investor in excellence

NHS
Rotherham
Clinical Commissioning Group

Commissioning Plan 2018-20

Your life, Your health

Contents

Section 1 to 8 provide the Strategic Overview and Direction of Travel
Section 9 provides detail on our Clinical Commissioning Priorities

1. Vision for Health and Social Care in Rotherham

Commissioners of health and social services and the respective provider organisation delivering services in Rotherham are prioritised by needs identified in our Joint Strategic Needs Assessment *JSNA*.

Through the Rotherham Integrated Care Partnership (Place) NHS Rotherham CCG, Rotherham Metropolitan Borough Council (RMBC), The Rotherham NHS Foundation Trust (TRFT), Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and Voluntary Action Rotherham (VAR) will seek to maximise the use of the Rotherham public sector pound.

Patient outcomes, including safety, safeguarding and experience remain the focus of all that we do. Providing the right care in the right place will mean that more people will receive care closer to their home. 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.

If as a local health economy we are going to achieve sustainable health care, the emphasis on commissioning community based primary care provision is paramount. The commissioning of primary care will be aligned to Rotherham's needs, where appropriate we will consider the targeting of resources in areas of highest need.

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

We are convinced that 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 recent years non elective hospital activity has grown faster than is affordable. Our plans will address this in the long term but it is likely that we will have to take some short term actions to keep costs under control until our longer term plans deliver.

Patients will receive diagnostic tests quicker so they will spend less time in hospitals. Better care pathways will mean that patients move smoothly between; supported self-care, primary care, social care, community services, acute and mental health hospital care and specialised services.

The CCG will continue to maintain the principle of a 'Rotherham Place' based approach to commissioning health care services. All local health and social care organisations will address collectively Rotherham's £75m efficiency challenges, being mindful of the overall sustainability of health and social services and the impact of organisations on each other (see section 5.2).

The CCG supports the direction of travel for Rotherham GPs in further developing Connect Healthcare Rotherham CIC (the Limited Liability Federation in Rotherham) to provide alternative models of care within the community setting. The CCG, through the Integrated Care System supports increased collaborative working between acute providers and we will work across the wider South Yorkshire and Bassetlaw footprint, to review existing services and develop plans for high quality safe sustainable hospital provision in the future.

1.2 About the Clinical Commissioning Group

In April 2016 Rotherham CCG set a clear strategic direction and long term (5 years) commissioning vision. With the plan now two years into delivery it is important to reflect on progress in delivering the plan, take account of any strategic change and to re-affirm the CCG's strategic vision and commissioning priorities in the context of an increasingly challenged local financial environment and changes in the commissioning landscape.

The CCG is a membership organisation, the 31 GP practices in Rotherham are its members, and they are grouped into eight localities. There are seven locality meetings (2 localities jointly meet) and link to the seven localities from a community service provision view. The CCG's main decision making body is the CCG Governing Body, five GPs, three executives, a nurse, a hospital consultant, and 3 lay members (for patient engagement, finance and audit and GP commissioning). The CCG ensures that it accesses the expert advice that it requires which includes having Rotherham's Director of Public Health and the Chair of Rotherham's Health and Wellbeing Board attending CCG Governing Body meetings.

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

In terms of executive delivery the CCG has eight executive GPs who lead on the delivery of the CCG's strategic priorities. The eight GPs are supported by 118 (99.79wte) directly employed CCG staff. As well as the GP Members Committee another four GPs provide additional clinical advice on areas such as safeguarding, clinical referrals, medicines management and mental health. The CCG has a contract with eMBED which supports the CCG in areas which include Business Intelligence and Information Governance. We purchase other support services such as Human Resources from other local CCG's.

The links show the members of our three committees: Governing Body, GP Members Committee, and Strategic Clinical Executive *CCG Governing Body and committees*. Further details of the CCGs governance structure are in Section 6.7.

The CCG works with individual practice patient user groups and have jointly developed with them our CCG patient network (see section 6.4) and the CCG works closely with Healthwatch.

The CCG is an integral partner in the Rotherham Integrated Care Partnership (ICP), and the Rotherham ICP is part of the South Yorkshire and Bassetlaw Integrated Care System which was named as one of the first areas in the country to be an Integrated Care System – putting the region at the forefront of nationwide action to provide joined up, better co-ordinated care breaking down the barriers between GPs and hospitals, physical and mental healthcare, social care and the NHS.

In accordance with the CCG's constitution, Rotherham CCG undertakes a vote of confidence from its member's each year. In 2017 we asked two questions:

1.1 Do you have confidence in the direction of travel? Of the practices who responded 100% said 'Yes'

2.1 Do you have confidence in the executive teams of the CCG? Of the practices who responded 100% said 'Yes'.

In 2014 we were the first CCG in the country to receive 'Investors in Excellence' and we achieved re-accreditation in 2016. We were in the top 6 CCGs nationally in the Health Service Journal Awards and received outstanding in the CCG Annual Assessment. All staff have twice yearly personal development reviews and we achieved a high 86% response rate to our staff survey, with positive feedback on; feeling valued by line managers, CCG commitment to patient care and positive action on staff health and wellbeing.

Other achievements include being the runner-up for the in the CCG Workplace Award and runner-up in the HFMA Finance Team of the year. Rotherham CCG has been chosen along with 11 other NHS Hospital Trusts to lead the way in the Healthy Workforce initiative, a commitment in the 'Forward View' to ensure the NHS as an employer, sets a national example in the support it offers its own staff to stay healthy.

In 2017, Rotherham CCG received green star rating for its Quality of Leadership under the CCG Improvement and Assessment Framework.

If you have any comments on the plan or would like further information relating to the CCG please contact us on rotherhamccg@rotherhamccg.nhs.uk, or by post to: Rotherham CCG, Oak House, Moorhead Way, Bramley, Rotherham, S66 1YY

Richard Cullen, GP
Chair CCG

Chris Edwards
Chief Officer /
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Geoff Avery, GP
Chair GP Members
Committee

Kathryn Henderson
CCG Lay Member

Robin Carlisle
CCG Lay Member

John Barber
CCG Lay Member

1.3 Plan on a Page

Our Vision

Your Life, Your Health

'Better Health and Care for Rotherham People'

Our Staff Values

RESPECT

Responsibility	Empowerment	Support	Positivity	Equality	Communication	Trust

Our Challenges

Health and Wellbeing
Be serious about prevention and improve healthy life expectancy to reduce health inequalities and avoid spend on wholly avoidable illness

Care and Quality
Reshape care delivery, harness technology, drive down variations in quality and safety of care so patients' changing needs are met and unacceptable variations in outcomes stop

Financial Balance
Match funding levels with wide -ranging system efficiencies to avoid a combination of worse services, fewer staff, deficits, and restrictions on new treatments

Our Objectives

Delivery
Commission high quality, cost effective healthcare, improve performance and improve the health and wellbeing of Rotherham people

Quality
Improve safety, patient experience and reduce variations in outcomes and health inequalities and ensure our providers' services are safe

Safeguarding
Work with partners to ensure all children and vulnerable adults are protected from harm, with a continued focus on Child Sexual Exploitation

Best Value
Deliver system wide improvements, innovations and efficiencies across the integrated care partnership to support sustainable services

Accountability
Ensure that the organisation and the integrated care partnership is effective, well led and well governed

Our Clinical Commissioning Priorities

Maternity & Children	Primary Care	Community Services	Clinical Referrals
Medicines Management	Mental Health	Learning Disabilities	YAS & Patient Transport
Cancer	End of Life Care	Continuing Healthcare	Unscheduled Care

Our Approach

Clinical leadership	Sustainable services across health and social care	Effective partnerships	Dependence to Independence	Effective Communication and Engagement (members, patients, public & partners)	Improved use of technology

2. National Context

2.1. CCG Commissioning Responsibilities

CCGs are responsible for commissioning the majority of services around health in England to meet all reasonable requirements of their local population. This includes most planned hospital care, rehabilitative care, urgent and emergency care (including out-of-hours), most community health services, mental health and learning disability services. NHS England has responsibility for commissioning in certain areas, including specialised services, core GP services, dental, pharmacy and optical services, however under the option to transfer responsibility for commissioning GP services to willing CCGs, Rotherham CCG undertook delegated authority for GP commissioning from 1 April 2015. Specialist wheelchair services, outpatient neurology and neuro-surgery, renal dialysis and surgery for morbid obesity from 1 April 2016 subject to confirmation from NHS England.

Health improvement services are 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.*

The following section sets out the planning documents that guide the direction of travel and expectations for the NHS.

2.2. Government Mandate

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

Every Government department produces a plan setting out its objectives and how they will be achieved. For NHS England this therefore sets out its' contribution to the Government's goals for the health and care system as a whole. For the first time, the objectives in the 2016-17 Mandate were underpinned by specific annual deliverables and goals to be achieved by 2020 or beyond. The 2017-18 Mandate continues this approach maintaining the direction set and defining annual deliverables for 2017-18 and again goals to be achieved by 2020 or beyond.

The objectives the Government has set for NHS England will help the NHS to deliver changes and seven-day services that mean:

- Access to consistent standards of urgent and emergency hospital care, senior doctors and diagnostics no matter which day of the week you are admitted
- Weekend and evening access to primary care
- Faster, more streamlined access to urgent care, seven days a week through the 111 phone number
- 24/7 access to mental health crisis care in both community and A&E settings

The mandate sets objectives for NHS England that reflect its contribution to the ambitions to 2020:

- **Objective 1:** Through better commissioning, improve local and national health outcomes, and reduce health inequalities
- **Objective 2:** To help create the safest, highest quality health and care service
- **Objective 3:** To balance the NHS budget and improve efficiency and productivity
- **Objective 4:** To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives
- **Objective 5:** To maintain and improve performance against core standards
- **Objective 6:** To improve out-of-hospital care
- **Objective 7:** To support research, innovation and growth

2.3. 'Five Year Forward View'

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

- Firstly, to get serious about prevention and improving the health and wellbeing of the nation, by backing hard-hitting national action on obesity, smoking, alcohol and other major health risks, supporting people to take more control over their own care and improve partnerships with voluntary organisations and local communities
- Secondly, support for the development of new models of care. Recognising there is not a 'one size fits all' care model for England, support the development of a number of new care models and a new deal for primary care. National leaders working together to provide meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied
- Thirdly, a focus on efficiency and funding . There are viable options for sustaining and improving the NHS over the next five years. However, this will require the NHS to achieve the very demanding efficiency aspirations set out in the Five Year Forward View as well as Government investment.

2.4. Delivering the 'Five Year Forward View'

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

2.5. The 'Five Year Forward View' for Mental Health

The Five Year Forward View for Mental Health, published in February 2016, sets out the case for transforming mental health care in England and describes the action required. It was intended as a blueprint for the changes that NHS staff, organisations and other parts of the system can make to improve mental health. In July 2016 a detailed implementation plan was published for achieving its ambitions, setting clear expectations for different services and the outcomes anticipated by 2020/21. In March 2017 the Five Year Forward View for Mental Health 'One Year On' report was published detailing the progress made.

2.6. 'General Practice Forward View'

The General Practice Forward View (GP Forward View), published in April 2016, committed to an extra £2.4 billion a year to support general practice services by 2020/21 to improve patient care and access and invest in new ways of providing primary care.

As part of this package NHS England is investing in a national sustainability and transformation package to support GP practices. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to speed up transformation of services.

2.7. Next Steps on the 'Five Year Forward View'

In March 2017, NHS England published *Next steps on the Five Year Forward View*, which takes stock of progress at the half way point of the *Five Year Forward View* and sets out priorities for the next two years.

It recognises the benefits from constancy of purpose and that the challenges being tackled require sustained action over several years, its starting point is the current legislative framework, and the funding the NHS has been allocated. It does not aim to be a comprehensive description of all the planned improvements for the NHS (maternity and children's services, diabetes, dementia care, care for people with learning disabilities, tackling inequalities, end of life care, and improving quality in challenged providers) and is not all the actions being taken to give effect to the Government's 2017/18 Mandate to the NHS.

However within the constraints of the requirement to deliver financial balance across the NHS, the main 2017/18 national service improvement priorities for the NHS are:

- **Improving A&E performance,** this also requires upgrading the wider urgent and emergency care system so as to manage demand growth and improve patient flow in partnership with local authority social care services
- **Strengthening access to high quality GP services and primary care**, which are far and away the largest point of interaction that patients have with the NHS each year
- **Improvements in cancer services and mental health** – common conditions which between them will affect most people over the course of their lives

2.5.1 Delivering the Nine 'must do's'

The nine 'must do' priorities described in 2016/17 remain the priorities for 2017/18 and 2018/19. These priorities are addressed throughout this Commissioning Plan and in the table below we signpost to where narrative can be found.

	Which 'must do'	Where it is addressed in our plan
1	Sustainability and Transformation Plans	Section 3.4
2	Finance	Section 5.3
3	Primary Care	Section 2.3
4	Urgent and Emergency Care	Section 9.4
5	Referrals to treatment times and elective care	Section 9.2
6	Cancer	Section 9.12
7	Mental Health	Section 9.8
8	People with Learning Disabilities	Section 9.9
9	Improving Quality in Organisations	Section 6.1

2.5.2 2018/19 Planning Guidance

Two year contracts and improvement priorities are already in place for the period 2017/19 based on the NHS Operational Planning and Contracting Guidance 2017-2019 published in September 2016 and reflected in the March 2017 document *Next Steps on the NHS Five Year Forward View*. The expectation is that 2018/19 plans are a refresh of plans already in place.

The CCG undertook a review of the progress in 2017/18 and deliverables in 2018/19 as set out in Annex 1 of the Planning Guidance. This covers: Mental Health, Cancer, Primary Care, Urgent and Emergency Care, Transforming Care for People with Learning Disabilities and Maternity. Annex 1 does not aim to be a comprehensive list of 'Next Steps' deliverables for 2018/19 but a re-cap of the key expectations.

2.5.3 National 'Right Care' Programme

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

The primary objective for 'Right Care' is to maximise value:

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

Using the Commissioning for Value Packs we identified the following areas to focus upon in year 1 of 'Right Care'. These areas offered opportunities in both spend and outcomes:

- Respiratory
- Mental Health - specifically Improving Access to Psychological Therapies
- Endocrine - specifically Diabetes
- Cross cutting – specifically prescribing

We are currently working through the 'Right Care' intelligence and local data, in collaboration with our local Right Care Delivery Partners, to identify our chosen opportunities for year two.

3. Integrated Commissioning in Rotherham

Delivery of our Commissioning Plan is underpinned and dependent on successful working with key partners and stakeholders. 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 Health and Wellbeing Strategy (H&WBS) and the Integrated Health and Social Care Place Plan (IH&SC) Place Plan and sets out, as a key partner, how we will support their delivery.

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

3.1. The Rotherham Integrated Care Partnership and the Rotherham Integrated Health and Social Care Place Plan

The Rotherham Integrated Care Partnership (ICP) is the local delivery arm of the wider South Yorkshire and Bassetlaw Integrated Care System (ICS), previously known as the Sustainability and Transformation Plan. The local ICP is about health and care partner organisations in Rotherham sharing responsibility for the planning and delivery of improved and sustainable health and social care for local people. By Spring 2018 the ICP will have published the second Rotherham Integrated Health and Social Care Place Plan (Place Plan), which will deliver a set of 'place' priorities under five workstreams aligned to the Health and Wellbeing Strategy aims:

- Transforming services for children and young people
- Transforming mental health services
- Transforming learning disability services
- Transforming urgent care services
- Transforming community care services

The Health and Wellbeing Strategy sets the strategic vision for improving health and wellbeing for all Rotherham people, the Rotherham Place Plan is the delivery mechanism for the health and social care integration elements of the strategy.

Rotherham's health and social care community, including RMBC, CCG and providers of health and care services, have been working in a collaborative way for several years to transform the way it cares for its population, and is passionate about providing the best possible services and outcomes. It is recognised that only through working together in a strong partnership, and with local communities, can sustainable services be provided over the long term.

Prevention, early intervention and the integration of health and social care services are the focus of the Place Plan; to transform the way services are delivered. This will require continuing to hold each organisation to account to ensure prevention and early intervention becomes part of all pathways.

National and local commissioning has supported increased community care over recent years to improve patient outcomes, improve flow through the system and reduce inefficiencies. Health and social care transformation programmes include developing alternatives to entering services or hospital admission and facilitating discharge. The Place Plan provides an opportunity to build on this to take a more holistic and integrated approach across physical and mental health, social care and the voluntary and community sector in order to develop and embed an integrated model of care which supports individuals and their carers and focuses much more on prevention.

During 2017 executive leaders from each of the organisations represented within the Integrated Care Partnership have been working to develop the governance framework through which we will work. The ICP Place Board structure, which includes a Delivery Team, Transformational Groups and enabling workstreams, has been developed and agreed collaboratively through an open and transparent approach. We will continue this approach through our continued journey of developing and delivering the Place Plan and its priorities, the governance will enhance the ethos and principles by which we already work.

3.2. Rotherham Health and Wellbeing Board and the Health and Wellbeing Strategy

The Health and Wellbeing Board is a statutory sub-committee of the Council. Locally, it is the single strategic forum to ensure co-ordinated 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 third Health and Wellbeing Strategy for Rotherham was produced in March 2018 in collaboration with the Health and Wellbeing Board partners. It fulfils the duty set out in the Health and Social Care Act (2012) to set the overarching framework for health and care commissioning plans for Rotherham.

The Health and Wellbeing Board and strategy sets the strategic vision of the Rotherham Plan, particularly in relation to integrating health and social care and improving health and wellbeing outcomes for local people.

The high level strategy involves the implementation of a number of workstreams, organisational strategies and action plans. The role of the Health and Wellbeing Board is to oversee implementation and to take action where needed to remove blockages, identify gaps and to hold organisations, worksteams and strategy leads to account for delivery; ensuring we maximise opportunities for improving health and wellbeing in everything we do, across all agendas, policies and strategies.

The H&WB Strategy includes four aims which the H&WB Board have agreed are the most important things to focus on to improve health and wellbeing outcomes for all Rotherham people, and that can be best tackled by a 'whole system' approach where involvement from all H&WB Board partners is needed.

- **Aim 1:** All children get the best start in life and go on to achieve their potential
- **Aim 2:** All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
- **Aim 3:** All Rotherham people live well for longer
- **Aim 4:** All Rotherham people live in healthy, safe and resilient communities

Each aim includes a small set of high-level priorities, which demonstrate the particular areas of interest that will contribute to achieving the aim.

Underpinning these aims is a set of principles that all Health and Wellbeing Board partners have committed to embedding in everything that they do, both individually as organisations, and jointly as a partnership:

- **Reduce health inequalities** by ensuring that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, is improving the fastest
- **Prevent physical and mental ill-health as a primary aim**, but where there is already an issue, services intervene early to maximise impact
- **Promote resilience and independence** for all individuals and communities
- **Integrate commissioning of services** to maximise resources and outcomes
- **Ensure pathways are robust**, particularly at transition points, so that no one is left behind
- **Provide accessible services** to the right people, in the right place, at the right time

3.3. The Rotherham Together Partnership and the Rotherham Plan

The Rotherham Together Partnership comprises representatives from various local organisations, working on a range of shared priorities. The aim is to improve the economic and social wellbeing of the borough.

The Rotherham Together Partnership Plan - 'The Rotherham Plan 2025'was launched in March 2017. It sets out the most important things that the Rotherham Together Partnership will do over the next few years to help improve the borough as a place, and make life better for local people. It describes the 'game changers' for Rotherham which are: building stronger communities, town centre, skills and employment, integrated health and social care, and a place to be proud of.

The wider partnership also provides an opportunity to explore where better outcomes could be achieved in relation to the wider determinants of health, for example: the environment people live in, education, employment, financial inclusion and transport; all of which contribute to the aims and priorities within the strategy.

3.4. Other Joint Work with Rotherham Metropolitan Borough Council

Whilst the majority of joint work is taking place within the scope of the Integrated Care Partnership, the CCG and RMBC have also proactively engaged in the development and delivery of the **'Better Care Fund' (BCF)** and **'Improved Better Care Fund' (iBCF).**

The BCF is an important Government Initiative to create a single joint budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services. The fund does not in itself create any new money but bringing existing budgets under joint commissioning responsibility is expected to lead to better outcomes and to ensure that we have a robust alignment across the health and social care system in Rotherham.

The Better Care Fund, along with the Integrated Health and Social Care Place Plan provide us with an opportunity to further improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with an improved service and better quality of life.

The BCF pooled budget 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. The pooled budget is made up of CCG funding as well as local government grants, of which one is the iBCF, first announced in the 2015 Spending Review. According to the grant conditions, the funding grant can be spent on three purposes:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

Where appropriate and in the best interest of patients, the CCG will continue to develop joint commissioning arrangements with RMBC. Key areas of service provision that the CCG (with agreement from our members) will further explore with RMBC include; Children' Services, Adult Social Care, Continuing Health Care, Mental Health and Learning Disability.

There are several joint commissioning posts across the CCG and RMBC for Adults, Children, Mental Health and Learning Disability. It is anticipated that there will be further joint posts as we continue to work closer together, particularly with the continued development of the Integrated Care Partnership.

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

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

We have developed a Carers Strategy jointly with RMBC and voluntary sector organisations. The strategy is the start of a renewed partnership to support carers in Rotherham. It includes plans to identify and work with young carers, elderly carers, dementia carers and working alongside GP practices and supporting staff by providing flexible working arrangements. The strategy recognises that informal carers are the backbone of the health and social care economy and it is hoped that the strategy will help in enabling them to continue this vital role. The strategy and action plan aims to help make their caring role more manageable and sustainable, ensuring that their needs are understood and their well-being promoted.

3.5. South Yorkshire and Bassetlaw Integrated Care System (ICS)

Sustainability and Transformation Plans (STPs) were announced in NHS Planning Guidance published in December 2015. NHS organisations and local authorities were asked to come together to develop 'place-based plans' for the future of health and care services in their area. Draft plans were produced by June 2016 and 'final' plans submitted in October.

The next step is for NHS and local councils to form Sustainability and Transformation Partnerships (STPs) to continue to build on the collaborative work. There are 44 STPs covering all of England with the aim to improve health and care by looking at the needs of the whole population in the area - not just those of individual organisations. Rotherham is part of South Yorkshire and Bassetlaw.

An Integrated Care System is where NHS organisations (both commissioners and providers), in partnership with local authorities, choose to take on collective responsibility for resources and population health. In return they get far more control and freedom over their health system, such as delegated decision making and devolved budgets. South Yorkshire and Bassetlaw has been chosen as one of the nine areas to work towards becoming an ICS.

SY&B ICS has a goal for '*everyone in South Yorkshire and Bassetlaw to have a great start in life, with support to stay healthy and live longer*'.

Its plan is based on five 'places' within South Yorkshire and Bassetlaw – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. The five place plans are the foundation of what will be delivered in each area and set out how improvements from new ways of working and prevention will be made. The place plans focus on aligning primary and community care, putting the greatest emphasis on helping people in their neighbourhoods and managing demand on services. They also hone in on improving health and wellbeing and the other factors that affect health, such as employment, housing, education and access to green spaces.

There are also eight priority areas of focus:

- Healthy lives, living well and prevention
- Primary and community care
- Mental health and learning disabilities

- Urgent and emergency care
- Elective and diagnostic services
- Children's and maternity services
- Cancer
- Spreading best practice and collaborating on support office functions

The plan focuses on people staying well in their own neighbourhoods, focussing on prevention, whilst introducing new services, improving co-ordination between those that exist and have staff working in the best way to meet people's needs.

Alongside re-shaping and strengthening primary and community services, by working as a network of 25 partners, access to specialist hospital care will be improved so that no matter where people live, they have excellent, high quality care and experiences. Where there are challenges to sustain capacity in South Yorkshire, we will work with partners in the ICS to develop solutions.

3.6. NHS England

The CCG is accountable to NHS England for delivery of agreed outcomes. In addition, the CCG works in partnership with NHS England in areas where the responsibilities of the two organisations overlap such as the interface between primary care commissioning (NHS England), hospital and community service commissioning (CCG) and specialist commissioning (NHS England). The CCGs partnership with NHS England on GP quality is described in section 9.3. The CCG will work closely with local professional networks (for pharmacy, eye care and dentistry) and NHS England for relevant care pathways.

