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

Rotherham's Integrated Health and Social Care Place Plan

2016-2020 V6.1 18 05 16 DRAFT

Part Two

Your life, Your health

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

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

Please note that the following applies to this version:

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

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

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20.1 CCG Commissioned Primary Care

Lead GP	Jason Page
Executive Lead	Chris Edwards
Lead Officer	Jacqui Tuffnell
Key Meeting	Primary Care Committee

5 year Strategic Direction and key priorities

The CCG received delegated responsibility for commissioning all general practice services on 1 April 2015. NHS England continues to commission pharmacy, optometry and dental services and we continue to work with them on these areas. The responsibility for GP workforce planning is now part of CCG responsibilities, but the maintenance of the Performers List and GP Accreditation and validation still remain with NHS England. Since taking responsibility, the CCG has developed an interim GP strategy, the full version is at the end of this section.

The CCGs approach to GP quality is described in Section 6.1. The CCG's IT strategy is important in supporting general practice and this is described in Section 10.

The CCG is working with practices to transform services over the next five years to achieve the following key outcomes:

- Improved consistency in access to general practice – aspiring to within 24 hours for an urgent appointment and within 5 days for routine appointments
- A combined, collaborative workforce across primary, secondary and community care providing a seamless pathway for patients with GPs as the linchpin for care
- Patients able to self manage their conditions from home utilising technology to connect with healthcare professionals
- 200 additional years of life
- All patients will be able to access equivalent services
- We will increase the wider workforce within general practice to improve consistency in patient experience

The interim strategy describes the 10 key strategic aims for general practice which have been devised from engagement events with patients, carers and clinicians:

- Quality Driven Services – benchmarking to ensure all services are high quality and sustainable
- Services as local as possible – developing new ways of managing patients and providing care closer to home
- Equality of service provision – ensuring equity of service provision across Rotherham and therefore equality of access for patients.
- Increasing appropriate capacity and capability – ensuring a sustainable, well trained workforce
- Primary care access arrangements – ensuring services meet demand
- New models of care – collaborating to deliver equity and sufficient capacity and capability
- Self care – empowering patients to have confidence to manage their condition(s)
- Robust performance management – to support practices to improve and ensure consistency
- Continued improvements to medicines management – 6 service redesign projects to improve prescribing
- Engaging patients to ensure patient pathways are optimised – empowering Patient Participation Groups

Progress made in 2015/16

Since taking on delegated commissioning good progress has been made on devising and implementing the GP strategy. The following actions have been taken to date:

- A Primary Care Committee has been established to govern primary care (GP) commissioning. The

committee is chaired by a Lay Member with specific responsibility for primary care with a further lay member and officers of the CCG providing a decision making role. The committee also has GP, NHS England, Health and Wellbeing Board and Healthwatch representatives. The committee meets in public on a monthly basis and papers for each meeting are uploaded onto the CCG website 7 days prior to the meeting. Since April, the committee has approved the following actions:

- An interim strategy for General Practice – setting the direction of travel for general practice in Rotherham
- Merger of Brinsworth and Surgery of Light practices – these are now known as Brinsworth and Whiston medical practices
- Approved the merger of Thrybergh and Magna practices
- A managed dispersal of Chantry bridge patients following a re-procurement exercise
- Approval to proceed with the building of new healthcare premises on the Waverley site
- Reprocurement of the current Gateway services provided from 3 practices: The Gate, Rosehill and Canklow
- Rotherham Strategic Estates plan
- General Practice Workforce plan
- Practices have also actively engaged in the extension of services to bring them closer to home:
  - Minor dermatology procedures
  - Joint injections
  - Phlebotomy
- The CCG has also supported the active alignment of GP Practices to their nearest Care Home which should be completed by 31st March 2016 . There are approximately 1500 patients in care homes and these are some of the most vulnerable patients. The alignment is anticipated to improve the care for these patients by improving communication between practices and care homes. In 2016-17 we will build on this alignment by putting in place a new enhanced service for care homes which will offer a proactive service for these patients.
- A practice dashboard has been developed to focus the primary care committee on the key quality and contracting areas and also support practices with the provision of benchmarking information on areas such as workforce.
- A waste campaign has commenced with focus on medication reviews and repeat prescribing
- Commenced a review of available technology to support patients to self care
- Working on a pilot of Saturday opening for routine appointments to support patients who struggle to attend weekday appointments
- Continued progress has also been made in the following areas:
  1. A Local Incentive Scheme (LIS) to ensure the CCG has GP engagement/member engagement into the commissioning and quality agenda.
  2. This scheme commissions GP commissioning audits; a prescribing incentive scheme to ensure that GPs prioritise both high quality and cost effective prescribing and time for GPs (in addition to the 8 Executive GPs) to take part in commissioning. GPs continue to be well engaged with all practices taking part.
  3. A Secondary to Primary Care Local Enhanced Service (LES) to enable care to be moved out of a hospital setting and into primary care and deliver our clinical referrals efficiency plans (section 5.2). Currently, this includes post operative wound management, the management of people with prostate specific antigen and anticoagulation, but there are proposals for other areas to be included as part of a managed shift of the management of follow ups from secondary to primary care
  4. The Long Term Conditions Case Management LES to improve the care of 12,000 patients at risk of readmission to hospital, which is key to our unscheduled care efficiency plan (see also section 5.1). This service will continue to focus upon those patients (up to 5% of the practice list size) who have been identified as being at the highest risk of admission to hospital either via the risk stratification tool or clinical judgement. In 2014, the CCG also responded to the national planning guidance and added an additional component to provide an annual health review for those 20,000 patients over the age of 75. It is planned to continue with this initiative. The funding for this scheme was made

recurrent and the uptake of the scheme is now close to the maximum level.

5. CCG commissioned Locally Enhanced Services with GPs on an annual basis. The CCG will review its LES to ensure they are still fit for purpose.
6. CCG commissioned LES with optometrists. In 2016/17 the CCG will continue to commission two LES; for cataracts and the detection of intraocular hypertension. These are intended to reduce the number of people who need to see hospital specialists. CCG pharmacy LES's for minor ailments and palliative care.

In 2016/17 spend in this area includes £0.6 million for the LIS and £1.2 million for the Case Management LES, plus funding for the CCG commissioned LESs.

Plans for 2016/17 and 2017/18

Review of capacity and demand and proposals to support practices to meet rising demand

- Reviewing telephone infrastructure and ensuring it is fit for purpose to meet demand and facilitate increased telephone consultations
- Working with practices to implement new workforce models
- An agreed funded transfer of some outpatient services from hospital to general practice if appropriate

Optimising care pathways to enable patients to remain out of hospital

- Improved management in primary care of patients with Type 2 diabetes
- Reviewing opportunities for delivering care pathways within the community

Implementing education and technology to enable patients to self care

- Promoting use of the minor ailment scheme
- Supporting patients by providing more information about their condition and opportunities to discuss issues e.g. condition 'cafes'
- Piloting the use of telehealth – which enables patients to test themselves at home e.g. blood pressure monitoring and text their result to the practice who would then take action if the result is out of range

Review of current reimbursement arrangements eg. Quality and Outcomes Framework to ensure that they meet the needs of Rotherham patients

Progress the Community Provider Model

- Continued high quality engagement with member practices to enable us to deliver our QIPP plans via the Commissioning LIS.
- Continued case management of people at risk of hospital admission

Quality Improvements

Care home alignment- the rationalisation of practices to care homes will improve communication between homes and practices and provide the basis for care to be delivered in an efficient and proactive way.

- The CCGs approach to primary care quality including peer visits, supporting protected learning time and practice manager meetings is described in Section 6.1.
  The secondary to primary care LES will allow patients to be treated locally at their GP practice. Examples are shown below:
- Minor dermatology procedures and joint injections are now being provided by the majority of GP practices minimising the requirement to attend hospital for these procedures.

The CCG is working with GPs to develop quality standards in relation to primary care to ensure that quality improvement is continuous and a focus within all practices.
Phlebotomy is now part of the CCG secondary to primary care LES and therefore GP bloods are now required to be provided by the practice or sub-contracted to be provided on behalf of each practice within 24 hours for urgent bloods and within 5 working days for routine bloods.

The CCG is working with practices to review their workforce and develop a sustainable workforce by using clinical pharmacists to support medication reviews, manage patients with complicated long term conditions and provide quality review of prescribing across practices. The CCG also supports the development of Healthcare Assistant roles and facilitating the training places for new roles in primary care e.g. Associate Practitioners as it is acknowledged that there will be insufficient nurses as well as GPs to deliver in future.

Innovation

Self care technology – We are piloting a system to enable patients to self test and notify practices of their results to enable patients to self manage their conditions and reduce the requirement for patients to attend practices. This is particularly helpful for working patients and those away from home for long periods.

Telephone infrastructure – Work is taking place to improve patient telephone access to practices by ensuring there is sufficient line and capacity to manage initial calls and the scope for telephone consultations.

Primary care dashboard – Rotherham CCG has internally developed a dashboard to bring together publically available data in relation to general practice to benchmark and support practice improvements

Alignment with the strategic aims of the Health & Wellbeing Strategy

The GP strategy aligns with the health and wellbeing strategy as it plans the following:

- Greater collaboration with public health colleagues in relation to prevention
- Optimising pathways to improve life expectancy
- Community provider model to not only focus on those who are unwell but keeping communities well

How will health inequalities be addressed

- Ensuring universal coverage of service provision by increasing the 'basket' of services which are required not a choice of practices.
- Case management- promotes prevention, early intervention and self-care and is undertaken by all practices. Patients are selected by clinical need and this is linked to social prescribing which addresses health inequalities.
- Care home alignment- Covers all care homes for elderly and EMI (Elderly Mentally Impaired)
- Local Enhanced services are reviewed and either decommissioned or rolled out to ensure universal coverage
- Closer working with public health to prevent ill health

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

We receive feedback on primary services through a number of mechanisms; through the Friends and Family Test, through the PPGs and the PPG Network, via Healthwatch Rotherham, and individually raised issues at community meetings and events.

The primary care team have engaged patients and carers via the Healthy balance event in June 2015 and through the Rotherham Patient Participation Group Network. A further primary care specific event took place in November to provide a more in-depth opportunity to participate in planning the delivery of the strategy alongside ensuring we are meeting the needs of patients.

Each of the local enhanced services now has an element of patient feedback built in and this is planned for when any new services are considered.

20.2 Unscheduled Care

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

Why is this a strategic priority?

Historically, the Rotherham health community has been an outlier for emergency admissions to hospital. This is not fully explained by the higher than average levels of morbidity and there is evidence that individual clinicians involved in hospital admissions such as GPs, ambulance staff, and accident and emergency doctors have different thresholds for admission. Whilst hospital admission may seem like the safest and easiest way of dealing with an emergency, for many people high quality care at home or in a community setting is a better, safer option.

A corner stone of our strategy is to commission alternative services to hospital admission, and to treat people with the same needs more consistently and deal with more problems by offering care at home or close to home. There are important links between this area and our plans to improve community services such as further developing the Care Co-ordination Centre and providing alternative levels of care (see Section 21.3). The Better Care Fund is described in section 21.13

In 2015/16, the CCG spent £59.3 million on unscheduled care. Planned spend for 2016/17 is £60.1 million.

5 year Strategic Direction

Managing Acute Emergency Care:

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

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

Managing out of Hospital Urgent Care:

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

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

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

We will strive to commission a system that supports patients to return home safely through our supported discharge pathways. We will work with local stakeholders to develop more integrated, responsive and co-ordinated care pathways. We will work with local providers to ensure that where appropriate and secure, we can have IT systems that help health professionals to share information in a manner that supports care pathways and upholds patient confidentiality.

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

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

Progress made in 2015/16

During 2015/16 demand for Accident & Emergency Services in Rotherham has slightly reduced overall, however there have been some significant periods of volatility with unprecedented high levels of demand in short periods of time. This has culminated in some extremely challenging times for the management of the unscheduled care system in Rotherham. 2015/16 has also seen an increase in emergency admissions of 1.5%. Specific progress has been made in the following areas to meet demand in the urgent care system:

- £12m Emergency Centre development on track to be delivered to plan by Spring 2017
- Further Enhancement of the **Care Co-ordination** centre allowing 24/7 day working
- Further Enhancement of the Case Management Programme.
- Clinically led patient level audits of emergency admissions on patients in the over 70s through both A&E and the Medical Assessment Unit**.** Action plans have been developed and will be implemented between the System Resilience Group and Clinical Referrals Management Committee.
- Support the implementation of year 2 of the transformation programme which focuses on the transformation of unscheduled healthcare services in Rotherham through the achievement of three key aims:
    - Achievement of the 4 hour A&E quality standard
    - Reduction in the acute bed base
    - Reduction in the number of emergency admissions
- Development of plans to extend and reconfigure the current medical assessment unit to provide enhanced ambulatory care, recruitment of additional consultants to meet the clinical standards for seven day working and ensuring seven day availability and development of frail and elderly pathways to avoid unnecessary emergency admissions for this cohort of patients.
- Investment of £3.1m in 2015-16 to further progress on the implementation of the seven day working agenda.

Plans for 2016/17 and 2017/18

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

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

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

Priority 1: Emergency and Urgent Care

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

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

The key outcomes associated with this priority are;
- Increase in the number of patients seen by the GP in A&E service
- Reduction in admissions of patients > 65 years
- Increase in the number of ambulatory patients

Priority 2: Structured Management of Acute Bed Base
- Aspiring to be a Perfect Ward, which will operate robust systems of discharge planning and patient flow
- A clear system for management of long stay patients
- Developing coherent system for managing outliers
- Introducing weekend working for consultants on medical wards and the Medical Assessment
- Site coordination service becoming fully operational, acting as a hub for managing patient flow
- Expanding role of the Care Coordination Centre so that it manages the interface between acute and community
- Consider the use of the Care Co-ordination Centre for other Health and Social Care services
- Continue to commission acute alcohol services to reduce alcohol related emergency admissions.
- Continue to focus improvements for adult and older people's mental health services

How are we going to achieve our intentions?

In May 2014 as a result of the national drive, NHS England determined that all CCGs should establish a system resilience group (SRG) to oversee the delivery of A&E performance, urgent and emergency care efficiency programmes and delivery of the 18 week referral to treatment standard. The SRG meets every four weeks and is attended by the CCG urgent care GP lead, chief officer, two further GPs (one acting also as LMC representative), senior representatives from TRFT, RMBC, Care UK, YAS and RMBC Consultant in Public Health. The SRG reports to the CCG Strategic Clinical Executive (SCE) and the Health & Well Being Board.

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

Quality Improvements

Reduce unnecessary hospital attendances and admission ensure right place right times.
- **GP led integrated care: Self care:** we will support patients to take more control over their condition and management. Key elements of support are through the GP case management and social prescribing projects described below and by our continuing care services described in section 21.10. **Case management** is made up of several projects: the **risk stratification** project enables accurate identification of people at increased risk of hospital admissions so that care can be tailored to individual needs to help avoid hospitalisation. The **GP case management** project funds additional clinical time in primary care to case manage patients at highest risk of hospital admission (as identified by the risk stratification tool). In 2015 the risk tool will be reviewed and resources targeted at the most complex patients and those most at risk of admission. Community nursing and social workers are refocused to provide input into patient reviews. There is a direct link with the **social prescribing** project where care co-ordinators refer people with non-clinical support needs to a wide range of voluntary and community sector providers to help patients manage their own conditions. The care coordination centre, alternative levels of care and falls prevention link with social prescribing and the case management programme.
- Better quality community nursing services which offer 7 day services including during the out of hours period will reduce overall and weekend mortality rates
- **Enhanced care co-ordination centre:** Rotherham **care coordination centre** introduced in November 2012 provides a single access point to health professionals so that they can make informed choices about the most appropriate levels of care for patients.
- **Emergency Centre;** this is a full redesign of emergency and urgent care services which will ensure that

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

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

Innovation

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

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

Alignment with the strategic aims of the Health & Wellbeing Strategy

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

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

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

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

20.3 Transforming Community Services

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

Why is this a strategic priority?
The majority of this section describes the important projects that the CCG is leading to transform the services provided by Rotherham NHS Foundation Trust's (TRFT). The CCG also makes important investments in community services from other providers, such as the Walk in Centre (Care UK), Rotherham Hospice (see section 21.11), general practice for example the case management programme (see section 21.2) and the voluntary sector including the award winning social prescribing scheme (see section 21.2). The table shows the spending profile of services commissioned to support vulnerable patients in their own home from TRFT. Some of the services are jointly commissioned through the Better care Fund (see section 21.13) **Table 1: Spending Profile for Community Services**

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

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

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

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

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

5 year Strategic Direction and key priorities

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

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

Progress made in 2015/16

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

A Better Community Nursing Service

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

Integrating Services

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

An Enhanced Care Coordination Centre (CCC)

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

Utilisation of Alternative Levels of Care

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

Plans for 2016/17 and 2017/18

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

1: Prevention of Admission and Discharge Pathways

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

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

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

The key outcomes associated with this priority are:

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

2. Integration of Acute and Community Care Pathways

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

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

The key outcomes associated with this priority are:

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

How are we going to achieve our intentions?

The Community Transformation Board has been working on four key initiatives which will be fully operational within the life of this commissioning plan. These initiatives will deliver the vision for a community health service that prevents admission and supports hospital discharge. The new service model will be future proof, meeting the demographic challenges faced by the local health economy. It will support primary care in the case management of people with long term conditions and deliver a sustainable health service outside the boundaries of hospital care. Figure 1 describes the four initiatives on community transformation

Figure 1: Summary of Key Initiatives

A Better Quality Community Nursing Service

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

Supported Discharge and Admission Prevention

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

An Enhanced Care Coordination Centre

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

An Integrated Out of Hours Service

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

Quality Improvements

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

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

Innovation

There are significant areas of innovation within Rotherham's current community services strategy.

