

# 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.

## 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
  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:
<ul style="list-style-type: none"><li>• Restructured community nursing service and GP practices into 7 localities</li><li>• An integrated falls and bones pathway</li><li>• Implementation of a Care Coordination Centre as a single access point</li><li>• Risk stratification of patients and Case Management approach for top 5%</li></ul>	<ul style="list-style-type: none"><li>• Integrated Rapid Response services</li><li>• Creation of a new IT portal providing visibility of community case load patients in the hospital</li><li>• Introduced Care Home Liaison Service</li><li>• Enhanced Care Coordination Centre provided on a 24/7 basis</li></ul>

The Rotherham model is comprehensive and covers a range of service areas. Further evidence is required to demonstrate detailed cost benefit analysis. However, an indication of the level of potential benefits realisation comes from an example at North Manchester General Hospital with the Common Assessment Support Service (CASS). This intermediate care pilot is based around timely assessment and effective use of re-ablement services to avoid hospital admissions and short term residential care needs. The CASS model demonstrates a likely cost benefit ratio over a five year period of £2.24 to £1 invested. This could be scaled up when factoring in the wider scale of the Rotherham MCP.

Evidence from the Salford Integrated Care Team approach demonstrates potential benefits of £5.29 for every £1 invested in a service hub.

We also intend to further develop new funding and risk sharing models across health and social care.

- **A new integrated Urgent and Emergency Care Centre** due to open in spring 2017, delivering a ground-breaking 'next available clinician' delivery model with innovative staffing solutions, hitting many of the requirements of the Keogh Review for Urgent Care.
- **A 24/7 Care Coordination Centre and associated rapid response teams** which manages system capacity and advises on the most appropriate level of care for patients to avoid hospital admission wherever possible.
- **One Public Estate approach for Rotherham.** There are emerging opportunities arising from closer linkages with the Sheffield City Region, including the Joint Assets Board which is leading on the One Public Estate approach on behalf of public sector partners locally. This alignment could include access to revenue funding to support the realisation of ambitious plans and focus on a transformational asset based approach. Rotherham is conducting a review of estate across health and social care, and RMBC is also leading a wider review across the Sheffield City Region.

We will make best use of existing assets, dispose of those not fit for purpose and further increase our use of joint service centres.

- **Integrated IT** across health, social care and care homes. Linking up Health and Care records is a must do and we have already made good progress. Our model of one provider for Health IT has facilitated a coordinated approach.
- **Further Development of our social prescribing service to cover mental health clients and facilitate earlier hospital discharge.** We already target the top 5% of patients at risk of hospitalisation using risk stratification and GP judgement. We have identified non-medical interventions for over 5000 patients with amazing success, saving money and improving outcomes for patients. We are further developing this approach and wish to move further and faster to develop more interventions for mental health clients and services to support early hospital discharge.
- **Further development of an Integrated Re-ablement Village.** We have co-located all re-ablement services and all partners are fully committed to further develop the integration of all services to offer the best possible recovery pathway.



The overarching vision for our health and care services is for people to live independently in the community, with prevention and self-care at the heart of our delivery. Our Local Place Plan supported by existing initiatives within our locally agreed Better Care Fund provides a real opportunity to improve the lives of the Rotherham population and 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 plan to achieve this through a multi-agency 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 on-going 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 already have effective joint commissioning arrangements which drive the integration of services, but we can do more. 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.

## WHAT DO WE MEAN BY ASSETS?



## WHAT DO WE MEAN BY ASSET-BASED APPROACHES?

1

Asset-based conversations between staff and patients



- Care planning,
- Coaching
- Shared decision making

2

Mapping and growing community assets



- Asset mapping,
- Directories of community assets
- Seed funding for VSOs

3

Connecting patients to community assets



- Link workers
- Navigators
- Health Trainers
- Peer supporters
- Social prescribing

4

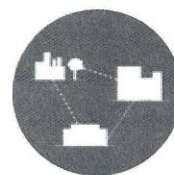
Working with communities to develop local provision



- Co-design
- Collaborative commissioning

5

Co-ordinating and mobilising assets in a place



- Local neighbourhood networks
- Community wellbeing centres
- Healthy Living Centres

We will work with communities to have a different conversation to understand what matters to them, with a focus on their strengths and values. These conversations will inform commissioners about requirements outside of traditional service models. People can be linked to mapped assets readily available in their local community or the wider borough. Where there are gaps in provision e.g. for people with learning disabilities, we will support, and where necessary, seed fund organisations to develop local services. This approach embeds an owned culture of wellbeing and prevention across communities as well as within statutory services in addition to demand shift with clear fiscal benefits.

