NHS ROTHERHAM

Notice is hereby given that a meeting of the NHS Rotherham Board will be held at 2.00 pm on Monday 15 November 2010 at Oak House, Moorhead Way, Bramley, Rotherham S66 1YY when the following business will be transacted

AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Notes</th>
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<tbody>
<tr>
<td>2.00</td>
<td>Apologies for absence (RK)</td>
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<tr>
<td>2.10</td>
<td>Declarations of members' pecuniary or non-pecuniary interests</td>
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<tr>
<td>2.20</td>
<td>To confirm the minutes of the Board meeting held on 18 October 2010 (AT)</td>
<td>Enclosure A</td>
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<tr>
<td>2.10</td>
<td>Matters arising</td>
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<tr>
<td>2.15</td>
<td>Chairman’s correspondence</td>
<td>Enclosure B</td>
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<td>2.20</td>
<td>Chief Executive’s report</td>
<td>verbal</td>
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<td>2.25</td>
<td>NHS White Paper</td>
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<td>2.25</td>
<td>To approve the winter plan for the local NHS (KA)</td>
<td>Enclosure Cx3</td>
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<tr>
<td>2.35</td>
<td>To receive the Local Safeguarding Children Board Annual Report and Business Plan and consider the implications for NHS Rotherham (JR)</td>
<td>Enclosure D</td>
</tr>
<tr>
<td>2.45</td>
<td>To approve a revised Performance Reporting Framework and note recent performance on health gain targets (RC)</td>
<td>Enclosure Ex2</td>
</tr>
<tr>
<td>2.50</td>
<td>To receive the performance report on Finance and Contracts (CE)</td>
<td>Enclosure F</td>
</tr>
<tr>
<td>3.00</td>
<td>To note progress on Efficiency Programmes (RC/CE)</td>
<td>Enclosure G</td>
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<td>To consider next steps in delivering efficiencies - with particular regard to referrals management (AB)</td>
<td>Enclosure Hx5</td>
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<td>A number of GPs have been invited to participate in the discussion</td>
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<tr>
<td>3.45</td>
<td>Break</td>
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<td>4.00</td>
<td>To receive assurance on workforce matters at contracted providers (PF)</td>
<td>Enclosure I</td>
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</table>

Performance Management

K:\primary care trust board\pct board papers 2010\public board papers\11 november 2010\2010 11 15 board public agenda.doc
14. To consider progress against Human Resource Key Targets (PF) Enclosure J

15. Pharmacy Services - lunchtime availability (KA) Enclosure K x 2  4.10

Corporate Business

16. To receive the minutes of the Audit Committee meeting held on 9 September 2010 (JG) Enclosure L  4.15

17. To receive the minutes, and Decision Summary, of the Yorkshire and the Humber Specialised Commissioning Group meeting held on 24 September 2010 (AB) Enclosure M x 2  4.20

18. To receive the minutes of the Professional Executive meeting held on 6 October 2010 (CC) Enclosure N  4.25

19. To receive the minutes of the Rotherham Community Health Services Committee meeting held 6 October 2010 (PW) Enclosure O  4.30

20. To receive the minutes of the Joint meeting of NORCOM held on 8 October 2010 (AB) Enclosure P  4.35

21. To receive the minutes of the Commissioner-only meeting of NORCOM held on 8 October 2010 (AB) Enclosure Q  4.40

22. To receive feedback from the Audit and Quality Assurance Committee meeting, held on 20 October 2010 (CC) Enclosure R x 2  4.50

23. To receive the minutes, and Decision Summary, of the Yorkshire and the Humber Specialised Commissioning Group meeting held on 22 October 2010 (AB) Enclosure S x 2  5.00

For Information

24. Medical Profession (Responsible Officers) Regulations 2010 (JR) Enclosure T  5.10

25. To note the approval of applications for new pharmacies (KA) Enclosure U x 2  5.15

26. Date, time and venue of next Board Meeting: Monday 13 December 2010 at 2.00pm at Oak House, Moorhead Way, Bramley, Rotherham
NHS ROTHERHAM

Minutes of the NHS Rotherham Board meeting held on
Monday 18 October 2010 in the Elm Room, Oak House

Present: Mr A Tolhurst (Chairman)
Mr A Buck
Dr R C A Collinson
Mr C Edwards
Mr J Gomersall

Mr M Hamstead
Mrs R Kapoor
Dr J Radford

In Attendance: Mrs K S Atkinson, Director of Strategic Planning
Dr R Carlisle, Director of Intelligence and Performance
Mrs P Fryer, Director of OD, Workforce and Governance
Mr A B Tenany, Board Secretary
Mrs H Watts, Assistant Director of External Relations

(Item 232/10) Mrs S Cassin, Head of Clinical Governance
(Item 233/10) Mr A Cribbis, Head of Organisational Development

222/10 Apologies
Apologies for absence were received from Mr Stonebridge and Mrs Wade.

223/10 Declaration of Members’ Pecuniary or Non-Pecuniary Interests
a) 231/10 GP-led Commissioning
Dr Collinson declared an interest in the above item.

224/10 Minutes of the previous meeting
The minutes of the Board’s special meeting - in regard to Shaping Our Future - held on
20 September 2010 were confirmed as a correct record.

The minutes of the (routine) Board meeting held on 20 September 2010 were confirmed
as a correct record.

225/10 Matters Arising (from the routine meeting)
a) 194/10 Chairman’s Correspondence - White Paper implications
Councillor Stone had accepted the invitation to attend Board meetings on a regular
basis.

b) 195/10c Chief Executive’s Report - South Anston branch surgery
Following the September Board meeting, a one hundred and fifty signature petition had
been submitted to the practice and passed on to NHS Rotherham officers. The Board
considered again the issues of the:-

i. journey some patients would now have to make to the premises at North Anston,

ii. reducing use of the premises at South Anston – which was partly due to reduced hours of availability,

iii. potential loss of a pharmacy in South Anston,

iv. adequacy of the practice’s publicity about their proposed closure at South Anston,

v. adequacy of the premises at South Anston.

The Board concluded that the Dinnington Group practice’s closure of premises did not merit active seeking of an alternative provider for that part of Anston.

c) 198/10 Corporate Parenting

Mrs Whittle would be the NHS Rotherham representative on the RMBC’s Board.

d) 202/10 Inspection by Ofsted and Care Quality Commission

The RFT had been given three months to comply with the requirement for a paediatric “expert” in the A&E department, but was now challenging the detail of the requirement.

226/10 Chairman’s Correspondence

Mr Tolhurst reported on his activities in the preceding month.

He had been pleased to attend the NHS Yorkshire and Humber Health and Social Care Awards evening – at which NHS Rotherham had two very worthy nominations, of which one had succeeded.

A meeting of chairs from South Yorkshire’s PCTs had discussed likely arrangements for GP commissioning consortia.

Mr Gomersall reported that he was now having regular meetings with the Chair of the Audit Committee for Rotherham Metropolitan Borough Council.

227/10 Chief Executive’s Report

Mr Buck presented his monthly update to the Board, highlighting the following:-

a) The success at the Awards evening was in parallel to the new NHS Rotherham website winning three separate national awards.

b) A response to the Coalition Government’s White Paper had been submitted and the Board endorsed its contents.

c) Over twenty staff would be leaving soon under the voluntary redundancy and voluntary early retirement scheme. A collective farewell event had been arranged for 2 November and Board members were invited to attend.
d) The executive summary for the serious case review of Child T was noted and Dr Radford confirmed that actions in response to the findings were in hand.

e) The executive summary for the serious case review of Child W was noted and Dr Radford confirmed that actions in response to the findings were in hand.

f) A numerical analysis of freedom of information requests since April 2010 was received.

228/10 White Paper

Consultation on the White Paper and some associated supporting papers had now closed. Two further papers had been issued for consultation - on Choice and on Information.

229/10 Governance Arrangements

Mr Tenanty explained that the departure of two of the six non-executive directors (NEDs) of the Board had prompted a review of NEDs’ presence on Board committees. At the same time, the opportunity has been taken to develop thinking about a merger of the Audit Committee with the Governance, Quality & Risk Committee.

The Board approved:-

a) A merging of the Audit Committee and the Governance, Quality & Risk Committee.

b) The selection of Mr Gomersall as Chairman of the newly merged committee, viz. Audit and Quality Assurance Committee (AQuA).

c) A ceasing of non-executive director input to the Communications & Public Engagement Committee.

d) A revised assignment of non-executive directors to the other committees.

The diagram showing committees of the Board, and the table of NEDs’ assignments to committees, would be updated ¹ and placed on the website.

Action: Board Secretary

It was also agreed that NEDs would only be involved with annual commissioning reviews of general medical practices on an exception basis.

The terms of reference for the AQuA were approved, subject to the inclusion of a statement explaining that the committee was to perform all functions that might be required of an Audit Committee.