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

20.4 Ambulance and Patient Transport Services

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

Why is this a strategic priority?
NHS Rotherham CCG is committed to commissioning an effective 999 service which will: • Respond quickly to a patient with an urgent health care need • Provide alternative advice for patients who do not require ambulance transport • Ensure that the patient is transported to the correct and most cost-effective service We are also committed to delivering a non-urgent Patient Transport Service (PTS) which will: • Ensure that patients are transferred in or out of health services in a timely manner

- Filter out patients who are not housebound and/or can co-ordinate their own transport
- Transport patients to a range of sites for treatment and care

The time taken to pick up 999 patients in Rotherham was consistently below target during 2015/16. We will work with the Yorkshire Ambulance Service (YAS) to improve Red 1 and Red 2 response times so that they hit the target of 75% by the end of 2015/16. We will work with YAS to ensure that paramedics and ambulance crews seek alternatives to A&E when transporting patients. We will establish close links with the Care Coordination Centre so that senior nurses can advise ambulance crews on the most appropriate service destination. Finally we will broaden the range of community facilities that ambulance crews can use when transporting patients.

5 year Strategic Direction and key priorities

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

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

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

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

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

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

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

Progress made in 2015/16

Emergency Ambulance Service

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

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

Commissioners, invested in three schemes were to support reduction in demand; Frequent Callers, Mental Health Triage in EOC and Increased Clinical Advisors in NHS 111. The Frequent Callers projects identifies frequent callers to the service and works with their GP and other health services to ensure their needs are

met in a more appropriate way. Commissioners invested in Mental Health Nurses within the 999 call centre to triage call and refer patients to the most appropriate Mental Health intervention. These initiatives have delivered a reduction in activity and small improvements in performance.

Patient Transport Services

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

We have been working closely with transport providers and staff at the acute trust to ensure the transport for discharge is an integral part of their discharge planning. Therefore ensuring it is undertaken in the most cost effective way and reducing the demand on the more costly on the day discharge transport service. We will commission additional transport support during periods of high demand to ensure the acute trust bed flow is managed efficiently

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

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

Plans for 2016/17 and 2017/18

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

Emergency Ambulance Service

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

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

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

Patient Transport Service

NHS Rotherham CCG will progress the work on the eligibility criteria for Patient Transport to ensure that it continues to target those in need. We will work with GPs and other health professionals to review and re launch the eligibility criteria and promote a better understanding of the costs involved. We will filter out those patients who do not require the service and in so doing deliver significant efficiencies within the contract. We will continue to reduce volumes of patients transported by PTS through rigorous application of the eligibility criteria.

We will evaluate the GP Urgent Transport Pilot currently delivered by UK Event Medical and make a decision

about whether to embed this in the urgent care pathway.

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

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

How are we going to achieve our intentions?

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

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

Quality Improvements

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

A broader range of service destinations for emergency or planned transport services

- Better integration between the ambulance service, primary care and community services
- Transport for patients to the most appropriate care setting

Emergency Ambulance Service

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

Patient Transport Services

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

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

Innovation

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

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

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

Reduction in Conveyance for Falls from Care Homes – The following steps are underway to support the management of falls in care homes so that people are not conveyed by ambulance to hospital when appropriate. The Rotherham Care Home Support Service has developed a system to support all care homes with the necessary interventions and protocol following a fall; immediately following a fall care home staff will contact 111 or an Advanced Medical Practitioner in the first instance. Follow up support for people who have fallen includes a multi-factorial falls assessment, bone density assessment and interventions and exercise regimes to prevent falls. YAS also provide education and advice to care homes to offer alternatives to calling 999 for falls.

Alignment with the strategic aims of the Health & Wellbeing Strategy

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

The Mental Health nurses in the 999 call centre will support the population of Rotherham access the correct mental health services in a timely manner. Reducing the need to attend ED inappropriately. For those patients whom attendance at a care facility is appropriate we have pathways in place to ensure they are transported to the most appropriate acre setting.

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

The hub and spoke approach to patient transport will mean that people with long term conditions can receive treatment in the community, nearer to home. The innovative work with Frequent Callers to the 999 service will ensure that s patients access the most appropriate treatment in a timely manner to improve their patient outcomes.

How will health inequalities be addressed

The nature of commissioning and delivering transport services provides challenges in terms of addressing health inequalities. The eligibility criteria used by providers ensures patients have equitable access to services. We work closely with providers to ensure their service delivery is equitable within the framework of the criteria.

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

We receive some, but limited feedback on both ambulance and patient transport services. Little data is collected through the Friends and Family Test; however some patient feedback is received through Healthwatch, which demonstrates both positive experiences, and some that could be improved.

The joint review of Patient Transport Services will have a strong focus on patient needs. It will require meaningful engagement with patients in order to be clear about the factors which are important to people. We will plan targeted engagement with service users to provide commissioners across South Yorkshire with a clear understanding of current and future requirements for patient transport services to enable us to design and procure an innovative service, planning work on this is due to start in January 2015

20.5 Clinical Referrals

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

Why is this a strategic priority?

The CCG funds hospital inpatient and outpatient services. The objective is to provide the right care at the right time and also to keep costs within affordable limits so that we maintain financial balance and can meet our obligations in other areas. Services planned in advance are called scheduled care. Keeping within affordable limits requires a step change in the efficiency of scheduled care, in some cases we wish to increase scheduled care particularly where more accessible services avoid the need for hospital admission, this includes successful fast track and one stop services. In other areas we are using an educational approach to reduce the need for hospital care by promoting self care, management in general practice and non face to face referrals such as virtual clinics.

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

In 2016/16 the CCG spent £68.1 million on scheduled care. Planned spend for 2016/17 is £66.7 million.

5 year Strategic Direction

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

Building on the successful use of clinical referrals management as a vehicle for change, the CCG will continue to develop the most appropriate and efficient clinical management of patients whose condition requires elective referral to hospital or result in emergency admission or assessment. The objective is to provide the right care at the right time and also to keep costs within affordable limits so that we maintain financial balance and can meet our obligations in other areas. Keeping within affordable limits requires a step change in the efficiency of elective care particularly where more accessible services avoid the need for hospital attendance and admission; this includes the development of one stop services and the development of new ways of working/pathways.

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

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

Progress made in 2015/16

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

Committee.

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

1. Focus on the follow up reduction programme with The Rotherham Foundation Trust where contracted ratios at peer average have been agreed at which any activity over these levels will not be financially supported. The programme includes the managed transfer of a proportion of follow ups into Primary Care;
2. Continuation of the haematology virtual clinic,
3. Development and implementation of an IV Therapy pathway to manage patients within the community who require IV antibiotics and other medication to prevent the need for admission to hospital or to allow earlier discharge from hospital.
4. Successful transfer of anticoagulation management to Primary Care for stable patients.
5. Continued educational approach taken with GP Practices through the use of top tips advice and targeted support to those GP Practices with the highest referral rates for non-elective and elective pathways.
6. Embedding the outcomes of joint clinical audits to support The Rotherham Foundation Trust to change clinical practice through increased support for Junior Doctors when making discharge decisions, reductions in Consultant to Consultant referrals and encouraging clinicians to look at alternative methods of delivery to reduce follow up appointment and emergency admissions.
7. Development and implementation of a prior approval process applicable to particular procedures within certain specialities. Exceptional cases/procedures included tonsillectomy, grommets, varicose veins and hysterectomy for heavy menstrual bleeding which are recognised procedures of limited clinical value (PLCV).
8. In order to improve outcomes for people with Diabetes and to increase and standardize quality of care, RCCG has looked at a number of best practices which have evolved nationally and which indicate what good diabetes care looks like. The RCCG has decided to base the Rotherham Diabetes Care model around the Portsmouth care model which focuses around “super six” care.

Plans for 2016/17 and 2017/18

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

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

The proposed 2016/17 changes in activity are, we plan 1% growth in outpatient firsts in line with the assumed forecast outturn for 2015/16, and we plan to increase non-elective admissions by 0.3%.

Key priorities will include:

1. Referral analysis, alternative ways of working and two way communication with all clinicians
    a. Monthly programme of clinical audits concentrating on the specialities and modes of referral that are experiencing most growth.
    b. Specialty specific discussion of areas identified by benchmarking or changing trends.
    c. GP communication/education; bite size newsletter, protected learning time, top tips, GP peer led visits.
    d. Communication with TRFT clinicians
    e. Extension of one stop services and virtual clinics
2. Care Pathways (including some with System Resilience Group and Mental Health QIPP Committee)
    a. Priority areas to be jointly agreed
3. Explore long term potential for radical changes to specific elective pathways

a. Explore different models of delivery for specific pathways, possible examples being single point of access for MSK/Physio/T&O, diabetes and pain services.
b. In order to improve outcomes for people with Diabetes and to increase and standardize quality of care, RCCG has looked at a number of best practices which have evolved nationally and which indicate what good diabetes care looks like. The RCCG has decided to base the Rotherham Diabetes Care model around the Portsmouth care model which focuses around "super six" care.

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

How are we going to achieve our intentions?

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

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

Several of the workstreams particularly those on care pathways interact with unscheduled care, medicines management and mental health QIPP.

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

	Committee)	
6	**Safe effective non face to face 'referrals'**	1. Review of current virtual Haematology and consideration of extension to other specialties, e.g. Fracture clinic and thyroid virtual clinics 2. Explore ways of making it much easier for GPs and consultants to communicate speedily with each other including the best electronic and management systems to make this possible and ways of funding consultants to provide more advice and less face to face contacts
7	**Explore long term potential for radical changes to specific elective pathways**	Explore the market with regard to the possibility of some elective pathways being provided by providers using GP expertise and funded outside of PBR mechanisms. Possible examples to be explored are year of care funding for diabetes or alternative ways of providing some neurology, dermatology, heart failure, cardiology, orthopaedics and pain services.
8	**Consider restricting some services to keep activity within affordable levels**	On page 11 we set out a list of 'least worst' options for restricting services that we will consider if non-elective and elective activity does not keep within affordable levels. We will discuss these options further with patients, clinicians and stakeholders before deciding.

Quality Improvements

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

Innovation

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

We are also working to develop a Diabetes Care Model with an emphasis on care closer to home which should be ready for implementation by 2017. Significant work has taken place in year in relation to the diabetes pathway, following the Super Six Model, to improve outcomes for Rotherham population and is now at consultation stage. We anticipate implementation in 2016/17

Alignment with the strategic aims of the Health & Wellbeing Strategy

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

How will health inequalities be addressed

We will reduce unnecessary variation between practices by benchmarking with reference to the burden of diagnosed ill health and carry out dialogue to understand the causes of high and low referral rates, emergency admissions rates and utilisation of diagnostics.

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

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

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

When we make substantial service re-designs we will ensure that providers and the CCG have involved patients in the initial decision making and subsequent evaluation, and that we consult with or inform patients

as appropriate, and in line with national guidance and best practice.

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

20.6 Medicines Management

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

Why is this a strategic priority?

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

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

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

The CCG's track record on effective medicines management is very strong. Prescribing costs\capita compares favourably to neighbouring CCGs and with CCGs with similar demographics. There are two prescribing incentive schemes, one that rewards practices for cost effective prescribing and one that rewards practices for achieving a range of prescribing quality targets. In 2015/16 Rotherham has experienced very strong prescribing cost growth this is linked to a strong growth in prescribing volume. Initiatives will be launched in 2016/17 to contain this cost growth and reduce medicines waste.
The Medicines Management team have for the past four years produced a range of practice key prescribing indicators, these are a series of prescribing interventions proven to reduce mortality and or hospital admissions. Practices are benchmarked against each other and any areas of concern addressed via the annual practice prescribing action plan and practice quality visits.

In 2016/17 the CCG will spend £48 million on prescriptions and on commissioned services (nutrition, continence and wound care). The 2016/17 uplift was 2.5% net of efficiency savings. This is less than the expected drug price inflation so in order to continue increasing benefits to patients the CCG will have to continue to deliver substantial efficiency savings.

5 year Strategic Direction

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

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

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

1. Nutritional Supplements
2. Nutritional Gluten Free and Specialist Feeds
3. Wound Care
4. Stoma Care
5. Continence
6. Oxygen

	Workstream	Project
1	**Cost efficiency programmes**	• A prescribing QIPP plan will operate throughout the financial year to help manage and contain prescribing cost growth. • A limited range of branded generic preparations will be introduced during 2016/17 • The medicines management team (MMT) working with TRFT has introduced the Blueteq web bases process for managing the prescribing of "drugs outside of tariff" • The CCG completed a procurement for the direct purchase and supply of wound care products. This scheme will be rolled-out across all of Rotherham by April 2016.. Compliance rates with the wound care fromaulry are between 95-97% ▪ Wound care products to be available whenever the patient requires them ▪ Encourage evidence base wound care management ▪ Increase District Nurse Patient contact time ▪ Facilitate discharge into the community ▪ Contain wound care prescribing costs • The CCG has launched a prescribing waste scheme direct to the public in collaboration February 2015. The learning from this scheme is being incorporated into the medicines management work plan for 2016-17 • Further patient engagement exercises are planned for 2016/17
2	**Performance Benchmarking**	Financial and quality benchmarking against other CCGs using RDTC and PRESCQIPP data.
3	**Key Prescribing Indicators**	Monitoring and helping practices to improve performance on a series of 14 evidenced based prescribing interventions. Additional Prescribing Key Performance Indicators are being developed The CCG intends to continue the current prescribing incentive scheme which rewards practices for improving the quality of their prescribing and also for cost effective prescribing.
4	**Prescribing Guidelines**	Key priorities include supporting practices with the implications of the NICE guidance on atrial fibrillation and lipid management
5	**RDASH prescribing pathways and share care agreements**.	• Dementia prescribing pathway. • Better prescribing for Attention Deficit Hyperactivity Disorder • Addressing antidepressant prescribing in the community. • Ensure shared care protocols are in place and adhered too.

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

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

Progress made in 2015/16

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

- A medicines waste campaign has recently been launched.
- Scheme to introduce practice pharmacists

Plans for 2016/17 and 2017/18

As above note:

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

How are we going to achieve our intentions?

Medicines management is overseen by the fortnightly medicines management committee (MMC) which is attended by two GPs, the CCG's medicines management team. The MMC reports to the multi-agency system resilience group. Joint prescribing agreements with local partners are agreed at the area prescribing committee (APC). Seven medicine management workstreams are listed later in this section, they divide into two overall approaches:

Working with all 33 GP practices.

An SCE GP and the CCG's medicines management team work with all 33 practices to advise on best practice, produce and disseminate guidance, produce benchmarking reports. Quality and efficiency outcomes and good practice are incentivised through the CCG Local Incentive Scheme (LIS). Currently the CCG medicines management team receives very positive feedback from member practices and the strength of relationships is resulting in above expected efficiency savings in 2016/7.

Quality Improvements

- The Key Prescribing Indicators are evidenced based interventions that improve mortality or reduce hospital admissions. Practices are benchmarked against each other to encourage practices that appear to perform less well to examine the relevant area.
- Improving the quality of each practices prescribing through annual prescribing efficiency plan.
- Monitoring and advising practices on NICE guidance and national safety alerts.
- Evidence that the waste campaign has been effective.
- The antibiotic quality premium has been achieved.
- Completion of the wound care direct purchase scheme. This project improves patient experience by identifying significant unmet need, it has improved timely access to dressings for patients and decreased the time spent by nurses obtaining dressings via prescriptions.
- The nutrition, continence, stoma and oxygen projects continue to work with their patient service user groups to improve the customer focus of the service.

Innovation

- The six service redesign projects are award winning examples that have improved service provision and addressed unmet need as well as resulting in substantial cost savings.
- The nutritional, continence and wound care procurements have created unique commercial partnerships that have released further efficiencies.
- Rotherham has an innovative practice budget setting mechanism, that ensures practice prescribing budgets are equitable. This is utilised by the prescribing incentive scheme to stimulate cost effective prescribing.
- The medicines waste campaign focused on obtaining the patients experience and seeing waste from the patient's experience. The campaign is designed to gather intelligence as to why waste occurs and as a result a range of bespoke interventions will be implemented to address these issues.
- The CCGs Medicines management Team will work with practices to help recruit mentor and train pharmacists to work directly in practices to address the potential workforce issues going forward due to GP retirements.

Alignment with the strategic aims of the Health & Wellbeing Strategy
Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing **-** The key prescribing indicators which are actively monitored and incorporated into the practices prescribing action plans. These indicators are based a series of prescribing interventions proven to improve mortality reduce hospital admissions.
How will health inequalities be addressed
• The Key Prescribing Performance indicators promote the equal access to key medications that are vital for long term condition management by reducing variations between individual practices. • The service redesign projects ensures that there is equity in the provision of the redesigned services across Rotherham • Practice prescribing budgets incorporate deprivation into the budget setting mechanisms, therefore practices with a relative high deprivation scores are not penalised financially.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
An extensive patient engagement exercise was undertaken in designing the medicines waste campaign. It is intended that this level of patient engagement will continue to discuss the impact of the campaign and how it should develop. The service redesign projects have all established a patient/service user group provide feedback and inform on future developments. Additional engagement have included: • work with carers of people with mental health problems, to identify areas of concern and solutions; • using links through Rotherham Participation Group Network to disseminate information via community channels

20.7 Mental Health

Lead GP	Russell Brynes - Adults Mental Health including Older People Richard Cullen – Children and Adolescence in Mental Health (CAMHS)
Executive Lead	Ian Atkinson
Lead Officer	Kate Tufnell
Key Meeting	Mental Health / Learning Disability QIPP Group

Why is this a strategic priority?
One in four adults experience mental illness at some point during their lifetime. Mental ill health is the single largest cause of disability in Rotherham. The JSNA shows that the economic downturn is having an adverse effect on people's mental health. Dementia is a particular challenge with the number of cases predicted to increase by more than 50% by 2025. The overarching priority is to deliver 'parity of esteem' - ensuring that people with mental health problems are treated with the same priority and urgency as people with physical health problems. The CCG carried out a fundamental review of mental health services in 2014 which showed there is still some way to go with regards to full delivery of parity of esteem hence the needs for transformation plans described below. The fundamental review showed that Rotherham benchmarks favourably with regards to the overall proportion of the budget that is allocated to mental health. In addition the CCG made £1.5 million of additional recurrent mental health investments in 2014/15, mainly through the Better Care Fund. The CCG will ensure that in 2015/16 its total spend on mental health (with all providers including general practice and the voluntary sector) will grow in line with the CCGs overall allocation increase. In 2014/15 the CCG spent £33.5 million on mental health, planned spend for 2015/16 is £35 million.