An evidence base to inform a more detailed investable proposition for Rotherham linked to wider asset based approaches will need to be developed. However, the *Wigan Deal* Programme demonstrates that for every £1 invested in community assets generates benefits of £1.95 per person over a five year period.

We will streamline and simplify care pathways, providing better information, advice and signposting to preventative service and the third sector for on-going 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.

Rotherham CCG and Rotherham MBC and provider partners will work together to achieve the following objectives. These are aligned with the outcomes set out in Rotherham’s Health and Well Being and Rotherham CCG’s Commissioning Plan.

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
9. Prevention, self-care and empowering citizens, communities and frontline staff will be at the heart of everything we do.

## Evaluation

We have a strong record of evaluation of our innovative projects and our partnership with Sheffield Hallam University delivers patient level evaluation on our key projects to gather evidence and inform our investment decisions. We will use evidence cost benefit analysis from other areas where we do not have local evidence.

## What STP transformation funding do we need?

Our key enablers for transformation at a local place base level would be enhanced with non-recurrent funding identified through the national STP fund in the following ways:

- **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).

Additional one – off funding of **£1.5m** would support the borough wide roll out of MCP working facilitating relevant one off initial infrastructure / set up costs within our system. We would also like to invest **£1.25m per annum** to trial new staffing models in primary care to ensure patients receive services in the right place, first time. This development should reduce non elective bed days by 20,000 and allow the Trust to reduce the bed stock by 31 beds recurrently saving £1.5m per annum. This will also support our strategy for sustainable primary care services.

- **A 24/7 Rotherham wide Care Coordination Centre (CCC)** which manages system capacity and advises on the most appropriate level of care for patients to avoid hospital admission wherever possible. Our aspiration is to enhance our CCC beyond Acute Hospital provision and co-ordinate care across Social Care, Acute and Mental Health services, improving access for patients through a comprehensive directory of services, driving efficiency and cutting down waste. The solution will also support the sharing of information among all health and social care professionals to quickly identify individuals at risk and where a needs assessment can be made and to identify the most appropriate pathway and correct deployment of resources. The CCC will also act as a single point of access for patients by giving them access to health and social care professionals on a 24/7 basis through which initial assessments can be undertaken and teams deployed to provide support and avoid potential hospital presentation or admission. The non-recurrent infrastructure cost for this work is estimated at **£0.46m per annum** and is expected to deliver at least £0.86m additional system wide efficiencies and also improve the efficiency, and further integrate health and social care services.

- **One Public Estate approach for Rotherham** – we are currently assessing the scale of the transformation required to inform the 30 June submission.



- **Integrated digital care records** across health, social care, care homes and citizens/patients. Excellent progress has already been made, with the Rotherham Clinical Portal connecting disparate health systems and the population of Social Care systems with NHS Numbers in preparation for further connectivity. We plan to further integrate systems by engaging suppliers to use national technical standards across Health and Social care and using the Rotherham Clinical Portal as a secure “window” into organisational systems, and to support our self-care agenda, citizens/patients will be able to view and add their own data and interact with Health and Social care professionals using modern technology. Finally, we are also planning to ensure we share and exchange information with other providers outside of Rotherham.

Integrated digital care records across health, social care and care home requires significant multi-year investment to move organisational processes from traditional paper based systems to electronic systems with a robust shared infrastructure platform. Non-recurrent cost estimates suggest approx. **£15m over 5 years** to meet full regional digital STP aspirations with a further **£0.4m** in the next two years to further integrate the Rotherham Clinical portal between Health and Social care. Potential cash and non-cash benefits would be circa £0.96m.

Further work will be undertaken to fully understand the transformation requirements to inform the 30 June submission.

- **Further Development of our social prescribing service to cover mental health clients and facilitate earlier hospital discharge.** Our national award winning Social Prescribing service was highlighted in the Five year forward View as exceptional practice and we have aspirations to expand the service to support hospital discharge and mental health service. We expect to increase referrals to 2000 per year we expect the cost to be an additional **£0.55m per annum**. Our evaluation shows we should expect further system benefits of £0.55m in savings and significantly improved outcomes.

