

# NHS Rotherham Clinical Commissioning Governing Body

Operational Executive – 26 January 2015

Strategic Clinical Executive – 14 January 2014

GP Members Committee (GPMC) – 21 January 2015

**Clinical Commissioning Group Governing Body - 4 February 2015**

## 2015 Commissioning Plan

Lead Executive:	<b>R Carlisle</b>
Lead Officer:	<b>L George</b>
Lead GP:	<b>J Kitlowski</b>

### **Purpose:**

For Governing Body members to approve the 2015 Commissioning Plan.

### **Background:**

Following the Governing Body Development Session in September and locality discussions in October, Governing Body Members were circulated the first draft of the commissioning plan in December. Since then there have been many amendments in response to feedback from GPMC, the public, stakeholders and in response to financial and planning guidance issued by NHS England.

This draft was approved by GPMC on 21 January, however there are still some areas to be finalised because we are awaiting final guidance from NHS England on outcomes and CQUINS. There may also be subsequent modifications following feedback from the Health & Well Being Board on 18 February, the final outcomes of contract negotiations at the end of February and feedback from NHS England.

To assist members understanding the development of the plan, amendments that have been made since the circulated December draft are marked in blue. More recent amendments since GPMC on 21 January are marked in green. Areas where guidance is still awaited are marked in yellow.

### **Analysis of key issues and of risks**

#### **Key points to note include:**

- The 5 year vision on page 4. (This includes an additional reference to welcoming new models of care).
- The plan on a page on page 9 (this includes a simplified list of 8 strategic aims and more prominence to safeguarding in particular Child Sexual exploitation)
- A list of 'least worst' options for keeping activity within affordable limits (page 11). These will be considered in more detail by the CCG in April/May 2015
- Comments about workforce capacity in general practice, A&E and psychiatry (p 22)
- The CCG's proposals on delegated commissioning for General Practice (page 59)
- Sections on Efficiency and Finance (Sections 8 & 9)
- Mention of 2014/15 performance challenges with regards to A&E and non-elective trajectories in Section 12. In 2015/16 the CCG is proposing to keep non elective flat, at 16% below their 2010/11 peak. Given the fact that non-electives rose by 4% in 2014/15 this is challenging, however the CCG has confidence that the plans outlined in the plan (particularly in Sections 5.1, 5.2 and 5.7) will deliver affordable trajectories and achieve



the best balance of developing community and primary care whilst keeping secondary care sustainable.

- The section on risks (Section 13) is derived from the highest risks in the organisations risk register, Members are asked to comment whether this section is a fair reflection of the key risks to delivering the plan.

#### **Patient, Public and Stakeholder Involvement:**

This is covered in the plan in 3 ways:

- throughout there are plan are speech bubbles and CCG responses.
- section 6.3 summarises what we do and has a link to the new CCG Communication and Engagement Plan '*Your Life, Your Health, Your Say*'.
- section 14 describes how we shared this plan.

Following completion of the plan we will also produce a shorter version and some illustrative patient stories to help on-going dialogue with the public.

#### **Equality Impact:**

Covered in the plan.

#### **Financial Implications:**

Covered in Sections 8 & 9

#### **Human Resource Implications:**

Covered in the plan.

#### **Procurement:**

Covered in the plan.

#### **Approval history:**

Final plan

#### **Recommendations:**

- The Governing Body is asked to approve the current draft.  
The Officer to be authorised to make amendments resulting from H&WBB feedback, contract negotiation finalisation, further guidance or feedback from NHS England and report any amendments to subsequent Governing Body meetings.
- A version to be placed on the CCG internet after 26 February 2015.

# Commissioning Plan

2015-2019

Final draft V3.1 28 01 15



This draft is for final discussion at GPMC on 21 January. Substantial amendments since draft one are highlighted in blue text. Yellow text are areas that still may be changed.

Amendments to GPMC version are in green

The draft could still be amended during the contract negotiations and following further guidance and feedback from NHS England

Documents will only be hyperlinked once the plan is available on the CCG website at the end of February.

Your life, Your health



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# 1 Executive Summary

## 5 year vision for health and social services in 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:

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

They will be underpinned by NHS Rotherham Clinical Commissioning Group's (CCG) solutions to the five year £75 million efficiency challenge:

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

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

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

Key measures of successful outcomes will include:

- **additional years of life** – 200 additional life years per year
- improving health related **quality of life for people with long term conditions** to the national average
- reduced avoidable time in hospital – **hospital admissions** will remain at their current level of 16% below their 2011/12 peak
- improved reported **patient satisfaction of hospital care** to the national average and maintain current very high levels of **satisfaction with GP care.**

The CCG will transform services over the next 5 years to achieve these aims. Our key local workstreams include:

- Transforming community services to ensure all patients can access high quality, fit for purpose community services with increased capacity for community teams
- **Strengthened general practice services, aligned to patients needs and using new models of care so that GP expertise in risk management is used where it is most needed**
- Transform urgent care to offer high quality, sustainable clinical services 24/7
- Ensuring mental health services are fit for purpose and accessible to patients
- Ensure all pathways are efficient. offer high quality services and patients have the best possible experience



This plan sets out Rotherham CCG's vision for the next 5 years and a detailed plan for 2015/16. On page 8 we summarise the CCG's purpose. The executive summary expands the **plan on a page** (page 9). In the introduction page 10 we summarise key achievements. We set our preferred plan to keep activity with affordable limits and also list a series of 'least worst' options for possible restrictions in services that we may have to implement if activity remains above affordable levels. We will discuss these further with patients and stakeholders in 2015.

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

### The Health Service Efficiency Challenge

Like all of the public sector the health sector faces a substantial efficiency challenge of £30 billion for the NHS overall over the next five years. NHS Rotherham CCG's share of this challenge is around £75 million.

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

**Provider QIPP:** *efficiencies passed on to all providers.* For the last three years and for the foreseeable future, providers have been expected to provide the same services with less funding. For example in 2015/16 providers will be given a 1.9% uplift in funding but are then expected to make 3.8% efficiency savings.. This means they will receive up to 1.9% less in absolute terms for providing the same services. When QIPP was introduced in 2011 finding the rounds of 4% efficiency savings involved avoiding duplication and waste but finding each additional annual efficiency saving is increasingly challenging.

**System Wide QIPP:** *efficiencies that are the direct responsibility of the CCG.* NHS financial allocations are expected to rise by around 1 - 2 % each year over the next five years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth would continue at around 6% a year because of the aging population, new medical technologies and rising expectations. System wide QIPP programmes are the actions required to keep overall growth at an affordable 1 - 2% level rather than the historical 6%. We have 5 CCG QIPP areas and the Better Care Fund which reports directly to the H&WB Board:

System Resilience Group	Transforming Community Services
Clinical Referrals Management Committee	Information Technology
Mental Health and Learning Disabilities QIPP Committee	Working Together (with SY hospitals and CCGs)
Medicines Management Committee	Better Care Fund

Our approach to efficiencies is described in detail in section 8.



We face five substantial **challenges**:

1. Although Rotherham people's health improves each year Rotherham is below the national average for key outcomes. For example **life expectancy is more than a year below the national average**.
2. There are unacceptable inequalities in health *within* Rotherham. **Life expectancy is eight years less in some parts of the Borough compared to others**.
3. At the moment **too many health problems are dealt with by hospital admission**. Rotherham's health service needs to be reshaped to meet the needs of its population more effectively and to enable more resources to be invested earlier to prevent problems as well as treat them.
4. **The health service efficiency challenge** (see box on previous page).
5. The population is living longer. This is good news in that most people are experiencing more years of good health, but it also means that there are more **people with multiple long term conditions** and people in Rotherham are experiencing more years of ill health than the national average.

We suggest five **solutions**:

- **Clinical leadership, both in primary and secondary care**. The CCG is a successful GP led, members' organisation and has made substantial progress working with other clinicians across Rotherham.
- **Supporting self care and improving quality of care at home**. Too many people are admitted to hospital in Rotherham. Although this is what the public and clinicians in Rotherham are used to, in the long term it is unsustainable. For most problems, patients prefer to be treated at home. High quality home care is also safer because even the best hospitals cannot eliminate all the risks of hospital admission, such as acquired infection and loss of independence.
- **Transforming out of hospital care**. The Rotherham NHS Foundation Trust (TRFT) provides both hospital services and many community care services. We will ensure there is an adequately funded and led community nursing service that is focussed on locality teams.
- **Better use of Information Technology**. IT systems that help patients to have more control over their health and information when they require it, and that help clinicians to access the information they need, and have options in addition to face to face consultations.
- **A stronger patient voice**. Our communication and engagement plan, 'Your Life, Your Health, Your Say' sets out how we will listen to patients across all areas of our work and ensure that what people tell us, informs how we commission and plan services. We will do this not only because it is best practice, but also because it is the best way to deliver our plans and meet our responsibilities. Being led by eight GPs and working with all our members who each hear over 100 patient stories a week gives us a head start in this area. In Section 6.3 we describe our full engagement strategy.

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

1. **Transforming Unscheduled Care**. By April 2017 we will transform how patients receive urgent care in Rotherham by integrating the current fragmented services provided by accident and emergency, walk in centre and GP out of hours into a single emergency centre where patients who need urgent treatment will get it from the most appropriate clinical advice first time without the need for onward referral. Patients who do not require urgent care will be signposted to other services. We will continue





to expand the GP led, multidisciplinary, case management of the 12,000 patients in Rotherham at highest risk of admission to hospital, maximising the visibility of case management plans to other clinicians. We will expand Rotherham's successful Care Coordination Centre that offers options such as urgent assessments and out-patient clinics as alternatives to hospital admission.

2. **Clinical Referrals:** The CCG will build on successes in improving care pathways and providing top tips advice to clinicians about planned and urgent referrals. We will reduce unnecessary hospital follow-ups down to national averages. This will include the managed, funded transfer of some follow ups to general practice. We will also reduce waste from duplicated diagnostic tests.
3. **Transforming Mental Health:** We will deliver Rotherham' Adult Mental Health Transformation Plan. This will include an enhanced mental health liaison service for adults and older people with acute problems; an improved dementia care pathway with more of the care being provided in the community prior to hospital assessment, improved access times for psychological treatments and increased voluntary sector support for people with long term mental health problems and dementia.
4. **Transforming Community Services:** We will invest in increased capacity and improve the locality focus of community nursing teams so that more people can be cared for in their own homes instead of being admitted to hospital and so that people who are admitted can return home as soon as possible. We will maintain £5 million of additional investment with a range of providers for additional out of hospital investments, including: GPs, a social prescribing project with Voluntary Action Rotherham and community end of life care delivered by Rotherham Hospice.
5. **Commissioning General Practice Services:** From 1 April 2015 the CCG will have delegated authority for commissioning general practice services. This means that decisions affecting general practice can be made locally in Rotherham and enable local GPs to have influence in the crucial priority of recruiting and retaining GPs and general practice staff to work in Rotherham.
6. **Medicines Management:** We will build on our award-winning successes in medicines management, working with all practices on quality, efficiency and delivering six specific service redesign projects. Reducing waste will be a key priority.
7. **Maximise partnerships with RMBC:** We will work with partners to deliver maximum value for the Rotherham pound. This will include delivering the outcomes for the 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.
8. **Maximise partnerships with other CCGs and Foundation Trusts in South Yorkshire:** to ensure that efficiency challenges that face all South Yorkshire health organisations are managed safely and sustainably. The specific priority areas are listed in section 3.

Key outcomes include:

- additional years of life – 200 additional life years per year
- improving health related quality of life for people with long term conditions to the national average
- reduced avoidable time in hospital – hospital admissions will remain at their current level of 16% below their 2011/12 peak
- improved reported patient satisfaction of hospital care to the national average and maintain current very high levels of satisfaction with GP care.



## NHS Rotherham CCG 'Purpose on a Page'

### NHS ROTHERHAM CLINICAL COMMISSIONING GROUP

#### **Our Responsibilities**

*NHS Rotherham CCG is a membership organisation of 36 practices which is responsible for commissioning a range of local health services on behalf of the people of Rotherham.*

*We are responsible for commissioning acute hospital and mental health services, community health services, ambulance and hospice services. From April 2015 we expect to have delegated responsibility for commissioning GP services and some specialist services.*

*We do not commission pharmacy, optometry, dental and most specialist services (which are the responsibilities of NHS England) or public health services (which are the responsibility of RMBC).*

#### **Our Mission**

*"Working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities"*

#### **Health and Wellbeing Board Vision for Rotherham**

*"To improve health and reduce health inequalities across the whole of Rotherham"*

#### **Our Values**

In **everything** we do we believe in:

- Clinical leadership
- Putting people first, ensuring that patient and public views impact on the decisions we make
- Working in partnership
- Continuously improving quality of care whilst ensuring value for money
- Showing compassion, respect and dignity
- Listening and learning
- Taking responsibility and being accountable

#### **Our Priorities**

Our four **key priorities** are:

1. **Quality** - improving safety, patient experience and outcomes and reducing variations
2. **Delivery** – leading system wide efficiency programmes that consistently achieve measurable improvements whilst meeting our financial targets
3. **Assurance** - having robust internal constitutional and governance arrangements, ensuring that providers' services are safe and ensuring vulnerable people have effective safeguarding
4. **Safeguarding** – ensuring all children and vulnerable adults are protected from harm



## Your Life, Your Health

"Working with the people of Rotherham to sustain and improve health services, to improve health and to reduce health inequalities"

### Challenges

- Life expectancy in Rotherham is one year less than the England average
- Life expectancy varies by eight years between different parts of Rotherham
- Too many people are admitted to hospital who do not need to be
- NHS Rotherham CCG has an £75 million efficiency challenge over the next 5 years
- Increasing numbers of older people with long term conditions

### Solutions

- Clinical leadership, both in primary and secondary care
- Delivery of effective out of hospital care
- Supporting self-care and delivering care as close to home as possible
- A stronger patient voice
- Better IT to improve communication, access to services and patient education

### Strategic Aims

Health and Wellbeing 'Strategic Aims'



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

**Unscheduled Care** ●●●●●  
 Emergency Centre, GP Case Management, 7 day working, enhanced care co-ordination centre

**Transforming Community Services** ●●●●●  
 Locality based nursing, safer discharge, admissions prevention, integrated out of hours

**Clinical Referrals** ●●●●●  
 Improving care pathways so patients get the right care at the right time including reducing the number of hospital follow-ups

**Medicines Management** ●●●●●  
 Increase quality, efficiency, reduce variation & waste across 36 practices, six service redesign projects

**Mental Health** ●●●●●  
 Deliver Adults and CAMHS transformation plans, including Adult MH Liaison and Parity of Esteem

**Co-Commissioning with NHS England** ●●●●●  
 Delegated responsibility for commissioning general practice and co-commissioning of Primary care and specialised services

**Maximise Partnerships** ●●●●●  
 To deliver the Better Care Fund and the joint children's agenda, with RMBC

**Maximise Partnerships** ●●●●●  
 Deliver the 'Working Together Collaboration', with other CCG's across South Yorkshire

### Corporate Priorities

Assurance

Delivery

Quality

Safeguarding \*

X National Pledges

X Better Care Fund Metrics

X Quality Premium Metrics

X NHS Ambitions

### Outcomes

- additional years of life – 200 additional life years per year
- improving health related quality of life for people with long term conditions to the national average
- reduced avoidable time in hospital – hospital admissions will remain at their current level of 16% below their 2011/12 peak
- improved patient satisfaction of hospital care to the national average and maintain current very high levels of satisfaction with GP care.

Across all life stages: 'Starting Well' 0-3 yrs / 'Developing Well' 4-19 yrs / 'Living & Working Well' 20-64 yrs / 'Ageing & Dying Well' 65+ yrs, And for all communities both geographical and communities of interest

\* Prevention of Child Sexual Exploitation is priority area for 2015/16. We will work with partners to address any issues that arise from the Jay & Casey reports into CSE and the Ofsted report into Children in need of help & protection.



## 2 Introduction

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

We are conscious that the language used in this version tends to be technical 'NHS language' but once the plan is agreed by external stakeholders we will produce a plain English version that will be used as part of our ongoing patient and public engagement activities and also a set of patient stories to encourage dialogue about the difference the plan will make. There is a glossary in section 15.

We have achieved a lot in our first two years as a statutory organisation.

#### Achievements in 2014/15

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

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

**Sustaining community investment;** Successful evaluation of our £5 million investments in additional services in the community including case management of 8,000 people at most risk of hospital admission. Substantially developed provision by the voluntary sector including national recognition of the Rotherham model of social prescribing.

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

**CCG and staff development;** Clinical executive received 100% vote of confidence from membership, First CCG in the country to receive Investors in Excellence, in the top 6 CCGs nationally in the Health Service Journal Awards. All staff have twice yearly personal development reviews. One of the highest response rates to the national staff survey and with 98% positive feedback on; staff opportunities to show initiative, support from line managers and senior management commitment to patient care.

We emphasise that to continue to have a successful health system in Rotherham, substantial change is required. Rotherham's health system is over-reliant on hospital admission as a solution to acute medical and social problems; our strategy will reduce this reliance. We will reduce investment in hospital services to allow us to increase investment in community services and other alternatives to hospital admission. This will be very challenging, to acute hospitals whose services will have to change substantially, to clinicians who will have to change patterns of care, and to patients who will receive services in a different way. We are convinced this is the best approach; whilst a hospital admission can often seem to be the safest option it is in fact a risky process. Even in the best hospitals there is a 1 in 10 risk of a harmful event occurring during admission. It is therefore incumbent on us to develop high quality community alternatives for as many patients as possible.



In 2014/15 both non elective and elective hospital activity have grown faster than is affordable. Our plans will address this in the long term but it is likely that we will have to take some short term actions to keep costs under control in 2015/16 while our longer term plans deliver. A commissioning event in December 2014 produced a list of 'least worst' options. We will discuss these further with the public and clinicians before implementing them.

### 'Least worst' options for keeping activity within affordable levels

- Group A: uncontroversial options that are included in this plan.
- B1: Options that could be implemented quickly e.g. by June 2015.
- B2: Options that could be implemented after June 2015.

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

#### Group A

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

#### Group B1

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

#### Group B2

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

We would like in particular to highlight 3 substantial changes in this refresh of our commissioning plan.

- We expect to take on important **additional responsibilities for commissioning GP services and some specialised commissioning services** (described in sections 5.12 & 5.13).
- **CCG prioritising safeguarding.** We are acutely conscious of the shocking findings set out in the Jay report in to child sexual health exploitation in Rotherham. Our commitment to preventing future abuse and supporting the victims of historical abuse is reflected in safeguarding being one of the CCGs 4 priorities. We address safeguarding specifically in section 6.2 and the commissioning implications for victim support in section 5.4.
- **A stronger patient voice.** This is summarised in sections 6.3 & section 11 of this strategy and described in detail in our Communications and Engagement plan, *Your Life, Your Health, Your Say*. [LINK](#)



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



**Julie Kitlowski, GP**  
**Chair CCG**



**Chris Edwards**  
**Chief Officer CCG**



**Leonard Jacob, GP**  
**Chair GP Members Committee**



**John Barber**  
**CCG Lay Member**



**Phillip Moss**  
**CCG Lay Member**

## Chair of Health and Wellbeing (H&WB) Board

The Rotherham Health and Wellbeing Strategy sets out the key priorities that the local Health and Wellbeing Board will adopt over the next three years to improve the health and wellbeing of Rotherham people. The Joint Strategic Needs Assessment, Health and Wellbeing Strategy, agencies' Commissioning Plans and the three outcomes frameworks demonstrate the journey from gathering data, to understanding whether we are achieving our goals.

There are great benefits from working in partnership, bringing together planning, funding and delivery of health and social care. We all aspire to reducing health inequalities and providing better care outside hospital. The CCG's Commissioning Plan aligns with the H&WBS and sets out, as a key partner, how they will support its delivery.



**Councillor John Doyle**



## 3 About the Clinical Commissioning Group

### 3.1 The Clinical Commissioning Group (CCG)

The CCG is a membership organisation, the **36 GP practices** in Rotherham are its members, and they are grouped into eight localities. The CCG's main decision making body is the **CCG Governing Body**, four GPs, three executives, a nurse, a hospital consultant, and 3 lay members (for patient engagement, finance and audit and GP commissioning). The CCG will ensure it accesses the expert advice that it requires which includes having Rotherham's Director of Public Health and the Chair of Rotherham's Health and Wellbeing Board attending CCG Governing Body meetings.

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

In terms of executive delivery the CCG has **eight executive GPs** who each lead on specific strategic areas. The eight GPs are supported by approximately 60 other directly employed staff. As well as the GP Members Committee another 4 GPs provide additional clinical advice on areas such as safeguarding, clinical referrals, medicines management and mental health. The CCG has a contract with North Yorkshire and Humber Commissioning Support Unit (NY&H CSU) which supports the CCG in areas such as intelligence, IT, human resources and some clinical and financial services (see Section 5.15).

The links show the members of our three committees: Governing Body, GP Members Committee, and Strategic Clinical Executive. [CCG Governing Body and committees](#) Further details of the CCGs governance structure are in Section 6.5.

### 3.2 List of CCG Statutory Responsibilities

The CCG's full responsibilities are detailed in its constitution. [RCCG Constitution](#). The main responsibilities are listed below and in section 6 of this plan we set out how we meet these responsibilities:

- Upholding the NHS constitution, CCG constitution and governance standards. [NHS Constitution](#)
- Quality assurance and quality improvement of commissioned services
- Quality improvement of GP services in partnership with the NHS England
- Safeguarding children and vulnerable adults
- Reducing health inequalities
- Public sector equality duty
- Public involvement in CCG and promotion of choice
- Training, innovation and research
- Environmental sustainability
- Delivering on relevant areas of the Governments mandate to NHS England and the NHS England's planning guidance, 'Everyone Counts'
- Achieving financial balance



### 3.3 List of CCG Commissioning Responsibilities

The CCG is responsible for commissioning health services to meet all the reasonable requirements of our local population, with the exception of: certain services commissioned directly by NHS England; health improvement services commissioned by RMBC; and health protection and promotion services provided by Public Health England. NHS England website sets out the full responsibilities for each agency. [CCG Commissioning Responsibilities](#)

Services commissioned by the CCG are:

- Urgent and emergency care (including 111, A&E and ambulance services) for anyone present in our geographic area
- Out of hours primary medical services (for everyone present in our area), except where this responsibility has been retained by practices under the GP contract
- Elective hospital care
- Community health services (such as rehabilitation services, speech and language therapy, continence services, wheelchair services, and home oxygen services, but not public health services such as health visiting and family nursing)
- Other community-based services, including (where appropriate) services provided by GP practices that go beyond the scope of the GP contract
- Rehabilitation services
- Maternity and newborn services (excluding neonatal intensive care)
- Children's healthcare services (mental and physical health)
- Services for people with learning disabilities
- Mental health services (including psychological therapies)
- NHS continuing healthcare
- Infertility services
- Delegated authority for GP commissioning from 1 April 2015
- Specialist wheelchair services, outpatient neurology and neuro-surgery, renal dialysis and surgery for morbid obesity from 1 April 2015 subject to confirmation from NHS England.

### 3.4 Relationships

We work with individual practice patient user groups and have jointly developed with them our **CCG patient network** (see section 6.3). The CCG works closely with **Healthwatch**, for example they are helping the CCG with public consultation on this plan.

The CCG is an active member of the **Rotherham Health and Wellbeing (H&WB) Board** and the **Rotherham Local Strategic Partnership**.

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





The CCG will work closely with **RMBC** to ensure that Rotherham's H&WB Strategy is delivered. Where appropriate we will enter into joint commissioning arrangements and pooled budgets. The important development of the Better Care Fund is described in Section 5.14.

The CCG will work in partnership with **Rotherham Public Health** to help them deliver their responsibilities and has a memorandum of understanding which sets out how public health specialists will support the CCG with our responsibilities.