5 year Strategic Direction

Children and young people mental health (CAMHS)

The national 'Future in Mind' (2015) strategy for Child and Adolescent mental health services, outlined the government's plans for transforming the 'design and delivery of a local offer of services for children & young people with mental health needs'. The key themes of the report were:

- Promoting resilience, prevention and early intervention.
- Improving access to effective support – a system without tiers.
- Care for the most vulnerable.
- Accountability & transparency.
- Developing the workforce.

The national strategy extends to 2020 and the CCG has developed our CAMHS Local Transformation Plan (LTP) in response, this plan outlines the key priority areas for service development in Rotherham. These are:

- Enhanced Crisis Service
- Enhanced Community Support Service
- ASD Support
- Prevention/Early Intervention
- Family Support
- Workforce Development
- Services for 'Hard to Reach Groups'
- Looked After Children
- Development of services through input from Children & Young People
- Child Sexual Exploitation
- Transition to adult services

These key priority areas were identified in consultation with all stakeholders across Rotherham and in particular from work specifically with children & young people.

Adults and Older people

In 2015 the CCG developed an Adult and Older Peoples Transformation Plan has eight key priorities:

- Improving data, pathways and outcomes
- Improved strategic and partnership working including workforce
- A newly commissioned Adult and Older Peoples Mental Liaison service that will ensure that mental health provision is a central component of the new Rotherham Emergency Care model.
- A more primary care focussed model
- Improved dementia Care pathway
- Improved transfers between RDASH and community services
- Improving access to psychological treatments (IAPT) (6ww and 18ww targets)
- Improved acute and rehabilitation pathway

In addition to the initiatives identified in the Mental Health Transformation plans the CCG will ensure that the following are delivered through the 2015/16 contract.

- Mental Health Choice - working with GPs and providers to ensure that patients are aware of their rights and are offered choice in mental health services and supported to make meaningful choice
- Greater parity for mental health by working to implement the new access and waiting times standards for mental health including psychological treatment waiting time standards and ensuring that by April 2016 50% of Rotherham people experiencing a first episode of psychosis will receive treatment within two weeks.

This will also help the CCG to work with partners to deliver the Crisis Care Concordat (http://www.crisiscareconcordat.org.uk/areas/rotherham/) – improving outcomes for people experiencing a mental health crisis. Working with NHS England and RDASH the CCG will develop health provision for local offenders as part of the NHS England Wave 2 Liaison and Diversion Pilot.

The CCG has commissioned additional support for historic victims of child sexual abuse and will respond further as recommendations emerge from the multiagency needs assessment described in section 6.2.

The first year evaluation of the Acute Alcohol Liaison service showed some success in reducing length of stay as the service develops in 2014/15 we expect to see it start to reduce admissions.

Progress made in 2015/16

CAMHS

During 2015/16 the CCG invested an additional £200k in RDaSH CAMHS services. This included £80k in additional therapy and general capacity, £55k in a CAMHS liaison post, £30k in the out of hours service and £35k in a single point of access (SPA).

The new CAMHS liaison post has worked with TRFT to agree new mental health pathways through A & E and has worked with NHS England on CAMHS Tier 4 step-up and step-down.

The CCG has worked closely with RDaSH on the CAMHS re-configuration which will provide a more locality focus and enhanced SPA and Crisis Response.

Additional general capacity has re-enforced the CAMHS Duty Team and this will further develop as a SPA.

The CCG has forged better links with children & young people (and their families) through interface with the Youth Cabinet and Youth Parliament and indirectly through work with the Rotherham Parents Forum and Healthwatch.

The CCG also worked with RMBC to develop a CAMHS website – www.mymindmatters.org.uk – for Children & Young people, families and professionals. This is regularly updated.

Adult and Older People

Over the last 12 month progress has been made in the implementation of the Adult Transformation plan with key achievements including:

- Dementia Carer resilience Service – established in April 2015 this service is designed to work with GP practices to support those caring for people with dementia. Already this new approach to supporting carers has been successful in being put forward as a regional finalist for the Putting People First / personalisation category of the Great British Care Awards
- Mental Health Social Prescribing - building on the success of the social prescribing programme an additional mental health social prescribing pilot was established in 2015/16. To date **awaiting data people have been referred to the new mental health social prescribing path with ** people successful being discharge from secondary care service.
- Adult Mental Health Liaison (7 day working) and Police Street triage both of which are key parts of the work the CCG is doing with partners to deliver the Crisis Care Concordat within the borough http://www.crisiscareconcordat.org.uk/areas/rotherham/) . In 2016/17 further work will be undertaken to expand this service to include Children and young people to create an all age service More details needed.
- Dementia Diagnosis rates – The CCG currently achieves higher than expected (compared to the expected population diagnostic rate) Dementia Diagnosis rates, in 2016-17 we will continue to build on this positive position as well as work to ensure the delivery of high quality post diagnostic health support.
- Dementia LES – In 2015-16 the CCG developed a Dementia Diagnosis LES, in 2016-17 we will look Work is ongoing to agree the implementation with Primary Care colleagues across the borough with the

expectation that this will be rolled out during 2016/17

- During 2015/16 the CCG worked with RDaSH to ensure the reduction in DNAs across adult services

Plans for 2016/17 and 2017/18

CAMHS

During 2016/17 and 2017/18, work will continue on the key elements of the CAMHS LTP. These area:-

- An enhanced crisis service – which will link to the Adult Liaison service at TRFT in-hours and the Crisis/Access service out of hours. This will also link to the local Crisis Care Concordat and the change by South Yorkshire Police to not detain children or Young people in a police cell.
- An enhanced community support services (Tier 3+) - which will support Children & Young People to either avoid an inpatient admission or step down more quickly back into community services. This will aim to reduce the costs of inpatient activity for Rotherham patients and enable them to remain locally based and supported in the community.
- Enhanced ASD support, particularly family (rather than school) based and will complement the service provided to school by the Autism Communication Team at RMBC. This is a recognised gap in provision.
- Support work with schools (through the CAMHS locality workers) to provide early intervention work. The CAMHS re-configuration identifies specific CAMHS Locality Workers who will link with local schools and support working with mental health issues. This should help to provide more focused early intervention services.
- Further development of a Family Support Service, through the Rotherham Parents Forum. This will focus on supporting families of children with emotional wellbeing and mental health issues before and once they access services. Such work will enable families to cope better with their children's emotional wellbeing and mental health conditions and avoid more severe issues.
- Further ongoing support for Children & Young people affected by CSE. This will supplement the established investment by the CCG.
- Provision of advocacy services for children through Healthwatch. This service previously has been provided on a non-commissioned 'ad-hoc' basis. This work will provide a resilient and ongoing service and enable the voice of children to be heard.
- Ongoing development of the CAMHS website – www.mymindmatters.org.uk – to include potential Apps, self-help elements, training (for professionals, etc.).
- Implementing a CAMHS Transition specification, to ensure that patients have a smooth journey when transitioning from CAMHS to Adult services (including also Learning Disability patients) and undertaking work to ensure how this process can be improved.

Adults and Older People

- Delivery of Adult transformation plan – phase one and two
- Working with partners to ensure the delivery of the Crisis Care Concordat (http://www.crisiscareconcordat.org.uk/areas/rotherham/) across the borough. The aim of which is to Iimprove the outcomes for people experiencing a mental health crisis through the delivery of services / initiatives, such as – Adult Mental Health Liaison Services, improvements in the crisis care pathway, development of crisis care plans etc.
- Improve access and waiting times for both the early intervention in psychosis and IAPT services to ensure the delivery of the national waiting times targets
- Improve the delivery of the Eating disorders pathway by working with colleagues from Doncaster and North Lincolnshire CCG to enhance the current provision.
- Working with colleagues from TRFT, RDaSH, primary care, Voluntary sector and patients to develop a new Perinatal pathway
- Works with primary care and RDaSH to implement the delivery of the Dementia diagnostic local enhanced service (LES)
- SMI registers and physical health
- Support people towards recovery through delivery of the mental health social care pathway.
- Review of existing inpatient provision at Woodlands to ensure that capacity matches demand.

How are we going to achieve our intentions?

The CCG has strategic commissioning forums well established for both CAMHS and Adult Mental Health

Services. This involves CCG clinicians, RDASH and key stakeholders from RMBC and TRFT.

Quality Improvements

CAMHS

Quality improvements link to the plans outlined above and include:-

- More focused and timely response to Children & Young People (C&YP) in Crisis. The Key Performance Indicator (KPI) will be that all C & YP will be seen within 1 hour of presenting in A & E.
- C&YP will be able to be better supported in the community and if they have to be admitted to an inpatient bed, they will be able to be discharged sooner.
- Families will have better support in general when C&YP are entering services and more specific support where their children have ASD.
- Schools, colleges, GP practices and RMBC Early Help centres will have clear direct links to the RDaSH CAMHS service through CAMHS Locality Workers, enabling C&YP to be directed to the most appropriate services for their situation.
- A dedicated advocacy service for C&YP.

Adults and Older Peoples Mental Health Services

- Improve the quality of patient and GPs satisfaction of services (15/16 target)
- Improved patient experience measured by the Friends and Family test
- Increase the number of people moving to recovery 50% of people referred to the mental health social prescribing pathway will be discharged from secondary care services
- Improve access and waiting time for mental health services including Psychological Therapies (IAPT) (15/16 target) replaced with 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral
- Improving the access times for people experiencing a first episode of psychosis replaced with 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral (national target for April 2016)
- Improving the outcomes of care for people experiencing a mental health crisis (15/16 target) replace with either Reduction in the number of patients attending an A&E department for a mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E (2015/16 quality premium) – or could modify this to % of people seen within 1 hour – current local target / or use the new psychiatric liaison target – we are expecting)
- Improve dementia diagnosis rates – 74% now – suggest we replace with post-diagnosis we don't really measure this / I guess we could link to the dementia carer resilience project
- Improve the support to practices and those caring for someone with dementia by ensuring that 100% GP practices will have an allocated GP carers Dementia Link worker
- Improve memory clinic waiting times for diagnosis and treatment – need to review in light of current debate
- improve dementia pathways with a more primary care focus – as above

Innovation

CAMHS

RDaSH have employed a Family Support Worker on a non-recurrent basis, but the commissioning of the Family Support service through the Rotherham Parents Forum is a new approach that will really focus on providing families with practical help, advice and support.

The further development of the liaison and crisis services will be a move closer towards a true 'all-ages' service which will eliminate the need for transition between services.

Adult and Older People

In phase one of the Adult Transformation Plan phase one the CCG has established a number of pilot projects which include:

- Dementia Carer Resilience service
- Mental Health Social Prescribing

- Adult Mental Health Liaison
- Street triage – a project to support South Yorkshire Police

All of the pilots are being externally evaluated by Sheffield Hallam University with the final evaluation reports expected in 2016.

In phase two of the transformation plan work has commenced with partners to develop a new improved gateway into services as well as looking at how the adults and older peoples mental health teams can work to provide a locality focused all age service (Need to check language used here is ok with everyone).

Alignment with the strategic aims of the Health & Wellbeing Strategy

The Rotherham CAMHS LTP aligns with the aims of the Health & Wellbeing Strategy in that it focuses on supporting children through their adolescence and early adulthood, which can be a time when some mental health issues manifest themselves, and provides support to the whole family when dealing with such issues.

Adult and Older People

Aim 3: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life. This will be achieved by improving support for people with enduring mental health needs, including dementia by:

- Helping them live healthier lives through initiatives, such as Dementia Carer Resilience, Mental Health Social Prescribing , supporting RDaSH to go Smoke free and commissioning a model of mental health that promotes recovery
- Reduce the occurrence of common mental health problems , such as providing support, advice and training to people with dementia and their carers, working with RMBC to develop the website mymindmatters.org.uk
- Reduce social isolation through initiatives, such as mental health social prescribing

Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing. This will be achieved for people with mental health problems by:

- Reducing the number of early deaths from cardiovascular disease and cancer by working to improve the access to physical health check for those individual's on the SMI registers
- Improving support for people with long term health ,such as dementia and disability needs to live healthier lives through developments by delivering a recovery model approach to mental health
- Increasing the opportunities for participation in physical activity seen in the recent investment of additional gym equipment on the Swallow nest wards.
- Reducing levels of alcohol-related harm through initiatives, such as the TRFT Alcohol Liaison service
- Reducing levels of tobacco use through initiatives, such as the RDaSH SmokeFree programme launched 1st March 2016

How will health inequalities be addressed

CAMHS

The further development of CAMHS locality workers will ensure that all geographical areas of Rotherham are afforded equal status. A family support service which is independent of the service providers will also help to break down communication barriers with families and ensure that families' voices are heard. The commissioning of a dedicated children's advocacy service will ensure that children who might not otherwise be able to understand their situation and the services that they are supported by, will be better informed.

The overarching aim of the adult mental health transformation plans are to deliver parity of esteem with the expectation that this will also include the delivery of quality physical health services and improve Health outcomes for people with mental health problems. To achieve this the CCG will:

- Work with RDaSH and primary care to align the health promotion data in secondary and primary care databases for patients with severe mental illness. This is an important step in ensuring parity of esteem for health promotion for this patient group so reducing the 20 year gap in life expectancy.
- Using the contract process to ensure that providers comply with the Equality Act 2010, reasonable adjustment standards, autism statutory requirement etc.

- Work with partners to tackle stigma and the inequalities that result from poor mental health, such as lower employment rates, poor housing, education and poorer physical health

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

Patient feedback is received through a number of mechanisms, all are used to inform service plans, and individual issues are addressed wherever possible;

- A low amount though Friends and Family Test (actions are in train to increase this)
- Other data collected by providers
- Directly to the CCG via patients and patient groups, and through engagement events
- Collected by Healthwatch and shared with the CCG
- Issues are raised through the Dementia Forum

CAMHS engagement

Patient engagement was a significant part of the original Emotional Wellbeing & Mental Health Strategy and the CAMHS LTP. The Youth Cabinet were involved in the development of the Strategy, the CAMHS website and LTP and the conclusions of the Youth Parliament report 'Mind The Gap', fed into the LTP. The Health Select Commission scrutinised CAMHS services in April 2015, working closely and informed by young people; the outcomes from this continue to be actioned and to feed into a variety of workstreams. Representatives of the Youth Parliament continue to be part of the Quarterly CAMHS Strategy & Partnership meetings. Non-recurrent funding will be used during 2015/16 to support a 'self-help' conference to be hosted by the Rotherham Youth Cabinet.

Worked with partners and young people to design and establish a young people's mental health website (My Mind Matters).

The Family Support Service will enable constant patient/family engagement and feedback to commissioners and service providers.

Young people have been involved in (visiting/inspecting) inpatient accommodation and suggesting ways that services could better meet the needs of young people. Between January and March 2016 an independent assessment will be undertaken around engagement, which will identify good practice, and areas for improvement. Work with Rotherham Parents Forum and Healthwatch highlighted issues faced by both young people and their families in accessing services, and has also informed a number of workstreams including patient & family engagement, communication and Autism post diagnosis support.

Adult and Older People

Over the past year both the CCG and RDaSH has worked with people with mental health problems, families/carers and other key stakeholder to inform the development of adult services / packages of care and future planning of services, such as:

- Mental health and Learning Disability QIPP Group
- Extensive engagement from summer 2015 to Jan 2016, led by RDaSH, and including all stakeholders, focused on and informing transformational change; this pre-consultation work will inform a subsequent consultation on service changes during 2016.

Carers have told us (PPG Network and dedicated workshop) about the issues in caring for people with mental health problems, and in particular people with dementia; this has informed the Carer's Resilience Project.

We have worked with medicines management in listening to the concerns of carers of people with enduring mental health problems, and ways that these issues could be addressed.
We have commissioned REMA to explore Access to Mental Health Crisis Care by BME groups

In addition, we have user and carer representation on a number of our key planning and working groups:- • Mental Health Social Prescribing Group • Dementia Carer Resilience Group (monthly meetings) • Membership by the CCG at the Dementia Action Alliance meeting (monthly meetings) • Community and service user representation on the MH Social Prescribing Group

20.8 Learning Disabilities

Lead GP	Russell Brynes / Richard Cullen
Executive Lead	Ian Atkinson
Lead Officer	Kate Tufnell
Key Meeting	Mental Health / Learning Disability QIPP Group

Why is this a strategic priority?
In Rotherham there are 1104 people with a learning disability (311 – aged 17 and under, 793 aged 18 and over). People with learning disabilities have higher levels of ill-health and much higher rates of premature death than the population as a whole. It is estimated that people with a learning disability are 58 times more likely to die prematurely. They are more likely to receive poor levels of health treatment as a result of 'diagnostic overshadowing', where people's health needs are overlooked due to focusing on their learning disability. Although the life expectancy is lower for people with learning disabilities, people are living longer and this means that the numbers of adults and older people with learning disabilities is increasing. National publicity on abuse of patients at Winterbourne View near Bristol highlighted the importance of good quality commissioning for people whose behaviour challenges services, and those with complex needs. NHS Rotherham CCG will work in partnership with RMBC to ensure that good local services are available to support people who challenge services and those with complex needs to prevent the need for expensive, out of area placements. National requirements which the CCG fully supports are set out in the Winterbourne concordat.
5 year Strategic Direction
The overarching priority is the delivery of the new Learning Disability enhanced community and inpatient model. The aim of which is to improve community services for people with learning disability and their carers thus reducing the need for admission to an Assessment and Treatment Unit. The CCG is fully committed to the 'Transforming Care' agenda and will work with colleagues from across both Doncaster and Sheffield (NHS and Local Authority) to continue to drive improvement in this area of provision. • Government Response to No Voice Unheard, No Right Ignored published November 2015 • Hidden Voices of maternity: parents with a learning disabilities speak out • The Learning Disabilities Mortality Review (Ledger programme) • CTR National Policy • The National Transformation Plan & National Service Model • Attain Review 2 recommendations – awaiting final document
Progress made in 2015/16
Over the last 12 month significant progress has been made in the implementation of the Adult Learning Disability Transformation plan with key achievements including: • **Provision of an enhanced community team providing a seven day service across the borough**. The

implementation of this new team has increased the support available to people with learning disability and their family to enable them to continue to live within the community.

