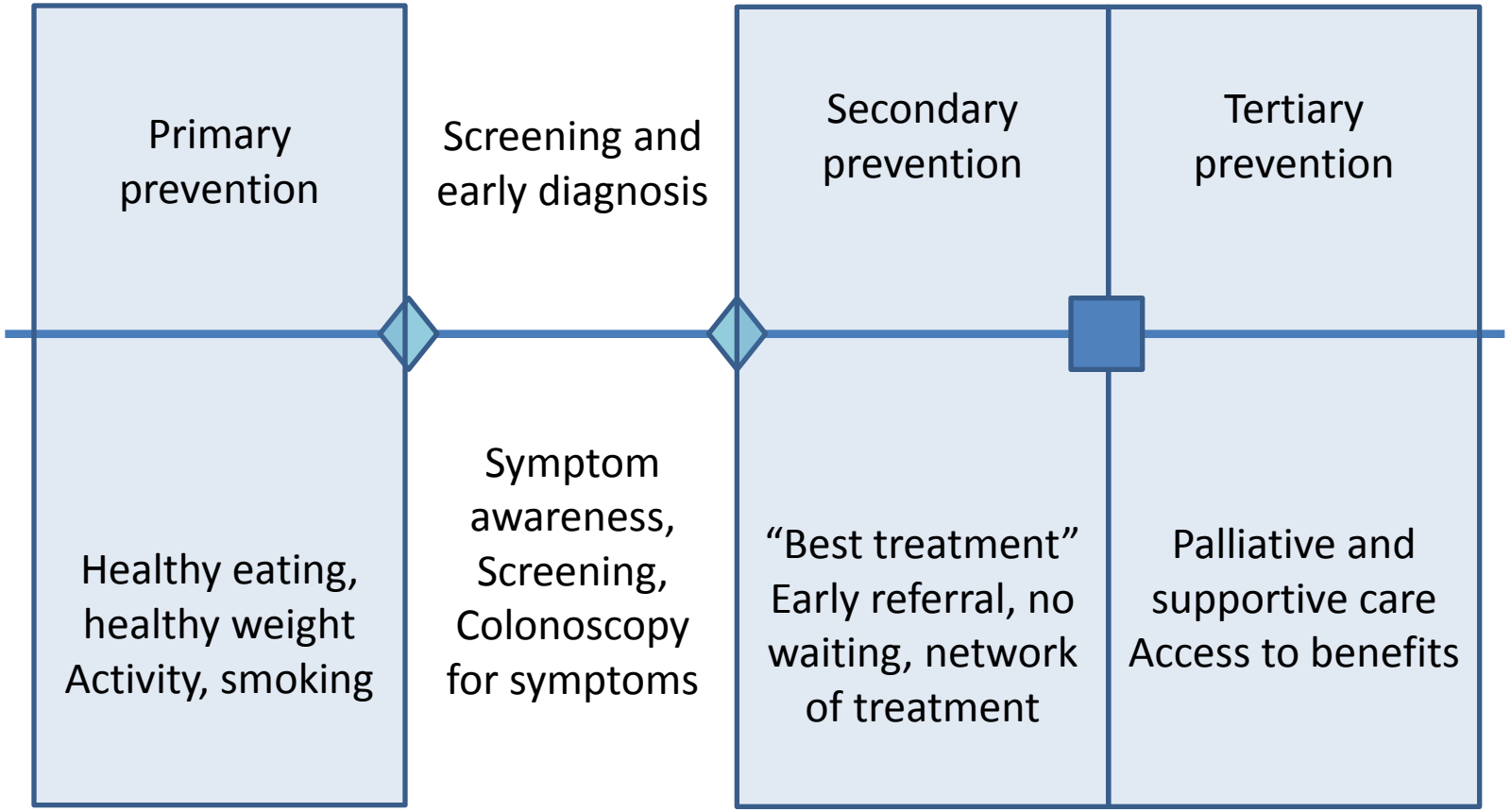
- We can see where the burden of disease is
- Is the model of care and well being right for population risk management?
- Inequalities ≠ prevention & prevention ≠ inequalities. Both are important!
- Prevention delivers most value, but not quickly in some cases. Primary, secondary, tertiary prevention
- Social model and medical model important. Pills, services and policies to achieve an outcome
- Systematically go through each pathway / programme. Spend & outcomes. What opportunities for better value by moving upstream

Prevention and liver disease

Specialist services make a unique contribution through networked services, and through effective drugs which can reduce onward transmission

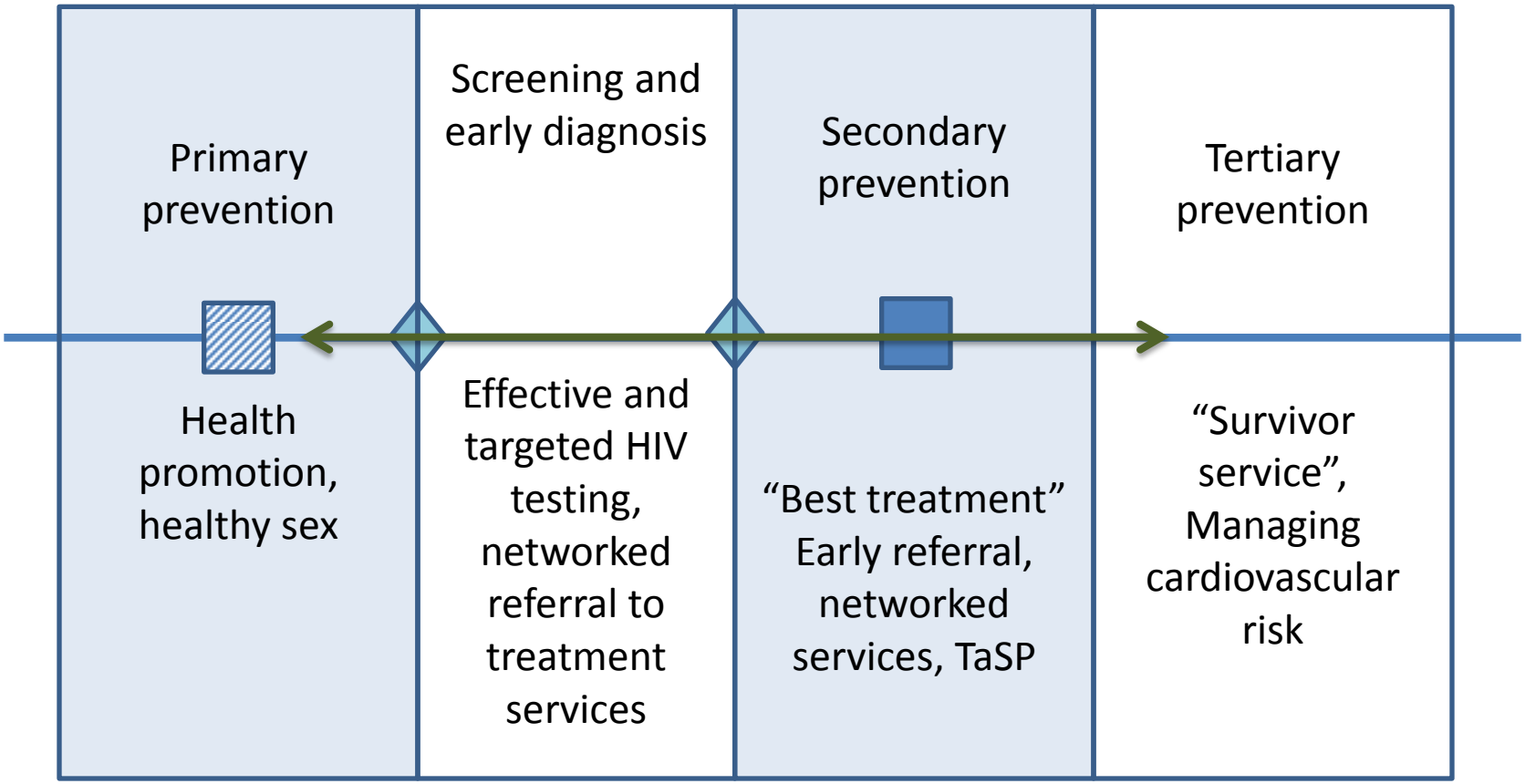


Prevention and cancer



HIV prevention is not just HIV prevention, but burden of disease in HIV

Specialist services make a unique contribution to prevention and early diagnosis



The STP in a broader context

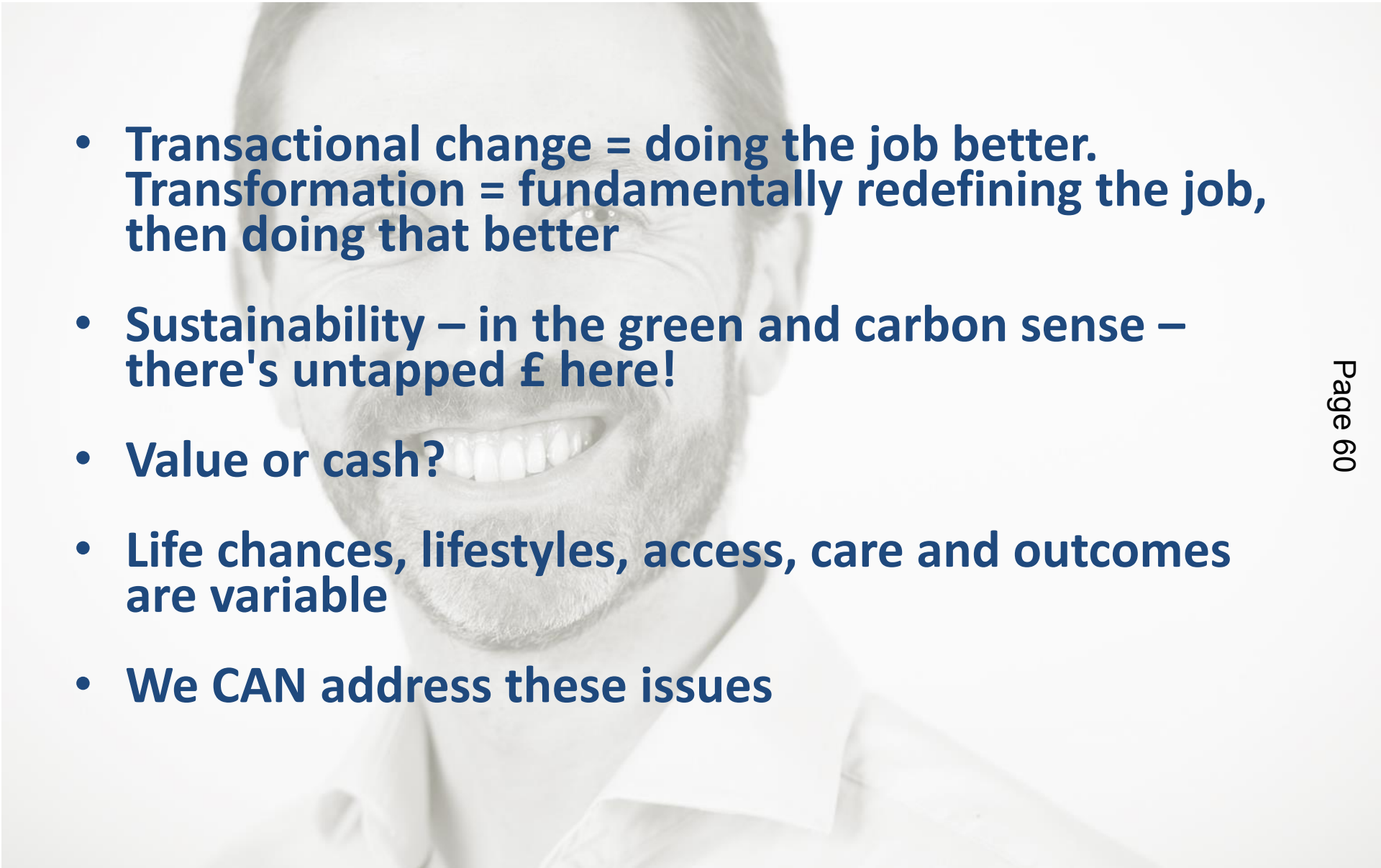
Key messages:

- Population
- Transforming and sustaining
- Prevention
- Broader context

Key messages: Population

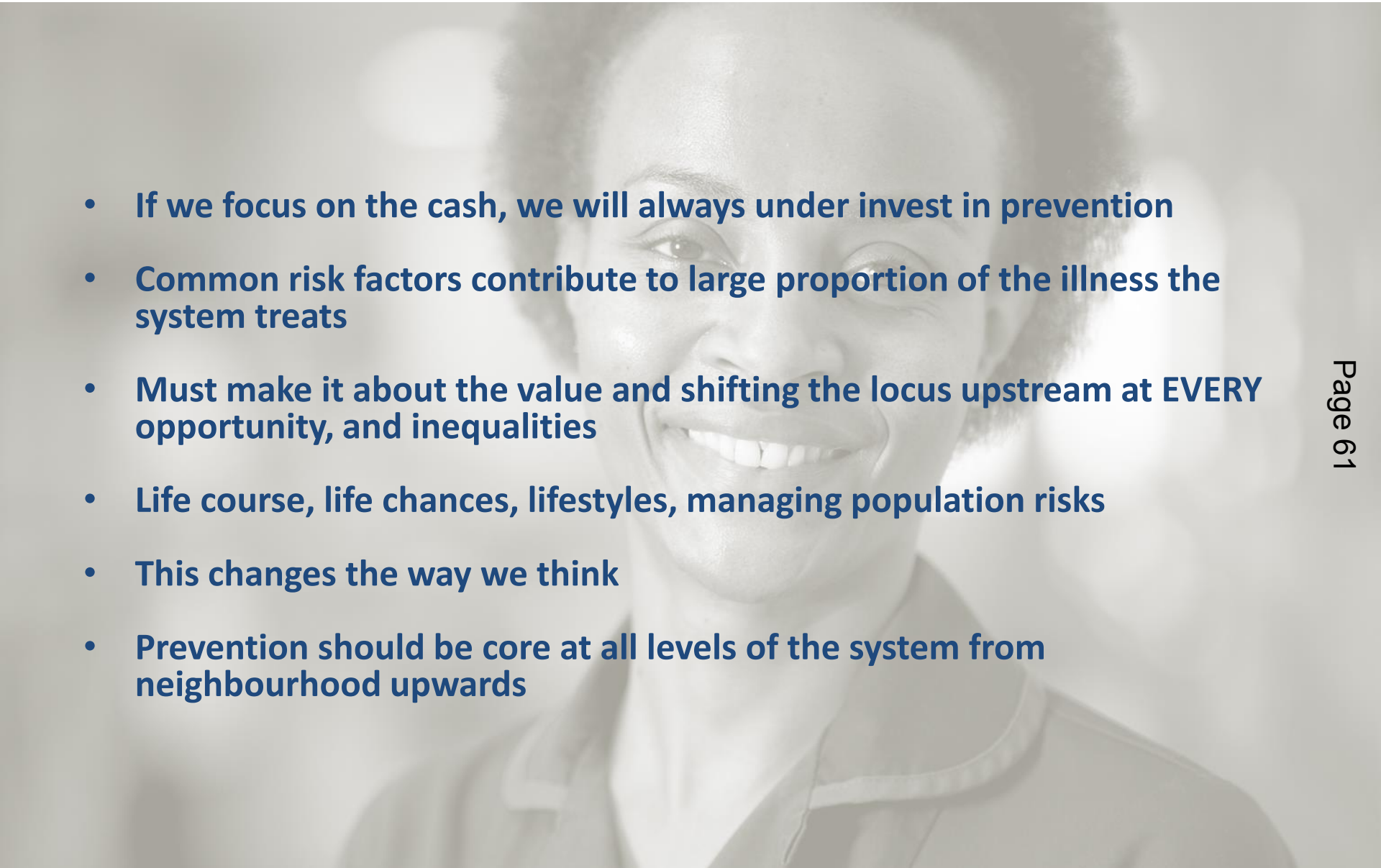
- Planning for young people, alongside the increasing needs of the ageing middle-aged cohort is key
- For cancer, CHD and mental health the population health risk factors highlight the need for coordinated action
- Prevention in local plans should address common risk factors at scale
- Specialised services and urgent emergency care are cross cutting areas which impact across the life course and disease pathways

Key messages: transforming and sustaining



- Transactional change = doing the job better. Transformation = fundamentally redefining the job, then doing that better
- Sustainability – in the green and carbon sense – there's untapped £ here!
- Value or cash?
- Life chances, lifestyles, access, care and outcomes are variable
- We CAN address these issues

Key messages: scaling up prevention



- If we focus on the cash, we will always under invest in prevention
- Common risk factors contribute to large proportion of the illness the system treats
- Must make it about the value and shifting the locus upstream at EVERY opportunity, and inequalities
- Life course, life chances, lifestyles, managing population risks
- This changes the way we think
- Prevention should be core at all levels of the system from neighbourhood upwards

Key messages: STP in a broader context

- Optimise and capitalise on the opportunities – inequality, housing, economy
- This is about life chances, but also about public sector reform
- Better place to live, healthier economy, health and care system as part of the system
- Focus the energy and input to where there is most need – a point about efficiency and inequality

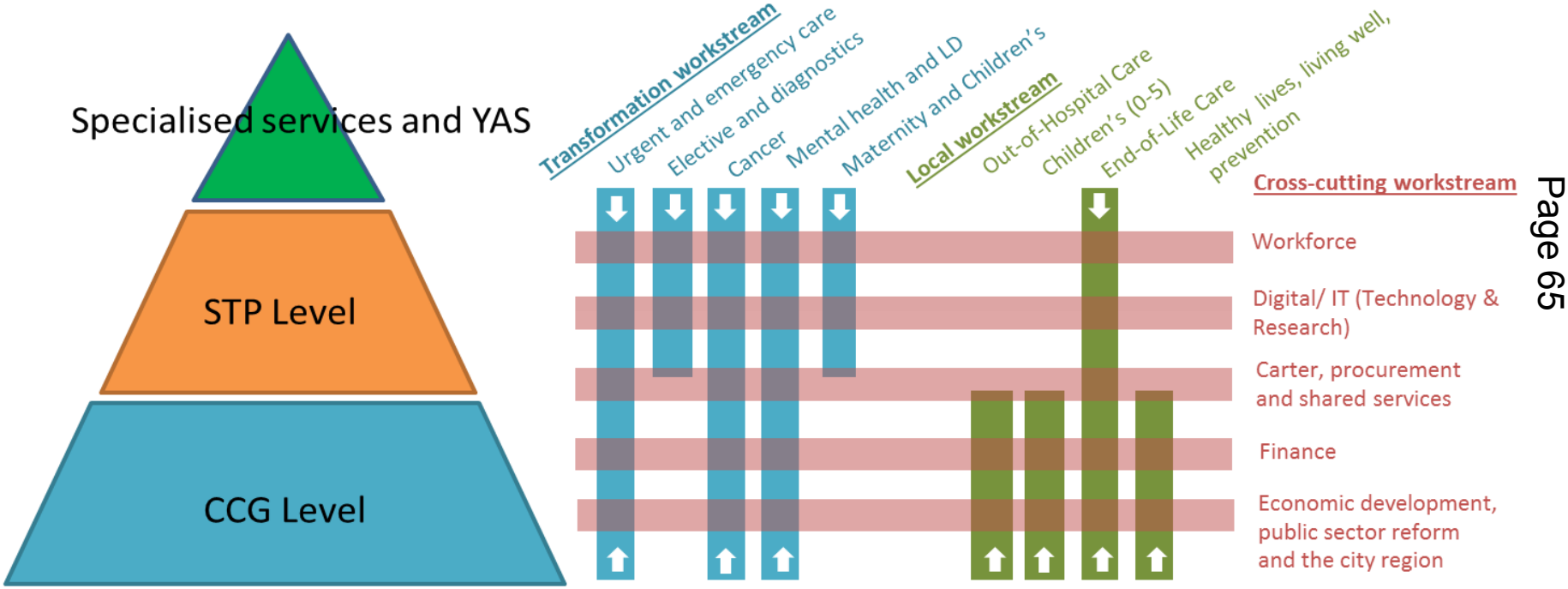
Keep the focus

The workstreams

A whistlestop tour

Emerging priorities

Workstream type*	Definition
Transformation workstreams	Primarily 'top down' from an STP level, with some contribution from 'bottom-up' CCG-level planning
Local workstreams	Primarily 'bottom up' from a CCG-level, with some contribution from 'top-down' STP level planning
Cross-cutting workstreams	Workstreams primarily focused on enablers which 'cross-cut' intersect with local and transformation workstreams



Local workstreams: key themes

Local Workstream	Theme
Out-of-Hospital Care	a. Supporting and developing Primary Care services b. Introducing locally responsive neighbourhood services c. Developing integrated, physical and mental health services d. Providing greater support for individuals to self care
Children's (0-5)	a. Developing multi-disciplinary child health teams b. Linking GP hubs to community child health services c. Developing child health records for sharing with other agencies d. Delivering joint primary/ acute care clinics
End-of-life Care	a. Providing hospice services for children and adults b. Providing palliative and EOL services in community and acute settings c. Delivering the five 'Priorities of care' identified in the report 'One Chance To Get It Right'
Healthy lives, health living and prevention	a. Increasing the focus of prevention initiatives on early years b. Developing upstream prevention initiatives i.e. focused on employment, housing etc. c. Developing downstream prevention i.e. focused on public health etc. d. Developing holistic primary care services

Each CCG in South Yorkshire and Bassetlaw has created place-based plans focused on their specific geographies as part of the operational/ commissioning planning process.
The key themes of planning across all five CCGs are summarised above.

Transformation workstreams: three scenarios

Workstream	Responding to guidance	+ Stretch Targets	+ Radical transformation
Urgent and emergency care	Determine the level of provision that is appropriate for a place setting	Consider and coordinate individual 'places' across the system to ensure consistency and synergy	**Whole-system UEC Reconfiguration reviewing access (designating hot/ cold, major/ minor and 24-7/ non 24-7 provision)**
Elective care (including diagnostics)	Implement the 'rightcare' recommendations	Tackle variation e.g. follow up rates – defining the ask of primary care	**Shift emergency episodes to elective (better care, more efficient and better outcomes)**
Cancer	Standardise quality and access, improve experience and reduce waste	Reconfigure delivery and workforce model across all settings	**Reconfigure system so workforce and treatment follows the patient**
Mental Health and Learning Disabilities	Enhance crisis and liaison services.	Develop alternatives to admission.	**Optimisation of resources/beds within SYB, no patients out of region**
Maternity and Children's services	Development of personalisation in maternity care choice and continuity of care	Develop a framework to offer greater choice and control across a larger geographical footprint	**Whole system redesign, range of maternity choices and personalized care across system**

There are five transformation workstreams that are being developed at an STP-level. A number of scenarios have been developed for each, ranging from 'expanding on the current state' to 'radical transformation'. Examples of options for each of the scenarios are summarised above.

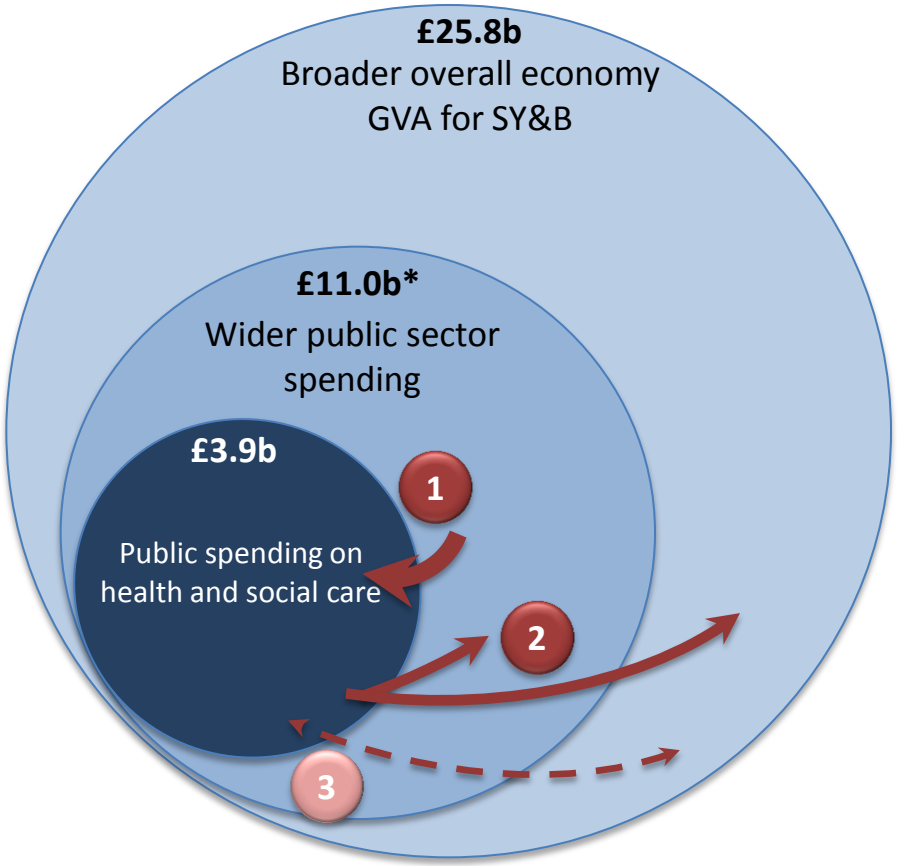
Crosscutting workstreams: three scenarios

Workstream	Responding to guidance	+ Stretch Targets	+ Radical transformation
Workforce	Explore opportunities for sharing workforce between organisations (horizontal)	Explore opportunities for sharing workforce between organisations (vertical)	**Explore opportunities for sharing workforce across the system**
Digital & IT	Provide primary care services online or through Apps	a. Encourage citizens to use tech as part of a H&W campaign with academic evaluation b. Important to deliver demand reductions in SY STP plan; Pilot?;T2DM, AF, post acute MI	**a. Issue all at risk and over 50's with a wearable linked to a GP led prevention campaign, reduce ill health** **b. Transfer 50-80% of LTC management to digitally delivered self-care**
Carter, procurement and shared services	Conduct shared service reviews e.g. HR, Finance, Procurement and IT	a. Extend shared services to MH trusts where appropriate b. Align corporate strategies	**Create common policies and procedures and joint key posts across the system**
Economic development, public sector reform and the city region	Significant investments in community capacity: seeing primary care seen as including but much more than General Practice	Create community hubs offering a 'one-stop-shop' for OOH health and public services, including social prescribing approaches	**More people supported to avoid spending time in expensive and inappropriate health and care settings**

There are five cross-cutting workstreams. Again a number of scenarios have been developed for each (finance will be presented later in the process), examples are summarised above.

Scope: this is primarily about leveraging public services to pursue our overall health system ambitions… interplay of "health" with housing, education, economy, inequality etc

Indicative size of different aspects of SY & B economy



1. **Focus 1: how can we re-imagine, re-design, 're-form' public services so that they can better support our overall aspirations to improve the health and wellbeing of our population**

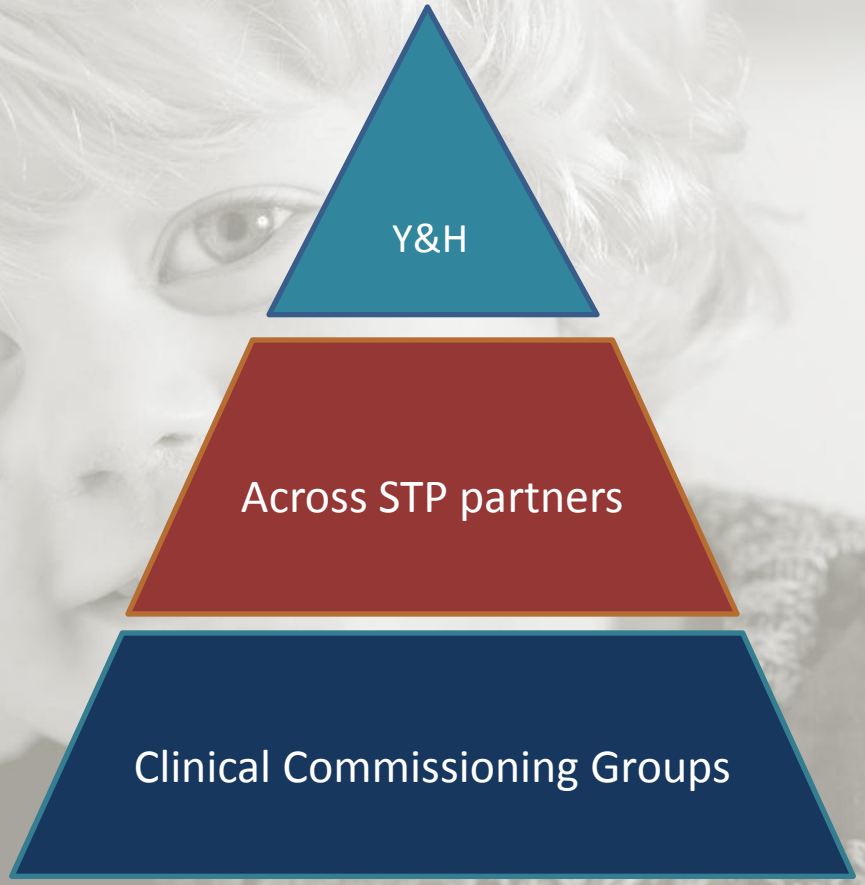
2. **Focus 2: what is the impact on the wider public sector economy, and economy more generally, of improving the health and care system. Note – important arguments to be constructed here if we want to pursue devolution opportunities – see later**

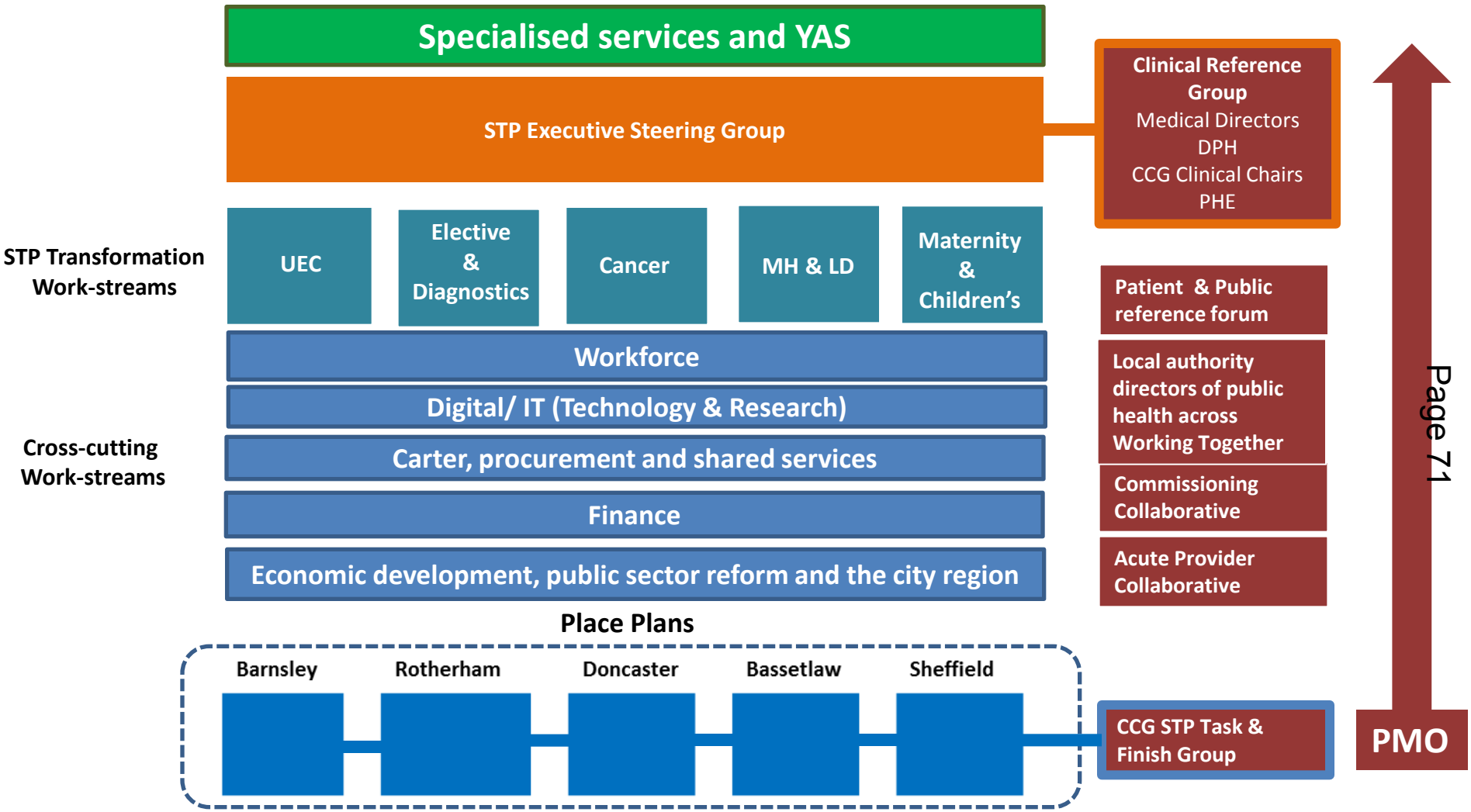
3. Proposing <u>not</u> to focus on the interplay between health system and parts of the regional private sector economy (e.g., pharmaceutical, medical devices, medical innovation etc.)

* Includes £4.9b on social security spending and £940 m on 'education'

Source: Public spending from New Economy Manchester Public Expenditure Tool; GVA analysis from ONS, Regional Gross Value Added (Income Approach), Dec 2015

How will we work?



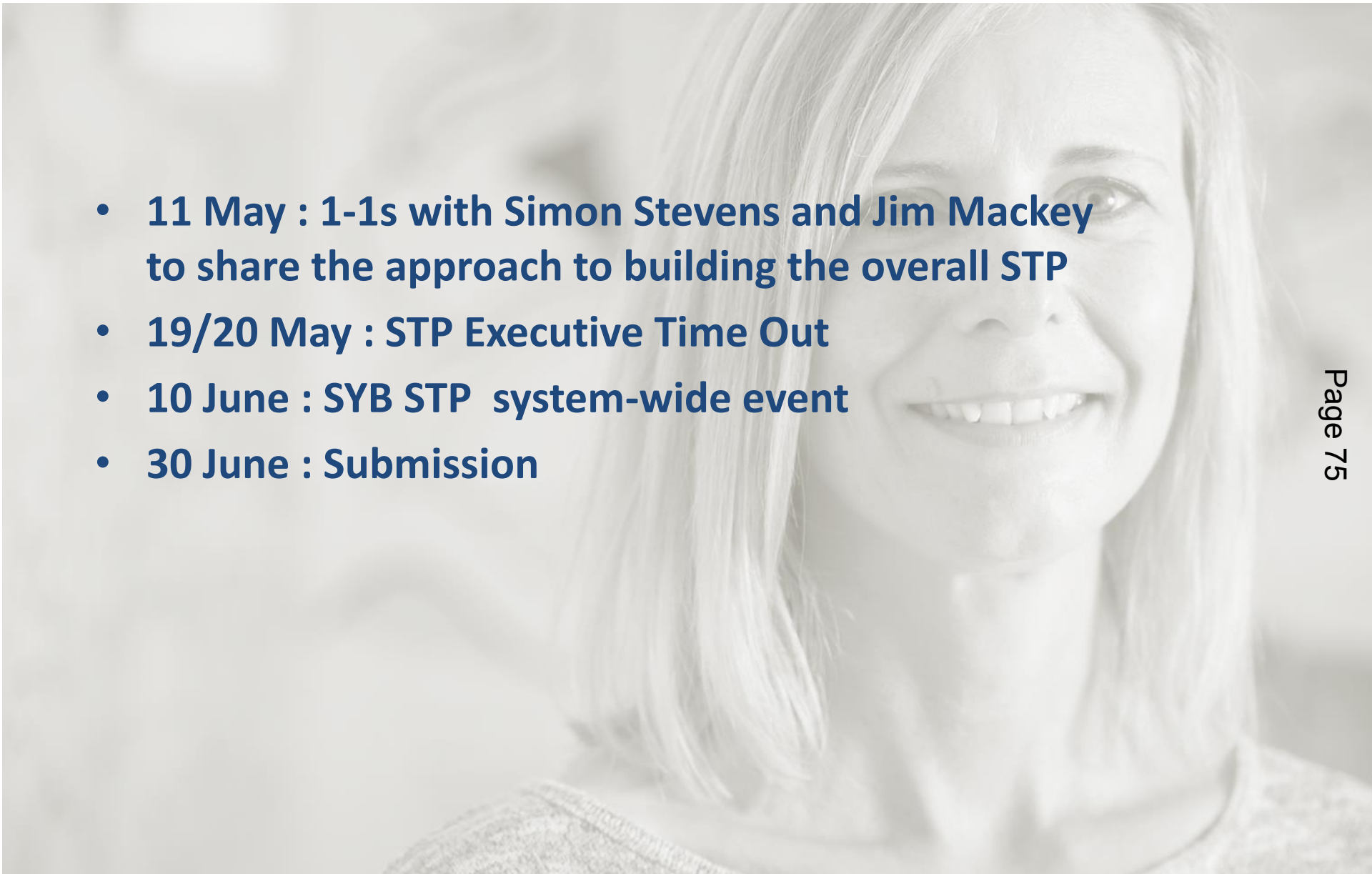

Specialised services and YAS
STP Executive Steering Group
Clinical Reference Group
Medical Directors
DPH
CCG Clinical Chairs
PHE
STP Transformation Work-streams
UEC
Elective & Diagnostics
Cancer
MH & LD
Maternity & Children's
Workforce
Digital/ IT (Technology & Research)
Cross-cutting Work-streams
Carter, procurement and shared services
Finance
Economic development, public sector reform and the city region
Patient & Public reference forum
Local authority directors of public health across Working Together
Commissioning Collaborative
Acute Provider Collaborative
Place Plans
Barnsley
Rotherham
Doncaster
Bassetlaw
Sheffield
CCG STP Task & Finish Group
PMO

Breakout sessions

Feedback

Next steps

Key dates and milestones for building the plan



- 11 May : 1-1s with Simon Stevens and Jim Mackey to share the approach to building the overall STP
- 19/20 May : STP Executive Time Out
- 10 June : SYB STP system-wide event
- 30 June : Submission

Thank you

Rotherham's Integrated Health and Social Care Place Plan

Rotherham is a fully co-terminus health and social care community with a population of 260,000, which makes a perfect test bed for new innovations. We have developed very strong, credible, robust joint working across our local Health and Care system, supported by cross stakeholder sign up to our strategy described within our 'local place plan'. We are all committed to whole system partnership working and passionate about providing the best possible services and outcomes for our population and maximising the best value for the Rotherham pound.

We have already made significant progress on delivery of the key enablers within our place base plan. As a Health and Care Community with the additional support of transformational funding at a local place level, we know that we can move further and faster to deliver the required transformation to support system sustainability. We believe our strong track record of patient level evaluation would also allow the wider system to learn from our innovations. On our journey we are already delivering in the following areas:

- **An Accountable Care Organisation** jointly providing Acute, Community and Emergency Primary Care Services.

- **A fully integrated Rotherham community model of care** based on a Multi-specialty Community Provider model (MCP) for community based services, which also incorporates principles from the Primary and Acute Care Systems (PACS) model. The Rotherham model maps resources to deprivation and is underpinned by comprehensive risk stratification. It encompasses the following services on a locality basis.

    1. All GP practices
    2. Voluntary sector
    3. National Award Winning Rotherham Social Prescribing Service
    4. Secondary Care Physicians
    5. Social Care
    6. Community Nursing
    7. Community Therapists
    8. Community Mental Health Services
    9. Hospice in the community
    10. Re-ablement services (including intermediate care)
    11. Fire Service
    12. Police

This innovation is in its third year of development, the table sets out key developments in years one and two:

Community developments made in **2014/15** include:	Community developments continued in **2015/16** include:
• Restructured community nursing service and GP practices into 7 localities • An integrated falls and bones pathway • Implementation of a Care Coordination Centre as a single access point • Risk stratification of patients and Case Management approach for top 5%	• Integrated Rapid Response services • Creation of a new IT portal providing visibility of community case load patients in the hospital • Introduced Care Home Liaison Service • Enhanced Care Coordination Centre provided on a 24/7 basis

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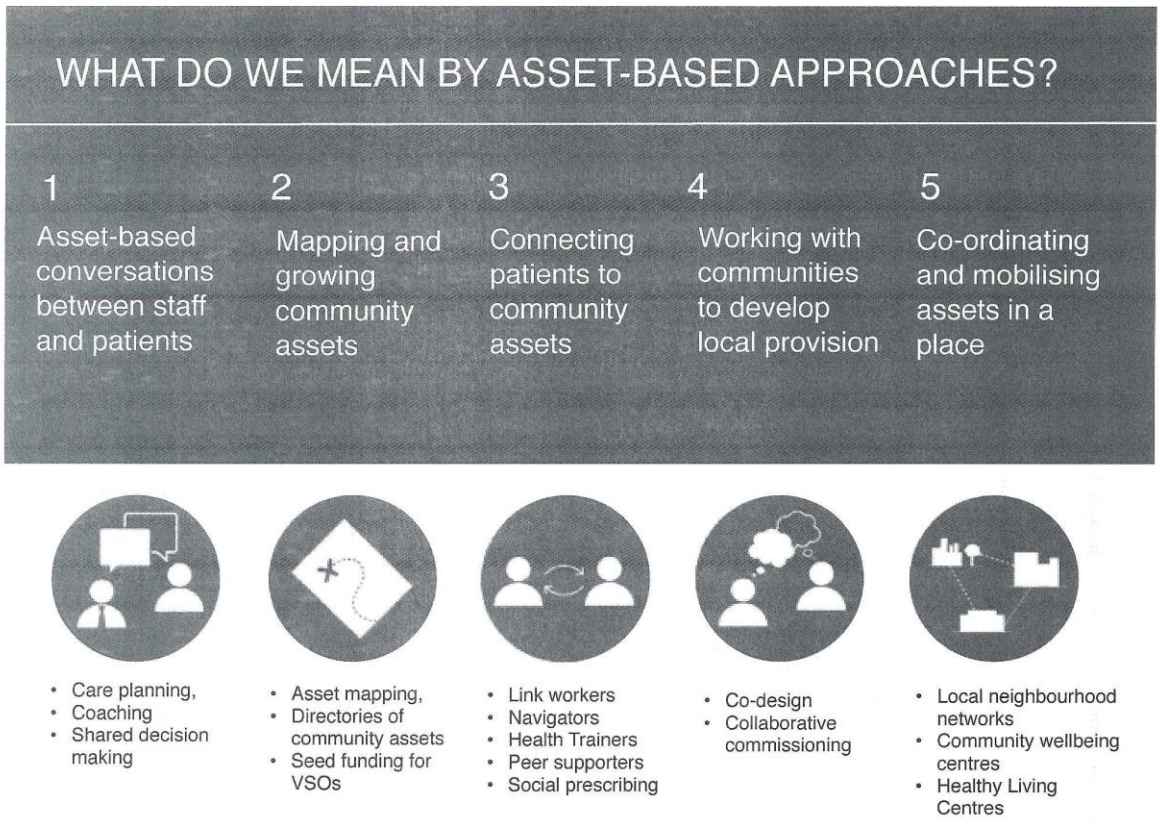

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2. An integrated commissioning framework with joint outcomes and service specifications
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7. Broader use of new technology to support care at home
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Further develop the prevention offer to better meet the needs of local people by targeting communities and individuals that can gain most benefit. The development of a comprehensive health improvement model presents new opportunities to increase capacity across the health and social care system, supporting individuals to make positive, sustained lifestyle changes by adopting a person-centred and a whole community approach to improving health and well-being. Initial funding would be to industrialise the approach, building on the evidence from the national NHS diabetes and CVD prevention programme, and moving forward using the Making Every Contact Count (MECC) model. We would use transformation funding to fast-track these schemes in partnership with the other communities in South Yorkshire and Bassetlaw. Further work will be undertaken to develop a strategy for transformation, using self- care and including telemedicine, for the 30 June submission.

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Rotherham Doncaster and South Humber NHS Foundation Trust | The Rotherham NHS Foundation Trust | Rotherham Metropolitan Borough Council – Where Everyone Matters | NHS Rotherham Clinical Commissioning Group | VoluntaryAction Rotherham

Rotherham's Integrated Health and Social Care Place Plan

2016-2020 V6.1 18 05 16 DRAFT

Part One

Your life, Your health

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

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Please note that the following applies to this version:

Text highlighted in yellow indicates that final confirmation is required (subject to guidance).

Page numbers, signposting and hyperlinks (currently denoted in *orange italic text*) will be completed in the final version.

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Your life, Your health

Rotherham's Integrated Health and Social Care Place Plan (Executive Summary)

Rotherham is a fully co-terminus health and social care community with a population of 260,000, which makes a perfect test bed for new innovations. We have developed very strong, credible, robust joint working across our local Health and Care system, supported by cross stakeholder sign up to our strategy described within our 'local place plan'. We are all committed to whole system partnership working and passionate about providing the best possible services and outcomes for our population and maximising the best value for the Rotherham pound.

We have already made significant progress on delivery of the key enablers within our place base plan. As a Health and Care Community with the additional support of transformational funding at a local place level, we know that we can move further and faster to deliver the required transformation to support system sustainability. We believe our strong track record of patient level evaluation would also allow the wider system to learn from our innovations. On our journey we are already delivering in the following areas:

- **An Accountable Care Organisation** jointly providing Acute, Community and Emergency Primary Care Services.

- **A fully integrated Rotherham community model of care** based on a Multi-specialty Community Provider model (MCP) for community based services, which also incorporates principles from the Primary and Acute Care Systems (PACS) model. The Rotherham model maps resources to deprivation and is underpinned by comprehensive risk stratification. It encompasses the following services on a locality basis.
    1. All GP practices
    2. Voluntary sector
    3. National Award Winning Rotherham Social Prescribing Service
    4. Secondary Care Physicians
    5. Social Care
    6. Community Nursing
    7. Community Therapists
    8. Community Mental Health Services
    9. Hospice in the community
    10. Re-ablement services (including intermediate care)
    11. Fire Service
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    This innovation is in its third year of development, the table sets out key developments in years one and two:

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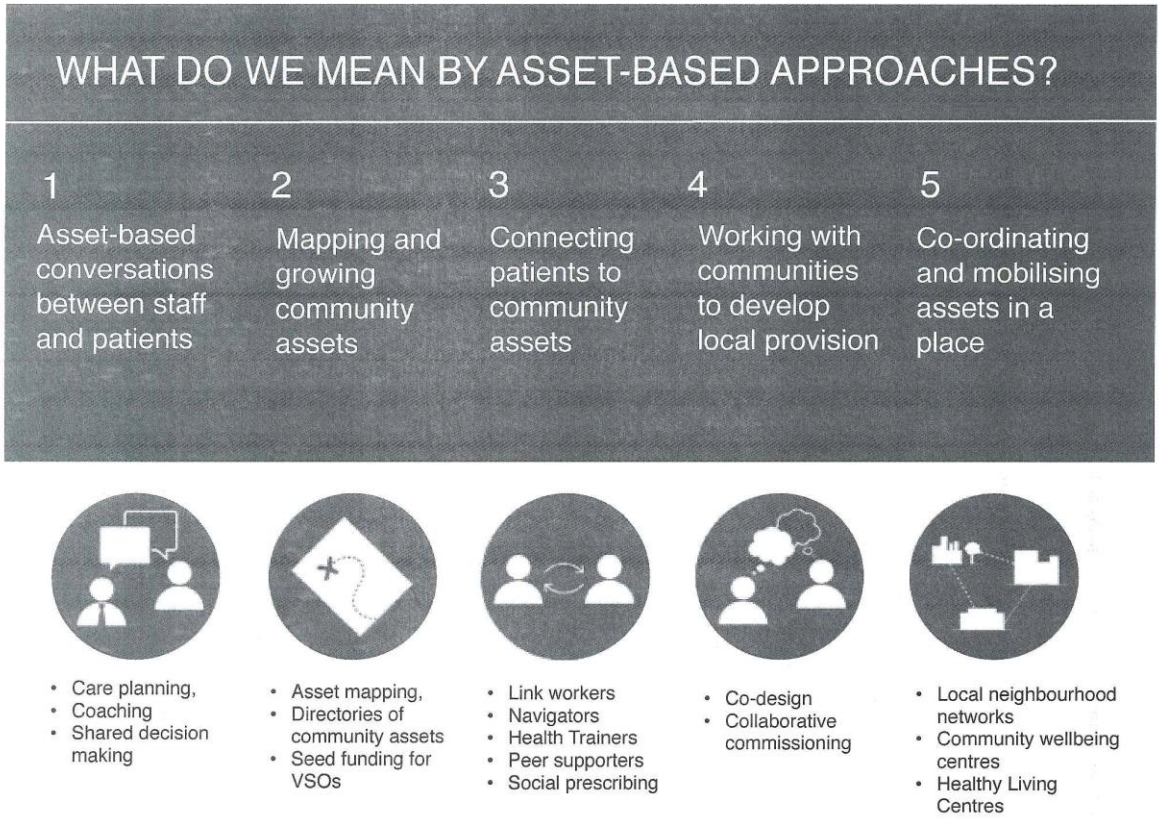

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1 About the Clinical Commissioning Group (CCG)

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 change and to re-affirm the CCG's strategic vision and commissioning priorities in the context of increasingly challenged local financial environment.

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.

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.

1.1 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

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1.2 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.

1.3 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 new Integrated Emergency Care centre that will open in 2017, achieved the first year of the Integrated Multi-specialty Community Provider Model (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 positive feedback on; feeling valued by line managers, CCG commitment to patient care and positive action on staff health and wellbeing. 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

Geoff Avery, GP
Chair GP Members Committee

John Barber
CCG Lay Member

Philip Moss
CCG Lay Member

Robin Carlisle
CCG Lay Member

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Your life, Your health

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

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 the following:

- **Additional years of life** – 200 additional life years per year
- **Reduced A&E waiting times** – 95% of people will be seen within 4 hours
- **Reduced number of hospital admission** - hospital admissions will remain at their current level of 16% below their 2011/12 peak.
- **Improved quality of GP consultation** – maintain current above average levels of patient reported satisfaction with GP care
- **Improved transfers of care** - 1% reduction in the delays transferring patients home or to a more suitable level of care
- **Improved access to services** – Maintain strong 18 week wait performance in secondary care, improve access to mental health services by delivering national waiting time requirements.

Note, the metrics will be revisited once the new 2016/17 CCG Assessment Framework is published

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

Aim 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.***

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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.

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2 Rotherham Partners

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

2.1 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.

2.1.1) 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

2.1.2) '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.

2.2 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 are currently developing a **Carers Strategy** jointly with RMBC and voluntary sector organisations. The strategy is the start of a renewed partnership to support carers in Rotherham and includes plans to identify and work with young carers, elderly carers, dementia carers and working alongside GP practices and supporting staff by providing flexible working arrangements. The strategy recognises that informal carers are the backbone of the health and social care economy and it is hoped that this strategy will help in enabling them to continue this role is vital. The strategy and action plan aims to help make their caring role more manageable and sustainable and ensure that their needs are understood and their well-being promoted. The additional responsibilities for local authorities and CCGs to access carers needs are summarised in Section 21.2.

2.3 Rotherham organisations' strategic plans

2.3.1 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*

2.3.2 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%.

2.3.3 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, ensuring parity of esteem. Efficiency plans will be discussed through the MH QIPP group and the CCG will scrutinise the quality impact assessments.

2.3.4 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.

2.4 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 21.3) 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 21.7). New ways of providing emergency care are discussed in section 21.2.

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 21.1). 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.

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***, 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:

1. 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.

2. 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. National leaders will work together to provide meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied.

3. 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 nationally by 2020/21, aimed to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

At a local level the 2016/17 Rotherham CCG financial allocation provides financial growth of £8.8m (2.3%) including primary care. Nationally prescribed funding commitments from previous years and other national changes consume this growth and funding local system financial pressures identified in 2015/16, will require the CCG to achieve significant savings in 2016/17. Achieving financial balance will therefore present a significant challenge.

In 2016 CCGs are required to produce two separate but connected plans:

- a one year Operational Plan for 2016/17 **(this plan),** organisation-based but consistent with the emerging Sustainability and Transformation Plan (STP).
- 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. The CCG 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 Five 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
5 year ambition on quality *(Box 1, page 8 5YFV)*	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 (21.9).
A radical upgrade in ***prevention*** and public health *(page 10 5YFV)*	The Local Health and Well-being Board supported strongly by the CCG and Public Health 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 documented for each commissioning area in sections 21.1 to 21.15, and we have quantified ambitions for increasing 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 (21.9).
Empowering Patients to have greater control of their own care, joint budgets, carer support, partnerships with the voluntary sector (*page 12 5YFV)*	The CCG will look to maximise and expand projects in the Better Care Fund (21.13). Self care and personal budgets (sections 21.2 & 21.10). Carer support in sections 21.6 & 21.13. The Rotherham model of social prescribing in partnership with the voluntary sector is covered in sections 9.3, 21.1 & 21.2. Our partnership with Rotherham Hospice is described in section 21.11. See section 21.2 and also the Social Prescribing Service which support patients and carers (Section 21.13).
Engaging Communities - breaking down barriers in how care is provided (*page 13 5YFV)*	This was also a key finding in our survey of the Rotherham public (Section 18), and is a key feature of Care Co-ordination (21.12), Social Prescribing (9.3) and Better Care Fund projects (21.13). The CCG will ensure that provider services prioritise the health needs of looked after children (21.9).
A Healthier NHS Workforce – supporting staff to stay healthy *(Box 2.1, page 12 5YFV)*	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.
Support for people with dementia *(Box 2.2, page 15 5YFV)*	This is covered in Section 21.13, Better Care Fund project BCF 1 and the more detailed Rotherham Adult and Older Peoples Mental Health transformation Plan, see section 21.7.
New Models of Care - integrated out of hospital care, multispecialty providers of community services and acute care systems (*chapter 3, page 16 5YFV)*	Our plans to transform Emergency Care (21.2) were fully endorsed by the Keogh Urgent and Emergency Care review and are based on partnership between urgent care providers in Rotherham and best utilising the different skills of clinicians with primary and secondary care. Our plans to transform community services are in section 21.3. Choice in maternity services is set out in section 21.10. 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, we believe this improves quality of care. We will continue to work with Care Home to give them access clinical records.

5 year Forward view	Rotherham CCG Commissioning Plan
A new deal for primary care *(Box 3.1, page 18 5YFV)*	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 21.5. 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 21.1.
5 year ambitions for mental health *(Box 3.2, page 26 5YFV)*	This is summarised in section 21.8 and set out in detail in Rotherham Adult and Older Peoples Mental Health Transformation Plan.
Five year ambitions for Cancer – what this might mean for patients *(Box 5, page 37 5YFV)*	Our plans for commissioning high quality cancer pathways that meet national requirements are set out in section 21.15.

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 Right Care 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 will deliver against each of these 9 key priority areas.

3.5 National Right Care Programme

The National Right Care Programme aims to help health economies find where they are wasting money on sub-optimal healthcare and how to replace that sub-optimal healthcare and save money. It provides an improvement methodology that meets the needs of all perspectives to deliver an efficient and sustainable health economy. The primary objective for Right Care is to maximise **value**:

- the **value** that the patient derives from their own care and treatment
- the **value** the whole population derives from the investment in their healthcare

The CCG will prioritise time to maximise the benefits of the Right Care programme, and to ensure it becomes embedded within the commissioning agenda.

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 *JSNA*, over the last 12 month Rotherham CCG has worked closely with partners to develop Rotherham's second Health and Wellbeing Strategy *H&WBS*. 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 The Health Need of Rotherham

5.1 Joint Strategic Needs Assessment

The health of people in Rotherham is generally worse than the average for England, full details can be found in the Joint Strategic Needs Assessment (JSNA). There is significantly higher than average deprivation, 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 81.3 years for women for 2012-14. Although this is below the National average it has improved continuously since 2002-04 for men (then level in 2012-14) 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 (1.4 males, 1.9 females) based on three years combined data for 2012-14. The gap in life expectancy between the most and least deprived parts of Rotherham for males is 9.5 years and females is 7.0 years (based on the same

2012-14 period). **The gap has changed little for males since 2002-04 and has increased by 2.5 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 65 and over is projected to grow by 35% between 2012-2028 and by 70% for those aged 85 and over 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 2014/15 there were almost 13,900 people in Rotherham with diabetes, and nearly 5,400 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.

5.2 Children and Young People

The 2015 Director of Public Health Annual Report describes children and young people's health through a life-course approach, from pregnancy and birth, through school years into young adulthood. It describes some of the work which is being done to address the inequalities in health experienced in Rotherham and suggests what could be done to make further improvements. The report can be viewed here:

SLT 2016 03 02 DPH Annual Report Final V1.pdf

In summary, there are 56,400 children and young people aged under 18 in Rotherham[1], (21.7% of the Borough's population, slightly above the English average of 21.3%). An analysis of the age profile predicts that the number of secondary school age children (11-17) will increase between 2016 and 2021 by 6%. As of the end March 2015 there were 1,923 Children in Need, 423 Children subject to a Child Protection Plan[2] and 410 Looked After Children in Rotherham[3]. Our high Child Protection rate and increasing complexity in the social care cases demonstrate that the needs of local children and young people and their families are rising.

Nationally there is a direct correlation between social care needs and deprivation. Nationally 19.7% of children are affected by income deprivation[4], in Rotherham this is significantly higher at 24.3% and for children living in our ten most deprived communities half of them are affected by income deprivation[5]. **The Deprivation Pupil Premium also shows a similar picture with more local pupils (31.8%) eligible than the national average of 28.6%.**

[1] Office for National Statistics population estimates, http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates
[2] Department for Education 2015 https://www.gov.uk/government/collections/statistics-children-in-need
[3] Department for Education 2015 https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015
[4] English Indices of Deprivation 2015 https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015
[5] Rotherham JSNA Child Poverty 2015 http://www.rotherham.gov.uk/jsna/info/23/people/55/children_and_young_people/8

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High rates of smoking in pregnancy are a particular concern in Rotherham affecting 18.3% of maternities compared to 11.4% in England. This contributes to complications during pregnancy and delivery and health problems throughout childhood. The number of babies born at low birth weight (8.6%) is above the English average of 7.4%, similarly infant mortality rate is 5.1 per 1,000 births, compared to England average of 4.0. The breastfeeding initiation rate of is one of the lowest in the region and this poor level of breastfeeding is associated with childhood obesity.

Obesity affects 9.9% of Rotherham school children aged 4-5 and 21.6% of Rotherham children aged 10-11[6], this is broadly in-line with national averages for 4-5 year olds but much higher than the average of 19.1% of 10-11 year olds.

Levels of **oral disease** in five year olds are much higher than average in Rotherham at 40% compared with 28% nationally.

For young people aged 15-24, 1,550 were diagnosed with a **sexually transmitted infection** in 2013; this is a rate of 4,940 per 100,000, higher than the English average. However, this figure should be interpreted with caution as it could also indicate an accessible and young person friendly service where people feel comfortable in seeking treatment.

Child Poverty

The most basic form of deprivation affecting children is low household income which impacts on a wide range of life chances. The Indices of Deprivation 2015* shows that 48,400 people or 18.7% of Rotherham's population were deprived of income (on means tested benefits or asylum seeker support) in 2013/14. Children aged 0-15 are most likely to be affected by low income with 12,050 (24.3%) of children aged 0-15 affected, 580 more than in 2008. At the neighbourhood level, the figures range from 3% to 62.5%, showing a polarisation in family income across the Borough.