We have developed a **carers action plan** jointly with RMBC and voluntary sector organisations. The plan has been implemented in Rotherham and includes identifying and working with young carers, elderly carers, dementia carers and working alongside GP practices and supporting staff by providing flexible working arrangements'. The additional responsibilities for local authorities and CCGs to access carers needs are summarised in Section 5.14.

The CCG will maintain strong relationships with **other CCGs** including meetings between Chairs and Chief Officers to share best practice and to jointly commission services where appropriate.

**CCGCOM** is a formal structure for areas where local CCGs choose to commission jointly and share best practice.

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

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

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

There are also six provider workstreams: sharing information, consistency of care, smaller specialties, specialised services, locums and procurement.

We work in partnership with the Local Education and Training Board on the important issues of workforce planning, particularly in the list of specialties that are challenging for Rotherham flagged up in Section 4.3.

SYCOM and Working Together are currently two forums where the CCG discusses Urgent Care with other CCGs, NHS England and other providers. In 2015/16 the CCG will discuss with partners how to evolve these meetings into a single **Urgent Care Network**.

With regards to **Networks and Senates**, our aim is to work in partnership with NHS England to ensure that the CCG and Rotherham GPs are appropriately represented on these new structures, however capacity issues will determine the level of input.



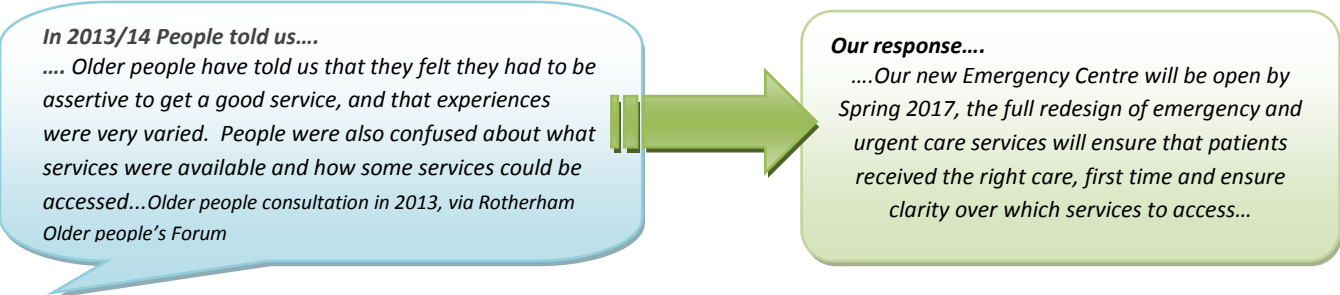
# 4 Context

## 4.1 Joint Strategic Needs Assessment

The health of people in Rotherham is generally worse than the average for England, full details can be found in the Joint Strategic Needs Assessment [JSNA](#). There is significantly higher than average deprivation, unemployment and long term unemployment. Life expectancy at birth is 78 years for men and 81.6 years for women. Although this is below the National average it continues to improve. Healthy life expectancy at birth is only 58.5 years for men and 60.3 years for women. This means that both men and women in Rotherham live 20 years or a quarter of their lives with at least one long term health condition.

Another striking health issue in Rotherham is the degree of inequality within the Borough. The gap in overall life expectancy between Rotherham and the national average is one and a half years based on three years combined data from 2010-12. The gap in life expectancy between the most and least deprived parts of Rotherham for males is 8.9 years and females is 6.4 years (based on the same 2010-12 period). The most disadvantaged communities appear to be improving less quickly than Rotherham overall.

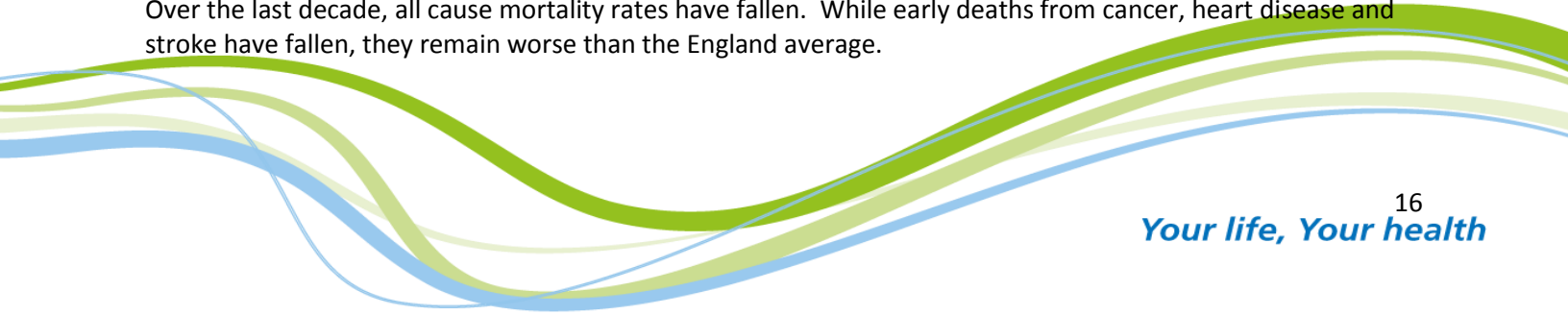
Economic growth and getting people into employment remains a priority for the Borough. The links between poverty and ill health are well established and the pace of improvement in health is likely to be threatened if unemployment remains high or employment opportunities are low paid or insecure. The emphasis on narrowing inequalities, targeting resources towards areas of greatest need and poverty reduction are focuses for the Joint Health and Well-being Strategy.



The population of Rotherham continues to grow and is projected to reach 265,600 by 2020. The age profile will be increasingly dominated by the elderly; the number of people aged over 65 is projected to grow by 35% between 2012-2028 and by 70% for those aged over 85 in the same period. Increasingly these people will be living alone. This will be associated with an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. At the moment there are more than 13,000 people in Rotherham with diabetes, and 5,369 on GP stroke registers. By 2025 we project that there will be over 4,500 people in Rotherham living with dementia. People are increasingly living longer with multiple long term conditions and this presents a challenge to services that are designed around managing individual conditions.

As a consequence of the post war baby boom, the growth of the older population is unlikely to be steady. The next two decades will see the baby boomers coming of retirement age and this is likely to create a bulge in need rather than a steady increase.

Over the last decade, all cause mortality rates have fallen. While early deaths from cancer, heart disease and stroke have fallen, they remain worse than the England average.





Another striking feature of the changing demography of Rotherham is the increasing number of people living alone. Potential consequences of this include poverty, loneliness and mental ill health. Mental ill health is the biggest cause of morbidity and incapacity and the growing burden of dementia is an increasing concern.

The consequences of sexual exploitation for the victims of abuse and their families will be significant and will be lifelong. Mental health support and understanding will require investment both in professional awareness and in services for those who have been abused.

In response to the growth in long term conditions and care needs, the number of informal carers has increased and is currently estimated at 31,000 at 2011 Census. The age profile of carers is following the same pattern as the general population and is believed to reflect the increasing number of spouse carers. The increase in the number of younger carers is more modest and this is likely to result in a widening of the “care gap” which could lead to greater demands on formal care services including acute care.

**In 2013/14 People told us....**

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

**In 2014/15 people told us....**

A number of people noted reliance on family carers and told us that carer support should be available 24/7

....‘my son gets any information I need, he keeps me up to date with medical things’...

...‘if I felt worse I’d ring my daughter and she would get an ambulance if I needed one’.....**Social Prescribing Survey**



**Our response....**

.... The CCG has developed a **carers action plan** jointly with RMBC and voluntary sector organisations. The plan includes identifying and working with young carers, elderly carers, dementia carers and working alongside GP practices and supporting staff by providing flexible working arrangements’...

Rotherham has a relatively small black and minority ethnic (BME) community but one that is growing and becoming increasingly diverse. The single largest minority ethnic group is Pakistani (Kashmiri) and the second is White Other which includes EU migrants. The health of EU migrants from Eastern Europe is generally poorer because of the poor social conditions in their native country. High levels of smoking and alcohol use are likely to pose significant threats to the health of these communities.

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

**Children and Young People’s Health**

Child poverty is the biggest barrier to improving outcomes for children and young people. In Rotherham about 11,480 children (23.1%) live in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is <60% median income), this poses an immense challenge to give those children the best start in life.

The improvement in educational attainment in Rotherham as measured by GCSE results, from 54% in 2008 to 60% (1% above the England average), is remarkable. It is a great achievement for Rotherham, its schools and the Council, but most of all for Rotherham children.

However, pupil absences from school are high at 5.11% for those aged under 16 (expressed as the percentage of half days missed by pupils due to authorised and unauthorised absences). To continue the improvement in educational attainment a reduction in pupil absence will need to be achieved.



The proportion of 16-18 year olds not in education, employment or training (NEET) is 7.4 %, higher than the England average of 5.8%. Disengagement at this time can have a significant and lasting impact on the young person's health and wellbeing.

Rates of sexually transmitted infections are high, measured using chlamydia diagnoses as a marker condition, and indicate high levels of unprotected sexual activity in 15-24 year olds. Under 18 conceptions are also high, although the most recent figures for Rotherham show significant improvement.

### **Maternal and infant health**

Infant mortality, the rate of deaths in infants aged under 1 year per 1,000 live births, is 5.1 in Rotherham, not significantly different from the England rate at 4.3. However, 3.5% of babies at term are of low birth weight, significantly higher than the England average. Both infant mortality and low birth weight are key markers of child and maternal health in a local population.

Significant inroads have been made in reducing smoking in pregnancy, the main avoidable cause of low birth weight and infant mortality. Rates of smoking at delivery in Rotherham have dropped from 26.1% (in 2009/10) to 19.2% in 2012/13. While this rate is still higher than the national average it demonstrates the impact intensive local interventions are making.

Breastfeeding initiation and maintenance are continuing challenges for us to give children the best start in life. Both are significantly worse than the England average.

Teenage pregnancy rates have fallen dramatically and were in 2012 statistically similar to England.

### **Obesity and physical activity**

In 2012/13, 22.2% of children at Reception were classed as obese or overweight which is slightly lower than the national average; however, 35.2% of children at Year 6 were classified as obese/overweight. In addition, estimated adult obesity (obese or overweight) prevalence was estimated to be 65% (2012). Both are significantly worse than the national average.

Only 48.9% of adults are physically active 34% inactive

Smoking prevalence is estimated to be 22.7% (2012) in Rotherham which is significantly worse than the England average this rises to over 30% for those in manual occupations

Levels of substance misuse and admissions to hospital due to alcohol related harm are significantly worse than the England average.

In summary, health needs in Rotherham are significantly greater than the average for England and are associated with striking level of inequalities; while there have been improvements in life expectancy, the key causes of early death remain largely preventable and related to lifestyle (obesity and lack of physical activity) and poverty. Many people in Rotherham are living longer and healthier lives; however, a significant number are not and the demands for health care from people with multiple comorbid long term conditions are likely to grow significantly as the population ages.



## 4.2 Rotherham Health and Wellbeing Strategy

The CCG has worked with partners to develop and implement Rotherham's H&WB Wellbeing Strategy in response to the finding of the Joint Strategic Needs Assessment and consultation about health inequalities. The strategy emphasises four parts of the life course:

- Starting well (0-3)
- Developing well (4-19)
- Living and working well (20-64)
- Aging and dying well (65+)

The strategy has six priorities for what we want Rotherham to look like in three years.



### **Priority 1 - Prevention and early intervention**

Outcome: Rotherham people will get help early to stay healthy and increase their independence.



### **Priority 2 - Expectations and aspirations**

Outcome: The expectations and aspirations of Rotherham people will be understood and matched by services that are delivered to borough-wide standards, tailored to an individual's personal circumstances.



### **Priority 3 - Dependence to independence**

Outcome: Rotherham people will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances.



### **Priority 4 - Healthy lifestyles**

Outcome: People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.



### **Priority 5 – Long term conditions**

Outcome: Rotherham people will be able to manage long term conditions so that they are able to enjoy the best quality of life.



### **Priority 6 - Poverty**

Outcome: Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skills and employment.

We will work with partners to identify and monitor key local outcomes discussed further in section 11 of this document. Key outcomes are dementia, smoking, alcohol, obesity, NEETs (16-18 year olds not in employment, education and training) and fuel poverty.



## 4.3 Other Rotherham organisations' strategic plans

### Commissioning plans

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

Rotherham will spend around £14.1 million on public health in 2014/15, commissioned by RMBC. The CCG as a H&WB Board member expects to see that the following public health services continue to receive priority: NHS health checks, obesity, school nursing, sexual health services, drugs and alcohol services, tobacco control and public health support to NHS Commissioning. **Plans for 2015/16 will be agreed at the Health and Wellbeing Board in February 2015.** [H&WB Strategy](#)

Spending on social services is the responsibility of RMBC, plans will be part of RMBC's 2015/16 Corporate Plan which will be agreed by Cabinet before 1 April 2015. The CCG's intentions with regards to the delegated commissioning of general practice are in section 5.11 of this document. Primary care pharmacy, optometry and dentistry services as well as most specialised hospital services are all commissioned by NHS England. NHS England's commissioning intentions for specialised services are attached. [NHSE commissioning intentions](#).

### Local hospitals plans

In section 6.1 we describe how providers' Medical Director, Chief Nurse and Trust Board will perform quality impact assessments on the cost improvements plans required to deliver their efficiency savings. The CCG will then assure itself on these quality impact assessments. The implications are also discussed at twice yearly Board to Board meetings with our two biggest providers. In the sections below we describe current progress with cost improvement plans for our main providers of acute services and mental health. **TRFT and RDASH will submit their plans to their regulator Monitor in March 2015 and these will then be linked to this document.**

### The Rotherham NHS Foundation Trust (TRFT)

Local hospitals have the challenge of continuing to improve quality whilst delivering year on year efficiency savings (see section 8). **The activity trajectories described in Section 8 of this document have been jointly agreed by clinicians in both primary and secondary care. The activity trajectories in the CCG's plan and TRFT's Monitor plan are consistent with each other.**

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

- All services should be provided as close to the patient as possible, the only reason for services being provided outside Rotherham is where there is a compelling reason of clinical safety or improved patient experience.
- The CCG's first preference is for TRFT to remain as a stand alone organisation focussed on delivering high quality, safe, local hospital and community services to Rotherham patients.
- In 2014/15 the CCG supported TRFT by non recurrent investment for its efficiency plans. Further support will include support to provide state-of-the-art facilities for the Emergency Centre (see section 5.1)



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

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

TRFT, like all provider trusts, have to make substantial efficiency savings in 2015/16 and in subsequent years, driven mainly by the national efficiency requirement and the subsequent reduction to prices through the national tariff. For 2015/16 the efficiency rate within the national tariff is 3.8%.

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

RDaSH like other providers has to deliver 3.8% efficiencies in 2015/16. The CCG has made a commitment that these efficiencies will be re-invested in mental health services for example with the voluntary sector and GP providers to improve services to people with dementia. Efficiency plans will be discussed through the MH QIPP group and the CCG will scrutinise the quality impact assessments.

## Voluntary Sector and Social Prescribing

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

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

An annual investment of £547,000 into the third sector has funded the infrastructure and commissioned extra services across the sector. There are five voluntary sector health advisers who link to all GP practices and are equal partners around the table when discussing the case management of patients with long term conditions. They act as a link to all the Voluntary & community Services and work with patients to find a service or activity that meets the patient's needs. In 2015 we will extend this model by additional investment in social prescribing for mental health patients (see section 5.4).



The service has been independently evaluated and has so far achieved between a 20-25% reduction in A&E attendances, patient admissions and out-patient attendances.

*...In 2014 people told us the value of social networks for improving and maintaining their health and wellbeing, this feedback at three separate focus groups in October and in a survey carried out by VAR...  
 ....would like to generally be more socially active to combat low mood and depression’...  
 ...I would like support to get out more; social lunches or support groups’...  
 ...I get a lot of depression and low mood – this is made worse as I am stuck indoors and the local centre is closing. I would like to see more people’...  
 ...’people with long term conditions often don’t realise they need support; this means that until now intervention has been at crisis...  
 ...’I didn’t think of myself as a sick person and I didn’t think I needed help’...*



**Our response...**  
*...we will continue to work with the voluntary sector to provide the nationally recognised Social Prescribing project and will extend the model for mental health patients’...*

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

- The public sector benefits, as it addresses inappropriate admissions into hospital and reduces Social care.
- The GPs benefit as it gives them a third option other from referral to hospital or to prescribe medication.
- The voluntary and community sector benefits as it supports their sustainability

And most importantly...

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

## Workforce Capacity

There are several areas where recruitment of clinicians presents risks to our transformation plans; general practitioners (see section 13 on key risks) accident and emergency specialists, community and general practice nurses and psychiatrists especially older people and children’s psychiatrists).

District nurse recruitment and retention is a key theme of our community services transformation plan (Section 5.7), mental health workforce both recruitment and modern models of care are key themes in our Mental Health transformation plan (Section 5.4). New ways of providing emergency care are discussed in section 5.1.

One of the reasons the CCG is requesting delegated authority for GP commissioning so it can better address the challenges of recruitment to the general practice workforce (section 5.12). We are working with the local GP training scheme to understand the aspirations of current GP registrars, working with the Local Education and Training Board on increasing practice nurse training and investigating new models such as physicians assistants.







# 5 Commissioning Areas

## 5.1 Unscheduled Care

*In 2013/14 People told us.....that people are still confused about when to use A&E, and when to use other services despite national and local campaigns.....Patient Participation Groups network, 29.10.13*

*In 2014/15 there is still confusion over what services should be accessed and when, the VAR survey as part of Social Prescribing Programme told us...  
 ...'I asked my GP for a call out, GP asked why I had called them and said I should have gone to the surgery – but I wasn't well enough'...  
 ...'I visited the walk in centre who then called an ambulance for me'...*

*...'111 always refer you to A&E rather than sort it out'... PPG Network December 2014*

**Our response....**

*....Our new Emergency Centre will be open by Spring 2017, the full redesign of emergency and urgent care services will ensure that patients received the right care, first time and ensure clarity over which services to access...*

<b>Lead GP</b>	<b>David Clitherow</b>
<b>Lead Officer</b>	<b>Chris Edwards – via the System Resilience Group</b>

**Why are we planning to invest in this area?**

Unscheduled care refers to unplanned health or social care admissions. Rotherham patients receive unscheduled care from a wide number of acute services but in terms of emergency hospital admissions 83% are TRFT, 6% to Doncaster and Bassetlaw NHS Foundation Trust and 7% to Sheffield Teaching Hospitals NHS Foundation Trust.

Historically, Rotherham health community has been an outlier for emergency admissions to hospital. This is not fully explained by the higher than average levels of morbidity and there is evidence that individual clinicians involved in hospital admissions such as GPs, ambulance staff, and accident and emergency doctors have different thresholds for admission. Whilst hospital admission may seem like the safest and easiest way of dealing with an emergency, for many people high quality care at home or in a community setting is a better, safer option. Our strategy will provide more alternatives to hospital admission, treat people with the same needs more consistently and deal with more problems by offering care at home or close to home. There are important links between this area and our plans to improve community services such as further developing the Care Co-ordination Centre and providing alternative levels of care (see Section 5.7). The Better Care Fund is described in section 5.14.

In 2014/15 there has been an unprecedented increase in demand for Accident & Emergency services in Rotherham with growth increasing from an underlying 1% per year to 5% per year in 2014/15. This has been part of increased pressure on other parts of the urgent care system (GPs, The Walk in Centre, Ambulance services and Social Services). It has led to an unsustainable 4% increase in non elective admissions which is discussed further in Sections 8 and 9. Part of our response to this is a media campaign discussed below.

In 2014/15, the CCG spent £58.4 million on unscheduled care. Planned spend for 2015/16 is £57.7 million.

**Key achievements in the last 12 months**

In 2014/15 we have further developed the initiatives we commenced in 2013 and undertaken significant work to transform community services. Progress made includes:

*In 2013/14 People told us .... that the trust people have in the services they use is important, as are the relationships they have with health staff and communication....Patient Participation Groups network, 29.10.13. This was reinforced through consultations in 2014.*

**Our response....**

*....we will continue to work with our partners to ensure patient experience is improved...*



- **Enhancing the Care Coordination Centre** which has been in operation since November 2012. We have seen significant reductions in GP admissions to the medical admissions unit in the first 2 years of operation. In 2014/15, we have extended the service to act as a supported discharge hub and provide proactive support to patients on the GP case management scheme. The service is now acting as a single point of access for community nursing referrals. Importantly the service now operates 24 hours per day 7 days per week.
- All GP practices are engaged in the **Case Management Programme** with 8,000 case management plans in place. Plans receive input from GPs, social workers, social prescribing workers, community nursing and, if needed, other allied health professionals. In 2014/15, we invested in additional GP support for all patients over 75 and work to improve care for patients in nursing and residential homes (see section 5.11).
- A series of important initiatives described in more detail in Section 5.7 including **increased capacity in district nursing, 3 supported discharge pathways, enhanced access to Alternative Levels of Care and a new integrated rapid response service.**
- Clinically led patient level audits of **emergency admissions on patients in the over 70s and emergency readmissions across the board.** Action plans have been developed and will be implemented between the System Resilience Group and Clinical Referrals Management Committee.
- Progress made with the **self care** agenda, with agreement at H&WBB introduce organisational practitioner skills programmes and plans to deliver workshops in GP Practices
- In February, the Emergency Care Intensive Support Team (ECIST) undertook a review of urgent and emergency care in Rotherham working in partnership with TRFT and Rotherham CCG. A full action plan was developed and work has taken place to implement the recommendations. A number of “perfect weeks” have been held to maximise A&E performance.
- Personalised budgets are nationally mandated. We have agreed policies and processes to work in partnership with RMBC to deliver personal health budgets through the service commissioned from the NY&H CSU. We have 40 patients currently in receipt of a **personal health budgets.**
- Rotherham CCG and TRFT approved the final business case for the creation of an emergency centre at TRFT. This will see primary and secondary care doctors and senior nurses working together in a new £12 million purpose built facility, co-located with mental health crisis teams, social care and services key to integration. Building work commenced in December 2014 and the new centre will open in Spring 2017. Action has already been taken to enhance senior clinical input to the A&E department and implement management and direction pathways to encourage self-care and the use of pharmacy.
- Approved a £4.1 million investment to deliver 7 day services across acute and community services

#### **What will we achieve for our investment including efficiencies?**

The CCG will build on the successes of previous years to embed the changes we have made in 2014/15. Our community transformation programme will begin to have traction transforming the way patients with long term conditions, the frail elderly and others who access urgent care services are managed. In 2013/14, emergency admissions were 20% lower than their peak in 2011/12. 2014/15 saw an unprecedented and we believe extraordinary rise in A&E attendances of 5% which had a knock on impact of a 4% increase in emergency admissions. **In 2015/16 we will reduce non electives from 2014/15 out-turn and then hold them at this level for the foreseeable future. This is extremely challenging because Rotherham’s activity is already 16% below their 2011/12 peak, however primary and secondary care clinicians have agreed that the combination of initiatives in this commissioning plan will deliver this challenge.** Instead more patients will receive immediate assessments followed by treatment at home or in the community. A full description of planned activity for both unscheduled and clinical referrals is in section 7. **Despite the rise in non elective activity in 14/15 activity in Rotherham is still 16% below its peak in 10/11 and well below the threshold for the implementation of the marginal tariff. If the marginal tariff does become applicable in Rotherham the CCG will discuss its use to reduce admissions with NHS England and at the System Resilience Group.**

In 2015/16 we will focus on 5 key priorities to deliver strong A&E performance, high quality and efficiencies in non-elective care: Admission prevention, Safer discharge and reducing lengths of stay, 7 day working, Integration and Communications\*



**\*In 2014 people told us....**

*... 'nurses were good but I didn't get any attention, I didn't know what was happening, there was no communication and I didn't like that attitude'...*  
*... 'I was treated as a person and not a number, I saw 2 doctors and 1 nurse, they explained everything in layman's terms – lovely'... PPG Network*



**Our response....**

*....we know that communication is important and that how people are treated is vital to ensure we continue to focus and improve quality of services...*

To deliver on these priorities we 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
- Focus on realising the full benefits of community transformation including – enhancements to the community hospital, falls service and fast response team and delivering 7 day services including the out of hours period which are targeted to GP practice populations and patients most at risk of admission to hospital
- **A media campaign aligned with national media messages about how to access Right Care, First Time including prominent signposting to Pharmacy First.**
- Robust contract and performance management frameworks
- Fully embed 7 day services across the hospital and community services

**In 2013/14 People told us .....**

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



**Our response....**

*....parking has been taken into consideration as part of the plans for the new Emergency Centre...*

- Embedding the expanded **care coordination centre**, see section 5.13
- Review the risk stratification tool and payment mechanisms for the case management programme to ensure that the right patients are being seen and practice remuneration is commensurate with complexity of cases
- Implement the findings from the readmissions audit **and the elderly acute admissions audit**
- Continue to implement the action plan to deliver **Rotherham's Joint Carers Charter**, in partnership with RMBC [Carers Charter](#)
- Continue to improve **acute alcohol services**, as described in the mental health (section 5.4)
- Continue to provide improved **children's services** (see sections 5.2 and 5.5)
- Improve acute services for **adult mental health, older peoples mental health** (including dementia) and ensure they are integrated with unscheduled care service. This is to include access to a mental health crisis team situated in A&E which will also work across the hospital wards to provide assessments where necessary.