- **Delivering Winterbourne requirements** – In 2015/16 the CCG has continued to work with partners to deliver the national Winterbourne standards with the introduction of Care and Treatment Review (CTR) and "at risk register" process. During this period the number of Rotherham people with a learning disability in a hospital placement has remained low.
- **Peer Support** - Feedback as part of the 2014/15 Public Consultation highlighted that people felt the introduction of a peer support role as part of the Learning Disability Service would be beneficial. Working with RDaSH and Speak UP the CCG has recruited a Peer Support to work as part of the local LD team to support them to deliver training, to work as part of the Care and Treatment Review (CTRs) team and develop communication information
- **Working with Expert by Experiences** - Over the past 12 months the CCG has worked with SpeakUP a self-advocacy organisation run by and for people with learning disabilities and/or autism on a wide range of issues. These include the completion of Community Treatment Reviews (CTRs) by their Expert by Experience team and recruitment of the peer support worker
- **Supporting people to access mainstream NHS Services** – Work has continued to support people to access mainstream health services with the introduction of a Learning Disability Liaison Nurse in TRFT and supporting GP practices to extend the Annual Health Check LES to include those aged 14 – 17
- **The Joint Health and Social Care Learning Disability Self-Assessment Framework (SAF)** is an annual review process which provides people with learning disability and family carers the opportunity to review and quality assure local services against national standards. In 2015 Rotherham achieved 6 Green and 1 Amber rating against the 7 Staying Healthy Indicators. (https://www.improvinghealthandlives.org.uk/securefiles/151110_1714//Rotherham.pdf)

Plans for 2016/17 and 2017/18

Learning Disability – Adults

- Work with partners from across the Transforming Care Partnership planning area to ensure delivery of the South Yorkshire and North Lincolnshire TCP Plan
- Move toward joint commissioning with RMBC
- Continue to review local inpatient requirements to support delivery of the nation bed planning assumptions across the SY & NL TCP footprint. Continue to develop the enhanced community team established in 2015/16
- Delivery of national Plan Targets
- Develop a Rotherham Care and Treatment Review (CTR) and 'at risk of admission' Policy
- Work with partners to ensure the delivering of the requirements of the new maternity guidance

How are we going to achieve our intentions?

The CCG will contract for community services and ATU with RDASH in 2015/16 whilst evaluating the impact of the changes made in 2014 and monitoring the bed requirements of the new service. We will require on going quality improvements. The two evaluations of the Assessment and Treatment unit will be used to inform our commissioning intentions for the 2016/17 contract.

We will continue a case management approach to individual bespoke personalised care packages to ensure patients require the services they require and that overall costs are kept in line with CCG allocations.

We will closely align our plans with RMBC's commissioning intentions for wider services for learning disabilities through a partnership agreement with RMBC, sharing commissioning intentions at the Joint LD Commissioning Executive and the LD Partnership Board (LDPB) meeting. The CCG will also work with partners from across the footprint to deliver the South Yorkshire and North Lincolnshire TCP delivery plan which is a three plan which will commence in April 2016.

The CCG will continue to explore the option of fully integrated commissioning of LD services for example with a shared budget for the whole of LD services commissioned by RMBC and the CCG. The issues we wish to address through integrated commissioning are: improved outcomes for patients; delivery against NHS England mandated outcomes; QIPP; financial transparency across the whole shared budget; and CCG running

cost capacity.

Quality Improvements

- Improve patient and carer experience of services
- Increase support and quality of care
- Reduce inappropriate admissions by ensuring that patients receive a CTR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients
- Reduce length of stay in hospital by ensuring that patients in an Assessment and Treatment Unit receive a CTR every 6 months
- Improve access for people with a learning disability to mainstream services by ensuring that patients have a hospital passport in place

Innovation

Key innovations delivered as part of the 2016/17 Commissioning Plan include:

- Commissioning an adults service model which is less reliance on inpatient services by strengthen support in the community with the provision of a service which operated 8am –6pm, 7 days a week.
- Working with people with a learning disability and /or autism to develop and improve the quality of LD services across the borough.
- The employment of an Expert by Experience to work as a Peer Support worker with the adults Learning Disability Team

Alignment with the strategic aims of the Health & Wellbeing Strategy

Aim 3: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life. This will be achieved by improving support for people with enduring mental health needs, by:

- Improving support for people with enduring mental health needs, including dementia, to help those live healthier lives.
- Reducing the occurrence of common mental health problems
- Reducing social isolation

Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing. This will be achieved for people with learning disabilities by**:**

- Reducing the number of early deaths from cardiovascular disease and cancer
- Improving support for people with long term health and disability needs to live healthier lives through developments, such as the enhanced community LD team
- Increasing the opportunities for participation in physical activity

How will health inequalities be addressed

The CCG will work with partners to address health inequalities by:

- Ensuring that people with learning disabilities get good care and support from mainstream NHS services, have access to information in in formats that they can understand and they receive appropriate support to help them to communicate, in line with the Accessible Information Standards .
- Ensuring that people with learning disabilities have good access to physical health care and preventative services
- Issuing contracts that require the providers comply with the Equality Act 2010, reasonable adjustment standards, autism statutory requirements etc.

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

Over the past year the CCG has continued to work with people with a learning disability and their families to inform the development of adult services / packages of care and future planning of services. This is done an in variety of ways:

- Through meetings ,such as the Learning Disability Partnership Board (LDPB) and Learning Disability Partnership Board Health Sub-group
- Consultation with people with Learning Disability, their carers/families and key stakeholder as part of the Two Attain Reviews undertaken in 2015/16.
- New posts/services established (LD liaison at TRFT and Peer Support) as a result of this consultation have

ongoing engagement embedded with and continuing to inform these roles.

- Working with Experts by Experience to inform the development and delivery of services, such as the Peer Support, Care and Treatment Reviews and specific piece of work completed to support service development, and including site visits.
- Working with NHS England to undertake a Health Needs Assessment to support the development of the South Yorkshire and North Lincolnshire TCP submission.

20.9 Maternity and Children's Services

Lead GP	Dr Richard Cullen
Executive Lead	Sarah Whittle
Lead Officer	Emma Royle
Key Meeting	Rotherham Children and Young People's Strategic Partnership Board

Why is this a strategic priority?

Pregnancy, birth and the weeks and months beyond, are a key time of change and development for parents, as well as for their baby. Supporting children to get the best start in life is a key priority for NHS Rotherham CCG and the H&WBB. The 2015 Director of Public Health Annual Report describes children and young people's health through a life-course approach, from pregnancy and birth, through school years into young adulthood. It describes some of the work which is being done to address the inequalities in health experienced in Rotherham and suggests what could be done to make further improvements. Further information in relation to health needs for children and young people can be found in section 5 of part 1.
The development of children's health will impact greatly on the future provision of health services and NHS Rotherham CCG are committed to developing children and young people's services, working together with key partners to ensure that children and young people grow to live, safe healthy lives and achieve.

The future of Health commissioning for children will involve much closer partnership between NHS Rotherham CCG and RMBC ensuring that the voice of the child, young person and parent is fully engaged in the commissioning process.

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

The important joint responsibility of RMBC and the NHS Rotherham CCG under the Care Act, such as transition assessments for 18 year olds, are summarised in section 21.13. A copy of the Children and Young People 'plan on a page' can be found at the following link: http://www.varotherham.org.uk/wp-content/uploads/2015/11/CYPS-POAP-plain-language-Oct-V1.pdf

5 year Strategic Direction

Pregnancy, birth and the weeks and months beyond, are a key time of change and development for parents, as well as for their baby. There is overwhelming evidence that conception through to the early years is a crucial phase of human development. The mental and physical health of mothers during and immediately after pregnancy can have lifelong impacts on the child. Supporting children to get the best start in life is a key priority for NHS Rotherham CCG and the H&WBB. The development of children's health will impact greatly on the future provision of health services and NHS Rotherham CCG are committed to developing children and young people's services, working together with key partners to ensure that children and young people grow to live safe, healthy lives and achieve.

A number of specific priorities have been agreed through consultation with the GP Localities, for the coming years. These will focus on:

- Integration of TRFT Acute & Community Children's Services
- Potential for locality working
- Develop Children's Joint Commissioning Strategies
- Efficiency agenda (number of hospital paediatrics beds, assessment beds & rapid assessments)
- Collaboration between South & Mid Yorkshire, Bassetlaw and Mid Derbyshire hospitals children's surgery and anaesthetic services (Working Together workstream)

Health commissioning for children in 2016/17 will involve more public participation to help influence our work and we will ensure that the voice of the child, young person and parent is fully engaged in the commissioning process.

The NHS Rotherham CCG has important responsibilities to work with partners to safeguard children. These responsibilities and the specific actions the CCG is undertaking with partners regarding child sexual exploitation are described in Section 13.3. The NHS Rotherham CCG is committed to ensuring that we commission the highest quality paediatric surgical pathways for Children and Young People, we will therefore work across South Yorkshire to review current surgical pathways of care.

Progress made in 2015/16

Some of the progress made during 2015/16 is outlined below:

- Engaged in the first phase of the South & Mid Yorkshire, Bassetlaw and Mid Derbyshire hospitals children's surgery and anaesthetic services review.
- A Children's Joint Commissioning Strategy has been developed in collaboration with RMBC identifying potential areas to be commissioned jointly.
- To support joint commissioning in the future, NHS Rotherham CCG and RMBC have jointly funded a new post - Joint Assistant Director – Commissioning, Performance and Quality.
- Implementation of the Special Educational Needs & Disabilities (SEND) Code of Practice has moved forward, and a SEND Joint Commissioning Strategy with nine priorities, is out to consultation.
- Smoother transition to adult services was identified as an area of need, and we have been working with partner organisations to map the current position in Rotherham, with the aim of implementing a consistent approach across all services.
- Progress has been made on production of pathways of care to help move care into community settings, reducing unnecessary attendances and admissions to hospital.
- Continued to support the work of Public Health by contributing to work on public health priorities, including infant feeding, teenage pregnancy, foetal alcohol syndrome and obesity.
- The development and piloting of a revised antenatal parenting programme provided jointly by midwives, health visitors and children's centre staff.
- A pilot for new children's asthma plans has been undertaken in three GP practices. The results of the pilot will determine next steps. Further work will be around asthma plans in schools.

Plans for 2016/17 and 2017/18

During the next two years, we will give particular focus to ensuring that care pathways across primary and secondary care are reviewed, agreed and in place, along with 'top tips' for GPs.

The main aim of this work is to ensure 'right care, first time', prevent inappropriate attendance at A&E and

inappropriate admissions to hospital. This will involve looking to increasing the number of children with complex, acute and long term health conditions being managed in community settings, closer to home. Care plans will be developed across primary and secondary care, improving patients ability to self-manage their conditions and improve transition from children's to adult services. This work has already been undertaken for asthma - diabetes and epilepsy are to follow. Communication between primary and secondary care will improve as a result of this work, giving a better experience of care for children, young people and their families.

We aim to support patients to access the 'right service, first time' by raising awareness for parents and carers about where to take their child when they are poorly, with the aim to reduce unnecessary attendances at A&E and to enable parents to access timely care within an appropriate setting. A revised children's acute care pathway will be implemented in time for the opening of the new emergency centre.

A review of paediatric community services will take place to assist with the updating of the service specifications and refreshing of the key performance indicators and ensure that services deliver measurable outcomes for children and young people.

Implementation of the recommendations, where possible, within Facing the Future for Paediatric Health (2015) will support this work. This will also look at the potential for locality working (paediatricians working more closely with GP localities) and improved integration of The Rotherham Foundation Trusts Acute & Community Children's Services.

Work will continue regarding the efficiency agenda (number of hospital paediatrics beds, assessment beds & rapid assessments).

Continued implementation of the SEND reforms and the Rotherham SEND Joint Commissioning Strategy will take place, working closely with RMBC and providers, including:

- Ensuring that systems are in place to ensure that children are identified early, with joint assessments and joint Education, Health and Care Plans.
- Parents and young people who would like more control are able to apply for a personal health budget
- We will also work jointly with RMBC and other organisations to ensure that transition to adult services for children with complex needs and long term condition, is a smooth as possible.
- A review of the Child Development Centre model of working will take place.

Maternity

- We will review the choices that are locally available for women accessing maternity services. We will work with service users and the public, to consider what more can be done to offer meaningful choice. This may include choice of how to access maternity care, the type of care women receive, where they give birth and where they receive their antenatal and postnatal care.
- We will work with partners to ensure that a robust Perinatal Mental Health Pathway is in place.
- We will publish a Rotherham Maternity Strategy.
- We will continue to support the work of Public Health regarding issues such as low birth weight, infant mortality, maternal health including mental health, and teenage pregnancy.
- During 2017/18 we will carry out a review of the new maternity service specification.
- We await the results and of the national Maternity Review carried out by NHS England and accompanying recommendations.

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

Service redesign and changes in polices will be written into newly designed service specifications, with clear performance indicators which we will use to robustly monitor commissioned services to help ensure positive outcomes for children and young people.

How are we going to achieve our intentions?
Delivering the commissioning intentions outlined above can only be achieved through working with key partners across Rotherham, ensuring a consistent approach to delivering joint aims and objectives. Service redesign and changes in polices will be written into newly designed service specifications, with clear performance indicators which we will use to robustly monitor commissioned services to help ensure positive outcomes for children and young people.
Quality Improvements
Current service specifications are being reviewed and new key performance indicators will be agreed. Paediatric care pathways and 'top tips' for GPs will continue to be revised and developed to improve the continuity and co-ordination of care, clinical effectiveness and communication giving a better experience of care for the patient. The NHS England review of Paediatric Asthma Services across Yorkshire and Humber has been completed and Rotherham contributed to this. Revised asthma plans are currently being piloted in three GP practices with the aim of rolling this out across Rotherham practices and then school asthma plans within schools. NHS Rotherham CCG are keen to implement the best practice tariff for epilepsy once published which will ensure that children with epilepsy receive the best standard of care. We will also work with NHS England and TRFT on the regional review of Epilepsy Services. Listening to children, young people and their families/carers and new mothers and their families, will ensure that commissioning for children's and maternity services is aligned to patient needs, dovetails with RMBC priorities and meets new policy changes.
Innovation
Joint work has taken place with RMBC to produce a children's joint commissioning strategy for Rotherham. This covers a number of areas including Early Years, CAMHS and Special Educational Needs and Disabilities (SEND). From this, sub strategies are to be developed – the first of which is the SEND Joint Commissioning Strategy. The strategies will include priority areas to be implemented and monitored jointly between NHS Rotherham CCG and RMBC. We will work in partnership with TRFT to implement the recommendations within Facing the Future for Paediatric Health. This will involve looking at new ways of working and improved communication between primary and secondary care. To reduce unnecessary A&E attendances by children, we will be innovative in how we raise awareness with parents. We will ensure the same messages are delivered by General Practice, midwifery, health visiting, school nursing and the hospital. We will continue promote the parenting guide for the acutely ill child to aid in these conversations to support behaviour changes.
Alignment with the strategic aims of the Health & Wellbeing Strategy
Aim 1: All children get the best start in life. We will continue to work with RMBC and TRFT on early intervention and prevention and will contribute to the review of early help services. ***Aim 2: Children and young people achieve their potential and have a healthy adolescence and early adulthood.*** *We are working jointly with RMBC and other organisations to ensure that transition to adulthood is as smooth as possible. Through the introduction of personal health budgets (SEND workstream) we will support children and young people with complex needs to live independent lives.* ***Aim 3: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life.*** We are working with TRFT and RDASH to produce and updated Perinatal Mental Health Pathway that is NICE compliant and meets the needs of the women of Rotherham. Child and adolescent mental health is discussed in section *21.6*

Aim 5: Rotherham has healthy, safe and sustainable communities and places. In partnership with Public Health, we will support children and young people to lead healthy lifestyles.

How will health inequalities be addressed

Children and young people under the age of 18 years make up 21.7% of the population of Rotherham. The health and wellbeing of Rotherham children is mixed. Infant and child mortality rates are similar to the England average. Approximately 10% of children aged 4-5 years and 21.6% of children aged 10-11 years are classed as obese (significantly worse that the England average).

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

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

Such issues have a significant effect on the future health of children. We will continue to work with Public Health to help reduce these inequalities and others, through programmes of work such as a revised antenatal parenting programme, the Infant Feeding Group and the Foetal Alcohol Syndrome Group.

Equality Impact Assessments will be carried out on all new and revised services specifications.

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

The Rotherham Parent Carers Forum has undertaken consultation on behalf of the CCG regarding experiences of health care, and have attended Governing Body to present this. This work has been used to inform the (currently draft) joint commissioning strategy for children and young people with special educational needs and disabilities, as well as the work taking place on new service specifications for paediatric community services. It also informed a Health event in March 2015, with around 150 people attending; and which was led by parents.

In addition, the partnership SEND 'In it Together' event took place on July 3rd 2015, with the aims of both engaging with and informing parents and young people.

A draft SEND joint commissioning strategy has been developed taking into consideration comments from the Parent Carers Forum consultation (July 2015). A stakeholder consultation strategy has been drafted (Aug 15).

Comments from the Friends and Family Test are also received on a monthly basis, which gives an overview of how people are experiencing using the services; there are specific forms for young people and parents to encourage feedback.

Work with the Youth Cabinet and Looked After Children Council has also directed work in producing a health information booklet for young people.

We have greed a new model of working for the Maternity Services Liaison Committee which involves GROW

visiting Bumps and Babies Groups in Children's Centres across Rotherham to obtain comments regarding experience of all aspects of maternal care in Rotherham. A substantial amount of feedback is received on maternity services through the Friends and Family Test, which is shared with GROW and the MSLC; GROW also provide feedback via the Bumps and Babies Groups. Engagement will also be built into the work to inform a new strategy for maternity services.

The CCG is working on consulting in other ways, with children, young people and their families. This involves, for example, working with the Rotherham Young Ambassadors through Healthwatch, and also through the Integrated Youth Support Service. Much of the consultation will be undertaken in partnership with RMBC.

We will work with The Rotherham Foundation Trust to develop questionnaires and other methods of consultation for children and young people using paediatric community services, to inform development of the new paediatric service specifications.

20.10 Continuing Care and Funded Nursing Care

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

Why is this a strategic priority?

The CCG has a statutory obligation and duty to fund Healthcare for clients who are assessed as meeting NHS Continuing Healthcare need via an in-depth assessment.

NHS Continuing Healthcare can be delivered in any setting, including the patient's own home or nursing home. However the majority of NHS Continuing Healthcare funded patients are delivered in specialised homes, where the NHS is responsible for the care home fees, including board and accommodation.