¹ table to be amended as per (b) above
230/10  GP-led Commissioning

Dr Collinson introduced a paper which set out proposals to enhance the input from GPs in the commissioning of services. The two key features of the proposals were:-

a) Until GP commissioning consortia arrangements were established by the government, NHS Rotherham remained the responsible body for the commissioning of health services.

b) The replacement, in the meantime, of the existing Professional Executive and the Practice-Based Commissioning Group with a single multidisciplinary group.

Proposals continued to be discussed with GP representatives and had, to date, seen the inclusion of a “GP Reference Group” to support the work of the group described in (b).

After some discussion, Mr Buck was authorised by the Board to continue discussions that would refine the proposal. The costed solution would be brought to the Board’s November meeting with the aim of recruiting to the numerous new positions before the calendar year end.

231/10  Better Health, Better Lives

Mrs Atkinson explained that the NHS Rotherham strategy “Adding Quality and Value” (agreed in 2009) had been reviewed. The result was thought to reflect the priorities of the new government and to be consistent with the reduced commissioning capacity available to NHS Rotherham.

The Board agreed a single sheet – showing priorities, ambitions and initiatives – subject to the initiative on alcohol misuse being upgraded from “maintenance” to “high priority”.

232/10  Clinical Governance Plan for 2010/11 - Mid-Year Update

Mrs Cassin explained that although the clinical governance plan for 2010/11 had not been brought previously to the Board, it had been developed via the Governance, Quality & Risk Committee. The plan sought to clarify the commissioner-only aspects of clinical governance.

The agenda paper was a mid-year update on progress against the plan. Board members recognised that much work had been undertaken to date, but felt that the update had not captured all that was either happening or should be happening. Mrs Cassin noted some examples of omissions.

The Board received the plan, and its update, and asked that a more comprehensive version be developed by officers – in liaison with the newly formed Audit and Quality Assurance Committee.

Action: Chief Executive
233/10 Organisation Development and Human Resources Plan

The Board received an update on progress, as at September 2010, against the agreed organisational development and human resources plan. Mrs Fryer acknowledged that the update in respect of “Effective External Partnerships” (table F) could usefully refer to Mr Gomersall’s work on developing a strategy on safeguarding requirements.

Because many changes were being effected in the next six months the plan had been reviewed. The Board agreed the proposed revisions to the plan, subject to some minor changes.

**Action: Director of Organisational Development, Workforce & Governance**

234/10 Performance Report – Vital Signs

Dr Carlisle presented a “Vital Signs Indicators” report, drawing attention to the following:-

a) The usual report on performance against health gain targets had been refocused, for this month, on performance against the vital signs. Every PCT was required to publish its performance annually against these indicators.

b) Subsequent months would see an alteration to the content of reports on performance against health care targets – in order to reflect changes in the performance and accountability frameworks.

c) Teenage pregnancy rates had fallen and a full report would be brought to the November Board meeting.

d) Rotherham’s GPs were being urged to increase the take-up of health checks by people with learning disabilities (VSC 22).

**Action: Director of Intelligence and Performance**

The Board thanked Dr Carlisle’s team for the comments shown against each indicator.

235/10 Performance Report – Efficiency Programmes

Dr Carlisle presented a report on progress in securing efficiencies, against the programme previously agreed by the Board, and drew attention to the following:-

a) The financial target for 2010/11 was likely to be met, but progress against securing longer term efficiencies was less certain.

b) The volume of GP referrals to hospital care remained high. Dr Collinson explained that the Clinical Referrals Management Committee had made less progress to date than was needed, but the arrangements currently under discussion were promising.

The Board asked to receive a full report, from all directors, on the pursuit of efficiencies. The discussion might be supported by the presence of some GPs interested in commissioning

**Action: Chief Executive**
236/10 Performance Report – Finance and Contracts

Mr Edwards presented the performance report on finance and contracts, drawing attention to the following:-

a) The government’s Comprehensive Spending Review was soon to be published. The implications for NHS Rotherham may take an additional few weeks to determine and revisions to the Medium Term Financial Plan were likely to be needed.

b) Expenditure on continuing health care far exceeded the set budget. The operating cost statement for end-August 2010 (p6 of the report) showed overspends on continuing health care (CHC) and on hospital and community health services. The confidential meeting of the Board held this same day discussed a briefing report on CHC which had been prepared for the Rotherham Metropolitan Borough Council’s Chief Executive.

The statement for end-September 2010 had just been produced and was tabled. The updated statement showed a worsening of the overspends. Information on that part deriving from “drugs outwith acute hospital contracts” would be shared with the Prescribing Committee.

c) NHS Rotherham remained on course to achieve its control total for 2010/11, but only because it had access to funds on a non-recurrent basis. There was a substantial risk, in subsequent years, that non-recurrent funds would not cover the recurrent overspend.

d) The required reduction in management costs for 2010/11 was expected to be achieved largely because of the high numbers of commissioning staff agreeing to be released from the organisation. Efforts to reduce the internal provider’s management costs continued. The proposed new commissioning arrangement would be counted as management costs and may not be less than the current level of spend.

e) Eighteen general dental practices were currently accepting new NHS patients.

237/10 Professional Executive

The minutes of the Professional Executive meeting held on 1 September 2010 were received and noted.

Direct access to magnetic resonance imaging (minute 161/10) was valued by some GPs. An assessment of its benefits was still in progress.

238/10 Rotherham Community Health Services (RCHS) Committee

The minutes of the RCHS Committee meeting held on 1 September 2010 were received and noted.
239/10 NORCOM

The (unadopted) minutes of the joint meeting of NORCOM held on 10 September 2010 were received and noted. Minute 4ai referred to the failure to date of some providers to reach agreement on future arrangements for breast screening. Commissioners were endeavouring to resolve the situation.

The (unadopted) minutes of the commissioner-only meeting of NORCOM held on 10 September 2010 were received and noted.

240/10 Practice-Based Commissioning

The 2009/10 Annual Report of Practice-Based Commissioning in Rotherham was received and noted. The key feature of the year has been the successful attempt to improve clinical engagement.

The (unadopted) minutes of the Practice-Based Commissioning Approvals Committee meeting held on 15 September 2010 were received and noted.

241/10 Yorkshire and the Humber Specialised Commissioning Group (SCG)

The 2009/10 Yorkshire and the Humber SCG Annual Report was received and noted.

The Board adopted a revised Establishment Agreement and Scheme of Delegation for the SCG.

242/10 Rotherham Partnership Board

The minutes of the Rotherham Partnership Board meetings held on 25 March 2010 and 10 May 2010 were noted.

243/10 Infection Control

The Board received the 2009/10 Annual Report on Infection, Prevention and Control. The Board agreed that the report provided assurance that all providers within Rotherham were fulfilling their legal obligations with regards to infection, prevention and control. The Board was pleased to note the good progress in 2009/10.

244/10 Research Governance

The Board received the annual report for 2009/10 on Research Governance and expressed its support for research activities to continue.

245/10 Date, Time and Venue of Next Meeting

The next meeting of the Board was scheduled to take place on Monday 15 November 2010 at 2.00 pm at Oak House, Moorhead Way, Bramley, Rotherham.
NHS Rotherham
Board – 15 November 2010

Chief Executive's Report

Contact Details:

<table>
<thead>
<tr>
<th>Lead Director:</th>
<th>Andy Buck</th>
<th>Lead Officer:</th>
<th>n/a</th>
</tr>
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<tbody>
<tr>
<td>Job Title:</td>
<td>Chief Executive</td>
<td>Job Title:</td>
<td>n/a</td>
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Purpose

This report informs the Board about national and local developments in the past month.

Shaping Our Future

We are making positive progress with the implementation phase of the Shaping our Future programme:

- Negotiations with the two foundation trusts and the Hospice are progressing positively;
- We have resolved most of the outstanding issues about support services and “non-aligned” staff;
- The Department of Health and NHS Yorkshire and the Humber have approved the proposed transfer of staff to Rotherham Hospice;
- We have made our submission to the Cooperation and Competition Panel; this concerns the transfers to Rotherham Foundation Trust and Rotherham, Doncaster and South Humber Foundation Trust only;
- The two foundation trusts are undertaking their due diligence exercises, and are liaising with Monitor to secure the necessary approvals for the transfers;
- The two foundation trusts are also liaising with the Care Quality Commission to make the necessary changes to their registration; the Hospice’s CQC registration application has been submitted and is being considered; we will need to terminate our CQC registration at the point of transfer;
- The Hospice has secured admitted body status with the NHS Pension Scheme;
- The business case for the social enterprise is being prepared and will be presented to the Board in December;
- We are preparing for the statutory TUPE process, which we anticipate beginning in February 2011.

Subject to all these processes being satisfactorily concluded, we expect the formal transfer of services and staff to take place on 31 March 2011.
**Rotherham Occupational Health Advisory Service** (ROHAS)

Members will recall that the special Board meeting in September - on the future of our community health services - noted that the proposed transfer of ROHAS to the Rotherham Foundation Trust had been withdrawn during the course of the consultation period.