**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.

- **Urgent and Emergency Care Centre Development with innovative ‘next available clinician staffing model’** which integrates GPs, A&E consultants, highly trained nurses and is not reliant on middle grade medical staff and significantly reduces waiting times. The centre will offer alternative services to 120,000 patients a year. The project requires a new capital build and transformation investment of **£5.5m capital funding** would enable to us to go further, faster in developing the model and would help us to realise system savings of £30m over 10 years. 2017 will see increased provision at the hospital site with the opening of the new integrated centre. The Walk in Centre will no longer be commissioned.

# 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

## 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](mailto: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**



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

### Corporate Priorities

#### Assurance

#### Delivery

#### Quality

#### Safeguarding (including Child Sexual Exploitation\*)

24 National Pledges

6 Better Care Fund Metrics

6 Quality Premium Metrics

7 NHS Ambitions

### Outcomes

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.

## *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.

## 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
<b>Non-elective Inpatient Admissions:</b> <ul style="list-style-type: none"> <li>Finished Consultant Episodes (FCEs): <b>7%</b> reduction</li> <li>Inpatient Spells: <b>11%</b> reduction</li> </ul> <b>A&amp;E Attendance:</b> <ul style="list-style-type: none"> <li>All patients: <b>17%</b> reduction</li> </ul> <p>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:</p> <ul style="list-style-type: none"> <li>By age</li> <li>By level of engagement with SPS</li> </ul>	<b>Non-elective Inpatient Admissions:</b> <ul style="list-style-type: none"> <li>Finished Consultant Episodes (FCEs): <b>19%</b> reduction</li> <li>Inpatient Spells: <b>20%</b> reduction</li> </ul> <b>A&amp;E Attendance:</b> <ul style="list-style-type: none"> <li>All patients: <b>23%</b> reduction</li> </ul> <p>Highlights importance of ensuring SPS is appropriate for patients who are referred</p> <p>Impact of SPS on older (80+) patient's needs to be understood through other measures</p>	<b>Non-elective Inpatient Admissions:</b> <ul style="list-style-type: none"> <li>Finished Consultant Episodes (FCEs): <b>53%</b> reduction</li> <li>Inpatient Spells: <b>51%</b> reduction</li> <li>Bed Days: <b>43%</b> cent reduction</li> </ul> <b>A&amp;E Attendance:</b> <ul style="list-style-type: none"> <li>All patients: <b>35%</b> reduction</li> </ul> <p>Highlights the importance of sustained engagement with VCS services</p>

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. Recognising 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 'Forward View Into Action' set out more specifics.

5 year Forward view	Rotherham CCG Commissioning Plan
<b>5 year ambition on quality</b> (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 <b>prevention</b> 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).
<b>Empowering Patients</b> 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).
<b>Engaging Communities</b> - 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).
<b>A Healthier NHS Workforce</b> – 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.
<b>Support for people with dementia</b> (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.
<b>New Models of Care</b> - 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
<b>A new deal for primary care</b> (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.
<b>5 year ambitions for mental health</b> (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.
<b>Five year ambitions for Cancer – what this might mean for patients</b> (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 months 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<sup>1</sup>, (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<sup>2</sup> and 410 Looked After Children in Rotherham<sup>3</sup>. 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<sup>4</sup>, 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<sup>5</sup>. **The Deprivation Pupil Premium also shows a similar picture with more local pupils (31.8%) eligible than the national average of 28.6%.**

<sup>1</sup> Office for National Statistics population estimates, <http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates>

<sup>2</sup> Department for Education 2015 <https://www.gov.uk/government/collections/statistics-children-in-need>

<sup>3</sup> Department for Education 2015 <https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015>

<sup>4</sup> English Indices of Deprivation 2015 <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

<sup>5</sup> Rotherham JSNA Child Poverty 2015 [http://www.rotherham.gov.uk/jsna/info/23/people/55/children\\_and\\_young\\_people/8](http://www.rotherham.gov.uk/jsna/info/23/people/55/children_and_young_people/8)

**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<sup>6</sup>, 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<sup>7</sup>.

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.