**In 2013/14 People told us....**

*.... That some older people have very limited contact with others and are isolated; more isolation possibly means more worry, more likely use of services...*  
*....that respiratory (breathing) problems are scary, so people with these are likely to go to A&E; but perhaps wouldn't if there was somewhere they could go to or call for advice and reassurance....*  
*.... there is a lot of support for self care, but people with long term conditions will need encouragement and support to live as healthily as possible; patient information needs to be accessible to everybody, and needs to be easy to understand, and there is a role for everyone in supporting family and friends in managing their health.... Patient Participation Group Network meeting,*



**Our response....**

*....the case management programme provides personalised, multi-agency care plans for those identified as most at risk of hospitalisation. In 2014/15 this was extended to include an annual health review for all patients over the age of 75. The case management programme includes the nationally awarded Social Prescribing scheme (see section 4.3) which helps people with long term health conditions access a wide variety of services and activities provided by the voluntary and community sector...*



The table below lists the four 2015/16 workstreams within the programme and the projects within these workstreams.

	Workstream	Project
1	GP led integrated care	<ul style="list-style-type: none"> <li>• Self Care</li> <li>• Case Management</li> </ul>
2	Transforming the unscheduled care pathway	<ul style="list-style-type: none"> <li>• Emergency Centre</li> <li>• Community transformation               <ul style="list-style-type: none"> <li>○ Care Co-ordination Centre</li> <li>○ Alternative levels of care</li> <li>○ Supported discharge pathways</li> <li>○ Better quality community nursing</li> </ul> </li> <li>• 7 day services (acute and community)</li> </ul>
3	Personalisation	<ul style="list-style-type: none"> <li>• Personal budgets for patients</li> </ul>
4	Pathways	Managed by CRMC: falls, frail elderly, end of life care, acutely ill child, COPD, cardiology/CVD Managed by MH/LD QIPP: adult and older peoples mental health including dementia, alcohol

### 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 the CCG Strategic Clinical Executive (SCE) and the Health & Well Being Board.

The Emergency Centre is the CCC's major project up to 2017, and is driven by the Emergency Centre Project Board which reports regularly to the SRG. The business case was approved by the CCG and TRFT Board in October 2014 [LINK](#). A Department of Health Gateway Review is planned to test the robustness of our implementation plans. 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

1. **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 5.8. **Case management** is made up of several projects: the **risk stratification** project enables accurate identification of people at increased risk of hospital admissions so that care can be tailored to individual needs to help avoid hospitalisation. The **GP case management** project funds additional clinical time in primary care to case manage patients at highest risk of hospital admission (as identified by the risk stratification tool). In 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.
2. Better quality community nursing services which offer 7 day services including during the out of hours period will reduce overall and weekend mortality rates
3. **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.

4. **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.](#)
5. **Personalisation:** Continuing Health Care patients have a right to have a personal health budget giving them more control over their care.
6. **Pathways:** redesigning care pathways initially focusing on those that account for the highest proportion of admissions.

**Innovation**

- 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
- Nationally recognised award winning social prescribing – a significant investment (£547,000 in 2014/15) in the third sector to provide non medical support for people with long term conditions
- Risk stratification – an innovation at scale which involves identifying the 12,000 people in Rotherham at most risk of hospital admission.
- Care Coordination Centre – a single access point for health professionals so that they can make informed choices about the most appropriate levels of care for patients.
- A £12 million purpose built facility to house a nationally recognised emergency centre TRFT site with an innovative approach to staffing and seeing patients quickly.

**Alignment with H&WB strategy**

Long term conditions is priority 5 of the H&WB Strategy. The outcome is ‘Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life’. The CCG leads this priority for the ‘living and working well’ life stage and supports its partners in its delivery through the three other life stages. The System Resilience Group has an agreed set of principles that are derived from the H&WBS.

**How will we address health inequalities?**

Much of the spend in this area is focused on caring for people from disadvantaged groups because the JSNA shows that they are the groups who suffer most premature morbidity. Currently most of the CCGs spend is on acute hospital treatment for conditions that have already become emergencies. The case management project, the social prescribing project, the risk stratification tool, and the personalisation agenda will all promote earlier intervention, individualised care and self care to help people live and work well. We will use Commissioning for Quality and Innovation (CQUIN) incentives to address health inequalities, including improving services for people presenting to acute hospitals with problems related to alcohol.

The redesign of care pathways will reduce blockages and increase flow through the system and enable more care to be provided at home or close to home. The care co-ordination centre will ensure that vulnerable people get access to appropriate urgent care.

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

**What patient engagement has informed the plan and what is planned in 2015/16**

Patients have told us that most important things to them are that services are safe and trustworthy, that they are treated as a person and not a number and that care is co-ordinated whether at hospital or at home.

Patients have told us that they want us to make emergency care work well, improve pathways of care to ensure patients see the right care at the right time and primary and secondary care work well together. Our work programmes have been targeted to respond to these wishes.

Extensive work from the outset of the emergency centre work programme including formal public consultation has ensured that patients have been involved in the design of the building and service model. 7 patient engagement events have been held throughout 2014/15 and we will continue this work into 2015/16.



## 5.2 Clinical Referrals

<b>Lead GP</b>	<b>Anand Barmade</b>
<b>Lead Officer</b>	<b>Robin Carlisle via Clinical Referrals Management Committee</b>

### Why are we planning to invest in this area?

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

Rotherham's health service benchmarks 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 2014/15 the CCG spent £68.7 million on scheduled care. Planned spend for 2015/16 is £67.8 million.

### Key achievements in the last 12 months

For several years until 2014 overall referral and elective activity has been maintained within affordable limits so we have avoided the need for sudden cuts to services or restrictions to referral. This represents a considerable achievement by all clinicians in Rotherham however activity in the first 6 months of 2014/15 has been above plan, specifically in elective, follow up and non-elective care.

The CRMC are currently revisiting the educational approach taken with all specialities starting with those with the most growth. The all member practice commissioning event in December considered whether in addition to the initiatives set out in this section there is a need to also introduce greater restrictions to referrals, the outcome is set out on page 11.

Principal achievements of the CCGs approach to referrals management include the haematology virtual clinic, introducing a single point of access into musculoskeletal services, gynaecology fast track appointments and substantially reducing follow ups including transferring suture removal and Prostate Specific Antigen (PSA) monitoring to primary care through a secondary to primary care Locally Enhanced Service.

### What will we achieve for our investment including efficiencies?

The CCG will continue its approach based on clinical leadership and peer influence. We will work with GPs and all referring clinicians and providers to ensure that referrals, elective and non-elective procedures are kept within affordable limits.

*In the October 2014 Priorities survey people told us that it was important that...*

*... 'patients need immediate and ongoing care supplied when needed. Waiting lists need to be cut. Patients are suffering needlessly due to time taken to receive appointments and subsequent follow-ups...*

*... 'safe, reliable care that is provided quickly to prevent deterioration of condition for patients is most important to me as this also saves time and money enabling more patients to be treated' ... Priorities Survey October 2014*

**Our response...**

*...this feedback confirms CCG direction. The Clinical Referrals Management Committee is addressing these issues, particularly around waiting times and follow up appointments, and is described in detail in this section...*



The 2014/15 planning guidance requires commissioners to consider providers' model of elective care to achieve a 20% productivity improvement within five years, so that existing activity levels can be delivered with better outcomes and 20% less resource. Benchmarking information shows that the CCG has a high rate of first outpatient appointment and GP referral compared to other Yorkshire and the Humber CCGs, a high rate of discharge following first appointment with no further follow up and a high rate of elective admissions. We will work with TRFT and general practice to improve these areas.

- We will keep the annual growth in first outpatients to 1% and electives to 1%.
- We will keep growth in diagnostics to 2.5% per year, because there will be more people requiring investigating in the community and guidance requiring diagnostics to be increased in some areas, these will mean considerable attention to reducing waste, particularly duplicate testing.
- Rotherham is a marked outlier in the number of follow up appointments each patient receives over the next two years we will reduce follow up appointments towards national average follow up ratio (a 5.9% reduction in 2015/16). Follow up ratios by speciality are being reviewed to inform reductions.
- Rotherham is also an outlier in the number of emergency admissions to hospital – we will **reduce non electives from 2014/15 out-turn and then hold them at this level for the foreseeable future** by increasing the proportion of people receiving same day assessments and so reduce the number of hospital admissions (see Section 5.1).
- We will develop clinical protocols for high volume elective procedures in Ophthalmology and Urology, and consider restrictions to referrals and some procedures of limited clinical value in line with other CCGs. If this is deemed necessary, areas that could be considered include ensuring that other referrals are made through GPs rather than directly and restricting minor surgery for benign skin lesions and varicose veins.
- We will upskill specialist nurses through our community transformation programme to reduce referrals for long term conditions, e.g. diabetes and heart failure

#### How are we going to achieve our intentions?

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

#### **In 2013/14 people told us ...**

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

**In the October 2014 Priorities survey** people told us that it was important that...

*...‘services were co-ordinated around them’...*

*...‘services worked well together across primary and secondary care’...*

*...‘medical pathways work well and patients see the right person at the right time’...*



#### **Our response...**

*...this feedback confirms the importance of the work being taken forward by the Clinical Referrals Management Committee as set out below, with a particular focus on services working well across primary and secondary care, improvements to patient pathways and identifying where quality services can be provided safely in GP practices (also see section 5.11)*



1	<b>Benchmarking, trend analysis, and two way communication with all clinicians</b>	<ol style="list-style-type: none"> <li>1. Regular review of trends in GP referrals, consultant referrals, A&amp;E referrals, other referrals and elective activity.</li> <li>2. Monthly programme of clinical audits concentrating on the specialities and modes of referral that are experiencing most growth.</li> <li>3. Specialty specific discussion of areas identified by benchmarking or changing trends.</li> <li>4. GP communication/education; bite size newsletter, SCE newsletter, protected learning time, top tips/map of medicine guidelines, GP peer led visits.</li> <li>5. Communication with TRFT clinicians</li> </ol>		
2	<b>Two way dialogue with all clinicians on benchmarking, trends and improved care pathways</b>	<ol style="list-style-type: none"> <li>1. Better information on self care</li> <li>2. More fast track services such as the successful fast track gynaecology service</li> <li>3. Consideration of a LES for coils that treat gynaecological problems</li> <li>4. More one stop services <a href="#">including continuing Paediatric rapid access.</a></li> <li>5. Potential restrictions to elective procedures such as minor skin surgery, varicose veins, tonsillectomy, hysterectomy and thresholds for hip and cataract surgery</li> <li>6. Potential for 'other referrals' to be redirected via back to GPs</li> <li>7. Strengthened educational approach through return of poor quality and inappropriate referrals</li> </ol>		
3	<b>Outpatient follow up reduction programme</b>	<ol style="list-style-type: none"> <li>1. Reduction in Follow ups</li> <li>2. Secondary to primary care Locally Enhanced Service</li> </ol>		
4	<b>Diagnostics</b>	<ol style="list-style-type: none"> <li>1. Reduction in duplicate and inappropriate diagnostic testing</li> </ol>		
5	<b>Care Pathways (including some with System Resilience Group and Mental Health QIPP Committee)</b>	<table border="0"> <tr> <td data-bbox="488 1066 878 1283"> <ol style="list-style-type: none"> <li>1. COPD</li> <li>2. Cardiology / CVD</li> <li>3. Children's care pathways</li> <li>4. Ophthalmology</li> <li>5. Urology</li> </ol> </td> <td data-bbox="878 1066 1446 1283"> <ol style="list-style-type: none"> <li>6. T&amp;O/MSK</li> <li>7. Dermatology</li> <li>8. Alcohol (with mental health QIPP group)</li> <li>9. Falls (with SRG)</li> <li>10. Dementia (with Mental health QIPP group)</li> </ol> </td> </tr> </table>	<ol style="list-style-type: none"> <li>1. COPD</li> <li>2. Cardiology / CVD</li> <li>3. Children's care pathways</li> <li>4. Ophthalmology</li> <li>5. Urology</li> </ol>	<ol style="list-style-type: none"> <li>6. T&amp;O/MSK</li> <li>7. Dermatology</li> <li>8. Alcohol (with mental health QIPP group)</li> <li>9. Falls (with SRG)</li> <li>10. Dementia (with Mental health QIPP group)</li> </ol>
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6	<b>Safe effective non face to face 'referrals'</b>	<ol style="list-style-type: none"> <li>1. Review of current virtual Haematology and consideration of extension to other specialties, e.g. Fracture clinic and thyroid virtual clinics</li> <li>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</li> </ol>		
7	<b>Explore long term potential for radical changes to specific elective pathways</b>	<p>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. <a href="#">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.</a></p>		
8	<b>Consider restricting some services to keep activity within affordable levels</b>	<p><a href="#">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.</a></p>		





### **Quality improvements**

Patient experience will be improved by improving the quality of referral information to consultants, high quality discharge letters back to GPs with advice and management plans. We will ensure that clinic and discharge letters are received in a timely manner including replying to the named GP.

Alternative ways of getting secondary care opinions such as expanding the current virtual haematology will be more convenient for patients. The changes will ensure that patients receive care as close to home as possible.

### **Innovation**

Key to the success of the workstreams is the involvement of all clinicians who make referrals we will use technology to make it easier for GPs and consultants to communicate with each other including web-based top tips videos, webinars to reduce the need for formal meetings and electronic surveys with survey monkey to get feedback from all clinicians and from patient members of the CCG patient user group.

Some medical innovations for example injections into the eye to reduce macular regeneration and injections into the bladder for incontinence are creating considerable additional activity. We will work with providers to introduce pathway tariffs which reflect the costs to deliver these services.

### **Alignment with H&WB strategy**

Quick access to high quality, evidenced based health care interventions are essential to ensure people start, develop, live, work and age well. Better use of patient decision aids is important for the dependence to independence priority.

### **How will we address health inequalities?**

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

### **What patient engagement has informed the plan and what is planned in 2015/16**

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.

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.

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.



## 5.3 Medicines Management

Lead GP	Avanti Gunasekera
Lead Officer	Stuart Lakin via Medicines Management Committee (MMC)

### Why are we planning to invest in this area?

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

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

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

The CCG's track record on effective medicines management is very strong. Cost growth has been below the national average for four of the last six years and compares favourably to neighbouring CCGs with similar demographics. NHS Rotherham CCG retained its prescribing incentive scheme, following the introduction of the Quality and Outcomes Framework, this rewards practices for remaining within their allocated prescribing budget. This is considered to be a success where NHS Rotherham CCG has benefited from very competitive prescribing cost growth over the last 5 years compared to both neighbouring CCGs and England. It is planned to extend this practice incentive to reward improvements in the quality of prescribing.

The Medicines Management team have for the past four years produced a range of practice key prescribing indicators, these are a series of prescribing interventions proven to reduce mortality and or hospital admissions. Practices are benchmarked against each other and any areas of concern addressed via the annual practice prescribing action plan and practice quality visits.

In 2014/15 the CCG will spend £45.2 million on prescriptions and on commissioned services (nutrition and continence). The 2014/15 uplift was 2.5% net of efficiency savings in 2014/15. This is less than the expected drug price inflation so in order to continue increasing benefits to patients the CCG will have to continue to deliver substantial efficiency savings.

### Key achievements in the last 12 months

- For the first 6 months of 2014/15 there was a £558,000 underspend on medications, however we are currently forecasting £258,000 overspend because of price fluctuations between pharmacy professional/dispensing fees, budget transfers from NHSE and a number of unexpected category M price increases that will increase costs in the second 6 months.
- The stoma prescribing service has been commissioned and has delivered impressive savings and received excellent patient feedback
- The blu-teq system for managing and auditing the prescribing on drugs outside of tariff has been introduced and will be producing data by Jan 2015.
- A project to identify prescribing waste has been started.

### What will we achieve for our investment including efficiencies?

- To maximise benefits to patients from the appropriate use of medicines, decrease side effects, increase the cost efficiency and decrease waste.
- Improve the ability of GPs in Rotherham to react to price changes in the drug tariff allowing savings to be delivered from switch programmes.



- To improve prescribing benchmarking against other CCGs with regard to cost and quality
- To continue to deliver six medicines management service redesign projects that improve services to patients and produce efficiency savings.
- To review the medicines management LES's before April 2015

#### How are we going to achieve our intentions?

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

#### 1 Working with all 36 GP practices.

An SCE GP and the CCG's medicines management team work with all 36 practices to advise on best practice, produce and disseminate guidance, produce benchmarking reports. Quality and efficiency outcomes and good practice are incentivised through the CCG Local Incentive Scheme (LIS). Currently the CCG medicines management team receives very positive feedback from member practices and the strength of relationships is resulting in above expected efficiency savings in 2013/4.

#### 2 Specific service redesign projects

The CCG has six specific prescribing projects where prescribing responsibility has been removed from GPs to either dietician's or nurse led services. Nutritional supplements, specialist food stuffs and continence and stoma equipment are now prescribed by specialist services. This has improved the service provision to patients and delivered financial efficiencies. Further work is ongoing with wound care.

##### **In 2014 People told us....**

*....'I am very happy with the prescription service. It is useful as it cuts visits to the surgery and chemist. Products are delivered to my door, usually within 48 hours after ordering. The ladies who answer the phone are polite and helpful'....*

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

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

**Through the Patient Participation Network people told us** about waste in the system, such as people getting medicines they don't need. Concern was also raised about the 'arms length' ordering by pharmacies that whilst it can be a convenient service it also reduces the chance for staff and patients to check that medicines are being taken correctly...

##### **Our response...**

*... The CCG is working with NY&H CSU to introduce electronic prescribing. If this is implemented well it will make receiving new and repeat prescriptions easier for patients. Care will be taken to take into account the concerns raised in its development. Both the stoma and incontinence projects have electronic user groups which help guide the projects and there is a user group for the waste management project...*



	Workstream	Project
1	<b>Cost efficiency programmes</b>	<ul style="list-style-type: none"> <li>• A prescribing QIPP plan will operate throughout the financial year to help manage and contain prescribing cost growth.</li> <li>• The medicines management team (MMT) working with TRFT will introduce the Blueteq web bases process for managing the prescribing of “drugs outside of tariff”</li> <li>• The CCG is undertaking a procurement for the direct purchase and supply of wound care products this will be completed by January 2015. This direct purchase of dressings will enable               <ul style="list-style-type: none"> <li>▪ Wound care products to be available whenever the patient requires them</li> <li>▪ Encourage evidence base wound care management</li> <li>▪ Increase District Nurse Patient contact time</li> <li>▪ Facilitate discharge into the community</li> <li>▪ Contain wound care prescribing costs</li> </ul> </li> <li>• The CCG is launching a prescribing waste scheme direct to the public in collaboration with Doncaster CCG in February 2015.</li> </ul>
2	<b>Performance Benchmarking</b>	Financial and quality benchmarking against other CCGs and agendas such as national QIPP reports.
3	<b>Key Prescribing Indicators</b>	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	<b>Prescribing Guidelines</b>	Key priorities include supporting practices with the implications of the NICE guidance on atrial fibrillation and lipid management
5	<b>RDASH prescribing pathways and share care agreements.</b>	<ul style="list-style-type: none"> <li>• Dementia prescribing pathway.</li> <li>• Better prescribing for Attention Deficit Hyperactivity Disorder</li> <li>• Addressing antidepressant prescribing in the community.</li> <li>• Ensure shared care protocols are in place and adhered too.</li> </ul>

### Quality improvements

- The Key Prescribing Indicators described above which are evidenced based interventions that improve mortality or reduce hospital admissions. Practices are benchmarked against each other to encourage practices that appear to perform less well to examine the relevant area.
- Improving the quality of each practices prescribing through annual prescribing efficiency plan.
- Monitoring and advising practices on NICE guidance and national safety alerts.
- The wound care redesign project will improve the patient experience; significant unmet need has been discovered, whilst delivering real and potential cost savings. This project will ensure that dressing use is in line with the evidence base. It will also improve the timely access to dressings for patients and decrease the time spent by nurses obtaining dressings via prescriptions.
- The nutrition, continence, stoma and oxygen projects will continue to work with their patient service user groups to improve the customer focus of the services.

### Innovation

- The six service redesign projects are award winning examples that have improved service provision and addressed unmet need as well as resulting in substantial cost savings.
- The nutritional and continence procurements have created unique commercial partnerships that have released further efficiencies.
- Rotherham has an innovative practice budget setting mechanism, that ensures practice prescribing budgets are equitable. This is utilised by the prescribing incentive scheme to stimulate cost effective prescribing.
- Engaging directly with patients to reduce waste.
  - The plan is to address the issue directly with patients, by engaging with Patient Practice Engagement and



voluntary groups across Rotherham to obtain an understanding of why medicines waste occurs from the patient's perspective.

- It is then planned to design methods by which patients can report medicines waste when it occurs so that interventions can be made within the supply chain to prevent the patient receiving unwanted medicines.
- The plan is to raise patient awareness by engaging with local media and encourage patients to realise that wasted medicines is a waste of the resources that fund the NHS that they contribute to.
- [Our work with the public will include work on reducing antibiotic usage which is harmful as well as wasteful](#)

**Alignment with H&WB strategy**

- The Key Prescribing Indicators ensure that a patient's chance of receiving a prescribing intervention that is vital in the management of their long term conditions is the same across all Rotherham practices.
- The continence service redesign project uncovered a number of patients whose mobility and independence had been compromised due to unsuitable equipment. The project has enabled the CCG to meet this unmet need and improve patients' independence.
- The stoma service redesign project has demonstrated improvements in the patient experience.
- The wound care direct purchase and supply project will ensure patients in the community have prompt access to products and evidenced based care across Rotherham.

**How will we address health inequalities?**

- The Key Prescribing Performance indicators promote the equal access to key medications that are vital for long term condition management by reducing variations between individual practices.
- The service redesign projects ensures that there is equity in the provision of the redesigned services across Rotherham
- We will carry out equality impact assessments on all polices and procurements

**What patient engagement has informed the plan and what is planned in 2015/16**

Both the both the stoma and incontinence projects have electronic user groups which help guide the projects. The waste management project is in partnership with Rotherham prescribing users.