ROHAS has now been transferred to the Public Health Team under the management of Joanna Saunders, Programme Manager for Staying Healthy. The team will move into Oak House at end-January 2011. A business case and detailed briefing is being developed for the future commissioning of the service.

This transfer decision was made to ensure that the unique support provided by the very small staff team can be maintained and developed. It can complement the focus of the Local Strategic Partnership in promoting health and wellbeing and employment opportunities across the Borough.

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**Claims Management Policy** (and Procedure)

The policy approved by Board in November 2007 has been reviewed and simply needed updating to reflect subsequent changes in terminology. The Board is asked to note that it has been updated in that way.

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**Communications Report – 9 October – 5 November 2010**

**Highlights**

- NHS Rotherham received a bumper crop of awards over recent weeks - the new website and the associated fitness campaign, ‘one small step’ received best NHS website award and the overall best website in the national Sitekit awards and was runner up in the national Association of Healthcare Communications and Marketing (AHCM) Awards for Best New Media and the Children and Young People’s Specialist Equipment Development Team received the Excellence in Commissioning Award at the Yorkshire and the Humber Health & Social Care Awards.

- Chairman, Alan Tolhurst’s reappointment for a further 4-year term was covered by Rotherham Advertiser, Rotherham Record, The Star, Yorkshire Post and Rother FM.

- The recent extension to Highfield Road Surgery was reported in The Star, Yorkshire Post, south Yorkshire Times and Rotherham Advertiser.

- Weight Management Camp success was celebrated in the Yorkshire Post, Dinnington & Maltby Guardian and The Star

- A wave of media interest was sparked by threats to cut the funding to the Ministry of Food. Articles appeared in The Guardian, Yorkshire Post, Rotherham Advertiser, the Star and Dinnington & Maltby Guardian.

- Coverage has continued around the outcome of the hearing for dentist Mr Siddiqui, both The Star and Rotherham Advertiser have covered the story in detail.

**Quick Statistics:**


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<td><strong>Number of media enquiries dealt with</strong></td>
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<td><strong>Number of articles in media</strong></td>
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**Website Statistics:**

Visit the NHS Rotherham website at: [www.rotherham.nhs.uk](http://www.rotherham.nhs.uk)

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**Top 10 pages**

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**New developments:**

- Stage 1 of a new A-Z of services for patients & GPs based on PBC data
- CMS email newsletters
- Seasonal flu health information section
- Cook It recipes section

**Key Words:**

Andy Buck, Shaping Our Future, **Rotherham Occupational Health Advisory Service**, Hospice, Claims Management Policy, website, Communications
NHS Rotherham

NHSR Board – 15th November 2010

Winter Planning 2010/11

Contact Details:

<table>
<thead>
<tr>
<th>Lead Director: Kath Atkinson</th>
<th>Lead Officer: Dominic Blaydon</th>
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<tr>
<td>Title: Director of Strategic Planning and Development</td>
<td>Title: Programme Manager – Long Term Conditions and Urgent Care</td>
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Purpose:

The report sets out winter planning arrangements for health and social care in Rotherham including resources and capacity put in place to manage the impact of winter pressures which includes the Christmas and New Year holiday period.

The Strategic Health Authority require NHS Trusts to approve their winter planning arrangements at Executive Team Level by the 1st November 2010 and to provide assurance that all NHS organisations within our borough have reviewed their capacity and capability to manage any expected increase in demand for the Winter Period. This report assists NHS Rotherham in complying with this requirement (Appendix 2)

Recommendations:

It is recommended that the NHSR Board:

- Note the arrangements that have been put in place to cover winter pressures.
- Endorse the Surge and Rapid Discharge Plan (Appendix 1)

Background:

The NHS Regional Planning Framework (October 2010) sets out the responsibilities of PCTs in relation to winter planning. PCTs are expected to;

- Provide the leadership role to the local health community in planning for winter, supporting and working with organisations to ensure they have risk based plans in place to meet the challenges of winter.
- Ensure that organisations providing NHS Commissioned Care fulfil their contractual duties in relation to both business continuity planning and winter preparedness
- Ensure that the PCTs own escalation plans for dealing with pressures recognises the higher-level requirements of winter preparedness.
- Take the appropriate management action where pressures in the local health system impact on service delivery.
- Ensure that there are clear protocols for the co-ordination of the health and social care economy in order to maximise the use of community hospital bed capacity in liaison with
local acute hospitals and any available local bed management system

- Monitor the impact/effects of winter on vulnerable groups, such as children, dialysis patients, elderly, physical disabled clients and mental health patients.

Since January 2010 NHS Rotherham and partner organisations across health and social care have established the Rotherham Emergency and Urgent Care Network. The main purpose of the group is to develop an integrated and effective Urgent and Emergency Care Services and pathways across the health and social care community. The group meets monthly and Winter Planning is a standard agenda item where any issues can be discussed and addressed. The group has recently developed:

- The Rotherham Surge and Mass Discharge Plan
- Real time monitoring of activity and performance across the health and social care

The following key areas have been covered in operational readiness (capacity and staffing) for the winter period:

- Primary Care/Out of Hours
- Rotherham Community Health Services
- Social Care
- Ambulance Services
- A&E/Critical Care Services
- Preventative measures
- Communications
- Industrial relations.

**Analysis of Risks:**

NHS Rotherham has identified the following risks which could affect operations during the winter period.

The social work service at the hospital will be affected during the local authority shut down period. This means that people who are in hospital and are fit for discharge but require a social care package may experience delays in discharge. This is no change to previous years and is recognised as an issue that needs addressing for future years.

The Advance Nurse Practitioner Service, a specialist nursing service delivered within care homes, is currently under review and not operating to the service specification agreed with the provider. This is affecting performance on reducing the number of A&E admissions from care homes. Failure to reverse this performance issue could put pressure on emergency services during the winter period.

**Return on Investment:**

NHS Rotherham’s Winter Plan does include non-recurrent investment through the PBC investment fund. This should provide help to ensure a reduction in the number of avoidable hospital admissions and reduced length of stay. As well as delivering potential saving within the health economy this short term investment will improve bed availability at the hospital
front end, where bed pressures tend to be greatest during the winter period.

Analysis of Key Issues:

NHS Rotherham has introduced a range of initiatives which will ensure better co-ordination of services and deliver targeted resource where necessary.

1. **Strategic Planning**

1.1 The Rotherham Emergency and Urgent Care Network meets monthly and has representation from across all partner agencies and aims to ensure integrated and effective care pathways for patients with emergency and urgent care needs. This enables a whole system approach for unplanned care, including winter planning.

1.2 NHS Rotherham is also collating daily sitrep reports looking at activity, performance, bed capacity, staffing issues and any effect this may be having on services. This is being done to collate information across health and social care; RFT, A&E, RCHS, YAS, WIC and GP Out of Hours. This will provide real time data to highlight any problems as they happen.

1.3 A Surge and Mass Discharge Plan has been developed for use by NHS Rotherham in collaboration with partner organisations. The plan is primarily based on supporting health care organisations to manage significant increase in demand in the event of a surge. The plan has been devised and agreed with partners and stakeholders. Once the surge plan has been triggered mechanisms will be put in place to increase patient flow.

1.4 The Urgent Care team is currently in the process of collating winter plans from the provider organisations in the health and social care community. Feedback indicates that most providers are fully prepared and resourced to meet the demands of the winter period.

2. **Rotherham Foundation Trust**

2.1 Rotherham Foundation Trust is confident it will be able to respond to the increase in demand over the winter. Contingency arrangements are in place to ensure urgent elective work will continue during times of unexpected pressure. There is an expected reduction in bed occupancy over the Bank Holiday period due to natural reduction in elective activity. The Trust has an escalation plan for In-Patient medical beds, and Accident & Emergency and Medical Assessment Unit within their Patient Flow Policy for Adults.

2.2 RFT is also looking at proposals for changes to Ward B1. This would be to provide enhanced diagnostics and therapy over weekends and evenings to improve patient flow. This will facilitate admissions avoidance and expedite discharge of patients.

2.3 The Trust’s Discharge Strategy Group is developing a priority work plan to coordinate
effective discharge planning for complex patients; frequently older patients with multiple co-morbidities, often with dementia, and fragile social support. This will aid any pressures on winter demands.

3. **Social Care**

Rotherham Borough Council will shut down during the Christmas and New Year period. This shut-down period is likely to have an impact on delayed hospital discharge times and hospital admissions. Rotherham PBC Approvals Committee has recently endorsed proposals to appoint a social worker to work alongside the Fast Response Service over the winter months. The provision of non-recurrent funding for this service will expedite discharge from A&E, CDU and the Medical Assessment Unit. As well as increasing bed availability during winter it will reduce admissions and increase likelihood that some admissions will only incur a short stay tariff.