As described in section 2.2, the Government Mandate to NHS England sets the direction of travel for the NHS and establishes objectives and requirements for NHS England for the provision of health services in England, helping to ensure the NHS is accountable to Parliament and the public.

3.6.1. Specialised Commissioning

The responsibility for commissioning a wide range of very specialist services lies with NHS England. Such areas include specialist cardiac surgery, specialist paediatric and neonatal critical care, adult critical care, specialist cancer drugs and radiotherapy and specialist mental health services (such as forensic services).

Although NHS England has responsibility for commissioning specialised services the CCG works collaboratively with NHS England to ensure quality safe pathways of care are commissioned across secondary and tertiary services and to ensure there is local input into specialist commissioning decisions. The Integrated Care System also continues to develop its role in supporting the specialised commissioning agenda. Since 2015/16 the following areas that were the responsibility of NHS England were transferred to CCGs:

- Specialist wheelchair services
- Outpatient neurology (GP referred)
- Tier 4 bariatric surgery

To date, specialised services have engaged patients via involvement in clinical reference groups. These will continue for services remaining with NHS England however regional specific conditions will also have direct patient engagement and involvement. Work is continuing in relation to vascular services, CAMHs and complex rehabilitation.

4. The Health Needs of Rotherham

RMBC have a statutory duty to prepare a Joint Strategic Needs Assessment (JSNA) in co-operation with Rotherham CCG and NHS England. The H&WBB is responsible for producing the JSNA and all members participate in the process. The JSNA is a public repository and summary of information from a wide range of sources relevant to health and wellbeing in Rotherham. It extracts available evidence of need into a series of answers to the following three questions for each issue or subject area covered: Why is this an issue? , What is the local picture? , What is the trend and what can we predict will happen over time?. The JSNA is used in the development of commissioning and service planning for health and social care services in Rotherham.

4.1. Joint Strategic Needs Assessment – what the data tells us

Further detail can be found in section 11.1:

- The health of people in Rotherham is generally poorer than the England average
- Life expectancy for men and women is lower than the England average and is 9 years lower for men and 7 years lower for women in the most deprived areas of Rotherham compared to the most affluent areas
- Rotherham's population is changing:
  - the number of older people is increasing, especially in the oldest age groups, and people will live longer with poorer health
  - our Black and Minority Ethnic communities are growing and changing, most evident amongst children and young people and a growing Roma community
- Deprivation in Rotherham is amongst the highest 20% in England, with 14,000 children (24%) living in poverty
- 11,800 people in Rotherham are economically inactive (neither working nor seeking work) due to long-term sickness
- 9.4% of working age people in Rotherham are claiming long term sickness or disability-related benefits
- 8,214 people in Rotherham are entitled to Carers Allowance with 5,627 receiving the payment due to their role as a carer
- Household incomes in Rotherham are lower than the Yorkshire and Humber and UK average and women earn only 79% of the average for women in England.
- 11,670 homes (10.6%) are in fuel poverty with localised rates up to 32%
- Rotherham's breastfeeding initiation rate is amongst the lowest in the region at 62.5%, contributing to levels of childhood obesity and paediatric hospital admissions
- 18.1% of mothers smoke during pregnancy. Smoking in pregnancy contributes to increased risk of stillbirth, low birth weight and neonatal deaths.
- 21.8% of children leaving primary school are obese, above the national average.
- 3.1% of 16-18 year olds in Rotherham are not in employment, education or training, higher than the 2.8% nationally.
- 1,059 people aged 15-64 in Rotherham were newly diagnosed with a sexually transmitted infection in 2016, the rate being below the national average.
- 71.4% of adults in Rotherham were overweight or obese in 2015/16, worse than the 61.3% average for England

- 1,847 hospital admissions in Rotherham during 2015/16 could be attributed to alcohol and 2,038 years of life were lost due to alcohol related conditions in 2016.
- 30% of the Rotherham population are estimated to drink at a level that puts their health at risk (over 14 units per week)
- An estimated 18.3% of adults in Rotherham smoke, above the national average of 15.5%
- There are nearly 1,487 smoking related deaths each year in Rotherham – 22% higher than the England average
- On average, mental health problems affect one in four people at some point each year, most commonly depression or anxiety but can be more complex disorders
- Half of people aged 75 years and over live alone and most experience loneliness, especially those alone by bereavement

4.2. Addressing the Health Needs of Rotherham People

In section 1.3 we set out our Plan on a Page, documenting:

Our Vision	The **Future**
Our Challenges	Threat to not achieving the **Vision**
Our Objectives	Tools to underpin achieving the **Vision**
Our Priorities	Most important activities to achieve the **Vision**
Our Approach	How we address challenges to achieving the **Vision**

Underpinning this are our CCG staff values:

- **R** • Responsibility
- **E** • Empowerment
- **S** • Support
- **P** • Positivity
- **E** • Equality
- **C** • Communication
- **T** • Trust

Our Vision is ***'Your Life, Your Health' - Better Health and Care for Rotherham People***

4.2.1. Our Challenges

As set out in 4.1, the health of the Rotherham population is generally poorer than the English average. We have a growing population, but notably, we will see a significant increase in the 85+ population. This leads to growing pressures on our health services, social care, informal care, supported housing and other services. Life expectancy, although lower than average, has been increasing. However, the average time spent in ill-health has also been increasing as people are living longer in poor

health, resulting in a growing number of people with high levels of need. The health service has a significant efficiency challenge and there are too many health problems dealt with by hospital admissions.

The challenges in Rotherham resonate with the three national gaps:

- **Health and Wellbeing** – a major cause of ill health and premature death is due to diseases that could be prevented by living healthier lives. We need to get serious about prevention and improve healthy life expectancy to reduce health inequalities and avoid spend on wholly avoidable illness.
- **Care and Quality** – there are variations in the quality of care received and differences in how services are delivered and the outcomes received. We need to work with partners to reshape care delivery, harness technology, drive down unwarranted variations in quality and safety of care so patients' changing needs are met and unacceptable variations in outcomes stop.
- **Funding and Efficiency** – the forecast is for demand for services to rise. We need to manage demand by supporting people to be healthy, increase productivity and efficiency to maximise available resources and redesign services to develop new ways of delivering joined up care. By matching funding levels with wide-ranging system efficiencies we will avoid a combination of worse services, fewer staff, deficits and restrictions on new treatments

4.2.2. Our Objectives

Our objectives underpin achievement of the vision and provide an instrument to measure and provide assurance at Governing Body level that we; are delivering high quality care, improving performance, quality and patient experience; that we are addressing health inequalities and safeguarding; that we are delivering system wide improvements and efficiencies and that we are an effective and well led organisation.

4.2.3. Our Strategic Clinical Commissioning Priorities

In reviewing the current Commissioning Plan the CCG consulted on the priorities within the plan to establish if they were still relevant and to understand any potential gaps. As set out in section 7, the range of people who took place in that consultation included the CCG Governing Body, Strategic Clinical Executive, GP Members Committee, all GP localities in addition to partners through the Integrated Health and Social Care Place Board, Health Select and Patient Participation Group.

Below we provide a brief overview of the 12 chosen priorities that the CCG will take forward. In section 9, we provide more detail on each of these priorities covering;

- Why it has been chosen as a priority
- What we have achieved/our successes since our last Commissioning Plan in this area
- What our commissioning intentions are going forward
- Quality improvements
- How we are addressing inequalities
- Patient engagement activities
- Key milestones
- Key performance indicators

To allow us to deliver the vision outlined within section 4 and taking account of our local needs and key challenges, we will prioritise the following 12 strategic developments:

- **Maternity and Children**

Commissioning high quality services that support the health and wellbeing of children and young people is a key priority. This will only be achieved through working in close partnership with RMBC to better identify and meet the needs of children and young people; and to ensure that the voice of the child, young person and parent is fully engaged in the commissioning process.

- **Clinical Referrals**

Building on successes in improving care pathways and providing top tips advice to clinicians about elective and non elective referrals, we will continue to ensure the avoidance of unnecessary hospital follow ups through challenging new to follow up ratios and further develop use of virtual clinics. We will re-commission pathways that do not meet the evidence base for clinical thresholds or patient outcomes.

- **Primary Care**

From 1 April 2015 the CCG received delegated authority for commissioning General Practice services, we believe that a key cornerstone to the success of delivering our plan is our ability to commission high quality, equitable primary care provision. There is an expectation that General Practice adapts to manage the increasing demand on their services and it is becoming increasingly important for practices to collaborate to meet these demands.

- **Unscheduled Care**

In July 2017 the new Urgent and Emergency Care Centre opened, integrating the previous fragmented services of A&E, Walk in Centre and GP Out of Hours, and we will continue to embed this new model of care. As a health community, focus will continue to be on actions to deliver the 95% A&E target, such as transforming our Ambulatory Care, continue to develop the Escalation Management System and, in partnership with the voluntary sector, continue to expand Social Prescribing.

- **Community Services**

Historically, the Rotherham health community has been an outlier for emergency admissions to hospital, and 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. We will commission alternative services 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.

- **YAS/Patient Transport Services**

Emergency Ambulance response is commissioned at Yorkshire and Humber level, we will continue to work with other CCGs to develop services on a South Yorkshire and regional footprint. The new Patient Transport contract will be embedded to reduce the number of providers and improve journey management.

- **Medicines Management**

Building on our award-winning successes in medicines management we will continue to work with all practices to improve quality, efficiency and to deliver specific service redesign projects. The focus will continue on innovative ways of managing cost growth, maintaining a strong focus on reducing medicines waste and supporting care homes to improve patient safety and reduce waste.

- **Mental Health**

Mental health problems are widespread, one in four adults experience at least one diagnosable mental health problem in any given year. We will continue to implement and build on the improvements made, this includes prioritising improvements in dementia care in the community, enhancing mental health liaison to delivery 24/7 provision, continued support to social prescribing and continued delivery of the Ferns pathway.

- **Learning Disabilities**

Working in partnership with RMBC, as part of the National 'Transforming Care' project we will ensure good local services are available to support people who challenge services and those with complex needs to prevent the need for out of area placements and we will focus on joint commissioning for supported living. We want all children, young people and adults with learning disabilities and/or autism to be able to live fulfilling and rewarding lives.

- **Continuing Healthcare and Funded Nursing Care**

The provision of Continuing Health Care is a statutory requirement for the CCG, we will continue to ensure that timely assessments and reviews of patients entitled to continuing health care are a priority.

- **End of Life Care**

Commissioning high quality palliative care (including end of life care) for Rotherham people remains an absolute priority for the CCG. Our aspiration is to commission clear joined up pathways that embrace all elements of palliative care, for adults and children, within primary care, acute and hospice settings.

- **Cancer**

Rotherham is part of the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance. Commissioning high quality cancer pathways that deliver treatment within the required national waiting times is an absolute priority for the CCG. We want better prevention, swifter diagnosis and better treatment and care for all.

4.2.4. Our Approach

We know the challenges to delivering our vision and we have identified the key priorities to support delivery of the vision. Below sets out the CCG's approach to addressing the challenges that get in the way of achieving our vision:

- **Clinical leadership -** the CCG is a successful GP led, members' organisation and has made substantial progress working with other clinicians across Rotherham and will continue to do so.
- **Sustainable services across health and social care** – to prevent admission to hospital we need to ensure that as a CCG, we commission high quality, safe community based (out of hospital) provision from across the health and care economy and to ensure the sustainability of primary care.
- **Effective partnerships** – provide the best possible services and outcomes for our population through a whole system partnership approach, recognising that only through working together can we provide sustainable services over the long term.
- **Dependence to Independence –** aim to manage health and care before someone needs to have hospital treatment or experiences problems in their life, in a way that is right for them, whether this is through providing information and advice, or through more active management.
- **Effective Communication and Engagement** – ensure a strong patient voice and effective engagement with practices and with all partners across the system to inform how we plan and commission services.
- **Improved use of Technology -** expand the use of IT systems that help patients to have more control over their health and information when they require it. Ensure interoperability of IT systems to help clinicians access the information they need, and have options in addition to face to face consultations.

5. Delivery

5.1. Activity

The CCG has worked closely with its providers, particularly TRFT to agree activity trajectories for 2018/19. TRFT is the main provider of services to Rotherham CCG patients. 82% of non-elective admissions occur at TRFT, 8% at Sheffield Teaching Hospitals NHS FT and 6% at Doncaster and Bassetlaw Teaching FT. For elective admissions, 67% occur at TRFT, 23% at Sheffield Teaching FT and 6% at Doncaster and Bassetlaw FT.

Trajectories agreed are reflective of national expectations for growth in activity and reflective of activity levels that are sustainable within the Rotherham system. The CCG has seen a small decrease in A&E attendances from 2016/17 of around 1%, with an increase in non-elective admissions of around 2-3%. Elective activity has seen a slight decrease of around 1-2%.

5.2. Finance

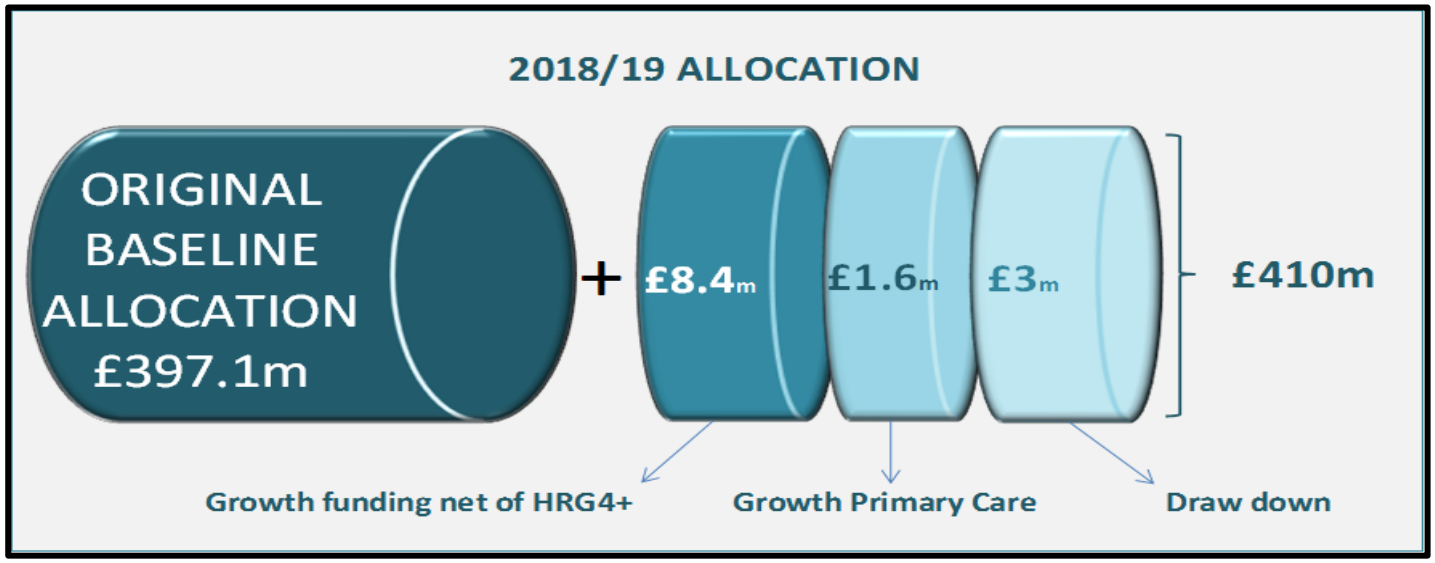
5.2.1. The Health Service Efficiency Challenge

Like all of the public sector the health sector faces a substantial efficiency challenge. NHS Rotherham CCG's share of this challenge is around £15 million per annum. In health service language, efficiency is called QIPP which stands for Quality, Innovation, Productivity and Prevention.

Whilst NHS financial allocations have increased each year the underlying rate of growth in demand for health services and the cost of providing services outstrip the increase. Demand and costs are high due to factors including an aging population, new medical technologies and rising patient expectation. QIPP programmes are the actions required to keep overall growth at an affordable level (1-2%) rather than the underlying level historically (6%). In Rotherham we have a number of QIPP programmes which enable QIPP to be delivered across the system.

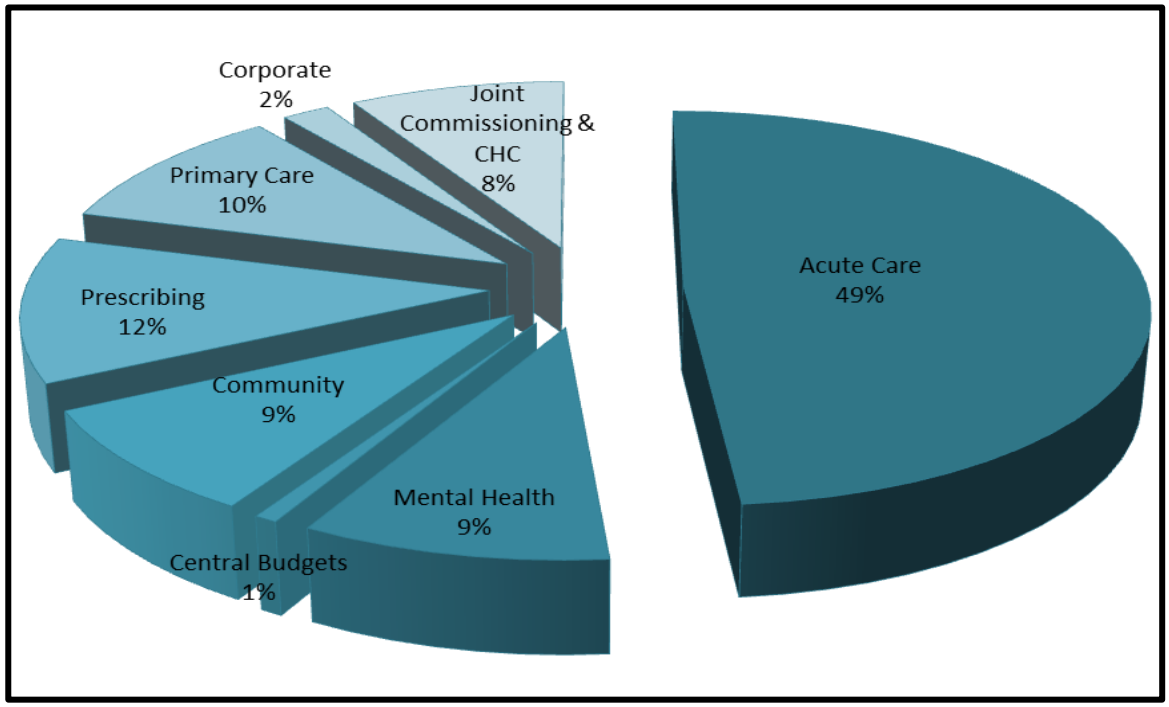
5.2.2. The 2018-19 Financial Plan

The CCG has £410m to spend in 2018-19. The illustration below shows the increases between the 2017-18 recurrent allocation and the 2018-19 assumed allocation.



Alongside growth funding, a significant source of funding is from QIPP savings (see efficiency section above) so it is important these savings are achieved. In 2018-19 we have an additional £3m of funds available to utilise on a one-off basis, drawn down from previously banked surpluses.

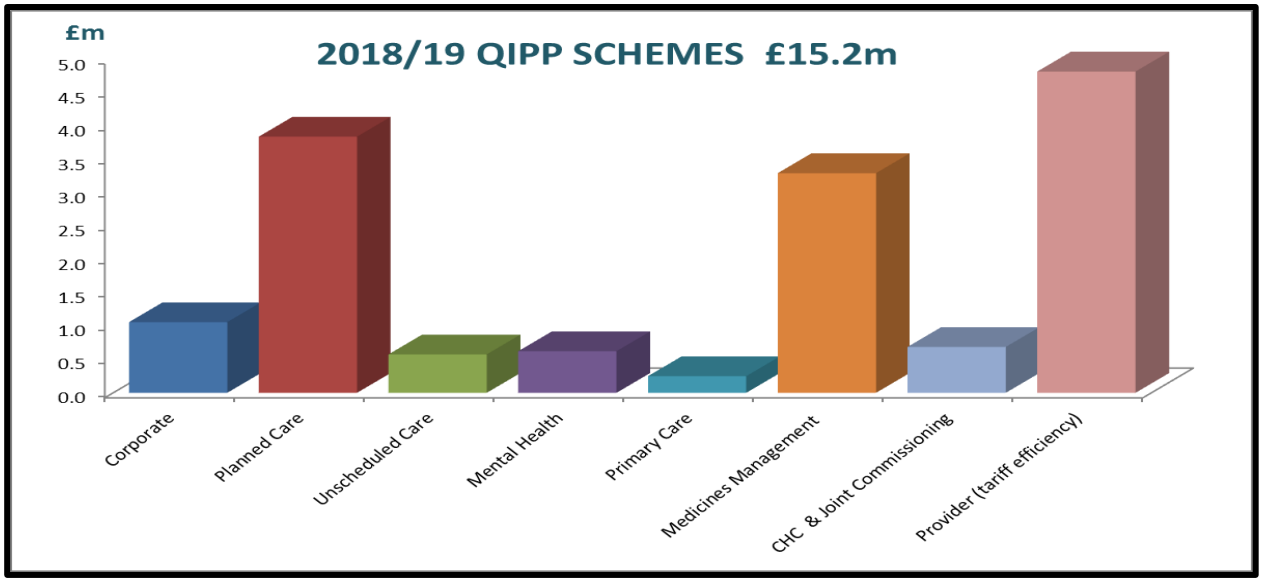
There are a number of priorities detailed in the NHS planning guidance which have been considered by our GP members. Details of the CCGs service specific priorities are laid out elsewhere in this Commissioning Plan, however the financial plan has been developed to underpin these objectives and as a result commits money to the areas illustrated below.



The NHS planning guidance sets out financial rules which the CCG must achieve

- to operate within the total commissioning allocation and the running costs allocation
- to ensure that a 0.5% contingency is maintained

These rules have been taken into account in setting the financial plan.



5.2.3. Risks to the financial plan

The financial environment is challenging and risks to achieving the plan include:

- Failure to manage growth in hospital activity will create financial pressure for both the CCG and TRFT if costs cannot be reduced as planned. 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. The CCG's QIPP delivery governance structure is well placed to identify where plans are not working and, with the relevant clinicians engaged, action can be taken to rectify problems during the year.
- Linked to the above, plans are predicated in part upon primary care having the appropriate capacity to deliver the services required in Rotherham. This is already being addressed through the primary care strategy and 2018-19 will be year three of a four year plan to strengthen primary care and ensure that all practices achieve a minimum standard and quality requirement.
- Previous years have seen significant increases in prescribing volume and price growth and there is an assumption that this will continue to some extent. This is exacerbated by shortages in the pharmaceutical supply chain which can occur at any time forcing prices to suddenly increase. In addition, NICE guidance may also have an adverse effect on cost growth.
- The CCG has a challenging QIPP plan, as do other local partners. The impact of savings across the wider footprint may is a risk to all partners. Impact assessments will support the identification of risk.

5.2.4. Procurement

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

5.3. Information Management

5.3.1. Introduction and Context

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

Given the significant financial challenge faced by the NHS there is an absolute need for enabling programmes linked to improved information technology to deliver increased Quality, Innovation, Productivity and Prevention (QIPP).

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

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

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

5.3.2. IT Delivery

The current responsibilities and configuration for the delivery of IT services to the CCG and Rotherham's General Practices are as follows. NHS England is responsible for primary care information services. It delegates the responsibility for operational management of GP IT services to CCGs. The Chair of the CCG is the GP IT lead, supported by the Chief Finance Officer who is the responsible officer for IT services to the CCG and its general practices.

The CCG IT department is a joint service with Doncaster CCG that provides the development and delivery of local IT strategy, programme and project management, data quality, GP system support services as well as managing the contracts for delivery of IT services to the CCGs and GPs.
IT services and Registration Authority services for the CCG and GPs are procured from The Rotherham NHS Foundation Trust (TRFT).

5.3.3. NHS Information Framework

The NHS Information Framework titled "Personalised Health and Care 2020: Using data and Technology to transform Outcomes for Patients and Citizens" was published in November 2014. The framework set out a programme for transforming information for health and care so that services could achieve higher quality care and

improved outcomes for patients and service users. It made a commitment to delivering improved digital access for people to healthcare services, their clinical records and other healthcare information and to improving the sharing of information between health and care professionals.