** Please note that Indices of Deprivation data on income and poverty uses a different measure to that referenced within the Public Health Outcomes Framework.*

Children living in the Most Deprived Areas

The 10 most deprived areas of Rotherham (the Super Output Areas, or SOAs, of Ferham, East Herringthorpe North, Eastwood Village, Canklow North, Eastwood East, East Herringthorpe South, Eastwood South, Maltby Birks Holt, East Dene East and Masbrough) have a combined population of 17,500, of which children aged 0-17 number 5,900 (33.6%), twice the proportion in the 10 least deprived areas. Half of children in the most deprived areas (3,000) live in families with three or more children, almost three times that observed in the least deprived. Of children in the most deprived areas, 43% are minority ethnic compared with just 4% in the least deprived. Children in the most deprived areas are 13 times more likely to live in poverty than the 10 least deprived.

Whilst children from across the Borough can receive some social care support, those in the most deprived areas are five times more likely to be designated as a Child In Need (Children Act 1989), than those in the least deprived areas. They are also four times more likely to be involved in some way with the team dealing with child sexual exploitation[7].

Life expectancy at birth for a baby born in the 10 least deprived areas is 9.5 years longer than for a baby born in the most deprived areas. Children in the most deprived areas are twice as likely to be disabled and more than twice as likely to live in a home where someone smokes.

[6] Public Health England NCMP Fingertips Profile Data http://fingertips.phe.org.uk/profile/national-child-measurement-programme
[7] RMBC CSE Needs Analysis 2015

5.3 Adults

SLP central hypothesis ***"illness is the main factor, not age: health care costs are greatest in final year of life, with the lowest cumulative lifetime costs seen in those who were oldest at death"***. This highlights the hidden benefit of prevention *

Over the last decade, all cause mortality rates have fallen by nearly 20%. 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 over 35%, particularly in females, although male rates have decreased recently. Further, respiratory disease mortality rates have fluctuated over the last decade with little net change by 2011-13.

However, a large decrease in 2012-14 has resulted in the lowest rates in the last decade for females and second lowest for males.

Potential Years of Life Lost (PYLL) reflects deaths in people aged under 75. About 6,500 PYLL are lost each year in Rotherham through causes considered amenable to healthcare. This is around 1,500 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.**

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 investment both in professional awareness and increased 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.

5.4 Prevention

Prevention is everyones business.To reduce acute admissions there needs to be a radical mind shift towards prevention. Prevention at scale and pace.

Shifting social norms must be tackled not only by individuals but by wide ranging action by health and care services, local government, media, businesses, society at large, families and the voluntary and community sector.

South Yorkshire and Bassetlaw STP proposes:

Local Government population health policies that facilitate prevention ie savvy state not nanny state, for example:

- Smoke free houses, cars, pets

LA implementation (with H&WB support) of policies that support healthy lifestyles especially tobacco control, alcohol, nutrition, for example:

- Review fast food environment (eg not near schools), use of salts and transfats in products sold locally, nutritional standards of publically procured food.
- Alcohol – policy intervention, community screening with brief intervention

At scale NHS disease specific prevention programme, for example:

- CVD, Diabetes

NHS to include lifestyle factors as a default within treatment/ care pathways

- Smoking cessation, alcohol brief intervention, physical activity
- Inequality and distribution of GPs, develop a broader social model of care eg include debt , housing, fuel poverty, social connectedness advise within surgeries.

NHS implementation of a population wide CVD programme

- NHS Health Check, diabetes,

Refocus of current lifestyle investment services, for example

- Fuel poverty, active transport, clean air, debt and poverty advise

Patient/ public engagement: community assets, shared responsibility, for example:

- Well North approach, resilient children, families and communities,

And finally…
"We are not tinkers who merely patch and mend what is broken... we must be watchmen, guardians of the life and the health of our generation, so that stronger and more able generations may come after"
Dr Elizabeth Blackwell (1821-1910), The First Woman Doctor

5.5 Health and Wellbeing Strategy

The CCG has worked with partners to develop the second Rotherham Health and Wellbeing Strategy in response to the findings of the Joint Strategic Needs Assessment and consultation about health inequalities. The strategy identifies five key aims for Rotherham that can best be tackled across the whole health and care system to achieve improvement:

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

Each of these aims is underpinned by a comprehensive action plan and the following supporting principles:

- To reduce health inequalities we need to ensure that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, is improving the fastest.
- Prevention of physical and mental ill-health should be our primary aim, but where it is already an issue, we should intervene early to maximise the impact of services for individuals and communities
- We will work with individuals and communities to increase resilience and enable people to better manage and adapt to threats to their health and wellbeing, using an asset-based approach that values the capacity, skills, knowledge, connections and potential within communities
- Integrating our commissioning of services wherever possible to support improvements in health and wellbeing and the reduction of health inequalities
- We need to ensure pathways are robust, particularly at transition points (e.g. from children and young people's services into adult services), to be sure that nobody is left behind
- All services need to be accessible and provide support to the right people, in the right place

Partners need to work together to make the best use of collective resources as public sector finances become increasingly stretched. The strategy shows how partner agencies within the town are joining together to offer a life course approach using the following policy objectives:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention

Our Health and Wellbeing Strategy has been developed with these as guiding principles, it provides a shared vision and a high level framework to support the Health and Wellbeing Board over the next three years to address the challenges faced in Rotherham.

Rotherham's Health and Wellbeing Strategy 2015-18 can be viewed here:
http://www.rotherham.gov.uk/hwp/downloads/file/4/rotherham_borough_joint_health_and_wellbeing_strategy_2012-15

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. ***Commissioning General Practice Services*:** From 1 April 2015 the CCG received delegated authority for commissioning General Practice services, we believe that a key cornerstone to the success of delivering our strategy is our ability to commissioning high quality, equitable Primary Care provision, we have over the last 12 months developed our local primary care strategy (see section 21.1). 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.
2. ***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 Integrated 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.

3. ***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.

4. ***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.

5. ***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.

6. ***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.

7. ***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.

8. ***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.

9. ***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.

10. ***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 21.10 we describe the priority areas for CHC moving forward.

11. ***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.

12. ***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.

13. ***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.

14. ***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.

15. ***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.

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 the following:

- **Additional years of life** – 200 additional life years per year
- **Reduced A&E waiting times** – 95% of people will be seen within 4 hours
- **Reduced number of hospital admission** - hospital admissions will remain at their current level of 16% below their 2011/12 peak.
- **Improved quality of GP consultation** – maintain current above average levels of patient reported satisfaction with GP care
- **Improved transfers of care** - 1% reduction in the delays transferring patients home or to a more suitable level of care
- **Improved access to services** – Maintain strong 18 week wait performance in secondary care, improve access to mental health services by delivering national waiting time requirements.

Note, the metrics will be revisited once the operating guidance for the 2016/17 CCG Improvement and Assessment Framework is published

9 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 8%: for electives, TRFT 70%, STHT 21% DBH 5%.

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 2.93% 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 0.11% increase 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.

10 Efficiency

10.1 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

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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	

10.2 Provider efficiency savings

Figure 10.1: Summary of Provider Efficiency Challenges for Rotherham 2015/16 -2019/20

QIPP Plans	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £m
2% Efficiency	(8.35)	(4.37)	(4.65)	(4.62)	(4.64)

10.3 System wide efficiency savings

Figure 10.2: Breakdown of System Efficiency Challenges for Rotherham 2014/15 -2018/19

QIPP Plans	2015/16 £m	2016/17 £m	2017/18 £m	2018/19 £m	2019/20 £000
Medicines Management	(1.92)	(3.13)	(2.14)	(2.19)	(2.24)
Unscheduled Care	(0.44)	(1.79)	(1.79)	(1.79)	(1.89)
Clinical Referrals	(6.64)	(1.79)	(3.82)	(3.82)	(4.04)
Mental Health	(0.51)	(0.85)	(0.50)	(0.50)	(0.25)
Continuing Healthcare	0.00	(0.50)	(0.50)	(0.50)	(0.50)
Primary Care	0.00	(0.52)	(0.36)	(0.37)	(0.38)
Non recurrent	0.00	(2.66)	0.00	0.00	0.00
Corporate Services	(0.10)	(0.25)	(0.10)	(0.10)	(0.10)
SUB TOTAL	**(9.60)**	**(11.48)**	**(9.21)**	**(9.27)**	**(9.40)**

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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 £74m.

QIPP Plans	2015/16 £ m	2016/17 £ m	2017/18 £ m	2018/19 £ m	2019/20 £ m
TOTAL QIPP	(17.95)	(15.85)	(13.86)	(13.89)	(14.04)

10.4 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 have since reduced by a further 10% to £5.5m.

10.5 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.

10.6 Commissioner Requested Services

The CCG has undertaken a review of 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.

11 Finance

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

11.1 Financial Planning Assumptions

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

- 1% Operating Surplus £3.6m
- 1% recurrent headroom £4.0m
- 0.5% Contingency £2.0m

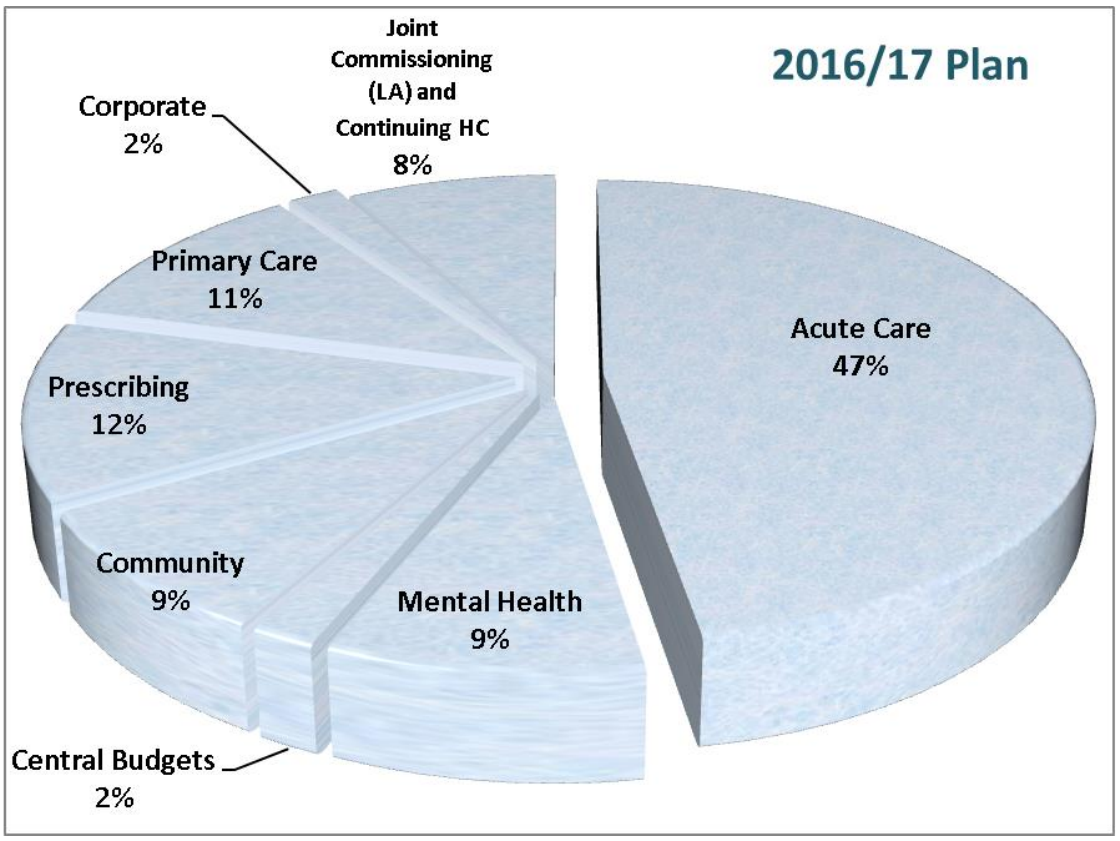
The CCG has approximately £395m to spend in 2016/17. The plan assumes that the required 1% surplus will be made although this presents challenging targets for savings. The assumed growth levels after this are 1.5% and 1.6 % respectively although this is not guaranteed.

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 0.1% in 2016/17 against 2015-16 outturn.
3. **Follow-up outpatients:** we plan to move to national average ratios which is a reduction of 11% against 2015-16 outturn.
4. **Planned admissions:** we plan to increase by 2.8% against 2015-16 outturn in 2016/17.
5. **Urgent admissions:** we plan to increase by 0.3% against 2015-16 outturn.
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 6%.
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.

11.2 Distribution 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. A simple overview of the distribution of funds is set out in the chart below:



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.

11.3 Better Care Fund

This is a pooled budget of £24.3 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.

11.4 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.

11.5 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. Plans are predicated in part upon Primary Care having the appropriate capacity to deliver the services required in Rotherham. This is already being addressed through the Primary Care Sub Committee's strategy and 2016/17 will be the first in a four year plan to strengthen primary care and ensure that all practices achieve a minimum standard and quality requirement. The risks to capacity are a concern and all practices will submit a mobilisation plan in 2016/17 identifying capacity which will assist in the CCG's understanding of the position.
4. 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.
5. 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.
6. 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.
7. The CCG is planning for higher than average levels of savings which are still needing further work particularly with the local providers who will sign off the quality impact assessments of their respective plans with Boards early in the financial year. The impact of these levels of savings across the wider footprint are expected to be addressed by the local sustainability and transformation plan (STP) and this itself brings more risk as set out in (7) below.
8. The local STP will need to demonstrate how localities are planning to achieve the required control totals across the patch – not just at organisation level. The consequent risk of not achieving this obligation is likely to be a loss of the national growth fund set aside for 2017/18 plus a possible withholding of the 1% headroom to contribute to South Yorkshire and Bassetlaw issues as a whole.
9. 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.

11.6 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.

11.7 Procurement

The CCG has a clear procurement strategy and plan for undertaking procurement activity. The CCG recognises that local supply chains are intrinsically good for the local economy, where appropriate the CCG will work in the best interests of patients to secure high quality provision through procurement activity.

11.8 Meeting the financial challenge 'Least Worst Options'

In 2015/16 both non elective and elective hospital activity has grown faster than is affordable. It is imperative that our plans address this in both the short and the long term. It is highly likely that we will take actions to keep costs under control in 2016/17 to manage 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.

'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 e.g.
  - 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

12 Statutory Responsibilities

12.1 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.

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.

12.2 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.

12.3 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 corporate 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
- supported the 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.

investor in excellence

Your life, Your health

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

12.4 Public Involvement in CCG and Promotion of Choice

12.4.1 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.

12.4.2 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.

12.4.3 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 .

12.4.4 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*

12.4.5 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

12.5 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.

12.5.1 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.

12.5.2 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

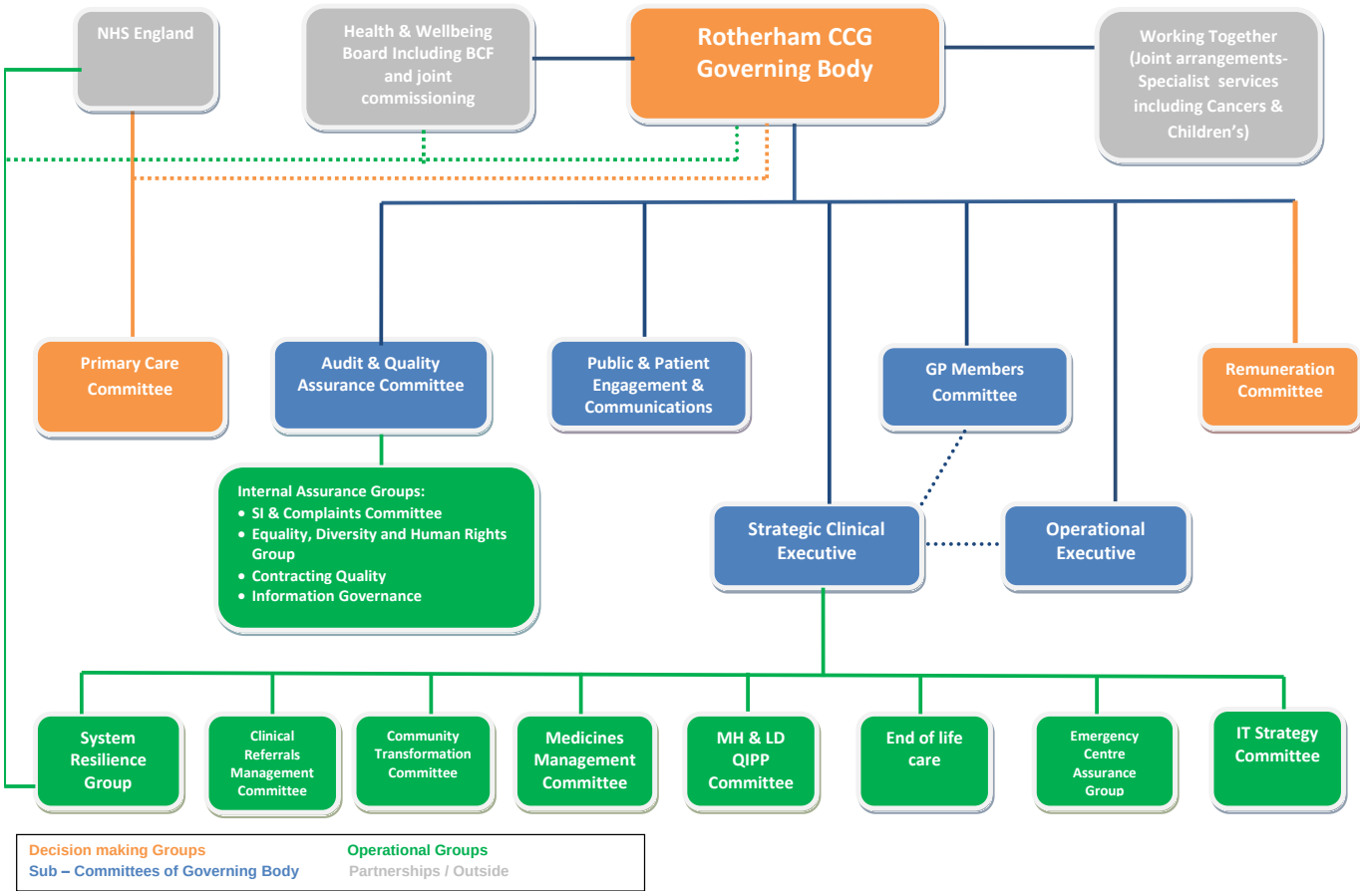
Health and Wellbeing (H&WB) Board

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



12.6 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:

12.7 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

12.8 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 73% nationally for similar organisations. The outcomes were overwhelmingly positive, examples being such as 97% of staff feel line managers value their work, 100% of staff feel that managers support them to access training, learning or development, 100% of staff have received mandatory training and an appraisal in the last 12 months and 99% of staff feel that their line managers are supportive in a personal crisis.

12.9 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.

1. Corporate leadership	2. Staff health and wellbeing and community engagement
'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.	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.
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**.	
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.	

13 Information Management and Technology

13.1 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

13.2 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).

13.3 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 2016 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
- 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.

13.4 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.

13.5 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.

13.6 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

14 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

15 Performance and Assurance

Note, the metrics will be revisited once the operating guidance for the 2016/17 CCG Improvement and Assessment Framework is published

15.1 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:

Outcomes

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

Key measures of successful outcomes will include the following:

- **Additional years of life** – 200 additional life years per year
- **Reduced A&E waiting times** – 95% of people will be seen within 4 hours
- **Reduced time in hospital** – reduced Length of stay XXXX excess bed days
- **Reduced number of hospital admission** - hospital admissions will remain at their current level of 16% below their 2011/12 peak.
- **Improved quality of GP consultation** – maintain current above average levels of patient reported satisfaction with GP care
- **Improved transfers of care** - 3% reduction in the delays transferring patients home or to a more suitable level of care
- **Improved access to services** – Maintain strong 18 week wait performance in secondary care, improve access to mental health services by delivering national waiting time requirements.

Note, the metrics will be revisited once the new 2016/17 CCG Assessment

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 plan has been reviewed and recently submitted to NHSE. The first five outcomes are chosen nationally, the 6th locally chosen.

1. Number of admissions to residential and nursing homes (12.6% reduction).
2. **Proportion of over 65s at home 3 months after discharge** (89.6% projected outturn)
3. Delayed transfers of care from hospital to reduce by 1%.
4. Emergency admissions will increase by 0.3% on 2015/16 outturn.
5. New national patient experience measure - plan is to improve the score year on year.
6. Emergency admissions within 30 days of discharge from hospital (reduce by 0.6% in 2016/17).

Quality Premiums: The national indicators making up the 2016/17 CCG Quality Premium are:

1. **Cancer** – this is a two part measure totalling 20% of the overall premium;
   - Demonstrate 4% improvement in the proportion of cancers diagnosed at stages 1 and 2 in 2016 compared to 2015; and
   - Achieve greater than 60% of all cancers diagnosed at stages 1 and 2 in 2016
2. **E-Referrals** – to earn 20% of overall premium, CCGs will need to either:
   - Meet 80% by March 2017 and demonstrate year on year increase in the % of e-referrals; or
   - March 2017 performance to exceed March 2016 performance by 20%
3. **GP Patient Survey** – to earn 20% of overall premium, CCGs will need to either;
   - Achieve 85% of respondents who said they had a good experience of making an appointment; or
   - A 3% increase from July 2016 publication on the % of respondents who said they had a good experience of making an appointment
4. **Improved antibiotic prescribing in primary care** – this is a two part measure totalling 20% of the overall premium;
   - Reduction in the number of antibiotics prescribed in primary care; and
   - Reduction in the proportion of broad spectrum antibiotics prescribed in primary care

The three **local** measures, worth 30% of the total **Quality Premium** (10% each), focus on the Right Care programme and have been identified from the Commissioning for Value packs, these are:

- % of people who are "moving to recovery" of those who have completed IAPT treatment
- Delayed transfers of care from hospital per 100, 000 population aged 18+
- People who have had a stroke who are admitted to acute stroke unit in 4 hours of arrival to hospital

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

- 18 Weeks Referral To Treatment – incomplete standard (25%)
- A&E 4 Hour Wait (25%)
- Cancer 62 day GP referral to treatment(25%)
- Ambulance Red 1 Emergency Calls 8 Minutes (25%)

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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

15.2 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.

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*

16 Risks

16.1 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 2016 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
- 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

17 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 (PPGs) 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. *Consultation database*

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' 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 Child and Adolescent Mental Health Services (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 Rotherham Limited Liability Partnership (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 Local Enhanced Service but further work needed
- Concern with Improving Access to Psychological Therapies

Hospital and Community

- Very supportive of Care Co-ordination Centre and of potentially extending the services
- Support for Multi—specialty Community Provider Model (community transformation), recognising it will continue to develop

Child Sexual Exploitation

- Supportive of CCGs response, positive comments regarding the Multi-Agency Safeguarding Hub

Joint Commissioning and Better Care Fund

- 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 2015/16 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 built on this feedback and 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 *HW consultation database*. See section 13.4 for information on our patient and public engagement work.

However the challenges in making sure that people have the opportunity to influence our planning remain these include:

- 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 finacial 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

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.
- Work with community organisations to extend our reach, supporting community members carrying out consultation with peers

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.

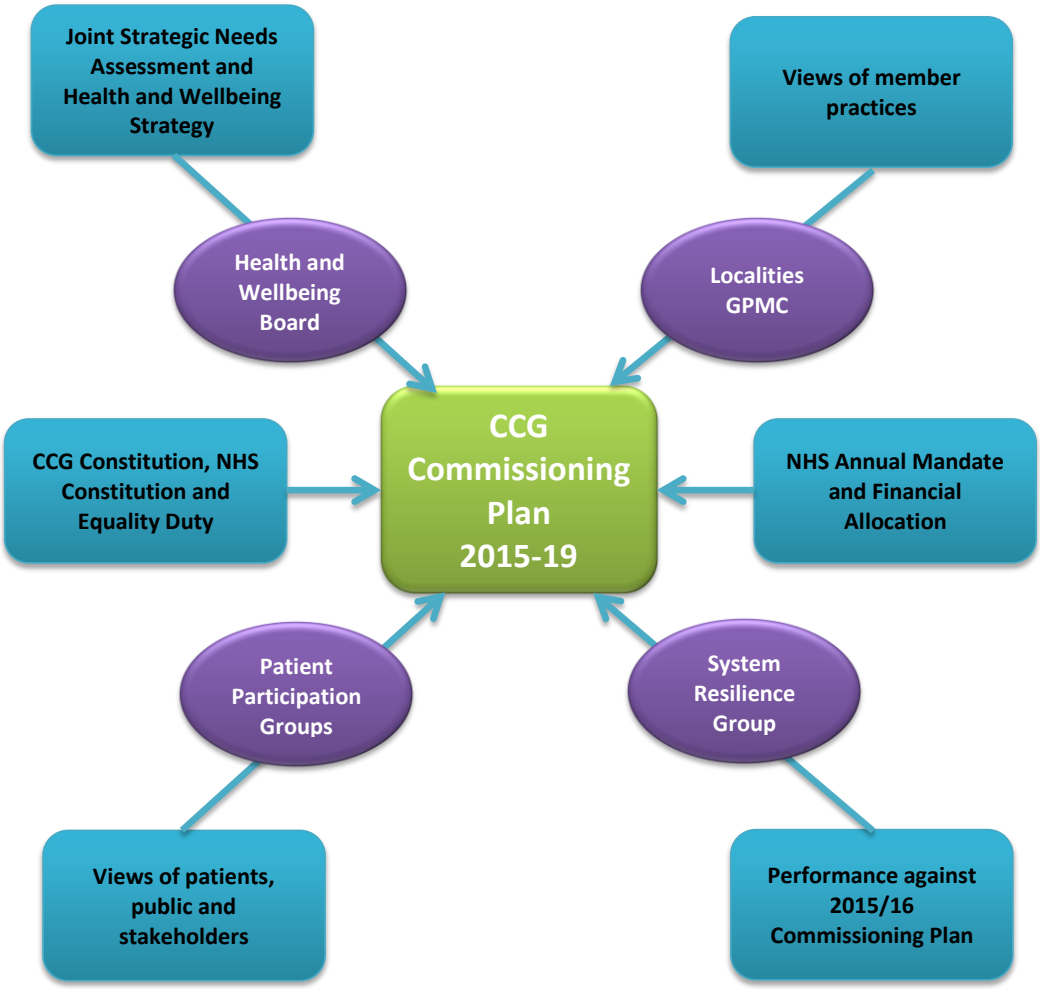
How to feedback comments on the CCG Commissioning Plan

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 17.1: Inputs into the development of our Commissioning Plan



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18 Glossary

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
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
GPMC	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
STP	Sustainability and Transformation Plan
SYCOM	South Yorkshire CCG Collaboration
TRFT	The Rotherham NHS Foundation Trust
YAS	Yorkshire Ambulance Service

19 List of hyperlinked documents

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Rotherham Doncaster and South Humber NHS Foundation Trust | The Rotherham NHS Foundation Trust | Rotherham Metropolitan Borough Council Where Everyone Matters | NHS Rotherham Clinical Commissioning Group | VoluntaryAction Rotherham

Rotherham's Integrated Health and Social Care Place Plan

2016-2020 V6.1 18 05 16 DRAFT

Part Two

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 green indicates that the content needs final confirmation subject to final contract agreements.

Page numbers, signposting and hyperlinks (currently denoted in *orange italic text*) will be completed for the final version.

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20.1 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 £0.6 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.

20.2 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 21.3). The Better Care Fund is described in section 21.13

In 2015/16, the CCG spent £59.3 million on unscheduled care. Planned spend for 2016/17 is £60.1 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, reducing hospital admission at every opportunity.

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 1.5%. 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
- Further Enhancement of the Case Management Programme.
- 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.
- Investment of £3.1m in 2015-16 to 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 21.10. **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

20.3 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 21.11), general practice for example the case management programme (see section 21.2) and the voluntary sector including the award winning social prescribing scheme (see section 21.2). 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 21.13) **Table 1: Spending Profile for Community Services**

Summary Of Community Services	£'000
Children and Young People's Services	3,954
Planned Care	5,651
Long Term Conditions, Intermediate Care and Urgent Care	14,469
CQUIN	602
Community Transformation including 7 day working	3,897
Total	**28,574**

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 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.

20.4 Ambulance and Patient Transport Services

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

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.

Calls to 999 and 111 will undergo Clinical Triage Before an Ambulance or A&E Disposition is made – 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.

See and Treat in Ambulance Service – 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.

Reduction in Conveyance for Falls from Care Homes – 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

20.5 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 scheduled 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 £68.1 million on scheduled care. Planned spend for 2016/17 is £66.7 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 in line with NICE guidance. 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 elective care particularly where more accessible services avoid the need for hospital attendance and 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 existing pathways.

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 re-commission pathways accordingly.

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 are, we plan 1% growth in outpatient firsts in line with the assumed forecast outturn for 2015/16, and we plan to increase non-elective admissions by 0.3%.

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**	1. COPD 2. Cardiology / CVD 3. Children's care pathways 4.	5. T&O/MSK 6. Dermatology 7. Dementia (with Mental Health QIPP group)

	Committee)	
6	**Safe effective non face to face 'referrals'**	1. Review of current virtual Haematology and consideration of extension to other specialties, e.g. Fracture clinic and thyroid virtual clinics 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. Significant work has taken place in year in relation to the diabetes pathway, following the Super Six Model, to improve outcomes for Rotherham population and is now at consultation stage. We anticipate implementation in 2016/17

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.

20.6 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 are however patients who could benefit from medication who do not receive optimal treatment, some patients receive unnecessary side effects from their treatment and there is considerable waste in the system when patients are issued with medication that they do not take.

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

The CCG's track record on effective medicines management is very strong. Prescribing costs\capita compares favourably to neighbouring CCGs and with CCGs with similar demographics. There are two prescribing incentive schemes, one that rewards practices for cost effective prescribing and one that rewards practices for achieving a range of prescribing quality targets. In 2015/16 Rotherham has experienced very strong prescribing cost growth this is linked to a strong growth in prescribing volume. Initiatives will be launched in 2016/17 to contain this cost growth and reduce medicines waste.
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 2016/17 the CCG will spend £48 million on prescriptions and on commissioned services (nutrition, continence and wound care). The 2016/17 uplift was 2.5% net of efficiency savings. 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. • A limited range of branded generic preparations will be introduced during 2016/17 • The medicines management team (MMT) working with TRFT has introduced the Blueteq web bases process for managing the prescribing of "drugs outside of tariff" • The CCG completed a procurement for the direct purchase and supply of wound care products. This scheme will be rolled-out across all of Rotherham by April 2016.. Compliance rates with the wound care fromaulry are between 95-97% ▪ 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 has launched a prescribing waste scheme direct to the public in collaboration February 2015. The learning from this scheme is being incorporated into the medicines management work plan for 2016-17 • Further patient engagement exercises are planned for 2016/17
2	**Performance Benchmarking**	Financial and quality benchmarking against other CCGs using RDTC and PRESCQIPP data.
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

- Delivery 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.
- Scheme to introduce practice pharmacists

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.
- Focus efforts on reducing medicine waste
- 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 two GPs, 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 33 GP practices.

An SCE GP and the CCG's medicines management team work with all 33 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 2016/7.

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

20.7 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 effect 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 £35 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 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
- 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 50% 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.

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

20.8 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.

- **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.
- **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 – 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
- Increase support and quality of care
- Reduce inappropriate admissions by ensuring that patients 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 patients 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 patients 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.

20.9 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 2015 Director of Public Health Annual Report describes children and young people's health through a life-course approach, from pregnancy and birth, through school years into young adulthood. It describes some of the work which is being done to address the inequalities in health experienced in Rotherham and suggests what could be done to make further improvements. Further information in relation to health needs for children and young people can be found in section 5 of part 1.
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.

A priority for the Children's Commissioners is to put in place an effective early help pathway and offer.
RMBC's Public Health service is currently undertaking the re-commissioning of 0-19 public health nursing services (which includes school nursing, health visiting, family nurse partnership and oral health promotion), and sexual health and substance misuse services for young people. Progress is being made with real engagement from partners moving this forward with enthusiasm and pace. An interactive on-line tool will be available for all partners and practitioners as part of RMBC Early Help Offer website. New contracts for these services will be implemented in April 2017.

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 21.13. A copy of the Children and Young People 'plan on a page' can be found at the following link: http://www.varotherham.org.uk/wp-content/uploads/2015/11/CYPS-POAP-plain-language-Oct-V1.pdf

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 18 years make up 21.7% 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 21.6% 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. High rates of smoking in pregnancy are a particular concern in Rotherham affecting 18.3% of maternities compared to 11.4% in England. The percentage of babies being born with a low birth weight 8.6% is higher than the England average of 7.4%. Whilst rates are improving, numbers of women smoking during pregnancy are particularly high. Similarly infant mortality rate is 5.1 per 1,000 births, compared to England average of 4.0. The breastfeeding initiation rate of is one of the lowest in the region and this poor level of breastfeeding is associated with childhood obesity.

The 10 most deprived areas of Rotherham (the Super Output Areas, or SOAs, of Ferham, East Herringthorpe North, Eastwood Village, Canklow North, Eastwood East, East Herringthorpe South, Eastwood South, Maltby Birks Holt, East Dene East and Masbrough) have a combined population of 17,500, of which children aged 0-17 number 5,900 (33.6%), twice the proportion in the 10 least deprived areas. Half of children in the most deprived areas (3,000) live in families with three or more children, almost three times that observed in the least deprived. Life expectancy at birth for a baby born in the 10 least deprived areas is 9.5 years longer than for a baby born in the most deprived areas. Children in the most deprived areas are twice as likely to be disabled and more than twice as likely to live in a home where someone smokes.

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.

20.10 Continuing Care and Funded Nursing Care

Lead GP	Richard Cullen
Executive Lead	Sue Cassin
Lead Officer	Alun Windle
Key Meeting	Weekly CHC Panel

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.

20.11 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.
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

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 21.3) 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 21.2) 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.

20.12 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.

20.13 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

What is the Better Care Fund?
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.
5 year strategic direction
The Rotherham Better Care Fund brings together 6 themes that are particularly important for joint working into a single jointly owned budget of £24.3 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.

The strategic objectives for each of the BCF schemes is documented within the BCF plan.

Progress made in 2015/16

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.

Plans for 2016/17 and 2017/18

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

How we are going to achieve our intentions?

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.

£24.3 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.

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 21.2.
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.

Quality Improvements

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.

Alignment with the strategic aims of the Health & Wellbeing Strategy

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.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
The Better Care Fund vision is based on the Health and Wellbeing Strategy and on what Rotherham people have said are the most important to them. Rotherham partners have a commitment to make sure that the views and reported experience of people who use local services are heard and acted upon. The comprehensive engagement that informed the BCF is documented within the BCF plan.

20.14 Child Sexual Exploitation

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.

20.15 Cancer

Lead GP	Richard Cullen
Executive Lead	Ian Atkinson?
Lead Officer	Janet Sinclair-Pinder

Why is this a strategic priority?
The 2015 Atlas of Variations highlights the fact that one year survival rates post Cancer diagnosis are lower in Rotherham than the National average. Mortality rates from any cancer in both the over and under 75's are also above the national average. Our challenge should therefore be to improve one and five year survival rates. Cancer targets are set up to try to deal with these issues and the CCG will work public health and wider community. 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. Intelligence, from Commissioning for Value (Right Care), suggests that in some specific areas of Cancer Provision, such as lung cancer, our spend on hospital care is significantly higher than peer averages.
5 year Strategic Direction and key priorities
Our key strategic objective is to commission high quality, timely seamless pathways of cancer care. We will do this by focusing our efforts in the following areas: 1. **Raising Awareness to support early identification and early diagnosis** with specific focus on 2week waits for urgent cancer referrals 2. **Treatment –** Commission high quality pathways of care for both local and tertiary cancer treatments 3. **Survivorship** – Focus on the need to address complications as soon as required reduce the need for unnecessary follow ups, support individuals to return to work.

Progress made in 2015/16
• Refocusing of CCG commissioning resource to increase focus and co-ordination of cancer commissioning. • Supported TRFT with Intensive Support Team visit reviewing cancer services, work with TRFT to monitor progress against the local improvement action plan. • Play an active role in the local Cancer Network • Undertaken root cause analysis on all 62 day breach patients to identify any learning form patient breaches.
Plans for 2016/17 and 2017/18
• Support on-going delivery of the TRFT Cancer Improvement action plan focusing on one year survival rates. • Continue to undertake root cause analysis on all 62 Cancer Breaches to identify opportunities for learning. • Focus work on awareness raising / early diagnosis / 2 week wait • Fully engage with the Cancer waiting times Task and Finish Group to improve the delivery of the 62 day target. • Fully engage with McMillan to maximise opportunity to deliver the CCG priorities specific to Survivorship.
How are we going to achieve our intentions?
• Working Together • Cancer Strategy Group • Cancer Task and Finish Group

Appendix 1: 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 £24.3 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 September 2015.

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 £45.7 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.

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

1. Scope overview
2. The CCG drivers and challenges
3. Estate overview
4. Key themes emerging from the review
5. Property strategy forward view
6. Summary of property opportunities
7. Investment considerations
8. Financial Analysis
9. Work Plan
10. Recommendations

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

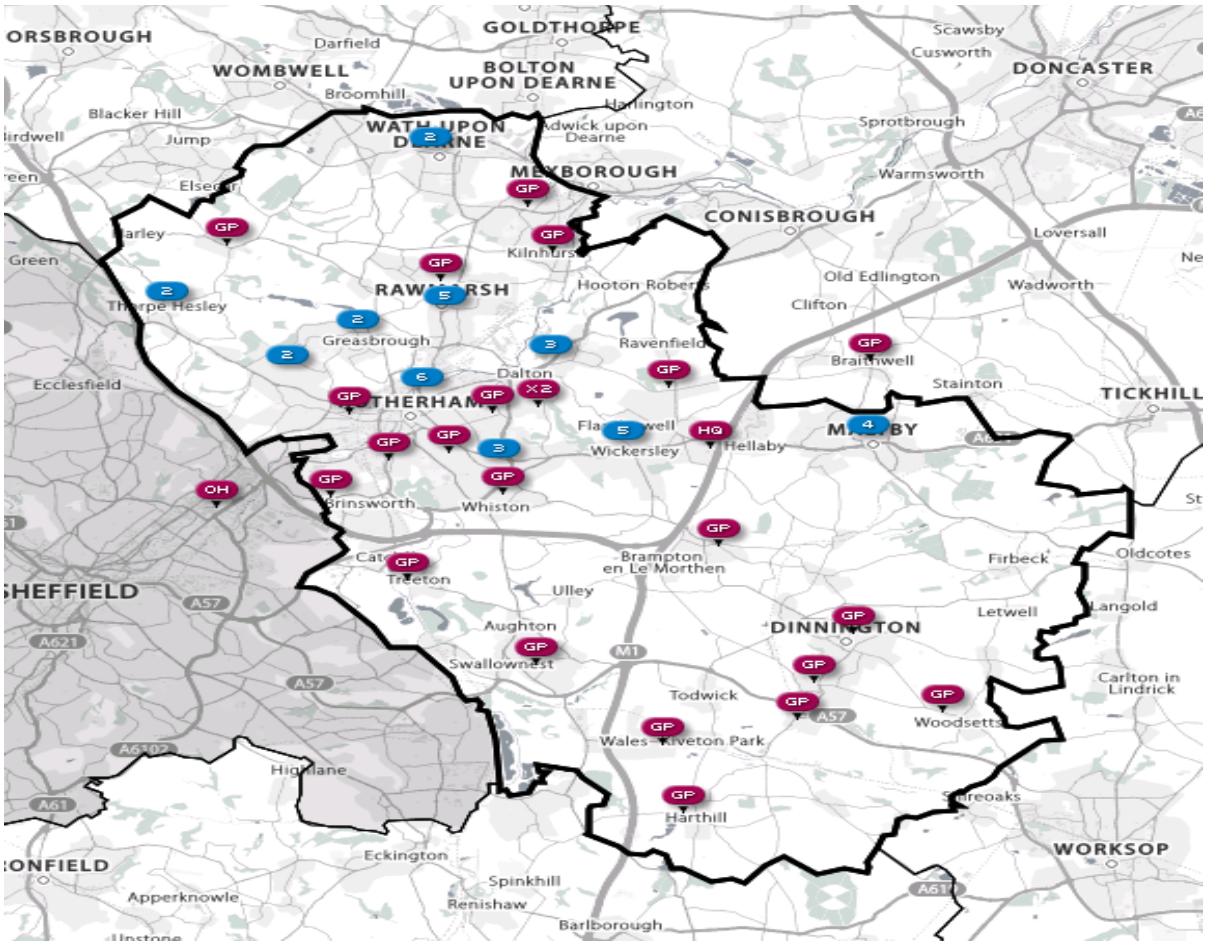
Total Cost of Estate

- **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

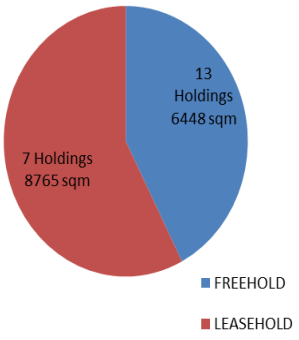
The Estate Overview – Estate Map



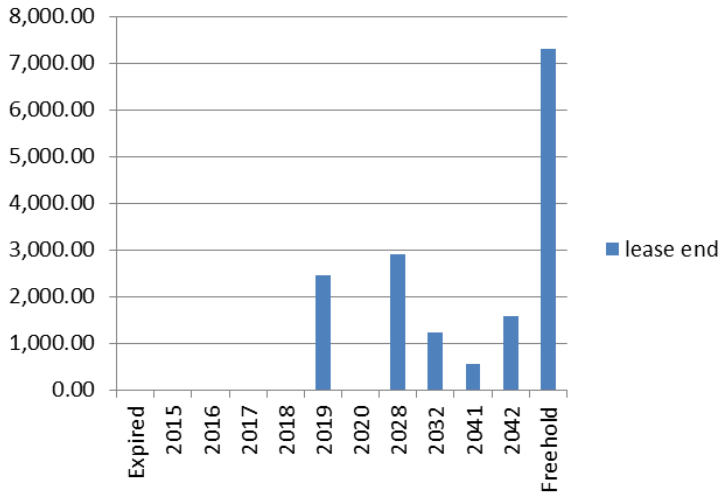
The Estate Overview

- 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)



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health

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

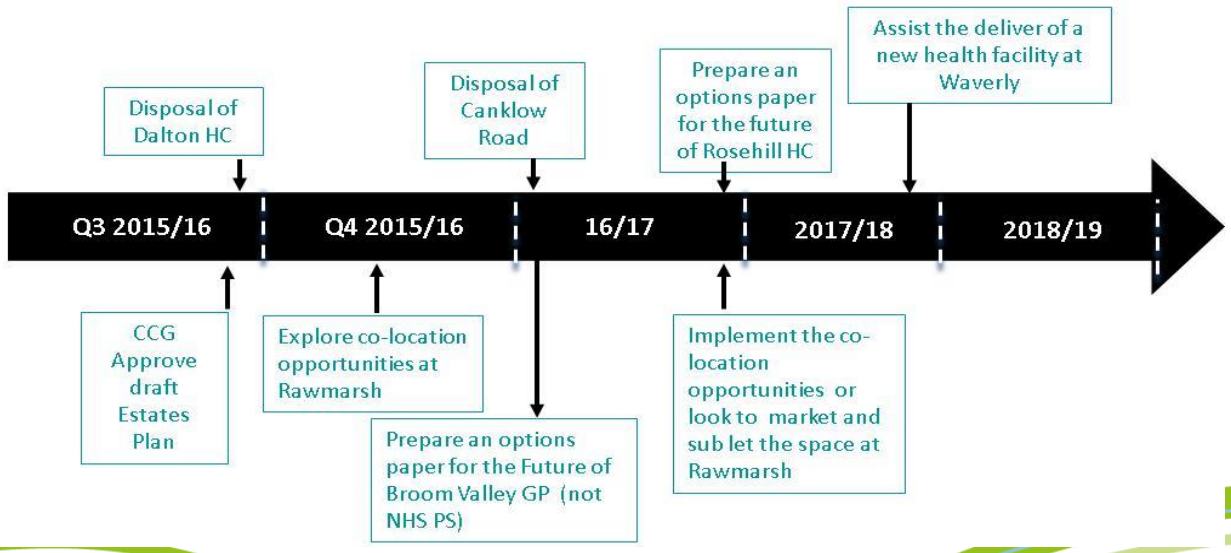
Indicative profile of running costs savings:

- **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 METROPOLITAN BOROUGH COUNCIL – REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**1st June 2016**
3.	**Title:**	**Joint Strategic Needs Assessment (JSNA) update for 2016/2017**
4.	**Directorate:**	**Assistant Chief Executive**

5. Summary

The Joint Strategic Needs Assessment (JSNA) is a statutory duty of the Health and Wellbeing Board to evidence the needs of people in Rotherham. The assessment underpins health and social care commissioning, service development and the Health and Wellbeing Strategy.

The JSNA was refreshed as a new online resource in 2013, replacing the former fixed document format of 2011. Following a period of consultation, the Health and Wellbeing Board signed off the final version of the JSNA in February 2014. The revised JSNA was used to inform the new Health and Wellbeing Strategy 2015-18.

The new JSNA format allows for updates of information so that the content is continually evolving in response to new data becoming available or additional content being required. Contributors from a range of service areas have been asked to provide any updates required on a quarterly basis.

The JSNA was subject to a review in 2015/16 which added a new overview of issues identified in the JSNA and made presentational changes to make it easier to find information about children and adults, and better understand the JSNA process.

The Health and Wellbeing Board are asked to endorse the current JSNA and agree that it be subject to further review to improve the content and format.

6. Recommendations

6.1 To endorse the updated Joint Strategic Needs Assessment.

a) acknowledge that service based contributors are asked to provide any updates to the JSNA on a quarterly basis.

b) agree that the the JSNA will be subject to further review during 2016/17.

7. Proposals and Details

7.1 Background

The provision of a Joint Strategic Needs Assessment (JSNA) is a statutory duty of the Health and Wellbeing Board under the Health and Social Care Act 2012. The JSNA is developed and maintained by Rotherham MBC in partnership with the Clinical Commissioning Group, Voluntary and Community Sector, and Healthwatch Rotherham.

The Rotherham JSNA is a comprehensive needs assessment for the borough which provides information crucial to our understanding of the demographics of the borough and the needs of citizens. The JSNA is used by commissioners to assist the development of service specifications and by providers in developing their offer based on the needs of potential service users.

The JSNA also serves as an evidence base for the Health and Wellbeing Strategy which should reflect the key issues identified. The JSNA is also a public reference resource available to all officers, partners, voluntary and community groups, students and residents.

The JSNA was produced as fixed documents in 2008 and 2011 but information in these dated quickly and it was agreed to develop a new online format in 2013. Following consultation with stakeholders a final version of the online JSNA was agreed by the Health and Wellbeing Board in February 2014.

7.2 Online JSNA

The JSNA website is hosted by the Council's website at:
http://www.rotherham.gov.uk/jsna/
The content is arranged under the home page and 7 sections:

- **Home page** – provides background to the JSNA, a link to the Health and Wellbeing Strategy, priorities, overview of key issues and downloads.
- **People** – information about Rotherham's population including numbers, age, gender, ethnicity and information about specific communities of interest
- **Places** – information about the environment, housing, transport, and profiles of the borough, wards and other localities
- **Economy** – information on poverty, deprivation, economy and labour market
- **Staying Safe** – safeguarding for children and adults, crime, domestic abuse, sexual abuse and CSE
- **Healthy living** – epidemiological information about lifestyles and behaviours such as tobacco use, alcohol misuse, substance misuse, teenage pregnancy, obesity (inc. eating habits and physical activity) education, and inequalities
- **Ill health** - epidemiological information about the major causes of disease and infirmity in Rotherham
- **Services** – describes a range of health and social care services with information on performance and user satisfaction

JSNA users can drill down from each of these sections to find relevant information, for example information on Education can be accessed under 'People' then 'Children

and Young People'. There is a search tool to help users find information using key words. For every topic, the JSNA provides answers to three questions:

1. Why is this an issue?
2. What is the local picture and how do we compare?
3. What is the trend and what can we predict will happen over time?

This approach enables the Board to easily identify and prioritise key current and emerging issues affecting health and wellbeing in the borough.

The JSNA is maintained by the Policy and Partnerships Team on behalf of Public Health. There is a formal process for updating the JSNA each quarter whereby all service contributors are asked to provide any new information or revision as required. Sections of the JSNA are also updated as and when required on an ad-hoc basis outside this process.

7.3 JSNA Review 2015

A review of JSNA content took place in 2015 and confirmed that the format agreed in 2014 remained appropriate subject to regular updating. The review highlighted the need for an overview of key issues which has since been provided via the Introduction page. It was also felt that information on children and adults, including their safeguarding, should be made more accessible. This has been addressed by adding new headings for both under the People section. Other feedback led to changes to the Home and Introduction pages to clarify the JSNA process.

7.4 Changing trends since the 2013/14 JSNA

The JSNA covers a wide range of issues and most characteristics of the borough change little over a few years. Most updates to the JSNA are ones of detail rather than indicating a significant change in trend.

An important update has been the Indices of Deprivation 2015, the first for five years. The new data shows that deprivation in Rotherham has become more polarised with the most deprived areas getting worse, whilst areas of low deprivation have improved. Increasing deprivation affecting the poorest people and areas in Rotherham has a significant impact on health, social care and wider social concerns, often increasing demands on services. Welfare reform continues to have a culmulative financial and social impact which is increasing following changes announced in 2015. However, many local people have found work with claimant unemployment falling from 8,900 in February 2013 to 4,500 in February 2016.

Health indicators show some contrasting trends typified by life expectancy at birth which improved for males from 77.8 years in 2009-11 to 78.1 in 202-14 but worsened for females from 81.7 to 81.3. A significant improvement has been the reduction in Under 18 conceptions which have more than halved since 2008 with rates reduced to the English average in 2013. There were also notable improvements in adult smoking prevelence, smoking in pregnancy, injuries due to falls in older people and excess winter deaths (since 2006).

Health indicators which showed adverse trends recently were low birthweight babies, overweight and obese children (Year 6), Premature deaths due to liver disease in

women and suicide deaths. The mental health indicator used in the Indices of Deprivation showed a deterioration between the 2010 and 2015 indices, particularly in more deprived areas.

The JSNA will continue to be updated as and when new information is published or through the quartlery review process. For example,new population projections are about to be published by the Office for National Statiuistics although these are not expected to differ much from the current projection for Rotherham.

8. Risks and Uncertainties

The JSNA attempts to provide an accurate information resource but cannot always provide the latest data or cover all topics. The JSNA provides a broad overview of population needs and should not be regarded as a needs assessment for a particular service or topic.

Although the JSNA has clearly been used in strategy development, the extent to which it is used in the commissioning and development of services is uncertain and hard to measure.

9. Policy and Performance Agenda Implications

The JSNA serves as a key evidence base for the Health and Wellbeing Strategy and associated development of priorities and policies. The JSNA further provides a link with other borough-wide strategies and plans, and to a range of more detailed service and topic specific needs assessments.

10. Background Papers and Consultation

Previous reports to the Health and Wellbeing Board: December 2013 and February 2014.

11. Contact Name

Miles Crompton
Policy and Partnership Officer
Email: miles.crompton@rotherham.gov.uk

Rotherham Metropolitan Borough Council

Public/Private Report
Council/or Other Formal Meeting

Summary Sheet

Council Report: Health & Wellbeing Board 1 June 2016

Title Healthy Ageing Framework - A co-ordinated whole system approach to Healthy Ageing for Rotherham

Is this a Key Decision and has it been included on the Forward Plan?
No

Strategic Director Approving Submission of the Report
Teresa Roche, Director of Public Health

Report Author(s)
Rebecca Atchinson, Public Health Principal, Healthcare Public Health
rebecca.atchinson@rotherham.gov.uk

Ward(s) Affected
All wards

Executive Summary
An initial draft of a Healthy Ageing Framework has been developed to raise the profile of the needs of our ageing community and improve the coordination of the healthy ageing initiatives across Rotherham. Further stakeholder engagement will be sought to agree a vision that will drive activity forwards and improve the health and wellbeing of our ageing population.

Recommendations
The Health and Wellbeing Board are asked to consider;

- The first draft of the Healthy Ageing Framework and provide comments
- The suggested consultation and engagement with stakeholders in health, social care and voluntary and community sectors.

List of Appendices Included
Healthy Ageing Framework

Background Papers
Healthy Ageing Framework (Appendix 1)

Consideration by any other Council Committee, Scrutiny or Advisory Panel
No further considerations

Council Approval Required
No further approvals

Exempt from the Press and Public
No exemptions required

A coordinated whole system approach to Healthy Ageing – Healthy Ageing Framework

1. Recommendations

1.1 The Health and Wellbeing Board are asked to consider;

- The first draft of the Healthy Ageing Framework and provide comments
- Consider the suggested stakeholder engagement for partners including health, social care and voluntary and community sectors.

2. Background

2.1 In Rotherham there are a number of strategies that set out priorities and outcomes for health, social care, housing and neighbourhoods for our ageing community. However, these are not always linked together, resulting in opportunities not being maximised.

2.2 The Cabinet lead for Health and Wellbeing tasked Council Officers to develop a Healthy Ageing Framework to drive forwards health and wellbeing activity on the "age well" agenda building on requests from the voluntary and community sector.

2.3 Guidance from the LGA (2012) "Ageing well: a whole system approach" recommends a "place based approach". This involves the public sector working together to deliver better value services to citizens through joint working and the reduction of waste and duplication. This allows for creative ways to work which overcomes departmental and agency silos. It also recommends using community assets (what the community already has rather than what is doesn't) to build and support capacity and social capital in local communities.

2.4 There has been good progress as a result of the development and delivery of the Better Care Fund and the intentions of the Healthy Ageing Framework intends to build on this.

2.5 There are a range of strategies and action plans that are delivering elements of the Healthy Ageing agenda. The challenge is how we ensure that there is a key golden thread that runs through all the strategies and ties "Healthy Ageing" projects together.

2.6 It is proposed that we do this by agreeing and using a common vision and establish a set of consistent tools to monitor performance and delivery against a high level set of outcomes. This would help us to develop an integrated set of principles and could be used to develop a commissioning model of excellence for healthy ageing in Rotherham.

3. Key Issues

3.1 We currently do not have a locally agreed vision for Healthy Ageing in Rotherham. It is suggested that we need to consult on a vision and plan to do this as part of the consultation with stakeholders in July 2016.
A initial draft of the vision;
"to improve the health and wellbeing of the ageing community of Rotherham. Rotherham services work together seamlessly to develop healthy, independent and resilient citizens, who live good quality lives".

3.2 We recognise that there are a broad range of approaches across the system to deliver health and wellbeing improvements. We plan to utilise a range of principles below, within the development of the Framework:

- Older people being viewed as an asset
- Maximise the use of the community assets to facilitate healthy behaviours within our ageing communities
- Prevention and early intervention to be woven into all pathways to foster independence, citizens improve quality of life and develop strong and supportive communities.
- The Outcome Based Accountability framework to be used to address strategic outcomes e.g. improved healthy behaviours, reduced feelings of isolation and loneliness, improved mental wellbeing and improving independence.
- Personal and community centred approaches which aim to enhance the lives of the people and within their local communities.
- Value based approaches to ensure that we prioritise the wider goals of wellbeing, independence, social connectedness, choice and control.

3.3 A key development for the Health Ageing Framework is the need for partners to agree to work to a number of overarching outcomes. The overarching outcomes proposed are:

- Increase Life expectancy
- Increase Healthy life expectancy
- Improve Independence and resilience
- Reduce hospital admissions

4. Options considered and recommended proposal

4.1 The aim of the Healthy Aging Framework is to develop a whole system approach .The Health and Wellbeing Board are encouraged to recommend changes in the approach.

5. Consultation

5.1 **Phase 1:** There has been consultation with senior managers across Councillor Roche's portfolio Adult Social Care, Housing & Public Health.
Phase 2: The proposed next steps include a wider stakeholder engagement event in July 2016 to shape the vision and framework and ensure it meets the needs and expectations of all stakeholders.

Phase 3: Agree next steps.

6. Timetable and Accountability for Implementing this Decision

6.1 Timetable to be agreed with the Health and Wellbeing Board.

7. Financial and Procurement Implications

7.1 The framework does not require additional funding. However it will require commitment from partners. It should provide the opportunity for Rotherham's service and projects that focus on healthy ageing to be more coordinated.

7.2 If the Framework is adopted it could influence procurement which will maximise the impact of any procured services in the future.

8. Legal Implications

8.1 There are no identified legal implications at this stage.

9. Human Resources Implications

9.1 There are minimal human resource implications at this stage

10. Implications for Children and Young People and Vulnerable Adults

10.1 The paper will support the health and wellbeing of vulnerable adults by shaping the future direction of services.

11 Equalities and Human Rights Implications

11.1 There are currently no additional equality or human rights implications. Equality issues will be considered as part of the wider stakeholder engagement event.

12. Implications for Partners and Other Directorates

12.1 The activity and reach of the document is cross cutting via a wide range of organisations.

13. Risks and Mitigation

13.1 The collaborative approach to shaping and developing the Healthy

Ageing Framework at the early stages should mitigate the risk of the framework not meeting the objectives of the wide range of stakeholders involved in the healthy ageing agenda.

13.2 The stakeholder engagement will help provide a wider viewpoint on Healthy Ageing framework. Engagement with the community and voluntary sector should help to provide the citizen lens on the framework ensuring that this meets their needs.

13.3 Consultation with older people through existing interest groups.

14. Accountable Officer(s)

Teresa Roche, Director of Public Health

Approvals Obtained from:-

Strategic Director of Finance and Corporate Services:- n/a

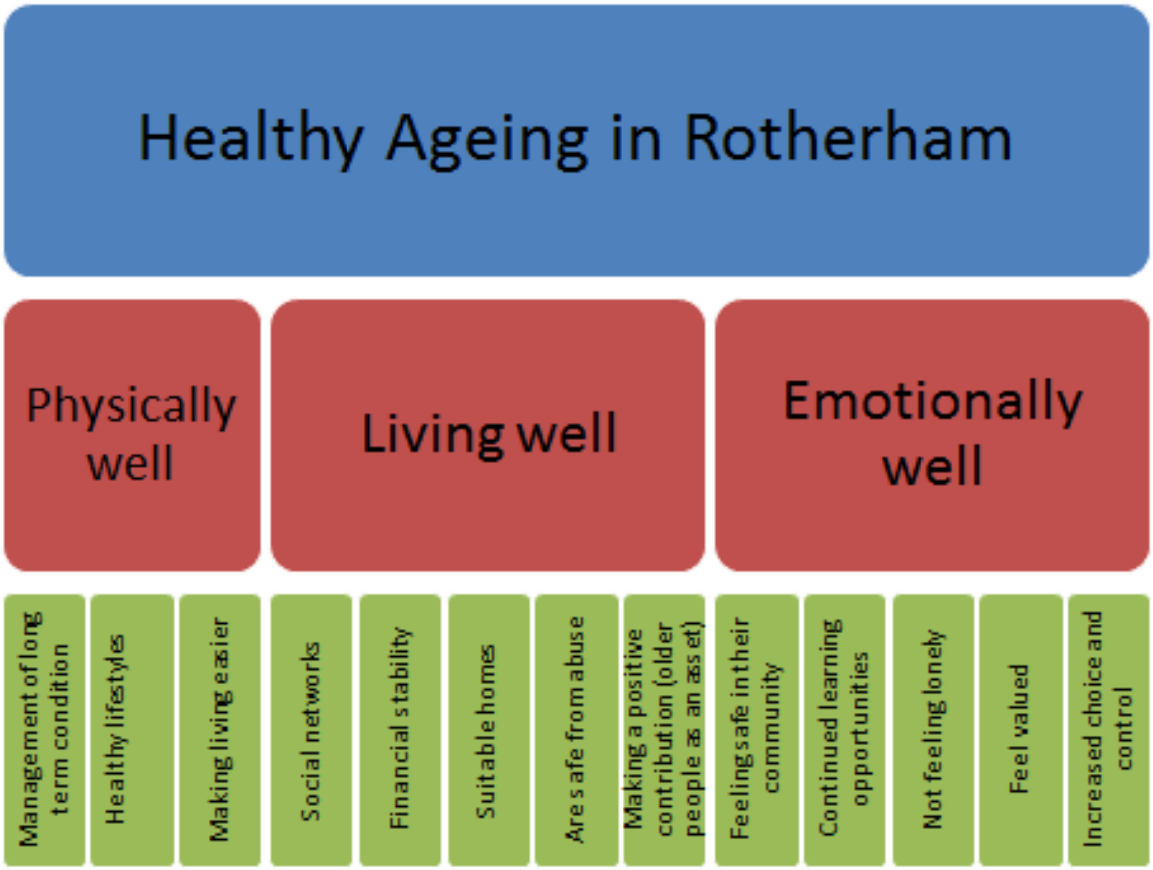
Director of Legal Services:- n/a

Head of Procurement (if appropriate):- n/a

Rebecca Atchinson, Public Health Principal, Healthcare Public Health

Appendix 1

First draft of Healthy Ageing Framework for discussion



Healthy Ageing Framework for Rotherham

The Cabinet lead for Health and Wellbeing has tasked Officers to develop a Healthy Ageing Framework to drive health and wellbeing strategy activity on the "age well" agenda.