4. **RCHS**

4.1 The Fast Response Service will be available 24 hours a day, 7 days a week over the Christmas and New Year period. The service will also have an attached social worker for a 5 month period over the winter months (see above).

4.2 In Intermediate Care the capacity and number of beds is believed to be sufficient to meet the anticipated demand over the winter period.

4.3 The in-patient service at Breathing Space will be open 24 hours a day, 7 days a week and will not be closed over the bank holiday period.

4.4 The Advanced Nurse Practitioner (Care Home Liaison Service) has been identified as a risk in this report. These specialist nurses can independently assess, diagnose and treat minor illnesses and injuries and can prescribe medication. Cover is provided to all care homes registered with the Care Quality Commission and within the boundaries of the Rotherham Local Authority. The service is scheduled to be available over the bank holiday period but is not currently fully operational.

5. **GP, Dental and Pharmacy Arrangements**

5.1 Arrangements are in place with GPs, Dentists and Pharmacists to ensure that people can access these services over the Christmas and New Year period. Pharmacy rotas have been completed and show a good spread of availability across the bank holidays. The Emergency Dental Service is also available for patients needing emergency dental treatment over this period.

6. **GP Out of Hours**

6.1 Care UK has already produced their rotas for all staff groups for this period to cover expected increases in demand over the bank holiday weekend. They also have additional doctors on standby over this period that can be called on to give extra cover. They expect their busiest times to be the weekend prior to Christmas (18th and
6. **Walk in Centre**

6.1 The Walk in Centre will be operating as normal, except for Christmas Day. The extended hours are now 8.00am to 9.00pm.

7. **Yorkshire Ambulance Service**

7.1 Demand is expected to peak in the second half of December due to the increase in celebrations and alcohol related incidents. YAS are currently meeting their performance targets. Handover of patient care from ambulance to acute trust is not considered to be a problem within Rotherham; much work has been undertaken to address this. YAS has plans in place to cope with unforeseen peaks. These will be triggered by a reduction in performance and/or an increase in demand.

8. **NHS Direct**

8.1 NHS Direct expect a sustained increase in demand over the winter period. Because NHS Direct work as a national call centre with a number of sites they can load share and move calls across the centres to manage activity and capacity across the country. Non essential off-line activity is kept to a minimum during the run up to Christmas and the early part of January. NHS Direct has an escalation plan in place to manage increase in demand and maintain business as usual.

9. **Learning Disability and Children’s Services**

9.1 Still awaiting information on these services

10. **Mental Health**

10.1 RDaSH will continue to operate their in-patient services as normal. The Crisis Intervention Team will continue to work the bank holiday period with the team supporting A&E as they do out of hours. The service does not anticipate an increase in demand over the winter period with regards to mental health/learning disability services. RDaSH has an escalation plan in place that outlines how it will manage periods of high demand and disruption for its services. RDaSH also has a Winter Plan in place that has been modelled on last year’s Pandemic Plan.

11. **Flu Immunisation**

11.1 All front-line NHS and RMBC employees whose role involves patient contact with the service users will be offered immunisations. Drop in sessions have been made available in various locations.

<table>
<thead>
<tr>
<th>Patient, Public and Stakeholder Involvement:</th>
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<tbody>
<tr>
<td>Communications on winter planning arrangements will reflect those of last year. Advice to the public will be carried out through local press.</td>
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</table>
**Equality Impact:**
Ensuring that robust winter plans are in place are key to the more vulnerable members of the community.

**Financial Implications:**
It is important to ensure that all the risks and issues highlighted in this paper have been considered as part of the forecasting process for contracts in which remuneration is activity driven and influenced heavily by winter pressures.

Approved by: John Doherty

**Human Resource Implications:**
The Trust has considered the possibility of industrial action that could impact on delivery of service and has reviewed workforce plans to ensure essential functions will be maintained.

Approved by: Peter Smith

**Procurement:**
There are no procurement implications.

Approved by:

**Key Words:**
Winter Planning

**Further Sources of Information:**
SHA winter planning checklist.
AMENDMENTS

DOCUMENT OBJECTIVES
An integrated framework to assist with the management of capacity and demand (surge) in health care.

INTENDED RECIPIENTS
NHS Rotherham, The Rotherham NHS Foundation Trust, Yorkshire Ambulance Service, General Practitioners, Rotherham Community Health Service, Rotherham Local Authority, Care UK

GROUPS/PERSONS CONSULTED
Representatives from all of the recipients above. The Emergency Care Network.

MONITORING AND REVIEW ARRANGEMENTS
The plan will be monitored by the NHS Rotherham Emergency Care Network. The plan will be reviewed annually by the Programme Manager for Urgent Care.

TRAINING/RESOURCE IMPLICATIONS
Staff awareness of plan and actions to be taken.

RATIFYING BODY AND DATE
RATIFIED
NHS Rotherham Board

DATE OF ISSUE

REVIEW DATE

CONTACT FOR REVIEW
Ms Gaynor Young, Emergency Planning Manager NHS Rotherham
Tel: 01709 303745
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1. Introduction
1.1 This integrated plan is intended for use by NHS Rotherham in collaboration with partner organisations. The plan is primarily based on supporting Health Care Organisations to manage significant increase in demand in the event of a surge. It is recognised that interface with social care will be critical to ensure effective management of patients. This plan has been devised and agreed with partners and stakeholders.

1.2 Each Health and Social Care Organisation has well developed surge plans and/or business continuity plans in place. These plans detail command and control processes, increasing capacity, service prioritisation and patient prioritisation. This plan outlines NHS Rotherham's integrated approach to managing surge.

2. Aims and Objectives
2.1 This document provides NHS Rotherham with a framework to support the management of surge across the health community. It facilitates the initiation of Rotherham's Accelerated Integrated Discharge (RAID) plan and complements existing partner organisations’ plans.

2.2 The plan will be activated to ensure a co-ordinated response in the event of a corporate interruption to services in relation to a surge.

The plan will be invoked when either:

A service is so severely affected that it is unable to maintain its key functions without support from other service areas.

The business interruption has affected more than one service and has potential to severely affect the overall key functions of the local health and social care community.

3. Managing Demand and Capacity in healthcare (Surge)
3.1 Surge is defined as

   The ability of the health service to expand beyond normal capacity to meet an increased demand for clinical care

   DH (2009)

3.2 Surge can be experienced when one or more of the following apply:

   • There is a significant increase in the volume of patients
   • There is a significant decrease in the number of staff available
   • The flow through the system is impeded at some point

3.3 This plan will not necessarily be introduced when the hospital goes on red alert during the winter period as this should be dealt with under business continuity arrangements. There needs to be a major incident or outbreak for this plan to be activated and all partner organisations will need to agree the initiation of the plan. The disruption on
health services may be prolonged and the response to managing a surge may need to be sustained.

3.4 Whilst it is acknowledged that most ill people will be cared for in primary care; the ability of health and social care services to cope will be placed under huge pressure. The impact can cause widespread disruption across the whole of the health and social care system. It is crucial that organisations work collaboratively in managing surge, as even though they individually may not be experiencing an impact, organisations experiencing surge will require support.

4. Notification/Activation

4.1 The surge plan can be activated by the following personnel.

NHS Rotherham Director on Call
NHS Rotherham Director of Public Health

Notification of a surge and a request to trigger the surge plan may be made by The Rotherham Foundation Trust Director on call, although, the decision to activate the surge plan will be made by the NHS Rotherham Director on Call or the NHS Rotherham Director of Public Health.

Once notified, the above officer will clarify which stage we are currently operating in (see 3 stages below). NHS Rotherham will co-ordinate the Major Incident Team and arrange a multi-agency meeting to determine strategy.

4.2 Surge is categorised into three stages:

- Standby – early stages of alert when organisations begin preparations for responding to a surge. Assessment of current conditions, raising awareness of imminent surge and distribution of information to stakeholders. (More likely in ‘rising tide’ event).
- Activation – the surge plan is triggered and mechanisms for increasing patient flow are put in place. (More likely in a ‘big bang’ event or request for the activation of RAID see Figure 2).
- Stand down – when surge has subsided but there may be residual risk of surge in the near future.

4.3 Any phased reduction in the quality and performance frameworks in primary and secondary care will be agreed through the Major Incident Team or Crisis Management Team in line with national and regional guidance.

Figure 1 outlines the key actions initiated by organisations when a surge is triggered.
Business Continuity Plan
- Accelerated Discharge Plan
- Critical and essential services prioritisation
- Agreed suspension of performance targets and contracts
- Trust command and control
- Daily Sitrep reporting
- Increase in Critical Care Capacity level as required

- Business Continuity Plans
- NHSR Command and Control system across GP practices
- Suspension of agreed non essential services
- Budding arrangements
- Essential Services only
- Targets Suspended

Surge Plan Activated by NHS Rotherham

- Business Continuity Plans
- Escalation Plan
- Set up additional PCC staffed by local GPs
- Additional locum GPs employed

- Business Continuity Plans
- Accelerated Discharge Plan (ADP)
- Cease non essential services
- Re-deploy Staff to areas of greatest need
- Single Point of Contact for referrals
- Targets suspended

- Business Continuity Plans
- Accelerated Discharge Plan (ADP)
- Non urgent PTS services suspended and resources deployed to support urgent calls.