The framework proposed a locally driven approach to decisions on systems, programmes, interfaces and applications, which will be supported by a set of nationally defined standards and definitions and clear expectations regarding interoperability. It identified that generally the IT systems, currently used in health and care, lack the capacity to share information and that this lack of inter-operability is a major and fundamental problem that has not been addressed successfully by previous national strategies.

The framework identified that local health economies needed to produce local digital roadmaps detailing the actions they will take to deliver the ambitions set out in the framework.

5.3.4. The Rotherham Digital Roadmap

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

Rotherham had an IT Strategy Group that included members from all key providers and the local authority, which oversaw the delivery of a co-ordinated approach to IT which had been established for many years. This group has now developed into the borough wide Interoperability Group to lead on the development of our digital roadmap and initiatives that support collaborative working and the improved sharing of information across our organisations. In support of this agenda, since 2013 we have been working together to develop a Rotherham clinical portal system to improve data sharing across organisational boundaries.

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

We recognise that there is a flow of patients outside of these boundaries, particularly into the neighbouring CCG areas in South Yorkshire and Bassetlaw, and intend to share and develop closer working through the Integrated Care System to ensure a collaborative approach to the development of our Digital Charter. This will ensure that roadmaps and the technologies that will be deployed are aligned and compatible for future integration. There also is recognition that where we can share learning and support future joint efforts, such as on areas including communications and engagement, it makes sense to do so.

Rotherham's local digital roadmap was developed in partnership during January to June 2016. Following review by NHS England the Rotherham Local Digital Roadmap was published in January 2017. This strategy sets out how locally in Rotherham we will take forward the aims of the framework. It is comprised of a universal capabilities plan addressing ten 'must do' areas and an aspirational capability development plan covering the period 2016-2020. The Rotherham Health and Social Care Interoperability Group is responsible for managing and monitoring the delivery of the roadmap.

5.3.5. Rotherham Health Record

A key element of our Digital Roadmap is the continued development and support of the Rotherham Health Record (RHR). The RHR is an integrated web based system which presents the information health and care workers need to make clinical decisions with confidence. The system is a bespoke solution developed by TRFT and governed by the Rotherham Health and Care Interoperability Group.

The RHR system consists of information pulled from a variety of underlying clinical systems, which is linked together and presented in a useful way according to who is accessing it, enabling colleagues from across Rotherham to work together effectively. For example, community nurses use the RHR to see when their patients have been admitted to hospital or are attending A&E. They can do so within the patient record view or they can proactively identify patients on their caseload who have been admitted using the community view, which shows lists of inpatients by GP. Having this information means they avoid visits to patients who are not at home, and most importantly are able to offer support to the wards where their patients are based.

The RHR provides an aggregated view of the following information at the patient level, offering care givers a more complete picture of who is inputting into the their patients' care, what they have done and what is planned:

- Summary, including current problems, medication, allergies and recent tests
- Problem view and diagnosis view
- Risks and warnings
- Procedures and investigations
- Live ambulance en-route
- Community caseload and lead
- Examination (Blood Pressure only)
- Events consisting of encounters, admissions and referrals
- Theatres, pathology, radiology and maternity

The system currently presents information from, and is used by TRFT (acute and community services), General Practices and Rotherham Hospice. Work is underway to link social care information from RMBC with the system to provide social workers with a view of the record. Following on from this, during 2018/19, it is expected that mental health information from RDASH will be integrated into the system.

As part of the future development of the RHR, there are specific milestones and plans to:

- Expand the number of users in primary care, mental health and social care
- Build patient access capabilities, focusing on patients on particular care pathways, e.g. diabetes, stroke, cancer, obstetrics
- Create more tailored views of information for specific pathways
- Extend the document sharing capability to include more partners' information
- Implement subscription-based text messaging alerts for staff triggered by patients being admitted or attending

A communications and engagement plan has been developed detailing how Rotherham health and social care services will promote the RHR and listen to patients' views. Communications and engagement leads across the partnership will work closely together to ensure that clear messages and innovative marketing materials are implemented through a variety of channels. The aim is to increase awareness of the RHR, and ensure patients, family and carers understand its benefits, as well as how to opt out.

The development of the RHR is a key driver to support delivery of the priorities within the Integrated Health and Social Care Place Plan.

5.3.6. Rotherham CCG IT Strategy

This strategy has been developed by consultation across the Rotherham Local Health Community, to support the delivery of the Rotherham local digital roadmap and aligned with the Rotherham Commissioning plan.

Rotherham CCG will ensure when delivering this strategy that information and new technology is equally accessible across vulnerable groups. At the point of implementation of each project a full equality impact assessment will be carried out and this will be subject to regular monitoring. Rotherham CCG's partners will also be required to share evidence that they have carried out equality impact assessments on their developments.

5.4. Performance Management

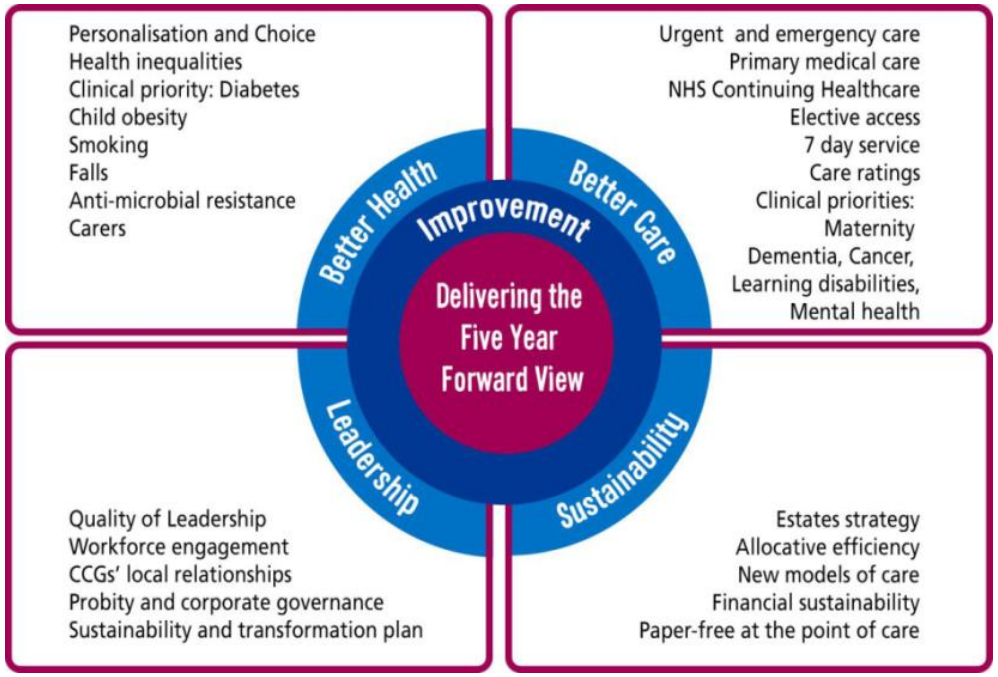
5.4.1. Outcomes

This section confirms the assurances and quantifiable improvements we will deliver over the next 5 years. We will commission services in line with local need, the NHS Five Year Forward View Next Steps and the NHS Constitution.

The CCG improvement and assessment framework (IAF) was introduced in 2016/17 and aligns key objectives and priorities, drawing together NHS Constitution and other core performance and finance indicators. The 2017/18 framework aims to maintain a high degree of continuity but acknowledges the rapidly changing environment required to transform the health and care system to meet its challenges. The next steps can only be delivered through place-based partnerships spanning

across NHS commissioners, local government, providers, patients, communities and the voluntary and independent sectors. The IAF reflects a CCG's fitness to operate successfully in this environment.

The CCG IAF maintains its four original domains as seen in the 2016/17 IAF diagram below. In addition to the diagram below, for 2017/18, indicator areas around patient safety and patient engagement have been added as well as additional indicators in the existing areas.



5.4.2. Performance Management

Performance management runs as a key theme throughout the CCG and is reviewed periodically to ensure it reflects current policy and the Improvement and Assessment Framework (IAF). A monthly performance report is produced for the Governing Body covering key outcomes against:

- NHS Constitution and Pledges
- Improvement and Assessment Framework
- Health Outcomes
- Better Care Fund
- Quality Premium
- Focus on performance; A&E, Referral to treatment, Improving Access to Psychological Therapies, Cancer, Delayed Transfers of Care and NHS 111
- Focus on Performance for NHS 111

NHS Constitution measures, the Improvement and Assessment Framework, the Better Care Fund, the Quality Premium and other broader health outcomes.
The IAF covers indicators within four domains; Better Health, Better Care, Sustainability and Leadership. The overall rating for 2016/17 was based on 55 indicators of the original intended 60. The remaining 5 indicators were excluded due to data availability issues nationally. The 2016/17 rating for the CCG was Outstanding, putting the CCG in the top 10% nationally. The 2017/18 rating is expected to be based on 51 indicators, including new indicators on access to Psychological Therapies, GP learning disability registers, emergency admissions in end of life care, sepsis awareness and patient engagement.

In addition to reporting on national outcomes the CCG will produce quarterly reports on the delivery of this commissioning plan and will be closely linked to the IAF metrics.

5.5. Risk Management

The CCG will ensure that the organisation is properly governed in accordance with best practice corporate, clinical and financial governance. The Integrated Risk Management Framework 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 to the achievement of the CCGs objectives are logged of the CCG Assurance Framework.

Risks to the organisation are identified and managed by all teams across the CCG. The CCG Risk Register captures all the operational risks to the organisation. As at January 2018 there were 20 entries on our Risk Register, with 14 scoring in excess of 11. As risk is all about horizon scanning and spotting issues that may occur, the CCG also maintains an Issues Log which describes issues that are impacting on the CCG now. There are currently 11 issues live on the Issues Log.

The key risks to delivering this plan are defined and logged on the Governing Body Assurance Framework (GBAF). These are then assessed and a risk appetite added which guides the organisation as to the level of risk it is facing, and provides a framework for action, for example, treat, tolerate, transfer or terminate the risk.

6. Statutory Responsibilities

CCGs have a number of duties which they must take into account when exercising their functions. These include duties to improve services, reduce inequalities, promote patient involvement, consult with patients and the public, provide patient choice, promote innovation and promote the integration of health services.

This section provides a high level summary of how these responsibilities are met. NHS England's comprehensive summary of CCG functions provides further detail, including specific legal duties.

6.1. Quality Assurance and Quality Improvement of Commissioned Services

The CCG's Chief Nurse works with the GPs responsible for the integrated acute and community contract, mental health, primary care and governance to maintain oversight and assurance of all quality issues.

Quality assurance of commissioned services is closely linked with GP quality, public involvement with the CCG, and safeguarding (see sections 6.2, 6.4 and 9.3).

The CCG's Deputy Chief Nurse and Head of Clinical Quality supports the Chief Nurse in the clinical quality agenda with regard 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 Deputy Chief Nurse role leads on Continuing Healthcare for adults and children, personal heath budgets and representing the CCG at the regional quality leads meeting.

The functions of a Clinical Commissioning Group (March 2013) state that it is the duty of a CCG to 'assist NHS England with securing continuous improvement in the quality of primary medical services'. The CCG's Primary Care team supports the Chief Nurse in the primary care quality agenda. Additionally, the roles lead on

development of long term conditions case management, the commissioning local incentive scheme and the Professional Leadership Training and Commissioning (PLTC) events.

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

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

- Assurance that providers' cost improvement plans (CIPs) have robust quality impact assessments and can be delivered without compromising quality and safety. It is requisite that CIPs be signed off by providers' medical and nurse directors and provide a 'line of sight' to ensure the commissioner is aware of any risks to clinical safety resulting from the requirements to make efficiencies.
- Monthly contract quality meetings with main providers where the agenda is set around the three main domains of quality, safety and patient experience in line with the NHS Outcomes Framework. Discussions include the review and monitoring of national and local quality standards set out in the main contracts hospital mortality rates, providers' Cost Improvement Plans, Commissioning for Quality and Innovation (CQUIN) and other Local Incentive Schemes, Serious Incidents, patient safety agenda, complaints and compliments, inspections, clinical audit, safeguarding, friends & family test (FFT), patient survey reports and staff surveys and staff FFT, Care Quality Commission. CQC inspections of TRFT and of Rotherham's Safeguarding and Looked after Children services were carried out in February 2015, the CCG ensures that any actions are addressed.
- The CCG has worked closely with TRFT to understand and put in place a process of continued improvement with regard to hospital mortality data. In 2013 this included patient level audit and a revision of TRFT's procedure for hospital mortality assurance. In 2014 TRFT worked with other Foundation Trusts in Yorkshire and Humber and the Improvement Foundation to have a continuous process of mortality review including peer comparison. Mortality remains a strong focus for the CCG and TRFT and is monitored through a new mortality report fed into contract quality meetings and local outcomes framework indicators (LOFI). Areas of improvement were identified including review of all deaths within 28 days, implementation of the 'Hospital at Night' initiative and improved 'Admit to Die' analysis.
- These help to provide intelligence to continuously improve processes to assure the CCG and TRFT that hospital mortality is managed appropriately.
- Agreement and monitoring of action plans developed due to under achievement against contractual quality standards which holds the provider to account for delivery through formal contract meetings.
- Holds all our providers to account to make further substantial reductions in clostridium difficile with a root cause analysis of all cases. We have a zero tolerance approach to MRSA.
- Monthly quality reports to both public and confidential sections of the CCG Governing Body covering issues, compliments, incidents, and complaints
- Serious Incident monitoring and performance management.
- An agreed programme of 4-6 annual clinically led visits to providers with agreed action plans for improvements in quality where appropriate.
- Taking part in monthly senior nurse walk round programme at TRFT and Chief Nurse walk rounds, both of these unannounced and at varying times during the day and night.

- Obtaining assurance from providers regarding the 'Compassion in Practice Vision and Strategy' for Nurses and Midwives and implementation of the 6 C's across services (Compassion, Courage, Competency, Commitment, Care and Communication).
- Working with providers to ensure their Quality Accounts are informative public facing documents and provide formal commissioner commentary for inclusion in the final draft.
- Assurance from contract quality meetings for contracts where Rotherham is not the lead commissioner such as Sheffield Teaching Hospitals NHS Foundation Trust and Sheffield Children's NHS Foundation Trust.
- Sharing information on quality with other commissioners to pool intelligence.
- All our main providers are signed up to the 'sign up to safety campaign'.
- The CCG uses a process of appreciative enquiry, developed to collate evidence relating to quality of commissioned services, gaining assurance, assessing risk, and undertaking in depth assessment where appropriate *(Appreciative Enquiry.)*
- GP Peer Review is the process, whereby each practice is visited every 3 years. The GP Primary Care Lead and the Head of Primary Care Quality have an open discussion with practices about their performance in comparison to other Rotherham practices with regard to prescribing indicators, elective and non-elective activity and enhanced services. Every year the performance of each practice is reviewed as part of a table-top exercise so that visits can be prioritised if needed. Actions identified as part of the visit are logged and followed up. This is intended to be a supportive process and part of the on-going dialogue between practices and the CCG.
- PLTC is a series of 6 meetings, held bi-monthly 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 brought responsibility for GP workforce planning to the CCG, however maintenance of the Performers list and GP accreditation and validation remains with NHS England.
- The CCG will continue to support Rotherham practice managers forum and the Rotherham practice nurse development forum.

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

In line with the recommendations made in the second Francis Report, the Keogh Review, 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.

With the increased emphasis on assurance driven by Francis, Keogh, Berwick and Winterbourne, the CCG Governing Body recognised the need for increased information and discussion. In response, a detailed quality and safety report, which includes safeguarding, patient safety, mortality rates, incidents and CQUIN is monitored through contract meetings and is received at each Governing Body meeting.

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.

Working with the CCGs largest provider of secondary care, the CCGs Chief Nurse's 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

The CCG fully endorses safeguarding as **a responsibility for all of us**. Regarding **children and young people** the Clinical Commissioning Group fully accepts its statutory duty to safeguard and promote the welfare of children; ensuring that robust governance arrangements are in place and welcomes being an active member of the Rotherham Local Safeguarding Children Board.

The Care Act 2014 highlights that the responsibility for co-ordinating adult safeguarding arrangements lies with Rotherham Metropolitan Borough Council (RMBC). The 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 the CCG commissions services meet the required standards. NHS Rotherham CCG will ensure that integrated working between Health and Social Care is at the forefront of providing Rotherham residents with safe effective care; this includes being an active partner on the Safeguarding Boards.

Huge safeguarding challenges remain around how agencies work together effectively to safeguard the public. The need to work collaboratively has been further heightened by the Children and Social Work Act gaining Royal Accent in April 2017. Guidance on how Clinical Commissioning Groups, Police and Local Authorities work together to improve local safeguarding and children in care processes is anticipated in Spring 2018. In the interim the CCG Chief Officer works closely with senior colleagues to drive up standards across the borough.

Key changes following publication of the Children and Social Work Act are:

- Allowing removal of Local Safeguarding Children Boards
- Transferring responsibility for Child Death Overview Panels from the Department of Education to the Department of Health.
- Establishment of a national Child Safeguarding Practice Review Panel.

6.3. Child Sexual Exploitation in Rotherham

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

The way we deal with child sexual exploitation in Rotherham today is very different than in the past. We are now operating with a much deeper understanding of this heinous form of abuse. We are working even more closely across agencies and sharing information to keep people as safe as we can. We accept that no single agency can tackle child sexual exploitation alone and that we need to work with our communities in new ways that puts victims and survivors first. We are clear that there is much more to do.

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

All health professionals either working for the CCG or commissioned by them are expected to be:

- Person-centred and to prioritise the person's best interests.
- Rooted in and informed by evidence.
- Aware of information gathered systematically, and to have checked with the person and others; with differences of opinion or contradictory information recorded.
- Analytical, considering impact of what is happening and evidence professional working knowledge.
- Able to provide an analysis of their information, drawing on professional judgement.
- Outcome focused not process driven.
- Holistic in approach, addressing the persons' needs within their family, their peer group and wider community.
- Aware of diversity, avoiding 'one size fits all' assumptions.
- Cognisant to strengths and promote resilience, as well as identifying risk and needs.
- Clear of the actions to be taken in order to deliver best practice.
- Transparent and open to challenge.
- Aware and reflective if/when new information is provided.

The CCG agreed safeguarding including CSE as one of its five organisational objectives within this Commissioning Plan.

The Casey report *Casey Report* in February 2015 concluded that RMBC was not fit for purpose and failed in its duty to protect vulnerable children and young people from harm. The CCG has proactively work with the nationally appointed commissioners and other partners to implement all aspects of the Casey report and the requirements of the multi-agency Improvement Board. In addition the CCG works collaboratively with the National Crime Agency (NCA). Senior staff support colleagues in the NCA to traverse complex NHS structures; this enables a swifter response to their inquiries and investigations. It also ensures that victims and survivors receive a more bespoke service from the NCA. CCG representatives within the Multi Agency Safeguarding Hub continue to work closely with GP Practices to provide the NCA with relevant information to assist them prior to contacting the victims and survivors.

For **looked after children (LAC**) Rotherham CCG takes its Responsible Commissioner role seriously for all its LAC and Care Leavers. This responsibility includes providing Looked After Children with regular planned health assessments, upon placement and an annual/bi-annual review thereafter. NHS Rotherham CCG will ensure that their identified health and welfare needs are prioritised, ensuring that our LAC receive a quality seamless health service. For our Rotherham LAC who live outside of the borough we will endeavour to ensure that the healthcare they receive is appropriate and meets their needs. Data on achieving regular planned health assessments will be monitored by the commissioner and provider of services, results will be shared with RMBC and at the Corporate Parenting Panel to provide external assurance. NHS Rotherham CCG has an expectation that all services it commissions will work with statutory and voluntary partners to reduce **domestic abuse**; this includes participating in Multi Agency Public Protection Arrangements (MAPPA) and Multi Agency Risk Assessment Conferences (MARAC).

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
- supported the increase in the health visiting workforce by 24 by 2015 to ensure that early help is provided in a timely manner
- support the delivery and quality assurance of the Family Nurse Partnership to support vulnerable families
- monitor health providers work with the healthy child programme and the early identification of health and welfare needs
- work with central government, partner organisations and RMBC to ensure that LAC receive timely and effective health care. Achieved through active membership of the RMBC's Corporate Parenting Group.
- Continue to monitor safeguarding standards in contracts, service specifications and compliance with Section 11 Children Act expectations
- ensure that the safeguarding agenda takes into consideration emerging national and local trends, for example work around child sexual exploitation and increase in self harm and suicides in young people.
- establish and publish a safeguarding dashboard of key performance indicators that will be shared with local partners and partners across South Yorkshire and Bassetlaw to allow for transparency and challenge in the system.
- support the development of the safeguarding adult's agenda, including, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards legislation.

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

Whilst the responsibility for co-ordinating safeguarding arrangements lies with RMBC, effective safeguarding is based on a multi-agency approach. The CCG is a willing multi-agency but challenging safeguarding partner and will continue to commission services that meet robust safeguarding standards, remaining committed to working together to ensure that safeguarding vulnerable clients is at the core of all that we do. In addition to the eight SCE GP members, the CCG employs a named GP for safeguarding at two sessions per week.

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

6.4. Communications and Engagement

6.4.1. Communications

The CCG is committed to communicating and interacting with a wide range of audiences, ensuring we get the right messages to the relevant audience, using the right platforms that meet their needs. This is vital to ensuring that local people understand not only the health services that are available to them in Rotherham, but the future direction of improvements to health and social care services in our local communities. As well as using traditional methods of communication, we will be innovative and creative in meeting the changing needs of our population.

Our communications will focus on informing, sharing, listening and responding. We will:

- Develop effective **two-way** communications systems where we share news, we listen and respond, and are visible
- Ensure that we develop a positive culture of **consistent, open and clear** communication that is concise and easy-to-understand.
- Identify **relevant and effective** communication tactics with key audiences and stakeholders

We will work in a joined-up approach with our Integrated Care Partners in Rotherham and across South Yorkshire and Bassetlaw to provide effective and timely information about the need for service change, the challenges facing health services and the decisions we make to improve health outcomes of local people.

Communications Priorities

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

Communications Principles

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

6.4.2. Why Public Involvement and Choice are Vital to the CCG

The Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006, maintaining a strong legal duty around patient and public engagement, and introducing a new legal duty for individual engagement. As a CCG we 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 '*Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England*' and '*Involving people in their own health and care: statutory guidance for CCGs and NHS England*'.

6.4.3. Service reconfiguration and consultation

This new statutory guidance for CCGs offers additional clarity, strengthening the focus on and need for public and patient engagement, proportional to any service change. Any public body wishing to make major changes to services (service reconfiguration) has a statutory duty to involve those who will potentially be impacted by the change- Section 14Z2 of the NHS Act 2012 states that this could be by being consulted, provided with information or in other ways.

The CCG wants to work with patients and the public from the start of any work where services could change. Reconfiguration plans will be informed by patient views and experience, with conversations taking place from the start between all stakeholders, and will include more active participation where ever possible.

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

6.4.4. The CCG's vision for involvement

The CCG has a track record of solid engagement with communities and stakeholders, while ensuring that engagement and participation is strongly allied to our organisational priorities**.** This is described in more detail in our communications and engagement strategy, *Communication and Engagement Plan* .

Our aim is that in all that we do we can demonstrate that the patient or their voice is at the table, that it is heard effectively and impacts on our decision making. It is important to us that we continually improve our engagement with patients and the public, and ensure that this work actively contributes to service improvement. To this end, we have established a Governing Body sub-group to oversee engagement and communications, and to ensure that we are carrying out the right activity, with the right people, at the right time to inform our work.

In addition, a Patient and Public Engagement and Experience report is received at each of our Governing Body meetings, describing current activity, outcomes and plans.

We continue to strengthen our engagement work, and to map activity systematically across all our workstreams, to evaluate, share information and identify gaps. This also helps us to demonstrate how we listen to patients across all our areas of work and how what people tell us informs how we commission and plan services. We also continue to work with stakeholders and partners, in a number of ways, including:

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

Section 7 has more details on how we have shared this Commissioning Plan with the public and with stakeholders and includes how feedback has informed and influenced our plan.