Background

Guidance from the LGA (2012) "Ageing well: a whole system approach" recommends a "place based approach". This involves the public sector working together to deliver better value services to citizens through joint working and the reduction of waste and duplication. This allows for creative ways to work which overcomes departmental and agency silos. It also recommends using community assets (what the community already has rather than what is doesn't) to build and support capacity and social capital in local communities.

Issues for Rotherham

Currently there is not a clear vision for Healthy Ageing for Rotherham. There are several strategies that set out priorities and outcomes for health, social care, housing and neighbourhoods for our ageing community. However, these are not always linked together, resulting in fragmented action and opportunities not being maximised.

Methodology

The following actions were undertaken:

- A literature search to review the evidence of place based working for an ageing population.
- A review of good working practice from other areas.
- An initial scoping exercise of existing services within Rotherham

Vision - *to improve the health and wellbeing of the ageing community of Rotherham. Rotherham services work together seamlessly to develop health, independent and resilient citizens who live good quality lives.*

Our ambition is to develop a Healthy Ageing Framework to deliver the ambitions of the Corporate Plan, Health and Wellbeing Strategy and the Sustainability and Transformation Plan. It will be used to help coordinate and maximise the impact of services for our ageing community.

There are a range of strategies and action plans that are delivering elements of the Healthy Ageing agenda. The challenge is how we ensure that there is a key golden thread that runs through all the strategies and ties the projects together. It is proposed that we do this by agreeing and using a common vision and establish a set of consistent tools to monitor performance and delivery against a high level set of outcomes. This would help us to develop an integrated set of principles and could be used to develop a commissioning model of excellence for healthy ageing in Rotherham.

Approaches to improve the health and wellbeing in older people

We recognise that there are a broad range of approaches followed across the system to deliver health and wellbeing improvements. We plan to utilise the range of principles below, within the development of the model.

- Older people being viewed as an asset across Rotherham
- Maximise the use of the community assets to facilitate healthy behaviours within our ageing communities
- Prevention and early intervention to be woven into all pathways to foster independence, citizens improve quality of life and develop strong and supportive communities.
- The Outcome Based Accountability framework to be used to address strategic outcomes e.g. improved healthy behaviours, reduced feelings of isolation and loneliness, improved mental wellbeing and improving independence.
- Personal and community centred approaches which aim to enhance the lives of people and within their local communities.
- Value based approaches to ensure that we prioritise the wider goals of wellbeing, independence, social connectedness, choice and control.

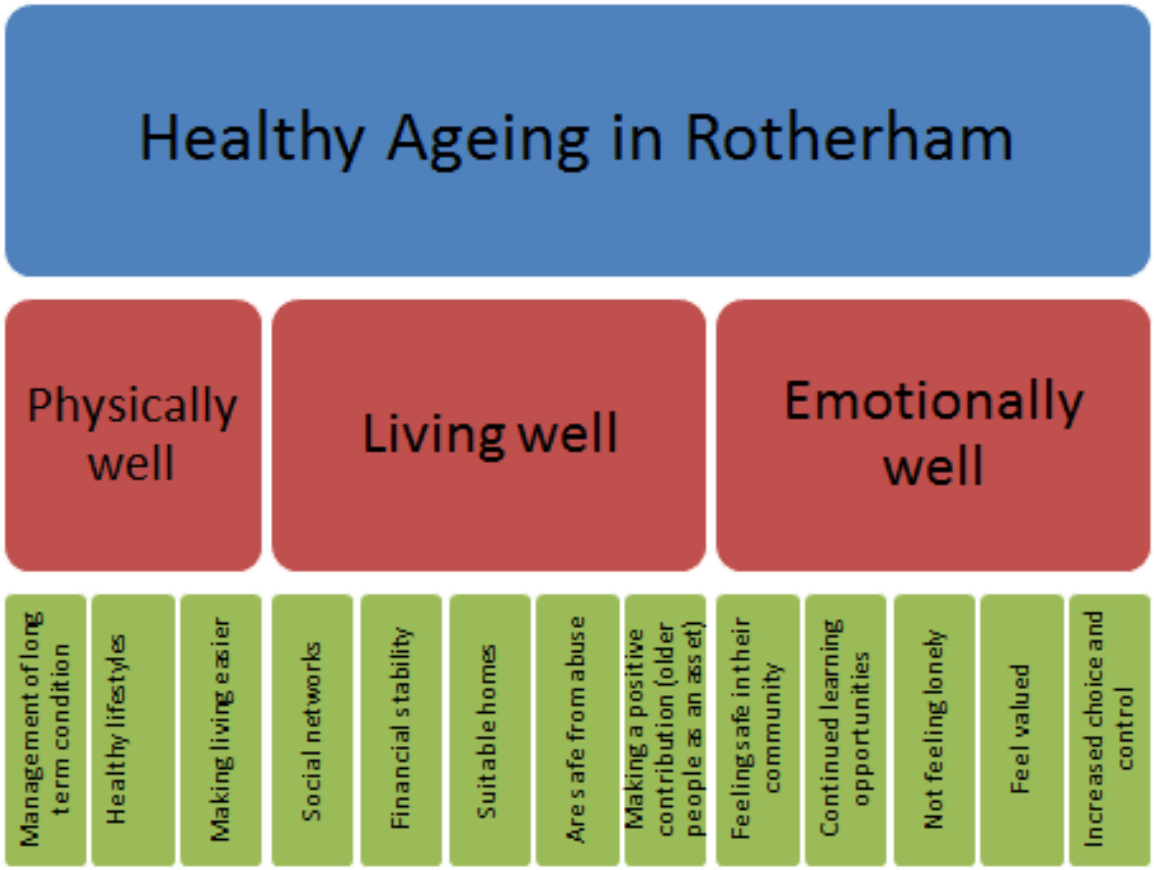
We plan to combine these principles to achieve a set of key outcomes which include:

- Increase Life expectancy
- Increase Healthy life expectancy
- Improve Independence and resilience
- Reduce hospital admissions

Projects that could be mapped against the framework include:

Projects	**Lead**	**Partners**
ADL Smartcare – iagewell-Rotherham	Adult Social Care	Public Health
Shaftesbury House	Adult Social Care	Public Health
Perfect locality	Rotherham CCG	
Active for Health	Public Health	TRFT Rotherham CCG
Social Prescribing	Rotherham CCG	VAR
Community Link Workers	Adult Social Care	
Community Connectors	Adult Social Care	Age UK
Better Care Fund projects	Adult Social Care Rotherham CCG	
Extra Care Housing	Commissioning	Adult Social Care Housing

First draft of Healthy Ageing Framework for discussion



Rotherham Metropolitan Borough Council
Neighbourhoods & Adult Services

NHS
Rotherham
Clinical Commissioning Group

1.	**Meeting:**	**HEALTH AND WELLBEING BOARD**
2.	**Date:**	**1st June, 2016**
3.	**Title:**	**Better Care Fund Plan 2016/17**

4. Summary

The purpose of this report is to provide an overview of the BCF Plan 2016-17 for consideration and ratification, so that the NHS England reporting deadline can be met.

5. Recommendations

That the Health and Wellbeing Board:

(i) Consider the contents of the BCF plan for 2016-17 and ratify the plan.

6. Background

6.1 NHS England advised that the BCF planning and assurance process for 2016/17 would be integrated, as fully as possible, with the core NHS operational planning and assurance process. However, this would not diminish the requirement for plans to be jointly developed with local government partners, and approved by Health and Wellbeing Boards.

6.2 In early March 2016, NHS England issued the BCF planning requirements for 2016-17 which included the completion of a financial planning template and a narrative plan with a comprehensive set of Key Lines of Enquiry (KLOEs)

6.3 There are eight conditions, which local areas have to meet through the planning process in order to access funding which is included in the KLOEs. These conditions require:

(i) That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs;
(ii) A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17;
(iii) Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;
(iv) Better data sharing between health and social care, based on the NHS number;
(v) 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;
(vi) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
(vii) That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
(viii) Agreement on a local action plan to reduce delayed transfers of care.

6.4 The plan has been jointly developed between Rotherham CCG and Rotherham MBC colleagues and is well aligned to the priorities within the Joint Health and Wellbeing Strategy 2015-18, the CCG Commissioning 2015-19, CCG Operating Plans 2016-17 and Provider Plans.

6.5 The CCG received initial written feedback from NHS England on 8th April, 2016, which confirmed that Rotherham HWB Board had submitted a detailed plan, which contains clarity on the deliverables in Rotherham for 2016/17. The HWB vision is clear and the KLOEs have clearly been used in indicating how the national conditions will be met. Overall, Rotherham has provided a very well written plan, the delivery of which may be impacted by the high risk nature of the health economy. Risks and mitigations are usefully included and sufficiently detailed.

6.6 Feedback also included the recommendation that Rotherham's plan needed to contain some evaluation of the schemes and that this would be strengthened by including quantitative data to support qualitative plans.

6.7 The Local Authority received verbal feedback from NHS England's BCF Development and Assurance Manager on 12th April, 2016, which highlighted that we were meeting the majority of KLOEs, but there were around 20 which they had assessed as being "partly met" or "not met". Further work was required on providing more detailed local demographic data, how the plan contributes to the local implementation of the Five Year Forward View, data that supports the case for change including unmet need, non-financial risks and categorisation of BCF schemes contained within the planning template which appeared to be having an impact on the level of funding provided for protection of social services and NHS commissioned out of hospital services..

6.8 The BCF plan 2016-17 now covers all the requirements set out within the guidance provided by NHS England.

6.9 The financial envelope for the BCF 2016-17 has been agreed. This has seen the BCF programme increase by circa £1.0m predominantly in Mental Health, Falls and Intermediate Care.

6.10 There is a requirement to create a fund for the Care Act for the Local Authority. The benchmark value is £0.77m – the proposed budget for Rotherham is £0.7m.

6.11 A revised Section 75 agreement covering the BCF programme for 2016-17 has also been developed and requires approval at the same Health and Wellbeing Board meeting on 1st June, 2016. NHS England guidance states that all Section 75 agreements need to be fully signed by all partner organisations by 30th June, 2016.

7. Contacts

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Nathan Atkinson, Assistant Director of Adults Commissioning, Rotherham MBC

Email: nathan.atkinson@rotherham.gov.uk

Rotherham Better Care Fund Plan

May 2016

Local Authority

Rotherham Metropolitan Borough Council

Clinical Commissioning Group

Rotherham Clinical Commissioning Group

2016/17

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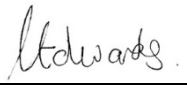
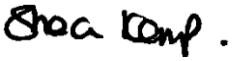
1. Plan Details

Local Authority	Rotherham Metropolitan Borough Council
Clinical Commissioning Groups	Rotherham CCG
Boundary Differences	The map in the attached document below shows that the geographical boundary of Rotherham MBC is co-terminus with Rotherham CCG. Map of Rotherham.docx
Date agreed at Health and Well-Being Board:	20/04/2016
Date submitted:	25/04/2016
Total agreed value of pooled budget: 2016/17	£24,323,000

2. Authorisation and sign off

Signed on behalf of the Clinical Commissioning Group	
By	Chris Edwards
Position	Chief Officer
Date	3rd May, 2016

Signed on behalf of the Council	
By	Sharon Kemp
Position	Chief Executive
Date	3rd May, 2016

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor David Roche
Date	3rd May, 2016

3. Vision for Adult Services

The overarching vision for our health and social care services is to empower people to live independently in the community. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better service and better quality of life. We will achieve this through a strategy of early intervention and prevention. We will integrate services to improve the health and well-being of people in Rotherham. We will focus on information, prevention, enablement, rather than providing ongoing support which increases dependence and reliance on health and social care services. We will build resilience by empowering individuals, families and communities and provide better support for carers so that they can continue in their caring role.

We will develop effective joint commissioning arrangements which drive the integration of services. We will promote multi-disciplinary working between primary care, social care, mental health, community health services and the voluntary sector. We will expand community based services, reducing reliance on the acute sector.

We will streamline and simplify care pathways, providing better information, advice and signposting to the third sector for ongoing support. We will ensure that better information sharing between health and social care services.

Service integration will be used as a vehicle to deliver "parity of esteem". Integrated locality teams will incorporate mental health staff, working alongside health professionals whose focus is on physical health. Care planning and support will address the psychological and physical needs of the individual, recognising the huge overlap between mental and physical well-being.

We will ensure that staff working in the health and social care economy understands the specific needs of people with mental health and learning disabilities. We will do this through training and education, effective partnership working and integrated care pathways. We will ensure that the appropriate care pathway is selected to support both the patients' physical and mental health. Our vision is consistent with that set out in Rotherham's Mental Health Adults and Older People's Transformation Plan which is available at:
http://moderngov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=103679

The Rotherham BCF Plan is consistent with the aims of the NHS Five Year Forward Plan. The Forward Plan emphasises the need to develop new care models to which support integration. A central theme of our plan is the development of integrated service models intermediate care services, locality teams, rapid response, carer support and first point of entry.

The overarching vision for Rotherham's BCF Plan can be translated into the following local priorities. These are aligned with the outcomes set out in Rotherham's Health and Well Being and Rotherham CCG's Commissioning Plan, CCG Operating Plan and Provider Plans.

1. An integrated health and social care delivery system which promotes joint working
2. An integrated commissioning framework with joint outcomes and service specifications
3. More care and support provided in people's homes
4. Integrated care planning that addresses physical and psychological wellbeing

5. Individuals and families taking more control of their health and care
6. Accurate identification and active case management of people at high risk of admission
7. Broader use of new technology to support care at home
8. A financially sustainable model that targets resources where there is greatest impact

The impact of the BCF Plan on patient and service user experience will be significant. As a result of the changes we will make, we expect that all service users, patients and their carers will have confidence in the care they receive and feel supported to live independently, manage their conditions and participate in their community. They will feel well and less likely to rely on acute services, resulting in a reduction in overall pressure on the hospital and health budgets. Although, when acute care is the best option for people, they are helped to move quickly back into their community when they are ready to do so. We will see a greater shift from high cost reactive care, to lower cost, high impact preventative activity. Our expectations are reflected in the service users feedback collected on a regular basis; for example through the Friends and Family Test carried out across hospital and community services.

4. Evidence Base

4.1 Health and Wellbeing Strategy

The Rotherham Health and Wellbeing Strategy (2015-18) sets out Rotherham's overarching vision to improve health and well-being, enabling people to live fulfilling lives, to be actively engaged in their community and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board has made a commitment to ensure the commissioning and delivery of services which are more integrated, person-centred, providing high quality care and accessible to all.

The Better Care Fund Plan contributes to the following strategic objectives identified in the local Health and Wellbeing Strategy.

- All Rotherham people enjoy the best possible mental health and wellbeing
- Healthy life expectancy is improved for Rotherham people and the gap in life expectancy reduced
- Rotherham has healthy, safe and sustainable communities and places.

The full Health and Wellbeing strategy is available at:

http://www.rotherham.gov.uk/hwp/downloads/file/4/rotherham_borough_joint_health_and_wellbeing_strategy_2015-18

The Health and Wellbeing Strategy takes account of the local health and well-being needs identified through the JSNA which is available at http://www.rotherham.gov.uk/jsna/

4.2 Rotherham CCG Commissioning Plan

The Rotherham CCG commissioning plan is currently in final draft format and the Better Care Fund plans for 2016-17 have been incorporated, the 2015-19 plan incorporates a section dedicated to the Better Care Fund, plan on a page with reference to Joint Working as a key priority, BCF Metrics and Quality Premiums and can be viewed at http://www.rotherhamccg.nhs.uk/

4.3 Sustainability and Transformation Plan (STP)

Every health and care system across England has been asked to come together, to create its own ambitious local blueprint for accelerating implementation of the Five Year Forward View. The South Yorkshire and Bassetlaw STP covers populations living in Sheffield, Barnsley, Rotherham, Doncaster and Bassetlaw.

The five CCG local place-based plans (Rotherham CCG's Commissioning Plan and BCF Plan) will form the foundation of the approach we will take to developing our STP. Key local priorities within local plans include: out of hospital care, end of life care, children's and healthy lives, living well and prevention.

Complementing these, and based on knowledge of local need and challenges and national guidance, five transformation workstreams have been established for South Yorkshire and Bassetlaw. Each is being led by both a provider or local Chief Executive and commissioner Accountable Officer.

The five priority workstreams are:

- Urgent and emergency care
- Elective care and diagnostics
- Cancer
- Mental health and learning disabilities
- Maternity and children's services

4.4 Joint Strategic Needs Assessment

Rotherham's JSNA shows that the population of Rotherham is at its highest ever level, at an estimated 260,800 in 2016. 49,800 people are aged 65 or over and 5,700 are aged 85 and over. By the year 2020, the number of older people is predicted to increase to 54,200 and the 85 year and over age group will increase to 6,900.

There are now estimated to be 3,100 people over 65 living with dementia in Rotherham. 10,300 people aged over 75 live alone, half of all people in this age group. Around 4,000 older people experience significant loneliness on a daily basis. Two thirds of householders over 65 own their own homes, although the proportion reduces with age to 52% of those aged over 85.

An estimated 18,500 people over 65 (40%) need some help with domestic tasks and 15,200 (33%) need help with self-care. 18% of people over 65 need assistance with some aspect of mobility such as walking or climbing stairs. 41% of people over 65 have some form of hearing impairment and 9% have a moderate or severe visual impairment. Incontinence affects 19% of people over 65, rising to a third of those aged over 85 years.

The number of older people (65+) is projected to rise by 7,300 (15%) between 2013 and 2021 and the number aged 85+ is projected to rise by 1,500 (28%) by 2021. The number of people aged over 75 living alone is projected to increase by 2,100 or 20% between 2012 and 2020. The number of people over 65 who need help with domestic tasks or self-care is predicted to increase by 17% between 2012 and 2020. The number of people aged over 65 with dementia is predicted to rise from 3,100 in 2012 to 3,700 by 2020, a 19% increase. The number of people over 65 admitted to hospital after a fall is predicted to increase by 20% between 2012 and 2020.

The JSNA predicts a substantial increase in the number of adults with additional health and social care needs over the next five years. This prediction is made on a backcloth of substantial reductions in social care investment. Also, increases to the NHS budget are unlikely to keep pace with the rising demand for services. So this strategy is important. If the demographic challenge is to be met it will require a joint approach to commissioning service delivery. Effective joint commissioning can remove duplication, increase economies of scale and, through early prevention, reduce interventions further up the care pathway.

The health and well-being needs of the ageing population continues to increase as older people are likely to experience disability and limiting long-term illnesses and lower quality of life. The JSNA highlights that falls in older people are of a particular concern because of the risk of hip fracture and subsequent morbidity and mortality. We are below the national average for injuries due to falls in older people. Our Integrated Falls and Bone Health care pathway is crucial in improving patient outcomes, providing early intervention to restore independence and prevent frailty.

Rotherham's Market Position Statement highlights that there is a predicted increase of 25% for formal support required by 2020 and a 58% increase in demand by 2030, particularly for those people with conditions such as dementia, depression, mobility, hearing impairment, incontinence and diabetes.

The Market Position Statement is available at:

http://www.rotherham.gov.uk/downloads/file/959/market_position_statement_for_older_peoples_services_2014

The Rotherham BCF plan is aligned with all of the above emerging population needs. The services currently funded through BCF and all the local priorities focus on addressing the impact of the ageing population. Through a combination of integration, prevention and case management the BCF Plan can deliver better outcomes for the growing population of older people and reduce pressure on the local health and social care economy

4.5 Mapping BCF Services

The Rotherham BCF Programme recently completed a full review of services funded through the Better Care Fund (Appendix 1). The review considered the following criteria when assessing the current BCF service areas;

Strategic Relevance	Does the service address BCF metrics?
Service Specification	Is there a specification for this service?
Performance Framework	Is there a performance framework in place?
Performance Issues	Are there any issues relating to performance of the service?

The report made the following recommendations for each service area

Ok	Service exists, strategically relevant with evidence of good performance
Review	Service exists, realignment required on funding or performance issues
Reallocate	Funding is not linked to the service area identified and needs reallocating
Merge	Merge schemes that relate to the same service area

The service review has been successful in understanding areas of unmet need within Rotherham and areas of excellence across the health and social care economy. The review also identifies services which require more detailed review due to performance or quality issues. 18 service areas have been identified for further review. A number of others require a service level agreement and specification so that it is clear what they do and how they will be monitored.

4.6 Examples of Reviews

Social Prescribing

Patients with long-term health conditions are reaping huge benefits from being prescribed non-medical treatments by their doctors. 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 at high risk of hospital admissions. The service has received a national "Excellence in Participation Commissioner" award.

The service reduces inappropriate admissions into hospital, reduces attendances at GP practices and provides sustainability to the voluntary and community sector. The service also improves quality of life, reduces social isolation and moves the patient from dependence to independence.

A review in October 2015 of the Social Prescribing service assessed the strategic relevance of the service, the impact it is having, the benefits and improvements that patients felt and the impact on BCF outcomes. For example, in the case of non-elective patient admissions the review showed a 7% reduction in Finished Consultant Episodes (FCEs), an 11% reduction in Inpatient Spells and there was a 17% reduction in all A&E attendances across all patients (Appendix 2).

More than 2,000 patients with long-term health conditions, and at risk of hospital admission, have been referred for a social prescription. All 31 GP practices in Rotherham have signed up to the project.

The evaluation also found even better reductions in those aged 80 and under, and for those who engaged with voluntary sector-led activities over a sustained period. 82% of service users, regardless of age or gender, also reported a positive change in their well-being within four months of being issued with a social prescription.

This analysis provides an excellent case for the social prescribing service remaining within the BCF programme in future years. It demonstrates how outcomes can be improved for patients through the appropriate use of BCF funding.

Intermediate Care

This service review demonstrated that Rotherham's Intermediate Care Service is performing well across the majority of KPIs. There are, however, issues with the eligibility criteria, the lack of nursing/EMI resource and delays with patient flow. The review references CCG audits which show that there are still significant numbers of hospital admissions that could be redirected to intermediate care. For example, an audit carried out last year showed that 23% of MAU admissions were avoidable. 14% these patients were subsequently admitted to hospital despite the fact that they did not have an acute medical need. The audit concluded that 29% of MAU admissions could have been dealt with in

an alternative setting. The alternative settings identified included intermediate care services. The review also highlighted gaps in the eligibility criteria. Patients with 24/7 nursing needs and/or those with high levels of dementia are currently unable to access the intermediate care service.

The Intermediate Care Review considers options for the future development of the service. The ambition is to provide a single centre of excellence for intermediate care. This will deliver economies of scale, broaden the range of people who can receive support and act as a vehicle for health and social care integration.

4.7 Directory of Services

Appendix 3 sets out the Directory of Services (DoS) for BCF that came from the review. The BCF DoS describes a new structure for categorising BCF funded schemes. The schemes are grouped using the following themes.

1. Mental Health Services
2. Rehabilitation, Reablement and Intermediate Care
3. Supporting Social Care
4. Case Management and Integrated Care Planning
5. Supporting Carers
6. BCF infrastructure

A brief analysis of each service categorised under the BCF plan 2015-16 (BCF01 TO BCF15) compared to the new Themes 1-6 is set out in Appendix 4 The BCF Review and Directory of Services provide clarity on where BCF funding is currently being invested and the strategic relevance of each scheme. Commissioners have prepared a review schedule, a monitoring tool and review template. The next steps are:

(i) To develop service level agreements and specifications for those services that don't have them
(ii) Undertake a series of individual reviews on services where there are funding or performance issues or where there are concerns regarding strategic relevance.
(iii) Commissioners monitor and review progress of the reviews throughout 2016-17

Although the service review has re-categorised existing services there has been no initial negative impact on provision. Where changes in funding have been identified in the financial plan for 2016-17 they relate to existing funding that has been pooled into the BCF budget. It is likely that the 'deep dive' reviews of specific provision identified through the 2015-16 service review will involve changes to service provision. A robust monitoring tool has been developed to ensure that impact of each review is closely monitored through the BCF governance structure and is discussed in detail later in the plan.

5. Case for Change

5.1 Record on Joint Commissioning

Rotherham has a strong record of joint commissioning between health and social care. We have a joint commissioning framework and governance structure which incorporates joint needs assessment, supply mapping, market analysis, pooled budgets and performance management. This has prepared

the way for new developments in integrated care which will support people with complex needs to remain independent in the community.

Services that are already subject to joint commissioning and/or pooled budget arrangements include the Rotherham Intermediate Care Service, Community Occupational Therapy Service and the Integrated Community Equipment Service. All jointly commissioned services provide support on activities of daily living, ensuring that patents achieve the highest level of independence. All services help prevent deterioration and minimises loss of function caused by illness or disability. They reduce the risk of admission to hospital by ensuring that people are living in a low risk physical environment where they can function autonomously. The service empowers patients so that they maximise their potential to engage in meaningful and productive activities/occupations. These services deliver health and social care outcomes. They perform well within a robust joint performance management framework.

Rotherham has been successful in achieving a 20% reduction in non-elective admissions to hospital over the last 4 years. This enabled a substantial investment in additional community services supporting the BCF Plan last year. The continued investment through the Community Transformation Programme will improve outcomes for service users and prevent future increases in hospital admissions that would otherwise be expected from the demographic changes.

5.2 Development of New Care Models

Despite these successes current models of care are not designed for the health challenges of today. The ageing population, changing disease burden, and rising expectations demand fundamental change. For example the following community transformation performance indicators can be driven down further through effective implementation of the BCF Plan

Table 1: Community Transformation KPIs Influenced by the BCF Plan

KPI	Performance 15/16	Target 15/16
People >50 years attending A&E with a fragility fracture	99/month	118/month
No. of people over 55 with a fractured neck of femur	23.7/month	23.0/month
No. of GP referrals to the Medical Assessment Unit	229/month	261/month
No. of unscheduled admissions of patients >65years	664/month	730/month
No. of long stay patients over 14 days	86.7/month	213/month

Changes to the traditional models of care have already started to gain traction. For example, in 2014/15 469 older people were permanently admitted to residential and nursing care, compared to a predicted out-turn of 410 people in 2015/16. 537 adults were in receipt of day care in 2015/16, compared to 644 the previous year. This year 85.2% of adults who received home care enablement services were discharged without needing any long-term formal care from social care services.

We have increased patient utilisation of residential intermediate care from 587 in 2014/15 to 613 2015/16. This has been achieved within the same cost envelope. Similarly, in 2015/16 550 adults received community and day rehabilitation services in Rotherham, compared to 500 2014/15.

5.3 How Can the BCF Plan Support Development of New Care Models

The BCF Plan provides an opportunity to support the development of new care models. BCF has the potential to offer better value for money, a more cohesive model of care and better outcomes for people. The Better Care Fund acts as a "stepping stone" to the longer term transformation of services. The requirement that local plans should be part of a five-year strategy for local health and social care services will be a helpful spur to look beyond the immediate short-term pressures and develop a shared vision of what future local services should look like.

This will include the move towards Multi-specialist Commissioning Providers (MCP). A new care model outlined in the NHS Five Year Forward View, which sees GP group practices expand, bringing in nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care. The implementation of the integrated locality team pilot outlined in Section 10 Key Priorities is intended to examine the far wider range of care needed by registered patients through a multi-specialist team in order to acquire learning for future models.

6 Analysis of Out of Hospital Services

Rotherham has a range of high quality Out of Hospital Services which promote independence, prevent hospital admission and support hospital discharge. Out of Hospital Services fit into 3 main categories:

1. Admission Prevention and Supported Discharge Care Pathways
2. The Care Coordination Centre
3. Locality Based Community Nursing Teams

Our Out of Hospital Services support the reduction of avoidable non-elective hospital admissions and re-admissions. They promote 7 day working, facilitate timely hospital discharge and improve patient experience.

6.1 Admission Prevention and Supported Discharge Pathways

In Rotherham there are three admission prevention and supported discharge pathways. These are all supported by the Better Care Fund.

Pathway 1: Hospital to Home

Pathway 1 supports patients who are medically stable, but cannot be supported at home with generic health and social care services. Rotherham CCG and Rotherham MBC jointly commission an Integrated Rapid Response Service to support discharge and prevent admission for this cohort of patients. The Integrated Rapid Response Service operates 24/7, 7 days/week, providing short term therapy, nursing and social care support.

Pathway 2: Intermediate Care

Pathway 2 provides residential rehabilitation to patients who cannot return home. The aim is to maximise independence and optimise patients who do not have nursing needs. The Intermediate Care Residential service supports all patients on Pathway 2.

Intervention focuses on active enablement with view to maximising independence and returning home. The service is provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy and treatment.

The care plan sets out agreed rehabilitation goals and milestones. The service is time-limited, normally no longer than six weeks with average stay of 18 days. There are currently 50 beds across the borough, commissioned jointly by RCCG and RMBC. The Intermediate Care Residential Service accepts admissions 7 days/week.

Pathway 3: Discharge to Assess

Pathway 3 provides 24/7 nurse-led care for adults with complex care needs who are medically stable. The pathway is for patients who need a place to recover from an acute illness before an assessment can be made about their long term care needs.

Pathway 3 provides residential assessment and rehabilitation for patients with nursing needs. It also supports patients who trigger positive for the CHC checklist but have not yet had an assessment.

Pathway 3 services are delivered by The Oakwood Community Unit, Breathing Space Inpatient Beds and Waterside Grange Residential and Nursing Home.

Oakwood is a 20 bed nurse-led unit situated in the grounds of Rotherham District General Hospital. Work is currently underway to reconfigure the unit so that it is better able to meet the needs of Pathway 3 patients.

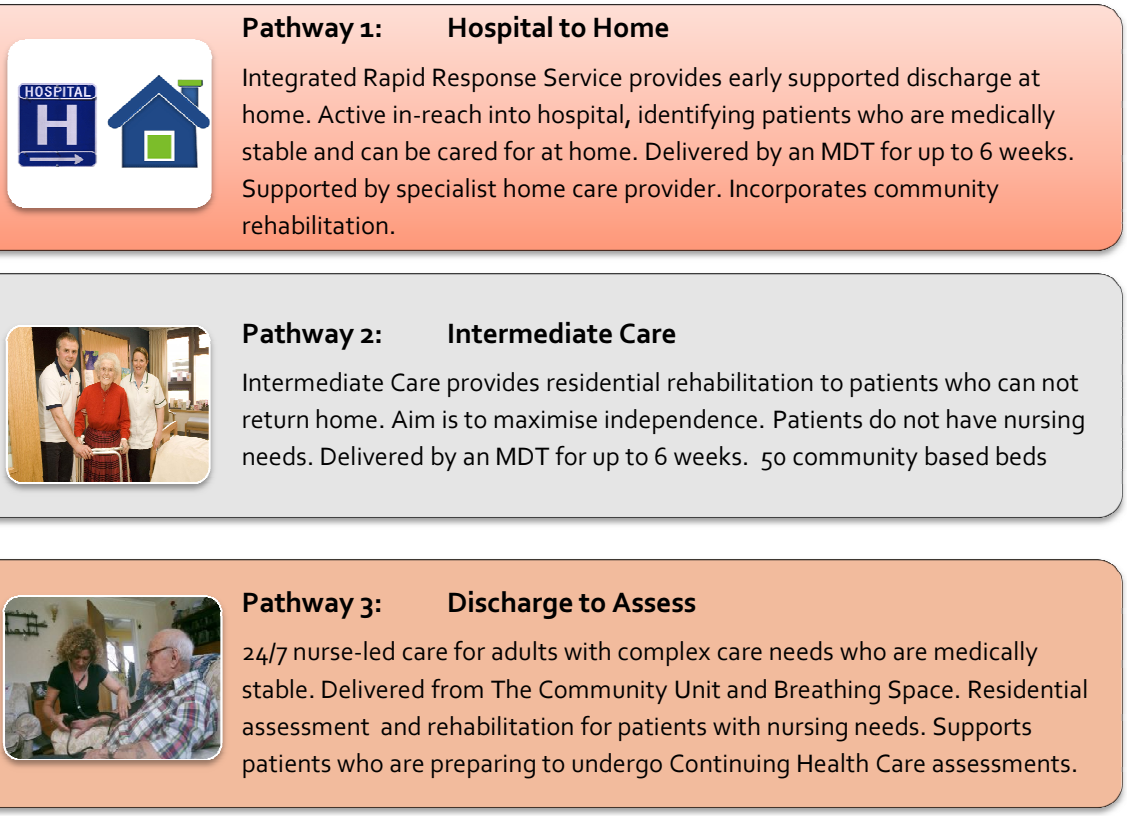
Breathing Space is a 20 bed nurse-led unit focusing on patients who have COPD and other respiratory conditions. It is both a step-up and step-down facility for this cohort of patients.

Rotherham CCG and Rotherham MBC also jointly commission, through BCF, 6 independent sector nursing home beds at Waterside Grange Residential and Nursing Home to support Pathway 3 patients.

The Community Unit, Breathing Space and Waterside Grange play a pivotal role in facilitating timely discharge from hospital for those patients who no longer require specialist acute care. All Pathway 3 services will receive admissions 7 days/week.

Figure 1 summarises the pathways that Rotherham currently operates for admission prevention and supported discharge.

Figure 1: Admission Prevention and Supported Discharge Pathways



6.2 Care Coordination Centre

The Care Coordination Centre (CCC) has been a key vehicle for delivering Better Care Fund outcomes in Rotherham.

The CCC acts as an access hub for community health services. On supported discharge the CCC holds a register of patients in an acute bed, whose medical episode is complete. It actively engages with the relevant community services to ensure that patients are placed on the right discharge pathway.

The CCC coordinates transfer to the relevant service. It monitors outcomes and identifies where there are capacity issues within each care pathway. The CCC supports the commissioning process by identifying where there is under and over-utilisation of services on each care pathway.

The CCC also receives all hospital based referrals for community nursing services. Transferring responsibility to the CCC for these calls will ensure that health professionals and patients are able to speak to a clinician about the most appropriate level of service. Figure 2 summarises the full functionality of the Care Coordination Centre.

Figure 2: Current Functions of the Care Coordination Centre

GP Support Service

Access point for GPs requre an alternative level of care for a patient. Advises on available range of services. Makes referrals, arranges placements and co-ordinates transport. Includes community pathway for suspected DVT.

Telehealth

Telehealth hub for patients with heart failure. Patients submit health data electronically. Collated and assessed to establish whether defined thresholds have been reached. Response coordinated.

Urgent Response Service

Single point of access for NHS 111 and the 999 ambulance service into alternative levels of care. CCC forms part of the YAS Pathfinder Project which supports ambulance crews when patients do not require A&E services

24/7 Service

Service will receive out-of-hours calls from patients and health professionals who require access to comunity health services or who have an urgent health need.

Supported Discharge

Service holds a register of patients in an acute bed, whose medical episode is complete. The CCC will actively engage with relevant services to ensure that patients are place on the right discharge pathway.

Single Point of Access for Community Nursing Referrals

Receive all hospital based referrals for community nursing services. The CCC carries out task allocation for all community nursing teams. Primary care referrals can be submitted to the CCC or direct to teams

6.3 Locality Based Community Nursing Teams

In Rotherham, our newly reconfigured, locality based community nursing teams support the transition from hospital to community. Although not currently funder through the Better Care Fund, they are a key vehicle for delivery of the 2016/17 BCF programme. The current service model incorporates 7 community nursing teams serving GP practice populations. The teams service geographical clusters of GP practices.

Additional resources have already been approved for investment into the community nursing service. New staff nurses have already been recruited and deployed. Clinical Team Leaders have been introduced to take responsibility for performance and quality. The new service model delivers better leadership and clinical supervision for staff, creating an environment where nurses can safely care for patients with a higher level of need.

The Community Transformation Team has worked with the provider to reduce the administrative burden on the community nursing service. Community nurses no longer responsible for completing Continuing Health Care assessments. There has been a full roll out of IT equipment for community nurses.

The focus on practice populations has supported partnership working between community and primary care. The service model uses an allocation formula which ensures equitable distribution of community nursing resources across the borough. Finally the service is now underpinned by a comprehensive service specification, a coherent system of governance and a robust performance management framework.

7. Adult Social Care Development Board

The Adult Social Care Development programme has been established to redesign the Rotherham approach to social care to ensure Care Act compliance, provide better outcomes for customers and generate savings. The programme direction is based on good practice nationally and pulls on resources regionally and further afield to support the delivery of improved outcome and best value. Five initial priorities have been identified:

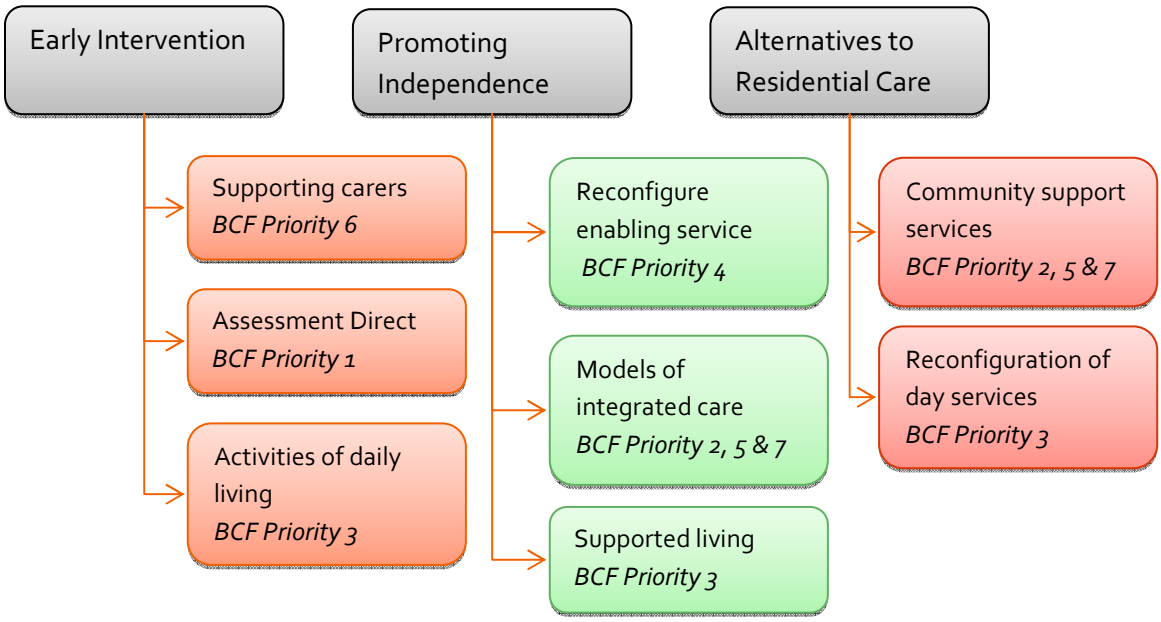
- Safeguarding
- Strategies
- Developing community assets
- The customer journey
- Alternatives to traditional care

Delivery of this programme in full is likely to take three to five years, the direction and scope of changes will need to be reviewed and reshaped through the programme. There are key decisions that will need to be taken around the size and shape of the in-house offer. Options will need to be worked up, consulted on and decisions made. Some changes which will improve the offer for the citizens of Rotherham are likely to cause significant concerns for customers already in the system and this need to be carefully balanced to ensure long-term sustainability. The timing of decision making will impact on the overall delivery of the programme. A development board consisting of partners within health and social care in Rotherham has been established to monitor delivery of the programme.

Changing adult social care cannot be done in isolation and this programme will have implications across the Council as well as a need to work closely with colleagues in the NHS and third sector to ensure that the programme acts collaboratively to improve outcomes for the citizens of Rotherham and support people to remain independent and connected for longer. Adult social care will need to develop better partnership arrangements with the independent sector to develop flexible and innovative options for the future. Resources from other areas that are further forward in this area of work are already being optimised and this will need to continue to do this as the programme progresses. It is vital that the programme develops and embeds a culture of co-production with people that use services and their families through regular use of experts by experience, working parties and involvement of customers in service design.

Figure 3 identifies the priorities of the Adult Social Care Transformation Programme that are most relevant to this plan. It also links each workstream to the relevant BCF priority (Section 10)

Figure 3: Summary of the Adult Social Care Programme and Links to the Better Care Fund



8. Improving Quality and Reducing Costs

This section of the BCF Plan considers some of the initiatives which have improved quality whilst at the same time increasing levels of efficiency. These initiatives support the reduction of avoidable non-elective hospital admissions and re-admissions. They promote 7 day working, facilitate timely hospital discharge and improve patient experience.

8.1 Risk Stratification

Rotherham has a well-established risk stratification tool, which uses a combination of primary and secondary care data to select the top 3% of the population who are at highest risk of hospital admission. This has enabled the targeting of case management on those who are likely to require intensive support further down the care pathway.

8.2 The Rotherham Case Management Programme

Having identified those people who are at greatest risk of being a high user of health and social care services, Rotherham' Case Management Programme places GPs at the forefront of care planning, self-management and care coordination. The main aims of the Case management Programme are;

- To reduce the unnecessary utilisation of secondary care services and therefore cost
- To facilitate improved quality and co-ordination of care in the community setting
- To improve the quality of care for older people
- To improve self-care by patients

The Case Management Programme is fully funded through the Better Care Fund. A key function of the programme is to empower GPs to act as care coordinators, taking overall responsibility for all health and social care input. The GP has a full understanding of the role of other parties in the care of an

individual patient. The Case Management Programme relies on the development of an integrated care plan which incorporates; medical review, analysis of social factors, exacerbation plans and place of care preferences. The integrated care plan is reviewed every 4 months and supported by regular MDT meetings with the full range of health and social care professionals.

8.3 The Social Prescribing Programme

The Rotherham Social Prescribing Programme is funded through the Better Care Fund. Its main function is to make the wide range of 3rd sector services in Rotherham available to the GP Case Management Programme. Voluntary Action Rotherham (VAR) have been commissioned to employ a social prescribing team which maps voluntary and community services across the borough. The team will attend case management MDTs and link patients into services that promote community integration and reablement. VAR provide a one-to-one service to people on the Case Management Programme, motivating, signposting and supporting them to access services in the voluntary and community sector. The service addresses directly the unmet social needs that often evolve from the case management process. These needs are met before intervention is required from formal social care. The service promotes self-care, protects social care services and supports a holistic approach to care planning.

This initiative has recently been recognised nationally and is being recommended for inclusion in Sustainability and Transformational Plans (STPs).

8.4 The BCF Service Review 2015/16

Rotherham MBC and Rotherham CCG have carried out a joint review of all service areas funded through BCF. The review measured services against the following criteria;

- Strategic relevance of the cost centre or service specification to the Better Care Fund
- Performance against BCF metrics
- Whether the funding is being used for the service it was originally intended for
- Whether BCF funding for that service area is value for money
- Whether the service is fully funded by the BCF or is funded from other sources

The review of BCF services was completed in December 2015 and informed the development of a local BCF Directory of Services . The Rotherham BCF Directory has delivered a simpler, more coherent structure to the BCF programme. It includes the cost of each service, a brief description of what it delivers and how it supports achievement of the BCF metrics. Alongside this Rotherham has agreed a schedule of service reviews for 2016/17. These reviews will target services where there are issues around strategic relevance, performance or value for money. The reviews will make recommendations on;

- Whether service should continue to be commissioned
- Whether the service requires redesign
- Whether the service requires investment or disinvestment

8.5 Supporting People with Dementia

Rotherham has invested in a range of initiatives aimed at supporting people with dementia. Many of these are funded directly through the Better Care Fund. All of these services contribute to the evolving multi-agency approach to dementia care.

Carers Support Service

This is a domiciliary based care service provided in the persons own home. People are provided with 30 hours flexible support. They are then reviewed and assessed for ongoing support requirements. The service is available 24/7.

Dementia Enabling

This service offers personal care, assistance with medication, social stimulation and carer breaks. The service is available 24/7.

Dementia Reablement

This service is available for 6 weeks, can be extended to 8 weeks. The aim of the service is to support discharges, offer support to prevent admission to hospital/residential care and to prevent readmission to hospital. The service will work to re-establish routine and support the family/carer. Available 24/7.

Dementia Support Workers

Dementia Support Workers assist people with dementia and their carers to identify their needs and to access services. Give information support and guidance. Signpost and refer to other services.

Memory Cafes

Monthly Memory Cafes are provided across four areas along with two Singing for the Brain Groups. The service aims to help people to come to terms with their diagnosis, live well with dementia, offers choice through person centred support planning, reduces social isolation, increases access to information, helps maintain independence and life skills, improves and maintains health and well-being, helps maintain hobbies and interests and helps avoid crisis such as unplanned admission to residential or hospital care.

Carers Information and Support Programmes (CrISP 1 & 2)

CrISP courses are for carers, family members or friends of people with dementia to improve knowledge, skills and understanding. CrISP 1 is designed for recent diagnosis of dementia. There are four sessions covering understanding dementia, legal and money matters, providing support and care, coping day to day and next steps. CrISP 2 is designed for families, carers and friends of people who have been living with dementia for some time. There are three sessions covering understanding how dementia progresses, living with change as dementia progresses, living well as dementia progresses including occupation and activities.

Carers Resilience Service

This service is provided jointly by Crossroads Care Rotherham, Alzheimer's Society and Age UK. Each GP practice has a named link worker who identifies and support carers of people with Dementia. The link worker takes referrals and can provide information sessions to staff as required.

When a carer is referred by their GP they are contacted by a Dementia Advisor within 5 days of the referral being received. An initial assessment of need is carried out. The period of support will be 1 month. Where appropriate carers are then signposted to other organisations who can offer support e.g. Assessment Direct, aids and equipment, social activities, benefits checks.

Cognitive Stimulation Therapy (CST) Sessions

These are provided in the community and offered to all patients and families as clinically appropriate following diagnosis. Sessions are led by OT's and nurses from the Memory Service. Sessions are delivered in line with the 'Making a Difference' programme, but with the added option of including relatives/carers if appropriate.

Occupational Therapy

The Memory Service has dedicated OT resources. OTs contributes to MDT case discussions and reviews. In terms of their direct clinical work with patients and carers the OTs offer a range of assessments and interventions focusing particularly on promoting and maintaining safety, meaningful activity, independence and well-being. The OTs are involved in a range of ways, for example they work collaboratively with social care re assessment and provision of assistive technology and other equipment/adaptations. They carry out ADL home assessment and environmental safety and improvement work, give input and guidance on a wide range of therapeutic interventions to support health promotion, falls prevention, well-being and quality of life

Social Prescribing

This is coordinated by Voluntary Action Rotherham. The Memory Service and GPs can refer people with Dementia for referral/signposting to activities, services, befriending and other sources of support.

9. What has the Better Care Fund Achieved This Year?

There have been significant achievements since the last BCF plan in 2015/16.

We have reviewed all jointly commissioned services during 2015/16. The review has highlighted where BCF schemes are strategically relevant, those services that have performance issues and those that require further investigation in 2016/17.

We have developed a Directory of Services for BCF. The directory provides clear visibility to all key stakeholders on what services are funded. It provides a summary specification for each service, sets out objectives and describes relevance to the BCF metrics.

We are successfully matching adult social care records with their NHS number, providing a single identifier that can be used across health and social care. We have already started to look at how we can match records to improve the quality of joint commissioning. We are also identifying the highest cost individuals across the health and social care economy with a view to providing a more integrated and cost-effective service.

We have expanded the Mental Health Liaison Service. The service supports wards and care homes when delivering care to people who have mental health issues. It focuses on those parts of the health and social care economy that work with people who have a physical condition. One of the key aims of this service is to reduce admissions to hospital and to limit average length of stay.

We have developed an integrated falls and bone health care pathway. There is evidence that reducing the number of fragility fractures among people over 55 years has an impact on health and social care costs later in life. The integrated falls and bone health service tracks older people who have had a fragility fracture and offers follow-up support to reduce the risk of falls and osteoporosis.

The Better Care Fund has been used to maintain provision of social care. This includes the use of direct payments, residential care and social work in case management programmes. All social care domiciliary care providers are now contracted to respond to urgent hospital referrals over the weekend to facilitate discharge. The BCF Fund has supported the recruitment of a Quality Officer (Health) within the Care Home Support Service. This post is integral in ensuring that health issues are addressed when monitoring contract quality and performance. The post will work flexibly across health and social care.

Through use of BCF we have commissioned 7 Adult Social Care Assessment beds to support discharge patients who require further assessments to optimise independence. 5 beds are designated to support hospital discharge for patients who require optimisation and further assessment. 2 beds are designated for step-up provision to prevent hospital admissions. The step-up beds are used for patients who have a combination of health and social care needs but do not require rehabilitation within an intermediate care facility.

This year we have extended the eligibility criteria for intermediate care services. Patients who are unable to take part in rehabilitation can now be transferred to an intermediate care unit provided they have rehabilitation potential. There are 2 designated "delayed rehabilitation" beds within each intermediate care unit that can accommodate patients who are non-weight bearing, receiving pain management medication or recovering from illness.

We have recommissioned the social care prescribing service to provide people with long-term conditions access to voluntary and community sector support. This service helps promote self-management and community integration, thus reducing hospital admissions and reliance on social care. We recently established a mental health social care prescribing pilot creating opportunities for mental health service users to sustain their health and wellbeing outside secondary mental health services.

Using the Better Care Fund we have increased the number of adults receiving a Personal Health budget so that they can commission their own continuing health care support.

Finally, we have established a community end-of-life hospice team to support families and carers allowing patients to die in their place of choice. This also contributes to reducing hospital admissions.

10. Key Priorities: 2016-19

The BCF Executive has identified the following priorities for 2016-19. These include;

1. A single point of access into health and social care services
2. Integrated health and social care teams
3. Development of preventative services that support independence
4. Reconfiguration of the home enabling service and strengthening the seven day social work offer
5. A reablement hub incorporating intermediate care
6. An integrated carers support service
7. A multi-disciplinary rapid response service
8. A single health and social care plan for people with long term conditions
9. A joint approach to care home support
10. A shared approach to delayed transfers of care (DTOC)

10.1 A single point of access into health and social care services

The Community Transformation Programme supported the development of a Care Coordination Centre (CCC), which acts as a portal into community health services. The key functions of the CCC are;

- Coordination of supported discharge care pathway
- Single point of access into community nursing services
- Single point of access for GPs when supporting patients with an urgent health need
- Central referral point for NHS 111 into community health services
- Clinical advice on the availability of alternative levels of care for ambulance patients

The CCC works alongside two other points of access. Assessment Direct is the central referral point for all social care support. There are a number of access points into RDaSH, in-house NHS mental health provider.

Rothercare is a telecare hub, supporting older people who use the community alarm service. It also provides a range of equipment which supports vulnerable people in their own home. Closer links between this service and the monitoring functions of Care Co-ordination Centre will also form part of this work.

What are we going to do?

We will create a "triage" function within Assessment Direct which will deflect people who do not require formal social care into preventive services. The team will deal with health and wellbeing visits, assistive technology and some elements of safeguarding. Within this context we will strengthen links with the voluntary sector and promote joint working between the Local Authority and NHS.

We will provide a single point of access into all community-based health and social care services. This will reduce costs associated with several call centres. The new 24/7 call centre will be more accessible

for people who require support. They will not have to decide which organisation to contact. There will be one telephone number for everything. Most importantly, the new integrated call centre will support greater integration of health and social care pathways.

10.2 Integrated Health and Social Care Teams

Evidence suggests that integrated health and social care teams are likely to achieve better results than those that operate within strict organisational boundaries. The Kings Fund identifies some of the key characteristics of a successfully integrated team.

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

What are we going to do?

We will develop a fully integrated health and social care team to support the Health Village. The team will be co-located and potentially support the same population as the current community nursing locality team. The team will have a single line management structure, joint service specification. It will incorporate named care coordinators responsible for supporting people with complex needs. We will develop a single portal that can be used across professional boundaries to store the integrated care plan and provide visibility on the full range of work being done with an individual. We will use the NHS Number to link records on this portal. We will develop a combined outcome framework which supports the strategic objectives of both the local authority and the CCG.

The integrated health and social care team will include community nurses, a community matron, social workers and allied health professionals. It will have a single point of access for all referrals. As well as focusing on structure, the process of integration will include a programme of relational transformation aimed out enhancing interpersonal relationships and breaking down cultural/ organisational barriers.

10.3 Development of preventative services that support independence

Rotherham is currently developing a “Healthy Ageing Framework” to improve the health and wellbeing of the ageing community. The framework will support the delivery of the ambitions within the RMBC Corporate Plan and Joint Health and Wellbeing Strategy. It will be used as a vehicle to optimise the impact of services and generate further investment through external funding applications. The framework and will help to ensure that Rotherham services work together seamlessly to create healthy, independent and resilient citizens.

Rotherham has a range of community services that focus on early intervention and prevention. These services promote independence by providing support with activities of daily living, physical activity initiatives, community equipment and community integration.

Occupational Therapy

National Institute for Clinical Excellence (NICE) Guidance – Mental Well Being and Older People (2008) concluded that occupational therapy and physical activity interventions actively promote the mental well-being of older people in the community. Occupational therapy enables people who have physical, mental and/or social care needs, either from birth or as a result of an accident, illness or ageing, to achieve as much as they are able to enhance their quality of life and maximise independence to their full potential. Department of Health guidance "Occupational Therapy in Adult Social Care in England" places emphasis on occupational therapy contributing to the health and well-being of the population in promoting self-reliance and resourcefulness for service users and their carers.

As the occupational therapy service works closely with health, social care, housing, education, employment, voluntary and the independent sector, this places the service in a key position to contribute to the delivery of a modern, personalised and integrated service.

Community Equipment

Audit Commission "Fully Equipped" guidance states that equipment for older people or disabled people provides the gateway to their independence, dignity and self-esteem. It is central to effective rehabilitation, it improves quality of life, enhances their life chances through education and employment and it greatly reduces morbidity at costs that are low compared to other forms of healthcare.

There is clear evidence that a good community equipment service

- Maximises a patient's ability to live independently
- Maintains health and improves quality of life.
- Reduces likelihood of further health problems (immobility, muscle contractures, pressure sores).
- Promotes social inclusion.
- Prevents accidents and falls-related admissions to secondary care.
- Reduces the need for 24 hour care from health and social care.
- Facilitates early hospital discharge as well as access to service in a planned way.

Activities of Daily Living Tool

We have commissioned an innovative web-based tool to help us to encourage people to maximise their independence by acting early. This is a nationally recognised tool which is in the process of being localised. The working title is "Iagewell-Rotherham", which we hope to use with people across the health, social care and voluntary sector workforce. This will help to link individuals to services or technology that will maintain their wellbeing and reduce the onset of ageing. The tool is strongly linked to the evidence on healthy ageing and the life curve and has been shown to deliver savings to the health and social care economy when embedded in our service delivery.

Promoting physical activity

Public Health and partners have recently been successful in winning a bid to develop post rehabilitation support for patients with seven long term conditions (Stroke, Cardiac, Heart failure, COPD, MSK, Falls, and Cancer). This project will provide tailored exercise programmes for patients post-rehabilitation. Patients on the programme will undergo condition specific group exercise activity aimed at optimising physical function and embedding a long term culture of regular exercise. The programme will also support patients to access appropriate exercise activity in their local community. The service will be accessible to GPs as part of the case management programme. It will also be available to patients on specific health care pathways. The intention is that referrals from health professionals will be made through the Care Coordination Centre.

The main elements funded by the programme include;

- 12 week condition specific group exercise programme
- Community buddies who provide individual support to patients requiring support with exercise
- Support with accessing appropriate exercise activity in the local community
- Targeted support for patients on the stroke, respiratory, falls and cardiac rehab, heart failure, MSK and cancer care pathways

What are we going to do?

We are committed to maintaining and improving these services despite the challenging financial framework within we operate. We will review our occupational therapy and equipment services so that they are fit for purpose. We will make best use of the resources available within Rotherham to include not just health and social care, but housing support. We will free up the occupational therapy service so that it provides more direct support to people struggling with activities of daily living. We will properly resource the equipment service so that it supports the work of the occupational therapy service. Finally we will continue to promote physical activity pathways for people who have had major health events.

10.4 Reconfiguration of the home enabling service

Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury.

The purpose of reablement is to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home. People using reablement experience greater improvements in physical functioning and improved quality of life compared with using standard home care.

Reablement is usually free for the first six weeks.

What are we going to do?

We will implement the outcomes of a recent service review, ensuring that the enabling service is fit for purpose and promotes value for money. The service will support people to maximise their independence using the "i-age-well" tool. We will ensure that the service is able to respond in a timely way to hospital discharges 7 days per week. We will rebrand the service so that it is incorporated into the intermediate care portfolio of service provision. We will link the service with

mental health services, providing important psychological support to people who struggle with motivation or depression.

10.5 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 element in driving this forward.

What are we going to do?

We will develop a fully integrated intermediate care offer, with the right number of beds to meet demand, more flexible eligibility criteria, increased provision of services in the home and more choice of housing.

We will build on our intermediate day care offer to support more people to regain control over their lives based on self-determined outcomes enabling people to remain in control of their lives, promote their health and well-being and remain outside of statutory services.

We will increase options for move-on Extra Care Housing provision, incorporating access to telecare and telehealth service.

We will merge existing intermediate care provision, including the Rotherham Intermediate Care centre (RICC) onto a single site, creating a rehabilitation/ reablement hub. Eligibility criteria for the new intermediate care service will be extended to include:

- People with 24/7 nursing needs
- People with dementia
- People who require a period of recovery/recuperation

10.6 An Integrated Carers Support Service

The National Carers Strategy Carers sets out the strategic vision and outcomes for carers. It states that carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals' needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, while enabling the person they support to be a full and equal citizen.

The key outcomes associated with this strategy are;

- Carers are actively sought and identified
- Carers are provided with appropriate up-to-date information, advice and guidance
- Carers receive Carers Assessments
- Carers are engaged and supported to plan for the future
- Carers' wellbeing is improved through the provision of emotional support
- Increased knowledge, skills and behaviours for Carers through training and development
- Carers Receive Health Prescribed support when appropriate

We are currently developing a co-produced Carers Strategy "Caring Together" which is due to go to the Health and Wellbeing Board in June 2016. The plan focuses on three outcomes:

- Carers in Rotherham are more resilient and empowered
- The caring role is manageable and sustainable
- Carers in Rotherham have their needs understood and their well-being promoted

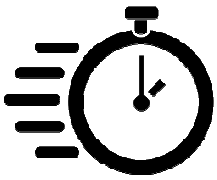
What are we going to do?

We will jointly commission an integrated Carers Support Service to support these outcomes. The service will incorporate health and social care professionals specialising in carer support, working in partnership with carers advocacy groups and third sector partners. The new service will provide information and advice on breaks from caring, lifestyle issues, family relationships, legal issues, employment and advocacy.

We will develop and Emergency Plan for Carers which sets out the support requirements for the cared for person if a carer is no longer able to offer support. Following assessment carers will be given a record of their needs and a copy of their support plan.