## 5.4 Mental Health (Adults, Older People and Child and Adolescent Mental Health)

<b>Lead GP</b>	<b>Russell Brynes</b>
<b>Lead Officer</b>	<b>Kate Tufnell by Mental Health &amp; Learning Disabilities QIPP group</b>

**Why are we planning to invest in this area?**

**Mental Health**

One in four adults experience mental illness at some point during their lifetime. Mental ill health is the single largest cause of disability in Rotherham. The JSNA shows that the economic downturn is having an adverse affect on people's mental health. Dementia is a particular challenge with the number of cases predicted to increase by more than 50% by 2025.

The overarching priority is to deliver 'parity of esteem' - ensuring that people with mental health problems are treated with the same priority and urgency as people with physical health problems. The CCG carried out a fundamental review of mental health services in 2014 which showed there is still some way to go with regards to full delivery of parity of esteem hence the needs for transformation plans described below. The fundamental review showed that Rotherham benchmarks favourably with regards to the overall proportion of the budget that is allocated to mental health. In addition the CCG made £1.5 million of additional recurrent mental health investments in 2014/15, mainly through the Better Care Fund. [The CCG will ensure that in 2015/16 its total spend on mental health \(with all providers including general practice and the voluntary sector\) will grow in line with the CCGs overall allocation increase.](#) In 2014/15 the CCG spent £33.5 million on mental health, planned spend for 2015/16 is £34 million.



### Mental Health Contractual arrangements:

The CCGs largest mental health contract is with RDaSH providing Children and Adolescent Mental Health Services (CAMHS), adults and older people's mental health services (around £26.3 million for mental health). We also have smaller contracts with Sheffield Care and Social Care Trust (SHSC) and South West Yorkshire Partnership Foundation Trust (SWYPFT). We spent £5.5 million on out of area mental health placements, of this £3.7 million was CCGs continuing care costs for mental health patients. We spend over £400K on mental health services through the voluntary sector. Very specialised services such as forensic services are commissioned by NHS England although there is a possibility that some aspects of responsibility for this will be delegated back to CCGs from April 2015 (see Section 5.13). Rotherham GPs have concerns about the local responsiveness of RDASH adult psychiatric services following the introduction a Single Point of Access 4 years ago.

#### **In 2013/14 People told us...**

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

....we've been all over with her....Carers Meeting, Autumn 2013

#### **In 2014 we were told that...**

...'getting people through the door to any service is vital as a first step. The door will be different for different people'...

...'people's needs are different, and vary at times and in stages of recovery and illness; there is not one size that fits all – there has to be a variety of choice and services..... Depression focus group October 2014



#### **Our response...**

... As a result of the fundamental review of mental health services in 2014, a key outcome is the introduction of a multi-agency Mental Health Liaison service which will ensure that people with mental health problems receive the right treatment in the right location at the right time...

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

There are important implications for the CCG and RMBC from the 2014 Care Act such as clarity on section 117 (Mental Health Act after care) agreements, more details in section 5.14.

### Key achievements in the last 12 months

- Carried out a fundamental reviews of Adults and Older Peoples and CAMHS services and prioritised transformation plans for both areas
- Agreed plans for an Adult and older peoples Mental health liaison Service based at TRFT which will reduce admissions and length of stay to the acute hospital for mental health patients including patients with dementia.
- Developed a strong multiagency Mental Health and Learning Disability QIPP group to ensure strategic oversight of the delivery of the transformation plans
- Reinstated the multi-agency CAMHS Strategy & Partnership group and worked with partners to produce the Rotherham Emotional Wellbeing and Mental Health Strategy for Children and Young People. [LINK](#)
- Issued a contract query for CAMHS. This was in response to issues raised by GP members that were substantiated by work with users and carers co-ordinated by Healthwatch. There has subsequently been an improvements in Tier 2 and 3 services as demonstrated through a series of GP surveys.
- Invested in an additional non recurrent CAMHS consultant and a pilot of single point of access to CAMHS Tier one services.
- Developed good links with the Rotherham Parents Forum, including establishing representation on the CAMHS Strategy & Partnership group.
- Delivered a new acute Alcohol Liaison service which is providing services to frequent users of hospital services, 50% of these people were previously unknown to other alcohol services
- Rotherham benchmarks highly in terms of the identified diagnosis of dementia the 10th best in England.
- Delivered the GP social prescribing project (see section 4.3). Since this project started it has supported over 800 people with mental health problems. This includes people with long term conditions who also have mental health problems and 482 people with dementia.
- Made additional investments in social prescribing by RDASH clinicians for patients with long term anxiety and



depression and stable psychotic conditions.

- Made additional investment in dementia carer resilience by working with Crossroads and Alzheimer’s Society.
- Increasing capacity and improving access to the Dementia Carers respite service.
- Resolved issues highlighted by Healthwatch leading to delays in discharge for Learning Disability patients.
- Worked with Public Health and partners to deliver a suicide-prevention and self-harm action plan.
- Improved dementia care by:
  - implementing the GP memory clinic referral pathway
  - GP Guidance on referral Memory Clinic produced. 95% of GPs surveyed reported the guidance to be either quite useful or very useful
  - Investing additional funding to support the service over the winter period

**In 2014 people told us....**

*...they need information at the start, but don't want to be overloaded. 'you don't know where to go – it's a fog and the direction isn't clear'. You need an information pack, you see the cancer ones everywhere – but we have never seen anything for alzheimers....*



**Our response...**

*.. additional voluntary sector support for people long term anxiety and depression and stable psychotic conditions and support for dementia patients and their carers and additional investment in social prescribing for mental health...*

**What will we achieve for our investment including efficiencies?**

The CCG made £1.5 million of incremental investment in mental health in 2014/15. The majority of this was for a new acute mental health liaison service which is part of the Better Care Fund (see Section 5.14). There were other additional investments in an additional CAMHS psychiatrist, single point of access to tier one CAMHS and investment for additional voluntary sector support for people long term anxiety and depression and stable psychotic conditions and support for dementia patients and their carers.

**In 2013/14 People told us....**

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



**Our response...**

*... we have developed a Rotherham Emotional Wellbeing and Mental Health Strategy for Children and Young People. We are working with the Rotherham Parents Forum, who are members of the CAMHS strategy and partnership group, to ensure we address these issues...*

Given the increases made in 14/15 there are no provisions for overall increases in mental health spend above inflation in 15/16. The CCG will continue to require nationally set efficiency targets (3.8%) from RDASH. Savings made by the CCG from the RDASH contract after inflation will be available for additional investment in mental health prioritised by the transformation plan. It is likely that this will lead to investments in primary care mental health services and in the voluntary sector.

The overarching priority for 2015 is to deliver the Adult & Older Peoples Mental Health and CAMHS transformation plans. The CAMHS transformation plan is part of a wider Rotherham strategy. Key CCG CAMHS deliverables are:

- Ensuring recent improvements in local responsiveness of Tier 2 & 3 services continue
- Single point of access to Tier one
- Evaluating the impact of the additional CAMHS consultant
- Re-configuration of the service to improve efficiencies and out of hours provision.
- Improve the locality aspect of service delivery
- Ensure effective transition of patients to adult services, both for mainstream CAMHS and Learning Disabled.
- Develop better links and understanding with TRFT in working with CAMHS patients.

The Adult and Older Peoples Transformation Plan is on the following [LINK](#). There are 8 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)
- 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 – 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.

#### **How are we going to achieve our intentions?**

The Adult & Older Peoples and CAMHS transformation plans will be overseen by the multiagency QIPP group, which has SCE and GP member group representation. Responsible officers at executive level have been identified for the CCG and RDASH and RDASH have appointed a Rotherham specific project manager to enable delivery as set out in the plan.

The QIPP group will have monthly high key outcomes report and a detailed report against milestones in the action plans. A high level report against the 8 key themes of the transformation plan will be reported each month to the GP Members Committee.

[Rotherham agencies have signed the Mental Health Crisis Concordat. This sets out how we will provide parity of esteem for people who need crisis support for mental health. We will produce with our partners and action plan by 31 March 2015 which will be available on our intranet.](#)

The CCG will work with NHS England and other CCGs to understand the implications of the 'Who pays?' guidance on aftercare for people who have been detained under the mental health act. This could result in a substantial increase in Rotherham CCGs costs.

#### **Quality improvements**

The CCG has agreed a new monthly high level outcomes report which includes  
Adults

- Improve the quality of patient and GPs satisfaction of services
- [Improve access and waiting time for mental health services including Psychological Therapies \(IAPT\)](#)
- [Improving the access times for people experiencing a first episode of psychosis](#)
- [Improving the outcomes of care for people experiencing a mental health crisis](#)





#### Older peoples

- Improve dementia diagnosis rates
- Improve memory clinic waiting times for diagnosis and treatment
- improve dementia pathways with a more primary care focus
- Improved patient experience measured by the Friends and Family test

#### Innovation

- Adults mental health liaison service
- Alcohol service
- Voluntary sector mental health social prescribing
- Street Triage - a project to support South Yorkshire Police in contact with acute mental health problems
- Dementia Carer Resilience
- CAMHS Tier 1 single point of access
- CAMHS 'Recovery College'
- CAMHS locality worker model

#### Alignment with H&WB strategy

- **Dependence & Independence** - Rotherham people with mental health illness and people with learning disability will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances
- **Aspiration & Expectation** - The expectations of Rotherham people with mental health illness and people with learning disability will be understood and matched by services that are delivered according to their needs and where they live
- **Healthy Lifestyles** - People with mental health illness and people with learning disability will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles within the limits of their disabilities.

#### How will we address health inequalities?

- The overarching aim of the mental health transformation plans are to deliver parity of esteem this also includes delivering high quality physical health services and outcomes to people with mental health problems
- **The CCG will commission a project worker 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
- Working with partners to tackle the inequalities that result from poor mental health, such as lower employment rates, poor housing, education and poorer physical health

#### What patient engagement has informed the plan and what is planned in 2015/16

The changes to CAMHS services were prompted by consistent feedback from GP members as the result of issues their patients were facing. This intelligence was added to by specific focussed work involving the parents of service users. This work was undertaken during consultation on the Rotherham Emotional Wellbeing and Mental Health Strategy for Children and Young People and has continued with representation by the Rotherham Parents Forum on clinical pathways development sub-groups and the CAMHS Strategy & Partnership group.

Priority 2.4 of the Adult mental health Transformation plan sets out the engagement to date and plans for the establishment of a specific service user group to monitor the delivery of the adult transformation plan.

As part of the development of the adults and older peoples aspect of the plan the CCG has undertaken a series of engagement with a wide range of stakeholder, such as patients, carers, Healthwatch, Alzheimer's society, various voluntary sector groups and PPGs.



## 5.5 Learning Disabilities

Lead GP	Russell Brynes
Lead GP	Kate Tufnell

### Why are we planning to invest in this area?

#### Needs and priorities

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.

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.

#### Contractual arrangements

The CCG’s largest contract is with RDASH which provides the CCG community health services for people with learning disabilities and also an Assessment and Treatment Unit (ATU) for people with more severe problems who need assessment and treatment. RDASH services are closely integrated with services delivered by RMBC.

The CCG also provides individual funding for bespoke rehabilitation for people detained under the mental health act, after care packages following detention under the mental health act (Section 117), for funded continued health care, funded nursing care and out of areas care.

In 2014/15 the CCG invested around £3 million in the RDASH contract and an additional £5.1 million in individual bespoke funding packages, including continuing healthcare.

Responsibility of the most challenging Learning Disability patients (Tier 4) patients rests with NHS England until March 2015, it is possible that some of this responsibility may be delegated back to the CCG in 2015 and we will work closely with NHS England to jointly co-ordinate care for these patients.

#### Key achievements in the last 12 months

The main change has been the re-location of the ATU and additional investment in community Learning Disability services (see quality improvements).

- Undertaken a review and public consultation on Learning Disability services
- Delivery of the Winterbourne Concordat requirements
- Positive feedback on Rotherham services from the Joint Health & Social Care Self-Assessment Framework



- The inclusion of a Learning Disability quality incentive in both TRFT and RDASH's contract
- Undertaken service –user led quality visit to inpatient units at Swallownest and Woodlands
- Improved awareness of autism and Learning Disability across mental health and other health services, such as GPs, TRFT

**What will we achieve for our investment including efficiencies?**

We will commission two evaluations of the new enhanced community and inpatient services. The initial evaluation of how successful the implementation of the new model has been will be completed in March 2015. A second evaluation of patient and carer experience will be completed in September 2015 covering:

- Supporting people to live more independently in the community
- Providing more peer support
- Improved access to community LD services through extended hours and 7 day working
- Developing a stronger focus on positive behavioural approaches
- Improving the psychological aspect of the service

Ensure equitable access for people with learning disabilities to mainstream services. This will be achieved with the development of an Acute liaison LD Nurse at TRFT and the delivery of training to staff in the mental health services. We will set target numbers and audit staff training.

The CCG will work with specialist services to deliver the Winterbourne Concordat to

- Reduce the number of people admitted to ATU
- Reduce the number of length of stay in hospital
- Reduce the number of people in out of area placements

The CCG will continue to work to develop Personal Health Budgets for people with Learning Disabilities in line with the requirements of the Budd report (on Winterbourne view). Further guidance on Transforming Care for people with Learning Disabilities is expected in early 2015 and the CCG will seek to implement this with partners.

An evaluation of current prescribing practice to ensure evidence based practice is in place, avoiding issues arising as a result of inappropriate pharmacology

**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 but not require the usual 3.8% efficiency savings from the new community investments. The two evaluations of the Assessment and Treatment unit will be used to inform our commissioning intentions for the 2016/7 contract.

***In 2014 people told us...***

*...carers told us that community support needs to be responsive and delivered by trained, consistent staff...*



***Our response...***

*...the enhancements to the community teams should address this and provide more access and flexibility...*

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 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

In 2014/15 the CCG addressed sustainability issues with the Assessment and Treatment unit by re-locating services to Sapphire lodge in Doncaster. This also generated funds for additional community investment in Learning Disability. In 2015 we will ensure that the expected improvements are being delivered.

- Improve patient and carer experience of services
- Increase support and quality of care
- Reduce inappropriate admissions
- Reduce length of stay in hospital
- Improving the timeliness and access to community services (through extended hours and 7 day working)

#### **In 2014 People told us...**

*...Carers who had visited Sapphire Lodge previously wanted assurance that their views and concerns had been heard and responded to; concerns had been raised that Sapphire Lodge felt less welcoming and friendly...  
...that travelling to Doncaster to visit people will be harder...  
...'health staff don't listen well, doctors could listen better and you have to wait a long time...  
...health staff are friendly and you can talk about your problems...*



#### **Our response...**

*...RDaSH have held consultations and asked for opinions on such things as uniforms and have looked at how they can make the unit more welcoming and have offered return visits...  
...the CCG and RDaSH will look at the issue of travel and provide support where needed...  
...we will work to improve patient and carer experience of services...*

### Innovation

- Working with RDaSH and SpeakUP to develop a peer support element to the service. Training opportunities for people with LD
- Delivery of Learning Disability and Autism training by Experts by Experience
- Service led quality visits to inform service development and commissioning assurance
- Working with TRFT to expand their programme of Learning Disability training across the organisation

### Alignment with H&WB strategy

**Dependence to independence** – people with learning disability will increasingly identify their own needs and choose solutions best suited to their personal circumstances.

**Aspiration and expectation** – these be understood and matched by services that are delivered according to their needs and where they live.

**Healthy lifestyle** - people with learning disability will be aware of health risks and be able to take up opportunity to adopt healthy lifestyles.

### How will we address health inequalities?

- Working with primary and secondary care providers to raise the awareness of learning disabilities, especially the requirements of reasonable adjustment.
- Improve communication through using easy read communications
- Ensuring that people with learning disabilities have good access to preventative health care
- Through the contract ensuring that providers comply with the Equality Act 2010, reasonable adjustment standards, autism statutory requirements etc.
- Improving services for people with Learning Disability attending TRFT by commissioning an Learning Disabilities Liaison nurse and working with the organisation to develop a Learning Disability Champions programme

### What patient engagement has informed the plan and what is planned in 2015/16

There was a formal consultation on the ATU and community investment changes in 2014. An evaluation of the impact on service users and carers will be carried out in 2015.

All changes and issues with services are fully discussed at the Learning Disability partnership board.



## 5.6 Maternity and Children Services

<b>Lead GP</b>	<b>David Clitherow</b>
<b>Lead Officer</b>	<b>Sarah Whittle / Emma Royle</b>

### Why are we planning to invest in this area?

Pregnancy, birth and the weeks and months beyond, are a key time of change and development for parents, as well as for their baby. 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.

Health commissioning for children in 2015/16 will involve much closer partnership between the CCG and RMBC ensuring that the voice of the child, young person and parent is fully engaged in the commissioning process.

[The important joint responsibility of RMBC and the CCG under the Care Act, such as transition assessments for 18 year olds, are summarised in section 5.14.](#)

The CCG has important responsibilities to work with partners to safeguard children. These responsibilities and the specific actions the CCG is undertaking with partners in response to the Jay report on child sexual exploitation are described in Section 6.2.

### Key achievements in the last 12 months

- Worked in partnership with RMBC to ensure that Section 3 of the Children's Act 2014 was implemented.
- Worked closely with RMBC on the launch of the Local Offer for Special Educational Needs & Disabilities (SEND).
- Co-production with the local parent's forum specifically regarding consultation with children, young people and their families.
- Carried out joint awareness raising sessions with RMBC, to staff, regarding the new SEND reforms.
- Commenced joint commissioning arrangements with RMBC focusing on Single Point of Access.
- Rolled out and evaluated the pathway to reduce 0-5yr A&E attendances.
- Developed ways to engage with General Practice to inform planning e.g. protected learning time events, top tips and visits to practices.
- Contributing to the development of the Pre-Birth and Beyond programme working with RMBC and TRFT.
- Worked with RMBC regarding the Early Years /Foundation Years Service review.
- Contributed to the development of a new children's pathway for the new Emergency Centre.
- Supported RMBC, TRFT & NHS England to help implement changes through a Breastfeeding Performance Clinic with the aim of improving breastfeeding initiation and also prevalence rates at six to eight weeks.
- Listened to Looked After Children regarding their experience of health services.

#### ***In 2013/14 people told us...***

*.....that it is less clear for children than for adults about what services to access... antenatal/postnatal consultation 2013  
 ....it's instinct, you want to see someone quick, so people go to the place they know and trust, and know it's always open...  
 ....we spend ages trying to decide whether or not to come here or not, but better safe than sorry..... A&E interviews*

#### ***Our response...***

*...examples of the areas we are working on is the development of a new children's pathway for the Emergency Centre to reduce confusion and work to reduce 0-5 year attendances at A&E...*



## What will we achieve for our investment including efficiencies?

### Maternity Services and Early Years

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

*In 2013/14 people told us how happy they were with the services they received and how helpful and friendly the staff were, this continues to be the feedback in 2014/15....*

*...I was completely confident in the care I received throughout the birth of my son, and am extremely grateful to the entire healthcare team for the support they provided to myself, my husband and our new son...*

*.....I would recommend this hospital to anyone and if I decide to have more children, will be having them at this hospital for sure! ... Patient Choice Website*

*...Fantastic staff on labour ward - midwives, consultant and doctor. Very supportive staff on postnatal ward. Helped tremendously with breast feeding. Will certainly recommend Rotherham Hospital.*

*...All staff went above and beyond their call of duty. For a new mum, they really put me at ease and help was always at hand.....Friends and Family Test*

### The Unwell Child

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

### Long Term Conditions and Care Closer to Home

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

### Special Educational Needs and Disabilities (SEND)

- 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 budget
- We are working jointly with other organisations, to ensure that transition from children into adult services is smooth
- Rotherham CCG has developed a carers action plan jointly with RMBC and voluntary sector organisations. The plan will be implemented in Rotherham and includes identifying and working with young carers



## 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 policies 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

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

## Innovation

### Midwifery and Early Years (Planned Care)

*...we will undertake a review to understand the number of babies born in Rotherham who are affected by Fetal Alcohol Spectrum Disorder...*

*...we will ensure that the new antenatal parenting programme, Preparing for Baby and Beyond, includes advice to mothers regarding the effects of alcohol consumption during pregnancy, on their babies, and raise awareness of Foetal Alcohol Spectrum Disorder...*

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

### Care Closer to Home (Planned Care)

- Care Closer to Home will transform the way acute care is delivered in the future. Newly designed care pathways starting in primary care, all the way through community and acute, will ensure that patients are seen in the right place at the right time, by the most appropriate person, reducing unnecessary hospital attendances and improving the patient experience.

### Unscheduled Care

- To reduce unnecessary A&E attendances by children, we will be innovative in how we educate parents. We will ensure the same messages are delivered by General Practice, midwifery, health visiting, school nursing and the hospital. We will promote the parenting guide for the acutely ill child to aid in these conversations to support behaviour changes.

## Alignment with H&WB strategy (and the Children and Young people Plan 2013 – 2016)

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



**How will we address health inequalities?**

We will carry out equality impact assessments on policies and procurements and service specifications. Partnership working is essential to reduce health inequalities across Rotherham. Through working closely with Public Health, RMBC and voluntary sector we can support:

- increased breastfeeding rates
- reductions in childhood obesity
- teenage pregnancy
- reductions in infant mortality through a reduction in smoking during and after pregnancy and ensuring the delivery of the safe sleeping policies
- Through working with children centres we can try and improve the number of people accessing courses to support non-working families to gain employment and reduce the amount of children living in poverty.

**What patient engagement has informed the plan and what is planned in 2015/16**

Work has been undertaken to listen to Looked After Children regarding their experience of health services.

Implementation of the SEND reforms has been carried out together with the Rotherham Parents Partnership. Rotherham CCG contributed to and participated in a successful event for children and young people, parents, carers and staff called 'In it Together'. This was regarding the SEND reforms and development of the Local SEND Offer.

Rotherham CCG have commissioned the Rotherham Parents Forum to carry out engagement work around mental health, and the wider elements of health (topics to be agreed with parents).

## 5.7 Transforming Community Services

<b>Lead GP</b>	<b>Phil Birks</b>
<b>Lead Officer</b>	<b>Dominic Blaydon</b>

**Why are we planning to invest in this area?**

The majority of this section describes the important project 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 5.9), general practice for example the case management programme (see section 5.11) and the voluntary sector including the award winning social prescribing scheme (see section 4.3). 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 5.14)

**Table 1: Spending Profile for Community Services**

SUMMARY OF COMMUNITY SERVICES	£000s
Children & Young People's Services	3,680
Planned Care	5,523
Long Term Conditions, Intermediate and Urgent Care	14,121
CQUIN	579
Pilots	3,165
Reablement	631
<b>TOTAL</b>	<b>27,699</b>

**In 2013/14 People told us....**

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

**Our Response...**

... the new community model described in this section, social prescribing and case management will go some way to address this...





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

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

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

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

### **Key achievements in the last 12 months**

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

#### ***A Better Quality Community Nursing Service***

We have delivered cost efficiencies within community health services, reinvesting the money saved into front-line staff. We have recruited 7 new district nurses and 7 clinical team leaders to support locality based community nursing. We have developed a better quality community nursing service, increasing capacity to deliver 7 day working and realigning the service so it targets GP practice populations. The service now supports episodic care of housebound patients and the case management of people with long term conditions.

#### ***Introduction of the Care Coordination Centre (CCC)***

The Care Coordination Centre has three key functions

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

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

#### ***Development of The Oakwood Community Unit***

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

#### ***Reductions in Falls Related Admissions***

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



### What will we achieve for our investment including efficiencies?

The Community Transformation Board has focused on how we can deliver a 7 day/week service that brings care closer to home. In order to do this more investment is required to extend hours of provision and enhance community health services. Investing in these services will help deliver positive health outcomes and free hospitals to focus on acute care. The Community Transformation Board has identified 5 priorities, which will support the transformation of community care pathways.