6.4.5. 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
- promoting case management for people with long term conditions
- continuing our third sector commissioned social prescribing programme, aiming to:
  - Improve outcomes for patients in terms of health, wellbeing, self-care and independence
  - Increase resilience of individuals and communities
  - Support dependence to independence
  - Reduce social isolation.

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

- using tools such as the ladder of engagement and the engagement cycle to plan and measure public participation
- providing good information, and raising health literacy
- providing a range of opportunities and mechanisms for engagement, aligned to CCG workstreams and priorities
- reaching out to diverse communities

We will continue to support and work with our Network of Patient Participation Groups to facilitate the development of strong practice based participation groups, offering a forum to consider cross cutting issues.

We will continue to work with Healthwatch, seeking to add value and avoid duplication in both our work and roles. We will build on the new mechanism for collecting and analysing patient experiences to identify emergent themes across health, and act responsively on this data.

We will increasingly look to extend our co-created work with patients, the public and the voluntary and community sectors. Existing work with Rotherham Parents Forum, and with Voluntary Action Rotherham among others has demonstrated the value of this approach.

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

- The 'Friends and Family Test (FFT)' identifies whether patients would recommend a health service to others needing a similar service. We will continue to work with all our providers to monitor the results, feedback and outcomes. We will share the information with the public, congratulate and challenge providers where appropriate and see how the information triangulates with other insights and feedback
- 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 a variety of mechanisms – web pages, social media, local press, community networks, and direct contact as appropriate.
- We continue to use different ways to listen to patient voices including social media, FFT, Healthwatch reports and comments from engagement activity, triangulating this feedback as possible and reporting on any emergent themes
- We will continue to develop our website and the use of social media to feedback to the community.

Assurance that our providers involve patients - The CCG holds providers to account over involvement in several ways

- regularly monitoring patient feedback, using FFT responses and feedback, and through quality reports
- ensuring that providers follow best practice and compliance with statutory guidance in the case of service change
- working jointly with providers on service transformation to ensure that opportunities for engagement and real influence on decision making are embedded in plans

Working with other organisations to engage effectively and maximise resources - The CCG has always worked effectively with partners, both within Rotherham and wider; to ensure that we use resources effectively where this benefits us all. We are working with colleagues to establish solid mechanisms for engagement and consultation both across Rotherham, and across South Yorkshire and Bassetlaw – http://www.healthandcaretogethersyb.co.uk. This has included supporting joint events and consultations, offering expertise, contributing to materials, and also contributing to a regional compilation of data from engagement activity. Working in this way enables us to target overlooked and unheard communities far more effectively.

6.5. Patient Choice

Choice is a key component of the ***NHS Five Year Forward View*** and is central to the future of the NHS. The CCG has a duty to enable patients to make choices, and to promote their involvement in decisions in respect of their care or treatment.

Choice is fundamental to the delivery of a truly patient-centred NHS as it empowers people to get the health and social care services they want and need. Giving the public and patients good information helps them to make effective choices that are right for them and their families.

It is written into the NHS Constitution that 'patients will be at the heart of everything the NHS does' and therefore have the right to make informed choices about their healthcare. This means that, by law, patients should be offered the opportunity to compare and make choices that suits their needs.

The CCG believes patient choice is crucial and should underpin the delivery of a patient-centred health service. Choice empowers individuals to obtain the health and social care services they need and deserve. Providing the public and patients with the correct information enables them to make effective choices that are right for them and their families.

Under the rights of the NHS Constitution for England and the NHS Patient Choice Framework, patients have the right to start consultant-led treatment within a maximum of 18 weeks, unless a patient chooses or it is clinically appropriate to wait longer.
More information about NHS waiting times can be found on the NHS Choices website

As set out in the NHS Constitution, patients have a number of choices about their care and treatment, these choices include:

- the right to choose your GP surgery, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons;
- the right to express a preference for using a particular doctor within your GP surgery, and for the surgery to try to comply;
- the right to choose which hospital to go to if your GP refers you to see a specialist as defined in national guidance;
- the right to be involved in decisions about your healthcare and to be given the information you need to do this;

For a full list of your guaranteed choices within the NHS you can read more about your rights and pledges as a patient on the NHS Choices www.nhs.uk/nhsengland/pages/nhsengland.aspx

To understand what service to choose if you feel unwell please visit our 'Your Health' page. http://www.rotherhamccg.nhs.uk/your-health.htm

In line with the guidance, '*Securing meaningful choice for patients: CCG planning and improvement guide',* the CCG undertook a self assessment against the requirements of the framework and developed an improvement plan to address any gaps.

6.6. 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*

6.7. NHS Constitution, CCG Constitution and Governance

The 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 NHS Constitution without the full involvement of staff, patients and the public. The NHS Constitution is a promise that the NHS will always be there for you.

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

6.7.1. The CCG Constitution

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

The CCG constitution sets out the arrangements to meet these responsibilities to ensure that decisions are made in an open and transparent way and that the interests of patients and the public are central. The constitution covers the responsibilities of individual member practices, the GP Members Committee and the CCG Governing Body and committees of the CCG Governing Body.

It includes the CCG's duties to manage conflicts of interest and maintain a register of interests of its members and employees.
The Constitution is reviewed on a regular basis by the GP Members and the CCG Governing Body.

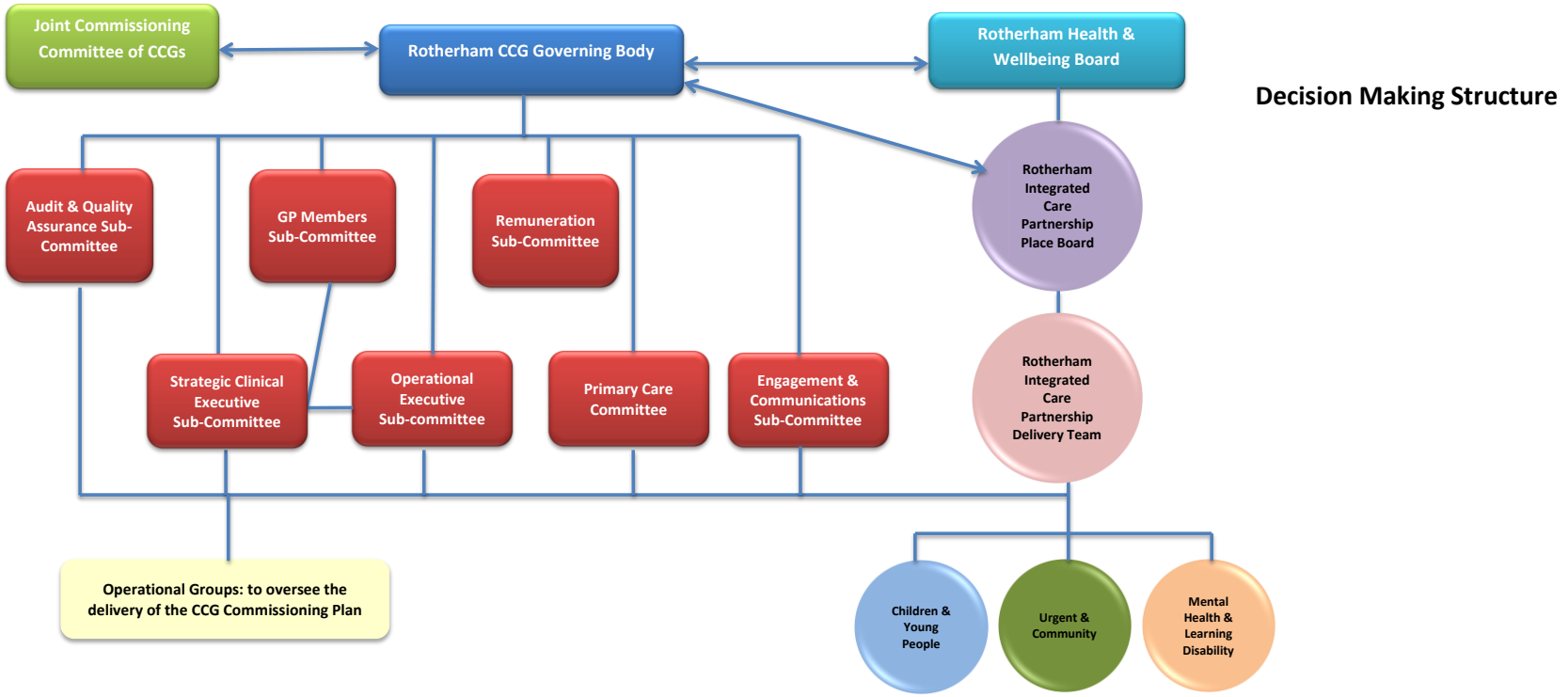
6.7.2. Governance

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

The role of the CCG Governing Body is to:

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

The Governing Body has a number of sub committee's details of which can be found in our constitution http://www.rotherhamccg.nhs.uk/Downloads/Constitution/Constitution%20-%20May%202016.pdf. The structure below details the interdependencies between each of the sub-committees and also the Health and Wellbeing Board.



Decision Making Structure

6.8. 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.
- 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.
- work to remove any unintended barriers that prevent equal opportunities for all staff.

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

The CCG is committed to advancing equality and diversity for patients, communities and the NHS workforce. NHS Rotherham Clinical Commissioning Group welcomes the introduction of the NHS Workforce Race Equality Standard (WRES) as a useful tool to identify and reduce any disparities in experience and outcomes for NHS employees and job applicants of different ethnicities. http://www.rotherhamccg.nhs.uk/workforce-race-equality--standards.htm

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

- ***Objective 1:*** Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within Provider contracts.
- ***Objective 2:*** Ensure appropriate and accessible targeted communication with local communities to ensure commissioners are aware of issues/barriers that influence commissioning decisions.
- **Objective 3:** Develop consistency of equality approaches across the CCG in respect of equality leadership, staff environment and access to development opportunities.
- **Objective 4:** 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.

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

6.9. Research and Innovation

'Research is vital in providing the evidence we need to transform services and improve outcomes e.g. in developing new care models, redesigning urgent and emergency care, strengthening primary care and transforming mental health and cancer services. By fully integrating research into our organisation we can out-perform organisations that do not; leading to better quality care and improved use of resources. Pursuing the use of evidence and evaluation will improve how we measure the impact of our work, meaning we can learn from what works well, and what doesn't. We wish to foster a culture in the NHS that seeks out research evidence and applies this evidence in decision-making. All of this will be underpinned by a strong infrastructure that is supportive of research and evaluation'.

NHS England – Research https://www.england.nhs.uk/commissioning/research/
Rotherham CCG is committed to supporting this vision of research in the NHS, and works to encourage research and development (R&D) in the services it commissions. We will be an active participant in Local Research Networks and Alliances, and the CCG will continue to ensure that it and its providers will meet the treatment costs of government funded and charitable research that is agreed at national level.

6.10. Education and Training

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

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

The CCG's response rate for the annual national NHS Staff Survey was 86%, the outcomes were overwhelmingly positive, examples being such as 97% of staff feel line managers value their work, 100% of staff feel that managers support them to access training, learning or development, 100% of staff have received mandatory training and an appraisal in the last 12 months and 99% of staff feel that their line managers are supportive in a personal crisis.

6.11. Environmental Sustainability

The 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 and aim to integrate economic, environmental and social considerations into our strategic decision making and be 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** - as an employer we will enhance the health and wellbeing of staff, patients, the public and suppliers and 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 minimises 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.

7. How we shared our plans

Numerous stakeholders have been engaged in the development of our Commissioning Plan and figure 7.1 below describes the inputs into its development. Feedback from GP members, the GP Members Committee (GPMC) and the Patient Participation Groups (PPGs) have been especially important in its development, as has feedback from the Rotherham Health and Wellbeing Board, Rotherham Integrated Care Place Board and Rotherham Health Select Committee. In addition, the CCG continues to undertake a breadth of consultation with members, patients and partners on areas within the Commissioning Plan.

Input from Joint Strategic Needs Assessment and Health and Wellbeing Board

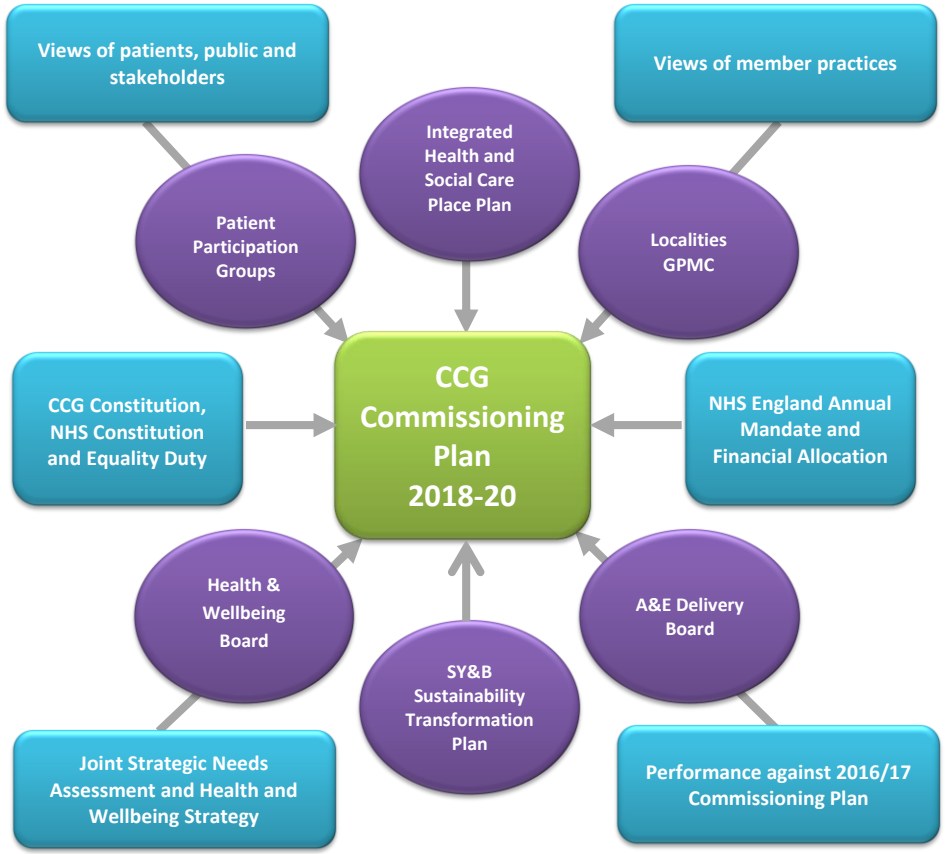
The JSNA, the Rotherham IH&SC Place Plan and H&WBS have been the key starting points for our plan, in addition to performance against the current Commissioning Plan and national planning documents.

Input from GP members, locality groups and GP Members Committee

The Commissioning Plan has then been drawn together from extensive dialogue the CCG executive has had with its member practices; directly from individual GPs, from locality groups and from the GPMC.

From the consultation we have confirmed that members are overall supportive of the direction of travel. Additionally the consultation identified two new priority areas of work, these were; explore how we can further support care homes and to explore the impact of secondary care prescribing on hospital discharges. These are identified with an * in the list below.

The full scope of work to be taken forward for each of the 12 clinical commissioning priorities is set out in section 9, this includes the 'must be dones' as part of the national planning expectations.



Recognising the breadth of work set out within our Plan, the Governing Body and Strategic Clinical Executive considered these further to identify the top 6 of highest priorities. These are identified in ***bold and italic*** below in the table that highlights some of the key areas of work.

Maternity and Children

- Ensure SEND (special educational needs and disability) joint commissioning strategy and action plan is delivered and embedded across all partners
- Implementation of the CAMHS (child and adolescent mental health services) Transformation Plan
- Deliver the 0 to19 healthy child pathway
- Transform Maternity Services

Clinical Referrals

- Review the Musculo-Skeletal (MSK) service and implement recommendations, including single point of access and 'Physio First'
- Implement Phase 2 clinical threshold and further consideration of health optimisation

Primary care

- Meet NHS England extended access requirements (access weekdays and Sat/Sun access)
- ***Implement all aspects of the Quality Contract***
- Waverley development (new practice by April 19)

Unscheduled Care

- Transform Rotherham Ambulatory Care
- Further develop the Escalation Management System
- ***Embed the new working model for Urgent and Emergency Care Centre***

Community Services

- ***Implementation of the Integrated Locality Model across Rotherham***
- ***Review of Re-ablement and Intermediate Care***
- Further develop the Care Co-ordination Centre
- *Development of a co-ordinated approach to care home support

Medicines Management

- Sustain position for Waste management and expand to care homes
- Implement electronic prescribing and electronic repeat prescribing
- Introduce the self-care initiative programme for a range of identified drugs
- *Support to secondary care prescribing to support discharge

Mental Health

- Continue implementation of dementia care in the community and continue roll-out the Dementia LES
- Continue to develop Ferns/Woodlands
- Continue to deliver Children and Young Peoples (CAMHS) Transformation Plan

Learning Disabilities

- Ensure the Rotherham 'at risk of admissions' process is in place (including C&YP / Autism

Continuing Healthcare (CHC)

- Continue to work jointly with RMBC to improved CHC services and implement a shortened assessment tool for CHC eligibility (adults and children)

End of Life Care

- Review capacity of palliative care provision across the Rotherham system

Cancer

- Continue to fully engage with MacMillan Living with Cancer and Beyond Programme
- ***Focus work on raising awareness /early diagnosis (new NICE guidelines) and two week wait***

Cross Cutting

- ***Implementation of the Rotherham Health Record***

Input from patients and the public

The 2018-20 Commissioning Plan, like previous plans, continues to build on strong foundations of engagement. It has been informed through engagement in our workstreams and projects throughout the year. This is demonstrated within individual sections of the plan (section 9) which show where engagement has informed our work, and how we are acting on what people have told us. See section 6.4 for information on our patient and public engagement work.

The Patient Participation Group held a focus meeting to consider our draft commissioning intentions and provided feedback on several specific areas, the feedback has been used to inform our plans.

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 2017
- 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

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

How to feedback comments on the CCG Commissioning Plan

The CCG aims to improve services for patients, this can only be done on the basis of feedback from patients, public and clinician's, please send any comments on the plan or any other issue relating to the CCG to the following e-mail address rotherhamccg@rotherhamccg.nhs.uk. Or by post to: Rotherham CCG, Oak House, Moorhead Way, Bramley, Rotherham S66 1YY

Acknowledgement

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

8. How we identified our Clinical Commissioning Priorities

In reviewing the current Commissioning Plan the CCG consulted on the priorities within the plan to establish if they were still relevant and to understand any potential gaps. As set out in section 7, the range of people who took part in that consultation included the CCG Governing Body, Strategic Clinical Executive, GP Members Committee, all GP localities in addition to partners through the Integrated Care Partnership Place Board, Health Select Committee and Patient Participation Groups.

Through this extensive consultation it was established that twelve of the fifteen areas were still priorities for the CCG. Of the three remaining it was felt that **Specialised Services** is the remit of NHS England (see 3.6.1); **Joint Work, including Better Care Fund** is dealt with elsewhere in the Commissioning Plan (sections 3.6 and 5.3) and whilst **Child Sexual Exploitation**, is a definite priority for the CCG, it is covered within Section7.3.

In addition to seeking confirmation of clinical commissioning priorities, the consultation also focussed on the direction of travel for each of the priorities. The consultation document was developed from the current Commissioning Plan and feedback from a Governing Body /Strategic Clinical Executive focussed session at the start of the process.

The outcome of the consultation confirmed the direction of travel in the main but also identified areas for consideration by the Strategic Clinical Executive and the GP Members Committee. The two significant areas identified as needing a higher priority for the CCG were: support to Care Homes and understanding the impact of secondary care prescribing on delayed discharges and primary care. Both of these, along with other feedback received will be incorporated into the programmes of work for the relevant priority areas and are described further in section 9.

On the following pages we provide further detail for each of our twelve **Clinical Commissioning Priorities**, which are:

1. Maternity and Children
2. Clinical Referrals
3. Primary Care
4. Unscheduled Care
5. Community Services
6. Yorkshire Ambulance Services and Patient Transport Services
7. Medicines Management
8. Mental Health
9. Learning Disabilities
10. Cancer
11. Continuing Healthcare and Funded Nursing Care
12. End of Life Care

8.1. Linking our Clinical Commissioning Priorities

In the table below we have identified the links between the CCG's Commissioning Plan and both the Health and Wellbeing Strategy and the Integrated Care Partnership Place Plan. This aim is to show the coalescence of many of the priorities within the three documents.

Health and Wellbeing Strategy Aims	Integrated Health and Social Care Place Plan	CCG Commissioning Plan
1. All children get the best start in life and go on to achieve their potential	Transformation 1: Children and Young People	Section 2.9: Maternity and Children Section 2.8: Primary Care
2. All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life (includes autism and learning disabilities)	Transformation 4 & 5: Mental Health and Learning Disabilities	Section 2.6: Mental Health Section 2.7: Learning Disabilities Section 2.8: Primary Care
3.All Rotherham people live well for longer (includes integrated commissioning, self- management/independence)	Transformation 2 & 3: Urgent and Community	Section 2.1: Unscheduled Care Section 2.2: Community Services Section 2.8: Primary Care
4. All Rotherham people live in healthy, safe and resilient communities		

9. CCG Clinical Commissioning Priorities

In this section of our Commissioning Plan we provide detail information for each of the 12 Clinical Commissioning Priorities.

9.1. Maternity and Children

Lead GP: Jason Page
Lead Officer: Mark Chambers/Paul Theaker

Why this is a strategic priority

Child health and maternity provision covers a range of preventative, routine and urgent care services or interventions within primary care, community or hospital settings, as well as integrated pathways for disabled children and young people or those with special educational needs aged between 0-25.

Supporting children to get the best start in life is a key priority for the CCG and the Health and Wellbeing Board. The 2015/16 Director of Public Health Annual Report describes children and young people's health through a life-course approach, from pregnancy and birth, through school years into young adulthood. It describes the work which is being done to address the inequalities in health experienced in Rotherham and suggests what could be done to make further improvements.

The development of children's health will impact greatly on the future provision of health services and the 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.

It is a requirement that health commissioning for children involves close partnership and joint working between the CCG and Rotherham Metropolitan Borough Council (RMBC) in order to better identify and meet the needs of children and young people; and ensuring that the voice of the child, young person and parent is fully engaged in the commissioning process.

The Rotherham Place Plan focuses on people and places rather than organisations to deliver services more effectively for children, young people and adults in their neighbourhood. It recognises the benefits of prevention and early intervention and of bringing pathways together and doing things once as a system across health, social care, schools and communities.

There are six service priorities within the Children's Transformation Programme, part of the Rotherham Place Plan, which seek to deliver the revised aim for children and young people within the refreshed Health and Wellbeing Strategy. Aim 1 of the Health and Wellbeing Strategy – All children get the best start in life and go on to achieve their potential – focuses on:

- Ensuring every child gets the best start in life (pre-conception to age 3)
- Improving health and wellbeing outcomes for children and young people through integrated commissioning and service delivery
- Reducing the number of children who experience neglect or abuse
- Ensuring all young people are ready for the world of work

The aims of the Health and Wellbeing Strategy for children and young people will be delivered through the Children's Transformation Programme:

- Child and Adolescent Mental Health Service (CAMHS) transformation
- An effective early help pathway through the review and improvement of the existing 0 – 19 offer
- Integration of acute and community services.
- A revised action plan for Special Educational Needs and Disabilities (SEND)
- Implement "Signs of Safety" for children and young people across all partner organisations
- Improved planning for transition and preparing for adulthood

What we achieved in our 2015-18 plan

- Work to redesign children's acute and community services to support 'Care Closer to Home' work stream.
- Completed gap analysis and 'next steps' against national maternity review 'Better Births'
- Engaged at South Yorkshire and Bassetlaw level
- Local Maternity System Group in place, along with task and finish groups
- Revised draft service specification for maternity services
- SEND joint commissioning strategy in place and action plan monitored at monthly SEND Joint Commissioning Group meetings
- Established a SEND Hub at Kimberworth Place in Rotherham
- Established a Designated Clinical Officer post for SEND
- A number of Children and Young People's pathways have been revised and associated parent/carer leaflets developed to support Care Closer to Home
- Child and Adolescent Mental Health Services (CAMHS) Section 75 Agreement between the CCG and RMBC.
- "Whole School Approach" pilot in schools
- Funding of the Rotherham Parent and Carers Forum to enable co-production and evaluation of services.