10.7 A Multi-Disciplinary Integrated Rapid Response Service (IRR)

The IRR service supports patients who are medically for discharge, can be cared for at home but are waiting for the appropriate health or social care package to be assessed and put in place. It also supports patients who are at immediate risk of hospital admission. The main interventions carried out by the IRR service include;



- Rapid MDT assessment and care planning
- Nursing intervention , including IV therapy if capacity allows
- Falls risk assessment
- Intensive rehabilitation services, including physiotherapy, occupational therapy and reablement
- Respite care e.g. due to carer breakdown
- Co-ordinating alternative levels of care

What are we going to do?

We will extend the IRR Service so that it incorporates social care.. The service will incorporate the following legacy services:

- Out of Hours Home Care Provider
- Care Home Support Advance Nurse Practitioners
- The Fast Response Service
- The District Nursing Twilight Service, Evening Service and Night Sister

The service will be accessed through the Care Coordination Centre. There will be a significantly stronger link between the out-of-hours social care services and renewed enabling service to ensure continuity of care and support

10.8 A Single Health and Social Care Plan for People with Long Term Conditions

When done well, care planning can be effective in improving the quality of life of people with long term conditions. Over the next two decades, shifts in demographics and disease management will result in a greater proportion of people than ever before, living well into their eighth and ninth decades of life. The majority of these people will also be living with at least one long term condition. Ensuring their care is well managed over the long term, including the approach to the end of their lives, will become an increasing challenge for the CCG and the local authority.

One major barrier to supporting this cohort of is the fragmented approach to care planning. Health and social care still have separate systems for preparing care plans. Although communication and connectivity has improved between health and social care professionals, they are hampered by a requirement to have separate care plans.

The Cochrane Review on integrated care planning found that it leads to improvements in physical, psychological and subjective health. Integrated care planning also affects people's capability to self-manage their condition. The studies showed that the effects were greater when it incorporated a single health and social care plan.

What are we going to do?

Rotherham will develop integrated health and social care plans for people on the long term case management programme. Now that social care and health records can be matched using the NHS number there is an opportunity to develop single care records and care plans. Using integrated care planning we can avoid duplication and multiple monitoring regimes.

10.9 A Joint Approach to Care Home Support

There are presently around 1,800 older people living in residential and nursing care homes in Rotherham. The number of residents is predicted to increase to 2,100 by 2020. This figure includes those residents that are financially supported by the Local Authority, self-funders and out-of-authority placements. Around 400 older people are admitted to residential care each year with complex needs.

Rotherham has a Care Home Support Service, funded through the Better Care Fund. The main aims of the Care Home Support Service are to:

- Ensure that the appropriate quality of care is provided in our residential and nursing homes
- Reduce A&E referrals, ambulance journeys and hospital admissions from care homes
- Meet the mental health needs of residents (via agreed Mental Health pathways)
- Develop personalised care planning residents at high risk of hospital admission
- Address health training needs of care home staff
- Ensure appropriate access to falls prevention services
- Promote healthy living initiatives
- Ensure quality of health and social care is being provided in residential and nursing care homes through contract compliance and care home support

What are we going to do?

We will carry out targeted interventions on residential and nursing homes who are outliers on emergency admissions. We will support GPs in the case management of patients who are at high risk of hospital admission.

These patients will be allocated a Care Co-ordinator from within the Care Home Support Service. The Care Co-ordinator will combine advanced clinical nursing and therapy practice with the co-ordination of personalised and integrated care plans. The Care Co-ordinator, alongside the Case Manager, will be responsible for co-ordinating the journey through all parts of the health and adult social care system.

We will support residential and nursing homes in meeting the needs of residents with organic and functional mental health problems. We will conduct an annual mental health assessment of all care homes. The assessment will identify residents with depression and dementia. We will monitor these residents, ensuring that they are sign-posted to appropriate health and adult social care services for support. We will identify residents who have memory problems and ensure that they are referred to the Rotherham Memory Service for a comprehensive dementia assessment.

We will deliver an extensive and comprehensive training programme agreed with RCCG and RMBC commissioners. Training courses will include: safeguarding, communication and dementia, life story sessions, active ageing, Parkinson's disease, safe feeding, swallowing and positioning, peg feeding, falls management and prevention, diabetes, oxygen therapy, hand hygiene, chest infections/respiratory conditions, infection control, oral hygiene, continence, ophthalmic care, oral care, equipment assessment including installation, cleaning and maintenance and tissue viability including effective use of mattresses and pressure area care.

We will have clear protocols with Rotherham's integrated stroke care pathway so that patients discharged from the stroke unit into residential/nursing care receive continued support and are reviewed after 6 months. Such patients are likely to have substantially different needs from those who return to their own home so the focus of intervention will be different.

10.10 A Shared Approach to Delayed Transfers of Care (DTOC)

Within the Better Care Fund Policy Framework (2016/17) there are new National Conditions which all BCF programmes must action. One of these is the development of a Delayed Transfer of Care Action Plan (Appendix 5) and a locally agreed target for the reduction of DTOCS.

The number of recorded Delayed Transfers of Care (DTOC) from the December 2015 National DTOC report shows that 2.2% of transfers were delayed. This is significantly lower than the national average of 3.5%. There has been significant progress in the last 12 months to support the reduction in DTOCs within Rotherham.

The requirements around DTOC are considered within the Rotherham CCG's Operating Plans for 2016-17. Rotherham CCG and its partners will monitor DTOCs through the System Resilience Group. The System Resilience Group has recently endorsed a Memorandum of Understanding (MoU) (Appendix 6) between Rotherham Foundation Trust, Rotherham CCG and the Local Authority on hospital discharge which has now been signed up to by all providers. The MoU covers DTOC and all other patients who are 'medically fit for discharge'. This figure for patients who are " medically fit for discharge" is usually higher than the DTOC figure, because it includes the following cohorts of patients

- Patients who require assessment for a new or existing care package (DTOC)
- Patients who need to have an existing care package restarted
- Patients who do not require a social care package
- Patients who may require a Continuing Health Care
- Patients waiting for an intermediate care or discharge to assess bed
- Patients who have been assessed as needing residential care but the actual home has not been selected.

The main purpose of the MoU is to ensure that patients are discharged as soon as they are medically fit and that they have the appropriate care packages in place which reduces the risk of readmission

What are we going to do?

We will develop robust risk sharing agreements relating to DTOC within the next quarter as part of further development of the MoU. We will also develop robust reporting systems which incorporate data on DTOC and other patient cohorts who have an impact on patient flow.

We will further develop our MoU through a robust review process. Future iterations will consider issues that expedite discharge, for example predicting times of discharge to enable effective community planning, the interfaces with integrated rapid response and management of MDT's for patients who change wards during their acute stay, effective discharges from Intermediate Care.

We will continue to work with partners through the "GP ward round" weekly meetings. This is a multi-disciplinary meeting which brings together front-line staff and senior managers to focus on facilitating discharges from hospital. The main aims of the meeting are to remove barriers to discharge and identify systemic issues that restrict patient flow. The "GP Ward Round is a key vehicle for achievement of BCF Metrics.

10.11 Relevance to The Health and Wellbeing Strategy

The BCF priorities will support the aims and objectives of Rotherham's Health and Wellbeing Strategy. Table 2 shows how the BCF priorities line up with those of the Health and Wellbeing Board.

Table 2: Relevance to Health and Wellbeing Strategy

HWB Aim	BCF Priority	Impact on HWB objectives
All Rotherham people enjoy the best possible mental health and wellbeing	A single point of access into health and social care services	• Improved support for people with enduring mental health needs, including dementia • Reduction in common mental health problems among adults • Reduction in social isolation
	Reconfiguration of the home enabling service	
	Integrated health and social care Teams	
	An integrated carers support service	
	Shared approach to delayed transfers of care (DTOC)	
Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reduced	Preventative services that support independence	• Reduction in early death from cardiovascular disease and cancer • Improved support for people with long term health and disability needs
	Development of a reablement hub incorporating intermediate care	
	A multi-disciplinary rapid response service	
	A single health and social care plan for people with long term Conditions	
	A joint approach to care home support	

10.12 Milestones and Timelines

This section of the BCF Plan maps out the key milestones associated with the key priorities.
Table 3 sets out the key milestones for delivery of this strategy.

Table 3: Key Milestones

Priority	Description	Milestones 2016	Date
1	A single point of access into health and social care services	Service model agreed by BCF Executive	31.08.16
		Commissioning arrangements agreed	31.10.16
		Service reconfiguration begins	01.01.17
		Single Point of Access in place and operational	01.04.17
2	Development of integrated health and social care teams	Identify pilot locality	09.03.16
		Service specification agreed by CT Board	30.04.16
		Appoint locality manager	01.06.16
		Recruitment of team complete	01.07.16
		Integrated locality team starts to operate	01.08.16
		Evaluation complete	30.06.17
3	Reablement hub incorporating intermediate care beds	Intermediate Care Review approved by CT Board	30.06.16
		New service model agreed by CT Board	01.09.16
		Pooled budget arrangements agreed by CT Board	01.09.16
		Project plan agreed for implementation of service model	01.09.16
		New service model fully operational	01.06.17

Priority	Description	Milestones 2016	Date
4	Preventative services that support independence	OT and REWS Review approved by BCF Executive	31.08.16
		New service model agreed by BCF Executive	31.08.16
		Project plan agreed for implementation of service model	01.11.16
		New service model fully operational	01.01.17
5	Reconfiguration of the home care enabling service	Home care enabling Review approved by Adults Transformation Board	31.07.16
		New service model agreed by Board	31.07.16
		Project plan agreed for implementation of service model	01.10.16
		New service model fully operational	01.04.17
6	A multi-disciplinary carer support service	Service map of carer services	31.03.17
		Service specification agreed at BCF Executive	01.06.17
		Commissioning arrangements agreed	01.06.17
		New service operational	01.10.17
7	A multi-disciplinary integrated rapid response service	Service model agreed by BCF Executive	31.01.17
		Commissioning arrangements agreed	31.01.17
		Service reconfiguration begins	01.04.17

Priority	Description	Milestones 2016	Date
		New service in place and operational	01.09.17
8	Single health and social care plan for people with long term condition	Scoping exercise completed on integrated care plan	01.09.16
		Develop common template for case management	31.11.16
		Develop IT solution for sharing care plan across systems	31.12.16
		Implement integrated care plan for case management	01.04.17
9	A joint approach to care home support	Development of care coordinator role	01.04.17
		Introduction of annual mental health assessments	01.06.17
		Development of a targeted care home training programme	01.09.17
		Introduction of protocols for stroke patients in care homes	01.09.17
10	Shared Approach to Delayed Transfers of Care (DTOC)	Development of an MoU on management of patients who are medically fit for discharge	01.05.16
		Embed daily MDT meetings on medical wards	01.05.16
		Introduce "trusted assessor" role to reduce duplication and improve patient flow	.1.06.16

11 National Conditions

11.1 Supporting Social Care Services

Rotherham's BCF Plan supports social care in three ways;

- Ring-fencing resource in the BCF budget for social care activities that support health outcomes
- Supporting integration, reducing duplication and generating efficiencies that can be reinvested
- Enlisting the support of the 3rd sector through effective social prescribing

Ring-Fencing

Theme 3 of Rotherham's BCF Service directory is "Supporting Social Care " This identifies a range of social care services that are strategically relevant and performing well. Decisions on future funding can only be taken if agreed between RCCG and RMBC. More importantly there would have to be drift in relation to performance or strategic relevance to precipitate a decision to remove these services. There has been no reduction in the funding made to this category of service from the 2015-16 BCF plan, the main difference is how the services have been categorised into 6 new Themes as discussed earlier in the plan.

Supporting Integration

Rotherham's Better Care Fund Plan includes a range of initiatives which support joint working across health and social care. These include; integrated locality teams, the care home support service and social care assessment beds. All these initiatives support social care by using resources from partner organisations to achieve social care outcomes. For example, the integrated locality teams will be responsible for initiating and reviewing social care assessments. Social workers will be able to access therapists and other health care professionals to assist with these assessments, delivering a more holistic service and reducing duplication.

3rd Sector Support

The Rotherham Social Prescribing Programme is funded through the Better Care Fund. The service protects social care because it intervenes early, before the need for formal care services. The Social Prescribing Service addresses directly those social needs that arise after significant life events; e.g. after loss of a partner or after diagnosis of a long term condition. The service promotes self-care, community integration and a holistic approach to care planning. There is local evidence that it has successfully reduced the cost of social care packages. Even where someone already has a social care package in place, the service can play a complementary role, reducing levels of dependence, maintaining engagement with informal support networks and boosting resilience.

11.2 Disabled Facilities Grant

The Disabled Facilities Grant is embedded within the 3 year Housing Investment Plan (HIP) which is approved by members. The funding is used for the provision of adaptations to disabled people's homes to enable them to live independently and to improve their quality of life. This will include the provision of Assistive Technology in 2016/17 due to the ending of the PSS Capital Grant in March

2016. The Strategic Director of Adult Social Care and Housing has been fully involved in the development and approval of the BCF plan for 2016/17 and is a member of the Health and Wellbeing Board, BCF Programme Board and BCF Executive Group. Both the Boards and group includes representatives from the CCG including the Chief Officer and Chief Finance Officer. This ensures there is a joined up approach in improving outcomes across the health, social care and housing sector.

11.3 Delivery of 7 Day Services Across Health and Social Care

Health and social care both recognise the need to improve the process for planned hospital discharge for vulnerable adults. At any one time, there are a number of patients in an acute bed, whose medical episode is complete, but who are awaiting further assessment, initiation of a care package or decisions on choice of a care home placement. The following services, funded through BCF operate 7 days/ week.

Integrated Rapid Response Service (IRR)

The IRR service supports people who are unable to remain at home because they have a temporary health and/or social care need. The service supports people to remain at home until they have recovered or until a long term care plan can be put in place. The service operates 7 days/week, 24 hours/day. It provides immediate support to patients who exacerbate in the community and has access to community beds which are also available 7 days/week.

Intermediate Care

Intermediate Care Services in Rotherham now receive referrals 7 days/week. Historically hospital discharges could only take place during the working week. Extending the time frame for referrals supports timely discharge and can prevent admissions during the weekend. There is a specialist Mental Health OT and CPN which carry out assessments and management of mental health for individuals whose needs affect their function and ability to undertake rehabilitation. This service also covers the Integrated Rapid Response service.

Hospital Social Work Service

The Hospital Social Work team can now carry out social care assessments and co-ordinate packages of care 7 days a week. Domiciliary care providers are also now contracted to respond to urgent referrals on a 7 day a week basis, delivering urgent packages of care.

A 7 day community, social care and mental health pilot to support hospital discharge and reduce delays has now been operational since December 2015. The hospital and Hospital Social Work Team now provide a joint approach to assessments and care planning on a 7 days a week basis. This new pathway also reduces length of stay in hospital medical wards. We will carry out a review of this pilot at the end of March 2016, with the intention of ensuring that this becomes a permanent arrangement to continue to support discharge and admission prevention.

Rotherham Equipment and Wheelchair Service

A review of the Integrated Community Equipment Service will be carried out in 2016/17 which will identify demand for community equipment to facilitate hospital discharge, in particular over the

weekend. A review of the satellite office provision enabling practitioners to collect health and social care equipment will also be carried out.

Mental Health Liaison Service/Learning Disability

The Adult (including older peoples) Mental Health Liaison Service pilot will continue in 2016/17. This service is to be externally evaluated by Sheffield Hallam University (SHU) in 2016-17. This service in conjunction with the Crisis Team provides a 7 day service. There are also several other health and social care commissioned Mental Health and learning disability Services that provide 7 day services to support this agenda that are not currently part of the BCF programme but contribute to meeting the objectives of the BCF.

11.4 Improving Data Sharing Between Health and Social Care

Improved data sharing between health and social care is a national condition of the Better Care Fund. All BCF adult social care records now have an NHS number assigned. The health and Well Being Board has agreed that the NHS number be used as a primary identifier.

The new social care system will go "live" later in 2016. This will include a new facility to integrate with the NHS "Patient Demographic Service" (PDS) allowing access to NHS numbers on the NHS spine. Whilst we are awaiting for that facility to go "live" we will add new NHS numbers manually and continue to use the local informatics team matching bureau for batch processing.

An operational data sharing agreement has now been developed and agreed by the CCG and Local Authority (Appendix 7) which sets out how data can be seen, when and how the data will be used. This ensures that Information Governance controls are in place for information sharing in line with Caldecott 2.

The new social care system will go "live" later in 2016. This will include a new facility to integrate with the NHS "Patient Demographic Service" (PDS) allowing access to NHS numbers on the NHS spine. Whilst we are awaiting for that facility to go "live" we will add new NHS numbers manually and continue to use the local informatics team matching bureau for batch processing.

Training materials have been issued which demonstrate to practitioners in adult social care how to use the NHS number field. This includes mechanisms for maintaining the NHS number. A weekly report is issued to managers detailing the number of NHS numbers updated each week. Managers are reminded to encourage practitioners to check/complete the NHS number field, wherever possible.

We will continually improve data sharing between health and social care through the use of NHS numbers in all correspondence. The use of the NHS number is an important stepping stone towards our main objective, the rapid and easy exchange of data between health and social care.

Rotherham MBC's strategy "Your Digital Council (Appendix 8) highlights the continuing importance of a digital infrastructure. This includes "broadband, online services, access and skills". The strategy describes opportunities which digital offers and the dependencies that exist between a strong economy, social well-being and modernised public services. The strategy includes the following commitments:

- Partners will develop an NHS "Local Digital Roadmap", ensuring that all electronic health and social care records are interoperable and ultimately paperless
- NHS staff will have real-time access to local authority client data where it is appropriate and legal to do so
- Local authority staff will be able to access NHS systems where it is appropriate and legal to do so, creating a single view of the Rotherham citizen
- Partners will work together to create a common sets of standards, which support the sharing of data cross local services. This will be enhanced by the adoption of a common identifiers such as NHS numbers and unique property reference numbers.
- Partners will work together to develop a web portal that allows multiple data sources to be interrogated from one location

The CCG and Local Authority have long recognised the importance of open APIs (application programming interfaces) in facilitating data sharing between systems and we have a long standing policy of mandating that suppliers provide open APIs wherever possible. The new social care system includes access to open APIs. Similarly the NHS has written the provision of open APIs in to the current national contract for the supply of GP clinical systems.

One of the commitments of the Rotherham CCG IT Strategy (2015/16) (Appendix 9) is to develop a clinical portal that will integrate information from health and care services across the local health community. As the system is developed it will give professionals access to all the data and information they need to deliver safe, high quality care. We also aim to develop patient access to the portal allowing them a common view of their health information for Rotherham health and care services. Work on the clinical portal has been on-going since June 2015. A single view of a patient's secondary care information has been developed and this has been linked with risk stratification data to provide a system for GPs to view the hospital activity of their patients who are at a high risk of hospital admission.

The Detailed Care Record Service of the Medical Interoperability Gateway (MIG) has been developed for primary care data to be viewed in the clinical portal. GP Practices have been contacted with guidance on how to register to gain access to the clinical portal. Over the period of this plan we will develop the clinical portal to provide safeguarding and end of life information, ensuring information governance is place to ensure security and confidentiality.

We will carry out a feasibility study for development of the patient portal. This will a provide results tracker for chronic patients and an ability to sign-post patients to appropriate service.

The use of integrated records, information and technology will support the reduction of unnecessary non-elective hospital admissions, promote 7 day working, support out of hospital/community based services and facilitate timely hospital discharge.

A joint working group known as "Rotherham Health and Care Interoperability Group" is in place. The membership of the group includes clinicians, GP's, Directors, IT Programme Managers from the Local Authority, CCG, TRFT, RDaSH and Rotherham Hospice. This group is the "parent" to a subsidiary group which is the "Information Governance Sub-Group" which ensures that all aspects of data sharing are properly considered at every stage of the development of our Local Digital Roadmap (which the BCF will form an important part of).

An Overarching Information Sharing Protocol is in place – this is a Tier 1 agreement that was created through the Council's 'Corporate Information Governance Group' and has been adopted across the local partners. In addition we have a specific Tier 2 agreement relating to data sharing for the BCF initiative.

All relevant IG controls are in place and we are fully compliant. RMBC is accredited against the PSN code of connection. Further, the Council complies with and meets Caldicott2 requirements via our submission to the IGSoC and via the IGToolkit.

The Council has a nominated SIRO (this is the Strategic Director of Finance and Customer Services). We have an Information Governance escalation group and a IG Board where all IG decisions are made. There is an annual mandatory DPA training provision and an e-induction process is in place.

As part of our Local Digital Roadmap programme we have developed a communication and engagement plan (Appendix 10). This plan has yet to be formally signed off and the communication described within has yet to begin.

At the heart of all the communications on these issues is our desire to ensure that citizens are educated and comfortable with regards to the way their data is being used. Throughout the campaigns we will put the following principles front and centre:

- Explain to people why data is being shared between partners and how this will benefit everyone
- Ensure that local people have clarity about how data about them is used – this will include
- Description of the personal confidential data shared
- Description of the de-identified data shared on a limited basis
- Explain who may have access to their data (i.e. who we are sharing with)
- Explain how people can exercise their legal rights with regards to their data

12. Measuring Success

12.1 BCF National Metrics

As part of the Better Care Fund Plan we will measure against the national metrics and Rotherham's agreed local metrics. The BCF Policy Framework establishes that the national metrics will continue as they were set out for 2015-16. In summary these are:

a. Non-elective admissions (General and Acute)
b. Admissions to residential and care homes
c. Effectiveness of reablement
d. Delayed transfers of care

The detailed definition of the non-elective admissions (NEA) metric is set out in the Planning Round Technical Definitions. The level of non-elective activity which BCF plans seek to avoid, in addition to reductions already included within the calculation of CCG operating plan figures, are clearly identified in the BCF planning return. The detailed definitions of the other three metrics are set out in Table 4

Table 4 – BCF Metrics Definitions

	Metric	Numerator	Denominator
2	Admissions to residential and care homes	The sum of the number of council-supported people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year. Data from Short- and Long-Term Support (SALT) collected by HSCIC	Size of the older people population in area (aged 65 and over). This should be the appropriate ONS mid-year population estimate or projection
3	Effectiveness of reablement	Number of older people discharged from acute or community hospitals to their own home or to a residential home for rehabilitation, with a clear intention that they will move on/back to their own home who are at home 91 days after the date of their discharge from hospital.	Number of older people discharged from acute or community hospitals to their own home or to a residential home for rehabilitation, with a clear intention that they will move back to their own home.
4	Delayed transfers of care	The total number of delayed days (for patients aged 18 and over) for all months of baseline period	ONS mid-year population estimate (mid-year projection for 18+ population)

Non-Elective Admissions

The metric reflects the overall CCG plan as submitted to UNIFY2 on the monthly activity template. The UNIFY2 submissions have been triangulated with current contract plans. There is the wider footprint of the South Yorkshire and Bassetlaw STP to take into consideration. The setting of CCG plans has been undertaken with consideration to previous year's activity levels, in the context of the 2016/17 financial challenge.

Delayed Transfers of Care (DTOC)

The Delayed Transfers of Care Plan is set to a level of realistic achievement within the financial challenge of 2016/17. Trend analysis has been undertaken prior to the setting of targets. The Delayed Transfers of Care Plan has set a target which is realistic within the challenges anticipated from demographic and service changes.

Permanent admissions of older people to residential and nursing care homes (per 100,000)

Rotherham MBC year end outturn for 2015/16 will show approximately 60 fewer admissions compared to 2014/15. An outturn of 410 admissions equates to a rate of 822 per 100,000. Further improvements through BCF initiatives will potentially deliver an additional reduction of 20

admissions next year giving an estimated total of 390 for the year. This results in an overall rate of 767 per 100,000. These figures take account of the increase in admissions rate resulting from the definition change in 2014/15. It also takes account of the estimated increase in the over 65 population for 2016/17.

Proportion of older people still at home 91 days after discharge from hospital into rehabilitation and reablement services

Rotherham MBC is projecting a year end outturn of 89.6%, which reflects an increased number of people benefitting from using rehabilitation and reablement services in 2015/16. This improves on our 2014/15 score of 83.5% but is just below our target of 90%. Rotherham MBC estimates that improvements to our service 'offer' will result in further improvement in 2016/17, making a target of 91% realistic. There is a need to strengthen our analysis on the longer term trend, in order to provide evidence based findings that support our projections.

In-patient Experience – proportion of people reporting poor patient experience of in-patient care

The 2014 score was published in late 2015 showed an improvement beyond the 2015/16 plan, with a score of 115.9. Current plan is to sustain this level of achievement. Numerator and denominator are not available until published nationally.

12.2 Impact on Local Metrics

Rotherham CCG Commissioning Strategy

The CCG Delivery Dashboard incorporates metrics which the BCF has an impact on:

- Number of patients admitted to hospital for non-elective reasons discharged at weekends/bank holidays
- Health related quality of life for people with long-term conditions
- Proportion of people being supported to manage their condition
- Proportion of deaths at home
- Hospital spells resulting from fall-related injuries patients aged 65 and over
- Additional years of life secured in conditions considered amenable to healthcare.
- All people over 65 or those under 65 living with long term conditions have their own co-ordinated care plan where the priorities set by the individual are supported by the care that they receive, resulting in improved health related quality of life.
- Emergency admissions and length of stay reduced by managing care more proactively in other settings.
- Proportion of people having a positive experience of care in all settings increased.
- Parity of esteem for people suffering with mental health conditions alongside those with physical health conditions.

RMBC Adult Social Care Metrics

A number of Key Performance Indicators from the Adult Social Care Outcomes Framework (ASCOF) will be supported by the initiatives identified in the BCF Plan as will some local performance measures and include the following:-

- Proportion of people using social care who receive self-directed support and those receiving direct payments
- A range of Service User and Carer survey ASCOF measures for example: reporting that they have a good quality life, the proportion of people who use services who feel safe, social care service users who feel they have control over their daily lives.
- Proportion of people aged 65 and over requiring social care support, plus impact on ASCOF relating to employment, settled accommodation, delayed transfer of care and rehabilitation measures.
- Supported housing placements - Learning Disability (18-64)

13. Impact Assessment

Table 5 provides a summary of the impact that BCF Change Programme will have on patients and the local health economy. We expect our changes to improve the delivery of NHS services. Specifically, we expect them to reduce activity in acute care, reduce reliance on formal social care, increase access to primary and community services and improve outcomes for people with long-term conditions.

If we do not deliver activity reductions in acute and social care, we anticipate significant financial pressures in the local health and social care economy. We anticipate that the changes proposed will have a significant impact on community services. Statutory and independent providers of health and social care will be partners with us in delivering this Better Care Fund Plan.

Rotherham partners have a commitment to ensuring that the impacts of our local plans are understand throughout organisations.

Table 5: Summary Impact Assessment

No.	Project	Patients and Service Users	Providers and Local Health Economy	BCF Metrics
1	Single point of access into health and social care services	• People can access the right care first time • Reduced duplication of assessments and visits to patient homes through better care co-ordination • Facilitates discharge and prevent unnecessary admission • Can respond to people who require support after using the community alarm system	• More controlled access to urgent care services • Reduces the time currently spent by the referrer in identifying and arranging appropriate care. • Improved access for professionals to a range of services. • Health professionals can make informed choices about the most appropriate level of care	• Non-elective admissions • Effectiveness of reablement • Delayed transfers of care
2	Integrated Health and Social Care Teams	• People don't have to re-tell their story every time they encounter a new service • People get the support they need because different parts of the system are now talking to each other • Home visits from health or care workers are combined	• Professionals can support patients to stay at home and minimise the need for hospital admission to hospital. • Increase in face to face clinical time. • Improved organisational reputation through delivering a responsive service and providing alternative to acute admissions.	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of care
3	A Reablement Hub Incorporating Intermediate Care	• Single rehabilitation coordinator who supports individual through whole care pathway • All therapists and carers on-site and accessible • More holistic approach to rehabilitation	• Generates efficiencies that can be reinvested • Reduced length of hospital stay for step-down patients • Greater impact on reducing hospital admissions because of increased use of	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of

No.	Project	Patients and Service Users	Providers and Local Health Economy	BCF Metrics
			step-up beds	care
4	An Integrated Carers Support Service	• Better access to benefits, information and advice • Reduction in social isolation for both carer and those being cared for • Improved health and well being	• Reduced likelihood of carer breakdown, which could lead to increase in costs of formal care • Care being used effectively as a resource to support people with long term conditions • Reduction in cost of social care packages	• Non-elective admissions • Admissions to care homes
5	A Multi-Disciplinary Rapid Response Service	• Immediate access to medical and social care support for those that have an urgent care need • Housebound patients can access the service • More likely to see and treat at home	• Reduction in number of unscheduled hospital admissions will release capacity in acute care • Reduced length of hospital stay for patients will improve patient flow in acute care • Team will support GPs to maintain high risk patients at home	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of care
6	A Single Health and Social Care Plan for People with Long Term Conditions	• One plan covering all aspects of care • Less confusion and duplication • Includes support with self-management and urgent response	• Greater visibility of what other professionals are doing • Reduces risks that arise from fragmentation of service • Reduction in bureaucracy	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement
7	A Joint Approach to Care Home Support	• More likely to see and treat at home • Single care coordinator who can support a resident throughout their stay • Better quality care and holistic	• Specialist team will have correct skill set to support people in residential care • Case management approach to care in residential homes • Better support for care home staff	• Non-elective admissions • Effectiveness of reablement • Delayed transfers of care

No.	Project	Patients and Service Users	Providers and Local Health Economy	BCF Metrics
		approach		
8	A Shared Approach to Delayed Transfers of Care (DTOC	• Shorter hospital stay • Better quality care packages delivered in a timely manner • Reduced risk of readmission	• Better patient flow through the hospital • Reduction in cost of acute care • Reduction in readmission costs for RFT	• Delayed transfers of care

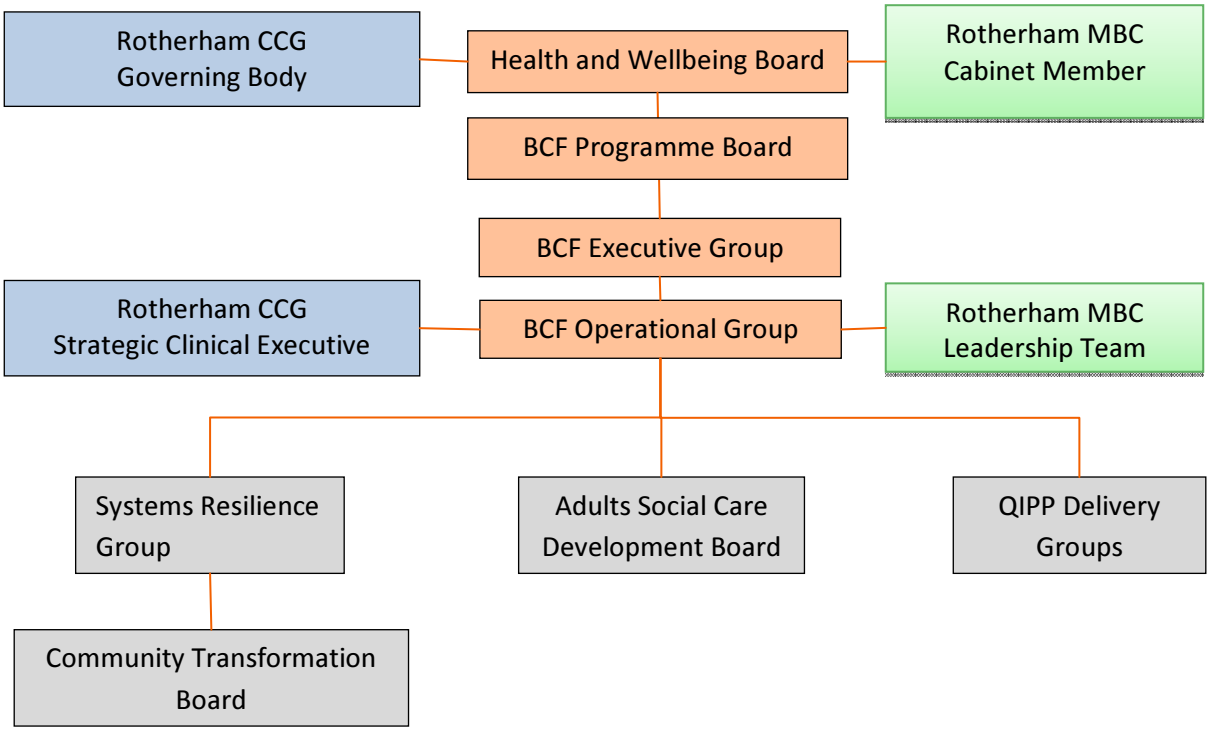
14. Governance Arrangements

14.1 Description of Current Governance Framework

The delivery of the BCF is fully integrated with the delivery of the Health and Wellbeing Strategy. In Rotherham the Health and Wellbeing Board has overall accountability for the BCF Plan.

Figure 4 sets out the current governance arrangements.

Figure 4: Current BCF Governance Structure



Role of Health and Wellbeing Board

Key responsibilities of the Health and Well Being Board include;

- Monitor performance against the BCF Metrics (national/local) and receive exception reports on the BCF action plan
- Agree the Better Care Fund Commissioning Plan/Strategies
- Agree decisions on commissioning or decommissioning of services, in relation to the BCF

Role of BCF Programme Board

Key responsibilities of the Programme Board include;

- Agree strategic vision and priorities for the future
- Make decisions relating to the delivery of the plan

Role of BCF Executive Group

The BCF Programme Board is supported by the BCF Executive Group, which has been meeting since July 2015. Both Board and Group consist of Chief Executives, Elected Members, Chief Finance

Officers, Directors from both the Local Authority and the Clinical Commissioning Group. Key responsibilities of the Executive include;

- Monitor delivery of the Better Care Plan through quarterly meetings
- Ensure performance targets are being met
- Ensure schemes are being delivered and additional action is put in place where the plan results in any unintended consequences.
- Report directly to the Health and Wellbeing Board on a quarterly basis.

Role of BCF Operational Group

The BCF Executive Group is supported by the BCF Operational Officer Group which meets every 6 weeks. The Operational group is made up of the identified lead officers for each of the BCF priorities, plus other supporting officers from the council and CCG.

- Ensure implementation of the BCF action plan
- Implement and monitor the performance management framework
- Deal with operational issues, escalating to the Task Group where needed

14.2 Review of Governance Framework

During 2016/17 The Health and Wellbeing Board will review the current governance arrangements. The review will identify where there are areas of duplication and put forward proposals for a streamlined governance framework that incorporates all elements of the commissioning cycle.

The review will make recommendations on a joint performance framework so that we can build on the outcomes of the service review and continue to monitor the performance and strategic relevance of BCF funded services.

The review will incorporate the development of a full suite of combined health and social care metrics for those services that have been integrated. The new governance framework will show clearly where joint decisions are made. It is really important that there is full visibility in relation to the decision making process. A streamlined and coherent governance framework will speed up decision making and create a positive environment within which commissioners collaborate.

15. Risk Assessment

Table 6 provides a summary of the risks associated with the development of the Better Care Fund

Table 6: Major Risks to BCF Action Plan

Key:

Likelihood * Impact = Score
1 = Low Impact or Low Likelihood
5 = High Impact or High Likelihood
Maximum score 25

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
Strategic Risks					
1	Poor alignment between service budgets and actual cost	4	3	12	The review process timetabled throughout 2016-17 will ensure the alignment of budget with actual costs. Monthly budget monitoring is in place and reports are regularly taken to the Operational and Executive groups regarding finance and any risks which require mitigation.
2	Shortfall of resources to fund the priorities identified in the plan	3	4	12	As above. The review process will seek to identify areas where budgets can be appropriately aligned to BCF priorities; this may include reconfiguration of service provision in year.
3	BCF services are not fit for purpose	4	3	12	New governance and performance framework will highlight those services that are not performing and set out a new

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
					structure for performance management
4	The introduction of the Care Act will result in a significant increase in the cost of care provision onwards that is not fully quantifiable currently	4	4	16	The financial implications of the Care Act have been included in the financial plan (£0.7m) Work to address Care Act compliance is incorporated in Adult Social Care Development Board Programme. Various models have been populated and provided evidence of demand for additional assessments (including carers' assessments and respite) at an approx cost of £0.850m. This information ensured that sufficient funds were established in 2015-16 and remain in BCF for 2016-17.
5	Compliance with Mental Capacity Act (MCA) incorporating the Deprivation of Liberty Safeguards (DOLS)	4	4	16	New DOLS team developed with new team manager and seconded full time Best Interest Advisors x 4.
6	Operational pressures restrict capacity to implement key projects identified in the BCF Plan	4	5	20	Our schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development. BCF Ops Group will oversee implementation of the 2016/17 programme, identifying areas where operational pressures are impacting on implementation and developing targeted strategies to free up the change process. Monitoring template in place for all BCF reviews and will be taken to Operational Group meetings to ensure early identification the risks associated with implementation/achievement.
7	Failure to achieve planned savings due to overspends in the system/ inability to meet targets will create financial risks (budget pressures) for the	3	5	15	Performance management framework via the System Resilience Group in place to monitor progress to ensure targets are achieved. Good forward planning with providers on activity reductions through regular contract performance meetings. BCF Operational Group will oversee implementation of the 16/17 programme. If

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
	respective parties				service improvements do not have the intended impact on hospital and care home admissions the BCF Operational Group will make recommendations on where service restrictions should apply, ensuring that the programme remains within budget.
8	Achieving savings in one area of the system, can cause unintended consequences of higher costs elsewhere.	3	3	9	All partners have made a commitment to ensure that if evidence of these consequences is seen, cash will flow to the right place across the system that all partners will benefit from. Both partners have agreed a 'risk pool' of £500K which has been included in the financial plan to mitigate the risk of non-delivery of non-elective savings and social care packages. The "risk pool" forms part of the BCF plan, which can be used if the plan results in any unfunded consequences on any part of the system. The BCF plan is monitored on a quarterly basis by the BCF Executive group, and any consequences will be reviewed.
9	Failure to meet the national conditions and performance outcomes agreed with NHSE	3	5	15	Joint governance arrangements and new performance framework will help mitigate this risk. Financial risk sharing is in place through the Risk Pool.
10	Lack of engagement from front line staff because do not buy in to the integration agenda or lack the skills	3	4	12	Changing organisational structure is not sufficient to achieve integration. We will work with local education and training institutions and with service providers to develop integrated ways of working and behaviours to transform the quality of health and social care. This issue will form part of individual implementation plans for new initiatives in 2016-17.

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
					Strong links are in place with all partners communication teams to ensure that change management occurs in the most effective and transparent way.
11	Social care not being adequately protected	3	5	15	No change in 2016-17 to the services that were identified in the BCF plan 2015-16 as fundamental to the protection of Social Care. BCF governance groups to take regular stock-take on current state of social care provision. Regularly review strategies for how the BCF can be enhanced to protect key services, particularly those that support admission prevention and reductions in formal social care.
12	Governance arrangements are insufficient to make investment decisions, ratify the vision and deliver key metrics	3	4	12	Governance arrangements scheduled for review this year. Programme has clearly defined purpose. Full engagement at CEO level. Clearly defined process for decision making with appropriate scheme of delegation. Clear system for disagreement resolution. Rules on data and performance management agreed.
Performance Risks					
13.	*Non-elective target not met;* BCF Schemes do not deliver the planned reduction in non-elective admissions resulting in higher cost. This is complementary to the programme within the System Resilience Group which focuses upon avoiding emergency admissions amongst other wider system issues of the CCG.	4	5	20	BCF commissioning intentions and investment in a number of work-streams have already taken place in 2015/16 including Integrated Rapid Response, Care Co-ordination Centre. The focus on out of hospital services will continue in 2016/17 through the BCF plan including Integrated Locality Pilot, rehabilitation and re-ablement hub.

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
14.	*Residential Care target not met;* BCF Schemes do not deliver a reduction in permanent admissions to residential care increasing costs to the LA. This may be due to delays in implementation of schemes i.e.	3	3	9	BCF Schemes aligned with Care Act (2014) and Joint Health and Wellbeing Strategy 2015-19. Change Management leads have been appointed to ensure successful implementation of projects that will complement the BCF objectives. Any delays in scheme progress will be mitigated by appropriate Working Groups including closer working relationships with Housing.
15.	*Delayed Transfers of Care (DTOC) target not met*; BCF Schemes do not deliver the planned reduction in DTOC which will result in higher cost to the CCG and/or The Rotherham Foundation Trust. This may be due to poor collaboration/ communication between health and social care staff or ineffective/ insufficient out of hospital services i.e. intermediate care.	3	3	9	Review of pathways from hospital to community to ensure that they meet patient demand and are fit for purpose is underway. Action planning taking place to reconfigure services as part of the review process. This includes development of social care assessment beds, changes to the hospital discharge team to support integration. System Resilience objectives complement the Better Care Fund objectives. Memorandum of Understanding in place which ensures a clear, effective integrated discharge process which considers both hospital and community and cross sector provision.
16.	*BCF schemes are delayed;* Delay in implementation of BCF schemes results in underspends, creates inefficiencies in service delivery and hinders integration. There is likelihood that targets will not be met if scheme implementation is delayed.	2	3	6	Regular reporting on progress of all BCF schemes through the BCF Operational and Executive Group Meetings to ensure that underspends are managed and risks mitigated through the risk share agreement. A review of BCF schemes has taken place which identified those schemes requiring a deep dive review to be undertaken in 2016-17.

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
OPERATIONAL RISKS					
17.	*Data sharing between health and social care;* Target on number of patients with NHS identifiable number is not met. This is a national condition, in not meeting the target there would be significant impact on the ability for integration /communication.	2	3	6	The officer lead for this objective at RMBC has provided updates at every operational group meeting throughout the 2015-16 and has given assurance that this target has been achieved.
19.	*Community Services;* BCF schemes increase demand on community services resulting in increased waits for health and social care assessments/ services	3	4	12	The BCF has identified new funding for social care and this will be reviewed as part of the work plan for 2016/17. Investment in community transformation programme through the CCG in 2015-16 will provide more targeted resource into the community in order to better meet demand.
20.	*Rotherham Population;* Schemes not targeted at the right populations resulting in pressures on the acute services	1	3	3	Using Joint Strategic Needs Assessment, Commissioning Plans/Strategies to support rationale for scheme development – incorporating intelligence of local population and demand in to service specifications to target appropriate cohorts of patients. Review of service implementation takes place once a scheme is up and running. Performance, quality and outcomes regularly monitored through performance submissions and meetings with providers.
QUALITY RISKS					
21.	*Provider destabilisation;* Shifting of resources could destabilise current service providers. For example force	2	4	8	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. CCG received Quality Impact Assessments from providers

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
	viability issues due to loss of funding in one area, cause issues with performance against contracts.				regarding their respective efficiency plans. LA will continue to engage with providers to ensure potential impact is understood and planned for.
22.	*Carers;* Risk that BCF impacts negatively on the support and experience of carers leading to a reduction in the number of carers. Carers may not be supported to continue to care through the various services currently in place, or the new services implemented, i.e. 7 day support for adult social care. If they cease to care this could result in increased costs for the LA and CCG	2	2	4	Existing support for carers is delivered through a number of services including respite, short break, carers emergency scheme, carers centre, carers assessment officers. The risk that services may be disrupted through the transformation/ integration process was identified and a risk pool allocated to ensure that carers and customers could continue to access services that they need throughout the process of change in 2016-17. They would also be able to benefit from any new services delivered, through the BCF and Care Act implementation. A revised Joint Carers Strategy has been developed which will link in to the BCF and other strategic objectives for Health and Social Care. Revised Carers Handbook in place which will be launched at the Carers week in June 2016.

16. Contingency Planning and Risk Sharing

A risk pool of £500,000 has been included in the BCF financial plan for 2016-17 to mitigate the risk of non-delivery of the non-elective savings requirement which is to dampen down growth and demand (rather than reduce admissions from 2014/15 outturn).

The risk pool is also in place to support any unintended consequences of successful initiatives on other parts of the system e.g. demand created from improved case management. Financial monitoring of schemes is in place and risks materialising in year will be monitored and mitigated through the risk pool and expected slippage on new investment through BCF. Planned analysis completed and proposals for use of year-in slippage to support risks in BCF will be agreed through the BCF governance structure as appropriate.

Risks are to be supported by the fund through the CCG, with cases for additional support to be considered through the appropriate governance structure in 2016/17.

A financial governance process is in place and the financial monitoring and performance information is to be provided at monthly operational group meetings and quarterly at Director and Member level. The financial framework will expose those areas of high risk in year and identify areas where slippage may be available to balance the financial pressure in year. The recurrent plans will be modified, where appropriate, as part of the planning cycle for both Health and Social Care in totality, with the introduction of a Section 75 pooled budget agreement from 2016/17.

The CCG has a robust plan with regards to keeping emergency admissions within affordable levels and has been very successful since 2011. All local stakeholders are key players in delivering these plans through the System Resilience Group. The CCGs contracts with providers specify that marginal tariff will apply if admissions exceed 11/12 rates, admissions above that rate will be funded at 30% of tariff, NHS England will manage through the System Resilience Group how the remaining 70% should be best invested to reduce admissions. Check this is still accurate with Keely/Louise??

All local stakeholders are members of the System Resilience Group. This plan has been approved by the Task Group, comprised of Health and Wellbeing Board members and will be formally approved by the Board at its next meeting.

17. Patient Engagement

Our Better Care Fund vision will enable us to deliver on our Health and Well-Being Strategy and vision. It is based on what Rotherham people have told us is most important to them. Rotherham partners have a commitment to make sure that the views and reported experience of people who use local services are heard and acted upon, and a “right first time” principle applies to the delivery of services whether they are provided directly by us or commissioned.

We engage with inspirational local people in a number of forums, both formally brokered (e.g. the Council’s Customer Inspection Team; the Rotherham Learning Disability Partnership Board; Rotherham Speak Up) and informal (e.g. Rotherham Older People’s Forum, the Carers4Carers

Mental Health Support Group) to understand the barriers for local people in accessing the most appropriate support, staying safe; and keeping well. We have used a variety of methods to capture the views and experiences of local patients, service users and their carers to inform our local plans.

Through the mapping of service users views and experience and understanding the journeys people take, we have identified a number of 'I statements' which demonstrate the outcomes local people want from better integrated, person-centred services. The BCF Plan will focus on achieving the following outcomes for patients and service users.

'I am in control of my care'

People want to feel central to decision making and development of their care plans, they want all professionals and services to communicate with each other to understand their care needs and ensure they receive the most appropriate care for their circumstances, and they want to be provided with the right information to help them to manage their conditions and make informed choices about their own health and well-being.

'I only have to tell my story once'

People want all organisations and services to talk to each other and share access to their information, so that they only ever have to tell their story once.

'I feel part of my community, which helps me to stay healthy and independent'

People want to feel independent and part of their community and want organisations to provide better information and support to help them to do this, understanding that this reduces social isolation and avoids the need for more formal care services later on.

'I am listened to and supported at an early stage to avoid a crisis'

People want support, advice and information at an early stage to help them look after their mental health and wellbeing, avoiding the need for more intense, high-level services when they reach crisis pint.

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'

People want a greater focus on preventative services and an increased capacity in community activity to prevent high intensity use of services and more formal care, and to help them better manage their conditions. They also want services to be available 7 days a week and information and advice to be more accessible. Understanding the journeys that people take into health and care services will help us to provide more appropriate information and support at times when people need it most.

'I feel safe and am able to live independently where I choose'

People want to stay independent and in their own home or community for as long as possible. They want to feel safe to do this and know that the right support is available when and where they need it.

Customer experiences will be closely monitored throughout the delivery of the BCF Plan via the 6 'I statements'. This will involve the Local Authority's Performance and Quality Team contacting service users and obtaining their views regarding the services they are receiving. This will help us to see the real impact of service reconfiguration and help us improve delivery based on customer feedback.

Through surveys, telephone and face to face interviews, the team will develop a number of case studies, to identify the positive and negative impacts that the BCF plan has had on customer experiences. Rotherham Council has in place a Customer Inspection Service, with individuals who are customers and experts by experience. This group will support the assessment of the impact of the BCF plan and help us to see the implementation through the eyes of the customer. These experts by experience will also help us to identify where further improvements are needed. All feedback will be used to further enhance and improve the customer experience.

An example of recent consultation which will be used to support BCF Planning in 2016-17 is the engagement event which took place in February 2016 (Appendix 11) with a focus on older carers, ran by Rotherham CCG and NHSE. It is anticipated that in conjunction with utilising this information as evidence of need to inform national planning, the intelligence emerging from this particular engagement activity will be used to inform the more local planning/development of carer support services. This fits in well with the recent development of a carers strategy and the priority identified in this BCF plan for an integrated carers service by 2019.

18. Engagement with Providers and Stakeholders

18.1 Evidence of Engagement

The Rotherham Health and Wellbeing Board has had consistent representation from the main local health providers (RDaSH) and the voluntary sector (Voluntary Action Rotherham). They are each represented at board meetings, and their contribution has been embedded through the key theme groups, and the ongoing discussions regarding BCF. This involvement has ensured they have been engaged throughout the process and are fully signed up to the principles and vision of the BCF Plan. Healthwatch Rotherham are key partners at the Health and Wellbeing Board, bringing added value and independence through their direct relationship with people who are using services.

Local health providers understand that Rotherham CCG has identified a range of services which now form part of the BCF. They are aware that the commissioning arrangements, specifications and targets for these services are likely to change significantly over the coming years. Locally the BCF will affect services delivered by Rotherham Foundation Trust (TRFT) and key voluntary sector partners. All provider organisations continue to express a willingness to work under the new commissioning framework, recognising the potential opportunities to improve outcomes for Rotherham people. TRFT is committed to delivering integrated health and social care pathways and regard the BCF as a vehicle through which these can be achieved. This is reflected in the Community Transformation Programme underway where TRFT are playing a lead role (Appendix 12).

Local healthcare providers are engaged through monthly clinically led QIPP (Quality, Innovation, Productivity and Prevention) groups where pathway redesigns, innovation and efficiency are key deliverables.

Rotherham CCG is working in partnership with RDASH, transforming mental health services in the borough. Regular transformation events are taking place with commissioners, providers (independent/VCS), service users and carers on this programme (Appendix 13).

Rotherham commissioners have a long established relationship with the local voluntary and community sector (VCS), both as partners in working to improve social capital locally, and directly as provider organisations. Commissioners engage formally through the Council's Contracting for Care and Provider Forums. There is additional engagement through the Adult Social Care Consortium. The VCS has a strong local voice with Elected Members and Trust Boards. We understand that the remit of the VCS extends far beyond that of our public services. VCS acts as an interface with people in our communities who do not use statutory services and who arrange their own care.

Voluntary sector partners have engaged with us in delivering a wide range of services, some of which are included in the BCF Directory of Services. The sector forms part of integrated care pathways in stroke, dementia care, carer support, and crisis services for people with mental health problems. We see BCF as a catalyst, helping to embed voluntary sector services into condition specific care pathways. The sector is also a key partner in prevention and early detection, signposting and offering advice and support to people who may be at risk of needing acute intervention. The BCF Plan supports this specifically through the Social Prescribing Programme.

One example of good practice in relation to provider/stakeholder engagement is the "Meet The Buyer" events which included representation from across the health and social care sector. These events also included independent and voluntary sector providers responsible for delivering social care services. The purpose of the meetings was to consult on the Health and Wellbeing Strategy, the impact of the Care Act, Better Care Fund and the adult social care development programme.

Providers and stakeholders are fully sighted on plans to transfer resources from acute services to the community. This includes community assets and workforce requirements. Assessment of workforce and capacity issues resonates through provider operating plans and will be an integral part of all BCF service reviews which take place in 2016-17.

18.2 Provider/Stakeholder Engagement Strategy

This section of the Rotherham Better Care Fund Plan sets out the communication and engagement strategy for 2016/17. It includes a range of ways in which provider representatives, including front line staff, can be involved in the development, implementation and evaluation of our programme. Clinicians and other practitioners will play a key role alongside service users and carers in ensuring that the BCF makes a positive difference to people's lives. As well as providers there is great interest and enthusiasm from the voluntary and community sector, services users and carers, and representatives such as Healthwatch. We have used a variety of methods to capture the views and experiences of local patients, service users and their carers to inform our local plans.

We will build on existing approaches to develop a strong service user and community voice within the Better Care Fund. This plan sets out our basic communications and engagement objectives, identifies the stakeholders we hope to work with, and confirms our commitment to the adoption of co-design principles.

In Rotherham we have identified 6 themes which incorporate all existing provision and the key priorities.

Theme 1:	Mental Health
Theme 2:	Rehabilitation and Reablement

Theme 3:	Supporting Social Care
Theme 4:	Case Management and Integrated Planning
Theme 5:	Supporting Carers
Theme 6:	Infrastructure (including Care Act)

Our communication and engagement programme will be based around these key themes, creating service user and stakeholder strategies for each. The overall strategy will be based on the following principles;

Collaboration	Bringing together clinicians, staff, patients, service users and the community together as equal partners
Evidence-based	Co-design an evidence base which will support service redesign
Capability	Developing the capacity of patients, service users and the community to engage effectively in identifying needs, planning, procurement, implementation and evaluation.
Review	After redesign has been implemented, using stakeholders and service users to evaluate impact, monitor quality and support performance management

Table 7 sets out a local map of all stakeholders, channels of communication and how we will keep people informed. Funding for communications and engagement activity and support will be part of the programme costs for the Better Care Fund Programme and will be confirmed once further development work has taken place.

Over the next few months we will be briefing stakeholders on the journey so far – how the Better Care Fund has been put together and where it is going. We will then work with them to refine the programme and develop an approach for involving relevant people from all the stakeholder groups in the development of each theme.

The BCF Plan is fully consistent with our provider's operational plans. Chief Executives of The Rotherham Foundation Trust (TRFT) and Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) (our two biggest health providers) support the Better Care Fund submission and clinicians and managers from TRFT and RDasH are fully engaged in delivery. TRFT and RDaSH are also members of the Health and Well-Being Board, Systems Resilience Group, Clinical Referral Management Committee and Joint Commissioning Performance Groups.

Table 7: Stakeholder Map

Stakeholder	***Channels***	***Reporting***
Service users / patients	Briefings, newsletters, websites. Range of participative events which are general and specific to the BCF themes/priorities. Use of existing for and meetings.	No set reporting periods
Health watch		
CCG Governing Body	Formal governance	6 monthly reports
Council, Cabinet and Scrutiny	Formal governance	6 monthly reports

Stakeholder	*Channels*	*Reporting*
Health and Wellbeing Board	Formal governance	6 monthly reports
MPs and Councillors	Briefings	Annual
NHS clinicians and staff	Briefings, newsletters, websites. Range of participative events which are general and specific to the BCF themes/priorities. Use of existing for and meetings.	No set reporting periods
RMBC staff		
Service providers		
3rd sector organisations		
Public	Website, newsletters and local publicity	

We will work with our provider partners adhering to best practice guidelines and relevant legislation (Health and Social Care Act 2012) to ensure that, when services change, we will engage, inform and consult. We will endeavour to secure the confidence of patients, staff and the public in change proposals. We will use NHS England's guidance for building proposals for major service change including the 'four tests'.

19. Funding Arrangements

Financial Risk Sharing and Contingencies

There is a risk sharing policy in the Section 75 Partnership Agreement (Appendix 14) and this has worked well in 2015/16, can be evidenced and has been audited twice in the last 12 months with significant assurance given on both occasions that the governance arrangements are in place and working within the framework and policies.

There will be two pools as in 2015/16 but the content and financial allocations have be re-classified following the review of the services in 2015/16. This change to the plan was approved by the BCF Executive Group on 16th March 2016.

Protection of Social Services

In 2015/16, all BCF schemes were reviewed and re-classified from 15 to 7 key themes. This included the definition of 'Protecting Social Care' which is embedded throughout the BCF themes.

Services funded through the BCF which help maintain essential social care services include Community based services, residential care, equipment and assistive technology, services for carers and 7 day social work support. More detail is shown in Table 9 including additional investments.

Total investment in social care has increased from £8.6m in 2015/16 to £9.3m in 2016/17, mainly in respect of equipment and adaptations and to meet additional cost pressures arising from the Care Act 2014.