- Business Continuity Plans
- Accelerated Discharge Plan
5. **Managing Surge in Primary Care**

5.1 It is anticipated that primary care will care for the majority of sick people in a surge. There may be pockets of activity following an outbreak or incident or more widespread disruption affecting the whole area.

5.2 To be able to monitor the impact across primary care there is a FluCon reporting system that may be adopted for other events including to enable NHS Rotherham to monitor capacity and demand across Rotherham GP Practices, Pharmacies, Walk in Centre and Out of Hours Services. For familiarity across partners the report will continue to be called FluCon but will be reporting on any other outbreaks or incidents that result in a significant surge in workload.

The FluCon Reporting System can be seen in Appendix 1.

5.3 General Practices have business continuity plans in place and these will be activated during a surge.

5.4 When a general practice is experiencing FluCon amber practices will implement their business continuity plans.

5.5 Practices have agreed to a Command and Control structure that NHS Rotherham will operate if primary care is experiencing FluCon Red or when a significant number are all on amber. This means that GPs and practice staff will move and work from other practices according to need. NHS Rotherham will determine where to distribute resources.

5.6 Practices have organised ‘buddy’ arrangements that enable them to offer cover and support across practices. These arrangements mean that practices will be familiar with the IT systems and organisation of their ‘buddy’ practices. Where possible GPs will primarily provide cover in their buddy groups; however there may be occasions where a GP supports a practice outside of these arrangements due to exceptional surge in a particular area.

5.7 NHS Rotherham holds an up to date GP locum list. These locum GPs can be called upon to provide additional support to primary care.

5.8 To support practices in their management of surge, a staged approach to work prioritisation has been developed and is available as guidance; these have been classified as

- Essential Clinical Work
- Non essential Clinical Work
- Non essential admin.

Practices will use their own judgement when determining when and which services they will cease during a pandemic. They will liaise with NHS Rotherham prior to suspending services. Practices will maintain all core essential clinical services that meet the immediate and necessary needs of the patient.

5.9 Protection of Quality Outcomes Framework (QOF) and Directed Enhanced Services (DES) payments will be in accordance with current DH guidance or local guidance dependent upon whether the surge is national or local.
5.10 To support the RAID process practices will be notified of patients that undergo accelerated discharge from hospital. Practices are advised to flag these patients, so in the event that if the patient contacts them within 72hrs of discharge they are triaged as a priority by a doctor.

5.11 To help GPs reduce the number of paediatric referrals they will be able to discuss possible referrals with a Specialist Paediatric Registrar (SpR) or consultant by contacting the hospital switchboard and asking for the SpR or consultant on call.

6. Managing Surge Out of Hours (OOH)
6.1 Core GP practice hours cover less than a third of the hours in a week. Ensuring primary care cover is comprehensive for the remaining time is critical for the effective management of surge. OOH services are an integral component of primary care provision, and as such may require support from the GP community to enable them to continuing operating during surge.

6.2 NHS Rotherham’s OOH provider is Care UK. They have identified that one of their biggest difficulties will be dealing with the increase number of home visits that are likely to be generated. Currently 15% of all calls generate a home visit; a substantial increase in call volume is likely to more visits. Home visits are more time consuming; GPs on average cover one visit per hour, whereas a GP working from a primary care centre can see approximately six patients per hour.

6.3 OOH will be part of the FluCon reporting system set up by NHS Rotherham. It is entirely possible that OOH experience surge and report FluCon red when the core GP provision in hours is reporting green.

6.4 Care UK can increase their capacity through additional on call GPs. These GPs will be used flexibly to either triage from home or assist with home visits in the event of a surge in demand. Rotas include on call GPs that will be activated in the event of surge. These GPs are on a rota that they fill about 6 weeks in advance, although increasing the on call rotas will incur additional cost.

6.5 Other call handlers from Care UK sites across the UK can be brought in to assist or calls can be diverted to other call centres within Care UK.

6.6 At FluCon amber clinicians/non-clinicians will be asked to remain on duty and/or requested to start early. All clinicians will undertake triage, primary care centre (PCC) consultations and home visits. Doctors may be asked to undertake home visits in their own vehicles. Call volumes and patterns will be continually reviewed and rotas increased to meet demand.

6.7 At FluCon red all staff will be notified to be on standby to be called on at short notice. Clinical management will assess and prioritise calls in the triage pool to ensure safe delivery of care. Other branches of Care UK would be approached for experienced GPs to assist. Registrars would be used for PCC consultations and home visits where appropriate. Redeployment of staff would be made to all essential roles. Mexborough Montague will be opened during the week (usually only open weekends). Call streaming would be implemented (clinician will assess details already on the system as taken by the call handler and prioritise appropriately).
Surge Planning

6.8 Overnight triage nurses are currently being recruited (September 2010) and will be available for clinical input out of hours.

6.9 Additional drivers are available to support domiciliary visits. Additional cars will be hired as required.

6.10 While GP's have agreed to abide by the command and control structure for in hours care, no such agreement exists for covering out of hours care. Within Care UK's contract with NHSR, Care UK is expected to engage with and be fully integrated with PCTs Major Incident Plans to ensure that it plays a full part in terms of cooperation and assistance in line with its role in the Major Incident Plan. Local GPs may be approached to step up their contribution to OOH services. Likewise out of hours GPs may be approached to support GPs in hours dependent upon the circumstances of the surge.

6.11 The OOH service is integrated with the Walk-in Centre (WIC) and resources will be used flexibly across both services to manage surge.

6.12 In the event of a significant demand on OOH services to the extent that service provision is inadequate, additional Primary Care Centres (PCC) would be requested to open across Rotherham. For the pandemic flu surge plan 2009 it was agreed that the following centres would be opened strategically according to need:

- Thurcroft Village Surgery
- Wath Health Centre
- Maltby Joint Service Centre
- Kiveton Health Centre.

6.13 GPs working in the PCC will be paid at the same rate as GPs working for OOH at Care UK.

6.14 Opening additional PCC will require a coordinated approach between Care UK, NHS Rotherham and local GPs. The responsibilities would be as follows:

_Care UK will:_

- Be the main hub for managing OOH activity
- Continue to handle all calls OOH
- Triage all calls
- Direct patients to the appropriate PCC
- Ensure effective communication with the PCC
- Support home visits through the provision of drivers
- Enable the use of Adastra at the PCC
- Provide additional training on Adastra if required

_NHS Rotherham will:_

- Secure the use of additional PCC facilities as identified above
- Support the coordination of additional GP cover for the PCC
- Coordinate additional call handlers if needed
- Support OOH with the provision of additional reception staff at PCC
Surge Planning

Local GPs will:
- Work flexibly to offer support and availability to staff the PCC
- Where a GP routinely works for the OOH, they are enabled to continue doing so by the practice.

6.15 When OOH is experiencing extreme demand NHS Rotherham through the Major Incident Team or Crisis Management Team will determine whether the situation is an example of force majeure, in contract terms, and contribute to the increased services costs incurred as result of managing surge.

6.16 NHS Rotherham in discussion with Care UK will negotiate flexibilities within payments where Key Performance Indicators are not been achieved due to prolonged surge activities.

6.17 NHS Rotherham will allow Care UK to elongate front-end messages from beyond the mandated 30 seconds to allow them to direct patients to an alternative service if appropriate eg National Pandemic Flu Service.

6.18 NHS Rotherham will include all OOH staff in the vaccination programme as a priority, including call handlers and drivers.

7. Managing Demand in the Walk in Centre
NHS Rotherham’s WIC is integrated with the OOH service and is managed by Care UK.

7.1 For infectious disease and contaminated persons infection control measures will be in place to minimise the risk of transmission, a dedicated room, cohorted waiting area and where possible different team of staff should care for infected/contaminated and non-infected/non-contaminated patients.

7.2 If there is an increase of 20% or more of patients presenting with symptoms or injuries, consideration needs to be given to opening up a separate primary care centre. This would be staffed by Care UK.

7.3 Additional staff would be rostered from within Care UK to cope with increase in demand.

7.4 All staff will be a priority for vaccination.

7.5 Chantry Bridge Medical Centre and the WIC are integrated; they share space and can move staff and resources to match demand. The practice would suspend all routine activity as agreed and direct resource to the WIC.