Commissioning intentions for 2018-20

The Children and Young People's Transformation Programme is one of five transformation workstreams and one of three transformational groups within the Rotherham Place Plan. It identifies six priorities for children and young people across the integrated care system which will form the main commissioning intentions through to 2020 at a strategic and operational level.

Priority 1: Implementation of the CAMHS Transformation Plan, including Section 75 (Place Plan) - The formal partnership (Section 75) agreement between the CCG and RMBC provides the opportunity to build on the direction of travel towards greater integration of CAMHS services. This priority will review other services at lower level CAMHS, specifically in schools and linked to social and emotional mental health needs, which may benefit from inclusion in the Section 75 agreement to strengthen the whole service approach and value for money. A clear pathway will be established and any identified gaps brought to the Children and Young People's Transformation and Partnership Group to engage key partners and determine a timeline to assess and meet any areas identified for improvement.

The recently published Green Paper – Transforming Children and Young People's Mental Health Provision will be explored through the CAMHS Strategy and Partnership Group for opportunities to be a regional pilot.

Priority 2: Delivery of 0–19 healthy child pathways (Place Plan) - To oversee and work in partnership with the Council (Lead Commissioner) and TRFT (Provider) in the delivery of service improvements within the Service Improvement Forum Action Plan. Ensure the service is meeting obligations to care leavers and SEND (i.e. up to 25 years).
RMBC's Public Health service re-commissioned the 0–19 public health nursing services and the new contract commenced on 1st April 2017 (which includes school nursing, health visiting, family nurse partnership and oral health promotion). Management of the contract now sits with the Council's Children's Commissioning Team alongside other former Public Health contracts including sexual health and substance misuse services for young people, which should enable further efficiencies and integration with health services including a review of special school and school nursing provision.

Priority 3: Children's Acute and Community Integration (Place Plan) - A whole family approach which will have strong links into the Early Help services commissioned and provided by RMBC. This is likely to have/need all age intervention to address whole households/families. This work stream will overlap with Priority 2 as the offer to 0 – 25 is considered.

Embed the new specification for Children's Community Nursing and Specialist Nursing to support the 'Care Closer to Home' workstream:

- Enhance the performance and quality monitoring arrangements for the services outlined within the service specification.
- Review the Child Development Centre service model and develop its' service specification.

Priority 4: The SEND Action Plan and Joint Commissioning (Place Plan) - The SEND priority is the most embedded in the children's transformation programme. A revised joint action plan focuses on continuing to ensure that at local level SEND statutory duties are delivered in line with the Children and Families Act (2014) and the SEND Code of Practice Statutory Guidance (2015). Recent SEND reforms focused on themes which now form the foundations upon which services are commissioned including: working towards clearly defined outcomes for the individual; co-production; and joint commissioning.

Ongoing actions which will continue into 2018/19:

- Co-ordinated assessments and provision of education health and care plans
- Working towards clearly defined outcomes
- Engagement and participation of parents and young people (co-production)
- Developing a 'Local Offer' of support
- Joint commissioning of provision – streamlined approach
- Personalisation and Personal Health Budgets
- Transition to Adulthood (Priority 6)

Further developments will include: a consistent performance management framework across partners and in particular the CCG and RMBC; budget sustainability including reviewing options for pooling budgets; sufficiency of provision in Rotherham; and preparing for adulthood (linked to Priority 6 below).

Priority 5: Implement 'Signs of Safety' for Children and Young People across partner organisations (Place Plan) - The 'Signs of Safety' operating model will be rolled out across the partnership to ensure it is understood across the place workforce and is used to work with families to identify and respond to risk when working with children, young people and families.

We will identify how a single operating model might enable all-age models in the future and how a consistent approach to risk and the management of risk across the system can be implemented.

Priority 6: Transitions and Preparing for Adulthood (Place Plan) - We will ensure that effective and appropriate arrangements are in place to meet the needs of young people with physical complex health needs and/or learning disabilities and/or mental health problems aged between 14 and 25 as they move from childhood to adulthood, we will do this by:

- Improving the graduated response and education, health and care plan (EHCP) provision within post 16 colleges to improve their offer (to include training for the workforce)
- Exploring links with Health Adult Services to better meet needs
- Increasing parents and young people involvement in the development of provision including promotion and increase of self-advocacy.
- Progression, skills development and sustained employment.

Cross cutting priority – Voice of the Child (Place Plan) - Across all the priorities there is a commitment to the real involvement of children and young people in decisions about their services. It means more than seeking their views, which could just mean the child or young person saying what they want, rather than being really involved in what happens.

It's what matters to people as opposed to what's the matter with them. Children and young people will have the opportunity to express their view(s) prior to sign off of the priorities and play an ongoing role in the delivery of the children's transformation programme.

Transforming Maternity Services – the Local Maternity System

The Children's and Maternity integrated care work stream within South Yorkshire and Bassetlaw is leading the development of the 'Local Maternity System' (LMS), which is the vehicle for the development and delivery of our plan to respond to 'Better Births', and which will have transformed local maternity services by the end of 2020/21.

The LMS is established and continuing to develop. A current working vision and four task and finish groups have been established, which are as follows:

- Clinical Governance Task and Finish Group
- Quality Measures Task and Finish Group
- Local Maternity Offer Task and Finish Group
- Maternity Voices Partnership Task and Finish Group

Quality Improvements

A number of current service specifications are being reviewed and new key performance indicators will be agreed.

Paediatric care pathways and 'top tips' for GPs will continue to be revised and developed to improve the continuity and co-ordination of care, clinical effectiveness and communication, giving a better experience of care for the patient.

Listening to children, young people and their families/carers and new mothers and their families, will ensure that commissioning for children's and maternity services is aligned to patient needs which is in line with RMBC priorities and meets new policy changes.

Addressing Inequalities

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

Smoking in pregnancy is known to increase the risk of a baby having a low birth weight. High rates of smoking in pregnancy are a particular concern in Rotherham affecting 18.3% of maternities compared to 11.4% in England. Similarly the infant mortality rate is 5.1 per 1,000 births, compared to England average of 4.0. The breastfeeding initiation rate of is one of the lowest in the region and this poor level of breastfeeding is associated with childhood obesity.

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

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

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

Patient Engagement – that has taken place or is planned

There is on-going consultation with parents and carers in relation to SEND at regular drop-in sessions and events. There is also Rotherham Parent Forum representation at key strategic meetings, for example, the SEND Joint Commissioning Group. The Rotherham Parents Forum has undertaken an exercise to ascertain the views of parents/carers in relation to the health elements of SEND provision and this has helped inform future SEND commissioning priorities.

There is a strong patient engagement element to developing the 'Local Maternity System/Better Births' and 'Forging Families' are leading on the engagement of pre and post-natal mothers in the process.

Key Milestones

Place Plan priorities (priorities 1-6):

- Develop a Children and Young People's Partnership and Transformation Board Place Plan priorities template, including associated outcomes, milestones and KPIs - *Q1*
- Ensure delivery against the Place Plan priorities, through effective on-going performance monitoring of priorities - *Q1-4*
- Develop new community services specifications for children's community nursing and specialist nurses to support the Care Closer to Home work-stream (priority 3) – *Q4*

Transforming Maternity Services:

- Engage at SY&B level to support strategic direction for the national requirements around maternity (Better Births) – *Q4*

Key Performance Indicators

Place Plan priorities (priorities 1-6):

- Emergency admissions for children with lower respiratory tract infections (Health Outcomes)
- Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19's (Health Outcomes)
- Percentage of children aged 10-11 classified as overweight or obese *(IAF 102a)*

Transforming Maternity Services:

- Reduce the number of neonatal mortality and still births *(IAF 125a)*
- Maternal smoking at delivery *(IAF 125d)*
- Improve Women's experience of maternity services (national maternity services survey) *(IAF 125b)*

9.2. Clinical Referrals

Lead GP: Phil Birks
Lead Officer: Janet Sinclair-Pinder

Why this is a strategic priority

One of the nine 'must dos' for every local system (Five Year Forward View), is improvement against, and maintenance of the NHS Constitution standard that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice. The NHS is experiencing significant pressure and unprecedented levels of demand. Around 1.5m patients are referred for elective consultant led treatment each month. The average annual growth in GP referrals between 2009/10 and 2014/15 was 3.9%, growth in 2015/16 compared to 2014/15 was 5.4%. For the same period, other referrals, which include consultant to consultant referrals grew by 6.7%. There is clearly a significant need for the NHS to manage the demand that flows into hospitals by ensuring that only the most appropriate cases are referred for face to face consultation. There is also evidence to suggest that a referral to hospital is not always necessary.

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. Keeping within affordable limits requires a step change in the efficiency of planned care, in some cases we wish to increase planned 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 none 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.

Rotherham is now working with the South Yorkshire and Bassetlaw Integrated Care System (ICS) and by 2025 the aims of the ICS are:

- Healthy life expectancy greater than the national average - upper decile outcomes for those receiving health and care interventions
- A difference in healthy life expectancy lower than the national average between a) the most and least deprived sections of our population, and b) those with mental and physical health disorders
- Equity of access to health and social care services for all citizens
- Waiting times for Child and Adolescent Mental Health Services (CAMHS) lower than the national average
- A balance of expenditure against the total resources available to our health and care system

What we have achieved in our 2015-18 plan

- Evaluated thresholds and effectiveness of certain procedures, where there is limited clinical outcome, undertaken in secondary care and consider future commissioning options
- Continued focus on reducing unnecessary hospital attendance and follow-up to align with national average
- Continued to improve care pathways and provide top tips advice to clinicians about planned and urgent referrals
- Evaluated procedures with limited clinical outcome undertaken and Phase 1 clinical thresholds implemented
- Continued constructive approach to reducing follow-ups to peer average levels
- Extension of virtual clinics from haematology to other areas such as endocrinology
- Developed sepia portal to enable clinicians to access patient information from SystmOne, Meditech
- Diabetes care model reviewed and implemented, focussing on the Super Six model of care
- Additional education for patients in primary care
- Quality contract to support managing people with diabetes in the community

Commissioning intentions for 2018-20

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

- Implementation across SY&B CCGs and NHS Trusts of the Commissioning for Outcomes Policy. This policy includes Phase 1 and 2 Clinical Thresholds, and incorporates the Plastics, Infertility, and procedures not routinely commissioned policies. Continued emphasis on reducing follow-ups as Phase 3 of the clinical threshold approach.
- Referral analysis, alternative ways of working and two way communication with all clinicians
  - Specialty specific discussion of areas identified by benchmarking or changing trends.
  - GP communication/education; bite size newsletter, protected learning time, top tips, GP peer led visits.
  - Communication with TRFT clinicians
  - Extension of one stop services and virtual clinics
- Care pathways (priority areas to be jointly agreed)
- Explore long term potential for radical changes to specific elective pathways

- Explore different models of delivery for specific pathways, possible examples being single point of access for Musculo-Skeletal (MSK)/Physio/Trauma and Orthopaedics
- Consider commissioning options to keep activity within affordable levels
- Ensure focus on 'Right Care' outcomes
- Review MSK service and implementation of recommendations, including single point of access and Physio First. Embed the new MSK CATS telephone assessment Service
- Continue to monitor diabetes care to ensure improvement in outcomes is being delivered.

Quality Improvements

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

Addressing Inequalities

Unnecessary variation will be reduced 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.

Patient Engagement – that has taken place or is planned

- Pilot for Physio First completed April 2017-used patient experience data and feedback and evaluated positively
- Use of patient feedback and experience
- Shared care protocols developed – patients followed up by GP (Care Closer to Home)
- Patient Participation Group discussions and public engagement at the CCG Annual General Meeting

Key Milestones

- Implement Phase 2 of clinical thresholds – Q4
- Delivery of agreed audit programme and implementation of recommendations for clinical thresholds – Q4
- Review of MSK service and implementation of recommendations which includes a Single Point of Access and Physiotherapy First – Q4

Key Performance Indicators

- Patients waiting 18 weeks or less from referral to hospital treatment *(IAF 129a)*
- Contain growth in elective activity (contractual)
- Achievement of outpatient follow up ratios (contractual)

9.3. Primary Care

Lead GP: Avanthi Gunasekera
Lead Officer: Jacqui Tufnell

Why this is a strategic priority

Primary care is paramount to delivery of the Five Year Forward View, the General Practice Forward View and central to the achievement of both the Rotherham Place Plan and the South Yorkshire and Bassetlaw Sustainability and Transformation Plan. There is an expectation that General Practice adapts to manage the increasing demand on their services and it is becoming increasingly important for practices to collaborate more to meet these demands.

Within Rotherham there are currently 31 practices with a high likelihood that within the next year this will reduce even further to 29 practices as it is recognised that 'at scale' improves sustainability. Since the launch of the General Practice Forward View, Rotherham has responded with a strategy to deliver this locally, at pace to provide stability for practices and the wider healthcare system.

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 several 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 keen to work with us. Together we came up with the Rotherham model of social prescribing.

What we achieved in our 2015-18 plan

- Improved equity across practices through development and implementation of the Quality Contract
- Optimising care pathways
- Care Home alignment with GP practices
- We have improved extended access to ensure all patients have access to evening and weekend appointments for routine and urgent care
- We have implemented telehealth technology which enables patients with long term conditions to monitor their condition and report to the practice
- All practices have completed 'Productive General Practice' providing support on areas they can make changes to improve their efficiency and productivity
- We have increased the number of e-referrals made instead of paper referrals
- New diabetes pathway developed and implemented to support primary care
- Care navigation has been rolled out to 10 practices
- Remote consultation rolled out to all practices therefore practices are able to link with care homes patients
- Developed workforce plan to ensure sustainability, capacity and appropriate skills of primary care workforce
- Successful implementation of Rotherham model of social prescribing to support people with long term conditions and the over 75 year olds

Commissioning intentions for 2018-20

Implement and monitor all aspects of the Quality Contract to ensure the intended quality improvements are achieved – The Quality Contract was developed in 2015 in response to a national review of general practice funding. The aim is to define good quality care more clearly in general practice and improve consistency along with mandating services to ensure the whole Rotherham population is able to access all services. The standards include access, cancer, mental health and long term conditions.

Implement Care Navigation across primary care (subject to evaluation) further 10 practices in 2017/18 and final 11 by 2018/19 – Care Navigation involves identifying services which are either self-referral or can be accessed without the requirement to see a GP. Training is provided to practice staff to use agreed criteria to ensure patients see the right person, first time. Patients are currently being navigated to a number of services including physiotherapy, pharmacy and mental health.

Meet NHS England extended access requirements – extended access weekdays, e-consultation and Saturday/Sunday access – A recent patient survey in relation to access received over 1700 responses. Work is taking place to address the issues identified in relation to improving access within normal opening hours and the availability of services at weekends.

Roll out **evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019. All Rotherham population have access to evening and weekend GP appointments.**

Waverley development – This project involves the commissioning of a new practice by April 2019. Waverley is a new housing development within Rotherham and a new shopping centre has now received planning permission which will also incorporate a new medical centre.

Achieve 100% e-referrals to consultant led services by October 2018 – Practices are receiving support to train staff to refer to secondary care electronically to enable patient choice and ensure there are not duplicate systems within secondary care

Supporting at scale working to improve the sustainability of practices - Support has been provided to enable the development of a GP Federation and facilitate the development of localities (groups of practices working together and more widely with the wider system e.g. community, social care, mental health, voluntary services. Creating a clear plan for the future of GP estate within Rotherham – the CCG has already developed a strategic estates plan however it is considered that a refresh of this is required in light of the work taking place as a wider system to support the appropriate movement of work from secondary to primary care subject to sufficient and appropriate staffing being in place.

Social Prescribing – continue to support the social prescribing project and look at other opportunities for expansion, such as the three month pilot for people with personal health budgets, continued development within the mental health service and the alcohol liaison team.

Extended Summary Care Record (SCR) - Practices have been asked to discuss with patients on their frailty register to add additional information on their Summary Care Record. The CCG are supporting practices to identify further cohorts of patients who would benefit from enriched SCR (cross border, dementia, LD) and to gain explicit consent from patient. The CCG have provided practices with guidance (further training if required) and are reviewing progress to meet the target.

Quality Improvements

Care home alignment is the rationalisation of practices to care homes to improve communication between homes and practices and provide the basis for care to be delivered in an efficient and proactive way. The CCGs approach to primary care quality including peer visits, supporting protected learning time and practice manager meetings is described in Section 6.1.

The secondary to primary care local enhanced service will allow patients to be treated locally at their GP practice. Examples include the minor dermatology procedures and joint injections are now being provided by the majority of GP practices minimising the requirement to attend hospital for these procedures.

The CCG has worked with GPs to develop quality standards in relation to primary care to ensure that quality improvement is continuous and a focus within all practices. There is both a primary care dashboard and quality contract specific dashboard which enables practices to focus on continuous improvement. The CCG hosts quarterly quality contract meetings with practices to discuss performance within their clustered population groups to address issues.

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

Addressing Inequalities

- Ensuring universal access to extended access seven days per week by ensuring patients are notified of the availability when contacting the practices/booking online
- Ensuring universal coverage of service provision by increasing the 'basket' of services which are required not a choice of practices.
- Case management promotes prevention, early intervention and self-care and is undertaken by all practices. Patients are selected by clinical need and this is linked to social prescribing which addresses health inequalities.
- Care home alignment covers all care homes for elderly and EMI (Elderly Mentally Impaired).
- Local Enhanced Services are created wherever possible to treat patients closer to home and reduce the requirement to attend secondary care.
- Closer working with public health to prevent ill health.
- Social Prescribing

Patient Engagement – that has taken place or is planned

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

The primary care team have engaged patients and carers via the Annual General Meetings each year event and through the Rotherham Patient Participation Group Network. A further primary care specific event took place in November 2016 to provide a more in-depth opportunity to participate in planning the delivery of the strategy alongside ensuring we are meeting the needs of patients.

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

Key Milestones

- Primary Care Quality Contract – implement and monitor five standards for 2017/18 – Q4
- Primary Care Quality Contract – develop and implement performance monitoring arrangements – Q4
- General Practice Forward View – provide training and implement care navigation in remaining GP practices (who sign up) – Q2
- Primary Care Self-Care – telehealth to be utilised in all practices – Q4
- Plan and implement access arrangements to meet NHS England delivery requirements of all population receiving extended access weekday evening and Saturday/Sunday (132 hours) by October 2018 – Q3

Key Performance Indicators

- Patient experience of GP services *(IAF 128b)*
- Primary Care access – percentage of registered population offered full extended access *(IAF 128c)*
- Primary Care Workforce (FTE per 1,000 weighted patients by CCG) *(IAF 128d)*
- Utilisation of the NHS e-referral service to enable choice at first routine elective referral *(IAF 144a)*
- Diabetes patients that have achieved all the NICE recommended treatment targets. Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children *(IAF103a)*

9.4. Unscheduled Care

Lead GP: David Clitherow
Lead Officer: Jacqui Tufnell

Why this is a strategic priority

The NHS Five Year Forward View states that the NHS provides around 110 million urgent same-day patient contacts each year. Around 85 million of these are urgent GP appointments, and the rest are A&E or minor injuries-type visits. Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system. They turn to A&E because it seems like the best or only option. The rising pressures on A&E services also stem from continued growth in levels of emergency admissions and from delayed transfers of care when patients are fit to leave hospital.

Local health and social care partners are required to transform current practice to ensure appropriate patient flow. We need to redesign the system to ensure people are not 'stuck' in hospital while waiting for delayed community health and social care.

We need to improve the processes to deliver more timely hand-offs between A&E clinicians and acute physicians, utilising best practice models such as 'discharge to assess', and 'trusted assessor' arrangements and developing seven day discharge capabilities.

Nationally we know there is a need to improve specialist mental health care in emergency departments to provide 24-hour mental health teams to support the growing number of patients requiring these services.

Rotherham's level of emergency admissions is in line with comparable CCGs. There are areas however, such as respiratory, where Rotherham is an outlier and where the variation cannot be fully explained by the higher than average levels of morbidity in the population.

It is our intention to contain emergency admissions. We are seeing a growth in emergency admissions this year compared to last but this is difficult to quantify due to recording issues. It is predicted that the increase in emergency admissions equates to 1 to 2%. Whilst hospital admission may seem like the safest and easiest way of dealing with an emergency, for many people high quality care at home or in a community setting is a better, safer option.

A cornerstone of our strategy is to commission alternative services to hospital admission, and to treat people with the same needs more consistently and deal with more problems, by offering same day emergency care, (ambulatory care), 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 2.5). The Better Care Fund is described in section 3.6.

What we achieved in our 2015-18 plan

- Delivered the Urgent and Emergency Care Centre business case;
  - Delivering of the capital scheme – centre opened July 2017
  - New model of working for U&ECC implemented including streaming into primary care
  - New IT model for U&ECC embedded
  - Block contract to mitigate the CCGs financial risk
  - Care UK contract novated early
  - Co-located the Care Co-ordination Centre onto the top floor of the UECC
- Agreement to integrate acute alcohol services with adult mental health liaison as part of the Core 24 compliance
- Implemented Escalation Management System (EMS) – to alert professionals to escalation issues across the Health and Social Care System
- Fully engaged with the South Yorkshire wide Urgent and Emergency Care network
- Piloted direct booking into GP out of ours services by NHS 111
- Expanded 7 Day Services
- Replacement risk stratification tool is in place to support the reduction of emergency admissions through GP led Case Management programme

- Continued to expand the GP led Case Management Programme of patients at highest risk of admission to hospital
- Aligned GP practices with care homes to provide improved continuity of care
- Implemented extended access hubs within primary care to provide full population coverage 6.30-8pm Monday to Friday and also availability on Saturday and Sunday mornings.
- Care navigation is now in place in 18 GP practices to ensure patients are navigated to the right service at the right time
- Front-door clinical streaming is now part of the model in the UECC
- Good practice for appropriate patient flow has been adopted
- 85% of all assessments for continuing health care funding now take place out of hospital in the community setting

Commissioning intentions for 2018-20

- **Deliver actions to meeting the 95% A&E 4 hour target** – An agreed Recovery Plan is in place that will be monitored throughout 2018-19.
- **Implement the Integrated Urgent Care (IUC) Service Specification -** To support the implementation of the national IUC specification, Yorkshire and Humber has developed a 111/ Integrated Urgent Care Specification which sets out the direction of travel for integrated urgent care across Yorkshire and Humber. We will support the implementation of this by:

- **Introducing NHS 111 On-line -** We have signed up to Phase 2 of a national programme to support service users to have digital access to urgent care services through the implementation of 111 online . This will provide service users with an alternative means for accessing health care services and information, initially out of hours. We will launch NHS 111 online in February 2018.
- **Supporting the development of consult and complete model of care by -** Direct appointment booking from NHS 111 into primary care during core hours by March - May 2018
- Direct booking into primary care during extended hours by March 2018
- Increase the number of directly bookable appointments for primary care out of hours – on-going during 2018
- Review the need to directly book appointments into the minors stream of the UECC – September 2018

- **Continuing work to achieve the national 'must dos' for A&E and urgent care** as follows:
  - Hospitals, primary and community care and local councils should also work together to ensure people are not stuck in hospital while waiting for **delayed community health and social care**. They need to:
    - ensure that the extra £1 billion provided by the Chancellor for investment in adult social care in the March budget is used in part to reduce delayed transfers of care (DTOC), thereby **helping to free up 2000-3000 acute hospital beds** – the equivalent of opening five new hospitals – and regularly publish the progress being made in this regard). As referred to in more detail below, this has resulted in an improvement in the DTOC level from 4.1% in September 2017 to 1.8% in October and 2.4% in November 2017. Early indication of December figures is that DTOC will remain under the 3.5% target.
  - Enhance **NHS 111** by increasing from 22% to 30%+ the proportion of 111 calls receiving clinical assessment by March 2018, so that only patients who genuinely need to attend A&E or use the ambulance service are advised to do this. GP out of hours and 111 services will increasingly be combined. By 2019, NHS 111 will be able to book people into urgent face to face appointments where this is needed. This work is ongoing with Yorkshire Ambulance Service
  - NHS 111 online will start during 2017, allowing people to enter specific symptoms and receive tailored advice on management. This will commence in Rotherham in February 2018.
  - Strengthen support to **care homes** to ensure they have direct access to clinical advice, including appropriate on-site assessment. GPs have been aligned to care homes, a care homes service is in place and the integrated rapid response team support care homes.
- **Transform Rotherham's Ambulatory Care** - Nationally 1 in 5 hospital admissions could have been avoided by better care plans in the community for Ambulatory Care Sensitive Conditions. We want to ensure patients with ambulatory care sensitive conditions are treated and discharged on the same day, not admitted into hospital overnight. To facilitate this we will:
  - Undertake an Ambulatory Care Review of existing provision and gap analysis against national best practice by April- May 2018
  - Develop a service specification for a new ambulatory care service and commission this service by July 2018 to embed in time for winter pressures.
- **Prioritise outcomes of acute hospital services review -** A review of all hospital services across South Yorkshire and Bassetlaw is currently underway and is expected to report in Spring 2018. The aim of the review is to ensure the system is sustainable and we will ensure this work is prioritised once reported.
- Continue to work towards integrating the acute alcohol service and mental health liaison service to become **Core 24** compliant (See Section 2.8 Mental Health)
- **Continued development of the Escalation Management System** including support for the implementation across South Yorkshire and Bassetlaw (SYB) Systems by March 2018.
- **Continued promotion of self-care advice for patients** and development of our behavioural change campaign.