If provision of NHS Continuing Healthcare is assessed as being safe to be delivered in a domiciliary settings, then NHS pays for healthcare through mainstream services such as community nursing or specialist therapists, and is responsible for supplementing care from contracted domiciliary care providers, however is not responsible for 'board and accommodation' fees.

5 year Strategic Direction and key priorities

The CCG has a statutory obligation and duty to fund Healthcare for people who are assessed against eligibility criteria for NHS Continuing Healthcare, NHS Funded care and Children's Continuing Care.

Therefore the CCG has to build upon the extensive quality work undertaken to continue to deliver specialist assessment of needs and effective decision making on eligibility against contemporary frameworks published by the Department of Health.
The CCG will with local partners continue to develop and extend the personalisation agenda for patients eligibly for Continuing healthcare, joint assessments and decision making.

Progress made in 2015/16

Key delivery changes undertaken have streamlined the service and reduced timescales within the process.

The community 'End to End' service ensures that each patient receives a dedicated nurse who leads and supports the patient from a referral to completion; any further review is undertaken by the same dedicated nurse.

The 'End to End' process commenced in the community has developed to include patients in the acute setting, significantly reducing the time spent in acute beds and facilitating early discharge.

National recording data for Continuing Healthcare has resulted in Rotherham significantly improving its position against other CCGs nationally. The current position is 103 out of 211 CCGs which indicates that Rotherham has moved to a more positive average position of activity and costs per 10,000 population in England.

Plans for 2016/17 and 2017/18

To continue to assess, fund and commission reasonable care packages that meet patient's needs with a focus on personalisation and commissioning for both eligible adults and children.

To assess patients for CHC eligibility in line with the requirements of the national framework for NHS Continuing Healthcare, NHS Funded Care and Children's Continuing Cares changing frameworks and that care packages are commensurate with patients' needs.

Further develop and maximise the use of mainstream services in delivering NHS Continuing Healthcare

We will continue to benchmark ourselves against other CCGs to understand how we compare on NHS Continuing Healthcare costs and activity with the aim of maintaining a position of between 90 and 110

To further develop Working partnership's with the RMBC, TRFT, Rotherham Hospice, Primary Care, domiciliary providers, care homes and the voluntary sector

To explore with partner organisations the possibilities of joint commissioning of social and healthcare budgets. And to continue to develop the personalisation agenda, and promotion of Personal Health Budgets.

Consider the opportunity to deliver an 'End to End' Continuing Healthcare Assessment service, for Learning Disabilities and Mental Health patients.

How are we going to achieve our intentions?

- Assess patients for CHC eligibility in line with the requirements of the national framework for NHS Continuing Healthcare and FNC and that care packages are commensurate with patients' needs
- Maximise the use of mainstream services in delivering NHS Continuing Healthcare
- We will benchmark ourselves against other CCGs to understand how we compare on NHS Continuing Healthcare costs and activity – the CCG current position is 103 out of 211 CCGs nationally and has higher activity and costs per 10,000 population than the England and North of England average
- Work in partnership with the RMBC, TRFT, Rotherham Hospice, primary care, domiciliary providers, care homes and the voluntary sector
- Continue to commission individualised services for children with complex health needs

Quality Improvements

Quality improvements will be driven through robust audit of the application of current National frameworks for adults and children with a focus on utilisation of multiple locally commissioned services. We will engage patients to empower them in reaching decisions about their care: the personalisation agenda will improve self-care and give patients ownership of their care.

Innovation

Further develop the right to request a personal health budget to all patients who receive NHS Continuing Healthcare in their own home and support the choice of Notional, Third Party and Direct Payments.

To improve patient engagement and feedback opportunities through the use of systems such as patient opinion and direct CCG feedback opportunities.

Alignment with the strategic aims of the Health & Wellbeing Strategy

Aim 4: Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing - The JSNA highlights the changing population demographics and the impact this will have on the number of elderly people with complex care needs: Many of these patients will possibly be eligible for CHC. CHC aims to deliver high quality aftercare for patients in their own home or care home setting.

Aim 1: All children get the best start in life and Aim 2: Children and young people achieve their potential and have a healthy adolescence and early adulthood - Equally children with complex care needs are also able to be assessed for continuing care to support needs that are not supplied by universal or complex commissioned services. It is recognised that many children with the Special Educational Need (SEN) reforms will also be eligible for Personal Health Budgets and have a right to request.

Aim 5: Rotherham has healthy, safe and sustainable communities and places - the personalisation agenda will put recipients of NHS Continuing Healthcare in control of their care and those opportunities for self-care and the use of alternatives to acute hospital admission maximised.

How will health inequalities be addressed

We will ensure that all patients are assessed for NHS Continuing Healthcare in line with the requirements of the National Framework to ensure that care packages are commensurate with need. We will engage hard to reach minority groups to increase awareness of continuing healthcare and the personalisation agenda and to understand their needs and wishes.

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

Patient and relative feedback is sought on each assessment that is undertaken, and patients have the opportunity to record feedback on the process and assessment that is undertaken. The CSU have additionally commissioned the Patient Opinion service as a measure to record feedback from service users and responsible individuals.

A communication strategy has been developed, ensuring people receiving Continuing Healthcare receive appropriate information, and have the opportunity to feedback their experience.

20.11 Palliative Care

Lead GP	Avanthi Gunasekera
Executive Lead	Ian Atkinson
Lead Officer	Nigel Parkes
Key Meeting	End of Life Care Strategy Group

Why is this a strategic priority?

Commissioning high quality palliative care services for the residents of Rotherham is an absolute priority for the CCG, within the Rotherham Health and Social Care economy, Palliative Care (inc end of life care EOLC) is provided across a range of core commissioned services for example, Primary Care, Acute and Community Services Community, Residential Care and Nursing Homes. In addition to this the CCG invests around £3m million in specialist palliative care provision from Rotherham Hospice.

5 year Strategic Direction and key priorities

The CCG aspiration is to work closely with local Health and Care providers to commission clear joined up Palliative pathways of care, these pathways will embrace all elements of Palliative care including:

- Hospice services for adults and children.
- Palliative Care & EOLC in Acute settings.
- Palliative Care & EOLC in community settings.

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

The CCG will continue to support the five 'Priorities of care' identified in the report 'One Chance To Get It

Right':

- Clear communication following recognition that a person may die in the next few days or hours.
- Sensitive communication with the dying person and those identified as important to them.
- The dying person and those identified as important to them are involved in treatment & care decisions.
- The needs of families and those identified as important to the dying person are explored, respected & met.
- An individual plan of care is agreed, co-ordinated and delivered.

The CCG will also follow the six ambitions laid out in the document 'Ambitions for Palliative and End of Life Care':

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help.

Progress made in 2015/16

In 2015-16 Rotherham Hospice continued with the roll-out of its re-design, implementing the out of hours element of the Hospice at home, in collaboration with Marie Curie, to provide a 24/7 service.

The CCG funded two posts, one based at the Hospice and the other at TRFT to provide training around 'One Chance To Get It Right'.

The CCG ensuring that crucial conversations about EOLC take place at the appropriate time for patients with long term conditions, the Case Management Project will be a major enabler of this. The CCG extended the eligibility for funding of the Case Management Project to all patients in nursing and residential homes, to fund additional GP time which will be important to better co-ordinate EOLC in nursing and residential homes.

Work continued around the roll-out of the EPaCCs electronic EOLC register, with the template being updated in line with reporting changes. Whilst uptake continues to be slow, the work undertaken has eliminated any IT issues and promotion to GPs continues. This development remains a priority for the CCG.

The Hospice@Home service continues to provide significant benefits in terms of reduced admissions to TRFT

Further work has continued relating to EOLC patients with dementia.

The Rotherham Foundation Trust has prioritised improvements in EOLC pathways within the hospital setting, evidence of senior clinical staff attending advanced communications training and reduction in complaints around communication issues at the end of life., reduction in readmission rates of patients in the last years of life, evidence of appropriate use of care plan for the last days of life, delivery of a 7 day palliative care team.

Plans for 2016/17 and 2017/18

1. Continue to review Hospital Mortality to understand opportunity for improvements in existing palliative care pathways
2. Further work will be undertaken to ensure the roll-out of the EPaCCs system and this may include the option to incentive up-take through the PMS premium in 2016/17.
3. Work with partners to embed into service provision requirements of the 'Care of dying adults in the last days of life' (Nice Guideline December 15)
4. Routinely commission the Hospice at Home model of delivery across the Rotherham area.
5. The CCG will work with The Hospice and TRFT to ensure that the Care Co-ordination Centre (CCC) is an active part of the EOLC pathway.
6. The CCG will also formalise the commissioning arrangements for Children's Hospice services.
7. The CCG will ensure that it is aware of and involved in any further developments towards a palliative care and EOLC payment system.

8. The CCG will as part of the locality model of care, look at how best palliative care patients can be more proactively managed, before the very end of their life

How are we going to achieve our intentions?

- The CCG is investing in additional nursing capacity through the transforming community services project (see section 21.3) and will consider using some of this funding to expand 24/7 coverage by the community EOLC service.
- Rotherham Hospice and TRFT care coordination centre will further develop protocols and working arrangements so that more EOLC patients who deteriorate can be offered the option of community services rather than hospital assessment (see section 5.1).

The CCG will ensure that crucial conversations about EOLC care take place at the appropriate time for patients with long term conditions, the Case Management Project (see Section 21.2) will be a major enabler of this.

The CCG has extended the eligibility for funding of the GP case management project to all patients in nursing and residential homes, this funds additional GP time which will be important to better coordinate EOLC in nursing and residential homes.

- The CCG, RDaSH and Rotherham Hospice will further develop care pathways for EOLC patients with dementia. The CCG will continue to work with TRFT and Rotherham Hospice to implement the five key priorities which make up the new EOLC model as outlined in the 'One chance to get it right' publication.

The CCG will continue to invest in the community EOLC service through the 'Better Care Fund'. This service will continue to provide community EOLC services, a 24 hour helpline, better record sharing and an electronic register to enable better case management between patients.

Quality Improvements

- Over the last 2 years the proportion of people in Rotherham dying in setting other than acute hospitals has increased from below 40% to above 50%
- More patients will have better conversations about the fact that they need end of life care
- More patients and families will have advanced directives.
- Patients care will be better co-ordinated.
- More patients will die in the setting of their choice.

Innovation

The Hospice has continued to provide innovative solutions to EOLC in Rotherham through the recent re-design and enhanced services such as psychological support.

All stakeholders will continue to work together on innovative solutions to specialist palliative and EOLC including, for example, the Amber Care Bundle.

Alignment with the strategic aims of the Health & Wellbeing Strategy

In line with the aims of the Health & Wellbeing Strategy, the CCG will ensure that people approaching the end of their life get high quality care, wherever that care is delivered. Continuing to implement the five priorities of 'One Chance To Get It Right', outlined above, will ensure that care is planned with the individual and the people close to them and tailored to their needs and wishes and includes management of symptoms, as well as provision of psychological, social, spiritual and practical support.
Work will continue to ensure that more people in Rotherham are able to exercise choice over their end of life care and the place of their death.

How will health inequalities be addressed

Work is ongoing at the hospice to increase the percentage of patients who receive EOLC and who don't have cancer, but some other condition.

- Currently there are variations in the quality of EOLC received by patients from different general practices depending on their practices level of training and capacity. The community EOLC pilot will work with individual practices to reduce this inequality.

• Currently patients with some conditions such as dementia do not always receive EOLC services to the same standard that patients with cancer receive. We will address this by working with all referring clinicians as part of our case management pilot and dementia strategy. • We will monitor the ethnicity of people receiving specialist EOLC services and ensure that this is representative of the Rotherham population.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
Patients and their families continue to have a vital input into determining the type of care and support provided in the last stages of life and this is integral to good EOLC. Work will continue to improve the quality of conversations with patients and their families who are approaching the end of life so that care is tailored to their individual needs.

20.12 Specialised Commissioning

Lead GP	Richard Cullen
Executive Lead	Chris Edwards
Lead Officer	Jacqui Tuffnell
Key meeting	Specialised Commissioning Oversight Group

Why is this a strategic priority?
Responsibility for commissioning a wide range of very specialist services lies with NHS England. Such areas include specialist cardiac surgery, specialist paediatric and neonatal critical care, adult critical care, specialist cancer drugs and radiotherapy and specialist mental health services (such as forensic services). Although NHS England has responsibility for commissioning specialised services the CCG needs to work collaboratively to ensure quality safe pathways of care are commissioned across secondary and tertiary services.
5 year Strategic Direction and key priorities
Responsibility for commissioning a wide range of very specialist services lies with NHS England. NHS England's have published commissioning intentions for these services. H:\Specialised commissioning\Commissioning Intentions 2016-2017 for Prescribed Specialised Services GW04131 final.pdf The CCG works with NHS England to ensure co-ordinated care pathways across areas of CCG and specialised commissioning and to ensure there is local input into specialist commissioning decisions.
Progress made in 2015/16
Two areas that were the responsibility of NHS England in 2014/15 were transferred to CCGs in 2015/16: • Specialist wheelchair services • Outpatient neurology (GP referred) All CCGs were asked to identify their key priorities for specialised service improvements. In Yorkshire and the Humber the following services were identified as priorities: Vascular – a service review has been conducted and an early options appraisal is being progressed Cardiac devices – a service review has been conducted with an overall recommendation to increase implantation across Yorkshire and Humber. Rotherham was identified as within the expected range for implantation. CAMHs – Tier 4 – a national procurement is in progress however this is intertwined with a review of Tier 3 services to enhance community availability to enable children to remain within their own homes with appropriate wraparound services. A plan for Rotherham has been submitted.
Plans for 2016/17 and 2017/18
It is likely following ministerial confirmation that the following services will be commissioned by CCGs from 2016/17 • Surgery for morbid obesity • Some highly specialised male urological procedures

• Some highly specialised adult haematology procedures • Primary ciliary dyskinesia management services for adults In addition to these formal transfers NHS England has set up Specialised Commissioning Oversight Groups to develop collaborative commissioning arrangements with CCGs to enable better aligned decision making to help restore pathway integrity and improve transition for patients between specialised and non-specialised services.
Quality Improvements
Opportunity for improving pathways – co-ordination across non-specialised and specialised pathways are expected to improve health outcomes for service specific patients Cardiac devices review – will ensure all patients appropriate for implantation receive their device CAMHS Tier 3 plus service will enable children to receive appropriate care in their home setting and avoid, where possible an inpatient stay.
Alignment with the strategic aims of the Health & Wellbeing Strategy
Aim 5: Rotherham has healthy, safe and sustainable communities and places - The ability to work across the pathway aligns with this aim.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
To date, specialised services have engaged patients via involvement in clinical reference groups. These will continue for services remaining with NHS England however regional specific conditions will also have direct patient engagement and involvement.

20.13 Joint Commissioning with RMBC (inc.) Better Care Fund

Lead GP	Julie Kitlowski
Executive Lead	Keely Firth
Lead Officer	Dominic Blaydon
Key meeting	Better Care Fund Operational Group

What is the Better Care Fund?
The Better Care Fund (BCF) is an important Government Initiative to create a single joint budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. The fund does not in itself create any new money but bringing existing budgets under joint commissioning responsibility is expected to lead to better outcomes. Public sector commissioners in Rotherham already align their commissioning strategies as much as possible to achieve best outcomes for each Rotherham pound through the Health and Wellbeing Board. The Health and Wellbeing Strategy 2015-19 places particular emphasis on a shared vision and leadership for improving health and care services and it provides the framework for the Better Care Fund proposals to ensure seamless, effective and efficient service delivery.
5 year strategic direction
The Rotherham Better Care Fund brings together 6 themes that are particularly important for joint working into a single jointly owned budget of £24.3 million. There are six national conditions that have to be addressed. 1. Plans to be jointly agreed 2. Protection for social care services (not spending) 3. As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends 4. Better data sharing between health and social care, based on the NHS number 5. Ensure a joint approach to assessments and care planning

6. Agreement on the consequential impact of changes in the acute sector

The plans have to achieve specific outcomes in seven areas:

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

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

Progress made in 2015/16

In the first year of operation significant steps have been taken to improve integration, strengthen community services in the health and social care economy and reduce unnecessary non elective admissions to hospital and premature admission to long term residential care.

Highlights of Progress to Date

- BCF01: Fully operational and is now operating extended hours from 9am-8pm. (further update/clarity required)
- BCF04: Extensive work has been completed to ensure a fully operational service is in place by January 2016.
- BCF06: social prescribing services are well established across the Rotherham Borough, events have enabled patients to share success stories and Sheffield Hallam was commissioned to evaluate the provision. There is now a mental health social prescribing pilot in development.
- BCF09: Continuing Healthcare adults and children are being offered information regarding Personal Health Budget's at the point of assessments. A work plan for PHB's is being developed for 15/16 including local PHB network involving PHB recipients and the voluntary sectors.
- BCF 14: Currently 57% of people receiving social care services having an NHS number recorded. An active and current project plan is capturing the NHS number for all new referrals in our social care database. Culture and process changes have been made to embed the maintenance and usage of NHS number in RMBC's day to day activities. The deadline for matching all NHS numbers with social care records is April 2016.
- BCF15: Fully operational and the number of deaths outside hospital is being kept at its current positive position. Strong links are established with the Care Co-ordination Centre to maximise admission avoidance.

Plans for 2016/17 and 2017/18

A new BCF plan will be proposed in 2016-17 that follows our customer journeys along the continuum of care, to ensure that BCF services are realigned so that they deliver the following key projects;

1. A single point of access into health and social care services
2. Integrated health and social care teams
3. A multi-disciplinary carers support service
4. A multi-disciplinary integrated rapid response service
5. A joint approach to care home support
6. Implementation of personal health and social care budgets
7. Development of a reablement hub incorporating intermediate care beds
8. Reconfiguration of the local authority residential bed base

How we are going to achieve our intentions?

The plan is overseen by BCF Executive Group which includes senior representatives from both the CCG and RMBC and reports to the Health and Well Being Board. The Executive Group is supported by an Operational Group which is made up of the identified leads for each of the BCF Schemes. In additional to local reporting plans and outcomes have to be assured by and report to NHS England.

£24.3 million represents only a small proportion of the total budgets that could potentially be shared

between the CCG and RMBC, the CCG will review the potential for increased shared budgets on an annual basis. Table 1 sets out the key schemes that RCCG and RMBC have worked on this year.