<sup>6</sup> Public Health England NCMP Fingertips Profile Data <http://fingertips.phe.org.uk/profile/national-child-measurement-programme>

<sup>7</sup> 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 everyone's 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](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

*Efficiencies passed on to all providers.* For the last five years and for the foreseeable future, providers have been expected to provide the same services with less funding. For the first time in 2016/17, providers will be given a 3.1% uplift in funding and are then expected to make 2% efficiency savings. This means they will

receive a net increase of 1.1% in absolute terms. When QIPP was introduced in 2011 finding the first 4% efficiency saving was relatively straightforward, and although in 2016/17 the requirement is lower there has inevitably been a build-up of unmet savings in providers as finding each additional annual efficiency saving is increasingly challenging.

### System Wide QIPP

*Efficiencies 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)
<b>SUB TOTAL</b>	<b>(9.60)</b>	<b>(11.48)</b>	<b>(9.21)</b>	<b>(9.27)</b>	<b>(9.40)</b>

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

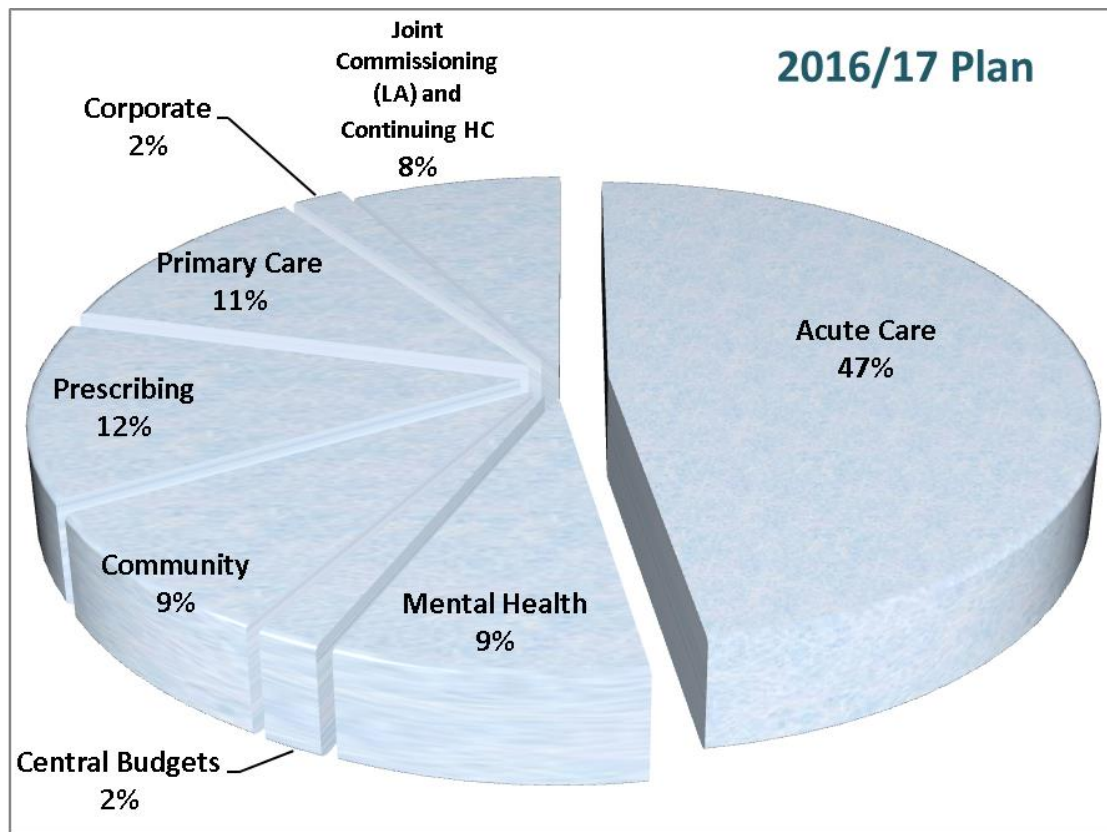
The CCG has approximately £395m to spend in 2016/17. The plan assumes that the required 1% surplus will be made although this presents challenging targets for savings. The assumed growth levels after this are 1.5% and 1.6 % respectively although this is not guaranteed.

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

In Section 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.