- **Review the Urgent and Emergency Care Centre -** The UECC opened its doors in July 2017 to deliver a new model of care. We want to review the implementation of the model of care and ensure delivery of our 2020 vision. We will undertake a review of the service in June/July, where we will have access to 12 months of data.
- **Digital Technology -** In other sectors of the health care system technology is being utilised to support better management of patients who experience unplanned care. During 2018/19 we will explore new digital ways to promote remote patient management and reduce time spent waiting in hospital.

Quality Improvements

Escalation Management System - A&E Delivery Board agreed to adopt an Escalation Management System (EMS) which responds to and reflects pressures within the local health economy for last year's winter planning (2016/17). It sets an escalation level for Rotherham Foundation Trust (Acute and Community, OOHs), YAS (local indicators), Social Care and Mental Health and provides visibility to partners on the pressures facing the organisations. The system is capable of alerting staff via email or text message when the escalation level changes. The four escalation levels that will operate throughout the year, have been aligned to the Opel Levels required by NHSE, this allows the system to respond proactively to increasing escalation in any part of the system and ensure collective actions are agreed to quickly deescalate.

Reduced DTOC - The current DTOC position in Rotherham (November 2017) is under the National Target of 3.5%. Rotherham has successfully reduced the DTOC levels from 4.1% in September 2017 to 1.8 in October and 2.4 in November 2017. Early indication of December figures is that DTOC will remain under the 3.5% target. Significant work has already taken place to integrate the discharge functions (health and social care) particularly for complex patients in the hospital. Early discharge planning and a focus on 'home first' as the principle ethos for supporting people to remain independent and reduce reliance on services is essential. This process should start in the emergency department prior to an admission. Support such as the integrated frailty team must link closely with discharge teams to understand the most appropriate support in the community to prevent, reduce or delay need for on-going services.

Addressing Inequalities

The nature of commissioning and delivering urgent care services provides challenges in terms of addressing health inequalities. We work closely with providers to ensure their service delivery is equitable.

Patient Engagement – that has taken place or is planned

In relation to the **Urgent and Emergency Care Centre** (UECC) during the four year transformational scheme, a number of events were held with the public including service user groups to both inform and share progress on the scheme. Engagement followed the whole project management process from the design of the build to the simulation events to test the model. Over 70 members of the public supported this event and feedback received was used to shape the service model design. During the later stages of the scheme regular updates were provided to the Patient Participation Groups (PPG), and their advice taken on how to communicate the changes being made to the public.

In preparation for the opening of the UECC, a workshop attended by nursing, clinical, operational and multi-agency colleagues was delivered in May 2017. The audience received a briefing in relation to revised Major Incident, Chemical, Biological, Radiological, Nuclear and Hazardous Materials (CBRN/HAZMAT), Lockdown and Business Continuity emergency plans.

In June, exercises Neutralise and Systematic, together involving up to 200 participants including volunteers and multi-agency partners were held on separate dates within the UECC to validate the revised emergency plans. Both exercises were live play simulations of the chemical and mass casualty incidents enabling UECC and operational staff to experience how they would manage the response and subsequent recovery from those incidents.

Before the centre was opened, we invited the Patient Participation Groups to attend an open day where they were taken on a tour around the new centre to see how the plans they had shaped played out in practice. The feedback was very positive, for example: *"I was very impressed by the new centre. It was obvious that a lot of thought and planning had gone into the design. I felt that there was more privacy for patients especially the glass sliding doors on the cubical. I can see it working very well as patients will have a quicker triage and treatment. A big thank you to all the staff who gave us a guided tour. It is good that for once Rotherham is leading the way in health care for the future."*

Now the service is operational, feedback on the service will be via the friends and family test and we continue to ask about service model delivery via the PPG's.
With regard to **primary care access**, a survey was distributed in November 2017 via various methods to seek as wide a view as feasible regarding how services could be improved. Over 1700 responses were received and these views are being utilised to shape how these services should look in future.

With regard to Community Service Integration Projects significant engagement has been undertaken with key stakeholders, staff and patient/carers over 2016-17 to date across a range of priority actions within the place plan including;

- Stakeholder modelling workshop
- Stand at the Rotherham Show
- Workshop held at Voluntary Action Rotherham with providers
- Staff workshop on integration and what good looks like
- Integrated discharge team engagement within patients and staff

There is also an engagement strategy and plan in relation to the Integrated Locality Pilot. This has resulted in significant engagement work throughout the duration of the pilot, which has helped shape and inform developments. The engagement plan will be completed upon the conclusion of the pilot, with the outcomes contributing to the final evaluation. This will inform the future implementation of the model.

Key Milestones

- Implementation of directly bookable GP appointments from NHS111 – Q3
- Implementation of revised pathways of care for ambulatory care – Q2
- Review of the UECC – Q2
- Provision of digital technology to support urgent care – Q4

Key Performance Indicators

- Contain growth in the number of non-elective admissions (*contractual target*)
- Contain growth in A&E attendances (*contractual target*)
- Achieve 4 hour access standard for A&E (*constitutional)*
- Inequality in unplanned hospitalisation for chronic ACSC and USCS *(IAF 106a)*

9.5. Community Services

Lead GP: David Clitherow
Lead Officer: Claire Smith

Why this is a strategic priority

The Five Year Forward View *sets a target of integrated health and social care services by 2020, it says that "Increasingly we need to manage systems–networks of care–not just organisations. Out-of- hospital care needs to become a much larger part of what the NHS does. And services need to be integrated around the patient."*

National and local commissioning has supported increased community care over recent years to improve patient outcomes, improve flow through the system and reduce cost. Health and social care transformation programmes include developing alternatives to entering services or hospital admission and facilitating discharge.

Historically, the Rotherham health community has been an outlier for emergency admissions to hospital, and whilst hospital admission may seem like the safest and easiest way of dealing with an emergency, for many people high quality care at home or in a community setting is a better, safer option. A cornerstone of our response is to commission alternative services to hospital admission, to treat people with the same needs more consistently and to deal with more problems by offering care at home or close to home.

Ultimately, we need to ensure that patients receive the support they need, in the appropriate setting and in a timely manner, and we need to ensure efficient use of services currently commissioned.

There has been substantial investment in additional community services over the past 2 years aimed at improving outcomes for service users and to prevent future increases in hospital admissions that would otherwise be expected from the demographic changes.

The CCG continues to make these important investments in community services from TRFT and other providers, such as the Rotherham Hospice, general practice (case management programme) and the voluntary sector including the social prescribing scheme. The table shows the spending profile of services commissioned to support vulnerable patients in their own home from hospital, some of these services are jointly commissioned through the Better Care Fund (BCF).

Table 1: Spending Profile for Community Services

Summary of Community Services	£'000
Long Term conditions, Intermediate Care and Urgent Care	14,446
Planned Care	6,227
Children and Young People's Services	3,877
CQUIN	612
Community Transformation including 7 day working	3,901
Total	**£29,063**

A focus on community services has helped to support other parts of the system (acute) in dealing with the increasing demand presenting at the front door. The BCF Plan 2017-19 and the Integrated Health and Social Care Place Plan will be instrumental in supporting further initiatives to reduce attendances.

Alongside this, the new UECC will stream patients at the front door to alternative appropriate provision. This model is reliant on robust community provision that is able to rapidly respond with an integrated approach to care.

The integration of services is underway and the main principles are:

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

What we achieved in the 2015-18 Plan

- Maintained investment in a range of providers for additional out of hospital investments, for example, social prescribing, community palliative care provision
- Integrated acute and community care pathways to support patients already at high risk of hospital admission identified through Case Management Programme
- The 'Village' locality pilot successfully established
- Evaluation of the 'Village' pilot commenced, full report January 2018
- Plans for Care Co-ordination Centre to expand to include mental health, with further analysis to take place to integrate social care in 2018
- Reconfiguration of community nursing services to serve GP practices, increased capacity and improved locality focus and quality of community nursing
- New integrated Rapid Response Service implemented merging functions of Fast Response and Out of Hours Community Nursing
- Review of intermediate care commenced
- Expansion of re-ablement offer (9 month pilot from November 2017) through iBCF by a maximum of 1000 hours per week to support home first approach
- Reconfiguration of Community Occupational Therapy service to provide resource in the Single Point of Access (SPA) for social care to support hospital avoidance and reliance on social care provision.

Commissioning intentions for 2018-20

The majority of work under this priority will be taken forward as a system through the Rotherham Place Plan. Through consultation on the Commissioning Plan, Care Homes were identified as an additional priority area.

Integrated Rapid Response (Place Plan)

Rapid Response is a recommended component of Intermediate Care/re-ablement pathways (NICE Guidelines; Intermediate Care including re-ablement, September 2017), although Rotherham has an Integrated Rapid Response service the service is currently unable to provide a response over 72 hours due to capacity and it is not closely aligned to re-ablement in order to prevent admission to hospital and long term care.

This priority therefore needs to be aligned with other Rotherham Place Plan Priorities such as the Integrated Point of Contact and the review and development of the re-ablement and intermediate care offer which NICE guidelines defines as including:

- Crisis response – to prevent an avoidable admission to hospital, offering an assessment and possibly short-term care (typically up to 48 hours but up to 7 days) if there is an urgent increase in health or social care need that can be safely managed at home.
- Home-based intermediate care – services are provided at home, by a team with different specialities (therapists, nurses, equipment, social care), that support rehabilitation and recovery and can assess for any ongoing needs including Continuing Health Care.
- Re-ablement – services are provided at home, mainly by social care professionals and specially trained social care staff. Enabling the re-learning of skills and promoting recovery to build confidence to live at home; and
- Bed-based intermediate care (which TRFT Integrated Rapid Response can currently spot purchase)

We will review the function of Rapid Response as part of the wider vision for a re-ablement and intermediate care offer based on the principle of 'Home First'. The team will deliver an urgent response service to people who are at risk of hospital admission or long term care but can be supported at home. They will also work in A&E and with the hospital discharge team to ensure timely and effective discharge home.

The team will be a multi-disciplinary team incorporating district nurses, advanced nurse practitioners, social workers, therapists mental health and re-ablement workers and will operate 24/7, 365 days/year, for a short period of time and to support where required an assessment of need.

Implementation of the Integrated Locality (Place Plan)

An evaluation of the Integrated Locality Pilot is currently underway and due to conclude in January 2018. Learning from this will help inform how we take the model forward across the seven localities in Rotherham. This will include the KPMG segmentation work and how we use this to shape the model. The scope of the priority includes the development of an integrated commissioning and operating model for community services.

The focus of this project is to develop an integrated health and social care model, incorporating mental health, Voluntary and Community Sector, community nursing, social care and GPs.

A jointly agreed implementation plan will be developed and monitored through the Community and Urgent Care Transformation Group. Information Governance is a key enabler in the achievement of this priority.

Care Co-ordination Centre (Place Plan)

In the first phase the Care Co-ordination Centre scope will be expanded to incorporate an urgent contact centre for people with mental health issues. In future there will be a core Multi-Disciplinary Team which will be physically integrated and/or virtually integrated (dependent on resource and appropriateness) to provide a critical mass for 24/7 cover and a breadth and depth of expertise for effective triage and resolution. There will be:

- streamlined leadership and management structures with specialist clinical/professional supervision
- a tiered support structure including:
  - non- qualified advisors to receive, data capture key data sets, process according to agreed algorithms, conduct quick assessments, provide advice, signpost and standard resolution such as amending care packages
  - specialist qualified staff for triage assessment, care co-ordination brief intervention, medical review/low level prescribing, introductory therapy groups.

There will be improvements in access to community health services through a comprehensive directory of services that are appropriately linked to NHS 111 for a 'consult to complete' response.

Re-ablement and Intermediate Care (Place Plan)
We want to develop a more integrated approach to the provision of intermediate care services to support more people to remain at home for longer.

Where a person has a stay in hospital the "Home First" option will be the preferred discharge pathway. We will rationalise the current community bed base and will re-invest in home-based, re-ablement, rehabilitation and recovery services.

A fully integrated team of health and social care professionals will provide a mix of community re-habilitation services, residential intermediate care and discharge to assess beds.

We will simplify hospital discharge and admission prevention pathways, with the adoption of the following pathways; Home-First, Rehab led intermediate care and Nurse led intermediate care.

Development of a Co-ordinated Approach to Care Home Support (Place Plan)
Much of the health care demand (and 20% of hospital admissions) come from care homes. There are also multiple teams and resources dedicated to care homes across health and social care; a care assessor, a care home support team, GP's linked to care homes, the hospice at home team. There are significant opportunities in bringing these teams together and working in a more joined up way.

We want to pursue the development of technology to link homes up better, use the CCC as their first point of contact, a model of trusted assessor and also have teams that can support care homes (like the Integrated Rapid Response or a more integrated care home team) to avoid them sending patients to hospital.

This priority will also include better end of life care planning to better improve this service and offer. The scope covers the work already underway through the Enhanced Health in Care Homes Framework such as development of electronic bed state tool and the Red Bag Scheme

Review of Community Services
The CCG and TRFT have undertaken a dedicated programme of work throughout 2017/18 to review activity and finance within the community contract on a service by service basis. The outcome of this review is currently being utilised to inform the activity plan for community services for 2018-19. Any adjustments proposed are subject to ratification both a financial and clinical perspective; however there will be no impact on the overall bottom line value of the contract.

Quality Improvements

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

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

Addressing Inequalities

A significant programme of work is underway supported by KPMG aiming to address the systematic problems caused by fragmentation of care, duplication of care and care not provided in the correct setting. The work places people at the heart of the new model of care. It will provide a system-wide view of clinical practice variation using benchmarking which will enable the CCG to identify unwarranted variation.

Patient Engagement – that has taken place or is planned

Significant engagement has been undertaken with key stakeholders, staff and patient/carers over 2016-17 to date across a range of priority actions within the place plan including; Stakeholder modelling workshop, stand at the Rotherham Show, workshop held at VAR with providers , staff workshop on integration and what good looks like and integrated discharge team engagement within patients and staff. There is also an engagement strategy and plan in relation to the Integrated Locality Pilot. This has resulted in significant engagement work throughout the duration of the pilot, which has helped shape and inform developments. The engagement plan will be complete upon the conclusion of the pilot, with the outcomes contributing to the final evaluation. This will inform the future roll out model.

Key Milestones

- Evaluation of the Integrated Locality Pilot to be completed – Q3
- Begin roll out of the Integrated Locality across the Borough – Q4
- Integration of Integrated Rapid Response with Mental Health and integration of Care Co-ordination Centre with Mental Health – Q3
- Completion of the Business Care for the Re-ablement Village – Q4

Key Performance Indicators

- Emergency re-admissions within 28 days of discharge from hospital (contractual)
- Delayed transfers of care from hospital *(IAF 127e)*
- Number of unscheduled admissions of patients > 65 years out of hours (contractual)
- Number of A&E attendances by care home residents (contractual)

9.6. YAS/Patient Transport Services

Lead GP: David Clitherow
Lead Officer: Julia Massey

Why this is a strategic priority

The National Ambulance Response Programme has driven improvements with the 999 service putting patient safety at the forefront of service deliver. The new categories for response ensure that the most appropriate resources is provided for each patient first time.

The delivery of a high quality Patient Transport Service (PTS) is key to supporting health services across Rotherham. The newly commissioned PTS service supports patient flow through the acute trusts including attendance at out- patient clinics and timely discharge transport home.

What we achieved in the 2015-18 Plan

- Continued to work with partners across the Yorkshire and Humber Footprint
- Continued to work with partners at a South Yorkshire and Bassetlaw level on non urgent patient transport services
- Implemented 'see and treat' in ambulances (safe and effective mobile healthcare)
- Implemented Urgent Care Practitioner scheme to reduce admissions and conveyance to hospital
- Introduced clinical triage for 999/NHS111
- Re-procured all patient transport including renal
- Continued to prioritise Paramedic Pathfinder approach to improve non conveyance and increase the number of patients referred to alternative levels of care.
- Improved hospital pre-alert and treatment plans for patients with suspected sepsis

Commissioning intentions for 2018-20

Emergency Ambulance Service

The Emergency Ambulance Service is commissioned on a Yorkshire and Humber footprint with Wakefield CCG as the lead commissioner. This enables CCG's to work closely both on a South Yorkshire and regional footprint to develop services. Locally community services are supporting the alternative levels of care Initiatives working closely with the ambulance service to accept appropriate referral. This is increasing the number of patients managed in the community as an alternative to the traditional hospital services. The work supports the new national ambulance response targets which ensure the most appropriate resource arrives within the most appropriate timeframe. Thus ensuring Rotherham CCG is able to support our ambulance providers achieve their performance in all their target categories.

We are working closely with the Association of Ambulance Chief Executives and the College of Paramedics to implement the recommendations of the **Ambulance Response Programme** (ARP) by October 2017, putting an end to long waits not covered by response targets. Actions taken will be subject to the results of evaluation and approval from Ministers. Changes are being proposed by the Yorkshire Ambulance Service during 2018 which meet the recommendations of the ARP.

Patient Transport Services

The new Patient Transport Contracts are being embedded within the acute trust and have reduced the number of providers on site. Plans are to be developed to work with referring clinicians to ensure the eligibility criteria is appropriate and applied. Work will be progressed to support patients to use technology to manage their own journeys.

National NHS 111 Service

NHS111 continues to offer the most appropriate route into urgent care services. The National Specification for 111 provision will be developed regionally during 2018/19 with a full procurement being undertaken for a new provider from April 2019. NHS 111 on line will be developed and delivered locally by February 2018 to support patients accessing the right care and signposting for self-care.

Quality Improvements

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

- A broader range of service destinations for emergency or planned transport services
- Better integration between the ambulance service, primary care and community services
- Transport for patients to the most appropriate care setting

Emergency Ambulance Service

The Ambulance Response Programme (APR) has been further developed and Yorkshire Ambulance Service are reporting response times in line with the new categories. The programme is being rolled out nationally following the pilot. The Ambulance Quality Indicators (AQIs) were introduced in April 2011 for all ambulance services in England and look at the quality of care provided as well as the speed of response to patients. The AQIs are ambulance specific and are concerned with patient safety and outcomes. YAS continue to deliver a strong performance in AQI's and commissioner will continue to work with YAS to ensure the correct Patient Pathways are accessible to ensure a smooth transition of care.

Patient Transport Services (PTS)
In order to deliver a high quality efficient service we procured the whole PTS this has reduced the number of providers and improved the management of journeys

We have worked with the new provide to develop an improved process for patients to manage their journey. This will allow patients to track their transport and inform the provider when they are ready.
The new contract has improved the quality of the transport services with a reduction in the age of vehicles operating, improved key performance indicators and improved flexibility with providers.

Addressing Inequalities

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

Patient Engagement – that has taken place or is planned

There are no planned commissioner lead consultations with patients, however providers continue to engage with service users to improve service delivery.

Key Milestones

- Monitor and report on the new ambulance quality indicators, including the revised clinical quality indicators – Q3
- Increase the number of ambulance patients referred to an alternative level of care or managed through the 'Hear/See and Treat' routes – Q4
- Improve the utilisation of the eligibility criteria for non- urgent patient transport – Q4

Key Performance Indicators

- 999 Category 1 Response times.

9.7. Medicines Management

Lead GP: Sophie Holden
Lead Officer: Stuart Lakin

Why this is a strategic priority

The CCG is responsible for all prescriptions issued by its' member practices and for drugs that are 'outside of tariff' issued by providers of secondary health care not funded by NHS England.

2016/17 Medicines Expenditure

GP Prescribing	£45,005,234
Non GP Prescribing	£4,058,952
Secondary care "drugs outside of tariff"	£6,267,567
Total	**£55,331,753**

Rotherham has traditionally been a high prescriber of medication as are all the neighbouring South Yorkshire CCGs. In 9 of the previous 14 years Rotherham CCG has benefited from a prescribing cost growth below that of England and the Yorkshire and Humber Region. In the majority of the previous ten years Rotherham's prescribing cost growth has been below that in neighbouring Doncaster and Barnsley.

This has been achieved by:

- The managed introduction of new drugs, and the effective use of established drugs through guidelines and RAG (red, amber, green) rating.
- The 5 service redesign projects (Nutrition, specialist feeds, continence, stoma and wound care) which in 2016/17 produced a combined estimated saving of £1,111,244.

Prescribing cost growth has been fuelled over the last two years by:

- Large increases in items (volume growth)
- Rapid fluctuations in the cost of well-established generic drugs
- Drugs being discontinued by one manufacturer and re-launched as a new brand with a different manufacturer at an increased price
- Continual drug supply problems with medication not being available at the drug tariff price (NCSO no cheaper stock obtainable)
- Drugs being declared NCSO and then returning to the drug tariff at a higher price

Given the current volatility of pharmaceuticals market and the fact that little manufacturing is UK based, the basic cost of drugs is dependent upon global economic factors. This financial year has seen an unprecedented number of NCSO drugs, (60-70 usually there are around 10 NCSO drug lines). Drugs that have recently had their NSCO status removed have returned to the drug tariff with a substantial price increase.

Rotherham has a high volume prescription area is therefore more exposed to the effect of rising drug prices than most CCGs. To countenance this Medicines Management Team (MMT) focused its activity in 2016-17 on reducing medicines waste and commencing a self-care programme.

The CCG's track record on effective medicines management is very strong. Prescribing costs\capita compares favourably to neighbouring CCGs and with CCGs with similar demographics. There are two prescribing incentive schemes, one that rewards practices for cost effective prescribing and one that rewards practices for achieving a range of prescribing quality targets.

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. Many of these indicators were in 2016/17 transferred into the quality control.

What we achieved in the 2015-18 Plan

- Implemented practice based repeat prescribing to reduce medicines waste
- Following an extensive patient consultation exercise a self-care programme has been launched. This will be expanded to include more items in 2018/19
- The MMT supported all practices with the introduction of electronic prescribing system (EPS) and electronic repeat dispensing (eRD)and facilitated training with community pharmacists across Rotherham
- Significant cost growth reduction delivered through branded generics and switch programmes
- Innovative service redesign projects delivered and continue to perform well; nutrition, specialist feeds, continence, stoma and wound care
- Work towards all Drugs outside of tariff (non-Payment by Results (PBR)) drugs being processed via the Blueteq system
- Supported workforce development e.g. practice pharmacists

Commissioning intentions for 2018-20

Waste and Self-Care

29 of Rotherham's 31 GP practices have stopped third party ordering, which will rise to 31 from April 2018, and with support from the MMT redesigned their repeat prescribing processes. As of September 2017 Rotherham achieved a **negative** item growth of -1.41% and a **negative** cost growth of -3.45%. Following Rotherham's lead another two CCGs in Y&H have now also stopped third party ordering.

We will:

- Continue to support practices in managing third party ordering
- Extend the waste medicines programme to care homes
- Increase the self-care programme in response to the continued patient engagement exercise and expand to include more items in 2018/19.