- 1: *A better quality community nursing service*
- 2: *Greater integration across health and social care*
- 3: *Development of an enhanced Care Coordination Centre*
- 4: *Increased Utilisation of Alternative Levels of Care (ALOC)*
- 5: *A robust governance framework for community health services*

By focusing on these priorities The Community Transformation Board will realign and extend services so that they support care closer to home. Figure 1 provides an illustration of the overarching vision.

### 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



*In 2014 Healthwatch Rotherham has looked at experiences shared by people discharged from a hospital, care home or secure mental health setting focussing on the experiences of homeless people.  
...“I think that at time of discharge, your home situation should be taken into account, talked about and made clear.”...*



**Our response...**  
*...supported discharge is one of the four key initiatives for the Community Transformation programme...*

### Quality improvements

The key benefits of the new service model for community nursing are;

- More nurses doing direct work with patients
- Local Area Teams are aligned to GP Practice populations
- Better connection between community nursing services and primary care
- Better distribution of resources based on weighted population
- Clear feedback loop for GPs into local community health services

The new model for community health services will make available a range of supported discharge options which respond to level of need. These pathways will reduce the need for acute care and provide an opportunity to reinvest savings back into the community. The “Discharge to Assess” pathway will ensure that joint health and social care assessments take place in an appropriate environment. Assessments will be followed up by community based rehabilitation services which support independence and reduce the long term cost of care.

The combination of service realignment and additional investment will deliver the following outcomes.

- All admission prevention care pathways will be accessible 7 days/week
- Reduce fragmentation and deliver economies of scale
- Reduce pressure on primary care because patients are receiving enhanced, integrated community health care packages
- Community beds will be able to support patients with rehabilitation and/or nursing needs
- Community bed capacity will be able to flex so there is increased availability during winter

The new service model for the Care Coordination Centre will provide clear visibility of patients in hospital who are medically fit for discharge. For these patients the CCC will be the interface between acute and community health services. It will ensure that patients are on the appropriate care pathway, liaising with the relevant community services to expedite discharge.

Finally a fully integrated Out-of-Hours will deliver a clear and simple approach to out-of-hours care. It will reduce fragmentation and increase efficiency. This, along with extra investment in front-line capacity, will ensure that admission prevention work can continue 7 days/week.

### Innovation

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

The new service model for community health services is innovative. It enhances the benefits of vertical integration with the acute sector and supports the development of integrated care pathways with social care. The new service model also provides a strong interface with primary care, placing GPs firmly in control of case management and giving them additional resources that can be used to support patients at home.

**Alignment with H&WB strategy?**

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

**How will we address health inequalities?**

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

**What patient engagement has informed the plan and what is planned in 2015/16**

We have consulted extensively with patient participation groups and local community organisations on the priorities within this workstream. Feedback shows that people want to receive care at home where possible. They want local community health services to support prevention activity and reduce levels of isolation. The additional capacity currently going into community health services should assist with this key objective. Additional capacity in community nursing alongside the development of alternative levels of care will focus care closer to home and ensure that health interventions take place before people become too ill.

## 5.8 Continuing Care and NHS Funded Nursing Care

<b>Lead GP</b>	<b>Richard Cullen</b>
<b>Lead Officer</b>	<b>Sue Cassin</b>

**Why are we planning to invest in this area?**

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.

Spend for 2014/15 on continuing healthcare (CHC) and funded nursing care (FNC) was £18.6 million and in 2015/16 we expect this to rise to £19.9 million.

**Key achievements in the last 12 months**

An entire review of NHS Continuing Healthcare process for both adults and children has been undertaken with key delivery changes undertaken. These include changing the responsibility for care management which has streamlined the process and supplied heightened assurance of a quality and efficient service to Rotherham's population.

The multiagency development of Personal Health Budgets policy process and procedure has been a key feature of work for both NHS Rotherham CCG and the Yorkshire & Humber Clinical Support Unit.

Both the Continuing Healthcare & Personal Health Budget services are provided by the Y&H CSU.



<b>What will we achieve for our investment including efficiencies?</b>
A high quality, efficient service for Rotherham’s citizens who are referred for assessment and/or meet eligibility for NHS Continuing Healthcare. Patients will be cared for in the right place at the right time and by the right professional and the need for acute hospital care will be minimised.
<b>How are we going to achieve our intentions?</b>
<ul style="list-style-type: none"><li>• 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</li><li>• Maximise the use of mainstream services in delivering NHS Continuing Healthcare</li><li>• We will benchmark ourselves against other CCGs to understand how we compare on NHS Continuing Healthcare costs and activity – the CCG current position is 50 out of 211 CCGs nationally and has higher activity and costs per 10,000 population than the England and North of England average</li><li>• Work in partnership with the RMBC, TRFT, Rotherham Hospice, primary care, domiciliary providers, care homes and the voluntary sector</li><li>• Work in partnership with the NY&amp;H CSU to ensure the delivery of a high quality CHC service.</li><li>• Continue to commission individualised services for children with complex health needs</li></ul>
<b>Quality improvements</b>
Quality improvements will be driven through robust contracting arrangements. We will engage patients to empower them in reaching decisions about their care: the personalisation agenda will improve self-care and give patients ownership of their care. As part of our re-negotiation of our contract with the CSU we will ensure that the quality of our service level agreement is made more specific, by developing robust key performance indicators and quality audits to ensure premium service delivery.
<b>Innovation</b>
The CCG in 2015 working with NY&H CSU will further develop <ol style="list-style-type: none"><li>1) The right to request a personal health budgets to all patients with receiving NHS Continuing Healthcare in their own home.</li><li>2) Patient engagement and feedback opportunities through the use of system such as patient opinion.</li></ol>
<b>Alignment with H&amp;WB strategy</b>
<ul style="list-style-type: none"><li>• 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 possible eligible for CHC. CHC aims to deliver high quality aftercare for patients in their own home or care home setting.</li><li>• 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.</li><li>• Opportunities for self care and the use of alternatives to acute hospital admission maximised.</li></ul>
<b>How will we address health inequalities?</b>
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.
<b>What patient engagement has informed the plan &amp; what is planned in 15/16</b>
Patient and relative feedback is sought on each assessment that is undertaken, and 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.



## 5.9 End of Life Care

### **In 2013/14 People told us....**

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

.....that everyone in Rotherham should be able to choose where they spend their last days and how they are care for...

*Patient Participation Groups network, 29.10.13*

### **Our response.....**

...Both the case Management Project (section) 5.10 and the community end of life care project invest in extra capacity for people with long term conditions including EOLC, this increases the clinical time available to have important conversations. The proportion of people dying in their chosen location has increased markedly in Rotherham over the last 2 years...

**Lead GP**

**Avanthi Gunasekera**

**Lead Officer**

**Nigel Parkes**

### **Why are we planning to invest in this area?**

Most end of life care (EOLC) is provided by families and by general services such as GPs, community clinicians, hospital clinicians, and continuing care workers working both in patients' homes, residential homes, nursing homes and hospitals. In addition to this the CCG will invest around £3.03 million in specialist End of Life Care from Rotherham Hospice. This provides a multidisciplinary service for patients with complex problems and provides specialist educational and practical support to other primary and secondary care staff. Around £2.24 million of this is from the CCGs core budget and £788,000 for the community end of life care service through Better Care Fund.

In view of the importance of the area and the fact that the Hospice generates a considerable proportion of its own funding the CCG's funding for the Hospice in 2015/16 will be unchanged and so not subject to the 3.8% efficiency requirements of other providers.

### **Key achievements in the last 12 months**

The Hospice has embarked on a service redesign which places the central Hospice building as a 'Hub' which engages patients in care provision and facilitation through the progression of their illness. Clinical services will be split into three delivery areas; Day Therapy and Inpatient Services (In-reach), Community Services (Outreach) and Patient and Family Support Services. The re-design also incorporates a 'single point of referral' and triage process and includes 7 day medical cover and non-medical prescribing for Advanced Nurse Practitioners.

The Hospice community pilot has continued to provide a reduction in emergency hospital admissions and is projecting 360 avoided admissions for the full year. It has also provided on average 600 calls per month through the 24/7 advice line. The pilot evaluated strongly at the community investment evaluation event in October, the CCG is minded to continue this investment through the Better Care Fund and consider the case for additional capacity to accept more referrals out of hours as part of the Transforming Community Services Initiative.

The Hospice has also been instrumental in the process to replace the Liverpool Care Pathway, outlined in the 'One chance to get it right' document. The CCG has provided non-recurrent funding for two posts to provide training and support for the implementation of the new model of End of Life Care. One post will be based at the Hospice and the second at TRFT.

Work is continuing on the rolling out of the Electronic Palliative Care Co-ordination Systems (EPaCCS). Templates and guidance have been prepared and 8 GP practices have signed up to trial the system.

### **What will we achieve for our investment including efficiencies?**

We will ensure that patients' care is better co-ordinated by improving the quality of conversations with patients who are approaching the end of life, better records, improved case management, including more use of advanced directives and better co-ordinated responses when peoples' conditions deteriorate unexpectedly.

This will mean that more people will be identified as being in receipt of end of life care, more people will have advanced directives and more people will die in their place of choice.



### How are we going to achieve our intentions?

The CCG is investing in additional nursing capacity through the transforming community services project (see section x) and will consider using some of this funding to expand 24/7 coverage by the community EOLC service.

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

The CCG will ensure that crucial conversations about EOLC care take place at the appropriate time for patients with long term conditions, the Case Management Project (see Section 5.11) will be a major enabler of this.

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

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

The CCG will continue to invest in the community EOLC service through the 'Better Care Fund'. This service will continue to provide community EOLC services, a 24 hour helpline, better record sharing and an electronic register to enable better case management between patients. The key deliverable to ensure continued funding will be to continue the demonstrable reduction in hospital admissions for EOLC patients. The pilot will be evaluated again in October 2015 to see that opportunities to avoid admissions are maximised and that the service continues to be well integrated with other community investment initiatives.

### 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 is implementing a new 'Hub' service model which will provide increased day therapy and community activity.

### Alignment with H&WB strategy

This work is key to the aging and dying well part of the strategy.

### How will we address health inequalities?

- Currently there are variations in the quality of EOLC received by patients from different general practices depending on their practices level of training and capacity. The community EOLC pilot will work with individual practices to reduce this inequality.
- Currently patients with some conditions such as dementia do not always receive EOLC services to the same standard that patients with cancer receive. We will address this by working with all referring clinicians as part of our case management pilot and dementia strategy.
- We will monitor the ethnicity of people receiving specialist EOLC services and ensure that this is representative of the Rotherham population.

### What patient engagement has informed the plan and what is planned in 2015/16

All patients in the community end of life care service are asked their preferred place of care and achievement against this is reported on. The evaluations of the community pilot in October 13 and October 14 have included qualitative reports from patients and their carers.



## 5.10 Ambulance and Patient Transport Services

<b>Lead GP</b>	<b>Julie Kitlowski</b>
<b>Lead Officer</b>	<b>Dominic Blaydon</b>

### Why are we planning to invest in this area?

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

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

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

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

The time taken to pick up 999 patients in Rotherham was consistently below target during 2014/15. 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.

### Key achievements in the last 12 months

#### *Patient Transport Services*

Activity with YAS is continuing to reduce with an in year reduction of 2%. This continues the trend of previous years. The Renal transport contracts continue to provide a high level of service provision and patient satisfaction. The flexible service model is being reviewed with a view to share the learning and success with other PTS providers.

The CCG has recently commissioned a PTS primary care transport pilot. During the winter period YAS will be able to convey patients who would otherwise require a home visit, to their own GP. The intention of this scheme is to free up GPs so that they do less travelling and have more face-to-face time with patients.

#### ***In 2014/15 people have told us...***

*...“Booked Medicar to come and pick me up for my appointment. They were running late and had not arrived and I was sending time panicking chasing them up. When they did eventually arrive but it was passed my appointment time at the Hospital. I was obviously very late for my appointment but was told off for been late, though this was not my fault and was told I was close to having the appointment cancelled. I was made to feel guilty though it was not my fault. The two services need to be working together”...*



#### ***Our response...***

*...we recognise that patient transport can be improved and in this section we outline our plans...*

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.

We have successfully moved existing activity from the hospital, extending PTS so that it is able to transport eligible patients to Intermediate Care, Breathing Space, Community Rehabilitation Services, Residential Care and community based outpatient clinics. 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.





#### *YAS 999 contract*

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

We have commissioned an Urgent Care Practitioner service operating during the winter period. The intention is that these practitioners will respond to less urgent 999 call-outs to treat on scene and/or prevent conveyance to A&E. We have also commissioned frequent flyers initiative which identifies those patients who contact 999 on regular basis. The intention here is to reduce the number of calls these patients make through effective case management and multi-disciplinary working.

#### **What will we achieve for our investment including efficiencies?**

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

##### *Patient Transport*

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

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

##### *Emergency Ambulance Service*

YAS are currently not achieving targets on Red 1 and Red 2 999 call-outs. 999 activity continues to increase in 2014/15 and we will work with YAS and the public to decrease this trend. NHS Rotherham CCG will work with YAS to ensure that patients are triaged effectively at the first point of contact. Patients who do not require an ambulance will be transferred to NHS 111 for support before they are conveyed. We will improve the patient flow from 999 calls through to the 111 system.

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

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

The care coordination centre will facilitate referral to breathing space, mental health services, Rotherham Hospice, the community hospital, fast response and intermediate care services. It will ensure that the receiving service is ready to take the patients within agreed timescales. We will introduce local performance measures to monitor the use of alternative levels of care.

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

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

We will review the current contracts in place for out of area hospital discharges and the Rotherham FT hospital discharge service.

Finally we will support residential and nursing homes to access alternative community support before phoning 999. Rotherham has a good record of reducing the number of residential/nursing home attendances at A&E. The Care Home Support Service and Advanced Nurse Practitioners have both contributed to better outcomes for patients in residential care. However there is still an opportunity to improve further.

#### **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
- The CCG will ensure through contract negotiations that YAS performance for Rotherham patients is at least equal to that of the YAS average.

#### **Innovation**

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

- Partnership working with the CCC to support on identification of appropriate level of care
- Use of an alternative provider to deliver GP urgent transport
- Development of a hub and spoke approach to PTS, so that it can transport vulnerable patients to a range of sites
- Development of the paramedic pathfinder service so that patients receive the most appropriate level of care

#### **Alignment with H&WB strategy**

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

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

#### **How will we address health inequalities?**

Vulnerable groups such as older people will receive a service which is more responsive to their needs. They will not be taken to A&E regardless of their condition but they will receive a proper assessment to enable the most appropriate care pathway to be offered.



## 5.11 CCG Commissioned Primary Care

<b>Lead Officer</b>	<b>Chris Edwards</b>
<b>Lead GP</b>	<b>Jason Page</b>

### Why are we planning to invest in this area?

This section describes our plans to continue to develop primary care services that the CCG has been responsible for since establishment in 2013. In Section 5.12 we set out our intentions to take on delegated responsibility for commissioning all general practice services from 1 April 2015. NHS England will still commission pharmacy, optometry and dental services and we will continue to liaise with them on those areas.

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.

This section describes the following areas:

1. A Local Incentive Scheme (LIS) to ensure the CCG has GP engagement/member engagement. This service 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.
2. 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.
3. The Long Term Conditions Case Management LES to improve the care of 12,000 patients at risk of hospitalisation 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 3% of the practice list size) which have been identified as being at the highest risk of admission to hospital, but will also include all nursing and residential home patients and an additional 2% of patients which can be selected on the basis of clinical judgement. Last year, 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 has been made recurrent and it is planned to increase uptake of the scheme to have maximum impact.
4. 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. In 2015/16 we will commission an orthopaedic injection LES.
5. CCG commissioned LES with optometrists. In 2015/16 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 2014 people told us that they are really positive about case management plans...  
 ...'I use it all the time'...  
 ...'useful if you need out of hours services – they don't know me'...  
 ...'I've given my folder to people at the hospital and the walk in centre, they thought it was great'...  
 ...'I can't believe how much my life has altered'...*



***Our response ...**  
 ...the feedback is testament that the case management plans are working well. We have made further investment into case management and have extended it to include an annual review for all patients over 75 years old...*

In 2014/15 spend in this area includes £0.7 million for the LIS and £1.2 million for the Case Management LES, plus funding for the CCG commissioned LESs.

The CCG is actively moving towards the situation where nursing homes have 1 GP practice providing the patient



services to the residents of that home. The CCG believes that this will lead to increased quality of care and to more effective safeguarding. The CCG has taken steps to ensure that patient choice is not compromised and has consulted widely to ensure that lessons learned from other health economies are taken on board.

**Key achievements in the last 12 months**

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

All 36 practices are engaged with the case management LES, at evaluation it was noted that those practices with a high level of engagement with the scheme have less growth in admissions than those with lower levels of engagement.

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

The CCG practices have improved prescribing quality whilst keeping prescribing cost growth with affordable levels.

**What will we achieve for our investment including efficiencies?**

- High quality engagement with member practices to enable us to deliver our QIPP plans.
- An agreed funded transfer of some outpatient services from hospital to general practice
- Better case management of people ‘at risk’ of hospital admissions

**How are we going to achieve our intentions?**

- We will continue our LIS that maximises GP engagement with the CCG and its QIPP plans
- We will develop LESs that allow patients to be treated in primary care rather than in hospital outpatients
- We will further develop the case management scheme to ensure patients are managed effectively in the community and hospital admissions are avoided
- The urgent care redesign project (section 5.1), has considerable implications for both out of hours and day time general practice services and should lead to a situation where over time more patients with general practice problems get seen in a general practice setting

**In 2013/14 People told us....**

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

**CCG Response....**

....Our new Emergency Centre will be open by Spring 2017, the full redesign of emergency and urgent care services will ensure that patients received the right care, first time and ensure clarity over which services to access...

- We will commission services from local optometrist so we can implement better care pathways for patients with cataracts and glaucoma

**Quality Improvements**

- 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 case management approach will increase the quality of care plans and reduce the number of patients requiring hospitalisation.
- The secondary to primary care LES will allow patients to be treated locally at their GP practice.

**Innovation**

- The case management approach uses the latest risk stratification tool and by involving all sectors it coordinates a whole system approach to managing long term conditions
- The secondary to primary care LES is an innovative scheme that will enable the CCG to move appropriate services out of a hospital setting and into the community
- Investments in mobile IT for GPs will improve quality of care for housebound, care home and nursing home patients.



<b>Alignment with Health &amp; Wellbeing Strategy?</b>
<ul style="list-style-type: none"><li>• The case management approach promotes prevention and early intervention and self-care.</li><li>• The secondary to primary care is part of an overall approach towards care closer to home and self-care</li></ul>
<b>How will we address health inequalities?</b>
<ul style="list-style-type: none"><li>• Secondary to primary care LES ensures universal coverage of provision</li><li>• All previous LES's will be reviewed and either decommissioned or rolled out to ensure universal coverage of provision and to a uniform quality</li><li>• Case management approach selects the patients on the basis of clinical need and is linked to social prescribing which addresses health inequalities</li></ul>
<b>What patient engagement has informed the plan and what is planned in 2015/16</b>
As part of the case management evaluation process we have surveyed patients on the scheme and followed up with a patient focus group. We found that the scheme was well received by patients who felt that it gave them greater control over their conditions.

## 5.12 Delegated Authority for General Practice Commissioning in 2015/16

**Lead GP: Jason Page, Lead Officer Chris Edwards**

In May 2014 CCGs were invited to express interest in co-commissioning primary care (i.e. general practice plus potentially other primary care services such as pharmacy and optometry.) Further guidance and options for this were published in October. [LINK](#)

NHS England is moving to a regional rather than a South Yorkshire footprint so if CCGs do not express interest there are risks to the local influence on primary care. NHS England is also looking to devolve commissioning responsibilities to local commissioners wherever possible.

### Consultation with CCG members

GP members, Local Medical Committee and the CCG Governing Body have been consulted and are fully supportive of the CCG taking on delegated responsibility for the commission of GP services from the 1<sup>st</sup> April 2015. Currently the CCG does not intend to take on responsibility for community pharmacy, eye health and dentistry.

### Workforce Development

There is a nationally acknowledged risk around primary care workforce and currently there is not a coherent plan to increase GP numbers either regionally or nationally. Current recruitment tends to focus on filling vacancies 'like for like' rather than considering skill mix to meet future service needs.

However, primary and community care is a key priority in the Health Education England Strategy 2013-2018 and this presents opportunities for Rotherham.

- There will be an extension of data collection to provide a more comprehensive analysis of the primary care workforce.
- Sustainable models of primary care training and placements are being developed.
- There will be investment in training to support service transformation and better continuity of care through better multi-disciplinary working across organisational and sector boundaries.
- More defined training routes for practice nurses and other primary care staff
- Increase in GP trainees



Rotherham currently has a full uptake in the GP training schemes and our plan is to ensure as many of these trainees become GPs in Rotherham.

### Commissioning Capacity and Capability

In order to prepare the CCG to take on the delegated responsibility of commissioning GP services the CCG will need to access NHS England resources. In addition to this the CCG has enhanced its workforce to ensure we are fully capable of taking on this responsibility from April 2015.

In section 10 of this plan we set out our plans for GP IT.

Current patient satisfaction with patient access in Rotherham is above national and regional averages. In Section 12 we set out our ambitions for patient satisfaction metrics.

### Governance

It is recognised that CCGs taking on delegated responsibility of the commissioning of GP services creates a conflict of interest. Our Governance section 6.5 outlines our approach to dealing with these conflicts.

NHS Rotherham CCG wishes to take full delegated responsibility for the commissioning of GP services from the 1<sup>st</sup> April 2015 and we see **5 benefits** to this approach.

1. **One commissioner for Rotherham** - will ensure services and pathways are seamless, and will allow the CCG to implement its strategy of moving services out of hospital and into community. This will help us improve patient experience and also modernise the Rotherham Health services at a quicker pace.
2. **Quality in practice** – as the local commissioner we are better placed to quickly identify and act on performance issues. We already have detailed knowledge of our member practices and will be able to tailor practice quality initiatives and training towards areas of local need. We will look to further enhance our practice quality visits to cover wider contractual issues.
3. **Local Contract for Rotherham Services** - This approach will give the flexibility to design a local contract for GP services that will meet local health needs of patients and ensure we get the maximum health benefit from the Rotherham Pound. We will be able to deal with the changes to the GMS/PMS contracts in a way that avoids unnecessary destabilisation of practices. We can also ensure the PMS premium is reinvested in Primary care in Rotherham in a way which contributes to the delivery of our overall plan.
4. **Local Incentive Scheme** - We can design a local Incentive Scheme which will ensure resources are targeted at areas where local health need is the highest. This will allow us to improve health outcomes for patients and ensure better value for money.
5. **Enhanced Services** - We can ensure there is no duplication in the enhanced services and maximise the health improvement effect and the value for money of these services.

**In summary**, we have a deeper knowledge of Rotherham GP services than the Regional model. We are also in a better position to improve quality and health outcomes as we can ensure local health needs are taken into account when we are designing contracts. Having one commissioner will also enhance relations with practices and allow the Rotherham Health community to have one coherent commissioning plan. Having one commissioner will also enhance the CCGs ability to commission joined up pathways and move more services out of hospital into community and primary care settings.

This will help to commission a resilient and fit for purpose Rotherham Health service.



## 5.13 Expected changes in Specialist Commissioning in 2015/16

**Lead GP Richard Cullen, Lead Officer Chris Edwards**

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).

NHS England's commissioning intentions for these services are on the [LINK](#). 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.

Two areas that were the responsibility of NHS England in 2014/15 will be transferred to CCGs in 2015/16;

- Specialist wheelchair services
- Outpatient neurology and neurosurgery

It is also likely following ministerial confirmation that the following services will be commissioned by CCGs

- Renal dialysis
- Surgery for morbid obesity

In addition to these formal transfers NHS England will be establishing arrangements to co – commission the majority of specialised services in partnership with CCGs. This will enable better aligned decision making to help restore pathway integrity and improve transition for patients between specialised and non-specialised services.