8. Managing Surge at The Rotherham NHS Foundation Trust (RFT)

Adults
8.1 RFT has an escalation policy for patient flow in the event of a surge within their ‘Patient Flow Policy Adult’ (this is currently under review). The escalation plan consists of 3 phases dependent upon severity. These identify trigger points at which concern is raised regarding the ability to effectively manage admissions promptly and within routine procedures. Each escalation phase has detailed indicators and interventions for the In-Patient Medical Division, A&E and MAU, Patient Flow/Discharge, and
Surge Planning

Paediatrics. The interventions include alerts and liaison with other organisations within the local health community to co-ordinate services. In the event of a major incident or outbreak (see 4.) the RFT Director on call will contact the NHS Rotherham Director on call to make a decision whether to trigger surge plan.

8.2 Critical and Essential services prioritisation will be operating to determine the Trust responses and actions. At FluCon red level critical functions only would be maintained; these are identified in their plan as:

- Urgent Care Pathways
- Rapid Access Clinics
- Accelerated Discharge Planning
- Sitrep data collection
- Security of patients and staff

8.3 The number of level 3 ITU beds can be increased from 5 – 14 as needed.

8.4 Robust infection control measures are in place for dealing with infected or contaminated/suspected patients. Plans include segregated areas in A&E, ITU and the wards. Where there are excessive numbers Ward A2 will become a dedicated ward for patients who are infected or contaminated.

8.5 The Rotherham Accelerated Integrated Discharge (RAID) plan will be triggered. There are two main elements to this; one deals with current in-patients and the other for A&E (Fig 2 and 3 RAID plan).

8.6 The triggering of RAID will simultaneously initiate the cessation of any reimbursement charges being levied against Rotherham Metropolitan Borough Council until the agreed recovery phase and date has been identified, agreed and completed.

8.7 The process for accelerating the discharge of patients requiring a Continuing Healthcare assessment has been expedited. Four members of staff from the Continuing Healthcare Team (CHT) based at Oak House will be deployed to the RFT and report to the Medical Directorate, additionally Social Services will deploy dedicated Social Workers to work with the CHT to rapidly assess and determine as to whether the CHC criteria has been met. No formal panels will be held, however the service lead form health and Social Services will jointly undertake random audits to assure the decisions.

8.8 The process for accelerating the discharge of patients who require a social care package has been expedited. Patients who were already receiving a package prior to hospitalisation and where there is no change to the needs of the patient or package, the named nurse or Social Worker will make the request to restart the care package within 4 hours.

8.9 If there is a change to an existing care package or a new referral for care then additional Social Workers will be deployed if necessary to the hospital to assess within 4 hours of referral. The care package will be initiated within 24hrs of the assessment subject to service provision availability.

8.10 If there is a depletion of social work staff in the hospital social work team due to a surge, then additional social workers will be deployed to the hospital to support the RAID process.
Surge Planning

8.11 The process for accelerating the discharge of patients requiring other community services has been expedited. A single point of contact will be established as part of Rotherham Community Health Services command and control process. This will allow movement of resource to areas of greatest need. Additionally District Nurses and Community Matrons will in-reach existing patients on their case load that have been admitted and work with the ward to discharge early. There will be a rapid discharge team based in A&E comprised of Fast Response Staff and Social Worker, these will support ward discharges when demand A&E is reduced.

8.12 To facilitate accelerated discharge from A&E, the case managers or members of the care management team will be allocated to A&E, and will work with the Fast Response Team and Social Worker will work together to form a rapid discharge team. The case managers will identify patients appropriate for rapid discharge and notify the Fast Response Team and/or Social Worker. If necessary further assessments will be undertaken in the discharge area.

8.13 RFT have identified a pending discharge area where patients medically fit for discharge, but require either a health or social care package following discharge can wait. RFT will allocate staff who will be responsible for the management of these patients until they are discharged.

8.14 On triggering the RAID plan, the current referral criteria for the Intermediate Care Residential Service and Breathing Space Inpatient Services are temporarily suspended. RFT will be able to refer anyone to Intermediate Care if their care needs can be met. The Unit Manager of the Intermediate Care Unit will make an assessment to verify that the Unit can meet the care needs of the patient waiting for discharge. This assessment will take place within 4 hours of referral. The patient will not have to have a rehabilitation need to be accepted into an Intermediate Care bed. For patients who still require some nursing support RFT will provide in-reach nursing care for patients transferred to Intermediate Care.

8.15 Similarly Breathing Space Inpatient Services will accept all referrals from the hospital if it is safe to do so.

8.16 RFT will keep a stock of basic equipment to supply to patients to support the RAID process. This stock will be replenished daily by REWS, and enough stock will be left to ensure cover over the weekends and bank holidays.

8.17 Patients in hospital who are classed as delayed discharges due to the fact they are waiting for a place to become free in their choice of care home, will be informed and placed in appropriate and suitable alternative accommodation until a place becomes available in the home of their choice. RFT and Social Services have agreed a communication process to mitigate this.

Children

8.18 With a surge elective and non-urgent services will need to be suspended. Free beds may need to be commandeered by paediatric services. The hospital team have identified which wards are the best for paediatric services.

8.19 There are no dedicated paediatric intensive care beds at RFT. However in the extreme event of no paediatric beds available regionally, RFT have plans in place to utilise adult intensive care beds should it be necessary.
8.20 By changing the criteria for discharge patient turnover can be increased. This may reduce the margin of safety for discharge but is likely to be essential in the event of a severe pandemic. The current need for a patient to be off oxygen for 24 hours prior to discharge was discussed; these criteria will need to be discussed and agreed by the paediatric team.

8.21 A Specialist Paediatric Registrar (SpR) or consultant will provide specialist advice to GPs in the management of children.

8.22 If staff become scarce and the surge escalates, there may be a need for nursing staff to be authorized to assess and discharge patients. The hospital team will determine when and how this will occur.

8.23 The hospital team will increase ward stocks of medications to facilitate a speedier discharge.
Surge Planning

Patient currently in hospital

Discharge planning process has commenced

Multi-disciplinary and multi-agency team to assess individual patients for discharge.

Requires Continuing Healthcare Assessment
- 4 Staff redeployed from NHSR team along with 3 additional Social Worker to RFT to be managed by Medical Directorate
- Work together to expedite CHC process

Requires a Social Care Package
- Existing packages restarted within 4hrs by Nurse.
  New packages assessed by SW within 4hrs or ASAP
- Care Packages initiated rapidly to facilitate discharge

Requires other Community Services
- Referral to Single Point of Contact
- Services initiated rapidly to facilitate discharge

Enablers
- Stop routine CHC Panels
- Stop routine CHC reviews
- Decisions made jointly on the ward by CHT and SW
- Additional staff from Community Services deployed to CHT
- Streamlining of paperwork

Governance/Risks
- Continue End of Life and very complex care package reviews
- Random audit of assessments and outcome decisions by CHC lead in Health and Social Services

Enablers
- Day Care Services Suspended
- Duty only deal with urgent referrals
- SW redeployed to support ADP
- Suspension of delayed discharges payments

Governance/Risks
- Knock on impact on community support services when day care is suspended
- Build up of routine
- Delayed discharge payments may increase

Enablers
- Suspension of non essential activity as outlined in Business Continuity Plan
- Set up a SPC to enable distribution of workload to where resource is.

Governance/Risks
- Non Urgent work over a period of time can become urgent
- Recovery Period longer
- Potential delay built in the system if SPC poorly organised

Multi-disciplinary and multi-agency team to assess individual patients for discharge.
Rapid Discharge Team comprises of:

- Case Managers or members of the care management team in A&E
- Dedicated Social Worker
- Community Nursing Fast Response Service

To facilitate accelerated discharge the following must be in place:

1. Rapid access to Patient Transport Services within 2hrs
2. Equipment Supplies and delivery
3. Rapid access to TTO medications
4. Regular Community Bed status reporting including Intermediate Care
5. Primary Care and OOH must be informed of all rapid discharges and a system put in place to ensure that if any of these patients contact them within 72 hrs of discharge they are triaged by a Doctor as a priority.
Surge Planning

9. **Yorkshire Ambulance Services**
   9.1 YAS has a comprehensive business continuity and escalation plans in place.
   9.2 YAS plans focus on freeing up resources internally to focus on urgent calls. PTS would be diverted to support urgent calls as routine services would cease and resources would be freed as a result e.g. Outpatients. For non-urgent responses PTS could be used to support the RAID plan. RFT would advocate the use of our current third party provider for PTS to focus on facilitating patient discharge.

10. **Rotherham Community Health Services (RCHS)**
    10.1 RCHS have business continuity plans in place that identify and prioritise essential services in the event of surge resulting from staff absence.
    10.2 RCHS are an invaluable resource in terms of surge management. They have a large number of qualified healthcare professionals with expert knowledge of community working.