The medicine waste and self-care programme are estimated to produce a total cost saving of £1,436,601 (£970,206 April – September 2017/18)

Electronic Prescribing and electronic repeat prescribing

30 of Rotherham's 31 practices are EPS enabled and 54% of all prescriptions are now sent electronically.

To maximise the functionality of electronic solutions to facilitate prescription ordering, improving the experience for patients, prescribers and reducing medicines waste we will:

- Continue to support practices in the implementation of EPS focusing on training community pharmacies and increasing the utilisation of eRD.
- Help practices manage the increasing utilisation of internet pharmacies and prescription ordering apps

Care Homes

Support to Care Homes has been identified by several stakeholders as a priority for 2018 onwards. To support this the MMT will work with the major care homes across Rotherham to improve the ordering of medicines focussing on improving patient safety and reducing medicines waste and will introduce home remedy schemes in Rotherham care homes

Branded generic and switch programmes

A total of 17 branded generics have been introduced over the last 18 months resulting in a cost reduction of £982,740. Switch programmes have produced a further cost efficiency of £404,498. Scriptswitch (prescription decision software) was introduced to all Rotherham prescribers in 2017. We will maintain the work so far and scope for further branded generic and switch opportunities.

Service Redesign Projects

These projects continue to perform well. In the financial year of 2016/17 the five service redesign projects generated an estimated cost efficiency of £1,111,243. The CCG in collaboration with TRFT will be re-tendering the nutrition contract in early 2018.

During 2017 a total of 50 CCGs have contacted the Rotherham MMT requesting information on the service redesign projects and waste programme. We will continue the success of these projects and scope opportunities for further development.

Incentive schemes
The MMT will update and refresh the two prescribing incentive schemes for 2018/19 ensuring ongoing relevance

Non-PBR drugs
It is the intention of the MMT that all non-PBR drugs will be processed via the Blueteq system. There is still some opposition from local consultant ophthalmologists to engage with Blueteq. The Rotherham MMT has started to work in collaboration with neighbouring CCGs in developing standardised Blueteq systems across South Yorkshire and will work in collaboration with CCGs across Y&H on gain share and contractual arrangements. The processing of non-PBR drugs will provide several challenges over the next 2-3 years with the introduction of an increasing number of biosimilars and also new agents, we will maximise the potential of newly introduced biosimilars.

Integrated Care Systems Work streams
The CCG will work in collaboration with the other SYB CCGs on identified work streams.

Secondary Care Prescribing
The consultation on the CCGs clinical commissioning priorities identified a potential impact of secondary care prescribing on delayed discharges and a potential issue in relation to pharmacy hospital discharges to ensure that patients who are admitted with correct medications are also discharged with the correct medications. In light of this feedback, the MMT will investigate these potential issues and whether the CCG can work with TRFT to address the concerns raised.

Quality Improvements

- The key prescribing Indicators are evidenced based interventions that improve mortality or reduce hospital admissions. Practices are benchmarked against each other to encourage practices' that appear to perform less well to examine the relevant area
- Improving the quality of each practices prescribing through annual prescribing efficiency plan
- Monitoring and advising practices on NICE guidance and national safety alerts
- Evidence that the waste campaign has been effective
- The antibiotic quality premium has been achieved

Addressing Inequalities

- The key prescribing indicators promote the equal access to key medications that are vital for long term condition management by reducing variations between individual practices.
- The service redesign projects ensures that there is equity in the provision of the redesigned services across Rotherham

- Practice prescribing budgets incorporate deprivation into the budget setting mechanisms, therefore practices with relatively high deprivation scores are not penalised financially.

Patient Engagement – that has taken place or is planned

An extensive patient engagement exercise was undertaken in designing the medicines waste campaign and was used to identify the impact of the campaign and how it should be developed. Engagement continues to take place to continue to inform the project.

All service redesign projects have been informed by on-going patient and service user feedback. Examples of other engagement work includes engagement with carers of people with mental health problems and review of minor ailments scheme, the MMT maintains an engagement record.

Key Milestones

Prescribing cost reductions.

- Prescribing cost reductions: a series of drug switches have been identified across South Yorkshire & Bassetlaw and on a Rotherham footprint. A 2018-19 delivery plan is in place. Progress against the end of year target will be monitored monthly – Q4
- Service/Pathway redesign: alternative methods of supplying. Nutritional supplements, Baby milks and specialist feeds, continence, stoma products and wound care products have been deployed in Rotherham. These projects will be tightly managed to ensure they deliver the required efficiencies and improvements in patient care – 5 service redesign projects.
- Applying guidance: a self-care initiative/programme has been planned and is due to be launched. In response to the NHSE OTC consultation – Q1.
- Effective use of Medicines (i): all 30 Rotherham GP practices have redesigned their repeat dispensing processes to reduce medicines waste. Further waste reduction initiatives and an extension of the medicine waste programme into care homes is scheduled – Q4.
- Effective use of Medicines (ii): to re-design the medicines ordering systems for an increasing number of Rotherham Care Homes – Q1.
- Interface prescribing primary/secondary care: Introduction of biosimilar products when they become available.

Key Performance Indicators

- Reduction in the number of antibiotics prescribed in primary care *(IAF 107a)*
- Appropriate prescribing of broad spectrum antibiotics in primary care *(IAF 107b)*
- Number of finance and quality "green" indicators (*Meds Management KPI*)
- Prescribing cost growth is to be below average for England *(Meds Management KPI)*
- Prescribing item growth to be below average for England *(Meds Management KPI)*

9.8. Mental Health

Lead GP: Russell Brynes
Lead Officer: Kate Tufnell (Adults) / Nigel Parkes (Children's)

Why this is a strategic priority

The 'Five Year Forward View for Mental Health' tells us that *"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services".*

Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. One in four adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.

Mental ill health is the single largest cause of disability in Rotherham. The Joint Strategic Needs Assessment (JSNA) shows that the economic downturn has had an adverse effect on people's mental health. Dementia is a particular challenge with the number of cases predicted to increase by more than 50% by 2025. The CCG will ensure that in 2015/16 it's total spend on mental health (with all providers including general practice and the voluntary sector) will grow in line with the CCG's overall allocation increase. The planned spend for 2018/19 is £36.8 million.

What we said we would do in our 2015-18 plan

- **Adults** - deliver adults and older people's transformation plan: improve dementia care pathway, Improve Access to Psychological Therapy (IAPT) services, commission adult mental health liaison, create greater parity of esteem, deliver crisis care concordat
- Achieved highest performing dementia diagnosis rate in Yorkshire and Humber supported by the introduction of a primary care dementia LES for diagnosis
- Re-commissioned Ferns/Woodlands in patient unit development as a dementia step down provision integrating physical and mental Health services
- Improved and sustained our local IAPT service
- Adult mental health liaison in place and positive external evaluation complete
- Mental health workers support work of locality pilot
- Introduced mental health social prescribing, including a strong evaluation
- Out of area placements reviewed, Crisis Care Concordat in place
- **Children's -** CAMHS waiting times significantly reduced, improved relationships with partners, commissioned autism post diagnostic support, improved transitions
- Invested £600K to transform CAMHS provision and access, enhance crisis services, enhance community support services (Tier3)
- Improve links between schools and wider C&YP services
- Commissioning intentions for 2018-20

Commissioning intentions for 2018-20

Children and young people mental health (CAMHS)

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

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

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

- Enhanced Crisis Service
- Enhanced Community Support Service
- Autistic spectrum disorder Support
- Prevention/Early Intervention
- Family Support
- Workforce Development
- Services for 'Hard to Reach Groups'
- Looked After Children
- Development of services through input from Children & Young People
- Child Sexual Exploitation
- Transition to adult services
- Develop eating disorder provision for C&YP
- Ensure agreed transition process is followed and that all C&YP and have a transition plan in place

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

Adults and Older people

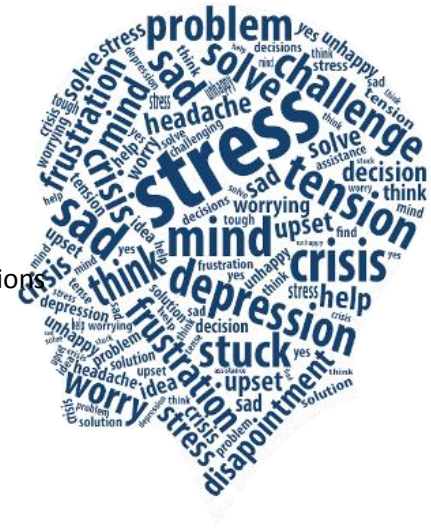
In 2015 the CCG developed an adult and older people's transformation plan has eight key priorities:

- Improving data, pathways and outcomes
- Improved strategic and partnership working including workforce

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

Looking forward we need to continue to build on the success we have had in delivering our 2015 priorities. The 'Five Year Forward for Adult Mental Health' published by NHSE in 2016 alongside our well-developed local needs analysis will guide our priorities to 2020 as described below:

- Continuation of our strategy to deliver dementia care in the community setting. Our intention is to move beyond diagnosis in the community to include routine follow up care and support.
- Ensure our local IAPT service is fit for purpose to deliver the national expectation for further improving IAPT access and recovery.
- We intend to further enhance our existing mental health liaison model to deliver 24/7 provision.
- We will review our existing adult community crisis and home treatment provision and where appropriate re-model to ensure integrated delivery with existing liaison provision.
- The CCG is keen to take opportunities to integrate where possible physical and mental Health. We will continue to pilot and evaluate the 'Ferns' inpatient provision.
- The CCG remains committed to the implementation of mental health social prescribing.
- Continue to embed a well-defined mental health presence within our locality plans and in the care co-ordination centre
- Ensure our early intervention in psychosis provision remains fit for purpose
- Work across the system to develop sustainable models of perinatal health
- Work with partners to ensure the suicide prevention remains a Borough wide priority
- Work with partners to promote pubic mental health
- We will ensure that people on the severe mental illness (SMI) registers receive an annual physical health check and interventions



Quality Improvements

- Increase dementia diagnosis LES coverage across GP practices to 100%
- Increase access to adult mental Health Liaison (Core 24)
- Improve access to social prescribing
- Reduce length of stay for people with dementia admitted to TRFT by delivering the new Ferns pathway

- Improving services for children with mental health services
- Ensure timely access to IAPT services
- Increase access to perinatal services
- Increase in the population of people with SMI on the GP register receiving annual physical health checks and interventions

Addressing Inequalities

- Ensure universal coverage for dementia diagnosis
- Ensuring universal access to the service is 24/7 (Core 24)
- Ensure people with mental health have good access to physical health and preventative services
- Issue contracts that require the providers to comply with the Equality Act 2010.

Patient Engagement

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

- Some feedback through Friends and Family Test (actions are taking place to increase this)
- Other data collected by providers
- Directly to the CCG via patients and patient groups, and through engagement events
- Collected by Healthwatch and shared with the CCG
- Issues are raised through the Dementia Forum

The core fidelity review has involved working with patients and carers to assess the current crisis and home treatment provision.

Key Milestones

- All children and young people will follow the agreed process in transitioning to adult services and all will have a transition plan in place *– Q4*
- Continue roll-out of the Dementia diagnosis LES – Q1
- Deliver Core 24 compliant service (Adult Mental Health) – Q4
- Mental health social prescribing delivery trajectory review completed – Q1
- Ferns ward evaluation completed – Q3
- Delivery of CAMHS LTP against plan – Q4
- Ensure delivery of the 5 year forward SMI register target – Q4

Key Performance Indicators

- People with 1st episode of psychosis starting treatment with a NICE- recommended package of care treated within 2 weeks of referral *(IAF 123c)*
- Percentage of people who are "moving to recovery" of those who have completed IAPT treatment *(IAF 123a)*
- Diagnosis rate for people with dementia, as a percentage of the estimated prevalence *(IAF 126a)*
- Proportion of people waiting 6 weeks or less from referral to entering a course of IAPT treatment *(Health Outcomes)*
- 95% of **children and young people** who present at A&E in crisis will be seen within 1 hour *(ICS)*
- 95% of **adults** who present at A&E in crisis will be seen within 1 hour *(ICS)*

9.9. Learning Disabilities

Lead GP: Russell Brynes
Lead Officer: Garry Parvin

Why this is a strategic priority

Rotherham's learning disabled population (18-64) is estimated to be 853 people, and it is estimated that this number will reduce by 4% by 2035. This reduction needs to be compared with other demographic changes and will have significant implications for planning, service development and market shaping.

- The numbers of learning disabled people with **severe** learning disabilities will remain static until 2035.
- Rotherham's older (65 plus) learning disabled population **will increase by 29% by 2035**

This is a good news story; learning disabled people in Rotherham are living longer. The challenge is that learning disabled people are more likely to experience chronic health conditions (e.g. obesity, diabetes) much earlier than the general population. 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 focussing on their learning disability.

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 as part of the national *Transforming Care* project 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.

It is estimated that Rotherham has around 789 children and young people and 2,328 adults (16+) who have autism. The number of over 18s in Rotherham with autism is predicted to increase by 3% by 2025 (and 7% by 2035). Over 65 year olds shows a predicted increase of over 15% by 2025 (and an increase of nearly 40% by 2035).

We want all children, young people and adults with learning disabilities and/or autism in Rotherham to be able to live fulfilling and rewarding lives within a community that accepts and understands them. We want people with autism to get a diagnosis and be able to access support if they need it, and depend on mainstream public and third sector services to treat them fairly as individuals to get the right information and help them make the most of their talents.

What we said we would do in our 2015-18 plan

- Both the CCG and RMBC have a shared commissioning post to ensure that the planning and delivery of learning disability services is co-ordinated across both the NHS and adult social care.
- Worked with partners across the Transforming Care Partnership (TCP) to ensure delivery of the South Yorkshire and North Lincolnshire TCP Plan
- Moved towards joint commissioning for LD with RMBC
- Review local inpatient requirements to support delivery of national bed planning
- Developed and embedded care, education and treatment reviews (CETR)
- Delivered GP training to support the annual health check directly enhanced service (DES)

Commissioning intentions for 2018-20

Continue to work with partners across the Transforming Care Partnership (TCP) to ensure delivery of the SY and North Lincolnshire TCP Plan - The Transforming Care Programme enters its final year in 2018. The national programme will close in March 2019. The TCP target is by 2019 is to have **10 -15** learning disabled detained in CCG commissioned beds and **20 – 25** learning disabled people in NHSE commissioned beds. There have been challenges in achieving this objective due to the complexity of meeting needs in the community. The CCG has set a target of having three learning disabled detained in CCG commissioned beds. This ambition is lower than the NHS England / TCP target of five. NHS England/ TCP target for NHSE / Secure beds is six**.** It remains Rotherham CCG's ambition to retain the ambition of having three learning disabled detained in CCG commissioned beds.

Focus on joint commissioning for supported living where appropriate, working with RMBC - The Council has an ambitious programme to develop a stepped approach to meeting the housing needs of learning disabled people from using shared lives, expanding key ring schemes, through to supported living. The programme will look to support learning disabled people in the Transforming Care Programme, building better transitions for young people moving from childhood to adulthood and learning disabled people funded via Section 117 aftercare or continuing health care.

Review high cost packages in partnership with RMBC for people with LD- Both the Council and the RCCG support people with complex needs. It is planned that a joint cohort programme review is undertaken. The focus in 2018/19 will be young people coming through transition.

Ensure Rotherham CETR process in place and deliver CETR Expert by Experience training - There is a CETR programme in place. Work will be done to ensure it becomes 'business as usual' for all partners (health, social care and education). Work is being undertaken with the TCP to ensure that there is an infrastructure to support the delivery of the CETR programme.

Rotherham 'at risk of admissions' process remains in place (including C&YP/Autism) - An 'at risk of admissions' process is in place and work will be done to review the people who are included this this cohort to understand needs and ensure that community services are fit for purpose to meet the needs of people with behavioural support needs.

Develop an integrated autism strategy by November 2018 - A delivery plan has been created which maps out for development of Rotherham's Autism Strategy. The ambition is that all children, young people and adults with autism in Rotherham are able to:

1. Live fulfilling and rewarding lives within a community that accepts and understands them
2. People with autism can get a diagnosis and access support if they need it
3. They can depend on mainstream public and third sector services to treat them fairly as individuals to get the right information and helping them make the most of their talents

The CCG are looking to start a pilot diagnosis and post diagnostic pathway. Discussions on a South Yorkshire footprint will be commenced about scoping if a shared pathway could be developed.

RMBC to complete the review of in-house learning disability services - A consultation has concluded and plans are being developed to look at how both the Council and RCCG work together to ensure that learning disabled people can access health and care services (including the third sector), have better days and can access meaningful employment.

Quality Improvements

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

Addressing Inequalities

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

- Ensuring that people with learning disabilities get good care and support from mainstream NHS services, have access to information in in formats that they can understand and they receive appropriate support to help them to communicate, in line with the Accessible Information Standards .

- Ensuring that people with learning disabilities have good access to physical health care and preventative services
- Issuing contracts that require the providers comply with the Equality Act 2010, reasonable adjustment standards, autism statutory requirements etc.

Patient Engagement – that has taken place or is planned

The development of the autism strategy will be undertaken in partnership with Rotherham Speak Up, parent support organisations

Key Milestones

- Deliver the required number of bed reductions as per Rotherham element of the plan – *Q4*
- Delivery of CETR Expert by Experience training – *Q3*
- Rotherham CETR process in place (CYP) – *Q4*
- Rotherham 'at risk of admissions' process in place (including C&YP and Autism) – *Q4*

Key Performance Indicators

- Ensure that patients receive a CETR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: adults – *ICS*
- Ensure that patients receive a CETR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: children – *ICS*
- Ensure that patients in an Assessment and Treatment Unit receive a Care and Treatment Review (CTR) every 6 months – *ICS*
- Reduce the number of people admitted in line with the South Yorkshire and North Lincolnshire LD TCP trajectory – *Local Reporting*

9.10. Continuing Healthcare and Funded Nursing Care

Lead GP: Jason Page
Lead Officer: Alun Windle

Why this is a strategic priority

The CCG has a statutory obligation to fund healthcare for clients who are assessed as meeting NHS Continuing Healthcare.

NHS Continuing Healthcare can be delivered in any setting, including the individuals' own home or nursing home. However, where NHS Continuing Healthcare funded individuals care is delivered in specialised homes 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 would not be responsible for 'board and accommodation' fees.

The NHS England Quality Premium Guidance sets out the measures and the levels of improvement for CCGs to achieve in order to qualify for the quality premium. It is intended to reward clinical commissioning groups for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

As from April 2017 the continuing healthcare indicators are:

- In more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility).
- Less than 15% of all full NHS CHC assessments take place in an acute hospital setting.

http://www.legislation.gov.uk/uksi/2013/2891/pdfs/uksi_20132891_en.pdf
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213137/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf
https://www.england.nhs.uk/wp-content/uploads/2016/09/annx-b-quality-premium-14-07-17.pdf

What we achieved in the 2015-18 Plan

- Developed a Continuing Healthcare training package for health and social care staff regarding national guidance, local processes and provision
- Implement processes fit for purpose with identified panels having an appropriate number, scope, size and membership
- Comprehensive range of policies and protocols established, training package developed and rolled out, fit for purpose process for panels in place
- Supported decision support tool (DST) process in the acute hospital setting
- Joint Continuing Healthcare Strategy Group and Joint Operational Groups with partner agencies
- Developed joint agency benchmarking
- Implemented an approved assessor and funding model

Commissioning intentions for 2018-20

- Continue to work jointly with RMBC to improved CHC services and implement a shortened assessment tool for reviews of CHC eligibility that will focus on ensuring the individuals needs are being met and the package of care remains appropriate (adults and children)
- Develop services further to improve compliance with national metrics
- Approve and implement an alternative discharge process for patients in acute setting to ensure optimisation of appropriate setting prior to Continuing Healthcare assessment
- A communication strategy will be developed ensuring people receiving Continuing Healthcare receive appropriate information and have the opportunity to feedback their experience.
- The CCG will aim to undertake 0% of Continuing Healthcare assessments in the acute setting and to complete 80% of cases within 28 days.

Quality Improvements

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

Addressing Inequalities

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.

Patient Engagement – that has taken place or is planned

Patient and relative feedback is sought on each assessment that is undertaken, and patients have the opportunity to record feedback on the process and assessment that is undertaken.

Key Milestones

- To approve and implement an alternative discharge process for patients in the acute setting that will ensure that they are optimised in the appropriate placement prior to full Continuing Health Care assessment – Q3
- To implement a shortened assessment tool for reviews of Continuing Health Care eligibility – Q2
- To implement a shortened review tool for reviews of children's Continuing Health Care eligibility – Q2

Key Performance Indicators

- Personal Health Budgets *(IAF 105b)*
- Less than 15% of all full NHS Continuing Health Care assessments to take place in an acute hospital setting *(IAF 131a)*
- Overall 85% of NHS Continuing Health Care assessments should be completed in 28 days (CHC KPI)
- Overall 15% reduction in outstanding reviews (61% current target 46%): Adults (CHC KPI)
- Overall 15% reduction in outstanding reviews (50% current target is 35%): Children (CHC KPI)

9.11. End of Life Care

Lead GP: Avanthi Gunasekera
Lead Officer: Ian Atkinson

Why this is a strategic priority

End of life care is care that affects us all, at all ages; the living, the dying and the bereaved. Reports and investigations too frequently identify poor care and we have a responsibility to do better and where ever possible strive to allow individuals to die in a place informed by individual choice. Around half a million people die each year and this is set to increase in line with the growing older population.

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

What we achieved in our 2015-18 plan

- Continue to develop pathways across community/inpatient palliative care that are clear and joined up
- Improve community access, particularly for those who have EOLC plan
- Involvement of Care Co-ordination Centre in the EOLC pathway
- Undertaken a review of deaths that take place within 24 hours of hospital admission, identifying areas that can be improved particularly across Urgent Care and Care Home pathways
- Improved EOLC planning by introducing electronic EOLC register across the system, using system incentives to undertake robust EOLC plans.
- Continued to commission community Hospice at Home services to support individuals to die in a place of their choice.
- Introduced new methods of supporting care homes through 24/7 Hospice at Home support and structured care home education process. In an attempt to reduce emergency hospital admissions.

Commissioning intentions for 2018-20

The CCG will continue to work closely across the Rotherham Place to commission clear joined up palliative pathways of care, these pathways will embrace all elements of palliative care including:

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

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

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

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

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

Working within the principles identified within the above national strategies the key priorities over the next two years will include:

- Continuous review of the local Hospice at Home Provision
- Continue to focus on the Care Home sector through structured specialist support and education
- Review EOLC pathways with the new Urgent and Emergency Care Centre at TRFT, using I.T solutions to track patients accordingly.
- Continue to enhance the quality of and increase the volume of EOLC plans across the Rotherham Place.
- Continue to embed the electronic EOLC register across the system
- Re-procure domiciliary care provision across the Borough, which will include packages for EOLC support.
- Ensure that EOLC is embedded in future new locality care models and any revised re-ablement strategy across the borough.
- Review system wide approach to the adoption of the national RESPECT agenda for Rotherham.

Quality Improvements

- Over the next two years the proportion of people in Rotherham dying in setting other than acute hospitals will continue to increase.
- 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.
- We will reduce the number of emergency admissions from care homes for patients with an EOLC plan.

Addressing Inequalities

- Work continues with hospice partners to increase the percentage of patients who receive EOLC and who don't have cancer.
- Currently there are variations in the quality of EOLC received by patients particularly in care home settings. The community care home 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.

Patient Engagement – that has taken place or is planned

Patients and their families continue to have a vital input into determining the type of care and support provided in the last stages of life and this is integral to good EOLC. Work will continue to improve the quality of conversations with patients and their families who are approaching the end of life so that care is tailored to their individual needs.

Key Milestones

- Involvement of the Care Co-ordination Centre in the EOLC pathway – Q4
- Achieve 40% implementation of the Case Management Palliative Care Template in Primary Care – Q4

Key Performance Indicators

- Percentage of deaths with three or more emergency admissions in the last 3 months of life *(IAF 105c)*
- Percentage of deaths not in hospital *(public health)*

9.12. Cancer

Lead GP: Jason Page
Lead Officer: Janet Sinclair-Pinder

Why this is a strategic priority

In July 2015 NHS England published its five year strategy for cancer. The aims outlined in the 'Five year forward view' are for better prevention, swifter diagnosis and better treatment and care for all. There is a commitment to make this a reality by 2020. It is recognised that there is variation in cancer care provision, outcomes and cancer pathways across England. Achievement of this strategy has seen the establishment of Cancer Alliances across the country. Rotherham is part of the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance.