## 5.14 Rotherham Better Care Fund

**Lead GP Julie Kitlowski, Lead Officer Keely Firth**

The Better Care Fund 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 Rotherham Better Care Fund brings together 15 schemes that are particularly important for joint working into a single jointly owned budget of £23.3 million. There are six national conditions that have to be addressed.

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



The plans have to achieve specific outcomes in seven areas:

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

The fund will improve outcomes in the following areas:

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

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

£23.3 million represents only a small proportion of the total budgets that could potentially be shared between the CCG and RMBC, the CCG will review the potential for increased shared budgets on an annual basis.

Ref no	Rotherham Better Care Fund Schemes	Description of Better Care Fund Schemes
1	<b>Mental Health Liaison Service</b>	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 5.4.
2	<b>Falls Prevention</b>	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.
3	<b>Joint call centre incorporating telecare and telehealth</b>	Development of telehealth and telecare services in Rotherham to ensure a co-ordinated response to individuals' needs through increased use of assistive technology.
4	<b>Integrated rapid response team</b>	Extend the current Fast Response Service so that it is capable of meeting the holistic needs of adults with long term conditions who experience an exacerbation. The new service will incorporate community nursing, social work support, enablement and commissioned domiciliary care
5	<b>7 day community, social care and mental health provision to support discharge and reduce delays</b>	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.
6	<b>Social Prescribing</b>	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.
7	<b>Joint residential and nursing care commissioning, quality and assurance team</b>	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
8	<b>Learn from experiences to improve pathways and enable a greater focus on prevention</b>	A clearer understanding of the journey through health and social care services for people with long term conditions. A shift in investment from high-cost, high-intensity users of health and social care, to low cost high impact community initiatives which focus on prevention.





Ref no	Rotherham Better Care Fund Schemes	Description of Better Care Fund Schemes
9	<b>Personal health and care budgets</b>	Individuals are provided with the right information and feel empowered to make informed decisions about their care. Our aspiration is to continue to deliver on these agendas and to extend our current plans to a wider group of individuals, ensuring that they have choice and control.
10	<b>Self-care and self-management</b>	Individuals are provided with the right information and support to help them self-manage their condition/s. Professionals are equipped with the right skills to enable self-care / self-management and promote independence.
11	<b>Person-centred services including GP case management</b>	Each individual in contact with services will have a person-held one page plan that informs them, their family and professionals involved with their care of their story, their plan and what they can do to keep themselves healthy, safe and living in the community. This incorporates GP case management.
12	<b>Care Bill preparation</b>	To ensure Rotherham adult social care is able to meet the increased demand and maintain / protect the existing level of service. <a href="#">A summary of the important implications for people in receipt of care and carers of the Care Act for RMBC and the CCG can be found on the following LINK.</a>
13	<b>Review existing jointly commissioned integrated services</b>	All jointly commissioned services will be 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.
14	<b>Data sharing between health and social care</b>	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. It is proposed that use of the NHS number as a unique identifier across all health and social care will create the starting point for the development of shared IT capacity locally.
15	<b>End of Life Care</b>	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.

## 5.15 Commissioning Support/Intelligent Commissioning

**Lead GP Julie Kitlowski, Lead Officer Robin Carlisle**

In 2013/14 the CCG spend around £6.1 million on internal costs; £5.2 million classed as running costs and £500K (mainly safeguarding and medicines management) outside running costs. The Operational Executive reviews overall CCG capacity in relation to its responsibilities every 6 months and is required to keep running costs within a threshold set at £21.28/head for 2015/16.

Approximately one third of CCG internal resources and responsibilities are delivered by a Service Level Agreement (SLA) with Yorkshire & Humber Commissioning Support. Since the CCG was established two services have been brought back into the CCG from the Commissioning Support SLA; communications and the head of IT function.

Like for like costs of services delivered by the commissioning support SLA will have decreased by 10% from 2014/15 to 2015/16.

Two more services will be brought back into the CCG (IT strategy and data facilitation (a shared service with Doncaster CCG) and Organisational Development (the CCG will retain the budget and deliver services using internal or external support as required).

The two biggest responsibilities managed through Commissioning Support are continuing health care and business intelligence. In continuing health care there have been significant in year performance issues. We



have reviewed the funding levels, the service specification and commissioning support management to ensure that performance will be delivered in 2015/16.

The biggest anticipated change with Business Intelligence is the roll out of RAIDR (Reporting Analysis and Intelligence Delivering Results). This is a comprehensive desk top intelligence system for GPs and CCGs that has been operating successfully for several years in the North East and is expected to provide a step change in how the CCG can access speedy intelligence on quality and efficiency.

Commissioning Support provides 7 other services for the CCG: parts of corporate governance, equality and diversity, human resources and mandatory training, individual funding requests, procurement, information governance and parts of finance.

## 6 Statutory Responsibilities

### 6.1 Quality Assurance and Quality Improvement of Commissioned Services

The CCG's Chief Nurse works with the GPs responsible for the acute contract, mental health, primary care and governance to maintain oversight and assurance of all quality issues. Quality assurance of commissioned services is closely linked with GP quality, public involvement with the CCG, and safeguarding (see [sections 6.2 and 6.3](#)).

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

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

The CCG works with our commissioned providers to secure continuous improvements in the quality of services, with particular regard to clinical effectiveness and outcomes, safety, and patient experience. This includes ensuring that health services are provided in an integrated way and that provision is integrated with health related or social care services, where it would improve quality or reduce inequalities.

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

- Assurance that providers' cost improvement plans (CIPs) have robust quality impact assessments and can be delivered without compromising quality and safety. It is requisite that CIPs be signed off by providers' medical and nurse directors and provide a 'line of sight' to ensure the commissioner is aware of any risks to clinical safety resulting from the requirements to make efficiencies.
- Monthly contract quality meetings with main providers where discussions include outcomes, experience, hospital mortality rates, providers' Cost Improvement Plans, Commissioning for Quality and Innovation (CQUIN), Serious Incidents, patient safety agenda, Care Quality Commission



inspections, audit, safeguarding, friends & family test (FFT), patient survey reports and staff surveys and staff FFT.

- The CCG has worked closely with TRFT to understand and put in place a process of continued improvement with regard to hospital mortality data. In 2013 this included patient level audit and a revision of TRFT's procedure for hospital mortality assurance. In 2014 TRFT is working with other Foundation Trusts in Yorkshire and Humber and the Improvement Foundation to have a continuous process of mortality review including peer comparison with other foundation trusts.
- Monitoring of national and local quality standards set out in the contracts the CCG holds with providers and application of financial sanctions for underachievement as appropriate.
- Monitoring of action plans developed due to underachievement against contractual quality standards and holding the provider to account for delivery through contract meetings.
- Healthcare associated infections; we hold all our providers to account to make further substantial reductions in clostridium difficile with a root cause analysis of all cases. We have a zero tolerance approach to MRSA.
- Monthly quality reports to both open and closed sections of the CCG Governing Body covering issues, compliments, incidents, and complaints.
- Serious Incident monitoring and performance management.
- An agreed programme of 4-6 annual clinically led visits to providers.
- Taking part in monthly senior nurse walk round programme at TRFT and Chief Nurse walkrounds, both of these unannounced and at varying times during the day and night.
- Obtaining assurance from providers regarding the "Compassion in Practice Vision and Strategy" for Nurses and Midwives and implementation of the 6 C's across services (Compassion, Courage, Competency, Commitment, Care and Communication).
- Working with providers to ensure their Quality Accounts are informative public facing documents and providing formal commissioner commentary for inclusion in the final draft.
- Assurance from contract quality meetings for contracts where Rotherham is not the lead commissioner such as Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Children's NHS Foundation Trust.
- Sharing contract monitoring information with other commissioners to pool intelligence.
- The CCG uses a process of appreciative enquiry, developed to collate evidence relating to quality of commissioned services, gaining assurance, assessing risk, and undertaking in depth assessment where appropriate [Appreciative Enquiry](#).
- [GP Peer Review is the process, whereby each practice is visited every 3 years. The GP Primary Care Lead and the Head of Primary Care Quality have an open discussion with practices about their performance in comparison to other Rotherham practices with regard to prescribing indicators, elective and non-elective activity and enhanced services. Every year the performance of each practice is reviewed as part of a table-top exercise so that visits can be prioritised if needed. Actions identified as part of the visit are logged and followed up. This is intended to be a supportive process and part of the on-going dialogue between practices and the CCG.](#)
- [Protected learning time is a series of 6 meetings, held bimonthly which have a strong focus on clinical quality and strong engagement from secondary care clinicians. Key focuses have been on appropriate referrals and the use of clinical pathways.](#)
- [The advent of co-commissioning will bring responsibility for GP workforce planning to the CCG, however maintenance of the Performers list and GP accreditation and validation will still remain with NHS England.](#)
- [The CCG will continue to support Rotherham Practice managers forum](#)

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



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

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

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

We make full use of Commissioning for Quality and Innovation (CQUIN) incentives. These are additional payments for providers who deliver improvements above the baseline requirements of the NHS Standard Contract. In 2014/15 the maximum value of the CQUIN is set at 2.5% of the full contract value.

We make full use of Commissioning for Quality and Innovation (CQUIN) incentives. These are additional payments for providers who deliver improvements above the baseline requirements of the NHS Standard Contract. **Detailed guidance on the 2015/16 national CQUIN scheme will be published at the end of January 2015. Below we have set out current thinking. CQUINs will be finalised during contract negotiations in February 2015.**

#### TRFT

##### Current national CQUINs (0.5% of contract value)

- Dementia
- Care of patients with acute kidney injury
- Identification and early treatment of sepsis
- Improving urgent and emergency care across local health communities

##### Proposed local CQUINs (2% of contract value)

- Clinical Communications including improving Timeliness of Clinic Letters and Discharge Summaries from Secondary Care to Primary Care Safeguarding
- Patient Experience
- Clinical leadership to QIPP programmes
- Implementing the recommendations of Francis, Keogh, Berwick and Winterbourne
- Safer discharge

#### RDaSH

##### Current suggested **National** mental health CQUINs are:

- Family and Friends Test (FFT)
- NHS Safety Thermometer
- SMI physical Health Checks

##### Proposed local CQUINs are:

- Patient experience
- Learning Disabilities and Dementia



- Care Planning
- Recovery
- Carers
- Safeguarding

In addition to the CQUIN incentives, the CCG make full use of the Local Incentive Schemes that are included in the NHS Standard Contract to ensure the delivery of quality services and promote innovative practice. The Local Incentive Scheme for 2015/16 will focus on those priority areas in both the CCGs Commissioning Plan and the NHS Outcomes Framework.

In section 5 we list quality improvement initiatives in each of the CCG's commissioning areas. These include:

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

In Section 12 we describe the outcomes that we will monitor to determine the CCGs eligibility for quality premiums.

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

## 6.2 Safeguarding

NHS Rotherham CCG fully endorse that safeguarding is **all our responsibility**. With regard to **children and young people** the Clinical Commissioning Group fully accepts its statutory duty to safeguard and promote the welfare of children; ensure robust governance arrangements are in place and welcomes being an active member of the Rotherham Local Safeguarding Children Board. The Care Act 2014 will take forward and transform Adult Social Care legislation. Rotherham CCG anticipates that this Act once given assent will set out comparable requirements to ensure that integrated working between Health and Social Care are at the fore front of providing the adults of Rotherham with safe effective care. This would also include the expectation that Rotherham CCG will be an active partner on the Safeguarding Adults Board.



The Alexis Jay report was published in August 2014; this was an Independent Inquiry into Child Sexual Exploitation in Rotherham 1997 - 2013. [LINK](#) The CCG like all other partners was shocked by the extent of the exploitation and has been working with partners to produce and manage a comprehensive local action plan. [LINK](#)

This action plan includes Recommendation 9 (Jay 2014) which specifically highlights the need for all services to recognise that once a child has been affected by CSE they are likely to require support and therapeutic intervention for an extended period of time. This may necessitate the commissioning of additional support for victims; as part of that multiagency response Rotherham CCG is working with Public Health to estimate what those on-going support and therapeutic needs may require in order to ensure that victim support and effective services are commissioned.

The CCG has reviewed and is assured of its own internal approach to addressing Child Sexual Exploitation; it has worked and continues to work closely with partner health organisations to provide a 'health' specific action plan based on the CSE National Working Group Recommendations.

The CCG is assured by the steps that are being taken by providers such as TRFT and RDASH to raise awareness and address Child Sexual Exploitation and to support the victims of historical abuse. Rotherham CCG facilitated a national CSE Conference September 2014, a Protected Learning Time event which included CSE for 605 GPs and GP Practice staff and is in the process of facilitating a CSE next steps event for all health staff in Rotherham in February 2015.

The CCG has agreed that CSE will be a priority work area for 2014/15 and will work with partners to address any issues that arise from the Ofsted report in November 2014, Department of Health response to the Jimmy Savile reports and the Casey report in January 2015.

For **looked after children (LAC)** Rotherham CCG takes its Responsible Commissioner role seriously for all its LAC and Care Leavers. This responsibility includes providing Looked After Children with regular planned health assessments, upon placement and an annual/bi-annual review thereafter. Rotherham CCG will ensure that their identified health and welfare needs are prioritised, ensuring that our LAC receive a quality seamless health service for our Rotherham LAC living in or out of area. Data on achieving regular planned health assessments will be monitored by the commissioner and provider of services.

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

The CCG is committed to:

- proactively work in partnership with Local Safeguarding Boards
- ensure that identified clinicians have the seniority and capacity to lead on safeguarding agendas
- support the expected increase in the health visiting workforce by 24 by 2015 to ensure that early help is provided in a timely manner
- support the delivery and quality assurance of the Family Nurse Partnership to support vulnerable families
- monitor health providers work with the healthy child programme and the early identification of health and welfare needs
- work with central government, partner organisations and RMBC to ensure that LAC receive timely and effective health care. Achieved through active membership of the RMBC's Corporate Parenting Group.



- Continue to monitor safeguarding standards in contracts, service specifications and compliance with Section 11 children Act expectations
- ensure that the safeguarding agenda takes into consideration emerging national and local trends, for example work around child sexual exploitation and increase in self harm and suicides in young people.
- establish and publish a safeguarding dashboard of key performance indicators that will be shared with local partners and partners across South Yorkshire and Bassetlaw to allow for transparency and challenge in the system.
- support the development of the safeguarding adult's agenda, including, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards legislation.

The CCG produces and publishes an Annual Safeguarding Vulnerable Clients report which incorporates children, young people and adults. This report provides assurance that all vulnerable clients in Rotherham are given significant consideration at all levels of service delivery and that the safeguarding reassurance is sought from health commissioners and providers and shared with and challenged by partner agencies, namely Rotherham Local Safeguarding Children's Board (RLSCB) and Rotherham Safeguarding Adult's Board (RSAB). Full information of how we will meet our responsibilities is in the CCG's Safeguarding Vulnerable Clients Policy.

Whilst the responsibility for coordinating safeguarding arrangements lies with Rotherham Metropolitan Borough Council (RMBC), effective safeguarding is based on a multi-agency approach. Rotherham CCG is a willing multi-agency safeguarding partner and has robust governance arrangements in place to ensure that its own safeguarding structures and processes are effective and that the agencies from which Rotherham CCG commission services meet the required standards. Rotherham CCG are committed to working together to ensure that safeguarding vulnerable clients is at the core of all that we do.

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

## 6.3 Public Involvement in CCG and Promotion of Choice

### Why Public Involvement and Choice are vital to NHS Rotherham CCG

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, maintaining one strong legal duty around patient and public engagement, and introducing a new legal duty for individual engagement. CCG's therefore have a duty to enable:

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

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

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



## NHS Rotherham CCG's vision for involvement

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

Our vision is described in more detail in our communications and engagement strategy, [Your Life, Your Health, Your Say](#). The strategy has informed this section of our plan, as have *'Transforming Participation in Health and Care'*, NHS England 2013, and the reports of Berwick, Keogh and Francis.

Driven by these three reports a Patient, Public Engagement and Experience report is received at each of our governing body meetings, describing current activity, outcomes and plans. In the last year we have strengthened the way we use engagement and patient experience to inform our work and plans; we can cite many examples of using patient voice in planning services; these appear throughout the plan. Our aim is that in all that we do we can demonstrate that the patient, or their voice is at the table, is heard effectively and impacts on our decision making. It is important to us that we continually improve our engagement with patients and the public, and ensure that this work actively contributes to service improvement. To this end, we have established a governing body sub-group to drive forward engagement, and are piloting mechanisms to manage both stakeholder information and comments and feedback,

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

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

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

In this annual plan, we are taking steps towards this, and our aim is to improve this year on year, section 14 has more details on how we are sharing this commissioning plan with the public and with stakeholders.

## What this means, and what we will do

**Individual participation, we will** ensure that patients and carers can participate as far as they want to in planning, managing and deciding about their care through

- extending the use of personal health budgets in continuing care
- continue our third sector commissioned social prescribing programme , this will:
  - Improve outcomes for patients in terms of health, wellbeing, self-care and independence
  - Increase resilience of individuals and communities
  - Support dependence to independence
  - Reduce social isolation.
- Ensure that providers are involving patients in all aspects of service redesign





## Public participation, we will

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

### *An example of ongoing engagement.....*

In 2012, we asked looked after children about their views and experiences of all health services. Many reported back that they had nothing to tell us, as they were fit and well! Others told us of staff that had made a difference to treatments through their kindness and attitude *'the nurse smiled at me'*; *'they always mend my glasses'*.

Where young people identified problems with services, we ensured that personal responses were sent, offering information and support.

Several issues came out of this work; one was around missing school because of hospital appointments – this was addressed immediately, with access being improved during school holidays. Another issue was around access to information - work is ongoing with this, with young people engaged in identifying the information they need and the format it should take.

The final issue to emerge was how young people attending health services on their own are listened to and treated, especially when they lack confidence, may use services inappropriately though lack of knowledge, and don't have an adult to support and advocate for them - this is an issue we continue to work on.

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

- The 'Friends and Family Test (FFT)' identifies whether patients would recommend a hospital or service to others. We will continue to work with all our providers to monitor the results, feedback and outcomes, and also ensure that it is rolled out effectively to the rest of our commissioned services by



March 2015. We will share the information with the public, congratulate and challenge providers where appropriate and see how the information triangulates with other insights and feedback

- The national patient survey shows that currently Rotherham patients report a slightly worse experience than the national average. We have set an ambition to improve this back to the current national average (see section 12).
- On the national GP survey Rotherham benchmarks well. We have set an ambition to maintain this position (see section 12).
- Publish evidence of what ‘patient and public voice’ activity has been conducted, its impact and the difference it has made. We will continue to systematically feedback to individuals where possible and to the community in general, telling people how what they have told us has informed our decisions. We will do this using electronic mechanisms, local press and community networks
- We continue to use a variety of mechanisms for listening to patient voice - including ‘the whispers’. We will triangulate data coming from these, for example
  - Comments from FFT as above, shared openly by providers
  - Online comments and stories via Patient Opinion and NHS Choices, for example
  - Data shared by Healthwatch
  - Informal information from community meetings and contacts
- We will continue to develop our website and the use of social media to feedback to the community
- We will continue to work with Healthwatch and RMBC to get views from patients and carers around complex care to support the Special Educational Needs and Disabilities (SEND) agenda

## Complaints

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

The CCG’s approach to dealing with complaints, in line with Department of Health guidance, is to ‘*listen, respond and improve*’. All feedback is welcomed including complaints about the CCG itself or about our provider’s services. We will do everything possible to try and resolve complaints. Complaint letters should be addressed to the Chief Officer or the Governance and Complaints Officer, detailed information about how to make a complaint is available on our website. [Complaints/concerns](#)

The CCG will liaise with NHS England on how complaints about general practice will be managed from 1 April 2015 when the CCG has delegated responsibility for general practice commissioning.

## 6.4 Health Inequalities

### Overall Approach

Section 4.1 of this plan summarises Rotherham’s Joint Strategic Needs Assessment (JSNA) which emphasises the striking degree of health inequality within Rotherham. One part of the JSNA was a specific consultation about health inequalities.

The CCG is committed to working with partners to reduce inequalities. *With partners we have reviewed the 5 steps in the Commissioning for Prevention report.* The CCG is a member of **Rotherham Partnership** which has three priorities: helping local people and businesses benefit from a growing economy; ensuring the best start in life for children and families; and supporting the vulnerable within our communities. Two important partnership projects are improving life in parts of the borough that are most deprived and the Families for Change project, which involves working with the 244 families in Rotherham with the most complex needs.



Section 4.2 of this document summarise **Rotherham's Joint H&WB Strategy**. Page 5 of the H&WBS lists 34 'big issues' that are being tackled following the JSNA and health inequalities consultation. All of these issues are reasons why Rotherham's health outcomes are lower than the national average such as: smoking rates, obesity rates, and low qualification and skill levels, or are reasons for substantial inequalities within Rotherham such as, meeting the needs of ethnic minorities and addressing gaps in life expectancy between the least and most deprived areas in Rotherham.

The CCG recognises that local supply chains are intrinsically good for the local economy. The CCG has to comply with stringent procurement regulations, as part of our procurement strategy the CCG will be mindful of local supply chains whenever possible.

The CCG will work in partnership with **Rotherham Public Health** to influence and help implement the Boroughs plans for Public Health commissioning. These include important areas such as NHS Health Checks which provides screening for cardiovascular disease and other conditions and services for important causes of inequalities in Rotherham such as smoking, obesity, sexual health and substance abuse, including alcohol. From October 2015 onward Rotherham Public Health will also have commissioning responsibility for delivery of universal community health services for 0-19s, which includes health visiting, family nurse partnership and school nursing.

The CCG is acutely aware of the inequalities in funding of different general practices in Rotherham and the potential impact this can have on patients. We will support **NHS England** as they address this through the implementation of the national single operating model.

In section 5 of this document we describe **our actions to address inequalities** in each of our areas of commissioning responsibility. These include:

- **Urgent Care:** the urgent care redesign will enable more care to be provided closer to home and the care co-ordination centre will ensure vulnerable people get access to appropriate urgent care.
- **Children and Maternity:** work in partnership with RMBC and the voluntary sector to support actions on giving every child the best start, these include infant mortality (smoking during and after pregnancy and safe sleeping policies), breastfeeding and teenage pregnancy. Work with RMBC to take forward the Special Educational Needs agenda.
- **Long term conditions:** the case management project is targeted at the 12,000 people who are most at risk of hospital admission, these are often the most disadvantaged. The social prescribing scheme offers non-medical interventions to those people with long term conditions who are most in need.
- **Hospital Care:** we will make use of the Commissioning for Quality Innovation Scheme to incentivise interventions for areas identified in the JSNA such as alcohol, smoking and obesity.
- **Mental health:** the Mental Health Transformation Plan prioritising investments in dementia services, services for people presenting with conditions caused by alcohol and voluntary sector support for people with long term mental health conditions. Work with partners to tackle the inequalities that result from poor mental health, such as lower employment rates, poor housing, education and poorer physical health.
- **Learning disabilities:** In 2014 we increased investment in community services for people with Learning Disabilities. The CCG is mindful of the lessons from Winterbourne view (see section 5.4) and closely case manages all learning disability patients who require in-patient care.
- **Community Services:** investment and realignment of community health services will promote early intervention, individualised care and self-care.
- **Continuing Care:** engage hard to reach groups to increase awareness.
- **Primary Care:** benchmarking with all practices to reduce unexplained variations in treatment, referrals and admissions.



- **Prescribing:** Key Prescribing Indicators promote equal access to key medications that are vital for long term condition management. We will utilise the Pharmacy Needs Assessment information to help develop services further.