The detailed financial plans will be submitted in the tables but the movement between 2015/16 and planned BCF for 2016/17 is provided below:

Table 8: Summary of Financial Plan

			ADDITIONAL INVESTMENT			ALLOCATION OF POOLED BUDGETS		
	THEME	2015/16 BCF	RMBC	RCCG	2016/17 BCF PLAN	RCCG POOL	RMBC POOL	TOTAL
		£000s	*£000s*	*£000s*	*£000s*	*£000s*	*£000s*	*£000s*
1	MENTAL HEALTH SERVICES	375		471	**846**	**846**		**846**
2	REHABILITATION AND REABLEMENT	12,532	166	482	**13,180**		**13,180**	**13,180**
3	SUPPORTING SOCIAL CARE	2,982			**2,982**	**2,982**		**2,982**
4	CASE MANAGEMENT AND INTEGRATED CARE PLANNING	4,842		254	**5,096**	**5,096**		**5,096**
5	SUPPORTING CARERS	670	50		**720**	**720**		**720**
6	INFRASTRUCTURE (including Care Act)	499		500	**999**	**999**		**999**
7	RISK POOL	1,416		(916)	**500**	**500**		**500**
	TOTAL	**23,316**	**216**	**791**	**24,323**	**11,143**	**13,180**	**24,323**

Table 9: Summary of Investment Profile

	Service Area	2015/16 BCF £000	Additional costs	2016/17 BCF £000	Strategic Relevance	Service Spec	Perf F/work	Perf Issues	Recommendation
		£000	£000	£000					
Theme 1: Mental Health Services									
1	Adult Mental Health Liaison	**375**	**471**	**846**					Incorporate CCG funding
Theme 2: Rehabilitation and Reablement									
2	Home Improvement Agency	60	15	75					Incorporate RMBC funding
3	PSS Adult Services Capital Grant	749	(749)	0					**Grant ended 2015/16**
4	Falls Service	275	152	427					Incorporate CCG funding
5	Home Enabling Services	1,556		1,556					Requires Specification and SLA
6	2 SSO reviewing officers to fast track assessments during reablement	98		98					Requires Specification and SLA
7	Community Stroke Service	175		175					Ok
8	Community Neuro Rehab	151		151					Review – performance issues
9	Breathing Space	2,064	160	2,224					Incorporate funding review
9	Breathing Space	2,064	160	2,224					Incorporate funding review
10	Expert Patient Programme	50		50					OK
11	REWS	634	170	804					Incorporates funding review
12	Community OT	753		753					Review
13	Disabled Facilities Grant	1,219	900	2,119					Ok
14	Age UK Hospital Discharge	158		158					Ok
15	Stroke Association Service	50		50					Ok
16	Stroke Social Work Support	27		27					Ok
17	Intermediate Care Pool	4,513		4,513					Review
	Total	**12,532**	**648**	**13,180**					
Theme 3: Supporting Social Care									
18	Direct Payments	1,643		1,643					Requires Specification and SLA
19	Residential Care	274		274					Requires Specification and SLA
20	Learning Disability Services	1,065		1,065					Review
	Total	**2,982**	**0**	**2,982**					
Theme 4: Case Management and Integrated Care Planning									
21	GP Case Management	2,200	(55)	2,145					Update BCF allocation
22	Care Home Support Service	264	51	315					Incorporate funding review
23	Death in Place of Choice	775	13	788					Incorporate CCG funding

Service Area		2015/16 BCF £000	Additional costs	2016/17 BCF £000	Strategic Relevance	Service Spec	Perf F/work	Perf Issues	Recommendation
24	Otago Exercise Programme	20		20					Ok
25	Social Prescribing	505	245	750					Incorporate CCG funding
26	Social Work Support (A&E, Case management, Supported Discharge)	1,078		1,078					Requires Specification and SLA
	Total	**4,842**	**254**	**5,096**					
Theme 5: Supporting Carers									
27	Day Care Services	350		350					Requires Specification and SLA
28	Carers Centre	100		100					Requires Specification and SLA
29	Carers Support Service	150	50	200					Incorporate RMBC funding
30	Reablement – Crossroads	70		70					Requires Specification and SLA
	Total	**670**	**50**	**720**					
Theme 6: Infrastructure									
31	Joint Commissioning Team	49		49					Review
32	IT to support Comm. Trans.	250		250					OK
33	Care Act Implementation	200	500	700					Requires Specification and SLA
	Total	**499**	**500**	**999**					
34	Contingency Fund	**1,416**	(916)	**500**					Managed in year
	Total	***23,316***	***1,007***	***24,323***					

20. Appendices

Ref.	Document	Synopsis and links
Page 3 **(embedded document)**	**Map of Rotherham**	This map was produced by Rotherham Borough Council to illustrate the 7 Area Assemblies across the borough
Page 4 **(web links provided)**	Rotherham Mental Health Adults and Older People's Transformation Plan	The plan sets out a plan on a page for the transformation of services to ensure people of all ages are able to live as normal and inclusive a life as possible. http://moderngov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=103679
Page 5 **(web links provided)**	**Health and Wellbeing Strategy**	The joint strategy which sets out the priorities of the health and wellbeing board for 2015 – 2016. http://www.rotherham.gov.uk/hwp/downloads/file/4/rotherham_borough_joint_health_and_wellbeing_strategy_2015-18
Page 5 **(web links provided)**	**CCG Commissioning Plan 2015-19**	The Rotherham CCG Commissioning Plan 2015-19 http://www.rotherhamccg.nhs.uk/
Page 5 **(web links provided)**	**Joint Strategic Needs Assessment**	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
Page 6 **(web links provided)**	**Market Position Statement for Older People**	The Market Position Statement has been developed by Rotherham Council to inform current and potential providers of social services in the borough of the direction of social care services for older people over the next few years. http://www.rotherham.gov.uk/downloads/file/959/market_position_statement_for_older_peoples_services_2014
Page 41	**RCCG Communication and Engagement Plan**	Rotherham CCG communication and engagement plan 2015-19 sets out how the NHS Rotherham Clinical Commissioning Group (RCCG), are committed to engaging, communicating and consulting with a wide range of audiences, using the right platforms and mechanisms. http://www.rotherhamccg.nhs.uk/Downloads/Publications/comms%20and%20engagement%20plan%20final%202015-16.pdf

Ref.	Document	Synopsis and links
Appendix 1	**BCF Service Review Programme**	The service review report sets out recommendations for the reconfiguration of the Better Care Fund. The report provides a breakdown of current funding identified within the BCF programme, overall cost of the service and costs that are covered through alternative funding streams.
Appendix 2	**Review of Social Prescribing Service**	Review details analysis, impact, outcomes, case studies, costs, and benefits.
Appendix 3	**BCF Directory of Services**	The BCF Directory of Services provides clarity on where BCF funding is currently being invested and the strategic relevance of each scheme.
Appendix 4	**Analysis of BCF Schemes**	Analysis shows re-categorisation of existing BCF schemes, showing no negative impact on provision
Appendix 5	**Delayed Transfers of Care Action Plan**	This is a local DTOC action plan which shows actions taken to delayed transfers of care from hospital.
Appendix 6	**Memorandum of Understanding**	Agreement between CCG, LA and Rotherham Foundation Trust which sets out roles and responsibilities in relation to hospital discharge for all patients who are medically fit for discharge..
Appendix 7	**Tier 2: Data Sharing Agreement**	An agreement between CCG and LA around sharing adult social care information with the Rotherham NHS Foundation Trust for the purpose of assigning NHS numbers to social care6records.
Appendix 8	**RMBC Digital Council Strategy "Your Digital Council"**	The Strategy shows the continuing importance of a digital infrastructure in Rotherham which includes "broadband, online services, access and skills to provide a modernised public service.
Appendix 9	**RCCG IT Strategy (2015/16)**	The strategy ensures that CCG has IT capabilities to support the delivery of its commissioning plan including the development of a clinical portal that will integrate information from health and care services .
Appendix 10	**Digital Road Map Communication and Engagement Plan**	A plan which details the benefits of a clinical portal and managing patients. Consultation with Healthwatch, community, voluntary sector and care homes.
Appendix 11	**Rotherham Engagement Event**	Presentation on evidence of need, with a focus on access to services for vulnerable carer groups.

Ref.	Document	Synopsis and links
Appendix 12	**Community Transformation 2**	Presentation on Stage 2 of Transforming Unscheduled Care
Appendix 13	**Rotherham Mental Health Transformation Event**	Paper showing updating on adult and older people's Mental Health transformation agenda.
Appendix 14	**Section 75 Partnership Agreement**	The agreement has been signed and agreed by CCG and Local Authority setting out commissioning intentions in the use of the BCF

Rotherham Metropolitan Borough Council
Neighbourhoods & Adult Services

NHS
Rotherham
Clinical Commissioning Group

1.	**Meeting:**	**HEALTH AND WELLBEING BOARD**
2.	**Date:**	**1st June, 2016**
3.	**Title:**	**Section 75 Agreement 2016-17**

4. Summary

The purpose of this report is to provide an overview of the Section 75 agreement for 2016-17 for consideration and sign off, so that the NHS England deadline can be met.

5. Recommendations

That the Health and Wellbeing Board:

(i) Approve the Section 75 agreement.

(ii) Delegate authority to senior officers from both RCCG and RMBC to make minor amendments in line with final guidance from NHS England prior to final sign off by 30th June, 2016.

6. Background

6.1 The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

6.2 The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. In 2016-17, NHS England has set a number of conditions, which local areas will need to meet to access the funding one of which details the requirement that the Better Care Fund is transferred into one or more pooled funds established under Section 75 of the NHS Act 2006

6.3 The purpose of the Agreement is to set out the terms on which we have agreed to collaborate and to establish a framework through which we can secure the future provision of health and social care services through lead or joint commissioning arrangements. It is also a means through which we can pool funds and align budgets as agreed between us.

The aims and benefits in entering in to this Agreement are to:

(a) improve the quality and efficiency of the Services;

(b) meet the National Conditions and Local Objectives;

(c) make more effective use of resources.

6.4 The Section 75 in place for 2015-16 has been revised and updated to align with the outcomes of the BCF service review which took place in December 2015. The main amendments include a revised structure for categorising BCF services, a review of the governance arrangements, an updated risk register, changes to the financial envelope and risk sharing arrangements.

6.5 The Section 75 covers all the requirements set out within the guidance provided by NHS England.

6.6 The financial envelope for the BCF 2016-17 has been agreed. This has seen the BCF programme increase by circa £1.0m predominantly in Mental Health, Falls and Intermediate Care.

6.7 There is a requirement to create a fund for the Care Act for the Local Authority. The benchmark value is £0.77m – the proposed budget for Rotherham is £0.7m.

6.8 The risk pool for 2016-17 is £0.5m

7. Contacts

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Agenda Item 5B

Dated 1st April, 2016

ROTHERHAM METROPOLITAN BOROUGH COUNCIL

and

NHS ROTHERHAM CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES FROM THE BETTER CARE FUND

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THIS AGREEMENT is made on 1ST day of April 2016.

PARTIES

(1) **NHS ROTHERHAM CLINICAL COMMISSIONING GROUP of Oak House, Moorhead Way, Bramley, Rotherham, S66 1YY** (the "**CCG**")

(2) **ROTHERHAM METROPOLITAN BOROUGH COUNCIL Riverside House Main Street Rotherham S60 1AE (the "Council")**

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services pursuant to the Care Act (2014) on behalf of the population of the borough of Rotherham.

(B) The CCG has the responsibility for commissioning health services pursuant to the NHS Act (2006) in the borough of Rotherham.

(C) The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund.

(D) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose. The Partners wish to extend the use of pooled funds to include funding streams from outside of the Better Care Fund.

(E) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(F) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also the means through which the Partners will pool funds and align budgets as agreed between the Partners.

(G) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) drive integration between the Health and Social Care Economy;

d) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services.

(H) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(I) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

2014 Act means the Care Act 2014

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this Agreement including its Schedules and Appendices.

Approved Expenditure means any expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

BCF Executive Group means the partnership group with responsibility for overseeing the operational management of this Agreement and the schemes under it, as detailed in clause 19 and Schedule 2

BCF Guidance means such guidance in relation to the Better Care Fund as issued from time to time by the department of Health, the department of communities and local Government, NHS England or the Local Government Association either in concert or separately.

BCF Operational Group means the officer group with day to day responsibility for the overseeing of the operation of the schemes in the Better Care Fund Plan in support of the BCF Executive Group, as described in 'clause 19 and Schedule 2.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 1st April 2016.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any Service User or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract) to be payable by any Partner(s) to the Provider as a consequence of (I) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and
(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund and for each Aligned Fund the Partner that will host the Aligned Fund.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other is exercise of both the NHS Functions and Council Functions through integrated structures as set out in Schedule 4.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 10.4.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 8.2.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1st April to 30th June

1st July to 30th September

1st October to 31st December

1st January to 31st March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification, and as set out in Schedule 4.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 Subject to Clause 2.3 and Clause 2.4 this Agreement shall continue for one year until 31st March 2017 (the "Initial Period").

2.3 Subject to Clause 2.4, the Partners may by agreement in writing extend this Agreement at any time during the period of the existing Agreement.

2.4 Where there is an obligation on the Partners under Law or BCF Guidance to have in place Pooled Fund arrangements in respect of the Better Care Fund, this Agreement shall continue in force until such time as such obligation ceases and either Partner has given notice to terminate under Clause 22 or the Partners agree alternative arrangements to meet the BCF Guidance and their statutory requirements.

2.5 The duration of each Individual Scheme shall be in line with this Agreement unless otherwise set out in the relevant Scheme Specification or agreed by the Partners.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme Specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements;

4.1.2 Integrated Commissioning;

4.1.3 Joint Commissioning

4.1.4 the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities")

4.2 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be completed and agreed between the Partners. The initial Scheme Specification is set out in Schedule 1.

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by the BCF Executive Group.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in co-operation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.4 The Partners shall comply with the arrangements in respect of the Joint (Aligned) Commissioning as set out in the relevant Scheme Specification and as detailed in Schedule 4.

6.5 Each Partner shall keep the other Partners and the BCF Executive Group regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

6.6 The BCF Executive Group will report back to the Health and Wellbeing Board as required by its Terms of Reference.

6.7 Staff in the integrated commissioning team may be made available under S113 of the Local Government Act 1972 to the Partner who is not their employer for the purposes of this Agreement, save that it is not intended that decision making power should be exercised by such employees on behalf of the other Partner.

Appointment of a Lead Commissioner

6.8 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.8.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.8.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year;

6.8.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.8.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.8.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.8.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the “Commissioner” and “Co-ordinating Commissioner” with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.8.7 undertake performance management and contract monitoring of all Service Contracts together with contract management and enforcement of contract conditions as necessary;

6.8.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract.

6.8.9 keep the other Partner and the BCF Executive Group regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 the Contract Price;

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 performance Payments;

7.3.4 the purchase of goods and services expressly contemplated in any Scheme;

7.3.5 approved Expenditure as agreed by the Partners;

7.3.6 capital expenditure as set out in any individual scheme.

("Permitted Expenditure")

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of the BCF Executive Group.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Service where there is a Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the BCF Executive Group and BCF Operational Group as required by the group and the relevant Scheme Specification;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

8.2.7 preparing and submitting to the BCF Executive Group and BCF Operational Group quarterly reports (or more frequent reports if required by either Group) and an annual return about the income and expenditure from the Pooled Fund together with an annual report and other requirements as set out in Schedule 5, and such other information as may be required by the Partners and the BCF Executive and Operational Groups to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met as set out in schedule 9;

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as required by it including supplying the quarterly reports referred to in paragraph 8.2.7 above to the Health and Well Being Board.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the BCF Guidance and the recommendations of the BCF Executive Group and shall be accountable to the Partners.

8.4 The BCF Executive Group may agree to the viring of funds between Pooled Funds.

9 NON POOLED FUNDS

9.1 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.2 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

9.2.1 which Partner if any shall host the Non-Pooled Fund;

9.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.4 Both Partners shall ensure that Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.

9.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

9.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the CCG Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

9.5.2 the Health Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.

10.2 Financial Contributions will be determined according to National Conditions regarding Better Care Fund contributions. The Partners may wish to vary this in the future pursuant to the aims of the Pooled Fund, but may only do so with the agreement of the BCF Executive Group.

10.3 Financial Contributions will, subject to the BCF Guidance, be paid as set out in the each Scheme Specification.

10.4 No provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the BCF Executive Group minutes and recorded in the budget statement as a separate item.

10.5 For the avoidance of doubt any charges received from Service Users shall be paid to the Council.

11 NON FINANCIAL CONTRIBUTIONS

11.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund). Save as otherwise stated in the Scheme Specification, no charges shall be made in relation to non-financial contributions

12 RISK SHARE ARRANGEMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The Partners have agreed risk share arrangements as set out in Schedule 3, which provide for financial risks arising within the commissioning of Services from the Pooled Funds. This is in line with the 2016/17 Better Care Fund Policy Framework; National Conditions to establish where

appropriate local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care.

Overspends in Pooled Fund

12.2 Subject to Clause 12.3, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the BCF Executive Group in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the BCF Executive Group is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedules 2 and 3 shall apply.

Overspends in Non Pooled Funds

12.5 Where in Joint Commissioning Arrangements either Partner forecasts an overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund that Partner shall as soon as reasonably practicable inform the other Partner and the BCF Executive and Operational Groups.

12.6 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund. The Lead Commissioner shall as soon as reasonably practicable inform the other Partners and the BCF Executive and Operational Groups.

Underspend

12.7 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of any Performance Payment Arrangement.

13 CAPITAL EXPENDITURE

13.1 Where capital expenditure forms part of the Pooled Fund it shall be identified and accounted for separately from revenue expenditure and treated in accordance with any specified grant funding conditions. Capital funding cannot be used to finance revenue expenditure, however, revenue funding may be used to fund capital expenditure if in agreement with the BCF Executive Group and is in compliance with the Hosts Financial Regulations and Standing Orders and recommended accounting codes of practice.

13.2 Any capital asset acquired from the Pooled Funds shall be the property of the Council, who shall be responsible for it.

14 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise. In principle where the pooled fund is hosted by the Council the Council regime shall apply, and where the pooled fund is hosted by the CCG, the NHS VAT regime shall apply.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties in accordance with the specification of requirements set out at Schedule 10. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the BCF Executive Group.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

The Partners shall comply with their agreed policies for identifying and managing conflicts of interest as set out in Schedule 7.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established a BCF Executive Group to manage and give oversight to the delivery of the BCF plan:

19.3 Its role is as follows:

- monitor delivery of the Better Care plan through quarterly meetings;
- ensure performance targets are being met;
- ensure schemes are being delivered and additional action put in place where the plan results in unintended consequences;
- make decisions relating to delivery of the plan;
- report directly to the Health and Wellbeing board on a quarterly basis .

19.4 The BCF Executive Group is based on a joint working group structure. Each member shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the BCF Executive Group to carry out its objectives, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.5 The terms of reference of the BCF Executive Group shall be as set out in Schedule 2.

19.6 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.7 The BCF Executive Group shall be responsible for the overall approval of the Individual Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.8 The BCF Operational Group shall be responsible for the day to day oversight of the BCF workplan, as set out in Schedule 2.

19.9 The BCF Operational Group shall ensure that the service lead for each service within the Better Care Fund Plan reports on a monthly basis on the performance of the services working to the requirements of the BCF Executive Group guidelines, and the requirements of NHS England and the BCF guidance.

20 REVIEW

20.1 Save where the BCF Executive Group agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund, Non Pooled Fund and Aligned Fund and the provision of the Services within 3 Months of the end of each Financial Year.

20.2 Subject to any variations to this process required by the BCF Executive Group, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.3 The Partners shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the BCF Executive Group.

20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination of the obligations on the parties to maintain a Better Care Fund.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 12, 15, 16, 21, 22 25, 26, 27, 28, 32, 33, 37 and 39.

22.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.6.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

22.6.5 the BCF Operational Group shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officers selected by the BCF Executive Group shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the council's Director of Adult Care and Housing and the CCG's Accountable officer or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator.

23.5 The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.6 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, subject to Clause 22.1 either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales.

26.2 This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.3 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in Schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act**.**

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail.

29.2 The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.2.1 personally delivered, at the time of delivery;

29.2.2 sent by facsimile, at the time of transmission;

29.2.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.2.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.3 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.4 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.4.1 to the Council, addressed to

Mr Graeme Betts
Interim Director of Adult Care and Housing
Riverside House
Main Street
Rotherham
S60 1AE
Tel: 01709 823928
E-mail: Graeme.betts@rotherham.gov.uk

29.4.2 to the CCG, addressed to

Mr Christopher Edwards,
Chief Officer NHS Rotherham CCG Oak House,
Moorhead Way,
Bramley,
Rotherham
S66 1YY
Tel: 01709 302009
Email: chris.edwards@rotherhamccg.nhs.uk

30 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

Signed on behalf of the ROTHERHAM
METROPOLITAN BOROUGH COUNCIL

Authorised signatory

Signed for on behalf of the
NHS ROTHERHAM CLINICAL
COMMISSIONING GROUP

Authorised signatory

SCHEDULE 1 OVERARCHING SCHEME SPECIFICATION

Part 1 – Better Care Fund Schemes

Unless the context otherwise requires, the defined terms used in this Schedule shall have the meanings set out in the Agreement. Further RCCG means the CCG and RMBC means the Council

1 Introduction

1.1 The Rotherham Health and Wellbeing Strategy (2015-18) sets out Rotherham's overarching vision to improve health and well-being, enabling people to live fulfilling lives, to be actively engaged in their community and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board has made a commitment to ensure the commissioning and delivery of services which are more integrated, person-centred, provide high quality care and are accessible to all people and which will work to improve health outcomes for local people.

1.2 The Better Care Fund Plan contributes to 4 of the strategic aims of the local Health and Wellbeing Strategy. In particular Aim 3 & 4 as described below:

1.2.1 Aim 1 All children get the best start in life;

1.2.2 Aim 2 Children and young people achieve their potential and have a healthy adolescence and adulthood;

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

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

1.3 The strategy sets out clear priorities which will be delivered through Rotherham's total place spending which is expressed in detail in the commissioning plans of the Council, Public Health and Rotherham CCG of the Better Care Fund Plan.

1.4 The full Health and Wellbeing strategy is available at:
http://www.rotherham.gov.uk/hwp/downloads/file/4/rotherham_borough_joint_health_and_wellbeing_strategy_2015-18

1.5 Rotherham has been successful in achieving a 16% reduction in non-elective admissions to hospital over the last 5 years (and enabled a substantial investment in additional community services).

1.6 The Rotherham BCF Plan is well-aligned with the population needs and schemes will focus on improving the integration of health and social care services, supporting better customer and patient outcomes through more streamlined working and through delivering person centred care to improve the customer and patient experience.

1.7 The Better Care Fund Action Plan brings together 33 schemes that are identified under 7 themes which are key to delivering the overall Health and Well-Being Strategy. These schemes have been initiated and supported by the Better Care Fund, and comprise a large component of the innovative schemes that partners in Rotherham are developing to improve the delivery and efficiency of community care. Additional investments of £1million have been added to the Better Care Fund for 2016/17, giving a total investment of £24.323m for all 33 schemes. The increase in investment has been predominantly in Mental Health, Falls and Intermediate Care. The 7 themes identified are as follows;

Theme 1: Mental Health
Theme 2: Rehabilitation, Reablement and Intermediate Care
Theme 3: Supporting Social Care

Theme 4: Case Management and Integrated Care Planning
Theme 5: Supporting Carers
Theme 6: Infrastructure
Theme 7: Risk Pool

Particulars of the schemes are set out in part 2 of this Schedule. The amount receivable by the Council for the Disabled Facilities Grant of £2.119m is included in this agreement.

2 Pooled fund structure

2.1 In meeting its duties and responsibilities to develop a pooled arrangement to support the BCF Plan, the Partners and Rotherham Health and Wellbeing Board has agreed the establishment of the following pooled arrangements:

2.1.1 Pool 1; Hosted by the CCG; Value of £10.952m; for all Themes excluding Theme 2 Rehabilitation, Reablement and Intermediate Care

2.1.2 Pool 2; Hosted by RMBC; Value of £13.323m; for Theme 2 Rehabilitation, Reablement and Intermediate Care including jointly commissioned integrated services and Capital Disabled Facilities Grants

			ADDITIONAL INVESTMENT			Pool 1 Pool 2 ALLOCATION OF POOLED BUDGETS		
	THEME	2015/16 BCF	RMBC	RCCG	2016/17 BCF PLAN	RCCG POOL	RMBC POOL	TOTAL
		£000s	*£000s*	*£000s*	*£000s*	*£000s*	*£000s*	*£000s*
1	**MENTAL HEALTH SERVICES**	375		471	**846**	**846**		**846**
2	**REHABILITATION AND REABLEMENT**	12,532	166	482	**13,180**		**13,180**	**13,180**
3	**SUPPORTING SOCIAL CARE**	2,982			**2,982**	**2,982**		**2,982**
4	**CASE MANAGEMENT AND INTEGRATED CARE PLANNING**	4,842		254	**5,096**	**5,096**		**5,096**
5	**SUPPORTING CARERS**	670	50		**720**	**720**		**720**
6	**INFRASTRUCTURE (including Care Act)**	499		500	**999**	**999**		**999**
7	**RISK POOL**	1,416		(916)	**500**	**500**		**500**
	TOTAL	**23,316**	**216**	**791**	**24,323**	**11,143**	**13,180**	**24,323**

OVERVIEW OF SERVICES INCLUDED IN THE TOTAL BCF POOLED BUDGETS

The host partner for Pool 1 is NHS Rotherham CCG, and the pooled fund manager is Keely Firth, Chief Finance Officer

The host partner for Pool 2 is the Council and the pooled fund manager is Mark Scarrott, Finance Manager, Adult Social Care and Housing

3 AIMS AND OUTCOMES

3.1 The aim of this partnership agreement is to provide integrated services for people within Rotherham by:

3.1.1 providing a community based occupational therapy service for people living in their own homes (DH Guidance Occupational Therapy in Adult Social Care in England, 2008);

3.1.2 providing an Integrated Local Equipment Service (HSC 2001/008:LAC (2001)13) and DH Guide to Integrating Community Equipment Services, 2001);

3.1.3 providing an integrated intermediate care service for Rotherham (HSC 2001/1: LAC(2001)1) and DH Intermediate Care: Halfway Home (2009);

3.1.4 providing a service which effectively assesses and provides Disabled Facilities Grants (Housing Grants, Construction and Regeneration Act, 1996);

3.1.5 providing a falls service (National Service Framework for Older People in England 2001);

3.1.6 providing a comprehensive adult and older people's mental health liaison service for all people who self-refer or who are referred urgently to The Rotherham NHS Foundation Trust and Accident and Emergency department;

3.1.7 establishing a community rapid Response team;

3.1.8 developing a 7 day discharge support scheme (national condition of BCF);

3.1.9 developing information technology solutions to share service user and patient information amongst health and social care practitioners (national condition of BCF);

3.1.10 developing better methods for improving the health and wellbeing of people with long term conditions through social prescribing;

3.1.11 improving support to individuals seeking to take on personal health or care budgets;

3.1.12 investing in out-of-hospital commissioned services (national condition of BCF);

3.1.13 developing a joint local plan for Delayed Transfers of Care (DTOC) (national condition of BCF);

3.1.14 providing joint assessments and care planning (national condition of BCF).

3.2 Outcomes from this agreement is to establish services which will:-

3.2.1 prevent admission and reduce risk of re-admissions to hospital;

3.2.2 prevent admission to a care home;

3.2.3 reduce length of stay in hospital;

3.2.4 promote safe effective and timely discharge;

3.2.5 prevent falls and/or to reduce the impact of a fall;

3.2.6 extend provision of 7 days services to facilitate hospital discharge;

3.2.7 increase levels of quality of life, physical and mental health, wellbeing and independence at home;

3.2.8 receive rehabilitation services in residential, community or day settings;

3.2.9 increase resilience and support self-management by empowering individuals, families, carers and communities;

3.2.10 improve patient and customer satisfaction by providing more integrated services;

3.2.11 provide good quality end-of-life care to enable a person to die in their preferred place of choice.

3.3 The BCF Executive Group through the BCF Plan 2016-17 has identified the following priorities for 2016-19;

3.3.1 a single point of access into health and social care services;

3.3.2 integrated health and social care teams;

3.3.3 development of preventative services that support independence;

3.3.4 reconfiguration of the home enabling service and strengthening of the seven day social work offer;

3.3.5 a reablement hub incorporating intermediate care;

3.3.6 an integrated carers support service;

3.3.7 a multi-disciplinary rapid response service;

3.3.8 a single health and social care plan for people with long term conditions;

3.3.9 a joint approach to care home support;

3.3.10 a shared approach to delayed transfers of care (DTOC).

4 THE ARRANGEMENTS

4.1 Prior to this agreement a high level service review took place to explore where and how the services could most appropriately be aligned with each other and with similar services provided by the Council, the CCG and other partners or organisations. The services now specified within these schedules reflect the initial findings of the service review; further in-depth reviews will take place during the life of this agreement.

4.2 The services have a long history of effective joint commissioning and service provision. Delegated responsibility for services will be considered as part of the review process as it is clear that with further discussion and potential development, there may be benefits to patients and service users, and service efficiencies to be gained from further consolidating and developing and integrating services.

5 FUNCTIONS

5.1 The Health Related Functions and the NHS functions shall be delivered through the fund, to the extent relevant and as set out within the BCF plan.

6 PERSONS ELIGIBLE TO BENEFIT

6.1 Services commissioned by the CCG shall be commissioned for the benefit of individuals for whom in relation to that service the CCG is the responsible commissioner; for services commissioned by the Council, the services shall be commissioned for the benefit of individuals who are ordinarily resident in the Borough of Rotherham.

6.2 The CCG and the Council shall each liaise with any relevant neighbouring authority or CCG in respect of individuals who are the responsibility of either the CCG or the Council but not both.

6.3 The CCG and the Council shall apply such relevant eligibility criteria for access to services as a are appropriate for the service in the light of their statutory duties.

Part 2 - FINANCE

Financial Principles

1 The Council and the CCG will make defined contributions to the costs incurred by the Council through deployment of the BCF monies as set out in this section. Financial resources in subsequent years will be reviewed and determined in accordance with the Agreement.

CCG Pool 1 Funding 2016-17

	RCCG Hosted Pool
	£000
Theme 1 Mental Health	
Adult Mental Health Liaison	**846**
Theme 3 Supporting Social Care	
Direct Payments	1,643
Residential Care	274
Learning Disability Services	1,065
Total	**2,982**
Theme 4 Case Management and Integrated Care Planning	
GP Case Management	2,145
Care Home Support Service	315
Death in Place of Choice	788
Otago Exercise Programme	20
Social Prescribing	750
Social Work Support (A&E, Case management, Supported Discharge)	1,078
Total	**5,096**
Theme 5 Supporting Carers	
Day Care Services	350
Carers Centre	100
Carers Support Service	200
Reablement – Crossroads	70
Total	**720**
Theme 6 Infrastructure	
Joint Commissioning Team	49
IT to support Comm Trans	250
Care Act Implementation	700
Total	**999**
Contingency Fund	**500**
Overall Total	**11,143**

RMBC Pool 2 Funding 2016-17

	RCCG Hosted Pool
	£000
Theme 2 Rehabilitation, Reablement and Intermediate Care	
Home Improvement Agency	75
PSS Adult Services Capital Grant	0
Falls Service	427
Home Enabling Services	1,556
2 SSO reviewing officers to fast track assessments during reablement	98
Community Stroke Service	175
Community Neuro Rehab	151
Breathing Space	2,224
Expert Patient Programme	50
REWS	804
Community OT	753
Disabled Facilities Grant	2,119
Age UK Hospital Discharge	158
Stroke Association Service	50
Stroke Social Work Support	27
Intermediate Care Pool	4,513
Total	**13,180**

Non-Financial Principles

2 Non-financial contributions to the Schemes are confined to current support for joint and integrated commissioning arrangements as detailed in Schedule 4. These will continue with no charges being made to the pooled fund.

Lead Officers

3 The table below provides lead officers contact details;

Partner	Name of Lead Officer	Address	Telephone Number	Email Address
Council	Mr Graeme Betts Interim Director of Adult Care and Housing	Rotherham Metropolitan Borough Council, Riverside House, Main Street Rotherham S601AE	01709 823928	graeme.betts@rotherham.gov.uk
CCG	Mr Christopher Edwards Chief Officer	NHS Rotherham CCG, Oak House, Moorhead Way, Bramley Rotherham S66 1YY	01709 302009	Chris.edwards@rotherhamccg.nhs.uk

4 The CCGs base contribution for 2016/17 will be £20.437m and the Council's base contribution (net budget) will be £3.886m.

5 In the event that the partners agree to extend this agreement, there will be no automatic annual uplift to the amounts stated in this agreement for any subsequent year. Any uplift to these figures will be determined by both partners as part of the annual budget setting process

6 It is expected that the Pool Managers will manage the Agreement within the approved budget for each financial year. Any proposed expenditure over and above the approved budget must be agreed in writing by the Chief Finance Officer of the CCG and the Strategic Director of Finance and Customer Services of the Council prior to any expenditure being incurred. Any overspend in the pooled funds shall be subject to the risk share agreement (Schedule 3) in the first instance. If all appropriate options in this agreement have been explored it will need to be jointly agreed with the Chief Finance Officer of the CCG and the Strategic Director of Finance and Customer Services of the Council that the overspend be borne in equal shares and may, subject to any National conditions applying in any subsequent year, be deducted from the following year's contribution of both the CCG and the Council to the Pooled Fund.

7 Any underspending in one year will be refunded to each partner based on percentage contribution to the pooled budget, subject always to the powers of the parties to make grants to each other outside the terms of this agreement.

8 The NHS maintains national, regional and local levies (covering, for example, staff training, research and development and clinical audit) that are resourced from the Rotherham Clinical Commissioning Group allocations prior to setting a Resource Limit. Accordingly, the Council will not be required to contribute to such levies. The Rotherham Clinical Commissioning Group will assist the Council to access these resources in the same manner as an NHS commissioner.

Payment Terms

9 The timing of payment shall be agreed annually in writing between the Chief Finance Officer of the Rotherham Clinical Commissioning Group and the Strategic Director of Finance and Customer Services of the Council in accordance with guidance as to the payment of contributions issued by the SOSH.

10 In the absence of any Agreement:-

10.1 The Council will invoice the Rotherham Clinical Commissioning Group on account one quarter of the estimated annual costs of the schemes on the first day of April, July, October and January each year.

10.2 The Council will invoice the Rotherham Clinical Commissioning Group within 30 days of the month end for employee costs incurred in respect of all attached employees and any other goods and services.

10.3 Each party shall provide such accounting information as may be required for the preparation of accounts and audit as may be required both during and at the end of each financial year recognising the need to ensure that both the Council and the CCG meet their specific financial reporting deadlines.

10.4 The Council and the CCG will pay invoices within 30 days of receipt.

Information

11 The CCG and the Council will provide all data required to assist with performance management of the service in a form approved by the BCF Operational Group and the BCF Executive Group and in accordance with the BCF Guidance.

12 The governance arrangements applicable to each individual scheme are set out in Schedule 2, Governance.

SCHEDULE 2 – GOVERNANCE

The actions within our BCF plan demonstrate the commitments of both the Council and CCG for transforming services and working in a more integrated way for the benefit of Rotherham people. This Partnership Framework Agreement further consolidates this commitment, and demonstrates our resolve to work in a transparent and integrated way.

Using the governance framework set out below all partners will monitor the BCF plan effectively ensuring plans are delivered through each of the 33 schemes.

The CCG and RMBC have co-terminus boundaries which supports the delivery of good governance. The BCF plan was produced through effective governance mechanisms which have been reviewed and updated to facilitate the implementation and delivery of the BCF plan.

These mechanisms are known and agreed with all partners within the health and social care sector in Rotherham, and there is a commitment from all, including TRFT and RDaSH to work within the governance framework.

1. GOVERNANCE ARRANGEMENTS

The Health and Wellbeing Board will have overall accountability for the delivery of BCF plan, and for the operation of the delivery of this Section 75 Partnership Framework Agreement they will:

- monitor performance against the BCF Metrics (National/Local) and receive exception reports on the BCF action plan;
- agree the Better Care Fund Commissioning Plan;
- agree decisions on commissioning or decommissioning of services, in relation to the BCF.

The framework below demonstrates the decision making structure and how the BCF plan will be delivered.

The management and oversight of the delivery of the BCF plan has been delegated to the BCF Executive Group, chaired by the HWB chair and including senior representatives from both the council and CCG.

The purpose of the BCF Executive Group is to:

- monitor delivery of the Better Care Plan through quarterly meetings;
- monitor the delivery of the programme of 'Service Reviews';
- monitor performance against the BCF Metrics (National/Local) to ensure they are being met;
- extra-ordinary meetings (where required) to fulfil NHS England requirements;
- ensure schemes are being delivered and additional action is put in place where the plan results in any unintended consequences;
- make strategic decisions relating to the delivery of the plan;
- Report directly to the HWB on a quarterly basis.

BCF Executive Group

The membership of the BCF Executive will be as follows:

- members of the RCCG: Members to include the Accountable Officer, and Accountable Financial Officer;
- members of the Council: Members to include the Accountable Officer, and Accountable Financial Officer;
- the Council or the CCG may elect or delegate a deputy to attend on their behalf. Deputising arrangements to be notified to the other members in advance of any meeting.

Role of BCF Executive Group

The BCF Executive Group shall:

- provide strategic direction on the individual schemes;
- receive the financial and activity information for the Better Care Fund;
- review the operation of this Agreement and performance manage the individual schemes;
- agree such variations to this Agreement from time to time as it thinks fit;
- review and agree annually a risk assessment;
- review and agree annually revised schedules as necessary;
- request such protocols and guidance as it may consider necessary in order to enable the pooled fund manager to approve expenditure from a pooled fund;
- review and agree recommendations from the Operational Group;
- receive reports from the system resilience group, providing information on the management of non-elective admissions.

The BCF Executive Group is supported by the BCF Operational Group, which is made up of the identified lead officers for each of the BCF actions within the plan, plus other supporting officers from the Council and CCG. The BCF Operational Group meets on a 6 weekly basis and reports directly to the BCF Executive Group.

The BCF Operational Group role is to:

- ensure implementation of the BCF action plan;
- implement and monitor the performance management framework;
- deal with operational issues, escalating to the BCF Executive where needed;
- make recommendations in relation to the commissioning arrangements of any individual or multiple scheme on the basis of the 'Service Review' process to the BCF Executive Group.

The BCF Operational Group shall

- receive 6 weekly reports on each scheme on its activity and finance information;
- receive regular updates and monitor progress of the identified 'Service Reviews' through the life of this Agreement;

- discuss and agree with each scheme operational changes or enhancements to improve patients experiences, and ensure financial and activity targets are met;

- discuss and develop operational options in the event of under or overspending or underachievement of performance related element of the Agreement.

The roles of the System Resilience Group, The Adult Social Care Development Board and other equivalent groups shall be to:-

- monitor and manage performance of a service (or group of services) which may be operating wholly or partly as a BCF scheme; or may be a service (or groups of services) that is not a BCF scheme, but has a significant impact on BCF metrics;

- monitor and manage performance in meeting the BCF targets for preventing emergency non-elective admissions to hospital;

- make operational decisions which ensures BCF metrics are delivered to time and to target, making recommendations to the BCF Executive Group and BCF Operational Group as appropriate;

- co-ordinate BCF and non-BCF services, to ensure integration within and between inpatient, community and third sector health and social care;

- take responsibility for setting and meeting ambitious targets for increasing levels of customer satisfaction with their health and social care services.

BCF Executive Support

The BCF Executive Group and BCF Operational Group will be supported by officers from the Partners from time to time.

2 MEETINGS

2.1 The BCF Executive Group will meet quarterly at a time to be agreed within 30 days following receipt of each quarterly report from each Pooled Fund Manager.

2.2 The quorum for meetings of the BCF Executive Group shall be a minimum of one representative from each of the Partner organisations with a minimum of two members of the group present.

2.3 The BCF Operational Group meets on a six weekly basis. Quorum for these meetings will be a minimum of four representatives from each of the schemes with at least two representatives from each organisation present

2.4 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

2.5 Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

3 DELEGATED AUTHORITY

3.1 The BCF Executive Group is authorised within the limits of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

- authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to any Pooled Fund; and

- authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

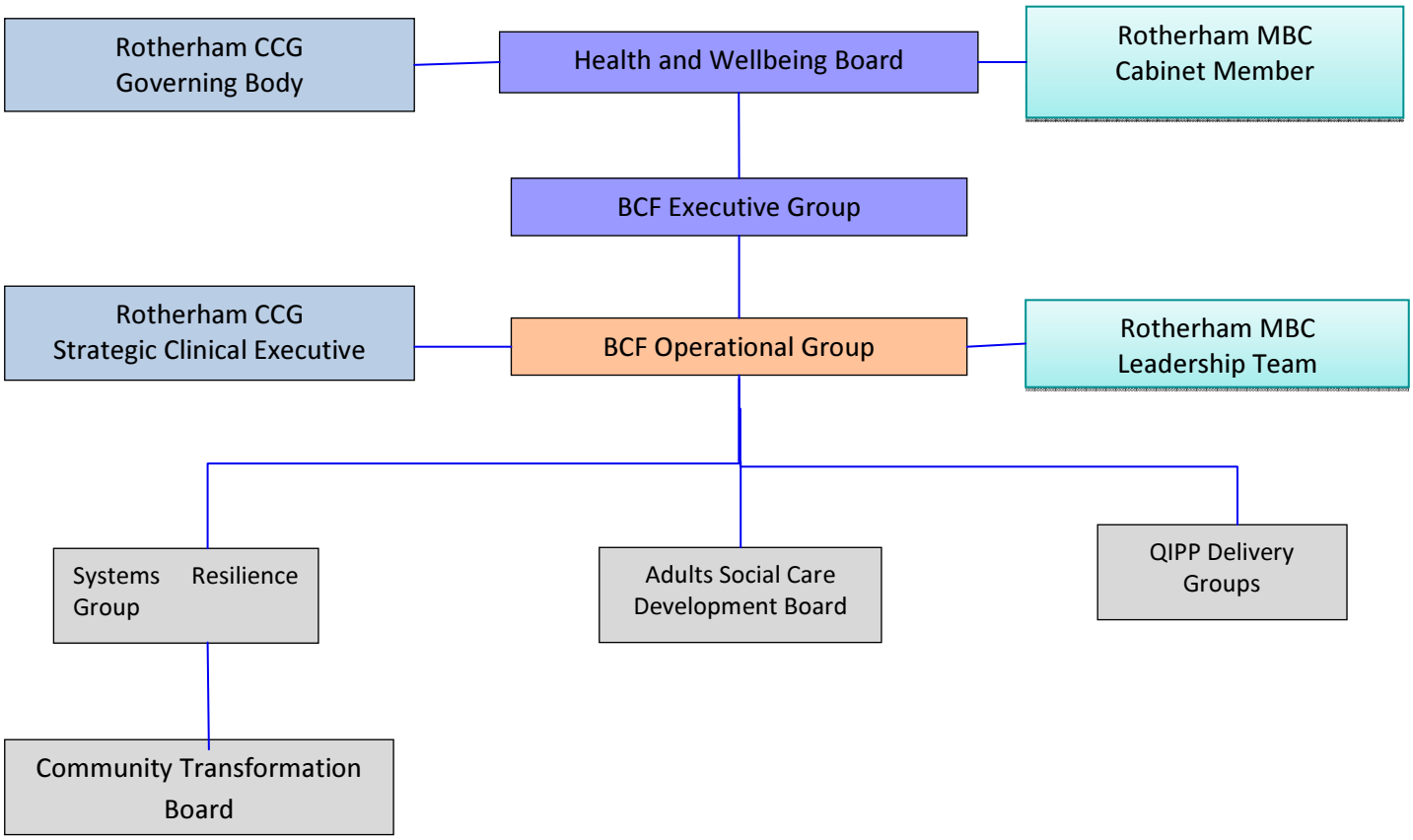
4 INFORMATION AND REPORTS

4.1 Each Pooled Fund Manager shall supply to the BCF Executive Group on a Quarterly basis the financial and activity information as required under the Agreement.

5 POST-TERMINATION

5.1 The BCF Executive Group shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

BCF Governance - Reporting Structure



ROTHERHAM METROPOLITAN BOROUGH COUNCIL ADULT CARE AND HOUSING
ROTHERHAM CLINICAL COMMISSIONING GROUP BETTER CARE FUND (BCF)

BCF EXECUTIVE GROUP

Purpose of the Executive Group
The purpose of the BCF Executive Group is to take responsibility for the delivery of the Better Care Fund plan for Rotherham; the strategic operation and delivery of the Framework Partnership Agreement; and to make recommendations for the strategic direction and management of the Better Care Fund to the Health and Wellbeing Board (HWB).

Functions of the Executive Group

- Take responsibility for the fund's feasibility, business plan and achievement of outcomes;
- Defining and realising benefits and budgetary strategy
- Monitor delivery of the Better Care Plan through quarterly meetings
- Ensure performance targets are being met
- Ensure schemes are being delivered and additional action put in place where the plan results in unintended consequences
- Undertake an annual review ("**Annual Review**") of the operation of this Agreement
- Undertake or arrange to be undertaken a review of each Pooled Fund, Non Pooled Fund and Aligned Fund and the provision of the Services within 3 Months of the end of each Financial Year.
- Arrange or oversee the production of a joint annual report- to be presented to the Executive Group within 20 Working Days of the presentation of the annual review ensure the fund's scope aligns with the requirements of the stakeholder groups;
- Address any issue that has major implications for the fund;
- Keep the fund scope under control as emergent issues force changes to be considered;
- Reconcile differences in opinion and approach, and resolve disputes arising from them;
- Report quarterly to HWB, and
- Take responsibility for any corporate issues associated with the fund.

In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

The role of the individual members of the BCF Executive Group Fund Board includes:

- Understand the strategic implications and outcomes of initiatives being pursued through fund outputs;
- Appreciate the significance of the fund for stakeholders and ensure the requirements of stakeholders are met by the fund's outputs;
- Be an advocate for the fund's outcomes;
- Have a broad understanding of fund management issues and the approach being adopted;
- Help balance conflicting priorities and resources;
- Review the progress of the fund;
- Check adherence of fund activities to standards of best practice, both within the organisation and in a wider context.
- To ensure the customer journeys/experience are delivering increased customer satisfaction as shown by the delivery of the measures, i-statements and the plan.

Chair
The meeting will be co-chaired by the respective Accountable Officers.

Membership of the Executive Group
CCG Chief Officer CCG Chief Finance Officer CCG Head of Urgent Care and Long Term Conditions RMBC Chief Executive RMBC Financial Director RMBC Director of Adult Care and Housing (DASS) Both parties will call in relevant officers for specific topics where required and a standing invitation will be made to Public Health Director to attend.

Quorate
One representative from each of the organisations, with a minimum of two members present

Frequency of Meetings
Quarterly

Co-ordination of Meetings
Joint Commissioning and Contracting Officer RMBC/RCCG will coordinate.

Governance
The group will report to the HWB.

Key Deliverables
• Ensure that the financial reporting framework is adhered to. • To be responsible for maintaining the risk register and ensuring risk mitigation plans are in place. • Recommend actions and deliver reports to the HWB, LGA and NHSE.

ROTHERHAM METROPOLITAN BOROUGH COUNCIL ADULT CARE AND HOUSING
ROTHERHAM CLINICAL COMMISSIONING GROUP

BETTER CARE FUND (BCF) OPERATIONAL GROUP

Purpose of the Group
To oversee the delivery of the Better Care Fund Plan for Rotherham, making recommendations to the Better Care Fund Executive Group to ensure effective action and implementation of the plan

Functions of the Group
• To provide the forum for BCF accountable operational leads to co-ordinate the delivery of the BCF Performance Measures and BCF Action Plan. • To ensure that effective performance management of the BCF Performance Measures takes place and where performance is not meeting targets appropriate and timely action is taken. • To ensure the effective delivery of the BCF action plan at operational level and allow for necessary operational partnership discussions to take place to meet the outcomes of the plan. • To ensure that the accountable leads of the BCF performance measures and the BCF action plan are collectively discussing their progress and key actions. • To identify the areas which need to be reported on progress and performance by exception to the BCF Executive Group. • To ensure the BCF conditions are met. • To co-ordinate partner activity within the BCF Plan, ensuring that all elements of the plan are linked together to deliver positive outcomes. • To ensure the Rotherham BCF Scorecard is updated on a monthly basis. To review risk and to oversee the implementation of mitigating action plans. • To ensure the customer journeys/experience are delivering increased customer satisfaction as shown by the delivery of the measures, i-statements and the plan.
Chair
The meeting will be co-chaired by the CCG Chief Finance Officer and the Director of Adult Care and Housing

Membership of Group
RCCG Chief Financial Officer RCCG Head of Urgent Care and Long Term Conditions RCCG Assistant Chief Officer RMBC Public Health Officer RMBC Senior Finance Manager RMBC Director of Adult Care and Housing RMBC Assistant Director, Independent Living and Support Both parties will call in relevant officers for specific topics where required

Quoracy
Two representatives from each of the organisations

Frequency of Meetings
Six weekly

Co-ordination of Meetings
Joint Commissioning and Contracting Officer, RMBC-RCCG will coordinate.

Governance
Each organisation maintains accountability for service specific operational delivery. The group will report to the BCF Executive Group. This does not replace existing performance management and accountability mechanisms, but will provide a specific focus and bring coordination to the BCF targets and actions.

Key Deliverables
• Maintain financial reporting framework. • Maintain a risk register appropriate to the level of group operation. • Coordinate the completion of reports for the Health and Wellbeing Board and the Department of Health

SCHEDULE 3 - RISK SHARING

The areas of risk Identified within the Partnership Framework Agreement are as follows:

- Under or overspending of budgets within Better Care Fund budget lines
- Risk of exceeding affordable levels of care outside the Better Care Fund

The following details proposals for the sharing of risks relating to the Better Care Fund.

1. Under or overspending of budgets with Better Care Fund budget lines

As part of the initial development of the BCF pooled budget a number of risks were identified where the individual schemes would potentially result in additional demand for services and/or additional costs, or the required efficiencies and reductions do not materialise to the extent planned. The pooled budget in total includes an amount of £0.5m as a risk pool.

In applying the risk pool funding it is important to have a jointly agreed approach and the following provides a proposal for consideration across both pools and by both partners.

2 Risk sharing proposal

General principles

It is proposed that the BCF Executive Group is the forum where decisions on the application of risk pool funding for either pool is made.

Risk is attributable to the scheme commissioner pro rata to the proportion of that scheme commissioned. This is to reflect where the levers for change and control sit.

Similarly, where the scheme is joint and there is one lead commissioner, the risk should be shared pro-rata to the proportion of that scheme commissioned.

3 Overspend / Underspend treatment

If an overspend is identified the following approach will be taken:

- Seek to cover the overspend from areas of underspend identified within either pool;
- Utilise the risk pool funding;
- Reduce uncommitted scheme allocations;
- Cover from resources outside the pool.

If an underspend is identified the following approach will be taken:

- Underspends remain within the pooled arrangement to support overspends elsewhere in the pool;
- Further joint schemes within budget lines to be proposed in year which can utilise the resources in year.

In all of these scenarios the BCF Executive Group is the forum where decisions would be made.

4 Risk of exceeding affordable levels of care outside the BCF

The use of the BCF pooled budget is anticipated to deliver greater outcomes for patients and the public, as well as anticipated reductions in non-elective spend. In the event that demand for acute non-elective care exceeds affordable levels it is proposed that the approach suggested above is taken.

- Seek to cover the reduction from areas of underspend identified within either pool;
- Utilise risk pool funding;

- Reduce uncommitted scheme allocations;

Where issues arise under this category the Partners shall meet and discuss the appropriate means of addressing the problem through the Health and Wellbeing Board or such other forum as the Partners may decide.

5. Risks Log

Key:

Likelihood * Impact = Score

1 = Low Impact or Low Likelihood
5 = High Impact or High Likelihood

Maximum score 25

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
Strategic Risks					
1	Poor alignment between service budgets and actual cost	4	3	12	The review process timetabled throughout 2016-17 will ensure the alignment of budget with actual costs. Monthly budget monitoring is in place and reports are regularly taken to the Operational and Executive groups regarding finance and any risks which require mitigation.
2	Shortfall of resources to fund the priorities identified in the plan	3	4	12	As above. The review process will seek to identify areas where budgets can be appropriately aligned to BCF priorities; this may include reconfiguration of service provision in year.
3	BCF services are not fit for purpose	4	3	12	New governance and performance framework will highlight those services that are not performing and set out a new structure for performance management
4	The introduction of the Care Act will result in a significant increase in the cost of care provision onwards that is not fully quantifiable currently	4	4	16	The financial implications of the Care Act have been included in the financial plan (£0.7m) Work to address Care Act compliance is incorporated in Adult Social Care Development Board Programme. Various models have been populated and provided evidence of demand for additional assessments (including carers' assessments and respite) at an approx cost of £0.850m. This information ensured that sufficient funds were established in 2015-16 and

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
					remain in BCF for 2016-17.
5	Compliance with Mental Capacity Act (MCA) incorporating the Deprivation of Liberty Safeguards (DOLS)	4	4	16	New DOLS team developed with new team manager and seconded full time Best Interest Advisors x 4.
6	Operational pressures restrict capacity to implement key projects identified in the BCF Plan	4	5	20	Our schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development. BCF Ops Group will oversee implementation of the 2016/17 programme, identifying areas where operational pressures are impacting on implementation and developing targeted strategies to free up the change process. Monitoring template in place for all BCF reviews and will be taken to Operational Group meetings to ensure early identification the risks associated with implementation/achievement.
7	Failure to achieve planned savings due to overspends in the system/ inability to meet targets will create financial risks (budget pressures) for the respective parties	3	5	15	Performance management framework via the System Resilience Group in place to monitor progress to ensure targets are achieved. Good forward planning with providers on activity reductions through regular contract performance meetings. BCF Operational Group will oversee implementation of the 16/17 programme. If service improvements do not have the intended impact on hospital and care home admissions the BCF Operational Group will make recommendations on where service restrictions should apply, ensuring that the programme remains within budget.
8	Achieving savings in one area of the system, can cause unintended consequences of higher costs elsewhere.	3	3	9	All partners have made a commitment to ensure that if evidence of these consequences is seen, cash will flow to the right place across the system that all partners will benefit from. Both partners have agreed a 'risk pool' of £500K which has been included in the financial plan to mitigate the risk of

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
					non-delivery of non-elective savings and social care packages. The "risk pool" forms part of the BCF plan, which can be used if the plan results in any unfunded consequences on any part of the system. The BCF plan is monitored on a quarterly basis by the BCF Executive group, and any consequences will be reviewed.
9	Failure to meet the national conditions and performance outcomes agreed with NHSE	3	5	15	Joint governance arrangements and new performance framework will help mitigate this risk. Financial risk sharing is in place through the Risk Pool.
10	Lack of engagement from front line staff because do not buy in to the integration agenda or lack the skills	3	4	12	Changing organisational structure is not sufficient to achieve integration. We will work with local education and training institutions and with service providers to develop integrated ways of working and behaviours to transform the quality of health and social care. This issue will form part of individual implementation plans for new initiatives in 2016-17. Strong links are in place with all partners communication teams to ensure that change management occurs in the most effective and transparent way.
11	Social care not being adequately protected	3	5	15	No change in 2016-17 to the services that were identified in the BCF plan 2015-16 as fundamental to the protection of Social Care. BCF governance groups to take regular stock-take on current state of social care provision. Regularly review strategies for how the BCF can be enhanced to protect key services, particularly those that support admission prevention and reductions in formal social care.
12	Governance arrangements are insufficient to make investment decisions, ratify	3	4	12	Governance arrangements scheduled for review this year. Programme has clearly defined purpose. Full

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
	the vision and deliver key metrics				engagement at CEO level. Clearly defined process for decision making with appropriate scheme of delegation. Clear system for disagreement resolution. Rules on data and performance management agreed.
Performance Risks					
13.	*Non-elective target not met;* BCF Schemes do not deliver the planned reduction in non-elective admissions resulting in higher cost. This is complementary to the programme within the System Resilience Group which focuses upon avoiding emergency admissions amongst other wider system issues of the CCG.	4	5	20	BCF commissioning intentions and investment in a number of work-streams have already taken place in 2015/16 including Integrated Rapid Response, Care Co-ordination Centre. The focus on out of hospital services will continue in 2016/17 through the BCF plan including Integrated Locality Pilot, rehabilitation and re-ablement hub.
14.	*Residential Care target not met;* BCF Schemes do not deliver a reduction in permanent admissions to residential care increasing costs to the LA. This may be due to delays in implementation of schemes i.e.	3	3	9	BCF Schemes aligned with Care Act (2014) and Joint Health and Wellbeing Strategy 2015-19. Change Management leads have been appointed to ensure successful implementation of projects that will complement the BCF objectives. Any delays in scheme progress will be mitigated by appropriate Working Groups including closer working relationships with Housing.
15.	*Delayed Transfers of Care (DTOC) target not met*; BCF Schemes do not deliver the planned reduction in DTOC which will result in higher cost to the CCG and/or The Rotherham Foundation Trust. This may be due to poor collaboration/ communication between health and social care staff or ineffective/ insufficient out of hospital services i.e. intermediate care.	3	3	9	Review of pathways from hospital to community to ensure that they meet patient demand and are fit for purpose is underway. Action planning taking place to reconfigure services as part of the review process. This includes development of social care assessment beds, changes to the hospital discharge team to support integration. System Resilience objectives complement the Better Care Fund objectives. Memorandum of Understanding in place which ensures a clear, effective integrated discharge process which considers both hospital and community and cross sector provision.

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
16.	*BCF schemes are delayed;* Delay in implementation of BCF schemes results in underspends, creates inefficiencies in service delivery and hinders integration. There is likelihood that targets will not be met if scheme implementation is delayed.	2	3	6	Regular reporting on progress of all BCF schemes through the BCF Operational and Executive Group Meetings to ensure that underspends are managed and risks mitigated through the risk share agreement. A review of BCF schemes has taken place which identified those schemes requiring a deep dive review to be undertaken in 2016-17.
OPERATIONAL RISKS					
17.	*Data sharing between health and social care;* Target on number of patients with NHS identifiable number is not met. This is a national condition, in not meeting the target there would be significant impact on the ability for integration /communication.	2	3	6	The officer lead for this objective at RMBC has provided updates at every operational group meeting throughout the 2015-16 and has given assurance that this target has been achieved.
19.	*Community Services;* BCF schemes increase demand on community services resulting in increased waits for health and social care assessments/ services	3	4	12	The BCF has identified new funding for social care and this will be reviewed as part of the work plan for 2016/17. Investment in community transformation programme through the CCG in 2015-16 will provide more targeted resource into the community in order to better meet demand.
20.	*Rotherham Population;* Schemes not targeted at the right populations resulting in pressures on the acute services	1	3	3	Using Joint Strategic Needs Assessment, Commissioning Plans/Strategies to support rationale for scheme development – incorporating intelligence of local population and demand in to service specifications to target appropriate cohorts of patients. Review of service implementation takes place once a scheme is up and running. Performance, quality and outcomes regularly monitored through performance submissions and meetings with providers.

	Risk	Likelihood	Impact	Score	Remedial Actions to Reduce Risk
QUALITY RISKS					
21.	*Provider destabilisation;* Shifting of resources could destabilise current service providers. For example force viability issues due to loss of funding in one area, cause issues with performance against contracts.	2	4	8	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. CCG received Quality Impact Assessments from providers regarding their respective efficiency plans. LA will continue to engage with providers to ensure potential impact is understood and planned for.
22.	*Carers;* Risk that BCF impacts negatively on the support and experience of carers leading to a reduction in the number of carers. Carers may not be supported to continue to care through the various services currently in place, or the new services implemented, i.e. 7 day support for adult social care. If they cease to care this could result in increased costs for the LA and CCG	2	2	4	Existing support for carers is delivered through a number of services including respite, short break, carers emergency scheme, carers centre, carers assessment officers. The risk that services may be disrupted through the transformation/ integration process was identified and a risk pool allocated to ensure that carers and customers could continue to access services that they need throughout the process of change in 2016-17. They would also be able to benefit from any new services delivered, through the BCF and Care Act implementation. A revised Joint Carers Strategy has been developed which will link in to the BCF and other strategic objectives for Health and Social Care. Revised Carers Handbook in place which will be launched at the Carers week in June 2016.

SCHEDULE 4 - JOINT WORKING OBLIGATIONS AND BCF INVESTMENT 2016/17

1. LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

a) The Lead Commissioner shall notify the other Partners if it receives or serves:

(ii) a Change in Control Notice;

(iii) a Notice of an Event of Force Majeure;

(iv) a Contract Query or Contract Default Notice;

(v) Exception Reports;

and provide copies of the same;

(vi) Serious Incident Reports

and provide copies of the same;

(vii) Adult Safeguarding Concerns.

(b) The Lead Commissioner shall provide the other Partners with copies of any and all:

(i) CQUIN Performance Reports;

(ii) Monthly Activity Reports;

(iii) Review Records;

(iv) Remedial Action Plans;

(v) JI Reports;

(vi) Service Quality Performance Report.

(c) The Lead Commissioner shall consult with the other Partners before attending:

(i) an Activity Management Meeting;

(ii) Contract Management Meeting;

(iii) Review Meeting

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

(d) The Lead Commissioner shall not:

(i) permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

(ii) vary any Provider Plans (excluding Remedial Action Plans); – RCCG; or Service Improvement Plans - RMBC);

(iii) agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

(iv) give any approvals under the Service Contract;

(v) agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

(vi) suspend all or part of the Services;

(vii) serve any notice to terminate the Service Contract (in whole or in part);

(viii) serve any notice;

(ix) agree (or vary) the terms of a Succession Plan;

(x) without the prior approval of the other Partners (acting through the BCF Executive Group such approval not to be unreasonably withheld or delayed.

(e) The Lead Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

(f) The Lead Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution.

(g) The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports).

5.2 OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

(a) Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

(i) resolve disputes pursuant to a Service Contract;

(ii) comply with its obligations pursuant to a Service Contract and this Agreement;

(iii) ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

(b) No Partner shall unreasonably withhold or delay consent requested by the Lead Commissioner.

(c) Each Partner (other than the Lead Commissioner) shall:

(i) comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

(ii) notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 6 - PERFORMANCE METRICS

Schedule 5: INTEGRATED PROVIDER PERFORMANCE MANAGEMENT FRAMEWORK

1. Purpose

1.1 This Schedule aims to ensure that Partners adopt an integrated performance management framework in order to plan, deliver, review and act on relevant information to commission improved outcomes for the people of Rotherham. It is the expectation that the Lead for each BCF Scheme will be responsible for ensuring this framework will be completed for each scheme.

1.2 The BCF Executive, supported by the BCF Operations Group will be responsible for ensuring the performance management framework for the BCF programme is in place, updates produced, and reports compiled for NHS England and the Health and Well Being Board.

2. Definition

2.1 For the purposes of this Schedule., "performance management" shall mean the overall process that integrates planning, action, monitoring and review and shall incorporate the following:

i. Identifying the aim, (e.g. purpose, mission, corporate aims, strategic goals etc.) and the action required to meet the aim (e.g. business plan, project plan, etc.);
ii. Identifying priorities and ensuring there are sufficient resources to meet them;
iii. Monitoring performance of any commissioned provider or voluntary organisation;
iv. Reviewing progress, detecting problems and taking action to ensure the aim is achieved;
v. Determining which services should be delivered; Benchmarking performance against an agreed and transparent set of measures.