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 Government's 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

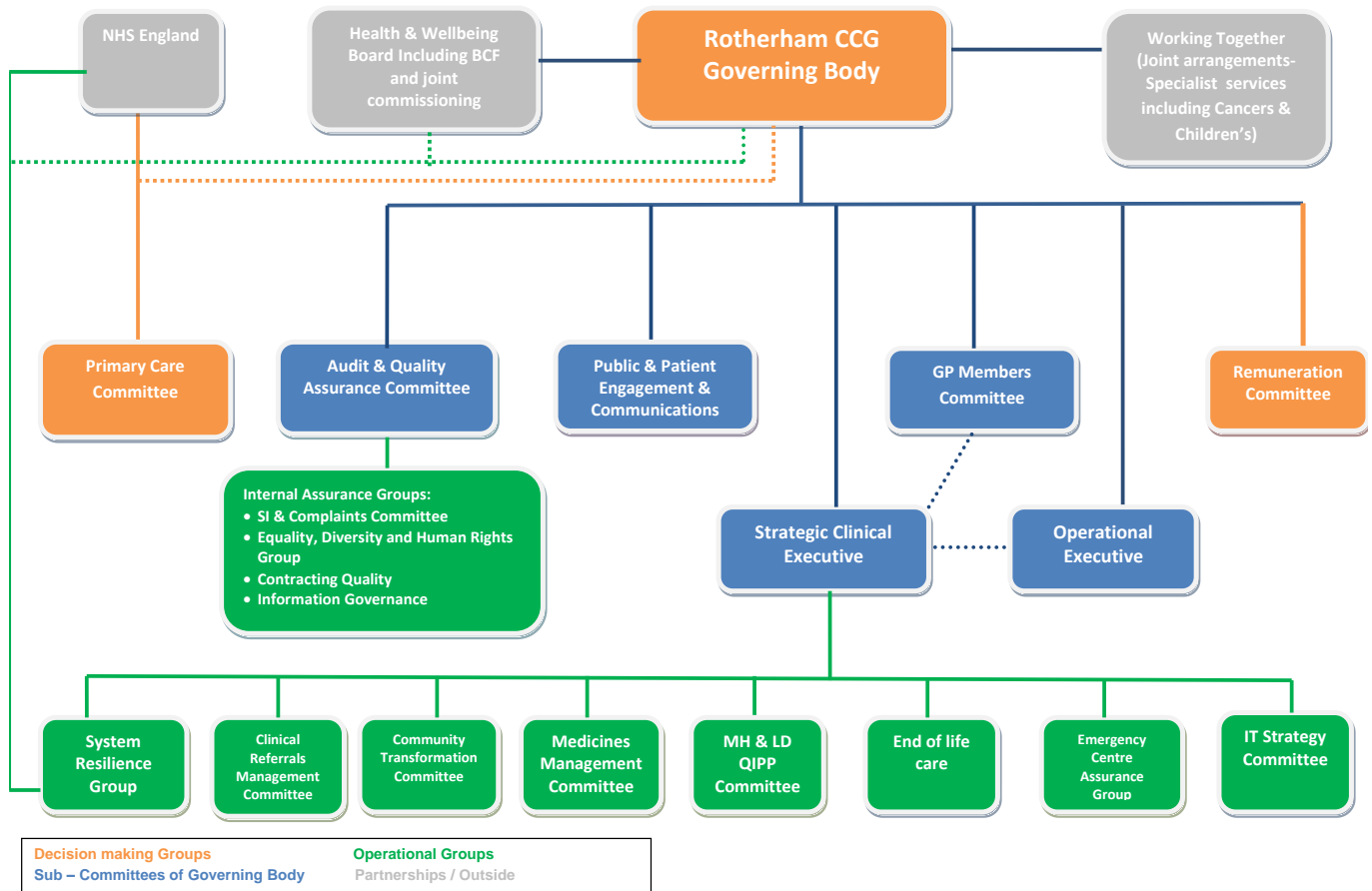
### **Health and Wellbeing (H&WB) Board**

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 1<sup>st</sup> 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 CCG'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 Practitioners, 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.