Rotherham Better Care Fund Schemes	Description of Better Care Fund Schemes
Mental Health Liaison Service	Development of an Adult and Older Mental Peoples Mental Health Liaison Service to improve care, reduce admissions and length of stay and ensure that mental health is a fully integrated in the new Rotherham Emergency Care Model. See Section 21.2.
Falls Prevention	Ensure older people are aware of the risks of falls and have opportunities to remain active and healthy in their community. Where a person is more at risk of a fall, they are provided with the right advice and guidance.
Integrated rapid response team	Integrate the current Fast Response Service, Advanced Nurse Practitioner and District Nursing Twilight Service. The main aim of the service is to assess patients who are medically stable but need additional support to remain at or return home. The service will co-ordinate and deliver care for patients for a time limited period.
7 day community, social care and mental health provision to support discharge and reduce delays	Extend current provision so that appropriate services are available 7 days a week, to enable timely discharge from hospital and avoid unnecessary admissions to hospital or residential care.
Social Prescribing	A portal for health professionals to access voluntary and community support services, to enable existing third sector providers and groups to complement the formal support that people with long term conditions receive. They are able to provide flexible, appropriate services that help people to self-manage.
Joint residential and nursing care commissioning, quality and assurance team	Approximately 1,700 people live in care homes in Rotherham, this workstream is to develop a joint approach towards quality assurance of residential and nursing care homes. CCG and RMBC will work closely to develop an integrated quality assurance service
Review existing jointly commissioned integrated services	All jointly commissioned services have been reviewed to establish if they provide value for money and are aligned with the BCF vision and principles. If services are not efficient and effective, services will be reconfigured or decommissioned.
Data sharing between health and social care	All Rotherham NHS correspondence uses the NHS number as primary identifier. RMBC has a plan already in development to enable this to be used on social care systems. The NHS number has been used as a unique identifier creating a starting point for the development of shared IT capacity locally. So far RMBC have successfully attached NHS numbers to 22,000 service users.
End of Life Care	Investment in enhanced community end of life care services by Rotherham Hospice to augment the current day hospice /Inpatient Patient Unit services with hospice at home provision.
Adaptations	Investment in minor and major adaptations to help people live independently within their own homes for longer. The aim is to improve health and wellbeing of individuals, reduce admissions to residential care and hospital and reduce the use/reliance on home care packages.

Quality Improvements

The fund will improve outcomes in the following areas:

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

Alignment with the strategic aims of the Health & Wellbeing Strategy

In particular the BCF aligns with the Health and Wellbeing Strategy Aim 3: *All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life* and Aim 4: *Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing.* Part of the priority is the need to ensure that people who have a long-term condition or disability and those with

mental health problems receive the right care in the right place at the right time. It is evident that too many people are admitted to hospital unnecessarily and are kept in hospital for too long due to inconsistences in discharge. The BCF supports this aim by integrating and increasing access to health services in the community and supporting the reduction of care that occurs in hospital. The BCF also ensures that services are in place across the health and social care economy to support the most vulnerable to remain independent for as long as possible, and to support those friends and family who provide unpaid care.
What patient engagement has led you to come up with your plan/what patient engagement is planned in this area?
The Better Care Fund vision is based on the Health and Wellbeing Strategy and on what Rotherham people have said are the most important to them. Rotherham partners have a commitment to make sure that the views and reported experience of people who use local services are heard and acted upon. The comprehensive engagement that informed the BCF is documented within the BCF plan.

20.14 Child Sexual Exploitation

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

20.15 Cancer

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

Why is this a strategic priority?
The 2015 Atlas of Variations highlights the fact that one year survival rates post Cancer diagnosis are lower in Rotherham than the National average. Mortality rates from any cancer in both the over and under 75's are also above the national average. Our challenge should therefore be to improve one and five year survival rates. Cancer targets are set up to try to deal with these issues and the CCG will work public health and wider community. Commissioning high quality cancer pathways that deliver treatment within the required national waiting times is an absolute priority for the CCG. We will work with our local primary care and hospital providers to ensure that assessment and treatment targets are delivered. Where Rotherham residents require highly specialist treatment in 'tertiary centres' we will work at a sub- regional level to improve existing pathways, this work will reduce the risk of breaching the key 62 day cancer treatment standards. Intelligence, from Commissioning for Value (Right Care), suggests that in some specific areas of Cancer Provision, such as lung cancer, our spend on hospital care is significantly higher than peer averages.
5 year Strategic Direction and key priorities
Our key strategic objective is to commission high quality, timely seamless pathways of cancer care. We will do this by focusing our efforts in the following areas: 1. **Raising Awareness to support early identification and early diagnosis** with specific focus on 2week waits for urgent cancer referrals 2. **Treatment –** Commission high quality pathways of care for both local and tertiary cancer treatments 3. **Survivorship** – Focus on the need to address complications as soon as required reduce the need for unnecessary follow ups, support individuals to return to work.

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

Appendix 1: Strategy for General Practice within Rotherham

1. Our vision for general practice within Rotherham

Plans and services of all commissioners and health and social service providers in Rotherham are prioritised by needs identified in our Joint Strategic Needs Assessment and the six Rotherham Health and Wellbeing (H & WB) Strategic outcomes(due to be reviewed in September 2015:

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

The CCG will work with practices to transform services over the next 5 years to achieve the following key outcomes:

- Improved consistency in access to general practice – aspiring to within 24 hours for an urgent appointment and within 5 days for routine appointments
- A combined, collaborative workforce across primary, secondary and community care providing a seamless pathway for patients with GPs as the linchpin for care
- Patients able to self manage their conditions from home utilising technology to connect with healthcare professionals
- 200 additional years of life
- All patients will be able to access equivalent services
- We will increase the wider workforce within general practice to improve consistency in patient experience

2. Introduction

Rotherham Clinical Commissioning Group (CCG) is responsible for commissioning the majority of health services for Rotherham patients as detailed in section 2.2 of the Commissioning Plan.

Primary care exists to contribute to preventing ill health, providing early diagnosis and treatment, managing ongoing mental and physical health conditions and helping recovery from episodes of ill health and injury (Ref: NHS mandate 2013). General practice plays a significant part in primary care and Rotherham CCG is committed to adhering to the principles of the NHS and how these are applied locally to best meet the needs of our population.

The CCG has an overall vision of working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities. Primary care, defined for this purpose as care that can be provided out of hospital by GPs and the teams they employ, is at the heart of the NHS and will play a central role in achieving this aim by ensuring a co-ordinated service for patients, centred on the needs of the people that we serve and not silo organisations.

We have fantastic examples of care in Rotherham but as our population increases and ages, it is critical that we respond by providing services in different ways to ensure we continue to sustain and improve during challenging times. Our key challenges within GP services include our own ageing workforce. Over 33% of GPs in Rotherham are due to retire in the next 5 years with limited availability of trainees to fill vacancies. In addition there are significant changes to funding arrangements for GP practices potentially destabilising investment and pressure to improve access.

Rotherham CCG believe a significant step forward in this journey included bringing back, the commissioning of primary care (GP services) to Rotherham, this was achieved in April 2015. We are already seeing the benefits of being able to respond to local issues with local knowledge as often it is difficult to understand and respond to our population from afar but with our dedicated resources we are able to ensure this is achieved. To ensure good governance is maintained, the CCG has created an additional committee, Primary Care Sub-Committee which is chaired by a Lay member of the CCG and meets monthly in public to discuss all issues affecting general practice. Healthwatch, NHSE and a representative from the Health and Wellbeing Board are all committee members. The CCG will continue to work with NHSE who commission other primary care services i.e. pharmacy, optometry and dental to ensure these services complement each other however this strategy is focused on GP services.

This strategy is a key component to ensure we continue to mould our journey to deliver our priorities and what we will do to make the vision a reality. The strategy aligns with the Health & Wellbeing board priorities and the CCG's commissioning plan which has a specific strategic aim of developing general practice. The strategy should also be considered as an enabler for, and read in conjunction with the RCCG Better Care Fund (BCF) plan which is a pooled budget of £24.3 million for health and social care.

There are some considerable challenges to be overcome as we move towards delivery of our vision. 56.8% of our population live with health-related problems. More people are living longer with more chronic diseases and medical treatments are getting more complex and expensive. We have to deliver healthcare differently as funds are not growing to deliver in its current format which could increase inequity in funding if it is not managed effectively.

We have developed our strategy by reflecting on feedback from our patients and the wider primary healthcare teams at market place and development events held in June 2015, as well as considering the challenges facing general practice. The following ten key principles have been identified to form the main elements of the general practice strategy:

1. **Quality driven services** – providing high quality, cost effective, responsive and safe services
2. **Services as local as possible** - teams working in community in conjunction with GPs, in-reaching into secondary care where possible
3. **Equality of uniform service provision** - addressing inequalities in Rotherham's life expectancy – we will focus on health prevention and education to support these areas along with 'baskets' of services to ensure equality across Rotherham
4. **Increasing appropriate capacity & capability** – as well as continuing to recruit to our workforce, we will develop new roles to support the GP and nursing workforces to ensure patients are well managed along with innovative models to manage patients conditions e.g. telephone support and extended use of pharmacists. We will also educate the public to feel confident in using different health professionals for their care.
5. **Primary care access arrangements** – ensuring our access to general practices meets the needs of our population
6. **Maximised use of integrated / aligned care pathways** – new models of care, taking a lead from the new Vanguard models and other good practice across the NHS
7. **Self care** – improved information including patient health portals, ability to monitor conditions at home/link to appropriate service when 'abnormal'
8. **Robust performance management** to provide assurance that safe and cost effective care is being delivered

9. Continuing our programme to **improve medicines management** with appropriate prescribing and reducing waste
10. **Engaging patients** to ensure patient pathways are optimised – to date engagement has been varied and the CCG is committed to finding alternative ways to ensure the patient voice is heard

We have developed our strategy for general practice, which was agreed at the Governing Body September 2015.

Engagement with local professional, patients and the public will continue as we develop more detailed operational plans. There will be continued opportunities for people to influence how we make our vision a reality. This strategy will be incorporated during 15/16 into the CCG overall commissioning plan to ensure that delivery and review remain high priority.

3. General Practice Plan on a Page 2015-19

Vision				
	Priority Area	Challenges	Solutions	Outcome
1	Quality Driven Services	Financial Uncertainty	• 4 year reinvestment plan • Benchmarking • Comparing practice quality and productivity • Delegated responsibility for general practice • New models of delivery	• Improved patient experience – ED1-3 • Improved efficiency
2	**Services as local as possible**	Capacity to deliver	• New ways of managing patients: ➢ Telephone consultations, skype video consultations ➢ Utilising our wider workforce ➢ Integrating out of hours and urgent care	• % reduction in patient attendances at GPs
		Care closer to home	Seamless services	• Improved efficiency • Improved patient experience
3	**Equality of service provision**	Inequalities in life expectancy equity of services	• 'Baskets' of services • Providers working together • Focused health prevention measures ➢ Working with public health	• 200 years of life per year • All patients able to access equivalent services
4	**Increasing appropriate capacity and capability**	Recruitment and retention	• Workforce plan ➢ Sufficient capacity and an appropriately skilled workforce • Effective succession planning • New workforce models ➢ More effective use of different professions ➢ Engaged and empowered workforce • Recruitment strategy ➢ Improved profile of Rotherham as a place to work ➢ Improved fill rates	• Improved workforce numbers • Improved workforce retention • Improved patient experience
5	**Primary care access arrangements**	Public expectation GP facilities Contract arrangements	• Review of arrangements and to pilot extended opening • Provision of wrap-around services to support GPs	• % reduction in patient attendances at A & E • Improved patient experience
6	**New models of care**	Contractual complexity	• Collaborating groups of practices to deliver care in the community • New emergency centre ➢ Secondary and primary care clinicians working together	• Improved efficiency • Improved patient experience
7	**Self care**	Increasing demand	• Education ➢ Patients confident to manage their condition(s) • Social prescribing ➢ Signposting & support to manage their condition(s) • Technology ➢ Proactive monitoring to enable fast response • Case management ➢ Clear plans of care	• % reduction in attendances – all services
8	**Robust performance management**	Different systems in place	• Performance dashboard to collate data • RAIDR to ensure consistency	• Ability to define & manage performance issues • Improved performance ED1-3
9	**Continued improvements to medicines management**	Reducing medicines waste	• 6 service redesign projects to improve prescribing • Prescribing Local Incentive Scheme	• Improved efficiency - QUILT • Safer medicines management
10	**Engaging patients to ensure patient pathways are optimised**	Improving patient involvement	• Effective Patient Participation Groups • Condition specific focus groups	• Services which meet the needs of the population

Steps to Make the Vision a Reality

There are the key enabling strands of work that underpin the strategy. These tackle the main issues and challenges facing general practice and will allow the CCG to turn the vision into reality. More detailed consideration of them is required in the short term to translate them into an implementation plan.

4. Context

4.1 Profile of Primary Medical Care in Rotherham

90% of all NHS contacts are with general practice. There are around 1.5M GP consultations every year in Rotherham with each patient seeing their general practice 6 times per year on average.

Rotherham's resident population is estimated at 259,800 who are cared for by a total of 36 GP practices (as at April 2015) alongside a centrally based walk-in centre providing 24/7 access. At the present time, five GP practices in Rotherham are singlehanded compared to 31 practices with multiple GP partners or which are alternative providers.

National average list size	6287
Rotherham average list size	7182

The CCG currently has 15 training practices. This is important as training practices play a significant role in supporting new GPs and encouraging them to stay in the area once they are qualified.

With regard to type of contract there are:

- 24 Personal Medical Services (PMS) practices
- 8 General Medical Services (GMS) practices
- 2 Alternative Provider Medical Services (APMS) practices (covering 4 practices)

A Limited Liability Partnership (LLP) is currently being formed by an appointed GP lead to enable practices to work collectively and be able to respond to the demands facing general practice. These demands are identified more extensively within this strategy.

4.2 Current General Practice

Whilst media attention is often focused on the challenges facing the heath service , it must be acknowledged that there is excellent work taking place in general practice, day in, day out to ensure patients receive high quality care. As a principle, it was agreed that these should be protected and preserved when thinking about any future model of care. They included:-

- GPs holding longer term contracts that build real commitment to the local community
- Registered list that leads to continuity of relationships and care•
- GP acting as the coordinator of care between other health and social care settings
- Appetite for innovative ways of working
- Keen to learn new skills through educational programmes designed by local GPs
- Practices beginning to work together to share good practice and learning
- Secondary to primary care Local Enhanced Service agreement where practices have agreed to work together to provide services for all patients when individual practices have not got capacity
- The delivery of high quality care e.g. anticoagulation, where the increased service quality being delivered is outstanding.

General practice incorporates the essential values of personal care, continuity of care, generalist skills and a holistic approach to patients. Prevention and the treatment of ill health both have equal priority.

It is also important to acknowledge the teams that support the clinical professionals such as practice managers, reception staff and apprentices without whom our services would not be fully functional.

4.3 Changes to Contractual Arrangements

NHS England are nationally leading changes to the payment arrangements for general practice to apply the principles of equitable funding. The aim of which is to by move to a position where all practices (whether GMS, PMS or APMS) receive the same core funding for providing the core services expected of all GP practice. The review of PMS funding, determined that any additional funding above this must be clearly linked to enhanced quality of services or the specific needs of a local population. Also that practices should have an equal opportunity to earn premium funding if they meet the necessary criteria. NHSE have determined that over the next four years commencing 2015/16 financial year, the current PMS premium paid to PMS practices will be reduced by ¼ each year and reinvested across Rotherham GP practices to enhance the quality of services. All practices will have equal access to the payment as detailed above. A decision regarding the phasing out of MPIG for GMS had already been determined with correction factor payments reduced by 1/7th over 7 years commencing 2014/15.

On a positive note, the funding released from the PMS review will remain within Rotherham and will be reinvested back into Rotherham primary care over the 4 year period described to achieve the following:

- Reflect joint area team/CCG strategic plans for primary care – supporting an integrated approach to delivering community based services
- Secure services or outcomes that go beyond what is expected of core general practice – ensuring premium funding is tangibly linked to providing a wider range of services or providing services to higher quality standards
- Help reduce health inequalities
- Give equality of opportunity to all GP practices
- Support fairer distribution of funding at a locality level

The GMS monies released from MPIG removal will not remain within Rotherham and it is understood that they will be reinvested into the 'global sum' for general practice (equitable funding level).

5. Our Key Priority Areas

5.1 Quality Driven Services

A high-quality service can only be delivered if there is a focus on three key quality dimensions: clinical effectiveness, safety and patient experience. It is crucial that the economic challenge does not change this focus. We will, therefore continue to support innovation in clinical practice and develop pathways that improve effectiveness and that enhance the patient experience as well as providing value for money. The CCG already supports protected learning time every 2 months, for all GP practices and sufficient time for localities to ensure they are clinically and professionally updated. There are four core components to this focus: quality, innovation, prevention and productivity. The CCG will continue to review benchmarking and learning from peers to support this agenda.

Funding for all practices should be equitable for delivery of service and also demonstrate value for money. Core contract activities will be remunerated in line with national agreements. Benchmarking information, comparing practice quality and productivity within our area and externally, will be used to ensure value for money.

We will look to achieve best value for money, driving efficiencies in the way general practice is delivered. Local practices have already embraced the opportunities to be more efficient in medicines management and prescribing with £1.8m savings in 2014/15.

The CCG already undertakes quality peer review visits to all GP practices and has developed a framework to support practices where there are quality concerns co-commissioning principles. The Care Quality Commission (CQC) have advised the CCG that they will be undertaking quality visits of all GP practices during 2015/16 commencing with 8 practices in June 2015. The CCG will work collaboratively with practices where any required improvements are identified.

5.2 Services as Local as possible

Our main aim is for general practice to sit at the heart of a patients care. Currently, when a patient requires secondary care intervention, care is handed over to the 'specialist' and handed back once treatment is complete or where protocols exist for care to continue in the community. Often patients could be more appropriately managed by their GP who has a holistic understanding of the patient and therefore increasing used of shared care protocols is a key aim of this strategy. This is difficult to achieve when there are capacity issues therefore patient management will take on a variety of forms e.g. skype and telephone consultations and utilising our upskilled nursing workforce.