In Rotherham, cancer incidence is higher than the average, especially for lung and colorectal cancer. Although the pattern of survival is about average in Rotherham, survival from prostate cancer is worse than average and death rates in people under 75 in Rotherham are 15% higher than the English average. The detection of cancer through the urgent 2 week wait pathway is worse than average and it is suggested that people may be putting off seeking help when thy have early signs and symptoms of cancer.

In order to address these issues, Rotherham, working together across the Alliance aims to:

- Achieve National cancer targets
- Improve patient experience
- Increase the proportion of cancer diagnosed at an earlier stage
- Reduce the amount of cancer diagnosed in emergency settings
- Increase survival rates

What we achieved in our 2015-18 plan

- Support on-going delivery of the TRFT Cancer improvement action plan, focussing on one year survival rates
- Implement NICE cancer guidelines
- Fully engage with MacMillan Living with Cancer and Beyond Programme
- Focus work on raising awareness /early diagnosis and 2 week wait
- GP quality contract includes cancer 2 week wait
- Agreed new high impact action plan for cancer
- Root cause analysis undertaken for all 62 day cancer breaches

Commissioning intentions for 2018-20

Progress has been made with implementing the ten high impact actions, however focus continues to ensure the cancer targets are consistently achieved.
The Early Diagnosis and prevention work stream has five projects:

Signs and symptoms - deliver targeted interventions to increase the awareness of signs and symptoms of cancer. Voluntary Action Rotherham has been commissioned to implement Cancer Champions in Rotherham with a go live date of January 2018. This involves the recruitment of volunteers to "spread the message" about signs and symptoms of cancer and to promote the importance of attending cancer screening.

Primary Care Workforce Education - sharing pathways across the region and undertaking workforce skills analysis. Rotherham will be providing training and education events for Primary care supported by the Alliance and Cancer Research UK. This includes locally developed resources including an online platform, video and podcasts for Primary Care Clinicians.

Screening - Rotherham is developing focussed work at targeted populations to maximise uptake and reduce variation of screening. This includes facilitating early role out of the bowel scope screening and promoting the use of the Rotherham GP automated communication system to follow up patients who have not attended their screening appointments.

Diagnostics - Rotherham is taking part in the development of a new model of care for diagnostics which is looking at capacity and demand across our diagnostics service and the priorities for access to diagnostics. Rotherham has been successful in a bid for funding to support our Vague Symptoms pathway. The pathway aims to shorten the interval from presentation to diagnosis, decrease the use of inpatient beds during cancer diagnosis, reduce the number of A&E or GP visits before a cancer diagnosis, improve the patient experience on the cancer diagnostic pathway and assist in diagnosing cancer at an earlier stage. The Pathway provides access to advice and guidance from a specialist and facilitates direct to imaging test.

Significant Event Analysis - Rotherham has developed quality standards to support improvements in the system and processes in primary care. This includes a root cause analysis and lessons learnt following a high quality analysis of cancer cases diagnosed outside of the two week wait pathway.

Engage fully with SY&B Cancer Alliance focussing on: delivery of national targets; identification, screening and diagnostics; high value pathways; and living with and beyond cancer.

We are working across South Yorkshire and Bassetlaw and North Derbyshire to develop site specific clinical pathways (prostate, urology, breast, lung, colorectal and Carcinoma of unknown primary (CUP)). The joint Cancer Board meeting has now been arranged. A member of the CCGs strategic clinical executive is establishing meetings with the clinical lead for cancer at TRFT to discuss root cause analysis in respect of breaches and to formulate a plan to develop better ways of working and pathways.

Continue to fully engage with MacMillan Living with Cancer and Beyond Programme - Rotherham has been successful in securing Macmillan funding to support the development of cancer survivorship support. This investment is being utilised to support the following:

- Implementing regional pathways for breast, prostate and colorectal cancer
- Implementing holistic needs assessment at key points in the cancer pathway and developing and utilising a universal electronic HNA tool
- Providing and promoting access to self-management and health and wellbeing education programmes and services, promoting and enabling healthier lifestyles and physical and emotional health.
- An education programme to educate and support services from all partner organisations of the needs of cancer survivors, to give confidence to these services to have conversations that matter with people affected by cancer and to "Make Every Contact Count" (MECC)
- Create a "Universal Door" in which people affected by cancer and their families can not only access the support services that are available within the local community, but that will put them in contact with a support advocate who will ensure the delivery of a person centred approach to their care.
- Developing a quality enhanced cancer care review within primary care that is informed by a quality treatment summary with a clear referral pathway for additional support into the cancer support advocacy service.
- Developing a quality treatment summary to aid integrated care pathways between primary and secondary care. This will include collaborative working between Sheffield Teaching Hospitals, TRFT, primary care and patient engagement

Quality Improvements

Patient access to diagnostics will be improved with equality of access across SY,B & ND. Emphasis on prevention and early diagnosis will improve outcomes for patients in respect of survival and quality of life. GP knowledge and skills will be improved with access to education and learning and local pathways to follow. For those patients who are living with and beyond cancer, there will be improved access to support and advice and quality of care

Addressing Inequalities

The Cancer Alliance is working to address inequalities by targeting specific groups, this includes improving uptake of cancer screening services for the black minority ethnic (BME) community and for people with learning difficulties.

Patient Engagement – that has taken place or is planned

A patient representative has been elected to sit on the Cancer Alliance Board. A key outcome for the Alliance is to capture patient experience.

Key Milestones

- Work with the ICS Cancer Alliance to improve early diagnosis and cancer prevention – Q4
- Implement pathway of care for vague symptoms (2 year pilot) – Q4
- Fully engage with the Macmillan Living With and Beyond Cancer (LWABC) Programme to implement the agreed actions outlined in the project initiation document – Q4

Key Performance Indicators

- Cancer (all) diagnosed at stage 1 and 2 *(IAF 122a)*
- Percentage seen within 2 weeks following an urgent referral by GP for suspected cancer (Constitution)
- Percentage seen within 62 days after a referral by GP *(IAF 122b)*
- Patient satisfaction rates ≥89% (Secondary care) *(IAF 122d)*

10. Glossary

A&E	Accident and Emergency	**JSNA**	Joint Strategic Needs Assessment
A&E DB	A&E Delivery Board	**KPI**	Key Performance Indicator
APC	Area Prescribing Committee	**LAC**	Looked After Children
BCF	Better Care Fund	**LMC**	Local Medical Committee
CAMHS	Child and Adolescent Mental Health Services	**LES**	Local Enhanced Service
CCC	Care Co-ordination Centre	**LIS**	Local Incentive Scheme
CCG	Clinical Commissioning Group	**LOS**	Length of Stay
CHC	Continuing Health Care	**LTC**	Long Term Conditions
CIP	Cost Improvement Plans	**MMC**	Medicines Management Committee
CRMC	Clinical Referrals Management Committee	**MMT**	Medicines Management Team
CSE	Child Sexual Exploitation	**MRSA**	Methicillin Resistant Staphylococcus Aureus
CQUIN	Commissioning for Quality and Innovation	**NHSE (SY&B)**	NHS England (South Yorkshire and Bassetlaw)
C&YP	Children and Young People	**NICE**	National Institute for Clinical Excellence
DBH	Doncaster and Bassetlaw NHS Foundation Trust	**OE**	Operational Executive
DH	Department of Health	**PbR**	Payment by Results
DTOC	Delayed Transfers of Care	**PPG**	Patient Participation Group
EDS	Equality Delivery System	**PTS**	Patient Transport Services
EMS	Escalation Management System	**PYLL**	Potential Years of Life Lost
EPS	Electronic Prescribing Service	**QIPP**	Quality, Innovation, Productivity and Prevention
EU	European Union	**RAIDR**	Reporting Analysis & Intelligence Delivering results
FFT	Friends and Family Test	**RDaSH**	Rotherham Doncaster and South Humber NHS Foundation Trust
FNC	Free Nursing Care	**RMBC**	Rotherham Metropolitan Borough Council
FYFV	Five Year Forward View	**SCE**	Strategic Clinical Executive
GB	Governing Body	**SEND**	Special Educational Needs and Disabilities
GPMC	GP Members Committee	**SHSC**	Sheffield Care and Social Care Trust
H&WBB	Health and Wellbeing Board	**SLA**	Service Level Agreement
H&WBS	Health and Wellbeing Strategy	**STH**	Sheffield Teaching Hospitals NHS Foundation Trust
IBCF	Improved Better Care Fund	**STP**	Sustainability and Transformation Plan
ICP	Integrated Care Partnership	**SYCOM**	South Yorkshire CCG Collaboration
ICS	Integrated Care System	**TRFT**	The Rotherham NHS Foundation Trust
IH&SC	Integrated Health and Social Care	**UECC**	Urgent and Emergency Care Centre
IRR	Integrated Rapid Response	**VAR**	Voluntary Action Rotherham
IT	Information technology	**YAS**	Yorkshire Ambulance Service

11. Appendix 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) http://www.rotherham.gov.uk/jsna/. There is significantly higher than average deprivation, unemployment and long term unemployment.

50,370 Rotherham residents (19.5%) live in the most deprived **10% of England**. Rotherham has **8,640** residents (3.3%) in Ferham, Eastwood, East Herringthorpe and Canklow living in the most deprived **1% of England**. The changing demographic will require the CCG and partners to consider where resources are allocated going forward.

Life expectancy at birth is 77.9 years for men and 81.6 years for women for 2014-16. Although this is below the National average it has improved continuously since 2002-04 for men (then levelled in 2012-14 and 2013-15 with a decrease of 0.2 years in 2014-16). Life expectancy has also improved for women but decreased between 2010-12 and 2013-15 before recovering again in 2014-16. Healthy life expectancy at birth has increased for men to 59.8 years. However there has been a decrease for women to 55.7 years.

Life expectancy at birth is 1.6 years less than the England average for men and 1.5 years less for women (2014-16). Overall, Healthy Life Expectancy has increased by 1.7 years for males and decreased by 4.4 years for females over the period 2009-11 to 2014-16. **This means that men in Rotherham will live 18 years of their lives with at least one long term health condition and women will live 26 years with at least one long term health condition**. The ongoing drop in female healthy life expectancy is more significant in Rotherham than in England with a 0.2 year drop in England compared to a 4.4 years in Rotherham.

Another striking health issue in Rotherham is the degree of **inequality within the Borough.** The gap in overall life expectancy between Rotherham and the national average is one and a half years (1.6 males, 1.5 females) based on three years combined data for 2014-16 (England: Male 79.5 years, Female 83.1 years).

The gap in life expectancy between the most and least deprived parts of Rotherham for males is 9.8 years and females is 7.6 years (based on 2013-15). **The gap has increased by 0.5 years for males since 2010-12 and by 1.0 years for females.**

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

The population of Rotherham continues to grow and is projected to reach 264,900 by 2020. The age profile will be increasingly dominated by the elderly; the number of people aged 65 and over is projected to grow by 18% between 2016 and 2026 and by 41% for those aged 85 and over in the same period. Increasingly these people will be living alone. This will be associated with an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer.

See Figure 1 the age profile pyramid which shows Rotherham's age profile for males and females alongside the England and regional average.

Figure 1: Age Profile Pyramids *Source: PHE, PHOF Fingertips 2018*

As at 2016/17 there were over 14,800 people in Rotherham with diabetes, and over 5,400 on GP stroke registers. By 2025 we project that there will be over 4,200 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.

Children and Young People

In summary, there are 56,600 children and young people aged under 18 in Rotherham[1], (21.6% of the Borough's population as at mid-2016, slightly above the English average of 21.3%). An analysis of the age profile predicts that the number of secondary school age children (11-17) will increase between 2016 and 2021 by 6%. As of the end March 2017 there were 2,612 Children in Need, 367 Children subject to a Child Protection Plan[2] and 485 Looked after Children in Rotherham[3]. Our high Child Protection rate and increasing complexity in the social care cases demonstrate that the needs of local children and young people and their families are rising.

Nationally there is a direct correlation between social care needs and deprivation.

[1] Office for National Statistics population estimates, http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates
[2] Department for Education 2015 https://www.gov.uk/government/collections/statistics-children-in-need
[3] Department for Education 2015 https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2014-to-2015

Nationally 19.9% of children are affected by income deprivation[4], in Rotherham this is significantly higher at 24.3% and for children living in our ten most deprived communities half of them are affected by income deprivation[5]. **The Deprivation Pupil Premium also shows a similar picture with more local pupils (31.8%) eligible than the national average of 28.6%.**

High rates of smoking in pregnancy are a particular concern in Rotherham affecting 17.0% of maternities compared to 10.5% in England (2016/17). This contributes to complications during pregnancy and delivery and health problems throughout childhood. There has been a downward trend and Rotherham are in line with similar areas. The percentage of babies born at low birth weight (7.5%) is very close to the English average of 7.4% (2015), similarly infant mortality rate is 3.5 per 1,000 births, compared to England average of 3.9 (2014-16). The breastfeeding initiation rate of 62.5% (2014/15) is one of the lowest in the region and this poor level of breastfeeding is associated with childhood obesity.

Excess weight (being obese or overweight) affects 23.9% of Rotherham school children aged 4-5 and 37.0% of Rotherham children aged 10-11[6] (2016/17). These are both above the national average for 4-5 year olds (22.6%) and 10-11 year olds (34.2%). The number of children overweight or obese was 770 at 4-5 and 1,098 at 10-11.

Levels of **oral disease** measured by (decayed, missing and filled teeth) in five year olds are much higher than average in Rotherham at 29% compared with 25% nationally (2014/15). 71% of Rotherham 5 year olds are free from decay, compared to 75% nationally.

For young people aged 15-24, 1,550 were diagnosed with a **sexually transmitted infection** in 2013; this is a rate of 4,940 per 100,000, higher than the English average of 3,433. However, this figure should be interpreted with caution as it could also indicate an accessible and young person friendly service where people feel comfortable in seeking treatment. Similarly, increased chlamydia detection is seen as indicative of increased control activity. Rotherham detected 617 cases of chlamydia in 2016, a rate of 2,033 per 100,000 aged 15-24 which is higher than the national average of 1,882.

Child Poverty

The most basic form of deprivation affecting children is low household income which impacts on a wide range of life chances. The Indices of Deprivation 2015* shows that 48,400 people or 18.7% of Rotherham's population were deprived of income (on means tested benefits or asylum seeker support) in 2013/14. Children aged 0-15 are most likely to be affected by low income with 12,050 (24.3%) of children aged 0-15 affected, 580 more than in 2008 (Indices of Deprivation 2010). At the neighbourhood level, the figures range from 3% to 62.5%, showing a polarisation in family income across the Borough.

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

[4] English Indices of Deprivation 2015 https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

[5] Rotherham JSNA Child Poverty 2015 http://www.rotherham.gov.uk/jsna/info/23/people/55/children_and_young_people/8

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

Children living in the Most Deprived Areas

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

Whilst children from across the Borough can receive some social care support, those in the most deprived areas are five times more likely to be designated as a Child In Need (Children Act 1989), than those in the least deprived areas. They are also four times more likely to be involved in some way with the team dealing with child sexual exploitation[7]. Life expectancy at birth for a baby born in the 10 least deprived areas (least deprived decile) is 8.7 years longer than for a baby born in the most deprived areas. Children in the most deprived areas are twice as likely to be disabled and more than twice as likely to live in a home where someone smokes.

The 2015 Director of Public Health Report focused on children and young people and the importance of starting and growing well. It highlighted the issues above and identified a series of eight recommendations. Progress includes:

- The Rotherham Hospital Foundation Trust (TRFT) Maternity Services achieved the UNICEF Baby Friendly Initiative and are working towards the community standards to achieve Stage 2 for Health Visiting Teams.
- Self-Harm Guidance has been distributed to all schools, colleges, GP practices and other venues where staff are working with young people.
- Implementation of part time advisory 20 mph speed limit zones outside six Rotherham schools in 2016, with further development of 10 more in 2017.

Adults

Over the last decade (2006-2016), all-cause mortality rates have fallen by 6%. While early deaths from cancer, heart disease and stroke have fallen (cancer less than heart disease although heart disease increasing gradually since 2011-13), they remain worse than the England average. In contrast, premature deaths from liver disease have increased by 29% between 2004-06 and 2014-16, particularly in females. Further, respiratory disease mortality rates have fluctuated over the last decade decreasing 14% overall by 2014-16. The overall small increase in recent years masks a large increase in rates for females and a large decrease in male rates.

Potential Years of Life Lost (PYLL) reflects deaths in people aged under 75. About 6,550 PYLL are lost each year in Rotherham through causes considered amenable to healthcare. This is around 1,400 years more than might be expected based on the England average. This CCG will aim to reduce this by 200 years per year over the next 5 years. There has been a good improvement in cancer and cardiovascular mortality rates which in 2015/16 were on target. Liver and respiratory disease were off target so may require further exploration.

[7] RMBC CSE Needs Analysis 2015

Potential Years of Life Lost (PYLL) from causes considered amendable to healthcare, per 100,000, target based on 2015/16 trajectory submitted in 2014/15 (Data relates to calendar years so 14/15 actually relates to 2014):

Under 75 mortality rate from cardiovascular disease	Target 63.70	14/15 86.50 (2015 = 76.8)
Under 75 mortality rate from respiratory disease	Target 27.60	14/15 31.20 (2015 = 41.3)
Under 75 mortality rate from liver disease	Target 15.80	14/15 18.90 (2015 = 18.0)
Under 75 mortality rate from cancer	Target 121.40	14/15 143.50 (2015 = 127.3)

Improvements have been made on health-related quality of life for people with long-term conditions, proportion of people feeling supported to manage their condition, unplanned hospitalisation for chronic ambulatory care sensitive conditions, and unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. **The main disease areas behind excess PYLL in Rotherham are the same as those creating inequalities in life expectancy; namely, circulatory disease, cancer and respiratory disease.**

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

Nearly 80% of premature heart disease, cancer, stroke and diabetes can be prevented. Researchers found that by making the correct lifestyle choices by following the four rules below the risk of developing diabetes, heart attack, stroke and cancer is reduced by 78%.

- Exercising regularly – The Chief Medical Officer recommends 150 minutes (2.5 hours) of moderate activity per week, in bouts of 10 minutes or more [8]
- Keeping a healthy weight – (having a BMI between 18.5-24.9)[9]
- Eating a healthy diet – high in fruit, vegetables & wholegrain, and low in red meat
- Never smoking – never having taken-up smoking is best[10] but stopping smoking will help improve health and wellbeing[11]

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

In response to the growth in long term conditions and care needs, the number of informal **carers** has increased and is currently estimated at 31,000 at 2011 Census. The age profile of carers is following the same pattern as the general population and is believed to reflect the increasing number of spouse carers. The increase in the

[8] Davies S (2012). Annual Report of the Chief Medical Officer. Volume One, 2011 On the State of the Public's Health. Department of Health.
[9] www.nhs.uk/chq/Pages/3215.aspx?CategoryID=52
[10] Ford E S, Bergmann M M, Kröger J, Schienkiewitz A, Weikert C, Boeing H (2009). Healthy living is the best revenge: findings from the European Prospective Investigation into Cancer and Nutrition-Potsdam study. Archives of Internal Medicine, Vol.169 No.15, pp.1355-62.
[11] www.nhs.uk/Livewell/smoking/Pages/Betterlives.aspx

number of younger carers is more modest and this is likely to result in a widening of the "care gap" which could lead to greater demands on formal care services including acute care.

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

The 2016 Director of Public Health Annual Report was the second report from the life-course series. It focused on "Healthy ageing: living well, living longer" adding life to years and years to life. It describes some of the work which is being done to improve the health of people in later life and to address the inequalities in health experienced in Rotherham and suggests what could be done to make further improvements. The report can be viewed here:
http://www.rotherham.gov.uk/download/downloads/id/3466/2016_dph_annual_report_%E2%80%93_healthy_ageing_living_well_and_living_longer.pdf

The report follows the WHO 'Life-Course Approach to Healthy and Active Ageing' provides four themes: Healthy Behaviours and Lifestyles; Age friendly environment & community supporting health; Encouraging social inclusion and positive mental health, independence and productivity; and, Quality integrated services and preventative interventions, all of which cover a broad range of issues. There are four high level recommendations:

- **Recommendation One:** All services should encourage lifestyle behaviour change in older people where appropriate, particularly in the most disadvantaged communities. This could be achieved through taking a systematic approach to Making Every Contact Count (MECC).
- **Recommendation Two:** The Rotherham Health and Wellbeing Board considers implementing the WHO 'Age Friendly Cities and Communities' and become the first area in South Yorkshire to achieve this accreditation, learning from other UK cities that have already begun this work. This would be complementary to the Borough's aspiration to be young people and dementia friendly.
- **Recommendation Three:** The social inclusion of older people in Rotherham needs to be at the heart of policy and delivery across the Rotherham Partnership, addressing issues such as maintaining independence, income and participation, mental health, loneliness & isolation. To achieve this goal, older people must experience proactive involvement and participation in life and society as a whole.
- **Recommendation Four:** All partners to deliver against the aspirations and commitments within the Rotherham Integrated Health and Social Care Place Plan, and to continue to strive for the highest quality services for older people. This is to include an increased focus on prevention, early identification and self-management, with clear pathways for lifestyle behaviour change for older people that support individuals to make changes when the time is right for them.

Prevention

"An ounce of prevention is worth a pound of cure." Benjamin Franklin (1706-1790)

Prevention is everyone's business. To reduce acute admissions there needs to be a radical mind shift towards prevention. Prevention at scale and at pace. All healthcare pathways should start with prevention to embedding it within the healthcare system.

It is recognised that the NHS can no longer afford not to focus on prevention given the fact that prevention and effective management of long-term conditions is likely to be more cost effective than treating the illness as it occurs. The Department of Health estimates that 70 per cent of the NHS budget is spent on long-term conditions, yet it is estimated that only four per cent of the total healthcare budget is spent on prevention[12].

It is estimated that clinical care only contributes to 20% of all health. The below table provides estimates the impact of the broader determinants of health.

Behaviours (30%)	Socio-economic factors (40%)	Clinical care (20%)	Built environment (10%)
Smoking 10%	Education 10%	Access to care 10%	Environmental quality 5%
Diet / Exercise 10%	Employment 10%		
Alcohol use 5%	Income 10%		
Poor sexual health 5%	Family / Social support 5%	Quality of care 10%	Built environment 5%
	Community safety 5%		

Source: Robert Wood Johnson Foundation

Shifting social norms must be tackled not only by individuals but by wide ranging action by health and care services, local government, media, businesses, society at large, families and the voluntary and community sector. By working together and with prevention at the heart of our plans we should be seeing improvements in the short, medium and long term.

South Yorkshire and Bassetlaw Integrated Care System formally known as the Sustainable Transformation Plan (STP) proposes:

- **Local Government population health policies that facilitate prevention** for example: smoke free parks, daily mile
- **LA implementation (with H&WB support) of policies that support healthy lifestyles** especially tobacco control, alcohol, nutrition, for example: health in all policies, review fast food environment (e.g. not near schools), use of salts and transfats in products sold locally, nutritional standards of publically procured food
- **At scale NHS disease specific prevention programme,** for example: CVD, National Diabetes Prevention Programme
  NHS to include lifestyle factors as a default within treatment/ care pathways, for example**:** smoking cessation, alcohol brief intervention, physical activity (Active for Health)
- **Social prescribing:** inequality and distribution of GPs, develop a broader social model of care e.g. include debt, housing, fuel poverty, social connectedness advise within surgeries.
- **NHS implementation of a population wide CVD programme:** diabetes, One you, Rotherham Get Healthy, Physical Activity Clinical Pad
- **Refocus of current lifestyle investment services**, for example: fuel poverty, active transport, clean air, debt and poverty advice
- **Patient and public engagement: community assets, shared responsibility**, for example: Well North approach, resilient children, families and communities

[12] www.nuffieldtrust.org.uk/news-item/prevention-is-better-than-a-cure#an-investment-worth-making