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

### CCG:

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

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

Under 75 mortality rate from:

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

### Health & Wellbeing Strategy

- [The CCG is working with partners to refresh the Health & Well Being Strategy by August 2015. This will have quantified ambitions for Potential Years of Life Lost, Obesity, Smoking and Alcohol.](#)
- Prevention and early intervention** - Rotherham people will get help early to stay healthy and increase their independence.
- Expectations and aspirations** - All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances
- Dependence to independence** - Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances
- Healthy lifestyles** - People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.
- Poverty** – reduce poverty in disadvantaged areas.

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

- Case management and social prescribing** – targeted at people most at risk of hospital admissions
- Parity of esteem** – in section 5.4 we describe how we will commission a review of our investments in mental health services and use the additional resources to deliver parity of esteem and a range of other improvements in mental health and learning disability services
- Community Transformation** – ensuring that community services and staff are distributed proportionately to need across the most disadvantaged areas



- d) **Better Care Fund** – This will provide an opportunity to improve the lives of some of the most vulnerable people in Rotherham, giving them control, placing them at the centre of their own care and support and in doing so providing them with better service and better quality of life.

## 6.5 NHS Constitution, CCG Constitution and Governance

### *NHS Constitution ‘.....The NHS belongs to the people.....’*

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

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

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

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

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

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

The CCG has a strong record of achievement in the delivery of the standards enshrined in the NHS Constitution. The standards are a requirement of the NHS Standard Contracts we hold with all providers and we monitor these through monthly performance meetings. Where performance concerns arise, the CCG holds extraordinary meetings to discuss in detail performance concerns and develop robust action plans. The CCG has regular Board to Board meetings with our key providers where any under-performance against the NHS Constitution Standards can be escalated. *Through the System Resilience group we forward plan so constitutional rights and pledges are maintained through busy periods.*

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

### The CCG Constitution

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

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

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



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

The Constitution is reviewed on a regular basis by the GP Members and the CCG Governing Body, [for example members are being consulted in February 2015 on changes resulting from the delegation of GP commissioning.](#)

## Governance

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

### The CCG Governing Body

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

The following sub committees have been established by the Group:

### GP Members Committee:

To be a strong advisory group to the Strategic Clinical Executive (SCE) and CCG Governing Body and to ensure that the member practices are linked into all of the wider commissioning decisions of the CCG. It is representative of all of the GP Practices in Rotherham and is mandated by them.

The committee's key role is to support the GPs on the SCE and to hold the SCE to account for its commissioning activities.

It should provide a 'reference' point for all commissioning developments.

Responsibilities:

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

### Strategic Clinical Executive:

To be the 'engine house' of the governing body, with regards to producing its plans and leading on delivery.

Specific functions include:

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

### Operational Executive

To receive information and to manage actions on specified areas.

- Operational delivery for the Group
- support of the governing body
- Corporate policy and strategy
- corporate assurance and risk management
- oversight of progress with vision, strategy and operating plan
- performance review and improvement



- partner and market relations/management
- preparation for meetings of the CCG Governing Board and SCE
- To agree which issues should be escalated to SCE or Members

### **Audit and Quality Assurance Committee**

To obtain assurance that:

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

### **Remuneration Committee**

Has delegated authority on behalf of the governing Body to:

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

### **Primary care Sub-committee**

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

- To oversee the development of an operational plan for safe and sustainable Primary Care Commissioning
- To oversee the development and agreement of primary care contracts for 2015/16
- To consider and act on the 'conflict of interest' of General Practitioners with reference to Primary care Commissioning.

### **Patient and Public Engagement & Communications Sub Committee**

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

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

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

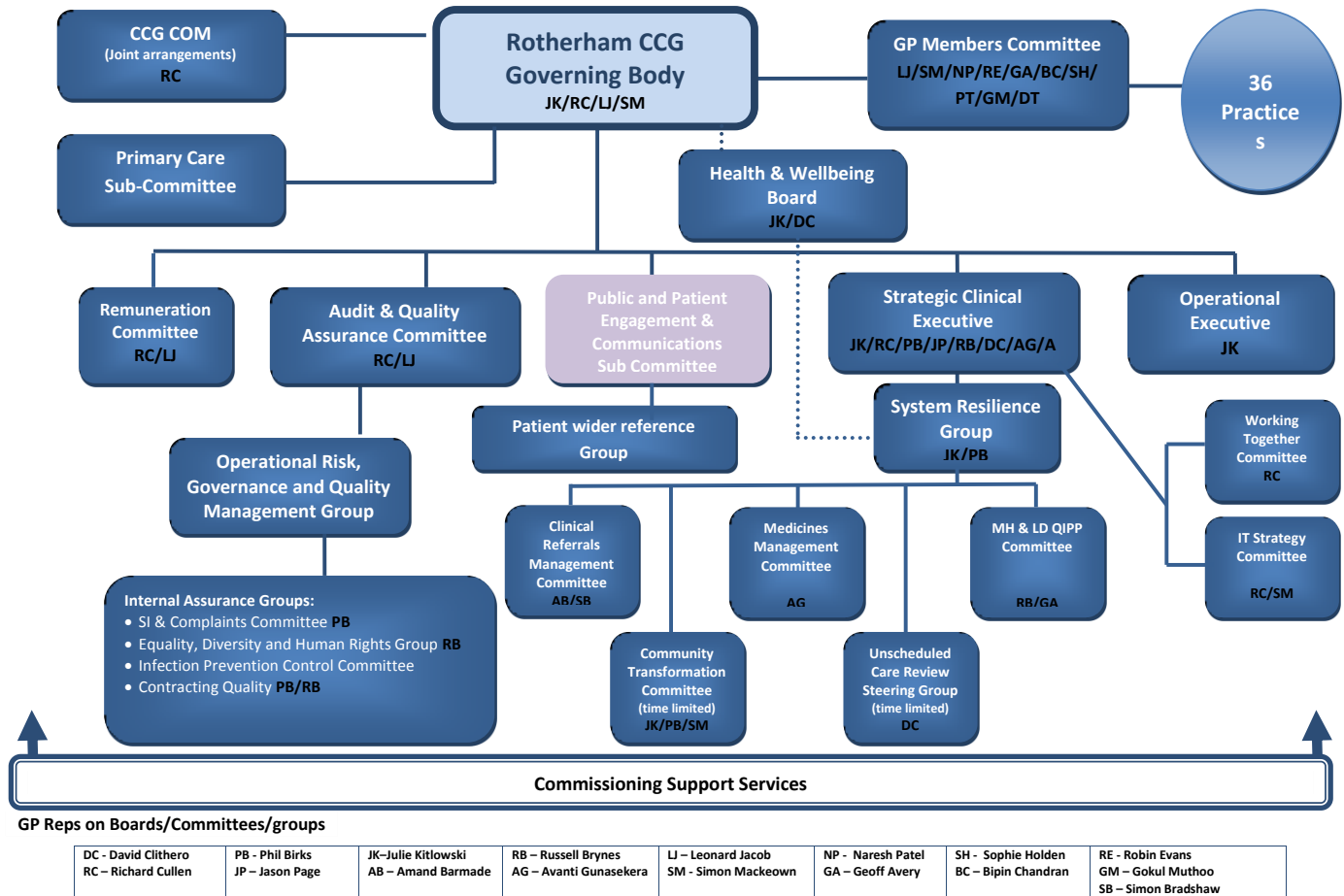
The H&WB Board is a statutory, sub-committee of the council. Locally, it will be the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing in order to secure better health and wellbeing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

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



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

### NHS Rotherham Clinical Commissioning Group Governance Structure, with GP representation



## 6.6 Public Sector Equality

The CCG is committed to equality of opportunity for all, regardless of race, gender, gender reassignment, religion or belief, sexual orientation, age, disability, maternity and pregnancy, marriage and civil partnership and we will strive to uphold the human rights of all staff and service users in accordance with the Equality Act 2010 and the Human Rights Act 1998.

### As a commissioner of health services:

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

### As an employer:

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





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

The CCG is committed to advancing equality and diversity for patients, communities and the NHS workforce. It has pledged its commitment to two measures to improve equality across the NHS, which would start in April 2015.

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

- Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within Provider contracts.
- Ensure appropriate and accessible targeted communication and engagement with local communities to ensure commissioners are aware of issues/ barriers that influence commissioning decisions.
- Develop consistency of equality approaches across the CCG in respect of leadership, staff empowerment and access to development opportunities.
- Demonstrate leadership in advancing the equality agenda internally and with partners and providers to ensure inequalities are addressed within a partnership approach to ensure equity of access and outcomes for patients.

We will be using the refreshed EDS 2 to further develop our equality objectives [Equality and Diversity Strategy](#).

## 6.7 Research and Innovation

High quality research is a core NHS role. The CCG will ensure that it and its providers will meet the treatment costs of government funded and charitable research that is agreed at national level.

The CCG is a member of **South Yorkshire Comprehensive Research Network** to ensure that patients in Rotherham have the opportunity to benefit from high quality research. The CCG also collaborates with **Yorkshire and Humber Academic Health Science Network** a collaboration of patients, health services, industry, and academia to achieve a significant measurable improvement in the health and wealth of the population. One branch of the academy is the **Yorkshire and Humber Improvement Academy** which is concerned with speeding up the widespread adoption of proven ideas particularly in the area of clinical safety.

In 2014/15 the CCG will contribute £40,000 to the **Rotherham Research Alliance**. This alliance of the CCG and TRFT promotes health research in Rotherham and manages local governance for health organisations including general practice. Having a strong research programme is beneficial to the Rotherham economy and increases the attractiveness of Rotherham providers to new recruits. [We will discuss with partners whether this funding should be continued in 2015/16 and which organisations should contribute to it.](#)

In addition to enabling new research, the CCG will implement new innovations where they are proved to be cost effective. This involves seeking out best practice from other organisations and quickly implementing research findings that have demonstrated patient benefit elsewhere. Our delivery groups responsible for areas such as unscheduled care, scheduled care and medicines management in particular will collaborate with other CCGs and agencies to implement what works elsewhere. The CCG will continue to work with providers to ensure they implement the NHS Institute 'six high impact innovations' (such as support for people with dementia, better use of technology and improved fluid balance) and will ensure we are assured of progress through CQUIN pre-qualification and through providers quality accounts. The CCG's IT strategy is summarised



in section 10 and is informed by Digital First. The CCG is considering the benefits of the 3 million lives transformational change but is mindful that our approach starts from a consideration of the needs of individual patient pathways and then considers if technology provides the best solution.

In section 5 we describe specific innovations in each of the areas we commission these include:

- The case management project, risk stratification and social prescribing schemes (section 5.1)
- The haematology virtual clinic and use of technology to improve communication between GPs and consultants, such as video top tips programme for clinical referrals (section 5. 2)
- The award winning nutrition and continence procurement projects and the set of key prescribing indicators (section 5.3)
- Early adapter of payment by results for mental health and clinical engagement on pathways and referrals.
- Acutely ill child pathway, education of parents to reduce unnecessary A&E attendances with children
- The Community Unit, Care Co-ordination Centre and alternative levels of care, fully integrated stroke care pathway which incorporates specialist psychological support, community stroke team and carer support workers
- Secondary to primary care local enhanced service that enables movement of services from hospital to community setting

## 6.8 Education and Training

The CCG is committed to maintaining the education and training of the NHS workforce. The CCG has links with **Yorkshire and Humber Local Education and Training Board** who are charged with ensuring that the planning, commissioning and quality assurance of NHS education and training is aligned with NHS commissioning plans. The CCG ensures that all its providers' contracts stipulate that they carry out their education and training functions. As an employer the CCG is committed to the education and training of its staff which is detailed in the CCGs organisational development plan. The CCG has developed plans for organisational sustainability and succession planning.

Rotherham CCG was the first CCG to achieve the national Investors in Excellence standard. The standard covers all activities within the organisation and is focussed on achieving what matters the most for the CCG, for its local public and patients and for its stakeholders. The CCG has a team of Investors in Excellence Practitioners, these work with all staff and the national Investors in Excellence team to regularly review that excellent working practices are fully spread throughout the workforce and in its engagement with stakeholders.

The CCG's response rate for the annual national NHS survey was 92% , compared to 75% nationally. The outcomes were overwhelmingly positive, examples being such as 98% of staff would recommend working at the CCG, 100% of staff feel that their senior managers are committed to patient care and 98% of staff feel that their line managers support them with difficult work tasks and are supportive in a personal crisis.



## 6.9 Environmental Sustainability

NHS Rotherham CCG is a socially and environmentally responsible organisation.

The Sustainable Development Strategy for the Health and Care System 2014 - 2021, the Social Value Act 2012 and the Climate Change Act 2008 requires public bodies to consider how to use its contracts to improve the economic, social and environmental well-being of our communities.

The CCG is committed to the NHS Carbon reduction scheme and there is an on-going focus to reduce the CCG's direct impact, including our: building related greenhouse gas emissions, business travel and waste going to landfill.

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

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

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

### 1. Corporate leadership

*'The NHS has the potential to touch almost every person in this country. By demonstrating how to reduce carbon emissions and promoting healthy, sustainable lifestyles, the NHS can lead the way to a healthier, happier society.'* – Neil McKay.

### 2. Staff health and wellbeing and community engagement

The CCG as an employer will enhance the health and wellbeing of staff, patients, the public and suppliers. We will improve the wellbeing of local communities, the economy and the environment through building relationships and minimising negative impacts.

### 3. Reducing our internal impact

We will support the government target to reduce the NHS Carbon Footprint by 80% by 2050. This will involve measuring our baseline and setting targets for;

#### a. Energy Management

#### b. Travel Reduction & Greener Travel

#### c. Material management and the waste hierarchy .

### 4. Sustainable commissioning and procurement

Sustainable procurement means purchasing goods and services in a way that maximises positive benefits and minimizes negative impacts on society, the economy and the environment through the full life-cycle of the product. The NHS spends around £11 billion a year. It contributes enormously to local economies and has the significant market power needed to drive innovation. The NHS contributes up to 10% of regional GDP, and in more deprived areas an NHS Trust can have an even greater economic impact. The majority of our impact comes from our commissioning and procurement activities. While we intend to focus on our internal impact, health and wellbeing of staff and embedding sustainability into the organisation as a priority this year, we must begin to put measures in place to challenge and support our providers to reduce their impact too.



## 6.10 How we will deliver the NHS 5 Year forward View

In October 2014 an alliance of NHS organisations including NHS England, Monitor and the Care Quality Commission published the Five year Forward view. [LINK](#) The table summarises key points and how these are addressed in our plan. On 23 December the 'Forward view into action' set out more specifics. [LINK](#)

5 year Forward view	Rotherham CCG Commissioning Plan
A radical upgrade in prevention and public health	The CCG strongly supports this and will work with RMBC to get maximal health gain from Rotherham's public health funding, to implement the Potential Years of Life Lost plan and to promote public health messages across Rotherham. The CCG's approach to Health Inequalities is in section 6.4 and <a href="#">includes quantifying ambitions for Potential Years of Life lost, smoking, alcohol and obesity</a> . The CCG will continue to work closely with partners on the reforms for children with special educational needs and disabilities (5.6).
Patients will gain far greater control over their own care, joint budgets, carer support and partnerships with the voluntary sector	The CCG will look to maximise and expand projects in the Better Care Fund (5.14). Self care and personal budgets (sections 5.1 & 5.8). Carer support in sections 5.4 & 5.14. The Rotherham model of social prescribing in partnership with the voluntary sector is covered in sections 4.3, 5.17 & 5.11. Our partnership with Rotherham Hospice is described in section 5.9.
Breaking down barriers in how care is provided	This was also a key finding in our survey of the Rotherham public (Section 14). This is a key feature of Care Co-ordination (5.11), Social Prescribing (4.3) and our Better Care fund projects (5.14). The CCG will ensure that provider services prioritise the health needs of looked after children (6.2).
Integrated out of hospital care, multispecialty providers of community services, integrated primary and acute care systems and the importance of the list based primary care	Our plans to transform Emergency Care (5.1) were fully endorsed by the Keogh Urgent and Emergency Care review and is based on partnership between urgent care providers in Rotherham and best utilising the different skills of clinicians with primary and secondary care training. Our plans to transform community services are in section 5.7. The CCG encourages GPs to federate to increase commissioning options for a wider range of services. The CCG's interest in innovative years of care models for areas such as diabetes, neurology and dermatology is flagged up in <a href="#">section 5.2</a> . The importance of primary care, and the current risks in that area, is the reason why the CCG wishes full delegation of GP commissioning (5.12).
5 year ambition on quality	The CCG has a robust approach to secondary care quality improvement and assurance (section 6.1) and currently works in partnership with NHS England on GP practice quality. This approach will be expanded as part of our delegated responsibility for GP commissioning (section 5.12). The CCG will ensure that the voice of the child, young person and parent is fully engaged in the commissioning process (5.6).
Support for people with dementia	This is covered in Section 5.4, Better Care Fund project BCF 1 and the more detailed Rotherham Adult and Older Peoples Mental Health transformation Plan, a <a href="#">LINK</a> in this document.
Support for carers	<a href="#">See section 5.14 and also the Social Prescribing Service which support patients and carers (Section 4.3).</a>
Enhanced health in nursing homes	The CCG will facilitate GPs to move towards 1 GP practice providing patients services to residents of individual homes because we believe this improves quality of care.
5 year ambitions for mental health	This is summarised in section 5.4 and set out in detail in Rotherham Adult and Older Peoples Mental Health transformation Plan mentioned above.
Choice in maternity services	<a href="#">Set out in section 5.6</a>



## 7 Activity

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

Rotherham clinicians agreed trajectories for keeping growth within affordable limits in early 2014. There has been over-performance against these trajectories in the first half of 2014/15 (particularly for non elective admissions, elective procedures and follow up outpatients). Forecast out-turn for non electives in 14/15 is a 4% increase compared to the 14/15 plan which was to flatline (non elective activity in Rotherham is still 16% below its 10/11 peak and Rotherham's non elective growth in 14/15 is expected to be below the national average). The CCG believes this over-performance was an exceptional event. There was a 5% increase in A&E attendances in 14/15, whereas A&E attendances have previously only risen slowly at 1% per year. The CCG believes the plans set out in this document will achieve a long term flat line in non electives, however as discussed in the introductory section the CCG is considering a list of least worst options to curb activity if either non electives or electives were above plan in 15/16.

The trajectories from March 2015 out-turn are:

- **first outpatients 1% growth**
- **electives;** 1% annual growth;
- **follow up appointments;** will be reduced by 5.9% over two years (to national average follow up ratios) and then remain flat
- **emergency admissions.** In 2015/16 we will reduce non electives from 2014/15 out-turn and then hold them at this level for the foreseeable future. This is extremely challenging because Rotherham's activity is already 16% below the 2011/12 peak, however primary and secondary care clinicians have agreed that the combination of initiatives in this commissioning plan will deliver this challenge. A subset of emergency admissions which are potentially avoidable are monitored for quality premiums, these admissions will be decreased by 3% per year (see section 12).
- **lab diagnostics:** 2.5% increase per year to enable the early diagnosis required to maintain increasing numbers of people with multiple conditions in community rather than hospital care
- **accident and emergency:** maintain at 2014/15 out-turn levels
- we will agree a new trajectory for reductions in the £3 million that we spend annually on excess hospital lengths of stay



# 8 Efficiency

## 8.1 Introduction

### The Health Service Efficiency Challenge

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

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

**Provider QIPP:** *efficiencies passed on to all providers.* For the last four years and for the foreseeable future, providers have been expected to provide the same services with less funding. For example in 2015/16 providers will be given a 1.9% uplift in funding but are then expected to make 3.8% efficiency savings. This means they will receive up to 1.9% less in absolute terms for providing the same services. When QIPP was introduced in 2011 finding the first 4% efficiency saving was relatively straightforward, and although in 2015-16 the requirement is now 3.8% finding each additional annual efficiency saving is increasingly challenging.

**System Wide QIPP:** *efficiencies that are the direct responsibility of the CCG.* NHS financial allocations are expected to rise by around 1 - 2 % each year over the five years starting 2014-15. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth would continue at around 6% a year because of the aging population, new medical technologies and rising expectations. System wide QIPP programmes are the actions required to keep overall growth at an affordable 1 - 2% level rather than the historical 6%. We have 5 CCG QIPP areas (numbered below), two groups which will enable QIPP to be delivered across the system and the Better Care Fund which reports directly to the Health and Wellbeing Board:

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



## 8.2 Provider efficiency savings

Figure 8.1: Summary of Provider Efficiency Challenges for Rotherham 2014/15 -2018/19

QIPP Plans	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
4% / 3.8% Efficiency	(8,945)	(8,935)	(8,596)	(8,269)	(7,955)

## 8.3 System wide efficiency savings

Figure 8.2: Breakdown of System Efficiency Challenges for Rotherham 2014/15 -2018/19

QIPP Plans	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Medicines Management	(2,376)	(1,869)	(1,918)	(1,969)	(2,022)
Unscheduled Care	1,017	(1,347)	(1,296)	(1,247)	(1,199)
Clinical Referrals	(4,034)	(3,279)	(2,196)	(2,087)	(2,007)
Mental Health	(350)	(462)	(445)	(428)	(411)
Corporate Services	(109)	(100)	0	0	0
<b>Total</b>	<b>(5,852)</b>	<b>(7,056)</b>	<b>(5,828)</b>	<b>(5,730)</b>	<b>(5,640)</b>

The schemes are summarised as follows:

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

The combined Provider and System Wide Efficiency savings is set out in the table below and totals £73m.

QIPP Plans	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
<b>TOTAL SAVINGS</b>	<b>(14,797)</b>	<b>(15,991)</b>	<b>(14,424)</b>	<b>(13,999)</b>	<b>(13,595)</b>

## 8.4 Commissioning costs

In light of the efficiencies the CCG is required to drive from its providers it is important that every possible efficiency saving has been made from the costs of commissioning. As part of the 2013 NHS reforms total commissioning costs for the former PCTs were reduced by 50%. Running costs allocated to the CCG was £6.2 million in 2014-15 and in 2015-16 will reduce by a further 10% to £5.5m. Of this £4.2m are direct costs (support to commissioning GPs by directly employed staff) and £2m are the costs of services from NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit (see section 5.11).



In 2015/16 CSU-costs will reduce by a further 5%, bringing the amount spent per head of population in Rotherham to £21.28.

## 8.5 QIPP Governance

The CCG and RMBC together with TRFT and RDaSH have an agreement not to de-stabilise partner organisations by introducing efficiency changes without considering and discussing their impact on other partners.

The System Resilience Group is a chief executive level group that meets monthly with partners in Rotherham, NHS England and the Yorkshire and Humber Ambulance service to oversee quality and efficiency across the whole system with a particular focus on unscheduled care. Four other QIPP groups report to the System Resilience Group; Clinical Referrals Management Committee, Medicines Management Committee, Community Transformation Committee and the Mental Health and Learning Disability QIPP Group.

Two other groups with a role in enabling QIPP report direct to the Strategic Clinical Executive; the IT Strategy Group and Working Together.

The Better Care Fund reports directly to the Health and Well Being Board. All QIPP groups are shown on the diagram in Section 6.5.

## 8.6 Commissioner Requested Services

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

# 9 Finance

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

## 9.1 Financial Planning Assumptions

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

- 1% Operating Surplus £3.9m
- 1% recurrent headroom £3.9m
- 0.5% Contingency £2.0m

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

1. A 1.7% growth in financial allocations in 2015-16 (£6.5m) and 1.7% in subsequent years.
2. **First outpatients:** we are planning for an increase of 1% in 2015-16 against 2014-15 outturn
3. **Follow-up outpatients:** we plan to move to national average ratios which is a reduction of 5.9% against 2014-15 outturn.
4. **Planned admissions:** we plan to increase by 1% against 2014-15 in 2015-16
5. **Urgent admissions:** we plan to reduce admissions from 2014-15 outturn





6. The costs of continuing care are estimated to rise by £1.0 million in 2015-16.
7. The plan assumes that running cost will not exceed the new allocation which has reduced by 10% for 2015/16.
8. The plan maintains 1% recurrent headroom as per the planning guidance.
9. A contingency of £1.7 million (0.5%) is built into the plan.
10. Prescribing growth is 7% **before** efficiency gains of 4.5%.
11. Tariff rules remain stable from 2015-16 to 2016/17.