3. Outline Framework

3.1 The performance management framework should incorporate three processes in relation to joint commissioning, i.e. Business Planning, Reporting and Review and Performance Improvement.

4. Commissioning Business Planning Process

4.1 This process consists of integrated commissioning plans, which should set out:

i. strategic objectives and key performance measures for 15/6
ii. the commissioning intentions for the strategic objectives and
iii. the timescales for achievement.

4.2 Contracts with service providers that state how performance shall be monitored, reported and reviewed will also be required.

5. Reporting and Review Process

5.1. This will involve monitoring overall progress against:

i. delivery of the strategic objectives in the integrated commissioning plans,
ii. delivery of the contracts as detailed in Schedule 4
iii. identifying the reasons for any under-performance of service providers.

6. Performance Improvement Process

6.1 To ensure action is taken where the continuation of current performance would lead to an outcome/target not being met.

6.2 The application of a range of tools and techniques to improve overall performance.

7. Commissioning Plan

7.1 The Partners shall agree an Integrated Commissioning Plan for each Service by 1 April each year. This will set out the "direction of travel" and the shared commissioning intentions for the development of the Services The plans shall be agreed by the Partners.

8. Contracts with Service Providers

8.1. The Host Partner shall be required to agree a contract with each third party provider regarding the outcomes they are to deliver.

8.2 Contracts with third party providers should:

8.3 Contracts with third party providers should:

i. Take account of the requirements of the relevant current plans of the respective partners and the actions agreed in response to external review;
ii. Include a requirement that the service provider develop a detailed service plan, which covers how the provider intends to achieve the said outcomes and the risk associated with not achieving them.
iii. Require the provider to regularly measure progress against achieving the outcomes and to report this to the Host Partner at a frequency to be agreed
iv. Require the provider to provide an improvement plan in the case of significant under or over performance.
v. Include a process whereby outcomes may be added/removed as a result of changing needs.

9. Reporting and Review Process

9.1. Regular meetings should be held between the Host Partner and the service provider to review the latter's performance.

9.2. The Host Partner shall monitor services having regard to national, regional and local key performance indicators, including:

i. Performance assessment framework indicators
ii. National performance indicators
iii. Audit and inspection recommendations
iv. Self-assessment Statement actions
v. Relevant operational plan indicators
vi. NHS clinical commissioning board targets
vii. Relevant core and Care Quality Commission standards
viii. Patient and Customer feedback

10. Performance Reporting and Review of the Section 75 Agreement

10.1 The pooled fund manager will be responsible for producing quarterly reports to the BCF Executive Group and Health and Wellbeing Board on or before 27th May, 2016, 26thAugust 2016, 25th November 2015 and 24th February 2016, using the attached template (Table 1).

10.2 The pooled fund manager will be responsible for producing an annual report to the BCF Executive Group and Health and Wellbeing Board on or before 31st March 2016 using a template that both parties will agree, to be based on the suggested format from NHS England.

10.3 The BCF Executive Group will be responsible for ensuring the timeline to ensure the data is collected, reported, authorised by the health and wellbeing Board, and submitted to the NHS England on their specified reporting dates, these being one day after the dates specified in section 9.1.

Rotherham CCG / RMBC BCF Metrics:

Metric		Baseline	Planned 2014/15	Planned 2015/16	Planned 2016/17
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Rate	694.6 1st cut 677.9 Final revision Dec 14	958.5 Revised impact of new definition applied	894.4 Revised impact of new definition applied	**767.8**
	Numerator	325 Rounded actual 324	469	446	**390**
	Denominator	46645 1st cut 47790 Final revision Dec 14	48930	49864	**50797**
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Rate	**87.7**	88.5	90.0	**91.0**
	Numerator	115 Rounded actual 114	115	117	**132**
	Denominator	130	130	130	**145**
Inpatient Experience: The proportion of people reporting a poor patient experience of inpatient care. (Average number of negative responses per 100 patients	Rate	**123.60**	123.08	121.96	**115.9**
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	Rate (Q3 & Q4 2013 14 & Q1 & Q2 2014 15)	13.27%	13.01%	**12.77%**	**12.17%**
	Numerator	3623	3481	**3482**	**3247**
	Denominator	27302	26756	**27264**	**26681**

Metric		Baseline	Planned 2014/15	Planned 2015/16	Planned 2016/17
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	Rate	Q1 – 405.3 Q2 – 332.2 Q3 – 389.0 Q4 – 537.6	Q1 – 537.6 Q2 – 537.6 Q3 – 537.6 Q4 – 535.2	Q1 – 535.2 Q2 – 535.2 Q3 – 535.2 Q4 – 533.0	Q1 – 769.4 Q2 – 707.8 Q3 – 563.8 Q4 – 677.4
Total non-elective admissions in to hospital (general & acute), all-age	Number of admissions (Definition has changed in 16/17 so cannot be directly compared)		**30226**	**30226**	**29417**

SCHEDULE 6 – BCF PLAN

A copy of Rotherham's Better Care Plan can be accessed by the following link:

http://www.rotherhamccg.nhs.uk/better-care-fund.htm

SCHEDULE 7 – POLICIES FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

Copies of policies for the management of conflicts of interest can be accessed by the following link:

ROTHERHAM MBC:

https://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEwjc5OnDjsPMAhXIJcAKHQnFDGkQFggdMAA&url=http%3A%2F%2Fwww.rotherham.gov.uk%2Fdownload%2Fdownloads%2Fid%2F296%2Fappendix_7_-_code_of_conduct_-_july_2012.pdf&usg=AFQjCNEZZwO76bsdIs2xekpXD82-BbK0Cg&cad=rja

NHS ROTHERHAM CCG:

http://www.rotherhamccg.nhs.uk/corporate-policies.htm

SCHEDULE 8 – INFORMATION SHARING PROTOCOL

A copy of Rotherham's information sharing protocol can be accessed by the following link:

http://www.rotherhamccg.nhs.uk/partnership-policies.htm

SCHEDULE 9- SPECIFICATION FOR GOVERNANCE AND FINAL ACCOUNTS REQUIREMENT

Specification for Governance and Final Accounts Requirement for LA and CCG hosting pools

Introduction and key principles for the operation of the pooled arrangements

The Better Care Fund was introduced by the Government to facilitate transformation in integrated health and care and is allocated to local areas to be operated through pooled budget arrangements under Section 75 (2) of the National Health Service Act 2006. Section 75 allows partners to make contributions to a common fund to be spent on agreed functions. To enable the effective operation of the pooled arrangements:

- Partners must sign a joint funding Agreement before starting to operate the pool.
- One Agreement can cover multiple pools
- Pooled budgets must follow the appropriate accounting arrangements
- The host partner is responsible for producing the year end accounts
- The accountable body is the organisation from where the money originated
- Conditions attached to individual funding streams are required to be met, e.g. disabled facilities grants
- The arrangements for operation of the pooled arrangements are required to ensure that the requirements of all partners to achieve economy, efficiency and effectiveness in their use of resources are met
- The arrangements for operation of the pooled arrangements are required to ensure that the regulatory requirements for each party are met, e.g. CCG has significant monthly reporting requirements to NHS England with nationally driven deadlines, as well as the requirement for the external auditors to express an explicit opinion on the regularity of their transactions.
- NHS Bodies are subject to a short timeframe for the preparation and audit of their accounts, Local Authorities currently have longer. By hosting, the parties must take ownership in ensuring that all accounts issues are progressed so as not to compromise the NHS timetable.

Specific requirements

On-going arrangements

1. Each partner will reference the pool to the organisational scheme of delegation and how this will operate in practice.
2. The coding arrangements in place within the ledger of the host organisation will need to ensure that the accounting requirements of the other partner are met.
3. The host can ensure that accurate and timely reporting of financial and non-financial information meets its own requirements but will need to ensure that information is available to meet the requirements of the other party also.
4. Budget monitoring updates will be provided quarterly to the Health and Wellbeing Board or its nominated sub group. Quarterly reports to be submitted to the CCG governing body and the Local Authority executive outlining the following:

- The level of contribution to the pooled budget
- Spend to date
- Performance to date
- How the pooled budget is performing overall

5. CCG will require monthly financial and non-financial reporting within the timescales of the CCG Reporting Timetable, in order to inform its internal management accounting, external reporting to NHS England and the identification of risk throughout the financial year. Reporting should also reflect CCG requirements and the reporting environment of the CCG.

6. The CCG will need to be able to work within the reporting and management environment of the Local Authority for elements of the pool and therefore multiple processes may need to be implemented.

7. The host partner will ensure that where elements of the pooled budget are ring-fenced for a particular purpose, the necessary supporting information is available to provide assurance that those elements have been used appropriately and to support the accounting arrangement applied.

8. The host will need to ensure that the VAT arrangements are compliant with both NHS and LA VAT regimes. Currently Local Authorities can reclaim VAT on purchases so if the CCG hosted the pool, it would need to retain records and administer the share for which VAT is reclaimable.

9. There must be a clear mechanism for alerting Governing Bodies as well as the Health and Wellbeing Board of concerns relating to delivery of projects, in line with the arrangements set out in Schedule 3 (Risk management).

10. In order to avoid difficulties in the consolidation of accounts, all the accounts should be maintained on a gross basis. Should accounts information be required on a net basis this can then be calculated.

11. The host organisation to provide access to relevant aspects of the ledger and accounts to enable internal audit monitoring as part of agreed Audit plans in-year.

Year End Closure of Accounts

12. The partners should consider the nature of each pooled budget in accounting terms and in particular whether the pool is a joint operation in accordance with IFRS11. If the arrangement is not a joint operation then its substance should determine the accounting. It may be a lead commissioning or aligned commissioning arrangement.

13. To meet requirements in relation to the preparation of annual accounts SI 2000/617 paragraph 7(6) the host must prepare and publish a full statement of spending signed by the accountable officer or section 151 officer, to provide assurance to all other parties to the pooled budget. This is required to meet the specified timescales for the publication of accounts and should include:

    - Contributions to the pooled budget, cash or kind
    - Expenditure from the pooled budget
    - The difference between expenditure and contributions
    - The treatment of the difference
    - Any other agreed information

14. All partners to discuss and agree with their external auditors the assurances required in order to sign off the year end accounts and particular requirements where the partner is not the pool host.

15. An annual return detailing a full statement of expenditure and linked to Annual Governance Statement Requirements must be received by the CCG in line with NHS Annual Accounts Reporting Timescales (noon 21st April 2017)[1] subject to confirmation by NHS England. This must be signed by the Section 151 officer.

16. A memorandum account would need to be produced for the Local Authority at closedown. CCG would be responsible for preparation of annual statements of account and Audit to the requirements of the Local Authority in relation to the pool it hosts.

17. The Annual Governance statement (CCG) will be required to report on internal control and risk management within the pool. This is part of the final accounts documentation which is subject to audit at the year end.

18. The CCG will have responsibility for ensuring that the Local Authority's statutory duties including financial reporting are met. This includes form of accounts, gross and net as well as ensuring that the required timescales are achieved.

19. Would require joint Agreement of Internal and External Audit of the pooled arrangement to inform Annual Governance Statement and to provide the required level of assurance to respective Audit Committees, Governing Bodies and the External Audit. This includes reviewing whether information received is accurate and correct.

20. The LA capital accounting regime for Disabilities Facilities Grant and other capital will need to be followed and accounts closure timescales adopted.

21. As the CCG will be required to report on its share of assets, liabilities, income and expenditure in accordance with IFRS 11, all reporting must be done in line with this accounting standard and enable the CCG to account for the pooled budget as outlined in the DH Manual for Accounts.

22. For its own assurance and to satisfy the requirement for delivery of value for money, each partner should set out clear requirements for evidence of how the resources provided to the pool have been utilised and how value for money has been achieved.

23. Information may be required to support Agreement of Balances exercises although further guidance for NHS England is awaited.

24. Where the better care fund is material (this is the case for the CCG) disclosure in the annual accounts will be necessary, in the format required by NHS England guidance to be issued.

Rotherham Metropolitan Borough Council
Neighbourhoods & Adult Services

NHS Rotherham Clinical Commissioning Group

1.	**Meeting:**	**HEALTH AND WELLBEING BOARD**
2.	**Date:**	**1st June, 2016**
3.	**Title:**	**Better Care Fund Quarter 4 Submission**

4. Summary

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

5. Recommendations

That the Health and Wellbeing Board:

(i) Ratify the Quarter 4 submission which will be submitted to NHS England on or before Friday, 27th May, 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 and 4 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 are operating as the first phase of our 7 day services plan and implementation of a 7 day working hospital

discharge pilot took place from 1st December, 2015, which will complete the intentions for 7 day working set out in the Rotherham BCF plan.

- The NHS number is being used as the primary identifier for health and care services and work is now completed to ensure better sharing between health and social care. There were 5,495 adults who were in the scope of the NHS number matching project and all in-scope BCF records have now been assigned an NHS number. Work is underway to ensure that training materials are provided which demonstrate to practitioners in adult social care on how to use the NHS number field for any new users of services.

9. Performance Data

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

9.2 Q4 data shows full year non elective admissions actual is below plan. Actual of 36,893 compared to a plan of 37,783. Q3 represents an under reported position, due to data quality issues experienced by the CCGs lead provider. This was rectified for Q4. A review of the data indicates if the under reporting was accounted for in Q3, the actual position would be just below plan for Q3.

9.3 Non-elective hospital re-admissions have reduced when comparing to Q1 and Q2. 11.9% for Q3 (Q1 13.4% and Q2 13.36%). Q4 data is not available due to national timescales involved in processing the SUS data.

9.4 Q4 shows a total of 401 admissions to residential care, which equates to a rate per 100,000 of 804.2. This is 68 fewer admissions than reported in 2014/15 and represents an approximately 16% “in year” rate reduction from the 2014/15 rate.

9.5 The proportion of older people still at home 91 days later after hospital discharge into rehabilitation – there has been an increased number of service users (121 in comparison to last year’s 117) and “effectiveness” has improved from 83.5% last year to 89.6% this year.

9.6 Delayed Transfers of Care from hospital is on track to meet the year-end target and there has been a marked reduction throughout the year in the number of days lost due to delayed discharges of care both at TRFT and RDaSH. In April 2016 a Memorandum of Understanding has been agreed between Rotherham CCG, the Council and The Rotherham Foundation Trust which will support the discharge process and ensure more effective integration.

9.7 Latest public information around the NHS Family and Friends Test shows a reduction of 123.08 to 115.9 in the rate of negative responses.

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 health and social care are new integration metrics that have been recently introduced. Rotherham can report favourably on the first two metrics.

10.2 We are now providing Personal Health Budgets to 77 adults and 20 children in Rotherham during Quarter 4.

11. Year End Feedback

NHS England have also requested feedback on progress in delivering the BCF plan in 2015/16 and provides an opportunity for local areas to consider the impact of the first year of the BCF.

Our key successes include the 7 day working pilot to facilitate hospital discharge, the matching of all in-scope social care records with the NHS number and the expansion of the Mental Health Liaison Service.

Key challenges include the level of hospital admissions during Quarter 1 and 2, financial pressures on jointly commissioned services to meet increasing demands and needs and the resources required by health and social care staff to devote time to the delivery of the BCF plan.

12. Conclusion/Next Steps

12.1 The quarterly format, and the timetable for submitting the quarterly and annual returns have been included within the new Section 75 Partnership Framework Agreement for the BCF for 2016/17, thus ensuring both the CCG and Local Authority are jointly responsible for compiling and submitting these reports to the HWB and NHS England.

12.2 The return will need to be fully completed and submitted to both the BCF Executive Group and Health and Wellbeing Board.

13. Background Papers

13.1 Appendix A: BCF Quarterly Data Collection Quarter 4 2015/16

Officer Contacts: Keely Firth, Chief Finance Officer, RCCG **Tel. No:** 302025

Officer Contacts: Nathan Atkinson, Assistant Director of Commissioning, RMBC **Tel. No:** 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 27th May 2016.

The BCF Q4 Data Collection

This Excel data collection template for Q4 2015-16 focuses on budget arrangements, the national conditions, non-elective admissions, 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) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Non-Elective Admissions - this tracks performance against NEL ambitions.

6) Supporting Metrics - this tracks performance against the two national metrics, locally set metric and locally defined patient experience metric in BCF plans.
7) Year End Feedback - a series of questions to gather feedback on impact of the BCF in 2015-16

8) New Integration metrics - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care
9) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key 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.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the 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 previous quarterly 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.

If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that 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 have been 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' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the 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 Q4
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 Q4

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 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.

5) Non-Elective Admissions

This section tracks performance against NEL ambitions. The latest figures for planned activity are provided. One figure is to be input and one narrative box is to be completed:

Input actual Q4 2015-16 Non-Elective Admissions performance (i.e. number of NEAs for that period) - Cell P8
Narrative on the full year NEA performance

6) Supporting 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 Q4 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) Year End Feedback

This tab provides an opportunity to provide give additional feedback on your progress in delivering the BCF in 2015-16 through a number of survey questions. The purpose of this survey is to provide an opportunity for local areas to consider the impact of the first year of the BCF and to feed this back to the national team review the overall impact across the country. There are a total of 12 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund
There are a total of 10 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Disagree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:
1. Our BCF schemes were implemented as planned in 2015-16
2. The delivery of our BCF plan in 2015-16 had a positive impact the integration of health and social care in our locality
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan

Part 2 - Successes and Challenges
There are a total of 2 questions in this section, for which up to three responses are possible. The questions are:
11. What have been your greatest successes in delivering your BCF plan for 2015-16?
12. What have been your greatest challenges in delivering your BCF plan for 2015-16?

These are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Leading and managing successful Better Care Fund implementation
2. Delivering excellent on the ground care centred around the individual
3. Developing underpinning, integrated datasets and information systems
4. Aligning systems and sharing benefits and risks
5. Measuring success
6. Developing organisations to enable effective collaborative health and social care working relationships
7. Other - please use the comment box to provide details

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 / Q3 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.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

9) Narrative

In this tab HWBs are asked to provide a brief narrative on year-end overall progress, reflecting on a first full year of the BCF, with reference to the information provided within this and previous quarterly returns.

Better Care Fund Template Q4 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

Funds pooled via a S.75 pooled budget, by Q4? If no, date provided?
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" please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

4. 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
	Forecast					
	Actual	Yes	Yes	Yes	Yes	
	Actual					
Expenditure From	Forecast	Yes	Yes	Yes	Yes	Yes
	Forecast					
	Actual	Yes	Yes	Yes	Yes	
	Actual					
	Commentary	Yes				
	Commentary					

5. Non-Elective Admissions

Actual Q4 15/16	Comments on the full year NEA performance
Yes	Yes

6. Supporting Metrics

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

7. Year End Feedback

Statement:	Response:
1. Our BCF schemes were implemented as planned in 2015-16	Yes
2. The delivery of our BCF plan in 2015-16 had a positive impact on the integration of health and social care in our locality	Yes
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions	Yes
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care	Yes
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Yes
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Yes
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality	Yes
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality	Yes
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality	Yes
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan	Yes

11. What have been your greatest successes in delivering your BCF plan for 2015-16?	Response and category
Success 1	Yes
Success 2	Yes
Success 3	Yes

12. What have been your greatest challenges in delivering your BCF plan for 2015-16?	Response and category
Challenge 1	Yes
Challenge 2	Yes
Challenge 3	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 end 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

Q4 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 boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	16
4. I&E	19
5. Non-Elective Admissions	2
6. Supporting Metrics	9
7. Year End Feedback	16
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 had not been previously stated that the funds had been pooled can you now confirm that they have now?	
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 a previous quarterly collection returned 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 have been met, 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 an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q4 Submission Response	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?
1) Are the plans still jointly agreed?	Yes	Yes	Yes	Yes	Yes	
2) Are Social Care Services (not spending) being protected?	Yes	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	Yes	
4) In respect of data sharing - please confirm:						
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	Yes	
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	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	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	Yes	
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	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
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 returned by the HWB.

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	£5,829,000			

Q4 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	£5,829,000	£23,316,000	

Please comment if there is a difference between the forecasted / actual annual totals 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	£5,829,000			

Q4 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	£4,689,000	£22,176,000	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	The risk pool is unutilised and there were underspends in a small number of areas due to services gaining traction throughout the year. The underspend has been reinvested in direct payment packages and non-elective activity.

Commentary on progress against financial plan:	The financial plan is on track and we are proposing to make an additional investment of £1 million in 2016/17, subject to the aprpoval of the Health and Wellbeing Board in June 2016.

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.

Non-Elective Admissions

Selected Health and Well Being Board: Rotherham

	Baseline				Plan					Actual				
	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	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16
D. REVALIDATED: HWB version of plans to be used for future monitoring. Please insert into Cell P8	7,447	7,570	7,438	7,728	7,638	7,514	7,382	7,670	7,579	7,491	7,745	7,503	6,378	7,776

Please provide comments around your full year NEA performance	Full year NEA actual is below plan. Q3 represents an under-reported position, due to data quality issues experienced by the CCGs lead provider. This was rectified for Q4. A review of the data indicates if the under-reporting was accounted for in Q3, the actual position would be just below plan for Q3.

Footnotes:

##########

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:	If final out-turn confirms 1st cut year end data on completion of quality assurance checks, then this measure will have exceeded 2015/16 target. Admissions as at year end data (Q4), shows a total of 401 admissions, this equates to a rate per 100,000 of 804.2. This is 68 fewer admissions than reported in 2014/15 and represents an approximate 16% 'in year' rate reduction from the 2014/15 rate of 958.5. BCF initiatives we estimate will

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?	On track for improved performance, but not to meet full target
Commentary on progress:	We are currently showing an increased number of service users have benefited from service in 2015/16 compared to last year (121 v 117). This is evidenced from the initial 1st cut data following the end of year 91 day 'ring round' since discharge of the three month cohort sample of service users. This achieves an improvement from 83.5% in 2014/15 to 89.6% and is just below 2015/16 target of 90%. We also estimate that further

Local performance metric as described in your approved BCF plan / Q1 / Q2 / Q3 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 to meet target
Commentary on progress:	Final SUS data not yet available to review year end performance.

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:	2014 score published in late 2015 displayed an improvement beyond the 2015/16 plan, with a score of 115.9. Current plan is to sustain this level of achievement. Numerator and denominator not available until published nationally.

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.

Year End Feedback on the Better Care Fund in 2015-16

Selected Health and Well Being Board: Rotherham

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. Our BCF schemes were implemented as planned in 2015-16	Strongly Agree	We have implemented 7 day working, matched all social care records with an NHS number, expanded the mental health liaison service, developed an integrated falls and bone health care pathway and recommissioned the social care prescribing service in 2015/16.
2. The delivery of our BCF plan in 2015-16 had a positive impact on the integration of health and social care in our locality	Agree	iniatives in 2015-16 to drive integration including; development of integrated MDT meetings through an established Transfer of Care Team underpinned by a Memornadum of Understanding. Also weekly multi-agency ward rounds (including VCS, MH, Social Care, Commissioning and Health colleagues) are in place to expedite discharges. This has supported the improvements in the DTOC targets for 2015/16.
3. The delivery of our BCF plan in 2015-16 had a positive impact in avoiding Non-Elective Admissions	Agree	All BCF community schemes have had a positive impact on reducing hospital admissions, in particular Fast Response beds, care home support service, social prescribing service and the mental health liaison service. GP practices are now linked to care homes with case management of patients in place (LES in place) to support the reduction in admissions from this sector across the borough.
4. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Delayed Transfers of Care	Agree	The 7 day working programme has ensured that patients can now be discharged from hospital on Saturdays and Sundays. Domicilairy care providers also accept new referrals over the weekend to provide a package of care to support needs. Also see example in question 2.
5. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Strongly Agree	The intermediate care and enabling service has had a positive impact in increasing the % of older people living at home after 91 days from hospital discharge - the outturn has increased from 83.5% in 2014/15 to 89.6% in 2015/16. Changes to eligibility and the referral process for Intermediate Care, to ensure the provision is flexible and has the ability meet the needs of patients has seen an increase in utilisation over the last 4 months
6. The delivery of our BCF plan in 2015-16 had a positive impact in reducing the rate of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes	Agree	The intermediate care and enabling service have a positive impact in reducing admissins to residential care with only 2% of service users requring 24 hour upon discharge. See question 3 response for further detail on GP in care homes.
7. The overall delivery of our BCF plan in 2015-16 has improved joint working between health and social care in our locality	Agree	Service (RICC), Community Occupational Therapy Service and the Integrated Community Equipment Service. Various initiatives are in place that support more integrated working arrangements such as the greement of the appointment of a quality officer (health) to work with the contract compliance team (council) supporting the contract quality/performance monitoring of care homes, the development of the MOU for hospital discharge process and the
8. The implementation of a pooled budget through a Section 75 agreement in 2015-16 has improved joint working between health and social care in our locality	Agree	The Section 75 agreement provides funds to local areas to support the integration of health and social care and assists us to achieve the national conditions and local objectives. It also allows us to transfer funding to other BCF schemes which are under financial pressure e.g. direct payments and domiciliary care.
9. The implementation of risk sharing arrangements through the BCF in 2015-16 has improved joint working between health and social care in our locality	Agree	Risk against the BCF programme has been monitored in year through the governance arrangements, with a robust risk register in place to help mitigate risks. The risk sharing arrangements have supported this process with the risk pool being used appropriately in 2015-16 to support both the council and CCG.
10. The expenditure from the fund in 2015-16 has been in line with our agreed plan	Agree	The service review process has ensured that all services are strategically relevent and are funded appropriately. This review highlighted several services for further deep dive reviews in 2016-17 but ensured that funding aligned appropriately to provision under a new system of categorisation. The governance arrangements in place whihc includes regular reporting on finance has enabled us to monitor spend throughout the year appropriately.

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

11. What have been your greatest **successes** in delivering your BCF plan for 2015-16?	Response - Please detail your greatest **successes**	Response category:
Success 1	We have established a 7 day community, social care and mental health pilot to support hospital discharge and reduce delayswhich has now been operational since December 2015. The Hospital Social Work Team now provide a joint approach to assessments and care planning on a 7 days a week basis. This new pathway also reduces length of stay in hospital medical wards. We will carry out a review of this pilot at the end of May 2016, with the intention of ensuring that this becomes a permanent arrangement to continue to support discharge and admission prevention.	2.Delivering excellent on the ground care centred around the individual
Success 2	We have successfully matched adult social care records with their NHS number, providing a single identifier that can be used across health and social care. We have already started to look at how we can match records to improve the quality of joint commissioning. We are also identifying the highest cost individuals across the health and social care economy with a view to providing a more integrated and cost-effective service.	3.Developing underpinning integrated datasets and information systems
Success 3	We have expanded the Mental Health Liaison Service. The service supports wards and care homes when delivering care to people who have mental health issues. It focuses on those parts of the health and social care economy that work with people who have a physical condition. One of the key aims of this service is to reduce admissions to hospital and to limit average length of stay.	2.Delivering excellent on the ground care centred around the individual

12. What have been your greatest **challenges** in delivering your BCF plan for 2015-16?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	Financial pressures on BCF funded schemes such as Community Occupational Therapy service, Integrated Community Equipment Service and intermediate care services due to increasing demand on service and increasing costs. This is having an effect on performance targets e.g. length of time for assessment, provision of equipment and adaptations and insufficient bed capacity during times of surge.	1.Leading and Managing successful better care implementation
Challenge 2	The number of non-elective hospital admissions have increased in Quarters 1 and 2 of 2015/16 which was having an impact on the delivery of the BCF plan. However, the NEA position at year end is slightly under plan. The position remains very challenging, however, and the CCGs NEA plan to meet the challenge is reflected in the 2016-17 operational plans submitted to UNIFY.	5.Measuring success
Challenge 3	The resources required for health and social care staff to devote to the BCF has increased significantly over the last 12 months. From March to May 2016, we have consulted with a wide range of key stakeholders to develop our BCF plan for 2016/17 and to also complete the planning template in order to meet requirements set by NHS England. This period which we had originally earmarked to carry out deep dive reviews of some of our BCF schemes. This work is also in addition to completing 4 quarterly reports per year. Therefore the process is both cumbersome and onerous if local areas are expected to continue to deliver this level of detail on a yearly basis.	5.Measuring success

Footnotes:

Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Leading and managing successful Better Care Fund implementation
2. Delivering excellent on the ground care centred around the individual
3. Developing underpinning, integrated datasets and information systems
4. Aligning systems and sharing benefits and risks
5. Measuring success
6. Developing organisations to enable effective collaborative health and social care working relationships
7. Other - please use the comment box to provide details

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	Installed (not live)	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 end of the quarter	77
Rate per 100,000 population	29

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 2016)	261,739

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
Q4 15/16 population figure has been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

Narrative

Selected Health and Well Being Board: Rotherham

Remaining Characters	29,165

Please provide a brief narrative on year-end overall progress, reflecting on the first full year of the BCF. Please also make reference to performance on any metrics that are not directly reported on within this template (i.e. DTOCs).
BCF Governance continues to closely monitor specific BCF projects, to ensure full and accelerated implementation of the two 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. A review will be carried out in 2016/17 to measure success and outcomes of this project. National Condition 4(i) - NHS Number being used as primary identifier for health and social care services Work now completed 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 and all BCF records now have an NHS number assigned. 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. We 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). Whilst we are waiting for PDS to go "live" we will add new NHS numbers manually. Training materials have been issued which demonstrate to practitioners in adult social care how to use the NHS number field in the incumbent system. This includes mechanisms for maintaining the NHSN in the interest of ensuring that the field is always populated and that it should be captured as early as possible during the social care pathway. The newly formed BCF Programme Board continues to take a lead in developing proposals for integration. The BCF PLan for 2016/17 has now been agreed by Health and Wellbeing Board members on 28th April, 2016, which details our key achievements, key priorities for 2016-2019, risk assessment, contingency planning and patient engagement. A new Section 75 agreement has been developed which will be approved at the Health and Welbeing Board on 1st June, 2016. All BCF schemes have now been recategorised into new themes e.g. mental health services, rehabilitation, reablement and intermediate care, supporting socil care, case management and integrated care planning, supporting carers and BCF infrastructure. A BCF Directory of Services has now been completed so that all key stakeholders can see a clear map of provision. A series of individual "deep dive" 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 betwee May and December 2016. Delayed Transfers of Care (DTOC) - This measure is on track to meet the year-end target 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

Rotherham Metropolitan Borough Council

Public Report
Health & Wellbeing Board

Summary Sheet

Council Report
Health and Wellbeing Board 01.06.2016

Title
Director of Public Health Annual Report 2015

Is this a Key Decision and has it been included on the Forward Plan?
No not a key decision. Not on forward plan

Strategic Director Approving Submission of the Report
Teresa Roche, Director of Public Health

Report Author(s)
Anna Clack, Public Health Specialist
01709 255872
anna.clack@rotherham.gov.uk

Ward(s) Affected
All

Summary

The Director of Public Health has a statutory responsibility to produce an Annual Report and the Council has a statutory duty to publish it.

This report focusses on an analysis of some of the key issues that affect the health and wellbeing of Rotherham's Children and Young People, and explores the health inequalities that exist for children between Rotherham and the rest of England. This report describes Children and Young People's health through a life-course approach, from pregnancy and birth, through school years into young adulthood.

The Report aims to engage with professional stakeholders across the Borough, to work together to deliver on a clear set of recommendations that will help improve the health and wellbeing of our Children and Young People. The recommendations are aimed at all statutory and voluntary partners across the Borough.

The recommendations evolved from sections in the report which highlight ***'our ambitions for Rotherham'***. The intention of this report is to sit alongside the Health and Wellbeing Strategy and to help inform the actions taken by the Health and Wellbeing Board. It also offers some practical interventions which will improve child health and contribute to reducing the health inequalities across the Borough. Future reports will report on progress against the recommendations and associated action plan.

Recommendations

1.1 That the Health and Wellbeing Board receives and notes the report.

1.2 That the Health and Wellbeing Board considers how they can support and take forward the recommendations in the Report.

List of Appendices Included

Background Papers
The Director of Public Health Annual Report 2014 (produced by the former DPH)

Consideration by any other Council Committee, Scrutiny or Advisory Panel
For Consideration by Cabinet and the Health and Wellbeing Board

Council Approval Required
No

Exempt from the Press and Public
No

Director of Public Health Annual Report 2015

1. Recommendations

1.1 That the Health and Wellbeing Board receives and notes the report.
1.2 That the Health and Wellbeing Board considers how they can support and take forward the recommendations in the Report.

1.1 2. Background

2.1 At the local level, the Health & Social Care Act (2012) gives local authorities the responsibility for improving the health of their local populations. The Act says that local authorities must employ a director of public health, and they will be supported by a new ring-fenced budget. The Act requires directors of public health to publish annual reports that can chart local progress.

2.2 This year's annual report is the first in a series that is planned to work through the life course, focusing on key health issues at different stages of our lives. The report looks at the importance of prenatal, childhood and young people's health issues.

2.3 The report identifies work already underway to tackle some of the key health issues for children and young people and highlights the areas where we need to focus our attention in the future to improve outcomes for them. From this, 8 overarching recommendations have been made which prompt a partnership approach to tackle the health inequalities that exist and improve health outcomes for children and young people in Rotherham. These recommendations will be incorporated into a Specific, Measurable, Achievable, Realistic, Timely (SMART) action plan which summarises the 'what we'd like to see' actions, so that our progress will be measurable for review in the next report.

3. Key Issues

3.1 Data from Public Health England on the health and wellbeing of Rotherham children and young people is given in its Child Health Profile.

The main issues for Rotherham children compared to the England average are:

- Children aged 16-18 not in education, employment or training (NEET)
- First time entrants to the youth justice system
- Children in poverty
- Children in care
- Children killed or seriously injured in road traffic accidents (though this indicator is based on very small numbers of deaths and varies year on year)
- Low birth weight babies

- Obese children aged 10-11 years (Year 6)
- Children with decayed, missing or filled teeth
- Mothers smoking in pregnancy
- Breastfeeding (initiation and continuation at 6-8 weeks)

4. Options considered and recommended proposal

Not applicable

5. Consultation

5.1 Consultation with Children and Young People is referred to throughout this report including the Rotherham Lifestyle Survey, which is undertaken annually with Year 7 and Year 10 pupils.

6. Timetable and Accountability for Implementing this Decision

Not applicable

7. Financial and Procurement Implications

None

8. Legal Implications

None

9. Human Resources Implications

None

10. Implications for Children and Young People and Vulnerable Adults

10.1 The report addresses how we can improve the health and wellbeing outcomes for children and young people across Rotherham and provides a focus on vulnerable groups.

11. Equalities and Human Rights Implications

11.1 The report highlights health inequalities and their impact on health outcomes for the population. Commissioned services are required to demonstrate how they meet equalities and human rights requirements.

12. Implications for Partners and Other Directorates

12.1 The recommendations from the report are a “call to action” for all partners and other directorates.

13. Risks and Mitigation

13.1 The recommendations will be supported by a comprehensive action plan, overseen by the Director of PH, which will track progress.

14. Accountable Officer(s)

Teresa Roche
Director of Public Health

This report is published on the Council's website or can be found at:-

http://moderngov.rotherham.gov.uk/ieDocHome.aspx?Categories=

Director of Public Health Annual Report

2015-16

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Rotherham Metropolitan Borough Council

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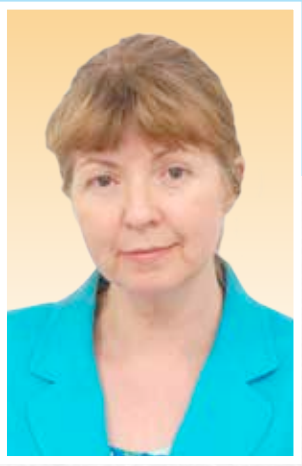
Foreword



Supporting good health and wellbeing for children, young people and families is central to improving health outcomes across our society. The report highlights the importance of improving safeguarding, health and wellbeing and the life chances of children and young people, especially those who are vulnerable.

This report looks forward to how health services, social care, the voluntary sector and the wider community can support our children and young people to have a better start in life, as Rotherham Council, together with the support of its partners, moves forward in its recovery journey, building a child-centred Borough.

All Directors of Public Health are required to produce an independent annual report on the health of their local population, highlighting key issues. I joined Rotherham Metropolitan Borough Council on 29 June 2015 and I am pleased to present my first annual report as Director of Public Health. The report highlights the importance of improving safeguarding, health and wellbeing and the life chances of children and young people, especially those who are vulnerable.

This year's annual report is the first in a series that is planned to work through the life course, focusing on key health issues at different stages of our lives – starting and growing well, living and working well and ageing well. The report looks at the importance of prenatal, childhood and young people's health issues.

We value the contribution of children and young people to our work and this report has been informed by a range of local consultations and surveys.

Throughout this report we refer to children and young people using the United Nations' definition: a 'child' is a person below the age of 18[1] and a 'young person' is a person between the ages of 15 and 24 years[2].

The foundation of every aspect of human development, physical, intellectual and emotional is laid down in early childhood. What happens during these early years (starting in the womb) has lifelong effect on many aspects of health and wellbeing, from obesity, heart disease and mental health, to educational

achievement and economic outcomes[3]. To thrive, our children and young people must be safe, healthy, have opportunities to enjoy life and have a sense of achievement and economic wellbeing.

Our children and young people are an asset and need to be nurtured. How we support them builds our future.

This annual report identifies work already underway to tackle some of the key health issues for children and young people and highlights the areas where we need to focus our attention in the future to improve outcomes for them.

The report is, therefore, my call to action for the whole health and social care community in Rotherham to share our knowledge, skills and expertise in a commitment to working in partnership to improve the health of our children and young people.

Executive Summary

Directors of Public Health are required to produce an independent annual report on the health of their local population, highlighting key issues. This report describes the health experience of children and young people in Rotherham and highlights the areas where our children and young people experience poor health or worse health than the national average.

The health of the Rotherham population is generally poorer than the English average. This leads to growing pressures on health services, social care, informal care, supported housing and other services. Life expectancy, although lower than average, has been increasing. However, the average time spent in ill-health has also been increasing, resulting in a growing number of people with high levels of need.

Data from Public Health England on the health and wellbeing of Rotherham children and young people is given in its Child Health Profile[4].

The main issues for Rotherham children compared to the England average are:

- Children aged 16–8 not in education, employment or training (NEET)
- First time entrants to the youth justice system
- Children in poverty
- Children in care
- Children killed or seriously injured in road traffic accidents (though this indicator is based on very small numbers of deaths and varies year on year)
- Low birth weight babies
- Obese children aged 10 –11 years (Year 6)
- Children with decayed, missing or filled teeth
- Mothers smoking in pregnancy
- Breastfeeding (initiation)

This report describes children and young people's health through a life-course approach, from pregnancy and birth, through school years into young adulthood. It describes some of the work which is being done to address the inequalities in health experienced in Rotherham and suggests what could be done to make further improvements.

Key Recommendations

By the end of this report you will have realised that it is very wide ranging and you will have noted that for each subject area we have reported examples of ***What are we doing about it in Rotherham?*** and ***Our ambition for Rotherham***.

However, whilst we will aim to accomplish all we'd like to see, the following recommendations have by necessity been refined from key areas that have been identified as likely to have the greatest impact for children and young people. These recommendations are eminently achievable if all the key stakeholders across Rotherham embrace the points and work together. They will sit alongside SMART (Specific, Measurable, Achievable, Realistic, Timely) actions relating to ***Our ambition for Rotherham*** in order to improve the health and wellbeing of children and young people in Rotherham.

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

The Rotherham NHS Foundation Trust

RDaSH leading the way with care

Voluntary Action Rotherham

NHS Rotherham Commissioning Group

The key recommendations from the report are:

1. Rotherham CCG to work closely with Public Health and service providers to ensure that **services** and **care pathways** for pregnant women and children and young people are integrated and take every opportunity to maximise public **health outcomes**. Particularly, reducing the risks associated with poor health behaviours (reducing smoking and alcohol use in pregnancy, increasing levels of breast feeding, reducing levels of overweight and obesity and increasing physical activity).
2. Public Health service providers and Children & Young People's services to work more closely to deliver **integrated health and early help services** for children and families
3. Partners to work together to **maximise opportunities for training** to improve health outcomes – for example by adopting Making Every Contact Count (MECC) principles and undertaking joint training on the effects of poor health behaviour on children and families

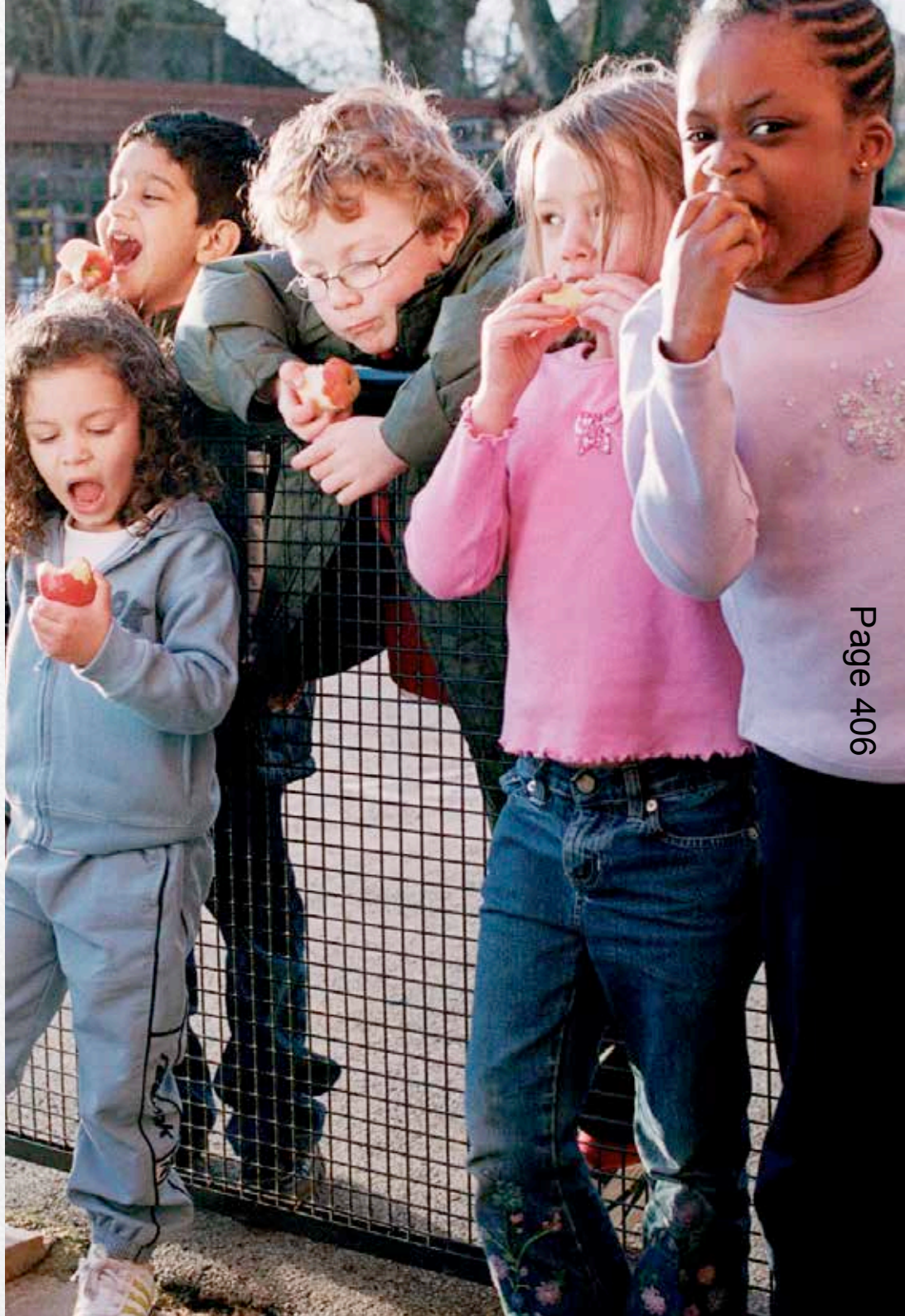
4. Schools and colleges should do more work to ensure that all children and young people are supported to **improve their mental health and wellbeing** – identifying clear pathways of support when children and young people experience mental health problems and raising awareness of self-harm and suicide prevention strategies

5. Rotherham CCG and the local service providers should ensure **better and more timely access** for children and young people experiencing **mental health problems**. This should lead to better recovery and outcomes

6. Rotherham MBC needs to work with all partners to develop a 'whole systems' approach to **tackling overweight and obesity**, including prevention and treatment strategies

7. The work programmes of the Health and Wellbeing Board and the Children & Young People's Partnership should be **integrated and add value** to the work of all partners

8. RMBC and partners review the need for a **poverty strategy** which seeks to address the economic wellbeing of families in order to reduce child poverty



Introduction

Supporting good health and wellbeing for children, young people and families is central to improving health outcomes. The foundations for virtually every aspect of human development physical, intellectual and emotional are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and wellbeing from obesity, heart disease and mental health, to educational achievement and economic status[5].

Children and young people are both shapers of, and shaped by, the world around them[6]. However, their health is strongly influenced by parents/carers, extended family members, peers and the community. It is therefore important not to view children as autonomous beings but to consider all the influencers on health decision making, choices and ability to access health and care services.

About Rotherham

The Joint Strategic Needs Assessment (JSNA) is a key source of information on the residents of Rotherham, providing a rigorous analysis of the issues that need to be addressed. The Public Health Outcomes Framework (PHOF), published by Public Health England is the main source of public health data and measures performance against a range of public health indicators including the wider determinants of health.

A summary of Rotherham's health and wellbeing status and of the key issues concerning Children and Young People is given below, with further links to data sources (including the JSNA[7], the latest PHOF scorecard and key children's data) given in Appendix 1 at the end of the report.

Summary of Rotherham's health and wellbeing status

The health of the Rotherham population is generally poorer than the English average. This leads to growing pressures on health services, social care, informal care, supported housing and other services. Life expectancy, although lower than average, has been increasing. However, the average time spent in ill-health has also been increasing, resulting in a growing number of people with high levels of need.

Rotherham's population was estimated at a record 260,100 in 2014[8] and is projected to grow by 2.5% to reach 266,500 by 2021. The population is becoming more ethnically diverse with the Black and Minority Ethnic (BME) population increasing from 4.1% to 8.1% between the 2001 and 2011 censuses[8]. It is projected that this level of diversity will increase further, illustrated in the more recent 2015 school census which shows that 15.7% of the borough's children and young people, are from BME backgrounds[9]. This is most evident in the central area of Rotherham where new migrant communities have settled alongside established ethnic minorities. Agencies need to take account of differing cultural needs and barriers that can limit access to services, such as poor English skills and different attitudes to health.

Rotherham is one of the 20% most deprived districts in England, which the Indices of Multiple Deprivation 2015 shows is driven mainly by high worklessness, low qualification and skill levels and poor health[10]. The inequality gap between the most deprived neighbourhoods and the rest of the borough has grown as deprivation has increased since 2007. High deprivation is reflected in high levels of financial exclusion, debt problems and fuel poverty.

Welfare reform is estimated to have taken £84 million per year from low income households in the United Kingdom[11], particularly affecting families with children and those who are long term sick, and further reductions will result from the welfare changes announced in the July 2015 budget. Pressures on household budgets have forced a growing number of people to use food banks. Rotherham is amongst the highest 8% of UK districts most affected by problem debt[12]. The majority of over-indebted people feel anxious, stressed and unhappy as a result of their situation, but only a minority are accessing advice[11].

Children and Young People

There are 56,400 children and young people aged under 18 in Rotherham[13], (21.7% of the Borough's population, slightly above the English average of 21.3%). An analysis of the age profile predicts that the number of secondary school age children (11-17) will increase between 2016 and 2021 by 6%. As of the end March 2015 there were 1,923 Children in Need, 423 Children subject to a Child Protection Plan[14] and 410 Looked After Children in Rotherham[15]. Our high Child Protection rate and increasing complexity in the social care cases demonstrate that the needs of local children and young people and their families are rising.

Nationally there is a direct correlation between social care needs and deprivation. Nationally 19.7% of children are affected by income deprivation[16], in Rotherham this is significantly higher at 24.3% and for children living in our ten most deprived communities half of them are affected by income deprivation[17]. The Deprivation Pupil Premium also shows a similar picture with more local pupils (31.8%) eligible than the national average of 28.6%.

High rates of smoking in pregnancy are a particular concern in Rotherham affecting 18.3% of maternities compared to 11.4% in England. This contributes to complications during pregnancy and delivery and health problems throughout childhood. The number of babies born at low birth weight (8.6%) is above the English average of 7.4%, similarly infant mortality rate is 5.1 per 1,000 births, compared to England average of 4.0. The breastfeeding initiation rate of is one of the lowest in the region and this poor level of breastfeeding is associated with childhood obesity. Obesity affects 9.9% of Rotherham school children aged 4-5 and 21.6% of Rotherham children aged 10-11[18], this is broadly in-line with national averages for 4-5 year olds but much higher than the average of 19.1% of 10-11 year olds.

Levels of oral disease in five year olds are much higher than average in Rotherham at 40% compared with 28% nationally.

Within school, at Foundation level, 67.4% of Rotherham children show a good level of development which compares well against the national average of 66.3%[19].

The school census 2015 shows the most common types of special educational need to be 'Specific Learning Difficulties' (23.0%) and autism (13.6%)[20]. Behavioural difficulties account for 17%, although this is lower than the England average (21%). A growing number of children and young people have multiple disability and complex needs which continue as they make the transition into adulthood.

Whilst educational attainment in Rotherham has improved over recent years[21], children and young people in the more deprived areas often have low aspirations. Of 16-18 year olds, 5.9% are not in employment, education or training (NEETS), which is above the national average of 4.7%. Youth unemployment (ages 16-24) in Rotherham is 21.3%, again above the English average of 17.3%[22].

For young people aged 15-24, 1,550 were diagnosed with a sexually transmitted infection in 2013; this is a rate of 4,940 per

100,000, higher than the English average. However, this figure should be interpreted with caution as it could also indicate an accessible and young person friendly service where people feel comfortable in seeking treatment.

Child Poverty

The most basic form of deprivation affecting children is low household income which impacts on a wide range of life chances. The Indices of Deprivation 2015* shows that 48,400 people or 18.7% of Rotherham's population were deprived of income (on means tested benefits or asylum seeker support) in 2013/14. Children aged 0-15 are most likely to be affected by low income with 12,050 (24.3%) of children aged 0-15 affected, 580 more than in 2008. At the neighbourhood level, the figures range from 3% to 62.5%, showing a polarisation in family income across the Borough.

*Please note that Indices of Deprivation data on income and poverty uses a different measure to that referenced within the Public Health Outcomes Framework.

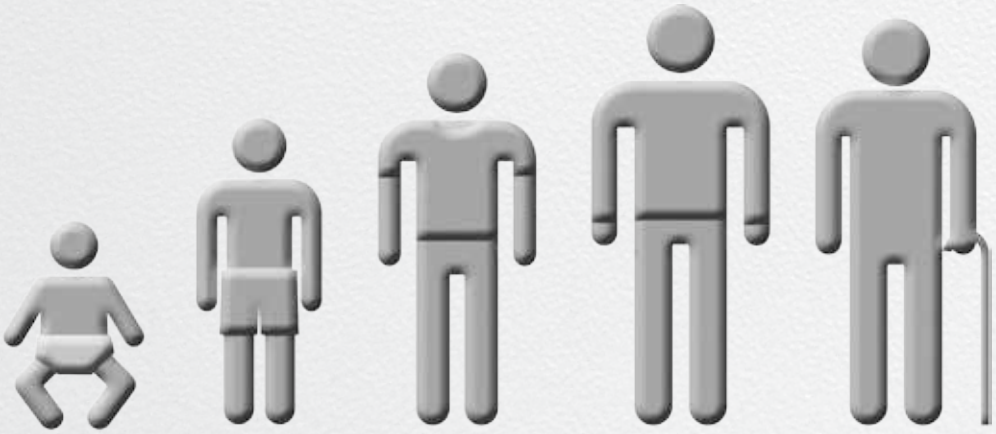
Children living in the Most Deprived Areas

The 10 most deprived areas of Rotherham (the Super Output Areas, or SOAs, of Ferham, East Herringthorpe North, Eastwood Village, Canklow North, Eastwood East, East Herringthorpe South, Eastwood South, Maltby Birks Holt, East Dene East and Masbrough) have a combined population of 17,500, of which children aged 0-17 number 5,900 (33.6%), twice the proportion in the 10 least deprived areas. Half of children in the most deprived areas (3,000) live in families with three or more children, almost three times that observed in the least deprived. Of children in the most deprived areas, 43% are minority ethnic compared with just 4% in the least deprived. Children in the most deprived areas are 13 times more likely to live in poverty than the 10 least deprived.

Educational achievement and attainment are clearly affected by deprivation. Only 36.7% of Foundation pupils in the most deprived areas reached a good level of development in 2013 compared with 73.2% in the least deprived. The gap is wider for young people taking their GCSEs with just 31.9% attaining the headline measure (data for period 2012-14), compared with 81.7% in the least deprived.

Whilst children from across the Borough can receive some social care support, those in the most deprived areas are five times more likely to be designated as a Child In Need (Children Act 1989), than those in the least deprived areas. They are also four times more likely to be involved in some way with the team dealing with child sexual exploitation[23].

Life expectancy at birth for a baby born in the 10 least deprived areas is 9.5 years longer than for a baby born in the most deprived areas. Children in the most deprived areas are twice as likely to be disabled and more than twice as likely to live in a home where someone smokes.



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Chapter 1: Pregnancy, birth and the early years

Healthy Pregnancy

From the moment of conception, through to birth and the first year of life, every aspect of a baby's environment influences its physical, emotional and social development[24]. Helping women make healthy choices during pregnancy is pivotal to improving outcomes for children and young people.

During pregnancy most women want to 'do the best for baby' and this heightened motivation can provide the opportunities and incentives for tackling unhealthy behaviours and promoting healthy ones; for example, helping women to stop smoking when pregnant and encouraging them to breastfeed following the birth.

However, we know that a woman's social circumstances can limit her from making healthy choices which may in turn be reflected in poorer outcomes of pregnancy and subsequent child development[25].

A number of measures are used to assess the health of mothers and babies. These include levels of infant death, babies born weighing less than 2.5kg, the number of women smoking in pregnancy, the number of babies born to teenage parents and the number of babies who are breast-fed. Of the 3,072 (live birth) babies born in Rotherham in 2014:

- 186 were born to teenage parents (mothers aged under 20); this equates to over 60 per 1,000 live births which is higher than England at nearly 37 per 1,000 live births. Of these, 44 were to mothers aged under 18, which is a rate of 14.3 per 1,000 compared to England's 9.4 per 1,000. Rotherham is average among its comparable statistical neighbours, whose rates for under 20 births range from 47 to 75 per 1,000
- 474 (18.3%) babies were born to mothers who smoke, compared to 11.4% in England. Rotherham's comparable neighbours' rates range from 10.8% to 22.0%
- 249 (just over 8%) were low birth weight (less than 2.5kg) compared to 7% in England
- 226 (7.4%) were born pre-term (before 37 weeks in pregnancy) compared to 10.2% in England
- Only 1,745 (62.5%) babies were breastfed at birth compared to 74.3% in England. Rotherham's comparable neighbours' rates range from 52.8% to 67.2%

Maternal nutrition and Vitamin D and Folate deficiency

A healthy and well balanced diet is an essential part of leading a healthy lifestyle and it is especially important for women who are pregnant or for women planning a pregnancy.

A healthy diet will benefit both mother and baby during pregnancy and also helps the mother to maintain a healthy weight once the baby has been born. During pregnancy women should aim to:

- Base all meals on starchy foods such as potatoes, bread, rice and pasta, choosing wholegrain where possible
- Watch the portion size of meals and snacks and how often women eat by avoiding 'eating for two'
- Eat a low-fat diet. Avoid increasing fat and/or calorie intake. Limit the intake of foods with a high fat content. Limit the amount of drinks, confectionary and other foods high in added sugars
- Eat fibre-rich foods such as oats, beans, lentils, grains, seeds, fruit and vegetables as well as wholegrain bread, brown rice and pasta
- Eat at least five portions of a variety of fruit and vegetables each day, in place of foods higher in fat and calories
- Always eat breakfast[26]

Weight gain in pregnancy is inevitable; it allows the baby to grow and gives them the best start in life. However, too much weight gain leading to maternal obesity has increased health risks for both the mother and child during and after pregnancy. The babies of women with a pregnancy BMI ≥35 have an increased risk of perinatal mortality compared with those of the general maternity population in the UK. National Institute for Health and Care Excellence (NICE) Guidance[27] states that pregnant women only need to eat an additional 200 calories per day in their final trimester, dispelling the common myth of eating for two. Maternal obesity is an increasing problem worldwide; in Rotherham over 5% of babies born in 2013 were to mothers with a BMI of over 40.

Folic acid (also known as vitamin B9) is very important for the development of a healthy foetus and it can significantly reduce the risk of neural tube defects such as spina bifida. Taking a folic acid supplement (400 micrograms daily) is hugely beneficial for women planning a pregnancy and during the first 12 weeks of

pregnancy, even if the mother is already eating foods which have added folic acid or foods rich in folate.

Vitamin D deficiency is recognised as a significant public health problem[28]. It is likely that deficiency is common in high risk groups such as pregnant and breastfeeding women, people with darker skin and those who are not exposed to much natural sunlight.

Vitamin D supplementation in pregnancy is therefore important; low level maternal vitamin D is associated with softening of the skull in newborns, restricted infant bone growth and is a risk factor for rickets. Maternal deficiency may also contribute to pregnancy related complications such as pre-eclampsia and gestational diabetes.

In Rotherham, there is a perception amongst health professionals that there is an increase in the number of children and adults presenting with low levels of vitamin D, however, this is currently anecdotal rather than based on hard data. While exact numbers are unknown, health professionals have identified a need for further action to be taken including the promotion of vitamin D and folate and increased access to the Healthy Start programme. Healthy Start is a Government scheme aimed at improving the health of pregnant women and children under four years[29].

What are we doing in Rotherham?

Healthy Start vitamins for women and children have been distributed through Rotherham Children's Centres, providing easy access for families in their local community. Unfortunately take up has been poor and this scheme could be improved to ensure that more eligible families take up the vitamin supplementation.

Our ambition for Rotherham

- Public Health England to provide up-to-date local information on the number of families entitled to and accessing the Healthy Start scheme
- Development of a robust pathway by The Rotherham NHS Foundation Trust to ensure a more effective system for distribution of Healthy Start vitamins to eligible families across Rotherham

Smoking during pregnancy

Smoking in pregnancy causes up to 2,200 premature births (babies born before full-term pregnancy), 5,000 miscarriages and 300 perinatal deaths (deaths that occur between 22 weeks in pregnancy and up to seven days after birth) every year in the UK[30]. It increases the risks in pregnancy for the mother and baby, including stillbirth and low birth-weight, and can have a longer term impact on the child's health as they grow and develop.

Smoking in pregnancy rates in Rotherham have significantly improved over the past five years but remain higher than the national and regional average. Younger women, those who have never worked and women from disadvantaged communities are most likely to smoke throughout pregnancy. Currently 18.3% of women in Rotherham continue to smoke up to the time they deliver their baby in hospital compared to 11.4% in England.

What are we doing in Rotherham?

In 2010 we made changes to the support provided to pregnant smokers. We made it easier for the women who want to quit to access support and based our stop smoking midwives in the antenatal unit so that all pregnant smokers, whether they want to quit or not, have at least one appointment with the service. This has led to more women seeking support to quit and bigger reductions in the number of women who continue to smoke whilst pregnant than have been seen nationally or in neighbouring areas. The changes we made mean that each year around 225 fewer women in Rotherham are smoking at delivery than five years ago.

Our ambition for Rotherham

- We would like to see the Rotherham Clinical Commissioning Group (CCG) ensure its service specification for community midwifery continues to require carbon monoxide screening of all pregnant women at booking and throughout pregnancy in accordance with the Yorkshire and Humber Stillbirth and Bereavement Recommendations (2015)[31] and ensure all smokers are given access to specialist support.