Three important local plans which will impact on general practice are the community transformation plan (which will improve and expand out of hospital care provided by teams from Rotherham NHS Foundation Trust), Rotherham Mental Health Transformation plan which will increase the locality focus of mental health services provided by RDASH and the Emergency Centre.

Integration with GP out-of-hours providers and other urgent care services will help to reduce duplication and confusion about how best to access urgent care. Rotherham CCG has committed to capital funding to build a new emergency centre on the Rotherham Hospital Foundation Trust site. Building work has commenced with a completion date in 2017, along with significant pathway work between primary and secondary care clinicians to ensure pathways are as seamless and effective as possible.

The CCG has also committed to the provision of 'social prescribing' to support patients requiring healthcare

5.3 Equality of Service Provision – Enhanced Services

GPs are contracted to provide "core services" (essential and additional) to their patients. The extra services they can provide on top of these are called „enhanced services" which are voluntary but, if taken up, often add to the quality of care. The CCG is committed to maximizing the uptake of enhanced services and will look to practices to collaborate with each other to ensure that patients have equitable access.

There are three types of enhanced service:

1. National enhanced services (NES) - services to meet local needs, commissioned to national specifications and benchmark pricing. The CCG is unable to influence these.
2. Directed enhanced services (DES) – must be commissioned by NHS England (optional for GPs to provide). The CCG will work with NHS England to ensure these arrangements are congruent with CCG aspirations.
3. Local enhanced services (LES) – locally developed and commissioned services designed to meet local health needs. These are now commissioned by the Local Authority and CCG.

Enhanced services address gaps in essential services or deliver higher than specified standards, with the aim of helping the CCG to reduce demand on secondary care and other health services. Enhanced services expand the range of services to meet local need, improve convenience and extend choice. The total investment by the CCG in 2014/15 was £3.4m. The number and variety of schemes has increased over the years as local enhanced services have been developed and the local enhanced services are currently:

- Case management
- Anticoagulation
- Aural care
- DMARDs (Rheumatology monitoring)
    - PSA

- Suture removal
- Acupuncture

In addition to this the CCG also has Local Incentive Scheme (LIS) which ensure that practices remain up to date with current practice. Rotherham CCG spends on average £4 per head of population, which is at the lower end of the national range

The CCG is responsible for providing services for all Rotherham patients so developing the capacity to help all eligible patients will be an important consideration when planning future expansions of general practice services.

5.4 Increasing Appropriate Capacity and Capability

Fewer trainees are choosing general practice when they qualify and more GPs are choosing to retire earlier than normal retirement age. Rotherham has a good track record of attracting trainees, predominantly due to a good reputation for education but also the proximity to Sheffield.

Until fairly recently, practices were almost exclusively run on a GP partner basis, with occasional use of locums to cover study, sickness or holiday absence. More recently, there has been a significant growth in locum and salaried GPs, with fewer being attracted to the partnership model. The primary care workforce is changing. An increasing number of GPs are working outside the traditional model with more sessional and locum GPs and utilisation of different professions, more typically nursing to undertake traditionally GP roles. The gender balance between male and female doctors is also changing which is also impacting on workforce availability as traditionally female GPs have chosen to work part-time. The success of the CCG will be dependent on its ability to embrace, utilise and develop potential across its whole clinical and non-clinical workforce. It will also work with provider organisations and the local authority to harness the skills of the wider primary care health and social care teams including district nursing, social work, pharmacy, podiatry, physiotherapy and others. A workforce plan is under development and will also incorporate the national 10 point plan – Building the workforce – new deal for GPs.

Practice size and sustainability is an important consideration. Rotherham has historically benefitted from having high quality services provided by practices of different sizes. In May 2015 the CCG Governing Body took the view that as opportunities arise the CCG will work to encourage small practices to work closer together in order to provide more sustainable services.

5.5 Primary Care Access Arrangements

Primary care access arrangements are set out in the GMS contract. This defines core hours as the period beginning at 8am and ending at 6.30pm on any day from Monday to Friday, except Bank holidays. The contractor must provide essential services at such times within core hours, as are appropriate to meet the reasonable needs of its patients. Practices offer a variety of systems for walk in access, telephone triage, same day and pre-booked appointments. Some practices close for one afternoon a month in order to have protected learning time however many increase their capacity during that week to ensure the same number of appointments are offered. Where practices are closed, arrangements are in place for patients to access the out of hour's service during this period.

It is acknowledged that access is one of the most significant concerns for the general public. As detailed below, the area requiring most focus is patient experience of making an appointment. From triangulating this data, we have commenced work with practices about their capacity for patients contacting their surgeries along with the service received once their call has been answered.

	ED 1										ED 2	ED3			
	Last GP/N they saw /spoke to was good at giving them enough time		Last GP/N they saw/spoke to was good at listening to them		Last GP/N they saw /spoke to was good at exp' tests / treatment		Last GP/N they saw/ spoke to was good at involving them in decisions about their care		Last GP/N was good at treating them with care & concern		Describe overall exp of surgery as good	Exp of making an appt as good			
	GP	Nurse	GP	Nurse	GP	Nurse	GP	Nurse	GP	Nurse			ED 1	ED 2	ED 3
Roth	87	83	88	82	83	79	76	69	83	80	86	74	81	86	74
Eng Av	86	81	88	79	82	75	74	67	82	78	86	77	79.2	86	77

The CCG will also work with practices to examine the options for extended hours to support access and redesigned service provision. At present, no GPs open on Saturdays with the known increase in impact on secondary care which is no longer sustainable. We will therefore review this evidence and pilot extended working arrangements to meet Rotherham population needs. This ambition will also support the new urgent care pathways which culminate with a new Emergency Centre opening in 2017.

5.6 New Models of Care

In October 2014, an alliance of NHS organisations published the Five Year Forward view. A significant element of this strategy is to review the local healthcare system to consider different models of delivering healthcare. Different variations of the models are emerging and NHSE announced in March the first wave of 29 Vanguard sites which will lead the way for piloting new operating models. It was also recently announced that Greater Manchester health and social care budgets will be devolved to the region's councils and health groups by April 2016 enabling local control over how budgets are allocated and with a main purpose to pool resources to improve out of hospital care.

As outlined in 4.2, the CCG has already committed to a new emergency centre which is based on a partnership between urgent care providers in Rotherham and best utilising the different skills of clinicians with primary and secondary care training. The CCG has also committed to transforming community services and already seen significant improvement to out of hospital care, focus is currently on the following:

- Better quality community nursing services
- Supported discharge and admission prevention
- Enhancing the Care Co-ordination Centre
- An integrated out of hours service

We will consider facilitating the availability of specialists and community teams in primary care settings. Consultants may work with federated groups of practices to provide integrated care, defaulting to primary and community settings rather than hospitals. This enhanced care will be provided in the home setting regardless of place of residence meaning those people who live in care homes will be able to access enhanced community and home based care. An effective case management Local Enhanced Service is already in place providing effective management of more than 12,000 patients who are at highest risk of hospital admission.

5.7 Self Care

The aim of self care is to prevent patient's conditions from deteriorating to facilitate them being able to remain at home, in familiar surroundings but with the knowledge that their condition is well managed. As well as the changes outlined above, which facilitate the most effective arrangements for long term care, patients and carers will be supported to take control of their long-term conditions through a variety of different ways. Case management and social prescribing are already in place to support patients. Community transformation projects will also refocus community nursing and social work time to input into patient reviews so all the patients needs are considered.

The CCG will also be considering the use of technology to assist patients to manage their conditions for example blood pressure monitoring at home with results reported directly into the GP to take action where results are abnormal.

Education will be a key component to self care, to empower patients and their carers to manage their conditions and to take a more active role in consultations and decisions about their care. . We know that to date, success in improving patient attendance and adherence has been patchy e.g. uptake for cardiac rehabilitation and we must work harder to devise innovative ways of reaching our population.

5.8 Robust Performance Management

As a CCG with delegated responsibility for GP commissioning, we have agreed trajectories for patient survey results with NHS England for the following three outcomes:

1. ED1 Satisfaction with quality of consultation at the GP practices
2. ED2 Satisfaction with the overall care received at the surgery
3. ED3 Satisfaction with accessing primary care

2014/15 performance is included within the primary care access arrangements section of this strategy. In addition to this, the CCG has developed a performance dashboard that provides the primary care sub-committee with an effective tool for high level monitoring of general practice key performance indicators. Data alone is not an indication of poor service provision however this enables the primary care sub-committee to focus attention on practices that are outlying to ensure that the primary care team are triangulating with other local intelligence to take the necessary steps and provide the committee with an appropriate level of assurance.

This also supports the published commissioning and quality principles for primary care. These identify the processes which will be followed in circumstances where the key performance indicators are not being achieved.

5.9 Continued Improvements to Medicines Management

The CCG is responsible for all GP prescriptions issued by its member practices. In 2014/15, the CCG spent £45.7 million on prescriptions and on commissioned services (nutrition and continence). The CCG is focused on ensuring all patients are receiving the right medications, at the right time, to date efficiency savings of over £1.8m have been achieved. A Prescribing Local Incentive Scheme commenced in 2014/15 and is reviewed regularly to ensure more effective practice is achieved.

5.10 Engaging Patients to Ensure Patient Pathways are Optimised

Rotherham CCG is committed to active and meaningful engagement with all its patients and potential patients Link to engagement and communications plan.

Patient Participation Groups have been in existence for several years; the changes to primary care commissioning will mean that the CCG can more effectively:

- Work with practices to ensure that wherever possible, practices have an active PPG, operating to acknowledged good practice (Link to NAPP website)
- That PPGs are supported through the PPG Network with information, shared good practice, and the opportunity to consider wider, cross Rotherham issues

However, PPGs are only one mechanism for patient and public engagement and experience. The CCG also aims to extend engagement, and work with a variety of organisations to improve the patient voice for specific communities, both geographical and communities of interest, for example people with specific long term conditions. If the CCG is to develop new ways of working; it will be vital to ensure

that patient experience actively and meaningfully informs new systems and processes. This cannot be done in one way, and may involve any of the following:

- Condition specific focus groups
- Patient interviews and/or diaries
- Patient experience – from survey work, consultations, and other feedback (ie social media, complaints and issues raised with other bodies such as Healthwatch)

6. Enablers to Delivering our Strategy

6.1 Primary Care Estates and Premises

The CQC has a mandate for ensuring that essential standards of quality and safety are met.

However, the CCG undertakes quality visits which encourage practices to offer premises that:

- Deliver care in the right place with the right access
- Provide the patient with an environment that is fit for purpose
- Ensures easy access with clear sign posting
- Meets all statutory and mandatory requirements including compliance with all relevant disability, fire, health and safety legislation

Rotherham Metropolitan Borough Council are currently reviewing all 'government' estate to ensure it is fit for purpose and utilised appropriately across all services. Whilst this is welcomed by the CCG, many general practices are privately owned by partners in the practice and will not therefore be captured under this review. The CCG will therefore undertake an assessment of the current estate suitability for primary care in Rotherham. The strategic direction is towards larger practices, able to provide a range of general medical services, enhanced services and community based healthcare.

6.2 Information Management and Technology

The CCG has developed its IT strategy through consultation with GPs, RMBC and providers and the following identified the key areas where IT development will support the general practice agenda

Practices should be able to access electronic information relating to their patients when they are treated in other parts of the health system. This particularly includes discharge and out patient summaries, pathology, diagnostics and care delivered in community settings.

The CCG is supporting the roll-out of SystmOne to practices as the system of choice. At present 8 practices use a different system, EMIS web which to date has caused a barrier to linking practices. EMIS web and SystmOne have now agreed to facilitate interoperability between the 2 systems which will significantly support the CCG's strategy to facilitate the exchange of information between practices and other local providers, dissemination of guidelines, audit etc. whilst ensuring patient confidentiality is maintained, there are appropriate levels of data protection and access will be undertaken only on a need to know basis.

The CCG is also supporting practices to utilise the Electronic Palliative Care Co-ordination Systems (EPaCCS) which enables the recording and sharing of patient's preferences and key details about their care with those delivering their care. The systems support co-ordination of care and the delivery of the right care, in the right place, by the right person, at the right time. EPaCCS is the most effective way of providing an EOLC register for patients in Rotherham, enabling information to be seen and shared by all parties involved in a patient's care. A template has been developed and IT solutions put in place to enable the sharing of this information across primary care. GPs have a key part in the roll-out of an electronic EOLC register in Rotherham and linking this to the PMS premium will provide an excellent incentive for the EPaCCS to be fully implemented and for patients to get real benefits from a co-ordinated and well informed approach to their care

The CCG is committed to ensuring that all patients have equal access to internet based services, in particular the ability to book appointments online and order repeat prescriptions which are then automatically forward to pharmacies for collection. 33% of practices are now live with EPS Release 2 functionality and 82% of pharmacies. Many general practices in Rotherham already offer the facility to online book but it is not well publicised and websites are not easy to navigate so a key aim will be

- The CCG is also committed to exploring best practice in relation to IT solutions for self care, it will therefore commission and IT workstream to review the following:
- Monitor and review telehealth solutions that can be used to support the elective referral programme
- Monitor and review telehealth solutions that can be used as part of Long Term Conditions management
- Observe the work ongoing in other health communities and the whole system demonstrator programme to identify opportunities for local telehealth implementations in particular, there is strong support across the NHS for Flohealth with positive feedback from where it has been implemented to date

Implementing (RAIDR) Reporting Analysis & Intelligence Delivering Results. The CCG is required to provider member practices with high quality information on patient activity and costs. In summer, 15/16 the CCG will pilot RAIDR which is a GP developed tool initially from the North East of England. It is expected that this tool will help practices better understand their patient flows and compare their activity with their peers. The tool has a range of Dashboard covering areas such as emergency admissions, patients who regularly attend hospital, risk stratification, linkages between prescribing and activity data. There are also screens that will help practices with tasks such as flu vaccination, dementia diagnosis and data quality. Over time it will be possible to develop screens that will make reporting for Locally Enhanced Services to become less onerous. If the tool pilots well the CCG will procure RAIDR for all practice in autumn 15/16.

Appendix 2: Estates Strategy for General Practice within Rotherham

NHS Rotherham CCG

Strategic Estates Plan

August 2015

Contents

Executive Summary

Rotherham CCG Estate Strategy (2015-20*)*

This paper provides a summary of the CCG local estate strategy review process and the proposals to support the NHS 5 Year Forward View:

1. Scope Overview:

- Review only covers NHS PS Primary Care buildings
- The CCG has a new General Practice Strategy that is being developed which this Strategic Estates Plan (SEP) is a key enabler for delivery

2. The CCG drivers and challenges:

- Care closer to home in order to reduce hospital admissions and tackle the health inequalities.
- CCG has had delegated authority for commissioning general practice services and requires an effective SEP

3. The estate overview:

- 20 properties, comprising 15,200 sq. m
- Costs of £5.2m p/a
- Very few Leasehold opportunities.

4. Key themes emerging from the review:

- Overall the estate is in a good condition.
- The health infrastructure impact of a new 20,000 person residential development at Waverly.
- There are challenges around vacant space and looking to bring two modern good quality properties to full utilisation.

5. Property Opportunities and savings:

- Disposals opportunities totalling receipts of £265k
- Cumulative running cost saving of £867k over the 5 year period.
- Address the void space at 2 purpose built clinical facilities at Rawmarsh Customer Service Centre and the PDL Bungalows

6. Other property considerations:

- A new health care facility will be delivered in the Waverly area as this new settlement builds out. NHS PS will support the CCG in the delivery of this facility. NHS PS would likely become the new owner of this property but this is to be confirmed

7. Recommendations

- The strategy and opportunities are endorsed by CCG and NHS Property Services

1 Scope overview

- The CCG has an overall vision of working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities.
- This strategy reviewed the CCG clinical strategy and NHS PS property in the CCG's area – a summary of the key themes is included in Section 4 of this report.
- Rotherham's resident population is estimated at 259,800 who are cared for by a total of 36 GP practices (as at April 2015) alongside a centrally based walk-in centre providing 24/7 access.
- The CCG has a new General Practice Strategy that is being developed which this SEP is a key enabler for delivery. Since April 2015 the CCG has had full delegated authority for commissioning general practice services
- Many general practices are privately owned by partners in the practice, this is starting to become more of an issue as GPs are now more likely to choose to become a salaried GP rather than take on a partnership.
- Dialogue with other NHS stakeholders and the Council has taken place in the development of this strategy and will continue as the opportunities are developed.

2 The CCG drivers and challenges

Health Inequalities and increase in Elderly care needs

- Life expectancy in Rotherham is one year less than the England average.
- Life expectancy varies by eight years between different parts of Rotherham.
- Too many people are admitted to hospital who do not need to be, which results in high costs of treatment.
- Increasing numbers of older people with long term conditions which has a direct impact of health needs.

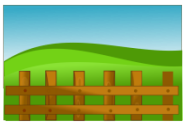
Clinical Strategy and Financial Implications

- Transforming community care and Care closer to home in order to reduce hospital admissions and tackle the issues listed above.
- Improved patient pathway so that patients are seen at the right place at the right time.
- Since April 2015 the CCG has had delegated authority for commissioning general practice services and this is a driver for a clear and effective Strategic Estates Plan.
- Maximising the partnership with RMBC to deliver optimum value for the Rotherham pound
- £75 million efficiency challenge over the next 5 years

3 The Estate Overview

Overall the estate is in a good condition as the former PCT invested heavily in the buildings with the council on joint medical centres.