<p><b>1. Corporate leadership</b></p> <p><i>‘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.</i></p>	<p><b>2. Staff health and wellbeing and community engagement</b></p> <p>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.</p>
<p><b>3. Reducing our internal impact</b></p> <p>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;</p> <ul style="list-style-type: none"> <li><b>a. Energy Management</b></li> <li><b>b. Travel Reduction &amp; Greener Travel</b></li> <li><b>c. Material management and the waste hierarchy.</b></li> </ul>	
<p><b>4. Sustainable commissioning and procurement</b></p> <p>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.</p>	

## 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 13<sup>th</sup> 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 31<sup>st</sup> 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 <ul style="list-style-type: none"> <li>Connect GP practices to TRFT WAN</li> </ul>
Clinical System Interoperability <ul style="list-style-type: none"> <li>EMIS Web and TPP Interoperability</li> </ul>
GP Practice Systems Optimisation <ul style="list-style-type: none"> <li>Paper-light status</li> <li>GP Practice system optimisation programme</li> <li>Digitisation of Referral Forms</li> <li>GP IT Training</li> </ul>

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:



<b>New Priorities identified</b>
Community Pharmacy access to patient summary information (SCR, Clinical Portal)
GP Trainee Assessment
GP Practice Systems Optimisation <ul style="list-style-type: none"> <li>• Medicine screening tools</li> <li>• e-Consultations</li> <li>• Video Consultations</li> <li>• Patient Electronic Health Monitoring</li> <li>• Clinical System User Groups</li> </ul>
Clinical System Interoperability <ul style="list-style-type: none"> <li>• Clinical Portal Development (Safeguarding, end of life)</li> <li>• Patient Portal</li> </ul>

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

<b>National Projects</b>
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'

### E V A L U A T I O N & M O N I T O R I N G

#### 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**

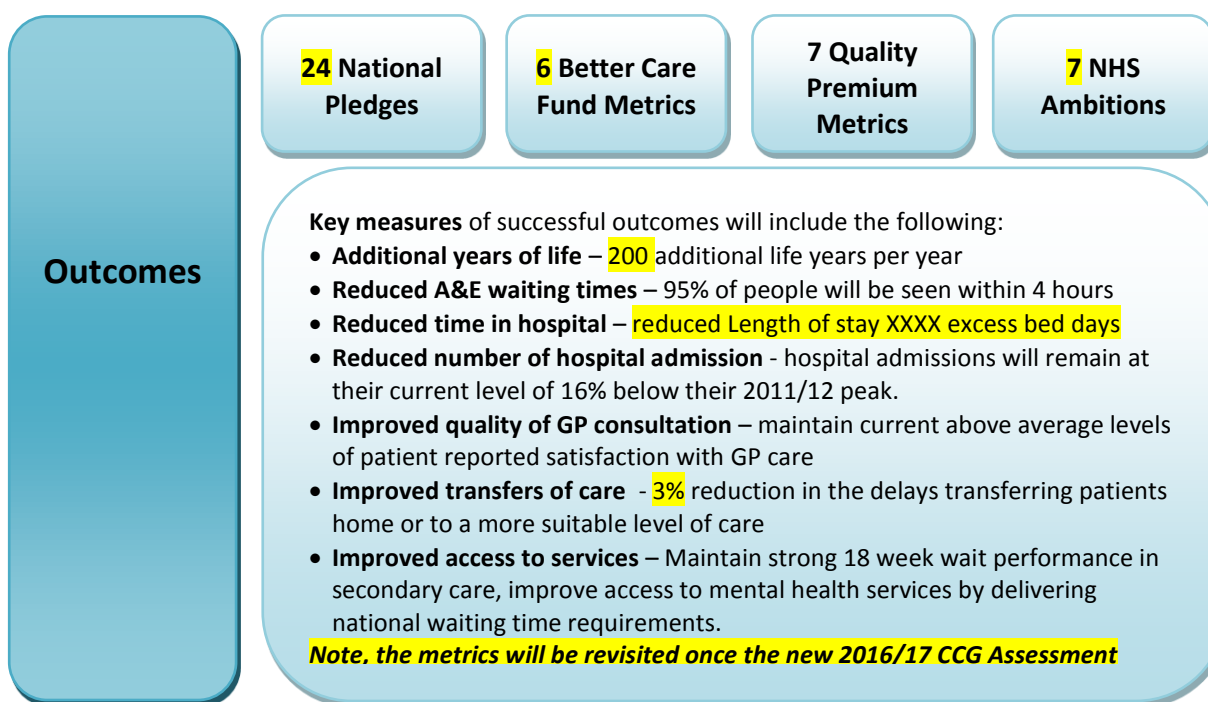
### 15.1 Outcomes

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:



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 6<sup>th</sup> 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%)

**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 policies. 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 summarising 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 financial 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](mailto: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*



## 18 Glossary

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



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