Alcohol in pregnancy

There is growing concern (and conflicting advice) about safe levels of alcohol consumption in pregnancy and the risk of Foetal Alcohol Syndrome Disorder (FASD) in children.

NICE guidance[32] and the Royal College of Obstetrics[33] generally agree that:

'Pregnant women and women planning a pregnancy should avoid drinking alcohol in the first three months of pregnancy. Following this, women who choose to drink alcohol during pregnancy should drink no more than one to two UK units once or twice a week.'

However, the National Organisation for Foetal Alcohol Syndrome-UK (NOFAS) takes a different stance and promotes the message that 'the only risk-free approach is to avoid alcohol completely'[34]. This recommendation is further reinforced by the recent review of the alcohol guidelines published by the UK Chief Medical Officer[35].

NOFAS describes the effects of alcohol on a baby as being mild or severe, ranging from reduced intellectual ability and attention deficit disorder to heart problems and even death. Research does suggest that up to 7000 babies are born annually in the UK with FASD[36] and Rotherham would expect around 30-35 babies born each year to have FASD.

Without support, people affected by FASD are at a higher risk of developing secondary disabilities and social problems such as: mental health problems; dropping out of school; becoming unemployed; homeless and/or developing alcohol and drug problems.

What are we doing in Rotherham?

Rotherham will be taking a consistent approach to messaging regarding alcohol in pregnancy, with the clear message 'No Alcohol equals No Risk'.

Public Health is leading an awareness raising campaign in 2016 to ensure that professionals and the public have a clear understanding of the risks of alcohol use during pregnancy and promote a greater understanding of FASD. This will need to encompass 'myth busting' for the family around the pregnant woman to ensure that advice is consistent. Pathways will be established to ensure that anyone who has concerns around FASD can contact a professional for advice, help and support.

Our ambition for Rotherham

- All partner agencies (including health and social care) in Rotherham signing up to promote the 'No Alcohol equals No Risk' message
- All midwives to receive alcohol brief intervention training and offer brief intervention at routine appointments

Sudden Infant Death Syndrome and safe sleeping

Eleven infants under the age of one have died from Sudden Infant Death Syndrome (SIDS) in Rotherham since September 2013. SIDS is the sudden, unexpected and unexplained death of an apparently well baby that cannot be explained after thorough investigation. However, there are often a number of possible causal factors and identified risk indicators that are thought to play a role in these deaths. The risk is recognised to be considerably higher for infants where indicators such as co-sleeping (baby sleeping with parent/carer on a bed, sofa or armchair), alcohol use and smoking are also present. Continuous and rolling interventions, including training for practitioners and awareness campaigns are essential and, evidence shows, are effective in reducing the number of SIDS death[37].

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What are we doing in Rotherham?

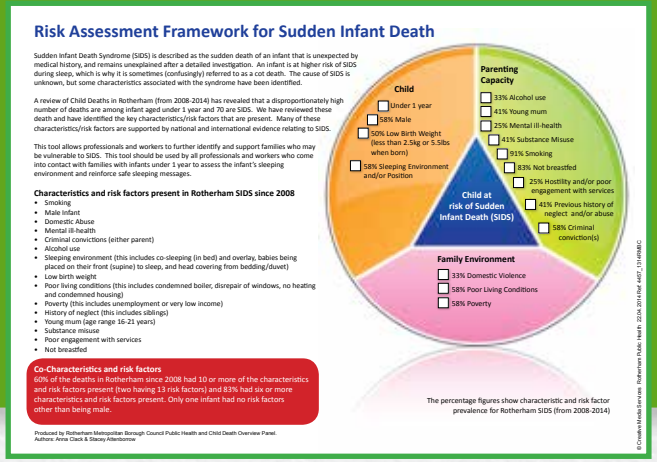
Since April 2012 Rotherham Public Health has been working with The Rotherham NHS Foundation Trust (TRFT) midwifery and health visiting service to implement a range of interventions to reduce the risk of Sudden Infant Death Syndrome (SIDS). A key intervention was the introduction of a sleep safe assessment form and observation to assess and action risks associated with SIDS.

The Rotherham sleep safe assessment involves discussion between a midwife or health visitor and a new parent of the risks relating to SIDS, and a check carried out by a health practitioner of the baby's sleeping environment, including how parents/carers put their baby down to sleep both in the day and at night. The sleep safe assessment is repeated in instances where any additional risks have been identified through further contact with services and where there has been a change in the infant's sleeping arrangements.

In the first year following the introduction of the Sleep Safe assessment and observation in Rotherham (which included robust training on SIDS and this procedure for all midwifery and child health practitioners), deaths from SIDS decreased significantly with only one death occurring in that year 2012/2013. However, since then deaths from SIDS have risen.

Rotherham Public Health supported The Rotherham NHS Foundation Trust to undertake an audit of the Sleep Safe assessment in June 2015. The findings identified some areas of development and an action plan has been drawn up. Significant work has been undertaken following the identification of areas highlighted in the action plan.

Rotherham Public Health and the Child Death Overview Panel have developed a SIDS risk assessment tool to support health and social care practitioners and workers to effectively assess the risk of SIDS in the families with whom they have contact. The Rotherham SIDS risk assessment tool has received national interest and has been replicated in a number of local authorities including Coventry and Warwick.



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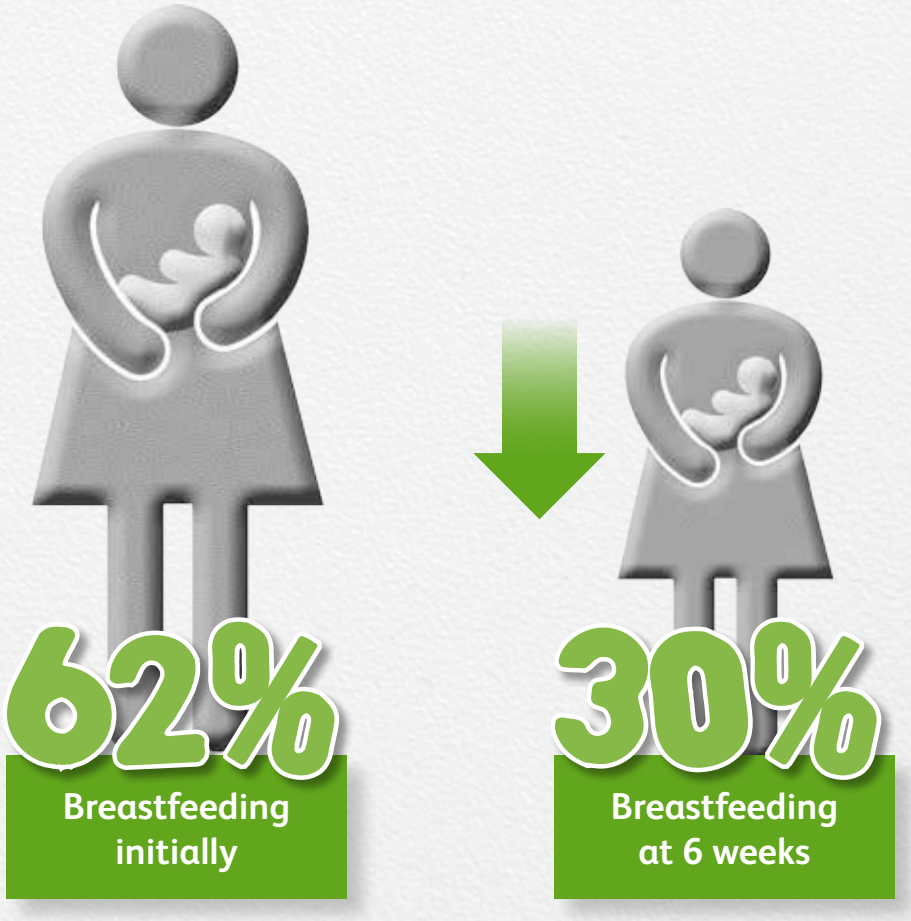
Our ambition for Rotherham

- The development of Joint Safe Sleeping guidelines and workforce training to reduce the risk of SIDS across all partner organisations in Rotherham including NHS, Police and the Local Authority
- The Rotherham Foundation Trust to undertake a re-audit in August 2016 to ensure further progress is being made

Breastfeeding

Breastfeeding has a major role to play in promoting health and preventing disease in the short and long term for both the infant and mother. Breastfed babies are less likely to suffer from conditions such as gastroenteritis, chest, urinary tract and ear infections, juvenile diabetes and childhood obesity. Mothers who breastfeed are less likely to develop some cardiovascular diseases, breast and ovarian cancer, and are less likely to have low bone density, which reduces the subsequent risk of fractures due to osteoporosis[38].

The Department of Health recommends that breast milk is the best form of nutrition for babies, and that all babies should be exclusively breastfed in the first 6 months of life. Moreover, babies should continue to receive breast milk along with appropriate solid foods beyond the first six months.



In Rotherham only 62% of mothers initially breastfeed when their baby is born, which is much lower than the national rate of 74%. This proportion falls further by the 6-8 week point, when only 30% of women are breastfeeding compared to 47% in England[39]. This latter measure is a key indicator of sustained breastfeeding and, given the significant long-term health benefits, we would like to see levels of breastfeeding prevalence at 6-8 weeks as close to the national average as possible.

Evidence shows that the proportion of babies that are breastfed at birth rises significantly in settings that have adopted the principles of the United Nations International Child Emergency Fund (UNICEF) Baby Friendly Initiative, by as much as 10%. The Baby Friendly Initiative provides support for healthcare facilities that are seeking to implement best practice and offers an assessment and accreditation process that recognises those that have achieved the required standard.

What are we doing in Rotherham?

The Rotherham NHS Foundation Trust Maternity Service is working towards achievement of UNICEF Stage 3 in 2016 and will also be leading and developing peer support for women who want to continue to breastfeed their babies. This will provide support in the maternity unit and in community settings including Children's Centres.

Our ambition for Rotherham

- The Rotherham NHS Foundation Trust should adopt the principles and achieve the UNICEF Baby Friendly Initiative standards trust-wide (including the Rotherham Health Visiting Service achieving Stage 2 standard by 2017). This will increase breastfeeding rates across the borough

Chapter 2: Support for more vulnerable families

Perinatal Mental Health and Postnatal Depression

The effect of a mother's mental health is as important as her physical health on the subsequent health of her child. A parent with a mental health disorder or difficulty can have a profound impact on the parent-infant relationship and, as a result, the child's own emotional development and wellbeing. Early attachment and good maternal mental health are therefore essential for children to thrive.

When a mother is mentally unwell she may find it difficult to look after herself; for example, not eating well, bathing or looking after herself in other ways. This may make it harder for her to care for her baby who requires a lot of attention and care. If help is not given to the mother at an early stage it can start to affect the attachment between the mother and baby. We know that babies are very sensitive to their environments and will be affected by how their parent/carer is feeling and behaving.

Postnatal depression is estimated to affect 10-15 % of mothers[40]. This represented approximately 450 women in Rotherham in 2014 (15 % of all women who had a baby in Rotherham).

When postnatal depression is very severe, mothers have been known to take their own life and that of their child. Maternal perinatal depression, anxiety and psychosis together carry a long term cost to society of just under £10,000 for every single birth in the country with 72 % of this cost relating to adverse impacts on the child[41].

No mother is immune to developing a mental health problem, but when mothers experience stress, poverty, exposure to violence (domestic, sexual and gender-based) and lack social support, the risk is increased. Mental health problems in the mother can make it difficult for her to function properly and give her baby the support it needs.

10-15%

…of mothers are affected by post natal depression

What are we doing in Rotherham?

Rotherham Clinical Commissioning Group (CCG) is leading a group which is looking at improving the mental health support for women from conception up until the child's first birthday.

Rotherham Health Visitors have been trained to identify mental ill health amongst mothers which enables them to provide help and support to the mother at the earliest opportunity.

Our ambition for Rotherham

- A National recommendation from Health Education England (HEE) and a Government mandate that every birthing unit should have access to a specialist perinatal mental health clinician
- Health Visitors to ensure that at risk women are identified at the earliest opportunity and supported/ referred appropriately as part of the Rotherham Perinatal Mental Health Pathway

Domestic Abuse

Domestic abuse can affect anyone. The Office of National Statistics estimates that each year around 2.1million people suffer some form of domestic abuse - 1.4 million women (8.5 % of the population) and 700,000 men (4.5 % of the population)[42].

The cross-Government definition of domestic violence and abuse is:

'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality'[43].

Domestic abuse can be psychological, physical, sexual or financial.

We know that pregnancy is not a safe time for mothers and babies. Domestic abuse can begin or get worse during pregnancy. Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of violence happened while they were pregnant[44].

It is distressing and frightening for children and young people who witness domestic abuse. Children living in a home where domestic abuse is happening are at risk of other types of abuse too.

If we apply national research locally we can presume that:

- 25% of children in the UK have been exposed to domestic abuse[45]; for Rotherham this equates to 12,500 under 16s or 14,100 under 18s[12]
- 62% of children in households where domestic violence is happening are also directly harmed[38]
- 40% of teenagers are in abusive dating relationships (including emotional or physical abuse) at any time[38]; for Rotherham this equates to 8,650 13-19 year olds who may be experiencing an abusive relationship[12]
- Children and young people can experience domestic abuse through seeing the abuse, hearing it from another room, seeing their parent's injuries or distress afterwards and being hurt by being nearby or trying to stop the abuse
- We know that when children and young people live with domestic abuse it will have an impact on them. It can affect their physical health, their mental health and emotional wellbeing and can interrupt their development

Teenagers can experience domestic abuse in their relationships. Nearly 75% of girls and 50% of boys have reported some sort of emotional partner abuse[46].

What are we doing in Rotherham?

The Independent Domestic Violence Advisor (IDVA) service works with people aged 16 years and upwards, supporting victims at high risk of serious harm or murder.

Within this service there is a Young Persons Domestic Violence Advocate (YPDVA), who can support clients of any age on an advisory basis working alongside children's services and will work with victims whose perpetrator is under 16 years of age.

The Independent Domestic Violence Advisors and the YPDVA have between them supported 537 clients from April 2014 – March 2015.

Multiagency training is provided for frontline staff on domestic abuse.

There is a domestic abuse care pathway that Rotherham GPs use to identify people at risk who may be experiencing domestic abuse and to refer patients to appropriate specialist services and support.

Our ambition for Rotherham

- Rotherham Public Health to ensure that all their commissioned services can show that staff have adequate training on domestic abuse so that staff can identify indicators of domestic abuse, know how to ask relevant questions to help people disclose and follow local referral pathways
- Rotherham Clinical Commissioning Group to ensure providers of antenatal care (in pregnancy) ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good practice, even where there are no indicators of such violence and abuse[47]
- Working with partners to ensure all health and social care providers create environments which enable people to disclose domestic abuse; for example, displaying information on domestic abuse and providing areas for private conversations
- RMBC, RCCG and NHS services in Rotherham to use national campaigns like White Ribbon Day to raise the profile of domestic abuse

Teenage Pregnancy

Teenage pregnancy rates have fallen dramatically in the UK over the last 10 years[48]. In Rotherham, only 186 babies (6%) were born to teenage parents compared to 325 (10%) in 2008[49].

The reduction in teenage pregnancy has been achieved through a package of interventions including:

- Educating young people (providing knowledge and skills) to experience positive and healthy relationships and good sexual health
- Improving access and use of effective contraception
- Engaging and supporting those most at risk of becoming young parents
- Improving support for teenage parents and their children

While the reduction in teenage pregnancy in Rotherham is commendable, intensive support is required for a number of vulnerable young parents to help them overcome the circumstances that place them at risk.

What are we doing in Rotherham?

In 2011 the Family Nurse Partnership (FNP) programme was introduced in Rotherham. This is a national programme which provides an intensive home visiting service for first time teen parents. FNP aims to improve pregnancy outcomes by supporting mothers-to-be to make informed choices about healthy pregnancy behaviours, as well as improving the future life course of young mothers, by supporting them to make changes to their lives and providing them and their babies with a better future[50].

The national evaluation of the FNP programme shows that it appears to improve early child development, particularly early language development at 24 months and may also help protect children from serious injury, abuse and neglect through early identification of safeguarding risks. There were also some small improvements in mothers' social support, relationship quality and self-efficacy. Young mothers were positive about the FNP programme, engaged very well with it and feel it helped to them to be good parents[51].

Our ambition for Rotherham

- All teen parents and their children accessing local Children's Centres

Family Nurse Partnership case study - Jade and Carl

Jade became pregnant aged 16 years. She had a family background of neglect and poor parenting, and had witnessed domestic violence. She was involved in a number of risk taking behaviours and was at risk of child sexual exploitation (CSE).

Carl, the baby's father, was known to social care and the police and had a history of abusive relationships.

The Family Nurse found it difficult to engage Jade in the pregnancy stage and initially met her in community settings including a local Children's Centre and youth cafés. Jade moved to supported accommodation and started to engage with midwifery and Independent Domestic Violence Advisor (IDVA) services. The Family Nurse explored Jade's own life story and family relationships to look at how Jade could make it different for her baby.

The programme approach supported Jade to feel listened to and understood. It was apparent that the approach taken by other services impacted on Jade's relationship and engagement with them. The relationship between Family Nurse and client and the use of programme materials supported Jade to consider her own patterns of behaviour and has supported her to end the cycle of an abusive relationship. She has also reflected on how her own child's life will be different from her own and his father's experience.

Jade has continued to engage and has become insightful regarding the impact of domestic abuse upon children. Following periods of low mood, she has built up her social contacts and enrolled at college, and appears to be maintaining positive relationships.

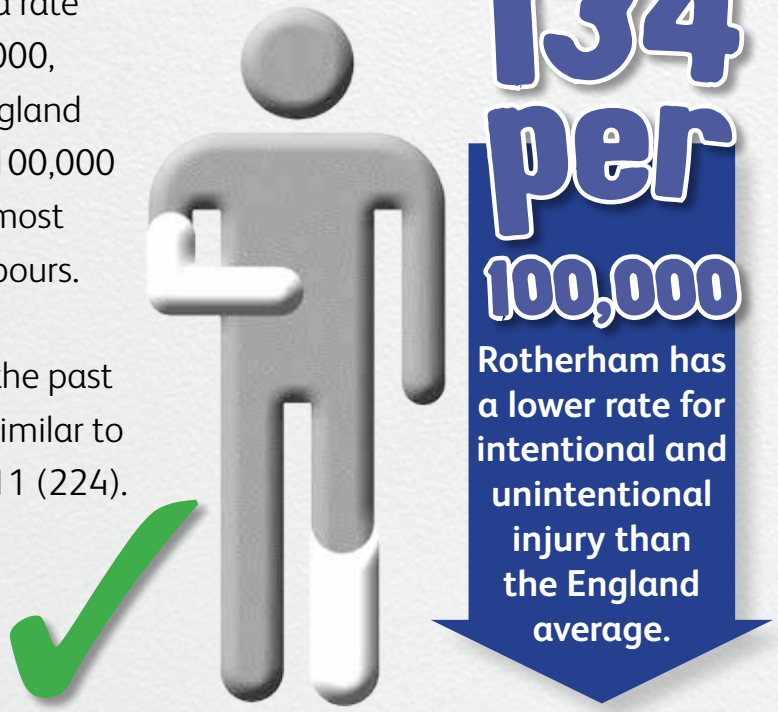
Jade's little boy is now 18 months old. He is fully immunised, achieving all development milestones and attending early years nursery provision. The attachment between Jade and her son is strong. Jade has worked hard to develop routines and skills in independent living and managing a budget to provide a stable environment for her son.

Unintentional and deliberate injuries in children and young people

Unintentional injuries remain a major safety risk for children in the UK, particularly for children aged under five[52].

In 2013/14 there were 216 emergency hospital admissions of Rotherham children under 5 caused by unintentional and deliberate injuries (including sprains, contusions (bruising), wounds, dislocations and fractures).

This equates to a rate of 134 per 100,000, similar to the England rate of 140 per 100,000 and lower than most statistical neighbours. Numbers have fluctuated over the past 4 years but are similar to those for 2010/11 (224).



What are we doing in Rotherham?

Home accident prevention assessments are conducted by health visiting teams and children's centres to raise awareness and reduce the risk of childhood injury.

The Rotherham NHS Foundation Trust Accident and Emergency department follows robust criteria when assessing any presented childhood injury to safeguard children and young people.

Our ambition for Rotherham

- Rotherham Public Health will conduct an in-depth review of all data relating to unintentional and deliberate injury in Rotherham. This will help to identify the types of accidents and trends to enable more targeted preventative advice and interventions

Early years development and ready for school

A child's life of learning begins at birth with brain development shaped by early experiences, setting the foundation for all learning that follows. The way very young children are cared for teaches them how to interact with the world and profoundly shapes who they will become. In essence, the first steps toward school readiness also lead to the resilience and positive behaviours needed for success in the workforce and in life.

However, too many pre-school aged children lack the key resources needed for a good start on the school readiness path. They fall behind, and their pre-school experience is playing catch-up, not forging ahead.

Evidence shows that high quality pre-school experience can have positive effects on children's development, giving them the best start[53].

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Rotherham's outcomes at the end of the Foundation Stage have been above national outcomes for the last three years as detailed in the table below:

Good Level of Development %	2013	2014	2015
All	56 % (52 %)	62 % (60 %)	67 % (66 %)
Boys	46.7 % (44 %)	55.1 % (52 %)	59.8 % (58.6 %)
Girls	65.3 % (60 %)	69.6 % (69 %)	75.2 % (74.3 %)
Free School Meal (FSM) recipients	40 % (36 %)	45 % (45 %)	52 % (51 %)
Non-FSM	60 % (55 %)	67 % (64 %)	70 % (69 %)

England figures in brackets for comparison.

Rotherham Borough Council's priorities are to improve outcomes for boys and for those children eligible for free school meals in order to close the attainment gap between them and their higher achieving peers.

What are we doing in Rotherham?

The introduction of Early Education Funding (EEF) for two year old children who meet the eligibility criteria (which encompasses the FSM criteria) has provided an opportunity for children at greater risk of not being school ready to access early learning at an earlier age. Of the 2 year old children in the Rotherham catchment area that are eligible for EEF, 82 % are taking up a place. This is above national levels (63 %) and is one of the highest in the country (2015 data). This means that these children are accessing high quality early education from an earlier age, contributing to closing the attainment gap for this vulnerable group.

Our ambition for Rotherham

- Early Years and Childcare Service working together to ensure that the assessment completed by the Health Visiting team and the 2 year old progress and health checks are integrated. Systematic joint assessment will further support the identification of children at risk of developmental delay to enable earlier intervention to maximise progress and close the attainment gap at an earlier age for children who are not achieving typical developmental milestones

Chapter 3: Primary school years

As children grow up they become increasingly aware of health-related matters and can be expected to take on additional responsibility for their health and wellbeing. The primary school years are therefore an opportune time to educate and provide lifelong skills that promote good health and wellbeing.

It is important to highlight the essential work required with families to ensure children can take advantage of opportunities to enhance health and wellbeing of parents/carers as well as children and young people.

Nutrition (food & drink)

National guidance for a healthy balanced diet recommends we should eat 5 portions of fruit and vegetables a day. This is important for children and young people to prevent them from developing some cancers, diabetes and cardiovascular diseases in later life.

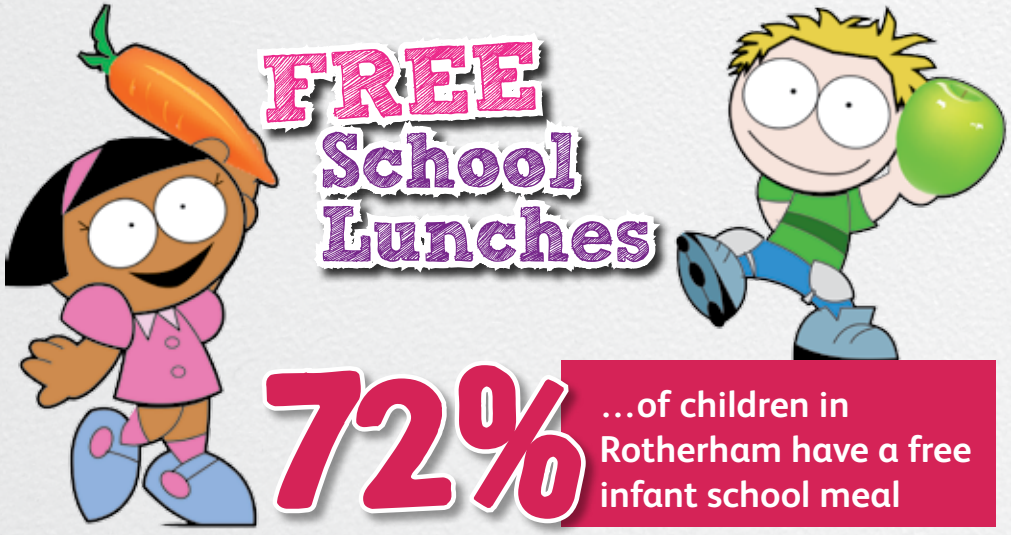
Children consume lots of sugar in their food and drink. These additional calories may also lead to heart disease and some cancers when they are older. Sugary drinks are a major problem and can also have an impact on dental health. Twenty-eight percent of 5 year olds in England have tooth decay and of these, 24% have 5 or more teeth affected. The maximum recommended daily amounts of additional sugar (that found in drinks, cereals, puddings) for 4-6 year olds is the equivalent to 5 sugar cubes, for 7-10 year olds is 6 cubes and 11 years plus is 7 cubes. A 330ml can of cola contains 9.5 cubes of sugar and a 240ml serving of orange juice is 6 cubes.

The Change 4 Life Sugar Swaps campaign[54] has a new smart phone app that helps people find out how much sugar is in the drinks they buy. The campaign also provides recommendations for cutting down on sugary drinks: using a glass to serve drinks (rather than out of the bottle), limiting the amount of fruit juice children have, being aware of portion size for drinks, or trying sugar free drinks, low fat milk, or sparkling water.

School meals provide healthy, nutritious, high quality food. School meals promote opportunities for good eating behaviours and provide the most vulnerable children with a nutritionally balanced meal. All local authority maintained primary, secondary, special schools and pupil referral units in England must meet national school food standards; Rotherham schools meet the required standards.

The number of school meals served each day in Rotherham has risen steadily year on year. This year 14,600 pupils in primary and 4,900 young people in secondary schools have a meal provided at school by Education Catering services on a daily basis.

From September 2014, all Reception and Key Stage 1 children have been offered a free school meal. This has led to an increase in the numbers of children accessing free school meals. The uptake of this universal offer of free infant school meals in Rotherham is currently 72% and is slightly lower than comparative local authority average, which is 79% (based on information from the first 6 months following the introduction of free school meals since September 2015).



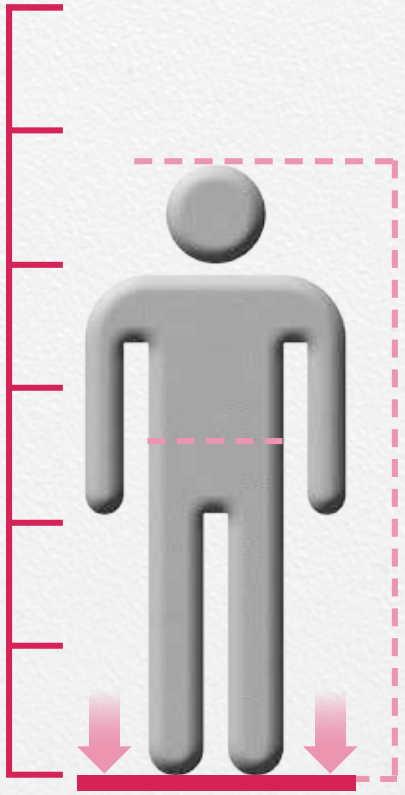
Overweight and Obesity

Childhood obesity is particularly harmful because of the number of children concerned, the fact that it limits a child's ability to enjoy a full and active life and that it increases the risks of diabetes, cancer, heart and liver disease in later life[55].

Children who are obese are more likely to have time off school, have lower self-esteem and experience poorer health. Obese children are more likely to go on to become obese adults and have a lower life expectancy and a higher risk of poor health and disability. Cases of type 2 diabetes are increasing as a result of increased obesity caused by poor diets and lower levels of physical activity.

Each year, children aged 4-5 (Reception year) and 10-11 (Year 6) are weighed as part of the National Child Measurement Programme (NCMP). This determines how many children in these age groups are underweight, healthy weight, overweight or obese. In Rotherham 10% of 4-5 year olds were identified as obese (2014/15), higher than the England average of 9.9%. Additionally, 22% of 10-11 year old pupils in Rotherham were identified as obese, worse than the England average of 19.1%. Among 15 local authorities in the Yorkshire and Humber region, Rotherham ranks 4th highest at Reception and 2nd highest at Year 6. Rotherham ranks similarly among Children's Services statistical neighbours (5th highest at Reception, 2nd highest at Year 6).

The NCMP and the Royal College of Paediatrics and Child Health define levels of overweight at an individual level as on or above 91st centile[56].



22%

...of 10 to 11 year old pupils in Rotherham were identified as obese in 2014/15

What are we doing in Rotherham?

Since 2009, over 1000 children have lost and maintained weight loss with the support of our RMBC commissioned services.

The benefits of the programmes go further than weight loss, with many children reporting improved confidence, self-esteem and even improved attendance at school.

The local planning framework has been revised and supports a number of actions to reduce the number of takeaways situated near to school premises.

Our ambition for Rotherham

- We would like to promote a whole systems approach to promoting a healthy weight for children and young people across the borough through the development of a new healthy weight action plan following the publication of the National Childhood Obesity Strategy, expected in early 2016. This will enable the linking of a range of sectors and influences including planning, housing, transport, children's and adult's services, business and health which will support us to tackle obesity and improve quality of life

The case study below is from Tom, a young man attending the MoreLife Club (Tier 2) programme:

'I have really enjoyed coming to MoreLife at Maltby Leisure Centre, I have met new friends, learnt lots of useful information on healthy eating and took part in new sports and activities'

Some of the successes Tom has experienced since joining the club:

- Forged friendships and met new families that are like minded
- Improved self-confidence especially in regards to his appearance
- Tom and his Grandad have both completely changed their lifestyle by reducing portion sizes, healthier food choices and becoming more active
- Tom and his Grandad have both joined Maltby's gym and swim membership and attend 5 days per week
- His fitness has greatly improved and taking part in the programme has spurred Tom to carry on being active

Tom has lost 6kg in weight and 7.6% body fat.

Physical Activity

Being active is important as it can help maintain a healthy weight as well as better cardiovascular health. It also has a positive impact on mental wellbeing, improving confidence and self-esteem as well as helping young people develop social skills through team activities.

All children and young people aged 5–18 should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day. Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week[57].

According to the Rotherham Young People's Lifestyle Survey, 23% of boys and 13% of girls in Year 7 and Year 10 reported that they engaged in vigorous physical activity for a least one hour every day. Nearly half of Year 7 and Year 10 children are taking part in vigorous exercise at least four times per week[58]. Overall 80% of Rotherham children take part in regular physical activity or sport.

It is essential that children and young people minimise the amount of time they spend sitting and watching TV, playing computer games or being sedentary and take more opportunities to walk and cycle. Low levels of physical activity in children are related to household income, with those in the lowest income brackets more likely to report low levels of activity.

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What are we doing in Rotherham?

This Rotherham Girl Can' is a developing initiative to increase physical activity and confidence in girls, utilising the positive messages in the national 'This Girl Can' campaign. New provision set up in Rotherham includes reduced cost, female only swimming sessions and female only satellite clubs based at local colleges.

As part of the strategic sports partnership in Rotherham, the children and young people's sport and physical activity sub group brings together key stakeholders to improve the physical activity and sports delivery system for children and young people. The group's achievements include developing an athletics satellite club programme, creating a junior schools football league, securing Sportivate funding for sports programmes for young people and a new primary school/PE officer.

Mega Active holiday provision delivers physical activity provision for children aged 5-14 years in the most rural and isolated areas of the borough. The sessions, run by Active Rotherham, engaged 471 young people in 2015.

Reduced rate swim passes, a Junior Gym programme and discounted sport specific satellite club programmes are offered.

The Active Ability Project is a Sport England four year funded project aimed at developing club pathways for people aged 14+ with a disability to participate in six key sports (athletics, cricket, swimming, boccia, power chair football, basketball). The project, coordinated by Active Rotherham and delivered through local clubs to ensure sustainability, engaged 93 young people in 2015.

Our ambition for Rotherham

- The children and young people's sport and physical activity sub group driving new partnership initiatives aimed at increasing participation for young people aged 5 and over
- A call to action through the 'Rotherham Get Active' campaign to encourage providers and the public to increase physical activity participation levels
- Active Rotherham to create a self-sustaining model for future Mega Active delivery, running the camps at zero cost to the local authority with partners taking a lead on their own local programmes

Oral Health

Oral health is a useful measure to assess the general health of a local community. It is an important part of health and wellbeing, affecting the ability to communicate, how you enjoy a variety of food, as well as your self-esteem and self-confidence.

Rotherham has high levels of tooth decay in 3 year old and 5 year old children when compared to national and regional averages. In 2013, 198 (6.1%) of 3 year old children sampled in Rotherham had 0.46 decayed, missing or filled teeth (DMFT), compared to 0.39 for Yorkshire and the Humber (Y&H) and 0.36 for England.

In 2011/12, 390 (12.6%) of 5 year old children in Rotherham had 1.44 decayed, missing or filled teeth (DMFT) compared to 1.23 for Y&H and 0.94 for England. This shows a significant deterioration within two years. Rotherham was found to have the worst oral health in South Yorkshire in both surveys.

Nationally, treatment for dental caries is the most common reason children aged 5-9 years have to be admitted to hospital for a general anaesthetic. In 2012/13 there were 1,015 admissions to hospital in Rotherham for extraction of one or more decayed primary or permanent teeth for 0-19 year olds, at a cost of £683,095[59].

There are a number of risk factors which are associated with poor oral health, including a high sugar diet and lack of dental hygiene (brushing teeth).

Evidence suggests that child oral health is related to socioeconomic status; children living in lower income households and social disadvantage experience disproportionately higher levels of oral disease.

1015 children

(0-19years) admitted to hospital in Rotherham for extraction of one or more decayed teeth in 2012/13

What are we doing in Rotherham?

A Rotherham Oral Health Improvement Strategy and action plan has been developed using a national evidence based approach[60], which is acting as a catalyst to increase the profile of oral health.

The action plan prioritises work with children and the Rotherham Oral Health Improvement Team is working in a number of Early Years settings, including nurseries, schools and special schools.

Our ambition for Rotherham

- Adoption of a whole setting approach for training in early years/schools (including special schools), with development of a comprehensive package of oral health preventative work, including developing policies, procedures, training, identifying school curriculum opportunities and the introduction of tooth brushing clubs
- Health practitioners promoting fluoride varnish and dental attendance. This will be incorporated into the new service specification for children and young people's public health services

Oral Health Case study – Kimberworth Community Primary School Toothbrushing Club

Teaching staff at Kimberworth Community Primary School had concerns around the oral health of their pupils and had sourced a number of toothbrushes and toothpaste for pupils but needed help and advice to develop a toothbrush club.

The Oral Health Improvement team worked with the school to develop a programme of work including basic oral health training for all school staff involved. Bright Bites and To Be a Star teaching packs, along with the Busy Teeth resource packs were demonstrated and given to teaching staff in all year groups. The team also contacted Kimberworth Park Dental Practice whose staff provided the classroom input. They also attended a Breakfast and Stay session to talk to parents. Now the breakfast club is running a toothbrushing club and 17 out of the 18 children attending report brushing their teeth at school after breakfast. The children took part in an informal chat about the day and what they had learnt. They all said they now brushed twice a day, not once. School staff are working up the programme for submission for a Healthy Schools Award. Kimberworth Dental Practice has offered more support and the oral health team linked them into another school local to the practice.

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Immunisation

Vaccination continues to be one of the most effective ways to protect the population from a wide range of serious infectious diseases. It is a major factor in reducing health inequalities and, without vaccination, outbreaks and epidemics may occur.

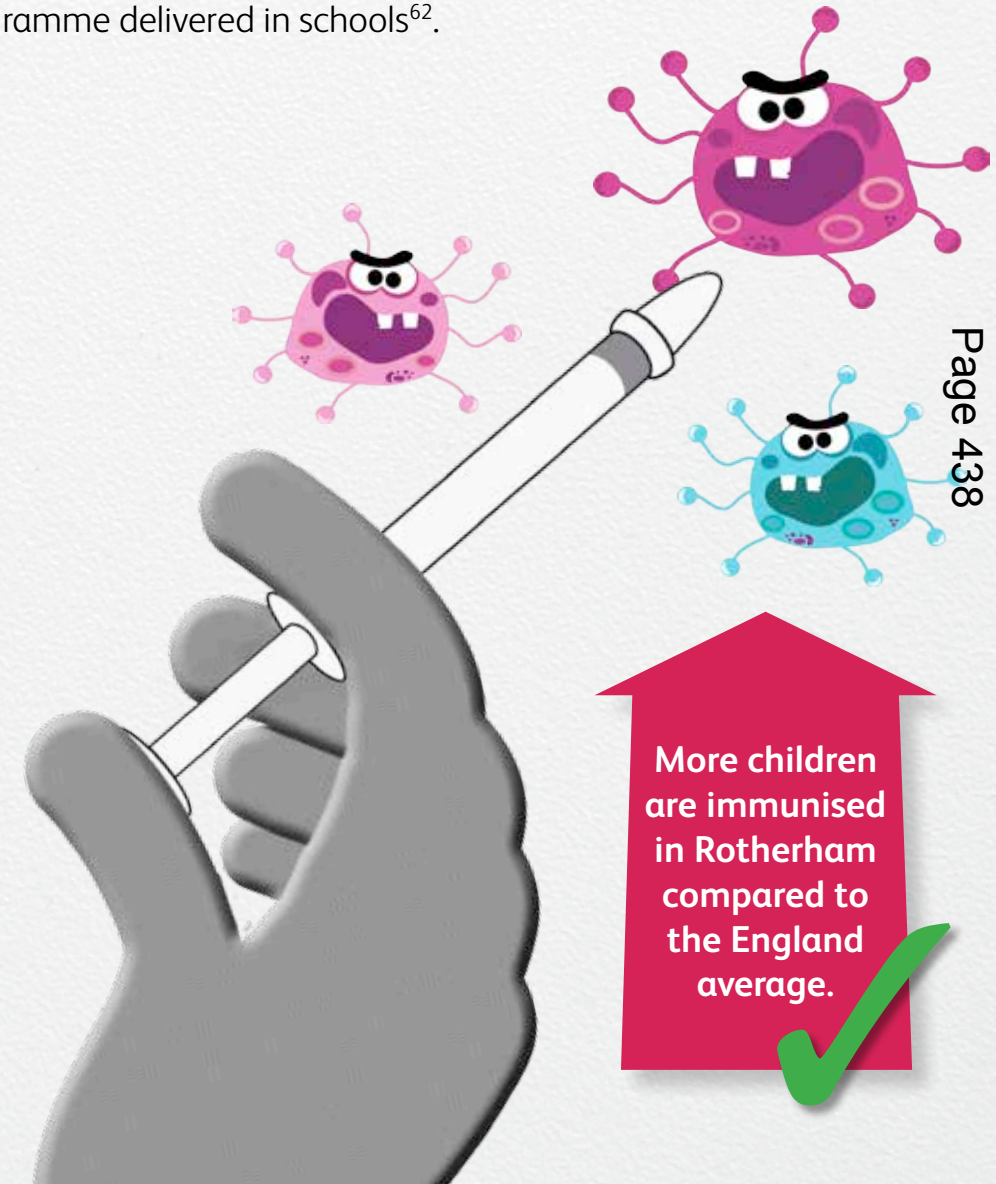
Vaccination is when a vaccine is given to you (usually by injection).

Immunisation is what happens in your body after you have the vaccination. The vaccine stimulates your immune system so that it can recognise the disease and protect you from future infection.

Despite the success of our national routine vaccination programmes[61], vaccine-preventable diseases such as measles, whooping cough and meningitis can still sometimes occur. Should our guard on vaccination slip these diseases are ready to resurge.

People in Rotherham are offered a total of 17 routine vaccinations for protection against 12 infectious diseases, many of which are part of the routine childhood immunisation schedule.

The schedule is primarily delivered through GPs, with the Human Papilloma Virus (HPV) and part of the Children's Flu vaccination programme delivered in schools[62].



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All Rotherham immunisation uptake figures for 2014/15 are above the England average with many significantly better:

Population Vaccination Coverage 2014/15[63]

	(Percentage immunised)	
Vaccination	**Rotherham**	**England**
Diphtheria/Tetanus/Polio, Pertussis, Haemophilus influenza type b (1 year old)	96.9	94.2
Diphtheria/Tetanus/Polio, Pertussis, Haemophilus influenza type b(2 years old)	96.4	95.7
Diphtheria/Tetanus/Polio, Pertussis, Haemophilus influenza type b (5 years old)	96.2	95.6
Diphtheria/Tetanus/Polio (5 years old) (B)	92.1	88.5
Meningitis C (1 year old) (1st dose)	n/a	n/a
Hepatitis B (1 year old)	n/a	n/a
Hepatitis B (2 years old)	n/a	n/a
Pneumococcal conjugate vaccine (1 year old)	96.8	93.9
Pneumococcal conjugate vaccine (2 years old) (B)	93.6	92.2
Measles, Mumps and Rubella (2 years old)	93.1	92.3
Measles, Mumps and Rubella (5 years old) (1st dose)	95.2	94.4
Measles, Mumps and Rubella (5 years old) (1st & 2nd dose)	91.4	88.6
Haemophilus influenza type b/Meningitis C (2 years old) (B)	94.0	92.1
Haemophilus influenza type b/Meningitis C (5 years old) (B)	95.0	92.4
Flu (65 and over)	76.6	72.7
Flu (at risk individuals) (6 months-64 years)	53.7	50.3
Flu (2 years old) (at risk)	56.4	53.7
Flu (3 years old) (at risk)	57.4	56.4
Flu (4 years old) (at risk)	53.3	52.3

In Rotherham a wide range of agencies work together to ensure that there is a high uptake of routine childhood vaccinations for community-wide immunity, which is known as 'herd immunity'. This reduces the spread of an illness and provides a level of protection to vulnerable and unvaccinated people. We know that vaccination coverage levels in Rotherham compare favourably with other areas across the Yorkshire and Humber region and Rotherham rates have remained consistently above national targets.

In 2008, a new vaccine called the Human Papilloma Virus (HPV) vaccine was added to the UK Childhood Immunisation Schedule. HPV may be passed on through sexual contact which can increase your risk to cervical cancer later in life. The vaccine, delivered through the Healthy Child Programme, is given in two doses to 12-13 year olds and protects against the most common cancer-causing types of HPV.

Public health will continue to be vigilant to ensure that the national routine vaccination programmes delivered for children in Rotherham maintain high rates of uptake as essential components of a safe and effective community health system.

The Director of Public Health has a responsibility for the vaccination coverage of the population of Rotherham. To discharge this duty of care, Public Health will:

- Work alongside Public Health England to ensure that coverage reaches Department of Health vaccination targets
- Respond in a timely and effective way to any disease outbreaks
- Promote the uptake of vaccinations through partnership working

What are we doing in Rotherham?

In 2014, Rotherham took part in the national childhood flu pilot for Year 7 and Year 8 and will continue to offer vaccination as part of the national roll out of the childhood flu programme. It is anticipated that, once fully implemented, it will ultimately avert many cases of severe flu and flu-related deaths in older adults.

Our ambition for Rotherham

- The two dose schedule for HPV (reduced from three doses) was introduced in Rotherham schools in September 2015, bringing benefits in the uptake of the vaccine. The screening and immunisation team (NHS England) should continue to work closely with the Rotherham school nursing service and head teachers to ensure that the benefits of this vaccine are communicated and making vaccination easily available
- Working with NHS England and partners (including RMBC and Rotherham Clinical Commissioning Group) to ensure the high uptake of flu vaccine among children in Rotherham to reduce the amount of flu circulating in the community

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Chapter 4: Secondary school years

Adolescence is not only a key transition point between childhood and adulthood, it is a distinct developmental stage in its own right, characterised by dramatic physical and neurological changes, and emotional development.

Young people increasingly take on additional individual responsibilities for their own health and wellbeing. They will be making a broader range of lifestyle choices, and will draw on care, support and advice from a wider range of sources – whether they be at home or in school, further education, in the workplace, or in the wider community. Psychological support, through these formative years in particular, is crucial to help young people have more control over their own health.

Rotherham Young People's Lifestyle Survey

The Rotherham Lifestyle Survey is open to all young people in Year 7 and Year 10 of secondary school and those in Pupil Referral Units. In 2015, 3,110 young people completed the survey. Highlights from the 2015 survey included:

- *Fruit is the most popular snack option of young people in Rotherham with 19% reporting that they chose fruit over crisps and chocolate*
- *20% reported that they considered themselves to be overweight with a further 3% reporting that they considered themselves to be very overweight*
- *75% of young people reported that they would know where to go to seek support for mental health problems*
- *80% of young people said they have never smoked*
- *More young people in Rotherham (26%) have used an electronic cigarette at least once than nationally (22%)*
- *58% of young people are obtaining their alcohol from family with their knowledge*
- *There has been a decrease in the number of Year 10 pupils who said they have had sex from 25% in 2014 to 23% in 2015 of these, 22% reported that they didn't use contraception*

Emotional Health and Wellbeing

Mental health is something we all have, but we sometimes tend to only think about it when things go wrong and we start to notice that we are becoming unwell. Mental health influences how we all think and feel about ourselves and others. It affects our ability to form friendships, learn and cope with life events.

Children and young people who are mentally healthy:

- Develop psychologically, spiritually, intellectually and emotionally
- Initiate, develop and sustain mutually satisfying relationships
- Use and enjoy solitude
- Become aware of others and empathise with them
- Play and learn
- Develop a sense of right and wrong
- Resolve problems and setbacks and learn from them

Good mental health is so important for children and young people and we know that when children and young people do have good mental health they are likely to have much better outcomes[64].

At any one time, between 10% and 20% of children will have a diagnosable mental health problem severe enough to require Child and Adolescent Mental Health Services (CAMHS) intervention. That is about three children in every class. Around 10% of children and young people have similar, but more severe, complex or persistent difficulties, referred to as mental health disorders. The prevalence of mental health disorders has been established by detailed studies, notably the Mental Health of Children and Young People in Great Britain[65] published by the Office for National Statistics (ONS), which built on the work of a previous study in 1999. We know that 75% of adult mental health problems occur before the age of 18[66].

If children and young people do not receive early intervention and adequate treatment for their mental health problems there is a higher likelihood that they will have poorer academic achievement, face higher unemployment, premature morbidity and long term physical and mental health problems[67].

Rotherham Youth Cabinet has had mental health as a priority area in their manifesto for the last three years. In 2013 they began by looking at self-harm, talking to their peers about how to improve access for young people seeking help and support around self-harm. They also talked with and questioned providers and

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service commissioners about what they were doing to support young people who self-harmed. The report had recommendations for action[68], including having clear and consistent messages about self-harm, having professionals trained and confident to be able to talk to young people about self-harm and a range of places for young people to get advice and support. These recommendations are being actioned by providers and service commissioners.

In 2014/2015, Rotherham Youth Cabinet investigated existing support networks for young people around emotional wellbeing and established ways to promote positive mental health. This included opportunities to work more closely with Rotherham, Doncaster and South Humber NHS Trust (the provider of CAMHS) and CAMHS Commissioners. Rotherham Youth Cabinet was also involved with the production of the website for young people on emotional wellbeing and mental health:
www.mymindmatters.org.uk

In 2015 a member of Rotherham Youth Cabinet and Rotherham Youth Parliament wrote a report on mental health services in Rotherham called Mind the Gap. The author talked to families, young people and officers. The recommendations from the report have been included in the work taking place to transform children and young people's mental health services.

What are we doing in Rotherham?

We are making good progress on the delivery of Rotherham's CAMHS Transformation Plan, in particular the focused work on early intervention and prevention.

We are delivering training for frontline staff, including Youth Mental Health First Aid and Suicide Prevention.

Rotherham Youth Cabinet's 2015/16 Manifesto outlines their action to investigate existing support networks for young people around emotional wellbeing and establish ways to promote positive mental health. They are hosting a conference in March 2016 to promote ways young people can stay mentally healthy.

Our ambition for Rotherham

- Rotherham Clinical Commissioning Group (RCCG) to ensure that anti-stigma and discrimination activity is regularly discussed at the Child and Adolescent Mental Health Service (CAMHS) Partnership Group meetings. Members of the CAMHS Partnership to work together on anti-stigma activities throughout the year involving young people, parents and carers.
- RMBC, RCCG, NHS services in Rotherham and the community/voluntary sector to support the Youth Cabinet to carry on their active and focussed work to address mental and emotional health and wellbeing.
- RMBC develop a workforce development strategy which details the level of training relevant to their role.

Self-harm

Self-harm is defined in the National Institute of Clinical Excellence guidelines (2004)[69], as:

'… an expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm, however, vary greatly from person to person. In addition, the reason a person harms him or herself may be different on each occasion, and should not be presumed to be the same'.

"I bottled up all my feelings and let it all out on myself instead of talking about it. Cutting myself made me feel like I could breathe again.'' (Rotherham young person)

Self-harm is any behaviour such as self-cutting, swallowing objects, taking an overdose, hanging or running in front of a car where the intent is deliberately to cause self-harm.

Anyone can self-harm. This behaviour is not limited by gender, race, education, age, sexual orientation, socio-economics, or religion. There are a number of factors that motivate people to self-harm, including a desire to escape an unbearable situation or intolerable emotional pain, to reduce tension, to express hostility, to induce guilt or to increase caring from others. However, some people who self-harm have a strong desire to kill themselves. Yet even when the intent to die is not high, those self-harming may express a powerful sense of despair and this needs to be taken seriously.

The estimates for self-harm amongst young people vary and indeed some may be an underestimate because many young people do not disclose that they are self-harming, treating themselves at home and never coming to the attention of services. However, one survey estimates that 1 in 10 young people self-harms at some point in their teenage years[70]. Over the past 40 years, there has been a large increase in the number of young people who deliberately harm themselves. The Mental Health Foundation suggests there are 'probably two young people in every secondary school classroom who have self-harmed at some time'[71]. Most young people who self-harm do not access acute services and are first noticed by people in the community; friends, teachers and family members[72].

In Rotherham, hospital admissions due to self-harm are the second lowest out of 15 local authorities in the Yorkshire and the Humber region for 2013/14[73]. However, in Rotherham, the people working with young people and the young people themselves report that it is an issue which needs to be a priority. Young people who self-harm may feel embarrassed or ashamed and worry that people will judge them, hence they do not always disclose and seek help.

In Rotherham we have developed guidelines on self-harm[74] to be used by anyone working with children and young people. The guidelines are about providing a timely and appropriate response to children and young people who may be self-harming.

The voice and experiences of Rotherham young people who self-harm has been listened to and used to help us include things which are important to them.

What are we doing in Rotherham?

There is an action plan in place which outlines what the Council, alongside its partners (including health, police and voluntary organisations), is doing to prevent suicides and support people who are bereaved by suicide . Actions on this plan are reported back to the Health and Wellbeing Board on a regular basis. This plan will be updated in 2016 to look at new actions and areas for work.

Our ambition for Rotherham

- The Supporting Children and Young People who Self Harm: Rotherham Self Harm Practice Guidance[75] to be distributed and in use in schools, colleges, health and youth centres
- Training sessions on the self-harm practice guidance provided to frontline staff who can cascade learning to others
- Annual review on levels of awareness and usage of the self-harm practice guidance amongst frontline staff

Health related behaviours: Tobacco

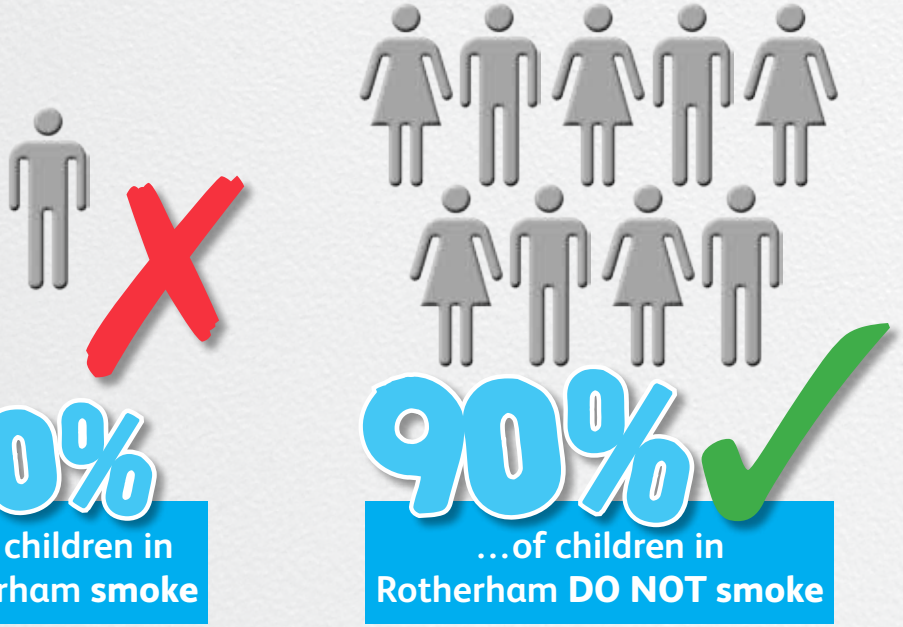
Smoking is an addiction of childhood; more than three-quarters of adult smokers started smoking before the age of 18. If we want to reduce smoking rates overall, we need to focus on preventing young people from becoming smokers.

Figures from the national What about YOUth survey[76] show that 10% of Rotherham's young people aged 15 smoke, with 7% of them smoking regularly (daily or weekly). This is higher than the national average and our neighbouring boroughs.

This raises concerns about where these young people are getting their cigarettes from, as the legal age of sale is 18; access to illegal tobacco and retailers who do not routinely check for proof of age need to be tackled to reduce smoking rates among young people.

Young people are more likely to smoke if they live with other smokers, so one of the most effective ways to reduce youth smoking is to help adults to stop. Quitting with support from our stop smoking services makes somebody four times more likely to succeed in their quit attempt.

A new concern is the increased use of electronic cigarettes, or nicotine delivery devices (NDDs), by young people. Until October 2015 there were no restrictions on the sale of these devices to young people and there remains little regulation of the products. We are also concerned that information from our local lifestyle survey suggests that, whilst only a small number of young people are regularly using NDDs, most of them do not smoke tobacco. Therefore, a device that is intended to help adult smokers switch to a less harmful alternative, may be inadvertently creating a new addiction for our young people.



What are we doing in Rotherham?

We currently work with youth services and schools to reduce uptake of smoking. We use a 'social norms' approach, which debunks the myths around the number of young people who smoke and promotes the fact that 9 out of 10 young people don't smoke. Youth services have also been using Tobacco Free Futures Smoke and Mirrors programme, which highlights the negative practices of the tobacco industry and encourages young people to look at tobacco harm in a new way.

We have also run joint promotional campaigns with Sheffield and Doncaster Councils to highlight the risks associated with illegal tobacco and the increased access it provides to children and young people. The Stop Cigs for Kids campaign encourages anonymous reporting of anybody who is selling illegal tobacco so Trading Standards can take appropriate enforcement action.

Our ambition for Rotherham

- All Rotherham schools reviewing their smokefree policies to ensure they are in line with current legislation and implement voluntary smokefree zones outside the school gate

Health related behaviours: Drugs and Alcohol

Drug and alcohol misuse can have a major impact on young people's education, their health, their families and their long-term chances in life. The majority of young people do not use drugs, and most of those that do are not dependent.

In the Rotherham Lifestyle survey, 63% of 11 and 12 year olds responded that they had never tried alcohol, yet this reduced to 24% among responses from those aged 14 and 15 years. Only 2% of those aged 11 and 12 responded that they drank alcohol regularly, but this increased to 10% among those aged 14 and 15.

When asked whether it was OK for young people their age to take drugs, only 3% of those aged 11 and 12 responded that it was ok compared to 12% of those aged 14 and 15. Less than 1% of 11 and 12 year olds reported that they use legal highs weekly or have tried them once. For those aged 14 and 15, cannabis was reported to be the most commonly used drug, with 9% of pupils saying that they have tried it at least once. Some reported using solvents, with over 3% having tried them once; 2% reported using them weekly and 1% using them monthly.

Among 16 and 17 year olds (Rotherham Post 16 Survey 2014 - unpublished) the picture for drug and alcohol use is very different:

- 75% reported that they drank alcohol. Of these, 44% reported that they only drank on special occasions. However, 24% reported that they drank weekly
- 57% reported that they got the alcohol from their parents
- 64% reported that they drank with friends and 32% drank alcohol with family
- 51% reported that they drank as it was fun and 30% to chill out/relax
- 74% reported that it was 'not ok' for someone their age to take drugs
- Mephedrone (commonly referred to as MCAT) was reported to be used by 9% of those aged 16 and 17 years and Spice by 6%
- When asked to pick a single drug of choice those aged 16 and 17 reported that cannabis was the preferred choice of 17%, solvents 2% and MCAT 3%
- Many had taken risks while under the influence of drugs with 39% reporting that they had walked home alone and 12% had taken sexual risks

Know The Score is the Public Health commissioned young people's substance misuse service. The service supports the case management of the small numbers of under 18s with complex substance misuse issues working alongside other health and social care professionals. The team also provides support to other professionals who are managing young people's substance misuse as part of a wider range of challenging behaviours or circumstances for young people, and deliver educational sessions aimed at providing basic levels of knowledge and signposting to services.

The young people who are accessing the Know the Score service are often very vulnerable:

- 17% were identified as a 'Child in Need' compared to 5% in similar services nationally[77]
- 26% reported as being affected by domestic abuse compared to the national figure of 17%[70]
- 13% reported being involved in sexual exploitation compared to 4% nationally
- 26% reported as being NEET compared to 17% nationally

There are a number of specific issues facing girls, including increased citation of alcohol as a problematic substance, involvement in self-harm, being affected by domestic violence and involvement in sexual exploitation.

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There is growing concern about the readily available New Psychoactive Substances (NPS) in the UK that are more commonly known as 'legal highs'. These substances mimic the effects of controlled drugs, but are sold legally as they are not marketed as a substance for human consumption.

The Home Office expert panel defines NPS as 'psychoactive substances, newly available in the UK, which are not prohibited by the United Nations Drug Conventions but which may pose a public health threat comparable to that posed by substances listed in these conventions'[78].

The main NPS groups include predominantly sedative drugs, predominantly stimulant drugs, hallucinogens and psychedelic drugs, synthetic cannabinoids and dissociative drugs.

Some substances described as 'legal highs' may not actually be legal (and 'legal' can imply they are safe or regulated, when neither is true). In 2013/14, nearly a fifth (19%) of the substances found in the 'legal high' drug samples collected by the Home Office's forensic early warning system in 2013-14 were controlled drugs[79].

In February 2015 partners (of the Young Persons Substance Misuse Education and Prevention Group) in Rotherham undertook a substance misuse survey with young people aged 16 plus. Of the 551 young people who responded to the survey, 3% disclosed NPS use. The survey data has been used by the establishments who took part to inform their own response to substance misuse and targeted delivery of key messages.

The Centre for Drug Misuse Research[80] found that the main drug of choice was synthetic cannabinoids (32%) followed by stimulants (18%) and psychedelics (18%). There were 341 unique chemical, commercial or brand named NPS reported. The reported source of the substances was from a combination of the following: shops (35%), friends (30%), websites (25%), at a friend's house (25%) or from a 'dealer' (25%).