20 Holdings / 15.2k sqm NIA / x Ha

	13 Holdings - 7510sqm NIA Health Centres		3 Holdings - 3502sqm NIA Hospitals
	0 Holdings Nursing/Care Home		3 Holdings - 4201 sq. NIA Offices
	1 Holdings (Car Park) Land without buildings		0 Holdings Other / Unknown

Top 5 properties (by size - NIA)

- **Rotherham Community HC** (Health Centre) 2914
- **Oak House** (Offices), 2461
- **220 BML (Badsley Moor Lane Hospital)** (Offices), 1740
- **Breathing Space** (Hospital), 1231
- **Aston Joint Service Centre** (Health Centre), 998

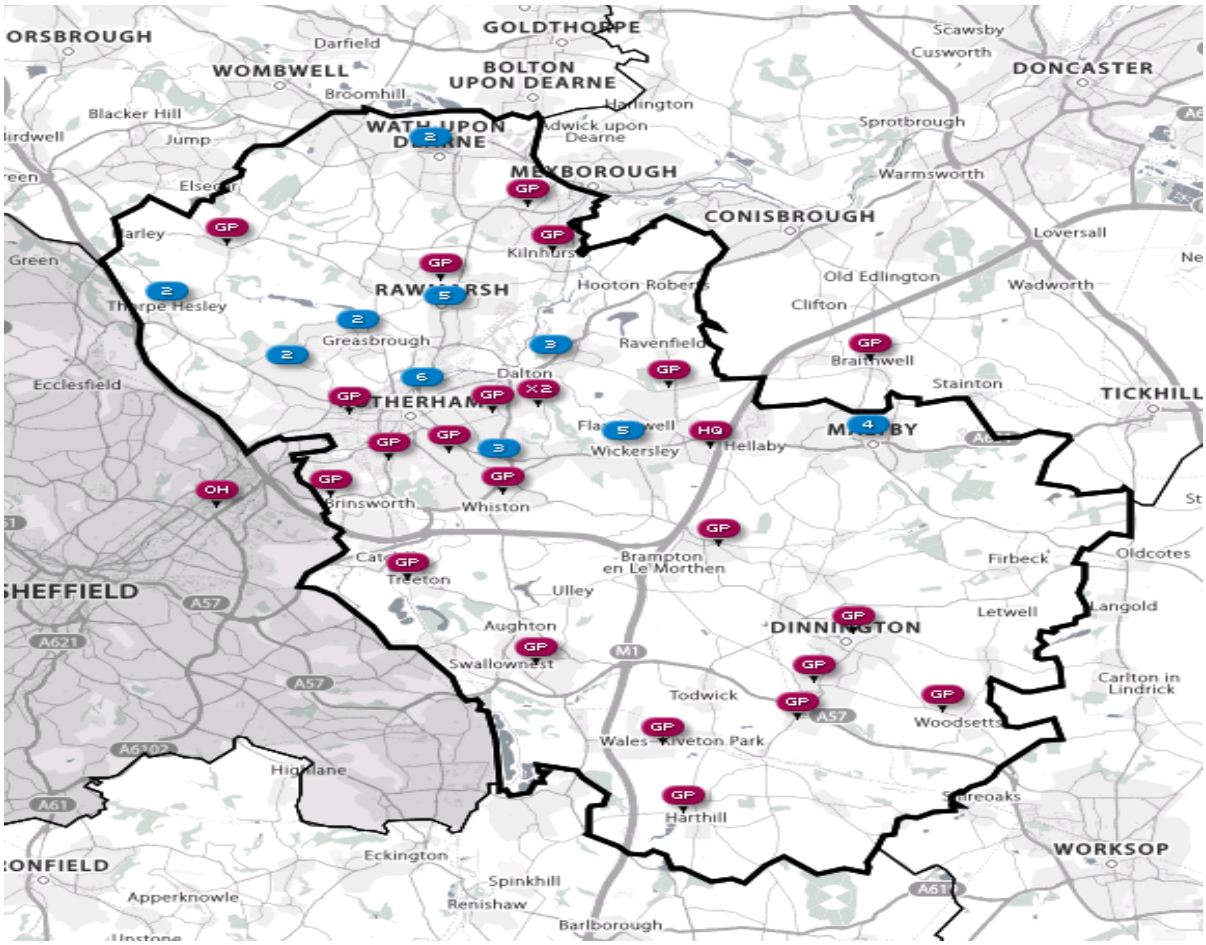
Total Cost of Estate

- **Based on 15/16 costs: £5.2m p.a.**

Top 5 Properties by Cost

Property	Running Cost £ p/a	Running Cost £ per m2
Rotherham Community HC (Health Centre)	£2,381,324	£817
Oak House (Offices)	£848,280	£345
220 BML (Badsley Moor Lane Hospital) (Offices)	£505.133	£292.61
Maltby Service centre (Health Centre)	£444,177	£779
Aston Joint Service Centre (Health Centre)	£280,324	£281

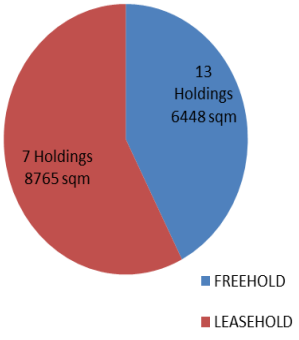
The Estate Overview – Estate Map



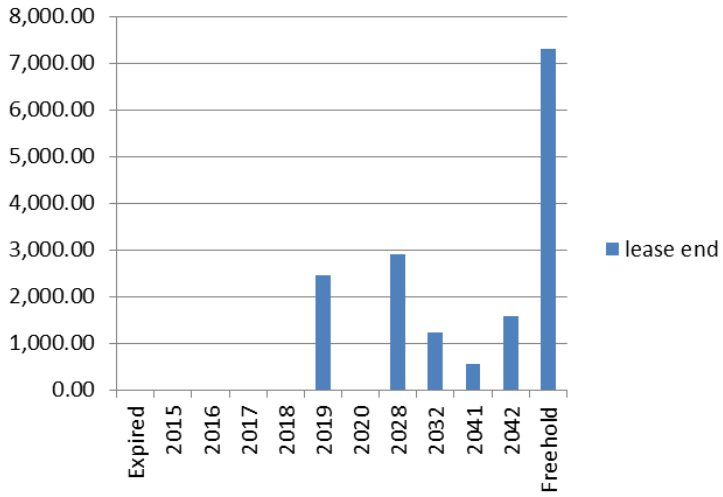
The Estate Overview

- Very few lease break opportunities and Oak house is a purpose built health admin building which is in an excellent location and popular with tenants.
- **Leasehold Opportunities (5 Years)**
- Oak house (CCG HQ and main admin base) end of lease 29.9.19

14.8K NIA sq m (20 Holdings)



Lease End + Break Profile (NIA sq. m)



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4 Key themes emerging from the review

1. **Immediate Priorities:**
   - Clinical leadership, both in primary and secondary care
   - Delivery of effective out of hospital care to reduce admissions
   - Supporting self-care and delivering care as close to home as possible and therefore a fit for purpose local estate
   - Better IT to improve communication, access to services and patient education

2. Healthcare planning and Challenges:

The JSNA and Health and wellbeing objectives are:

- Prevention and early intervention
- Expectations and aspiration
- Dependence to independence - to tackle the marked health I equalities in Rotherham
- Healthy lifestyle – to tackle the marked health I equalities in Rotherham
- Managing long term condition- Rotherham has increasing number of elderly with these
- Reducing poverty -to tackle the marked health I equalities in Rotherham

3. Service Model Developments /Changes:

- Care closer to Home to reduce hospital admissions and tackle the above challenges
- Improved consistency in access to general practice – aspiring to within 24 hours for an urgent appointment and within 5 days for routine appointments

4. Financial considerations:

- The CCG has a £75 million efficiency challenge over the next 5 years
- Efficiencies passed on to all providers who must make 3.5% saving a year
- Finding each additional annual efficiency saving is increasingly challenging
- Rotherham will spend around £14.1 million on public health in 2014/15, commissioned by RMBC

5. Existing strategies and plans:

- Rotherham Health and Well Being Strategy that will be refreshed by September 2015 delivering the outcomes of the Better Care Fund and working with partners to improve public health outcomes in Rotherham.
- A new General Practice Strategy is being developed which this SEP is a key enabler for delivery.

6. Key site requirements:

Overall the estate is in a good condition as the former PCT invested heavily in the buildings with the council on joint medical centres. However the following are the key challenges the SEP must tackle:

i) Waverly

- The impact of the Waverly residential development (circa 20,000 new patients) and the subsequent new Primary Care provision needed for which the capital finance will be provided by S106 developer contributions.
- Linking to the Waverly development the future of nearby Treeton medical centre (NHS PS owned).
- NHS PS can provide assistance to the CCG regarding these issues and the path to future delivery.

ii) Rawmarsh Customer Service Centre (RMBC owned, NHS PS long lease)

- Rawmarsh Customer Service Centre – The building is currently underutilised with a high vacancy rate (42%) but is an excellent modern purpose built building. A co-location opportunity exists with a cluster of GP practices and/or the vacant space could be marketed. (Options paper needed).

iii) PLD Bungalows (NHS PS owned)

- Are part of the 220 Badley Moor Lane site (NHS PS owned) have recently become vacant (100%). There were purpose built as a residential/day care for learning difficulties. They are part of and central to a large integrated wider health complex at BML that was built on a former hospital site. Given this they will have to retained for some kind of health or health related use and an options paper and/or a planning appraisal will need to be conducted to determine their future use.

iv) GP Estates Issues

- The future of Broom Valley GP (privately owned) which is in a poor condition. (Options paper needed)
- Canklow Road (NHS PS owned) poor quality building, potential to dispose and move to private premises.
- Rosehill medical centre (NHS PS owned) is small and in a poor condition.(options paper needed).
- A new health facility has opened at Dalton and the former Dalton MC (NHS PS owned) can be disposed.

5 Property Strategy Forward View

 **Clinical Estate**	Overall the estate is in a good condition and most sites have had recent investment. NHS PS have identified with the CCG some sites that are in a poor condition and need replacement or surplus to requirement. Need to tackle the key void space at Rawmarsh. A new facility is needed to meet planned growth at Waverly. This will funded by developers as part of a S106 agreement.	→	Dispose of surplus sites at Dalton Health Centre (new build complete) and review of the poorer quality sites at Rosehill and Canklow Road (options papers needed). Assess the future of Broom Valley GP (options paper needed). Fully utilise the Rawmarsh Centre through co-location of nearly by GP practices or sub letting. Help deliver the new facility at Waverly linked to the existing GP facility in Treeton.
 **Admin Estate**	Oak house (CCG HQ) has a lease end opportunity, however the CCG have confirmed the property is ideal for them. The 220 BML is 100% occupied by the council and forms the Learning Disability Service. PLD Bungalows were purpose built for a service that didn't develop the numbers required to make it viable. They are part of the above complex/site and are vacant and need to be found a new use.	→	Retain Oak house and 220 BML. Fully utilise the PLD Bungalows. An options paper and potentially a planning assessment would be required. Then marketing.
 **Estate Metrics**	Running costs: NHS PS estate £5.2m p/a Estate footprint: 11,012sq. m of clinical space across 16 property holdings. 4,201sq. m of back office space across 3 property holdings.	→	Running costs: Target to reduce the ongoing running cost to less than £5m p/a Around a 4% saving. A cumulative saving of £857k over the 5 year period. Estate footprint by March 2020: - 10,612sq. m. of clinical space across 13 properties. - 4,201sq. m of back office space across 3 property holdings. - Reduction of void.

6 Summary of Property opportunities

Summary of financial benefits:

Opportunity Area	15/16	16/17	17/18	18/19	19/20	Totals	One-off capital receipts	One-off maintenance avoidance
Consolidation and disposal opportunities	63	12	0	0	0	**75**	£265k	TBC
Improved utilisation and sub/let savings / maintenance avoidance Marketing of surplus (void) space	0	126	0	0	0	**126**	0	TBC
Leasehold opportunities – - Exits - Regears	0	0	0	0	0	**0**	0	TBC
Totals	**63**	**138**	**0**	**0**	**0**	**201**	**£265**	**TBC**

Summary of non-financial benefits:

- Reconfiguration of the estate to better meet the commissioners needs
- Disposal of property that is surplus to need or is not fit for purpose.
- Full utilisation of quality modern purpose-built estate at Rawmarsh Service Centre and PDL Bungalows at Badsley Moor Lane.

Consolidation and disposal opportunities:

Opportunity	Estimated Running Cost savings £k pa	Estimated disposal proceeds £k	Target Financial Year of savings
Disposal of Canklow Road GP Surgery (NHS PS Owned)	**£4k**	**£48k**	**16/17**
Disposal of Dalton Health Centre + Land (NHS PS Owned)	**£63k**	**£125k**	**15/16**
Disposal of Rosehill Medical Centre (NHS PS Owned)	**£8k**	**£92k**	**16/17**
Totals	**£75k**	**£265K**	

Canklow Road

Rosehill Medical Centre

Improved utilisation and sublet savings:

Opportunity	Estimated Running Cost savings £k pa	Maintenance Avoidance £m pa	Target Financial Year
Option 1 Rawmarsh Service Centre. Improve utilisation by facilitating with the CCG the co location of 3 x privately owned GP practices	£85k	Tbc	16/17
Option 2 Rawmarsh Service Centre. Market the vacant space (or residual space if 1 or more of the GP relocate)	£85k	tbc	16/17
Market the 4 PLD Bungalows at 220 Badsley Moor Lane (offices/residential other)	£41k	TBC	16/17
Totals	£126k	£TBA	

Rawmarsh Customer Service Centre

Leasehold exit opportunities

Opportunity	Estimated Running Cost savings £ p/a	Estimated disposal proceeds £ p/a	Target Financial Year
None (Oak house is the only opportunity, it was purpose built as the PCT HQ and the CCG and other tenants want to remain)	**0**	**0**	**N/A**
Other property considerations: A new health care facility will be delivered in the Waverly area as this new settlement builds out. A facility of al least 1300 sq. m is agreed in the S106. NHS PS will support the CCG in the delivery of this facility. NHS PS would likely become the new owner of this property but this is to be confirmed			

Oak House current CCG HQ

7 Investment considerations

Investment considerations:

- NHS PS to offer support to deliver the health care element of the Waverly development where a health care centre of at least 1300 sq. m is stipulated in the S106 signed on 03/03/2011. Negotiations with the Local Planning Authority and developer will take place and a delivery route would be worked up in due course. It is envisaged that this would be a NHS PS asset but developed using capital from developer contributions.
- Currently there is land held by NHS PS adjacent to the Treeton Medical Centre for a new build scheme to replace the ageing building. The practice has so far not indicated that they would like NHS PS to pursue this new build through a customer capital scheme. There is potential to link this with the new build at Waverly. Options need to be discussed with the CCG and practice and agreed by the Primary Care sub-committee

8 Financial Analysis

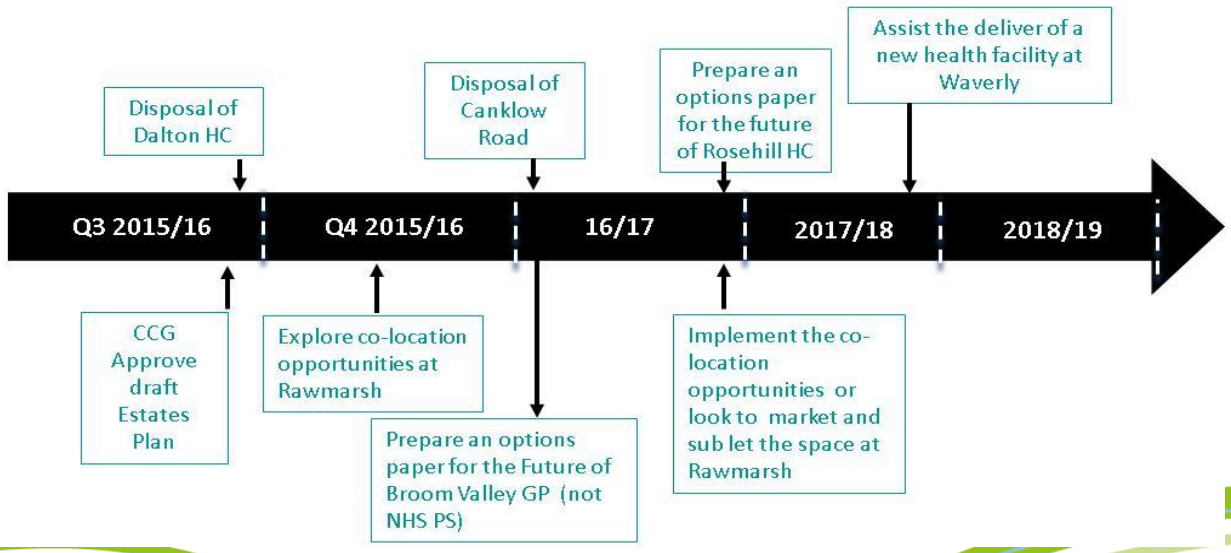
Indicative profile of running costs savings:

- **Cost savings profile based on full year benefit from the year of the event with cumulative benefit.**
- **Disposal proceeds shown in year of receipt**

Target financial Year	15/16	16/17	17/18	18/19	20/21	5 Year Total
- 15/16 savings	63	63	63	63	63	315
- 16/17 savings		138	138	138	138	552
- 17-18 savings			0	0	0	0
- 18/19 savings				0	0	0
- 19/20 savings					0	0
Total 5 Year Running Cost savings	63	201	201	201	201	867
Disposal Proceeds £k	125	140	0	0	0	265
Net Benefit £k	187	341	201	201	201	1132

9 Work Plan

- NHS PS is working with the CCG to deliver the strategy.
- Timeline of work programmes and planned disposals



10 Recommendations

Example CCG Estate Strategy (2015 -19): Recommendations for CCG approval:

1. Implementing priority healthcare changes
   - The CCG has a new General Practice Strategy that is being developed. This Strategic Estates Plan is a key enabler for delivery.
   -

2. Cost reduction opportunities
   - The review has identified costs savings of £200K.
   - These costs saving can be made with little impact on service delivery
   - The disposals identified will be added to E-Pims and offered to all priority purchasers including the local councils. If no interest is received NHS PS will openly market the properties
   - The capital receipts are based on estimates, market valuations will be carried out to ensure the disposals receive best value.

3. Dealing with void space
   - NHS PS will look at co-location opportunities with the CCG and individual GPs focused on the Rawmarsh Service Centre in Q4 of 2015/16.
   - If this doesn't produce results then NHS PS will actively market the space in 2016/17.
   - Following an options appraisal NHS PS will actively market the vacant space at the PDL Bungalows in 2016/17.

4. Improving estate utilisation
   - The actions listed in the above section are the key to improving estate utilisation in Rotherham.
   - The utilisation will continue to be monitored and reviewed and any significant changes will be addressed by the CCG and NHS PS in line with this strategy.

6. Work Plan
   - The plan at section 9 outlines a number of key projects that will need to be progressed to realise the savings.
   - These projects need to be worked through utilising NHS PS Asset management teams, Capital and Facilities teams.
   - NHS PS and the CCG will work together to drive forward the opportunities and optimise the benefits.