**Adult Services**
10.3 A single point of contact will be established as part of command and control system. This will streamline referrals and enable resources to be targeted to areas of greatest need.
10.4 Fast Response Services will be utilised to support RAID.
10.5 Community Matrons will in-reach to facilitate early discharge.
10.6 Team Leaders from District Nursing service will supplement the Continuing Healthcare Team as they sit on panels and understand the process.
10.7 The hospice minibus will be utilised to support the RAID process.
10.8 Rotherham Equipment and Wheelchair Services will ensure that stocks of equipment at RFT to enable RAID are adequate.
10.9 Additional stocks of pressure relieving mattresses and masks will be held at Breathing Space for the Fast Response Service to access.
10.10 REWS will operate an on-call over the weekend to ensure access to specialist is available.

**Children’s Services**
10.11 The Children’s Community Nursing (CCN) team have specialist skills and expertise in managing sick and complex needs children. During a surge they will be able to maintain children with complex health needs at home for longer. They will also support children whose discharge is accelerated, though follow up or as a resource for parents and carer’s who may need reassurance.
10.12 A single point of contact will be established for referral to community children’s services.
11. Local Authority

11.1 Social Work Team for adults will support the RAID, this will done in line with Business Continuity plans. Additional Social workers from the community will support cover at the hospital; community Social Workers will cover urgent duties only.

11.2 Dedicated Social Workers will form part of the Rapid Discharge Team working with the Fast Response and Case managers.

11.3 Protocols for accelerated Continuing Healthcare Assessment to streamline process and paperwork have been developed.

11.4 Day care services would be prioritised and suspended where necessary as part of Adult Services Business Continuity planning. This may free up additional resource to support surge management.

11.5 Exploring possibility of using transport services that are usually utilised for Day Care along with 2010 provider.

11.6 Agreement on who can authorise restart of existing care packages where no change has been identified.

11.7 Intermediate care is able to apply interim accelerated discharge arrangements to maximise service capacity.

11.8 Intermediate care capacity can be increased across Rotherham by utilising existing Residential Homes and the team in-reaching in conjunction with spot contracting arrangements as required.

11.9 Daily community bed status reporting will be coordinated through Netherfield Court and services will contact them for updates.

12. NHS Direct

12.1 Whilst 60% of calls are completed within NHS Direct without the need for onward referral to another health service, pressures on the NHS Direct service could still impact on other parts of the NHS, particularly during the event of a surge. NHS Direct NHS has an escalation plan in place to help minimise these.

13. Recovery

13.1 Decisions regarding prioritisation and reintroduction of quality assurance, performance frameworks and targets will be made by the Major Incident Team or Crisis Management Team.

13.2 There will a gradual resumption to restore services to pre-surge standards of clinical care.

13.3 In the recovery phase there will be a backlog of work before services will be operating normally. Staff may be tired, bereaved or have annual leave to catch up on, this will impact on service recovery and must be taken into account by the Major Incident Team or Crisis Management Team prior to the introduction of performance frameworks.
13.4 Organisations will identify priorities for ‘catch-up’ on deferred services and treatments.
This report aims to provide a picture of potential/occurring surge for primary and secondary health services in each SHA (or equivalent) across the UK. The information needs to be collated by the Lead PCT on a daily basis and then reported to the SHA and onwards to the DH (using this report form).

The Devolved Administrations should report as above, with the local NHS equivalents (i.e. PCTs and Trusts) reporting to the Lead PCT or regional NHS equivalent (i.e. SHA), with some final collation at the national coordination centre before onwards reporting to the DH.

(This will be confirmed in the event of a surge).

Data must be for the proceeding 24 hour period ending 0800 today (day of reporting)
- PCT and Trusts need to submit data to their Lead PCT by 13:00
- Lead PCT to submit data to SHA by 14:00
- SHA & DAs to report to DH by 15:00

hscreporting@dh.gsi.gov.uk

NB: All fields on both Primary Care and Secondary Care worksheets are mandatory

### FLUCON STATUS

<table>
<thead>
<tr>
<th>PRIMARY CARE</th>
<th>SECONDARY CARE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Including community pharmacies, GPs, Out-of-hours &amp; Ambulance services etc)</td>
<td>(Including Mental health, Speciality &amp; Foundation Trusts etc)</td>
<td>SURGE 0 GREEN</td>
</tr>
</tbody>
</table>

**PANDEMIC NOT YET IN LOCALITY / PREPARATION OR RECOVERED**

- Current status as ‘normal’ for season
- Preparatory work underway
- Available appointments at GPs
- Increased number of ‘worried well’
- Reviewing plans for business continuity
- Returning to normal operation

**LOW SURGE: SLIGHT EFFECT ON SERVICES**

- Implementation of business continuity plans
- Planned closures
- Reduction in non-critical services
- Enhanced coordination between health and social care

**MEDIUM SURGE: MODERATE EFFECT ON SERVICES**

- Triage of patients attending service
- Implementation of admission and discharge criteria
- Unplanned closures of some critical services and treatment

**HIGH SURGE: MAJOR DISRUPTION TO SERVICES**

- Critical – services not coping
- Demand outstripping supply for critical services
**Winter 2010 ASSURANCE FRAMEWORK**

**Trusts Name:** NHS Rotherham

**Name/s of Winter Lead/s:** Dominic Blaydon  
**Form Completed by:** Chris Brown/Adele Taft  
**Date:** 29th October 2010

<table>
<thead>
<tr>
<th>Winter Preparedness (All Trusts)</th>
<th>Trust Assurance Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Planning</td>
<td></td>
</tr>
<tr>
<td>a By 1st November 2010 Trust Executive Teams will have approved winter planning arrangements to include risks identified in DH Gateway letter 14382 Preparations for winter planning and reporting dated 10th September 2010</td>
<td>Winter Planning arrangements have been completed. They will be considered for approval at the Management Executive Group on 2nd November, the Professional Executive on 3rd November and at the NHSR Board on 15 November 2010. This fits in with the decision making cycle at NHSR. The plans have already been endorsed by the Emergency Care Network and Practice Based Commissioning Group.</td>
</tr>
<tr>
<td>b Trust plans will have been shared with NHS organisations in the local health economy as well as the Ambulance Services and Local Authority/ies</td>
<td>Rotherham’s Emergency and Urgent Care Network meets on a monthly basis. Winter Planning is a standard agenda item where any issues can be discussed and addressed. The Rotherham Surge and Mass Discharge plan has been shared with and approved by this group. The group includes representatives from the ambulance service and the local authority.</td>
</tr>
<tr>
<td>c Through local unscheduled care/emergency care networks agreement about where and how special arrangements will have discussed and agreed local risks and how these risks will be managed</td>
<td>Rotherham’s Emergency and Urgent Care Network has representation from all partner agencies across the local health and social care community. The main purpose of the group is to develop integrated and effective Urgent and Emergency Care Services and pathways across the health and social care community.</td>
</tr>
<tr>
<td>Winter Preparedness (All Trusts)</td>
<td>Trust Assurance Comment</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td>The Network ensures ease of access to appropriate services in line with national standards. It aims to deliver a system wide care pathway approach to admission avoidance and discharge planning. The Network engages with external organisations whose services contribute to the effective delivery of emergency care. It works with health and social care commissioners to determine priorities, promote knowledge of developments in emergency care and agree local standards and protocols to facilitate comparative audit and training.</td>
</tr>
<tr>
<td>d</td>
<td>Confirmation that special arrangements for the Christmas and the New Year period are included in the above plans</td>
</tr>
<tr>
<td></td>
<td>NHSR collate and share arrangements for Christmas and the New Year period across health and social care. A document incorporating all rotas and cover arrangements will be produced by NHS Rotherham by 30th November</td>
</tr>
</tbody>
</table>

2 Risk Assessments

| a | The Trust has undertaken a specific risk assessment on which planning assumptions are based to ensure ‘business as usual’ |
|   | Extreme weather has been identified within the emergency planning risk register. This has been fed into the corporate risk register. |
| b | The Trust has considered the possibility of industrial action that could impact on delivery of service and has reviewed workforce plans to ensure essential functions will be maintained. This planning should also consider fuel and other critical supplies. |
|   | Industrial action is identified within the risk assurance framework monitored by the Rotherham Community Health Services governance process. The business continuity framework also contains business specific plans to be put in place in such an emergency. |