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

Income and Expenditure (including non recurrent)	2013/14 £000	2014/15 £000	2015/16 £0	2016/17 £000	2017/18 £000	2018/19 £000
Income ( <i>inc Strategic Investment Fund b/f</i> )		346,148	356,827	357,709	361,191	364,774
Expenditure		342,611	353,259	354,027	357,450	360,973
<b>Surplus</b>		<b>3,537</b>	<b>3,568</b>	<b>3,682</b>	<b>3,741</b>	<b>3,801</b>
Strategic Investment Fund c/f		10,832	8,332	5,832	3,332	832

## 9.2 Source and Application of Funds

There are a number of priorities detailed in the planning guidance which have been considered by our GP members. There are three sources of funding available; QIPP savings, growth funding and funding allocated for system resilience. These are forecast to total £20 million. The planned use of the funds is set out in the table below:

### TABLE TO FOLLOW

There is increased focus on 7 day working in all parts of the health service, parity of esteem for people living with Mental Health issues and better care for people requiring integrated health and social care services. There is also an ongoing requirement for the CCG to support GP practices in transforming the care of patients aged over 75.

Plans for system resilience will be embedded early in the year following the allocation of funding from 1<sup>st</sup> April 2015 rather than later in the year.

## 9.3 Better Care Fund

This is a single pooled budget for health and social care services to work more closely together in the Rotherham area. The plans were developed and implemented throughout 2014/15. These will be reviewed and refined to ensure that the national conditions will be achieved against a range of performance metrics. The total fund is £23 million in 2015-16.

It will include expenditure on re-ablement services e.g. intermediate care, stroke and emergency response services, community services and adult social care. The national metrics will include avoiding emergency admissions and delayed transfers of care and enhancing patient/service user experience. More details are given in Section 5.14.



## 9.4 Non Recurrent Initiatives

There are a number of non-recurrent initiatives which are designed to enable the enhancement and transformation of services in a community setting to avoid unnecessary admissions. Services will be invested in recurrently if reviews in October 2015 can evidence that the objective of avoiding admissions has been achieved.

The key schemes include:-

- Community Hospital,
- Fast Response;
- Care Coordination Centre
- End of Life Care

## 9.5 Risks to Recurrent Balance

1. The continued focus to reduce clinical referrals growth and unplanned admissions to hospital is reliant upon transformational change across the health community driven by clinical leaders and service providers. If clinical referrals and admissions are not managed within planned levels then reductions in spending across a range of services will be inevitable.
2. Failure of local providers to achieve the required efficiencies of 20% over five years (as per the planning guidance) may affect viability leading to the interruption or cessation of service provision and failure to achieve the contract.
3. The recent national review of allocations formula has resulted in the CCG being £16.5m (5.1%) over its target allocation. The plan to reduce funding levels to the target requirement does not present an immediate financial risk but limits the amount of investment that can be made to support the growing demands inherent in an ageing population.
4. Prescribing risks:
  - Shortages in the pharmaceutical supply chain can occur at any time forcing category M prices to suddenly increase.
  - NICE guidance can at any time have an adverse effect on cost growth forecasts.
  - Failure to agree therapeutic guidelines with secondary/tertiary care providers
5. Changes to the structure of the tariff could generate unplanned financial pressures - our plan is predicated upon a neutral impact of any changes to tariff.
6. Continuing health care continues to be an area with increasing demand and the plan may be compromised in the current climate with additional risks from the retrospective caseload.

## 9.6 Further Actions Required

1. Sustained clinical leadership is required of the efficiency programmes set out in section 8 (prescribing, mental health, community transformation, planned care and unscheduled care). Chief amongst these is unscheduled care with GP leadership and engagement essential to drive a system which is less dependent upon hospital admissions (Rotherham wide QIPP leadership structures are show on page 75).
2. Monitoring of other financial risks not including the current efficiency programmes which could impact upon financial balance.
3. The investments to be made non recurrently require clear project management by a lead officer and the evaluation of the outcomes of the investment to quantify the scope for delivering the recurrent efficiency requirements.



4. There are downside scenario plans in place to mitigate the risks inherent within the plan. A range of additional actions with timescales and values would be implemented if required but the CCG considers these far less preferable than successfully implementing the actions set out in this plan.

## 9.7 Capital

There is no capital expenditure in 2015-16 due to the asset base transferring to NHS Property Services in 2013-14.

## 9.8 Cash

The CCG's Maximum Cash Drawings figure will be adhered to for CCG operational activities in 2015/16.

# 10 Information Management and Technology

## 10.1 IT Strategy

The CCG has developed its IT strategy through consultation with GPs, RMBC and providers and agreed it at the multiagency Rotherham IT strategy group. In addition a survey has been conducted with the GP membership to assess their priorities for the IT strategy and ensure that their needs are fully reflected within it. Through this engagement new priorities have been identified for:

- The implementation of RAIDR (Reporting Analysis & Intelligence Delivering Results). This is a major new intelligence system for GP providers and commissioners bringing together clinical and financial information from primary and secondary care (and potentially social services). It will help practices with clinical quality and administration and allow commissioners at an aggregate level and practices at individual patient level to have integrated information including dashboards on activity, risk scores, urgent care, finance and prescribing.
- The development of bi-directional messaging and tasking between clinicians across different care settings
- A review of clinical templates to improve the display of information
- Improvement to the information transferred from urgent care settings to primary care
- Digitisation of referral forms
- Enhanced training in the use of General Practice systems
- Work with RMBC to enable data sharing where required with social services once the governance challenges of this national initiative can be resolved (See Better Care Fund project 14, see Section 5.14)

The current responsibilities and configuration for the delivery of IT services to the CCG and Rotherham's General Practices are as follows. NHS England is responsible for primary care information services. It delegates the responsibility for operational management of GP IT services to CCGs. In NHS Rotherham CCG Dr Richard Cullen the GP IT lead, supported by the Deputy Chief Officer, is the responsible officer for IT services to the CCG and its GPs. During 2014 the CCG have appointed a Head of IT, jointly with Doncaster CCG, to lead on the development and delivery of local IT strategy and manage the contract for delivery of IT services to the CCG and GPs. IT programme and project management, data quality and GP system support services are procured from NY&H CSU. IT services for the CCG and GPs are procured from TRFT. GP practices gave support for continuing this arrangement in an electronic survey in November 2014.



In April 2014 the IT programme and project management, data quality and GP system support services currently provided by NY&H CSU will be taken back in house and provided by a joint team working directly for Rotherham and Doncaster CCGs. The review of IT service provision is on-going and all General Practices have been asked to identify any issues with their current service provision and improvements they would like considering for the future service. It is expected that a new Service Level Agreement for the IT service provision for 2014 – 2016 will be in place by 31<sup>st</sup> March 2015.

There is a full NHS Rotherham CCG IT Strategy [IT Strategy](#), which will deliver on the ambitions identified in 'Personalised Health and Care 2020: Using Data and Technology to Transform Outcomes for Patients and Citizens.' A summary of the key priorities for delivery in the IT strategy, in addition to the new priorities listed earlier, is below:

- **Electronic transfer of clinical letters:** implementation of the electronic transfer and receipt of clinical letters from TRFT and RDaSH.
- **Patient Online Access:** implementation support for all practices to enable patient access to the full GP record by April 2016
- **EPS (Electronic Prescription Service) Release 2 implementation:** continued rollout of EPS to Rotherham General Practices to achieve 70% implementation by 31<sup>st</sup> March 2016
- **Clinical portal:** continued development of the clinical portal with TRFT to introduce further functionality to the system including initial work to develop an interface for patients and links to social care systems
- **e-Referrals:** review and implement the benefits of the NHS e-Referral Service when it replaces the Choose and Book Service and pilot the Advice and Guidance service for secure messaging between clinicians.
- **Emergency Care IT system:** lead a programme of work to specify and procure a new IT system for the planned Emergency Care system. The procurement phase will run through 2015 with expected contract award in December 2015 and the implementation phase to follow in 2016.

## 10.2 Information Governance

Information Governance for the CCG is provided by the CSU, who are both our source of expert information governance advice and also handle patient identifiable information on our behalf. During 2014 we have sought formal approval as an Accredited Safe Haven and as an authorised user of Risk Stratification data. Applications for both of these have been submitted to the Health and Social Care Information Centre and NHS England respectively and the outcome is awaited.

In 2015 Information Governance support will be essential to ensuring that we put in place effective and fair methods for information sharing between health and care professionals. Programmes of work will be carried out to develop frameworks that underpin data sharing through the clinical portal and between health and social care agencies to support the aims of the Better Care Fund. We will implement this work together with the CSU and the Information Governance functions of our partners.



# 11 Communication 'Plan on a Page'

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<p><b>Our Priorities</b></p>	<ul style="list-style-type: none"> <li>• Effective 2-way communication with all our stakeholders and the people of Rotherham to listen, inform, support, shape and plan health services.</li> <li>• Make sure that all stakeholders have easy access to the information they need; from GPs and member practices to stakeholders and the public</li> <li>• Build trust and credibility in Rotherham CCG, making sure that the CCG is easily recognisable</li> <li>• Manage and develop the reputation of Rotherham CCG as the local leader of the NHS</li> <li>• Make sure that patients, their views and experiences are at the heart of local health commissioning</li> </ul>				
<p><b>Key Messages</b></p>	<ul style="list-style-type: none"> <li>• We are a membership organisation of local clinicians working together to secure the best possible healthcare</li> <li>• We will commission services that provide the right care in the right place. at the right time</li> <li>• We are committed to working together with our partners, patients and the public to achieve the best health outcomes</li> <li>• We are a listening organisation that actively seeks out and values the views of staff, members, partners, patients and the public</li> <li>• We act on feedback to shape and improve services.</li> <li>• We make sure that decisions about services are based on evidence of local need and outcomes.</li> </ul>				
<p><b>Target Audience</b></p>	<p>Patients and the public</p> <p>Provider/partner organisations</p> <p>Key influencers/political figures</p> <p>Media</p>	<p>Clinicians</p> <p>Our staff and members</p> <p>Health and Wellbeing Board</p> <p>Voluntary sector</p>			
<p><b>Our Principles</b></p>	<p>Accessible and Inclusive</p> <p>Clear and Concise</p> <p>Open, Honest and Transparent</p>	<p>Flexible &amp; Innovative</p> <p>Consistent and Accountable</p> <p>Targeted &amp; Responsive</p>	<p>Proactive</p> <p>Two-way &amp; Timely</p> <p>Cost effective &amp; Proportionate</p>		
<p><b>Tactics</b></p> <p>Working closely with Local Strategic Partners (Not an exhaustive list)</p>	<table border="1"> <tr> <td data-bbox="558 1392 1019 1879"> <p><b>Internal – staff and members</b></p> <ul style="list-style-type: none"> <li>• E-newsletters</li> <li>• Intranet</li> <li>• E-mail</li> <li>• Briefings</li> <li>• Protected Learning Time</li> <li>• Meetings and committees</li> <li>• Blogs</li> <li>• GP Commissioning Events</li> <li>• Practice Managers Commissioning forum</li> <li>• Engagement and Communications Sub Committee</li> </ul> </td> <td data-bbox="1019 1392 1498 1879"> <p><b>External</b></p> <ul style="list-style-type: none"> <li>• Media Relations – print and broadcast</li> <li>• Website</li> <li>• Social and Digital Media</li> <li>• Events</li> <li>• Printed materials</li> <li>• Advertising &amp; Branding</li> <li>• Blogs &amp; Social Media</li> <li>• Networks and patient groups</li> <li>• Surveys &amp; Consultations</li> <li>• Focus groups</li> </ul> </td> </tr> </table>			<p><b>Internal – staff and members</b></p> <ul style="list-style-type: none"> <li>• E-newsletters</li> <li>• Intranet</li> <li>• E-mail</li> <li>• Briefings</li> <li>• Protected Learning Time</li> <li>• Meetings and committees</li> <li>• Blogs</li> <li>• GP Commissioning Events</li> <li>• Practice Managers Commissioning forum</li> <li>• Engagement and Communications Sub Committee</li> </ul>	<p><b>External</b></p> <ul style="list-style-type: none"> <li>• Media Relations – print and broadcast</li> <li>• Website</li> <li>• Social and Digital Media</li> <li>• Events</li> <li>• Printed materials</li> <li>• Advertising &amp; Branding</li> <li>• Blogs &amp; Social Media</li> <li>• Networks and patient groups</li> <li>• Surveys &amp; Consultations</li> <li>• Focus groups</li> </ul>
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[Link to follow to communication plan](#)



## 12 Performance and Assurance

### Outcomes

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

**Self Certification** our plan confirms that:

- We will deliver the NHS Pledges and the standards in the NHS Constitution
- The CCG will undertake assurance that Provider Cost Improvement Programmes are deliverable and safe by April 2015
- Management of health care acquired infections results in no cases of MRSA.

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

1. Referral to treat time (admitted, not admitted and incomplete) & diagnostics waits
2. Cancer Waiting Times Standards: 2 week wait, 2 week (breast symptoms), 31 Day First Treatment, 31 Day Surgery, 31 Day Drugs, 31 Day Radiotherapy, 62 Day GP Referral, 62 Day Upgrade & 62 Day Screening
3. Ambulance Performance Red 1 Cat A calls, Red 2 Cat A calls & Cat A 19 calls
4. A&E Performance
5. C.Difficile
6. Mental Health: Dementia, IAPT Access, IAPT Recovery & Mental Health Access - 18 Weeks & 6 Week
7. Patient Satisfaction at a GP Practice, Patient Satisfaction at a Surgery & Patient Satisfaction with access to primary care

The CCG is also works with partners on the two other outcomes frameworks relevant to the Health and Well Being Board, the **Social Care outcomes framework** and the **Public Health outcomes framework**.

From the wide range of metrics, three sets of outcome are relevant for the CCG's external performance. Metrics in bold are in more than one outcome set.

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

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



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

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

**Quality Premiums:** The final guidance and list of indicators for the 2015 16 Quality Premium will be released at the end of January 2015. The 2014 15 Quality Premiums were:

1. **Potential Years of Life Lost (PYLL).** 7000 years of life are lost in Rotherham each year by people dying before their time, we will reduce this by an average of 200 life years each year over the next five years (3.2% decrease).
2. **Avoidable Emergency Admissions** will be decreased by 3% per year (overall admissions will be maintained at 20% below their 2011/12 peak).
3. The proportion of people who enter Improving Access to Psychological Therapies (IAPT) will be at least 16.5% of all people in Rotherham, who are estimated to have depression by 2015 and this will be maintained at least this level by 2019.
4. Family and Friends Test – we will fully implement the Friends and Family test roll out to maternity, mental health and general practice, meeting objectives for coverage and learning from the intelligence gathered.
5. Medication errors reporting- to maintain Rotherham's current high levels of reporting of medication errors and implement the learning from them
6. We will ensure there is no increase in Alcohol related hospital admissions and readmissions.

RC to insert here on Friday 4 lines from Andrew on GP access outcomes.

Next line

Next line

Next line

## 2014/15 performance

There have been several significant performance issues in 14/15. Non elective over-performance is discussed in section 7.

Forecast out turn for A&E performance will be very close to the 95% levels. Extraordinary performance clinics have been held with the assistance of the Emergency Care Intensive Support team which has led to a robust action plan and there will be a look back exercise conducted by the System Resilience Group on the 3 weeks period of marked pressure on the urgent care system in January 2015. This will include review of which 14/15 Operational resilience initiatives will be continued in April 2015 and what additional initiatives will be put in place for winter 2015.



2014/15 C. Difficile outcomes will be very close to the national target and around national average. Performance clinics have been held with participation from NHS England and Public Health England. All 14/15 cases have had full route cause analysis, no cases have been the result of lapses in care and non have been the results of cross infection.

Joint performance clinics have been held with RMBC for both acute and mental health delayed transfers of care. Improvements are expected as a result of greater attention to the metric, changes in community services including the discharge to assess model described in sections 5.1 and 5.7 and multi-agency training on Deprivation of Liberty.

## Performance management

The CCG has a performance management framework that sets out its vision, methods of reporting, data quality, partnership arrangements, accountabilities and escalation policies. [This framework will be reviewed in the early part of 2015 to ensure that it reflects the planning Guidance “The Forward View Into Action: Planning for 2015/16” and meets the Governing Body requirements.](#)

NY&H CSU Business Intelligence team produce a monthly performance report for the CCG Governing Body that will cover the performance against key outcomes required by NHS England [Delivery Dashboard](#) shows as an example the February 2014 Governing Body performance report. The current reports concentrate on a limited number of key metrics and then exception reporting against the full range of the NHS Outcomes framework.

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

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





# 13 Risks

## Risk Management Framework

The CCG will ensure that the organisation is properly governed in accordance with best practice corporate, clinical and financial governance. The **Integrated Risk Management Policy** gives the CCG a clear view of the risks affecting each area of its activity; how risks are being managed, the likelihood of occurrence and their potential impact on the successful achievement of the CCGs objectives. Risks are identified and managed by all teams across the CCG, the CCG **Risk Register** captures all the operational risks to the organisation. If a risk scores in excess of 11 and is 'strategic' then it is escalated to the **Assurance Framework**. The CCG Assurance Framework captures the high strategic potential risks to the organisations strategic objectives. As at November there were 63 entries on our Risk Register, with 19 scoring in excess of 11, and there were 24 entries on our Assurance Framework, with 15 scoring in excess of 11.

### Key risks to delivering this plan are:

- GP recruitment and retention affecting pathways provided by GPs and the availability of GPs to take part in commissioning
- NHS Efficiency challenge
  - Quality implications – cumulative impact of year on year 4% efficiency requirements causing a negative impact on patient safety
  - CCG affordable trajectories – CCG not able to keep non-elective and elective activity within affordable trajectories.
  - Viability of local services could be affected by providers efficiency plans.
- NHS funding - central decisions on CCG resource allocation could affect the CCG's viability
- Loss of local focus and changed role of NHS England
  - Primary care co-commissioning – resources may not be available to effectively discharge the CCG's new responsibilities
  - Specialist commissioning - risk of the CCG not being able to address its new specialist responsibilities effectively and risks that over spends in areas of NHS England responsibility could be transferred to the CCG
- Ability to recruit to Senior Leadership of the Public Health Function in Rotherham - may compromise the CCG's and partner's ability to address public health challenges
- Wider implications of the Rotherham Child Sexual Exploitation reviews - may affect partners focus and ability to prioritise other important agendas
- Patient transport services - Yorkshire Ambulance Service not meeting targets impacting on patient safety.



## 14 How we shared our plans

Numerous stakeholders have been engaged in the development of our Commissioning Plan and figure 14.1 below describes the inputs into its development. Feedback from the Rotherham-wide consultation on the H&WB Strategy and feedback from GP members, the GP Members Committee (GPMC) and the Patient Participation Groups have been especially important in its development. The consultation table lists some of the meetings and events at which the Commissioning Plan has been discussed at and the comments received [LINK](#)

### Input from Joint Strategic Needs Assessment and Health and Wellbeing Board

The JSNA and H&WBS have been the key starting points for our plan. In the 'plan on a page' (page 10) we reference how the CCG's strategic aims are aligned with the strategic aims of the H&WBS.

### Input from GP members, locality groups and GP Members Committee

The consultation table documents the extensive dialogue the CCG executive has had with its member practices in drawing up the strategy. This has been directly from individual GPs, via the six monthly all practice commissioning events, from locality groups and from the GPMC.

In our 2014/15 plan issues that were of high importance to members included: improvements to community services, improving mental health services particularly for children and for people with dementia and further developing the Care Co-ordination Centre.

From the consultation during October and November 2014 with localities we have confirmed that members:

- Support the Emergency Care Centre and direction of travel
- Have seen improvements in Mental Health, but there is still work to do
- Support the direction of travel for Community Transformation
- Are happy with the excellent prescribing service, and want it to continue along the same lines
- Believe that clinical referrals have made significant improvements over the last few years
- Agree with the direction of travel for co-commissioning of primary care and specialised services and that the CCG will be taking more of a role in these areas
- See Patient Education as a key area to develop

Subsequent feedback from members has included extensive discussion on delegated authority for GP commissioning, a workshop at the 4th December Commissioning event on 'least worst' options if activity remains above affordable levels (see section 2) and a series of suggestions about GP recruitment and retention.

### Input from patients and the public

The Patient Participation Group Network considered the 2014/15 Commissioning Plan and provided feedback on several specific areas. This work led to the production of a short and simple, public facing version of the plan, which has been well received by the public, partners and stakeholders alike.

The 2015/16 plan has been informed through engagement in our workstreams and projects throughout the year, this is demonstrated within individual sections of the plan which show where engagement has informed our work, and how we are acting on what people have told us.



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

- the NHS re-organisation was complicated and confusing to many; it will take time for people to understand the roles and responsibilities of the new organisations.
- 'big picture' conversations about the whole of our £340 million portfolio sometimes struggle to do justice to important individual details and concerns
- there are nationally imposed constraints on our planning timetable. We do not receive financial allocations and important payment rules until mid-December but our providers require clear intentions from us in time to negotiate contracts well before the 31 March.

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

- social media and extended the use of our website
- electronic and paper surveys
- formal consultations
- targeted events, meetings, workshops and focus groups
- attendance at community events
- a stakeholder and community conference in July 2014
- continued work with Rotherham PPG Network
- attendance at community meetings to both share information and hear people's concerns
- work with voluntary and community organisations to make sure we hear from potentially overlooked communities

The early drafts of the 2015/16 Commissioning Plan were circulated to key stakeholders and partner organisations, and comments received have been addressed in the final version. We used several of these mechanisms to share priorities and principles, and asked for comments and feedback on these, including:

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

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

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

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



## How to feedback comments on the CCG Commissioning Plan

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

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

## Acknowledgement

We would like to thank all CCG staff, executive GPs, member practices and Health and Wellbeing partners for their contributions to and feedback on the development of this plan. We would also like to thank Patient Participation Groups, in particular members of Rawmarsh and Stag PPG's, Voluntary Sector organisations and members of Healthwatch for their important contributions.

**Figure 14.1: Inputs into the development of our Commissioning Plan**





## 15 Glossary

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



## 16 List of hyperlinked documents

To complete for final version

Document hyperlinked	Page Number
Communication and Engagement Plan	
CCG committee structure	
NHS Rotherham CCG Constitution	
NHS Constitution	
CCG Commissioning Responsibilities	
Rotherham Joint Strategic Needs Assessment	
H&WB Strategy	
NHSE Commissioning Intentions	
Carers Charter	
Emergency Centre Business Case	
Children's and Adolescent Mental Health Services Transformation Plan	
Adults and Older Peoples Mental Health Transformation Plan	
Primary Care Commissioning Guidance	
NHSE Commissioning Intentions for Specialised Commissioning	
Care Act Implications for Rotherham	
Commissioning for quality policy/procedure on gaining assurance and identifying failing services using an appreciative enquiry approach	
Diagram of 4 key quality reports	
Jay Report	
Jay Report Action Plan	
Communication and Engagement Plan	
Complaints Website	
Equality and Diversity Strategy	
5 year forward view	
Forward view into action	
Adults and Older Peoples Mental Health Transformation Plan	
IT Strategy	
Communication and Engagement Plan	
NHS Rotherham CCG Delivery Dashboard	
NHS Rotherham CCG Assurance	
Commissioning Plan Performance Report	
Commissioning Plan 'sharing our intentions'	