Rotherham's Know The Score service is not currently working with any young people who consider NPS as their main drug of choice. This does not reflect that there isn't a problem with NPS use in young people in Rotherham, but that the service is currently working with very complex and high level drug users. Intelligence from other young people's agencies indicates that there is use and experimentation locally. In a 'snap shot exercise' for a Youth Offending Team (YOT) worker caseload, of 30 clients, 17 reported NPS use.

What are we doing in Rotherham?

Rotherham has been part of the Amy Winehouse Foundation Resilience Programme for schools; 8 have taken part. This is a four year programme that works to prevent the effects of drug and alcohol misuse on young people. We also aim to support, inform and inspire vulnerable and disadvantaged young people to help them to reach their full potential.

Know The Score are delivering awareness raising sessions for key staff. We are also sharing intelligence on NPS use and points of sale for Trading Standards to act upon.

Our ambition for Rotherham

- Every secondary school and college should provide consistent substance misuse education that promotes resilience. This will be enabled by seeking support from PSHE or Pastoral leads, Head Teachers and Governing Bodies and providing each school with up to date local information and teaching packs to complement the curriculum. The local information and teaching pack will be pulled together by the Young Persons Substance Misuse Education and Prevention Group currently chaired by the RMBC Healthy Schools Consultant.
- Every partnership agency for example; education, police, fire, health, local authority and voluntary sector, should maximise their potential and the free parent/carer education resources, such as those available from Alcohol Education Trust) to educate as many parents/carers as possible in their employ or that they have contact with on alcohol use in young people, to delay the onset and prevent harm. This can be managed by the Young Persons Substance Misuse Education and Prevention Group.
- Improve the intelligence from young people and front line agencies on emerging drug trends. This will be achieved by re-aligning the current Drug Intelligence Meeting and the Young Persons Substance Misuse Education and Prevention Group undertaking further surveys of young people aged 16+. This information will be used to develop messages and can be shared widely to aid prevention and harm minimisation.

Health related behaviours: Sexual health

The overall sexually transmitted infection (STI) rate (excluding chlamydia) for Rotherham in 2014 was 767 per 100,000 people. This is nearly one in every 100 people in Rotherham. This rate is higher than the Yorkshire and Humber rate but lower than the national rate (829 per 100,000). Of those newly diagnosed with an STI in 2014, 62% were aged between 15 and 24 years across Yorkshire and Humber.

In the Rotherham Young People's Lifestyle Survey, 25% of Year 10 pupils (14/15 year olds) said that they had had sex. This is in line with national figures that say that 31% of males and 29% of females aged between 16 and 24 say that they had had sex before they were 16[81]. Of those (in the Rotherham survey) who said that they had had sex, almost half said they had done so after drinking alcohol. In addition, 5% of those in the Rotherham survey who said they had had sex did not use any form of contraception.

Chlamydia is the most common STI in Rotherham and we have a high detection rate among our young people aged between 15 and 24 years of age. This also suggests a considerable level of unprotected sexual activity amongst our young people.

What are we doing in Rotherham?

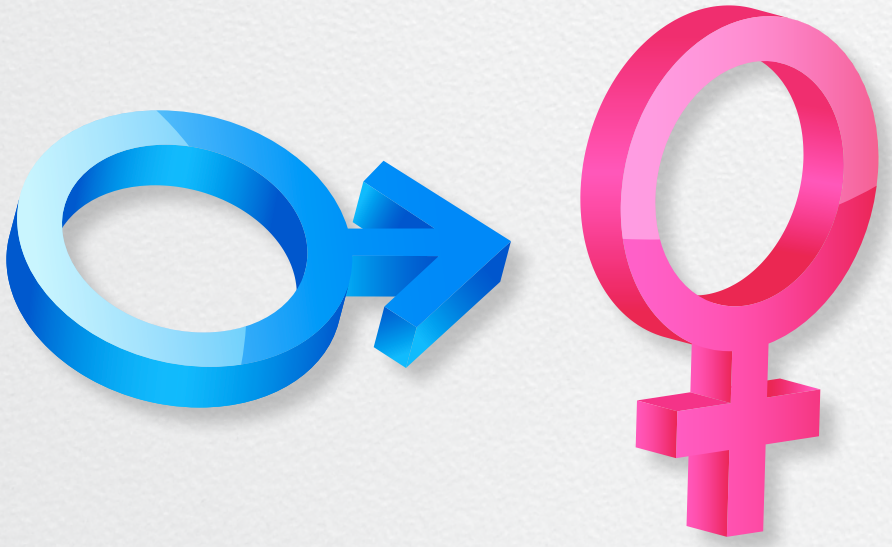
Good quality Personal, Social and Health Education (PSHE) is a key component in reducing risk taking behaviour among young people. Providing young people with opportunities to develop skills and confidence around healthy relationships is key to improving health and wellbeing. Rotherham schools are encouraged to focus on healthy relationships. PHSE should not just focus on facts about health, it should also enable young people to develop skills and understanding that will help them better manage their lives.

Rotherham Sexual Health Strategy (2015–2017) has identified key actions, agreed by all partners, to promote better sexual health for the population. These include the promotion of the importance of good quality sex and relationship education in all our schools.

Rotherham PH and RCCG have funded a Theatre in Education initiative which will be offered to all secondary schools over the next few years. 'Chelsea's Choice' is a powerful, interactive production tackling relationships, grooming and sexual exploitation.

Our ambition for Rotherham

- All schools in Rotherham should adopt a recognised 'gold standard' in relation to sex and relationship education
- All Head Teachers and Governing bodies fully supporting sexual health initiatives within their schools



Risky sexual behaviour can have a number of consequences which include unintended pregnancy and the spread of STIs which can have a range of long term consequences including pelvic inflammatory disease and cervical cancer in girls and infertility in both girls and boys. As approximately a quarter of our young people under 16 are likely to be sexually active, it is important that we make sure that they have confidence to attend sexual health services and have early access to professional advice, support and treatment

The Sexual Offences Act 2003 provides that the age of consent is 16. Sexual activity involving children under 16 is, therefore, unlawful. Children aged under 16 are particularly vulnerable to exploitation and abuse.

Sexual health services have a particular role to play in identifying risk and managing the impact of sexual abuse or exploitation. It is important that all service providers of sexual health provision in Rotherham are aware of child protection and safeguarding issues and the possibility of abuse and/or exploitation and work collaboratively to protect all children under 18 years of age.

What are we doing in Rotherham?

In Rotherham, 15–24 year olds are screened as part of the National Chlamydia Screening Programme. Chlamydia often has no symptoms but if it is left untreated it may have serious health consequences. This means that we want to keep the detection rate of chlamydia in Rotherham high. This is because we know that there is a high background rate in the community and having a high detection rate suggests we are identifying it effectively and treating it.

Contraception is widely available to young people at the main sexual health service clinic in Rotherham town centre, at GP surgeries and at youth clinics across the Borough. We need our young people to be able to access the most effective and appropriate form of contraception for them and to have a choice of where and when they can access it.

All Rotherham service providers have robust guidelines and referral pathways in place for risk assessment and management of child sexual abuse including child sexual exploitation.

Our ambition for Rotherham

Sexual Health services in the right locations and open at appropriate times for young people. Service providers should:

- Review where and when services are provided and consult with young people and review regular customer satisfaction feedback.
- Conduct mapping exercises of service locations, times and usage with young people after consultation and survey reviews.
- Report back findings through the Contract's Performance Management Framework.

Chapter 5: Late adolescence

Late adolescence marks the move into adulthood where young people are reaching a level of autonomy including accepting responsibility for themselves, making independent decisions and financial independence. This key transition stage, emerging into adulthood, is where we would hope that young people are equipped with the skills and knowledge to make positive health choices and decisions. However, in necessary support of this process the local economy needs to provide opportunities and a level of aspiration and the subsequent education and employment prospects to allow young adults to flourish.

Employment and Training

A healthy employment rate results in a lower dependence on benefits. This, in turn, leads to higher self-esteem and can help tackle some of the mental and physical health problems that worklessness can cause.

The number of young people Not in Education, Employment or Training (NEET) in Rotherham has reduced by 14% since 2013. In October 2015, 5.4% of young people in Rotherham were identified as NEET compared to 4.8% nationally. The percentage of those who are identified as 'not known' is also tracked in relation to NEET. In October 2015 Rotherham 'not known' was 6.4% compared to the national average figure of 19.4%.

Those eligible for free school meals, those who have been excluded or suspended from school, those with their own child and those who have a disability are more likely to be NEET.

What are we doing in Rotherham?

Education, health and social care have developed a partnership approach to retain young people (Year 12 and 13) in learning and reduce the number of NEET in Rotherham.

Early Help Teams are conducting focused case work to reduce NEET at age 17 using a Youth Contract approach.

Targeted work with vulnerable 18 year olds in partnership with Early Help Teams and Job Centre Plus.

Our ambition for Rotherham

- For education, health and social care partners to strengthen the universal offer to support vulnerable children and young people through transitions
- Information sharing with health, education, social care and job centre plus to be more systematic and robust

Road Safety

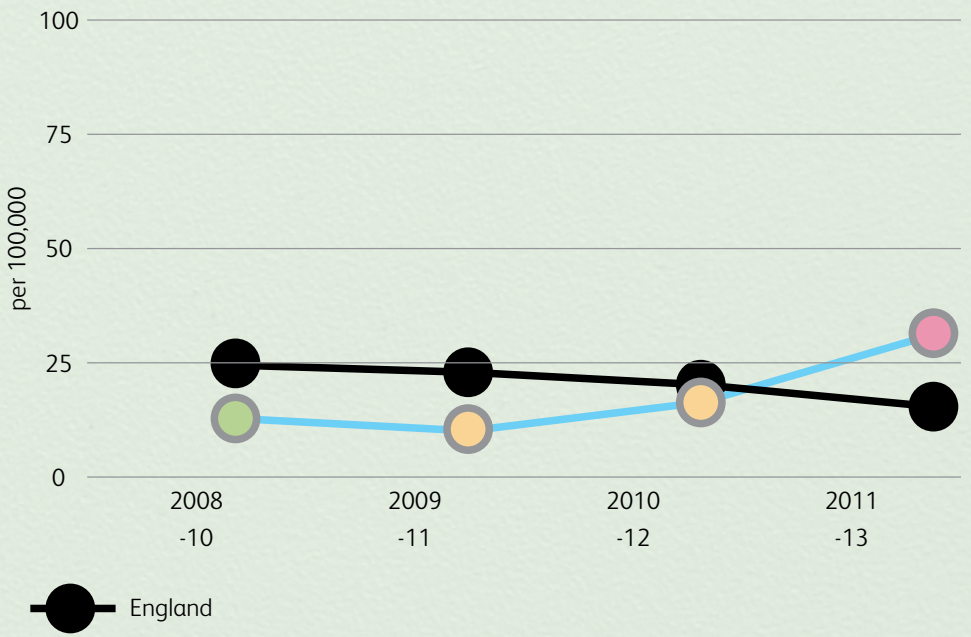
Road accidents are a leading cause of death and a significant cause of hospital admissions in the 0-17 age group. Casualties disproportionately affect children and young people from disadvantaged backgrounds: a child in the lowest socio-economic group is 5 times more likely to die in a pedestrian accident than a child in the highest socio-economic group[82].

The rate of children aged 0-15 killed or seriously injured in road traffic accidents was worse for Rotherham compared to the England average for the period 2011-13 (over 30% higher). This rate has increased by over 70% from 15.9 to 27.6 per 100,000 since 2008-10 (see chart below). Latest data for 2012-14 shows an increase to 28.2 for Rotherham but a further decrease for England to 17.9.

Of the total number of children and young people killed or seriously injured on Rotherham roads, 44% were pedestrians, 28% motor cyclists and 17% car users.

Children killed or seriously injured in road traffic accidents

Rotherham



Period		Count	Value	Lower CI	Upper CI	Yorkshire and the Humber	England
2008-10		25	15.9	10.3	23.5	30	23.6
2009-11		22	15.0	9.4	22.7	29.9	22.1
2010-12		28	18.9	12.5	27.3	28.4	20.7
2011-13		41	27.6	19.8	37.5	27.0	19.1

(Source: Department for Transport, published by Public Health England)

It is well evidenced that developments including; education and training, improvements in vehicle technology/construction and highway engineering, the introduction of road safety policies such as speed limits, enforcement of legislation, and behavioural change have contributed to a national reduction in the numbers killed or seriously injured on Britain's roads[83].

In Rotherham a range of road safety interventions are in place to reduce the number and severity of road collisions that occur. These include speed reduction initiatives, such as 20mph limits in designated zones where children and young people are accessing play and recreation areas. Some of these initiatives are delivered in partnership with the South Yorkshire Safer Roads Partnership (SYSRP) of which Rotherham MBC is a member.

This is a multiagency partnership that exists to coordinate efforts to reduce road collision casualties in South Yorkshire and is made up of:

- Each of the four South Yorkshire districts including elected Members
- South Yorkshire Police
- South Yorkshire Fire and Rescue
- Yorkshire Ambulance Service
- South Yorkshire Safety Cameras
- Highways England
- Health service providers

Overall the number of KSIs in Rotherham reached a historical low with only 88 recorded in 2014. This reduction reflects the robust local initiatives delivered by both the local authority and the Safer Roads Partnership to improve road safety.

What are we doing in Rotherham?

The Driver for Life education programme was developed in Rotherham and is now a South Yorkshire initiative. This education programme is aimed at drivers in the 17-24 age group, particularly young men, who are heavily represented in casualty statistics. The programme is designed to raise awareness of issues that contribute to collisions, make young people aware of their responsibilities as drivers and change attitudes and behaviour to make them safer and more considerate drivers.

There are also interventions aimed at younger children. The Crucial Crew personal safety education programme for Key Stage 2 pupils (10 and 11 year olds) aims to provide children with the knowledge, skills and strategies to make choices in everyday life to enable them to stay safe and well. The event includes a road safety session which includes teaching children how to cross the road safely using a puffin crossing and also highlights the distance needed for a vehicle to stop in an emergency[84]

Our ambition for Rotherham

- To ensure the continued and rolling introduction of 20mph zones across Rotherham
- To ensure the Crucial Crew programme is delivered to all Key Stage 2 pupils across Rotherham

Suicide

Suicide and suicide attempts are a major cause of preventable deaths and significant long-term health issues and disability. A death by suicide causes significant human and economic costs.

In 2012, the Government launched a strategy for the prevention of suicides called Preventing suicide in England: A cross-government outcomes strategy to save lives. Young people were identified as a group needing specific attention. Nationally the suicide rate among teenagers is below that in the general population[85].

However, we know that young people are vulnerable to suicidal feelings. In 2012/13 the ChildLine website had 18,000 visits to the pages relating to suicide; a year later this increased to 37,000[86].

In Rotherham we have had four deaths of young people up to the age of 18 between the years 2011 and 2013. We also know that several Rotherham children have been bereaved as a result of suicide, losing a parent or someone close to them.

Suicide is a complex issue and is often the result of several factors for that person. Young people are more at risk when some of the following are happening in their lives:

- They have an existing mental health problem or behavioural difficulties
- They misuse substances
- They experience family breakdown
- Bullying
- School problems/exam pressure
- Abuse or neglect in the family
- Mental health problems within the family
- A suicide or death of someone close
- Recent loss of employment
- Are isolated or living in rural communities
- Have attempted suicide before
- Have had a recent bereavement
- A suicide of someone who is a high profile celebrity or another young person

These are just some of the reasons. In addition, young people who are care leavers, those in the Youth Justice system and Looked After Children are particularly vulnerable.

In May 2015 Rotherham Council published an independent report into the suicides of the four young people who died between 2011 and 2013[87]. The report acknowledged the very complex situation with limited national policy direction. Rotherham has gained knowledge and learning following this report and work continues, led by the Rotherham Suicide and Self-Harm Group.

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What are we doing in Rotherham?

Rotherham Local Safeguarding Children's Board (LSCB) has a response plan which is put into action when there is a death of a young person by suicide or there is a serious self-harm incident. Partners like South Yorkshire Police, health organisations including mental health services, schools and colleges and voluntary sector partners work with RMBC on this plan. The plan looks at who else might be vulnerable and how we can support these young people, how to get support information out to people including families and carers and the wider community.

Rotherham has established a care pathway to ensure support is provided to children and young people bereaved by a sudden and traumatic death including suicide. Families that have been bereaved by a sudden death have told us that it has been very helpful to know that this support is available for their child.

Frontline workers have been able to attend Youth Mental Health First Aid Training. This is a national and international course with lots of evidence to show that it is effective.

Frontline workers have also been able to attend suicide prevention training. Reports from those attending show that they feel more confident to be able to support someone who is at risk of suicide.

We have launched the Supporting Children and Young People who Self Harm: Rotherham Self Harm Practice Guidance for everyone who works with young people.

The CARE about suicide resource is a pocket sized booklet for the general public and workers to help identify people who may be at risk of suicide and direct them to help.

Our ambition for Rotherham

- Implementation of the actions within the Rotherham Suicide Prevention and Self Harm Action Plan
- Launch of a Rotherham social marketing campaign to target young people
- As part of the emerging Workforce Development Strategy training needs for workers on mental health including suicide prevention will be identified.

Chapter 6: Cross cutting projects/ Transformation

CAMHS (Child and Adolescent Mental Health Service)

In 2014 a national group called the Children and Young People's Mental Health and Wellbeing Taskforce started to look at the emotional wellbeing and mental health support for children and young people. This group wanted to look at how to make it easier for children, young people, parents and carers to access emotional and mental health help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.

Their work led to the production of the report called Future in Mind and the following key themes were the ones they felt were important:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

Nationally funding was made available for services which support the emotional wellbeing and mental health of children and young people. All areas, Rotherham included, had to write a plan (the Transformation Plan) to show how they would improve the emotional wellbeing and mental health support to children, young people and their families in line with the themes above. This plan was coordinated by Rotherham Clinical Commissioning Group with input from RMBC, NHS services including mental health services, the voluntary sector and parents and carers, young people[88].

What are we doing in Rotherham?

Implementation of the CAMHS Transformation Plan is now underway, which includes: up to six schools piloting a whole school approach to emotional wellbeing and mental health, drafting a workforce development strategy, improvements to crisis provision for young people and targeted work with hard to reach groups like lesbian, gay, bisexual and transgendered young people.

Our ambition for Rotherham

- Schools taking part in the 'whole school' pilot scheme developing their own action plans to show how they are going to improve the emotional well-being and mental health of their school community working with support from other organisations like RMBC, NHS services, voluntary and community groups
- For schools involved in the pilot scheme (above) to share their learning with their cluster group
- Subsequent CAMHS Transformation funding to have a strong focus on early intervention and prevention

Special Educational Needs and Disabilities

In 2015 there were 1040 (2.3%) children and young people with a Statement of Special Educational Needs (SEN) or an Education, Health and Care Plan (EHC Plan or EHCP) 0.5% below the national average of 2.8%

The school census 2015[89] shows the most common types of special educational need to be learning difficulties (40%) which is below the national average (44.5%) and autism (11%) with Rotherham above the national average by 2%. Behavioural difficulties has been replaced with a new primary need code of Social Emotional Mental Health with Rotherham's children and young account for 12.5% which is below the national average of 16.7%. A growing number of children and young people have multiple disabilities and complex needs, continuing as they make the transition into adulthood.

Young people with special educational needs and/or disabilities (SEND) often face additional barriers, with the transition between children's and adult social care regularly cited as one of the most difficult experiences of young people and their families[90].

Within Rotherham a number of issues were cited by disabled children and their parents around transition from children's social care to adult social care[91]. These included:

- *Transition planning typically starting too late and is too focused on short-term goals*
- *Low expectations of some key health professionals*
- *Not enough suitable opportunities for young adults with SEND, including realistic options for supported employment and apprenticeships*
- *Not enough clear outcomes and limited personalisation*

The Rotherham Vision for SEND

Our vision for our children and young people with SEND is the same as for all our children and young people; that they be safe, happy, healthy, confident and successful, contributing to a thriving, inclusive community that is welcoming to all.

Their achievements, supported by effective settings and services working in partnership with families and communities, will enable them to enjoy independence and fulfilling lives.

What are we doing in Rotherham?

The SEND Joint Commissioning Strategy Group has developed a Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND). The strategy outlines the Rotherham SEND Joint Commissioning approach and identifies nine key areas of work that will be jointly taken forward.

Our ambition for Rotherham

- The development of the joint SEND Education, Health and Social Care Assessment hub to ensure timely and robust education and health care plans are developed in Rotherham that focus on the outcomes that are important to, and for, children, young people and their families

Chapter 7: Update on the 2014 Director of Public Health Annual Report

The last DPH Annual Report was produced by Dr John Radford in 2014. The following table provides a summary of the recommendations within the report and an update on what has happened since.

Recommendation	Progress
The Health and Wellbeing Board needs to ensure a common framework for preventative management of multiple conditions including mental ill health and to ensure we integrate risk factor management and rehabilitation in all disease management and care delivery.	Rotherham Health and Wellbeing Board approved a revised Health and Wellbeing Strategy in September 2015. This strategy includes five aims to improve health and wellbeing across the life course. The strategy specifically looks to improve mental and emotional health and wellbeing and to reduce the difference in health outcomes between our most and least deprived communities.
Rotherham Children's Board and the Council work with schools and the voluntary and community sector to reduce the impact of poverty on the borough's children.	Within Rotherham's new Health and Wellbeing Strategy the impact of child poverty on health and educational achievement is highlighted as an area for action. Working alongside the new Children's Partnership Board, the Health and Wellbeing Board will work to minimise the long-term implications of child poverty by supporting the Early Help strategy and working with families with multiple and complex needs.

Recommendation	Progress
Rotherham's secondary schools should be encouraged to adopt stay-on-site policies at lunchtimes.	Rotherham's new Health and Wellbeing Strategy highlights the impact of stay-on-site policies in reducing consumption of unhealthy food during the school day. There is also some evidence that such policies reduce access to tobacco and can contribute to lower take-up of smoking among young people.
The Health and Wellbeing Board needs to consider the relationship between its long term goals in the Health and Wellbeing strategy and the need to take action now to reduce the three main causes of inequality: cancer (especially lung cancer), cardiovascular and respiratory deaths.	One of Rotherham's Health and Wellbeing Strategy aims is focused upon improving life expectancy and reducing the differences in health between our most and least deprived communities. Much of this difference is a result of cardiovascular disease, cancer and respiratory disease. Rotherham Clinical Commissioning Group is leading partnership work to reduce potential years of life lost to early, and often preventable, death.

Recommendation	Progress
We must offer everyone aged 40-74 a NHS Health Check every five years. Screening 20% of the eligible population annually with a 90% uptake.	NHS Health Checks continue to be commissioned by Rotherham Public Health and delivered by local general practices. Uptake of the Health Check is low in Rotherham, and we are currently not meeting the targets for the proportion of eligible population being offered a Health Check. A promotional campaign has been running throughout the summer of 2015 with the aim of increasing uptake.
	The local uptake rate is increasing year on year from 6.6% (2013/14), 13.5% (2014/15) and is currently 17.5% (as of Quarter 2 2015/16). This is approximately a 2% increase each quarter.
	This mirrors the Yorkshire and Humber increase per quarter and is not far off the regional performance rate of 20.2%.
	A promotional campaign has been running throughout the summer of 2015 with the aim of increasing uptake and awareness of the programme.

Recommendation	Progress
Physical activity should be commissioned as a direct intervention to prevent morbidity in long term conditions.	Rotherham Public Health, in partnership with Rotherham CCG and others, has been awarded £500K from Sport England to deliver the Active for Health Research Project. This is an innovative 3-year physical activity programme to improve the recovery of people with long term conditions including cardiac, heart failure, COPD, cancer, stroke, lower back pain and falls. This is a research project which will help to develop the evidence base for the role long term physical activity can play in rehabilitation.
	Physical activity continues to be promoted through the Rotherham Healthy Weight Framework.
Stopping smoking should be the key priority for the Borough in tackling excess cancer deaths	Services to reduce tobacco use in Rotherham were revised in 2014 to put a greater emphasis on preventing young people starting to smoke; smoking is an addiction of childhood, with more than three-quarters of adult smokers beginning to smoke before the age of 18. We also continue to offer high quality stop smoking support for people wanting to quit and to reduce the number of women who smoke during pregnancy. The percentage of adults who smoke and of women who smoke during pregnancy remain higher than the national average, but are showing a reducing trend.

Recommendation	Progress
The CCG should actively promote awareness of early signs and symptoms of cancer and how and where to seek help as this could quickly save lives	NHS England is leading work to implement NICE Guidance published in June 2015 on Suspected Cancer: Recognition and Referral.
	This includes changes to some referral routes including more 'direct to test' recommendations and a lower threshold for referral based on symptom combinations with a positive predictive value[92] (PPV) of three or more (previous guidance was based on PPV of five or more).
Faster referral pathways and lowered thresholds for referral by GPs, particularly for lung cancer, are required to ensure a higher proportion of lung cancers are detected through the 2 week wait system.	The lung cancer pathway has been reviewed with Rotherham Foundation Trust and faster referral pathways and lower thresholds achieved.
Rotherham CCG should continue to prioritise reducing the use of prescribed non-steroidal anti-inflammatory drugs.	Three of Rotherham CCG's 14 Key Prescribing Indicators (KPIs) are focused upon non-steroidal anti-inflammatory drugs (NSAIDs) and reducing their use in CVD patients. Since implementing the KPIs there has been a continued decrease in the percentage of patients with an active repeat prescription for NSAID.

Recommendation	Progress
Reducing the volume of alcohol consumed in the Borough needs to be the agreed theme for the introduction of Making Every Contact Count (MECC), whilst maintaining quick and easy access to services that can respond to those identified as risky drinkers.	The Making Every Contact Count (MECC), approach has not been introduced within the borough. Further discussions are needed at the Health and Wellbeing Board to determine whether this is revisited as part of the implementation of the new Health and Wellbeing Strategy.
	Options for identification and early intervention in respect of alcohol consumption are maximised locally with the Primary care alcohol contract offering screening and interventions in GP practices. The Lifeline alcohol service is proactively offering screening and awareness raising in the community. Health trainers actively screening and provide general awareness raising campaigns.
Services and GPs should be active in making the hepatitis vaccine available to risk groups and better clinical screening for early detection and treatment.	The Gate Surgery specialises in supporting those people who have difficulty accessing mainstream health and social care services, proactively working across a range of complex and interlinked issues affecting adults and families who are at a greater risk of or currently experiencing poor health, substance misuse or risk of neglect or sexual exploitation.
	A Hepatitis screening history is undertaken for all new clients to ensure early detection of blood borne viruses to reduce the risk of transmission and improve prognosis of the patient through vaccination and advice.

Recommendation	Progress
Hepatitis prevention needs to be a priority for environmental health and for the sexual health and the drugs service.	Commissioned services for drug services and the Integrated Sexual Health Services have performance indicators relating to hepatitis screening and these are monitored at formal performance meetings. A newly commissioned third sector provider (Plusme) promotes blood borne virus testing (Hepatitis B, Hepatitis C and HIV).
	Targeted work has been undertaken to increase the take up rates on Hepatitis B vaccination and to ensure those individuals that have agreed to it are actually receiving the vaccination.
Rotherham MBC should develop a Rotherham Mental Health Strategy outlining local action to promote wellbeing, build resilience and prevent and intervene early in mental health problems.	Work has not started on the development of this strategy, however, early intervention and prevention work is included in the CAMHS Transformation Plan which will focus on schools and the wider community. There is a commitment within the new Health and Wellbeing Strategy to do this work and it will start in early 2016.
Mental health promotion messages should be an agreed theme within Making Every Contact Count (MECC).	The Making Every Contact Count (MECC) approach has not been introduced within the borough. Further discussions are needed at the Health and Wellbeing Board to determine whether this is revisited as part of the implementation of the new Health and Wellbeing Strategy.

Recommendation	Progress
Rotherham MBC should note the significant effect of air quality on mortality and that improvement in air quality, particularly reducing levels of PM 2.5 to PM 10[93] should be a priority for the Borough.	The Council has responsibilities for monitoring, modelling, air quality action planning, and the declaration of Air Quality Management Areas in hot spots. A recent Air Quality Health Inequalities Impact Assessment has established a link between levels of deprivation, poor air quality and poor health outcomes in Rotherham.
	Local work includes; • Measuring the levels of PM 2.5 to obtain evidence of 'hotspots' which can give us a better understanding of the local picture in Rotherham • Submitting a bid to DEFRA for funding to install a ''Green Screen'' to reduce levels of air pollution and protect health at a local primary school located next to a busy main road in an Air Quality Management Areas. Although unsuccessful on this occasion, further funding opportunities are being pursued • Exploring opportunities to mitigate the effects of air quality arising from new developments in the borough

Recommendation	Progress
Rotherham Clinical Commissioning Group and NHS England should consider flu vaccination a priority for Rotherham. Achieving 90% uptake of flu vaccination in the extension of immunisation to all children under 18 this September should be a priority for the Health and Wellbeing Board	The Screening and Immunisation Team (SIT) coordinate the NHS England-commissioned screening and immunisation programmes across South Yorkshire and Bassetlaw.
	Uptake in the following programmes is generally good and improving: • Childhood immunisation programmes delivered through NHS primary care • Programmes for children and adults 'at risk' of serious complications of diseases due to other underlying health conditions • Programmes delivered for healthcare workers and RMBC frontline staff
	The 2015/16 seasonal flu vaccination programme is underway, with a focus on the extension of the childhood flu vaccination programme, which will be delivered to all children in years 1 and 2.
	We anticipate that the children's programme, once fully implemented, will avert many cases of severe flu and flu-related deaths in older adults and people in clinical risk groups. We should continue, however, to work hard to ensure that we are communicating the benefits of the vaccine among all recommended groups and making vaccination as accessible for as many as possible.

Recommendation	Progress
Rotherham Clinical Commissioning Group should implement the local actions outlined in the Chief Medical Officers 2013 Annual Report on Antimicrobial Resistance.	Each Clostridium Difficile and Methicillin- Resistant Staphylococcus Aureus case is reviewed and scrutinised at a monthly Post Infection Review panel, chaired by Rotherham CCG, with microbiology, infection prevention and control, medicines management and public health in attendance. The panel's responsibility is to determine whether the case was unavoidable and if there had been any lapses in the quality of care. Learning is embedded into future practice, with a particular focus on appropriate antibiotic prescribing.
	The Rotherham Foundation NHS Trust leads a multiagency Antimicrobial Stewardship Group which monitors and implements a range of interventions to ensure we are prescribing fewer antibiotics and making sure they are only prescribed when needed. Part of its wider role includes promoting better hygiene measures to prevent infections and measures to tackle the next generation of healthcare associated infections.
	Rotherham CCG has appointed a lead nurse with responsibility for infection prevention and control who will work closely with the medicines management team, infection prevention and control teams based in the hospital, community and public health.

Chapter 8: Key Recommendations of Report

1. Rotherham CCG to work closely with Public Health and service providers to ensure that **services** and **care pathways** for pregnant women and children and young people are integrated and take every opportunity to **maximise public health outcomes**. Particularly, reducing the risks associated with poor health behaviours (reducing smoking and alcohol use in pregnancy, increasing levels of breast feeding, reducing levels of overweight and obesity and increasing physical activity)
2. Public Health service providers and Children & Young People's services to work more closely to deliver **integrated health and early help services** for children and families
3. Partners to work together to **maximise opportunities for training** to improve health outcomes – for example by adopting Making Every Contact Count (MECC) principles and undertaking joint training on the effects of poor health behaviour on children and families
4. Schools and colleges should do more work to ensure that all children and young people are supported to **improve their mental health and wellbeing** – identifying clear pathways of support when children and young people experience mental health problems and raising awareness of self-harm and suicide prevention strategies
5. Rotherham CCG, Public Health and the local service providers should ensure **better and more timely access** for children and young people experiencing **mental health problems**. This should lead to better recovery and outcomes
6. Rotherham MBC needs to work with all partners to develop a 'whole systems' approach to **tackling overweight and obesity**, including prevention and treatment strategies
7. The work programmes of the Health and Wellbeing Board and the Children, Young People and Families Partnership Board should be **integrated and add value** to the work of all partners

We will develop a comprehensive action plan to support the delivery of the recommendations over the coming year. Working together with partners the actions will contribute to improvements in the health and wellbeing of children and young people in Rotherham.

Appendix 1: Data sources

The Joint Strategic Needs Assessment (JSNA)

http://www.rotherham.gov.uk/jsna/ is a key source of information on the residents of Rotherham.

Much of the data included above is from Profile data published by Public Health England e.g. from the Rotherham Child Health **http://www.rotherham.gov.uk/jsna/downloads/file/98/child_health_profile_2015** and Public Health Outcomes Profile (PHOF) **http://www.phoutcomes.info/** for Rotherham.

Data within the Profiles is generally sourced from the Office for National Statistics or the Health and Social Care Information Centre. Re-use of this data is subject to the Terms and Conditions of the data source.

Data from Public Health England

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Data from the Office for National Statistics

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Data from the Health and Social Care Information Centre

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[73] Public Health England 2014 Hospital admissions as a result of self-harm http://fingertips.phe.org.uk/profile/cyphof/data#gid/1938132709/pat/6/ati/102/page/3/par/E12000003/are/E08000018/iid/90813/age/245/sex/4

[74] Rotherham Suicide Prevention and Self-Harm Action Plan 2015/2016 can be accessed at: www.rotherham.gov.uk/info/200068/mental_health/803/independent_report_on_suicide/2

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[91] Rotherham SEND Joint Commissioning Strategy and Consultation 2015 [to be published]

[92] Positive predictive value is the probability that subjects with a positive screening test truly have the disease.

[93] PM 2.5 and PM 10. Particulate matter, or PM, is the term for particles found in the air. Some particulates occur naturally, originating from volcanoes, dust storms, forest and grassland fires, living vegetation, and sea spray. Human activities, such as the burning of fossil fuels in vehicles, power plants and various industrial processes also generate significant amounts of particulates. The 10 micrometer and 2.5 micrometer sizes have been agreed upon for monitoring of airborne particulate matter by the regulatory agencies. This is because of their small size, particles on the order of ~10 micrometers or less (PM10) can penetrate the deepest part of the lungs such as the bronchioles or alveoli. Similarly, so called fine PM, particles smaller than 2.5 micrometers, PM2.5, tend to penetrate into the gas exchange regions of the lung (alveolus).

Rotherham Metropolitan Borough Council

Public
Health and Wellbeing Board

Summary Sheet

Council Report
Health and Wellbeing Board – 1st June 2016

Title
Suicide Prevention and Self-Harm Action Plan Update 2015/2016

Is this a Key Decision and has it been included on the Forward Plan?
It is a priority within RMBC Corporate Plan 2016/2017

Strategic Director Approving Submission of the Report
Teresa Roche, Director of Public Health (DPH)

Report Author(s)
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Ward(s) Affected
All

Summary
This paper will provide a six month progress report on actions detailed in the Rotherham Suicide Prevention and Self Harm Action Plan for 2015/2016.

Recommendations
That the Health and Wellbeing Board:

1.1 Accepts and endorses the report on actions taken by the Rotherham Suicide Prevention and Self Harm Group for 2015/2016.

1.2 Endorses the areas for future activity, including a commitment to continue Rotherham's Real Time Surveillance work and the social marketing campaign work.

1.3 Receives an update report on the work of the Rotherham Suicide Prevention and Self Harm Group once a year and exception reports as appropriate

List of Appendices Included
Appendix 1- Rotherham Suicide Prevention and Self Harm Action Plan 2015/2016

Background Papers
Department of Health, Statistical update on suicide February 2015 (2015), https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405411/Statistical_update_on_suicide_acc.pdf

HM Government (2015) Crisis Care Concordat: http://www.crisiscareconcordat.org.uk/

HM Government (2015), Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives, www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf

Public Health England (PHE), (2014) Guidance for developing a local suicide prevention action plan: information for public health staff in local authorities, https://www.gov.uk/government/publications/suicide-prevention-developing-a-local-action-plan

The National Mental Health Intelligence Network (NMHIN) and Public Mental Health Team launched the Suicide Prevention Profile on the Fingertips website in March 2015. This provides the latest data on suicides for local areas. http://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide.

Consideration by any other Council Committee, Scrutiny or Advisory Panel
Public Health Directorate Leadership Team.

Council Approval Required
No

Exempt from the Press and Public
No

Title (Main Report)

Suicide Prevention and Self-Harm Action Plan Update 2015/2016

1. Recommendations

That the Health and Wellbeing Board:

1.1 Accepts and endorses the report on actions taken by the Rotherham Suicide Prevention and Self Harm Group for 2015/2016.

1.2 Endorses the areas for future activity, including a commitment to continue Rotherham's Real Time Surveillance work and social marketing campaign work.

1.3 Receives an update report on the work of the Rotherham Suicide Prevention and Self Harm Group once a year and exception reports as appropriate

2. Background

2.1 The delivery of the Rotherham Suicide Prevention and Self Harm Action Plan is an action within the Rotherham Health and Well Being Strategy.

2.2 Suicides are not inevitable. They are often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This can only be done by working collaboratively across all sectors within Rotherham.

2.3 The All Party Parliamentary Group (APPG) on Suicide and Self-harm published an "Inquiry into Local Suicide Prevention Plans in England" January 2015. The APPG considered that there were three main elements that are essential to the successful local implementation of the national strategy. All Local Authorities must have in place:

a) Suicide audit work in order to understand local suicide risk.
b) A suicide prevention plan in order to identify the initiatives required to address local suicide risk.
c) A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan.

2.3 Suicide prevention is a Public Health Outcome Framework indicator (PHOF), the Director of Public Health established a Suicide Prevention Group in 2012. This group developed an action plan based on the six areas for action outlined in the Government guidance: "Preventing suicide in England: A cross-government outcomes strategy to save lives":
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

3. Key Issues

The Rotherham Suicide Prevention and Self Harm Group are able to report the following actions based on the six national areas for action and an additional two which are Rotherham specific.

3.1 Increase local level of understanding suicide and establish reporting mechanisms to strategic partners

Actions include:

- The Rotherham Suicide Prevention and Self Harm Group continues to meet bimonthly to review progress on the action plan, receive suicide audit data and recommend any necessary response, for example, for high risk groups.
- Rotherham participated in the national real time suicide surveillance pilot from September 2014 to May 2015. However in Rotherham we have arrangements in place between South Yorkshire Police (SYP) Vulnerable Persons Unit, Rotherham Clinical Commissioning Group (RCCG) and Public Health to continue to respond to suspected suicides as soon as we receive notification. Suicide data received in real time enables an immediate response.
- A Suicide Audit Report looking at the epidemiology of suicides from the period 2009-2014 was prepared by RMBC, RCCG, SYP and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).

3.2 Reduce risk in high risk groups- Children and young people

Actions include:

- Partner organisations of the Rotherham Local Safeguarding Children's Board (LSCB) signed up to the Rotherham Suicide and Self-harm Community Response Plan in September 2015. This plan is currently being reviewed by a multi-agency Task and Finish Group in light of national guidance and lessons learnt from Rotherham. It is anticipated that this will be complete by end of June 2016.
- A workshop was delivered by Public Health and Educational Psychology (RMBC) to Heads of primary and secondary schools on 21st May 2016 outlining the purpose of the Rotherham Suicide and Self-harm Community Response Plan and their response to suspected suicides, serious self-harm and critical incidents. Local case studies were included in the training. Forty participants attended this workshop representing 31 schools.
- Rotherham Self-Harm Practice Guidance was launched at the end of November 2015 and hard copies have been sent to all schools, colleges, School Nursing, GPs, Voluntary sector organisations and Early Help Teams. The guidance is available on the My Mind Matters website; www.mymindmatters.org.uk.
- Social marketing suicide prevention campaign for men is due to be launched June 2016. Social marketing campaign for young people still to be developed.
- Rotherham Public Health funded the reprint of the CARE about suicide resource for Universal workers and the general public. This has now been distributed to Partner organisations.

3.3 Tailor approaches to improve mental health in specific groups

Actions include:

- My Mind Matters website, launched in July 2015, was promoted to all schools and colleges.
- CAMHS Transformation plan incorporates actions to look at vulnerable and at risk groups, for example Lesbian, Gay, Bisexual and Transgendered young people (LGBT).

3.4 Reduce access to means

Actions include:

- Reminders to patients about safe storage of medication.
- CARE about suicide training for frontline staff advises workers to be vigilant regarding access to means.

3.5 Better information and support to those bereaved by suicide

Actions include:

- The Children and Young People's Bereavement pathway has been received very positively by families. It was reviewed in April 2016 to reflect organisational changes. The pathway will be promoted again to frontline staff in Early Help, Multi Agency Safeguarding Hub (MASH) and Children and Adolescent Mental Health Services (CAMHS).
- SYP Vulnerable Persons Unit distributes the national suicide bereavement resource, 'Help is at hand' to all families bereaved by a suspected suicide. Schools and colleges have been made aware of this resource.
- Further discussions are taking place with Rotherham Samaritans about support to families bereaved as a result of suicide.

3.6 Support media in delivering sensitive approaches to suicide and suicidal behaviour

Actions include:

- Use of Partner organisation's communications to promote messages to the general public; websites, Qmatic screens (RMBC), Rotherham Public Health Channel and twitter feeds from SYP and RMBC to highlight support to people affected by suicide.
- Local media has promoted the CARE about suicide resource and helpful organisations both local and national.
- Media summit to be held.

3.7 Data collection and monitoring

Actions include:

- Rotherham participated in Public Health England's 'real time suicide surveillance' pilot from September 2014 to May 2015.
- Suicide Audit report produced December 2015 which looks at suicides from 2009 to 2014.

3.8 Workforce Development

Actions include:

- CARE about suicide training run by Public Health Specialist and Human Resource Officer for over 200 workers in Revenues and Benefits, HR and Housing.
- Applied Suicide Intervention Skills Training (ASIST- 76 people attended this training 2015/2016
- Safe Talk- 41 people attended this training 2015/2016
- Youth Mental Health First Aid (MHFA) - 3 courses delivered, 35 people attended.
- Adult Mental Health First Aid- 4 courses delivered, 51 people attended.

ASIST and Safe Talk courses were funded by monies from the CAMHS Local Transformation Plan and Rotherham LSCB. The Adult MHFA courses were funded by RCCG with the training provided by Rotherham Public Health. Youth MHFA courses are funded by Rotherham Public Health. These figures do not include MHFA courses run by staff in RDaSH and The Rotherham NHS Foundation Trust (TRFT).

4. Options considered and recommended proposal

N/A

5. Consultation

5.1 The Rotherham Suicide Prevention Group will organise opportunities to listen to and learn from families bereaved by suicide. In particular we will be looking to include the families who participated in the Independent report 2015. We will use this opportunity to talk about local suicide prevention actions.

5.2 Young people, including members of the Youth Cabinet, will be involved in the suicide prevention social marketing campaign for young people.

5.2 Partners of the Rotherham Suicide Prevention and Self Harm Group will finalise the priorities for 2016/2017 at their meeting on the 19th May 2016. These will be informed by national best practice and local suicide audit data.

5.3 The actions will be cross referenced with the recommendations made in the 2015 report: An Independent Review of Actions Taken Following a Group of Suicide Events in Rotherham.

6. Timetable and Accountability

6.1 The Rotherham Suicide Prevention and Self Harm Action Plan will be implemented from May 2016 through to March 2017.

6.2 Reviews of progress will take place at the bi monthly meetings of the Rotherham Suicide Prevention and Self Harm Group.

6.3 An annual update report will be given to the Health and Wellbeing Board (HWB).

7. Financial and Procurement Implications

The report will have financial implications:

7.1 Workforce Development

RCCG and Rotherham Public Health are funding further adult MHFA courses in 2016/2107.

Youth MHFA- through the CAMHS Local Transformation Fund another Instructor will be trained to bring the capacity within RMBC to 3 workers. Funding will be required to run the courses; manuals, venue and refreshment costs.

Funding will be required to secure future courses in 2016/2017 for ASIST (£3900 per course plus venue hire) and Safe Talk (£600 per course plus venue hire).

7.2 Reduce risk in high risk groups

The Rotherham social marketing campaigns for men and young people will require funding this financial year. Estimated costs for this are starting at £2000 for limited activity to £14000 for a more targeted social marketing campaign for high risk groups.

7.3 Reduce access to means and Data collection and monitoring

To continue with the real time suicide surveillance work. Estimated costs include Officer time from SYP Vulnerable Persons Unit, RDaSH, RCCG and Rotherham Public Health.

8. Legal Implications

8.1 N/A

9. Human Resources Implications

9.1 Suicide prevention is a partnership approach requiring commitment from Officers from all Health and Well Being Board members. In particular Officer

time from Partner organisations to deliver MHFA Training and conduct the real time suicide surveillance work.

10. Implications for Children and Young People and Vulnerable Adults

10.1 The needs of children, young people and vulnerable adults are addressed within the Rotherham Suicide Prevention and Self Harm Action Plan. The real time surveillance work monitors changes which are then reported to the Rotherham Suicide Prevention and Self Harm Group and appropriate action taken.

11 Equalities and Human Rights Implications

11.1 These are addressed within the action plan and the real time suicide surveillance work monitors changes which are then reported to the Rotherham Suicide Prevention and Self Harm Group and appropriate action taken.

12. Implications for Partners and Other Directorates

12.1 Suicide prevention is a partnership approach requiring commitment from Officers from all Health and Well Being Board members in particular the coordination of MHFA training.

13. Risks and Mitigation

13.1 Research in Scotland (Scottish Public Health Observatory, 2015) indicates that there is a clear linear relationship between deprivation and the overall suicide rate. Whilst our data for Rotherham shows there is a moderate positive relationship between deprivation and suicide, the most deprived wards do have a higher concentration of suicide risk factors, for example, unemployment and mental health problems. Both the suicide audit results and the real time suicide surveillance data indicate that Rotherham suicide numbers continue to increase.

13.2 Families and communities bereaved by suicide are at higher risk of subsequent suicides than the general population. Postvention work in this area is an important in suicide prevention work.

14. Accountable Officer(s)

Teresa Roche, Director of Public Health (DPH)

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SUICIDE PREVENTION AND SELF-HARM ACTION PLAN

2015/16

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS

Suicide is not inevitable. It is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity.

In 2012 the Government produced “Preventing suicide in England A cross-government outcomes strategy to save lives”:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf

The strategy outlined six areas for action:

1. Reduce the risk of suicide in key high risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

This action plan outlines the actions agencies across Rotherham are taking to prevent suicides.

Rotherham takes suicide prevention seriously and the Director of Public Health Chairs the Suicide Prevention Group who are tasked to implement this plan. The Health and Wellbeing Board will receive a minimum of annual updates against the plan.

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
1. Increase local level of understanding suicide and establish reporting mechanisms to strategic partners: - **Health & Well-Being Board** - **Elected members** - **Clinical Commissioning Group** - **Safe Guarding Adults Board** - **Safeguarding Children Board** - **Rotherham Health Protection Committee**	Rotherham Suicide Prevention and Self Harm Group chaired by Director of PH to meet bi monthly Local Suicide Prevention and Self Harm Group reports to the Rotherham Health Protection Committee and the Rotherham Health and Wellbeing Board. Annually review membership of the Rotherham Suicide Prevention and Self Harm Group, ensuring voluntary sector membership.	Public Health Specialist (Mental Health)	Terms of Reference reviewed annually Update reports produced Membership reviewed annually	Terms of reference agreed including reporting mechanisms agreed and reviewed annually. Rotherham Suicide Prevention and Self Harm Group's membership reflects the partnership approach to suicide prevention.	**GREEN**
	Annual update on the epidemiology of suicides and actions taken against suicide prevention is provided to the Health and Well Being Board.	Rotherham Suicide Audit Group	April 2015	Partner activity of suicide prevention reflects local need	**GREEN**

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
2. Reduce risk in high risk groups- Children and young people	Rotherham Suicide and Self-harm Community Response Plan(2015) for children and young people to be revised to include the following : • Circles of vulnerability • Out of hours support and information • Management of severe self-harm behaviour • Letter and public information leaflet for use in schools and collages • Emerging national guidance	Consultant in Public Health Public Health Specialist (Mental Health)	Plan adapted by June 2015 Partner organisations signed up to the Rotherham Suicide and Self-harm Community Response Plan by September 2015	Rotherham Suicide and Self-harm Community Response Plan (2015) adapted and approved by Partner organisations	**AMBER**
	Rotherham Suicide and Self-harm Community Response Plan(2015) to be actioned within 24-48 hours of any event	Led by LSCB Supported by all agencies involved in Rapid Appraisal Process	In the event of a suspected death by suicide of a young person	Rapid Response process will ensure this happens. Rotherham is participating in the PHE Real Time suicide Surveillance Pilot. Rotherham Suicide Audit Group reviews all suicides.	**GREEN**

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Ensure every school and college has been equipped with support materials in the event of self-harm or suicide. To include the following: • Template letter for schools to use to inform parent and carers • Policy for dealing with suicide or sudden death • Multi agency care pathway for emotional/ mental health issues.	Public Health Specialist (Mental Health)	June 2015	Schools and colleges using the recommended best practice	**AMBER**
	To launch the Child and Adolescent Mental Health (CAMHS) pathways for universal workers (incl self-harm, emotional health and wellbeing , ASD, ADHS, post abuse)	CAMHS Commissioners RMBC and RCCG to lead	Pathways to be launched in spring 2015	Universal workers across Rotherham working to the same pathways. Young people, parents and carers receiving consistent approach	**AMBER**
	Update the GP Top Tips and Directory of Services annually	RCCG CAMHS Commissioner	Ongoing	GPs make appropriate referrals	**GREEN**
	Support schools and colleges in identifying mental health problems in pupils through collaborative working between education and health professionals:	Public Health Specialist (Mental Health) working with CAMHS commissioners from Rotherham CCG, RMBC and CAMHS providers.	All schools and colleges received CAMHS Top Tips and Directory of Services in March 2015	Schools and colleges using CAMHS Top Tips and Directory of Services.	**GREEN**

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	- Promotion of the CAMHS Top Tips – Guidance on the referral of children and young people with emotional wellbeing issues into universal, targeted and RDaSH CAMHS services - Directory of Services – Information on services that provide emotional wellbeing support.				
	Development and launch of the Rotherham Self-Harm Practice Guidance 2015	Public Health Specialist (Mental Health) working with Rotherham Youth Cabinet and Rotherham Suicide Prevention and Self Harm Group	Guidance approved at H&WBB March 2015 Launch and promotion of guidance April 2015	Safe, timely and effective response to children and young people who harm themselves or are at risk of harming themselves.	**GREEN**
Reduce risk in high risk groups: Children and young people & middle aged men	Development of a local awareness campaign to target high risk groups. Two campaigns planned for 2015/16 based on local data: - Young people (15-21) - Males Campaigns will include social media marketing	Editorial Group to include PH Specialist (Mental Health), RMBC Communications & Media Manager, Rotherham Youth Cabinet, Rotherham Suicide Prevention and Self Harm Group.	Work Commencing April 2015		**AMBER**

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	techniques. Sources will include Public Health Channel, Qmatic Screens, social networking, PH website and non-health sites to promote messages. Campaigns to look at non health organisations and sites which could promote these messages				
Reduce risk in high risk groups : People experiencing domestic abuse	Promote awareness of this group amongst GPs – Development of GP Guidance / Referral pathway for people experiencing domestic abuse. Ongoing promotion of tis resource and annual review	PH Specialist, RMBC, Head of Contracts and Service improvement, CCG & RDaSH	Ongoing promotion of the flowchart and annual review July 2015	GPs better equipped to identify and support patients experiencing domestic abuse.	**GREEN**
Reduce risk in high risk groups: Rotherham residents affected by the changes to welfare reform	Training for frontline customer services using the CARE about suicide resource	PH Specialist (Mental Health), HR (RMBC), RDaSH Crisis Service working with Team Managers within RMBC to deliver training sessions for frontline customer service staff within RMBC	Training commenced February 2015. Training sessions ongoing until May 2015. .	Staff feeling better equipped to support people who may be in distress and/or expressing thoughts of suicide	**GREEN**

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
Reduce risk in high risk groups: witnesses of suicide	Develop supportive and signposting information for people who witness a suicide.	RDaSH and PH Specialist (Mental Health) with input from the Rotherham Suicide Prevention and Self Harm Group.	April 2015 leaflet send out for consultation May 2015 leaflet launched and used by frontline services for example SYP	People who witness suicides receiving timely and supportive information.	**AMBER**
3. Tailor approaches to improve mental health in specific groups	Development of the Emotional Health and Mental Health website for young people, parents/carers and professionals which will provide information on: - signposting - different mental/emotional health topics - self help - help in a crisis - looking after yourself	RMBC Commissioning & Public Health, working with Rotherham Youth Cabinet, Rotherham parents and carers and CAMHS Partnership Group.	Website developed with input from Rotherham Youth Cabinet, parents/carers and professionals March/April 2015 Launched May 2015	Comprehensive and reliable information on a variety of mental/emotional health topics including self-help guidance.	**GREEN**
	The new Rotherham Health and Well Being Strategy to incorporate targets and actions to improve the emotional health and well-being of children and young people(By Sept 2015).	Rotherham Health and Well Being Board	From April 2015 onwards	Partners all working to improve the mental health and well-being of children and young people.	**AMBER**

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	The development and implementation of the Emotional Wellbeing and Mental Health Strategy for Children and Young People 2014-2019.	RMBC and RCCG Commissioners & RMBC PH, working with Rotherham CAMHS Partnership.	Strategy has been approved by the H&WBB. Implementation is ongoing and monitored quarterly.	Improved services and support for children and young people in Rotherham regarding their emotional health and well-being.	**AMBER**
4. Reduce access to means	Suicide audit group bimonthly meetings to identify any hotspots using reports from the police and mental health services. Minutes and actions are recorded. Actions are initiated. Actions incorporated in Suicide Prevention and Self-Harm Action Plan	Attendees include: PH, RCCG, SYP & RDaSH. Meetings chaired by PH PH Specialist to work with other agencies as and when required (Local Coroner's Office, Highways Agency, Samaritans, colleagues within RMBC, local media)	Hotspot work initiated as and when areas are identified. Actions recorded and reported to the wider Suicide Prevention and Self-Harm Group.	Action taken at hotspots which could include: -installation of physical barriers and or moving ligature points -encouraging help seeking behaviours -increasing the likelihood of a third party intervention through surveillance and staff training -responsible media reporting	**GREEN**
	Local partners to share actions and learning to reduce suicide particularly after a serious incident (SI)	Provider Services for example: RDaSH, SYP TRFT	SIs discussed at each Suicide Audit meeting	Suicide prevention practice is shared across organisations	**AMBER**

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	with Suicide Audit Group and the Rotherham Suicide Prevention and Self-Harm Group.				
5. Better information and support to those bereaved by suicide	Development of the Rotherham Adult Bereavement pathway Promotion of pathway across the district which will be monitored by the Rotherham Suicide Prevention and Self Harm Group.	Public Health Specialist (Mental Health) working with the Rotherham Suicide Prevention and Self Harm Group	Development of pathway March 2015 Launch of pathway April 2015	Adult Bereavement pathway in place Improved post bereavement support for adults	**AMBER**
	To continue to promote and review the LSCB Bereavement pathway for children and young people bereaved as a result of suicide or sudden death.	Public Health Specialist working with Rotherham LSCB and the Rotherham Suicide Prevention and Self Harm Group	Launched in January 2015 Review due January 2016	Children and young people received timely and appropriate support when bereaved by suicide or sudden death.	**GREEN**
	Explore having a single point of contact for the bereaved.	South Yorkshire Police and Coroner's Office	June 2015	Bereaved families have a single point of contact.	**AMBER**

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
6. Support media in delivering sensitive approaches to suicide and suicidal behaviour	Develop a clear communications strategy between RMBC and its strategic partners which proactively promotes suicide prevention approaches.	RMBC Communications & Media Manager working with Communication leads from RDaSH, TRFT, SYP and RCCG.	Work commenced February 2015 and is ongoing	Agreed communications strategy across all statutory partners.	**AMBER**
	Commission a local awareness campaign to target young people (aged 15-21 years) as a high risk group	Public Health Specialist (Mental Health) and Marketing and Creative Services Manager (RMBC) working with the Rotherham Suicide Prevention and Self Harm Group.	Commencing March 2015	Media campaign launched and reviewed.	**RED**
	Hold a media summit/workshop for local media on suicide prevention.	RMBC Communications & Media Manager working with Communication leads from RDaSH, TRFT, SYP and RCCG. Support given from Public Health Specialist (Mental Health) and Rotherham Suicide Prevention and Self Harm Group.	Planning to commence April 2015	Summit/workshop held.	**RED**
	Promotion of the Rotherham CARE about suicide resource. CARE about suicide resource to be on every statutory partners'	RMBC Communications & Media Manager working with Communication leads from RDaSH, TRFT, SYP and RCCG. Support given from Public	Launched April 2014 To be on all statutory partners' websites by April 2015	Increase in confidence of universal workers and the general public to ask about suicide and take appropriate action	**GREEN**

Suicide Prevention and Self-Harm Action Plan 2015/2016

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	website	Health Specialist (Mental Health)			
7. Data collection and monitoring	Participation of Rotherham in the Real Time Suicide Surveillance Pilot (South Yorkshire). Data is reviewed at the Rotherham Suicide Audit meetings	Rotherham Leads PH Specialist (Mental Health) and Mental Health Coordinator South Yorkshire Police (SYP).	Commenced September 2014. Review April 2015	General themes and trends reported back to Suicide Prevention and Self Harm group and actions to reduce risk reflected in action plan. Real time public health interventions for suicide prevention. Identifying at risk groups will inform commissioning cycle.	**AMBER**
	Suicide audit group bimonthly meetings to identify any hotspots using reports from the police and mental health services. Minutes and actions are recorded. Actions are initiated. RDaSH to share SIs with the Suicide Audit	Attendees include: PH, RCCG, SYP & RDaSH. Meetings chaired by PH PH Specialist to work with other agencies as and when required (Local Coroner's Office, Highways Agency, Samaritans, colleagues within RMBC, local media)	Suicide audit group to meet every bimonthly and review each death by suicide and agree follow-up actions.	General themes and trends reported back to Suicide Prevention group and actions to reduce risk reflected in action plan. Real time public health interventions for suicide	**GREEN**

KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Group to enable public health prevention actions to be identified.(Serious Incident Reports). Suicide Audit group agrees actions. Actions are reviewed at next meeting. Generic actions are reported back to the wider Suicide Prevention and Self Harm Group.			prevention. Identifying at risk groups will inform commissioning cycle.	
	Provision of epidemiological evidence to shape the development of services to support the emotional and mental health of children and young people (Needs Analaysis)	RMBC Public Health and RCCG	Annually	Services reflective of local epidemiology	**AMBER**
8. Workforce Development	Provision of 6 Adult MHFA Training during 2015/16	RCCG, RMBC PH and RDaSH	Commencing April 2015- March 2016	Improved awareness of mental health, reduced stigma and awareness of local services	**AMBER**

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KEY AREAS FOR ACTION	ACTION	ACTIONED BY WHOM	TIMESCALE	OUTCOMES	RAG STATUS
	Provision of 4 Youth MHFA Training during 2015/16	PH RMBC and L&D Leads	Commencing April 2015	Improved awareness of mental health, reduced stigma and awareness of local services	**AMBER**
	To roll out further ASIST courses and other suicide prevention and self-harm courses to frontline workers	PH RMBC and L&D Leads	ASIST courses commence May 2015 Discussion re further courses commencing April 2015	Improved response to people in emotional distress	**GREEN**
	Delivery of a GP Projected Learning Time Event on mental health crisis	RCCG	2015/16	Increase awareness of the Mental Health Crisis Care Pathway	**RED**

Glossary

ASIST	Applied Suicide Intervention Skills Training
DPH	Director of Public Health
MHFA	Mental Health First Aid training
PH	Public Health
PHE	Public Health England
PHS	Public Health Specialist
RCCG	Rotherham Clinical Commissioning Group
RDaSH	Rotherham, Doncaster and South Humber NHS Foundation Heath Trust
TRFT	The Rotherham Foundation Hospital Trust

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