3 Business Continuity

<p>| a | The Trust has Business Continuity Management plans and has tested these plans within the last 12 months |
|   | NHS Rotherham has an up to date Business Continuity Plan. The plan is tested on a regular basis. A specific Emergency Planning Exercises has taken place over |</p>
<table>
<thead>
<tr>
<th>Winter Preparedness (All Trusts)</th>
<th>Trust Assurance Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>b The Trust business continuity plans include:</td>
<td>Can confirm that the NHs Rotherham has a local policy on adverse weather arrangements for staff and patients. Local agreements are in place with key partners such as the Yorkshire Ambulance Service, Rotherham MBC and police foce.</td>
</tr>
<tr>
<td>A local policy on adverse weather arrangements for both staff and patients and has local agreements in place with partners eg. Ambulance, local authority, police and voluntary agencies</td>
<td></td>
</tr>
<tr>
<td>c Processes in place to ensure the timely and accurate delivery of data/information as set out by the Department of Health and the Strategic Health Authority</td>
<td>Processes are in place at RFT for all daily, weekly and monthly SHA and DH data/information returns.</td>
</tr>
<tr>
<td>d Agreed protocols and metrics (an agreed health economy wide set of metrics to monitor demand in the system) are in place for the co-ordination of the health and social care economy in order to maximise the use of community hospital bed capacity and residential and nursing home bed capacity, protocols for rapid discharge arrangements and identification of vulnerable people.</td>
<td>NHSR is currently piloting a daily sitrep report looking at activity, performance, bed capacity, staffing issues and any effect this may be having on services. This is being done by collating information across health and social care; Rotherham Foundation Trust, A&amp;E, Rotherham Community Health Services, YAS, WIC and GP Out of Hours. This will provide real time data to highlight any problems as they happen. Rotherham Foundation Trust has also developed a priority work plan to coordinate effective discharge planning for complex patients. Rotherham does not have a community hospital, but there is now an agreement that Breathing Space beds could be used more flexibly to aid discharge from hospital along with the Intermediate Care beds.</td>
</tr>
<tr>
<td>f The Trust has reviewed its facilities and estates plans for maintenance of critical assets e.g. CT scanners for the winter period as well as ensuring contingencies are in place to maximum mortuary capacity.</td>
<td>RFT has appropriate business continuity plans in place to maintain critical assets and staffing levels and has also put plans in place with local Funeral Directors to maximise mortuary capacity. There will be the provision of CT over the bank holiday this will be for urgent acute cases and covered by the Radiologist on call service. In principle the service will be available 24 /7 over the bank holiday period. Plans have been submitted for RFT to provide</td>
</tr>
<tr>
<td>Winter Preparedness (All Trusts)</td>
<td>Trust Assurance Comment</td>
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<td>---------------------------------</td>
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<tr>
<td></td>
<td>additional sessions over the extra bank holidays during 2010/11. This is to increase the access to the service to prevent delays in patient management; approval for proposed funding is awaited. RFT is in possession of two CT scanners unless there is a complete disaster which takes both systems out. RFT is confident that it will be able to offer a resilient service.</td>
</tr>
<tr>
<td>g For PCTs Only</td>
<td>Care UK has produced their rota for all staff groups for this period to cover expected increases in demand over the bank holiday weekend. They also have additional doctors on standby over this period that can be called on to give extra cover. Care UK has an internal escalation plan that makes provision for routine predictable changes that are established using a forecasting system and exceptional predictable variations. Care UK also forms an integral part of the Rotherham Surge and Mass Discharge Plan for Out of Hours services.</td>
</tr>
<tr>
<td>4 Vaccination</td>
<td>The mass vaccination plan has been reviewed and this has been approved by the Joint Health and Social Care Emergency Planning Group and has been submitted to Board for ratification. A seasonal flu vaccination plan has been approved and circulated. The pandemic flu plan has been reviewed and is currently out for consultation.</td>
</tr>
<tr>
<td>a The Trust has a Director-level led vaccination programme to ensure the maximum possible uptake of seasonal flu and pandemic flu vaccines in priority public groups and frontline health and social cares staff as appropriate to the organisation.</td>
<td></td>
</tr>
<tr>
<td>b The Trust has systems in place to include vaccination update data is reported onto the ImmForm system in line with national requirements within the specified timeframes</td>
<td>NHSR’s Public Health Department report data on behalf of NHSR staff. This function is provided by the Primary Care Contracting team at NHSR for GPs. The Foundation Trust report their own data.</td>
</tr>
</tbody>
</table>
# Winter Preparedness (All Trusts)

<table>
<thead>
<tr>
<th></th>
<th>Escalation</th>
<th>Trust Assurance Comment</th>
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</thead>
<tbody>
<tr>
<td>5</td>
<td><strong>a</strong> The Trust has internal escalation processes as well as local escalation plans with partners to manage surge management and has reviewed Adult Critical Care Network escalation plans and Children’s Critical Care network escalation plans to include patient transport.</td>
<td>The Rotherham Surge and Rapid Discharge Plan has been developed with partners to provide a whole system approach in the event of a surge. The Rotherham Accelerated Integrated Discharge process had been stress-tested by RFT and partner agencies and an action plan has been developed. RFT has robust internal Escalation Plans that have been shared with NHSR. Adult and Children Critical Network Plans are in place, including patient transport (Embrace for Paediatrics).</td>
</tr>
<tr>
<td></td>
<td><strong>b</strong> The Trust has ensured that all staff with on call responsibilities have an up to date copy of the Yorkshire and Humber Regional Escalation process and are familiar with how to use it.</td>
<td>All on call staff have been offered training in the last 12 months. All staff are aware of local escalation policy. The regional escalation process has been circulated amongst key staff.</td>
</tr>
<tr>
<td></td>
<td><strong>c</strong> The Trust has reviewed and agreed plans with partners to include the ambulance services that minimises the need for any diversion of patients between hospital sites and hospitals as part of their bed management arrangements.</td>
<td>Plans have been made implemented to increase and improve care pathways between partner organisations. Hours have also been increased at the Walk In Centre.</td>
</tr>
<tr>
<td></td>
<td><strong>d</strong> The Trust has agreed plans in place to escalate and manage the handover of care from the Ambulance Service to the A&amp;E and all other hospital departments minimizing the risk of delayed Ambulance turnaround (as per the Ambulance contract).</td>
<td>There has been considerable work undertaken around turnaround this year with YAS, ensuring the handover is smoother and more efficient. This would be escalated as required.</td>
</tr>
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</table>

## 6 Infection Control

<table>
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<th>ТО</th>
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<tbody>
<tr>
<td></td>
<td><strong>a</strong> The Trust has reviewed its local infection control outbreak management arrangements with the local Health Protection Unit/Public Health teams.</td>
<td>The PCT follows the HPA outbreak plan. Arrangements have been discussed and reviewed via the South Yorkshire Joint Partnership Board.</td>
</tr>
</tbody>
</table>
|   | **b** For PCTS only to complete  
The PCT working with local public health teams has ensured infection control arrangements in the independent sector by working with local authorities and | The commissioning arm of the PCT has established a strategic infection prevention and control committee, with representation from providers of health and social |
<p>|   |                                                                ТО                                                                                                                                          |                                                                                                                                           |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>local authority/NHS commissioners to ensure up to date infection control plans (to include staff training programmes) are in place.</td>
<td>care within Rotherham – outbreak reports are a standing agenda item of this committee. As commissioners we work closely with the HPU, Neighbourhood Services (Environmental Health) and the Local Authority.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7</th>
<th>Communications and Media Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>The Trust has reviewed its Winter Communications strategy to include how the Trust working with partners will 'warn and inform' patients, staff and the public of disruptive events to service provision e.g. infection control outbreaks and reduced visiting. The Trust is currently reviewing its winter communications strategy and is working with partners in the foundation trust and local authority to ensure work is coordinated and comprehensive across the borough.</td>
</tr>
<tr>
<td>b</td>
<td>The trust has tested on call systems in and out of hours to include checking local switchboards have up to date rotas and mobile phone coverage for staff on call. On call numbers for all staff on the on-call rota have been confirmed. It has also been confirmed that there are no problems with mobile phone coverage for staff on-call should they be contacted at home. The switchboard at RFT receives and acts upon up to date rotas.</td>
</tr>
<tr>
<td>c</td>
<td>The Trust has reviewed its Communication on call systems, all staff have been updated on the role for On Call and have the knowledge, skills and facilities to cascade information out of hours. The trust does not operate a communications on call system. However the director on call does have access to contact details for communications personnel in the event of a media or communications incident.</td>
</tr>
</tbody>
</table>
NHS Rotherham

Board - 15 November 2010

Local Safeguarding Children Board, Annual Report and Business Plan - Implications for NHS Rotherham

Contact Details:

<table>
<thead>
<tr>
<th>Lead Director:</th>
<th>John Radford</th>
<th>Lead Officer:</th>
<th>Catherine Hall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Director of Public Health</td>
<td>Title:</td>
<td>Nurse Consultant Safeguarding Children</td>
</tr>
</tbody>
</table>

Purpose:

This paper presents Rotherham Local Safeguarding Children Board (RLSCB) Annual Report 2009/2010 and Business Plan 2010/2011 and highlights how health partners contribute to safeguarding children in Rotherham. It provides assurance to NHS Rotherham, as commissioner of health care, that health providers in Rotherham are meeting their statutory duty with regard to child protection.

The report provides an overview of key issues and activities taking place across the health economy in relation to child protection arrangements. It signposts the Board to provider trusts annual safeguarding children reports and provides assurances to NHS Rotherham (NHSR) of compliance with safeguarding duties and responsibilities as specified under Section 11 of the Children Act 2004.

The paper takes the opportunity to highlight areas that require further attention by NHSR and provider trusts.

Recommendations:

The Board is requested to:

- Note receipt of RLSCB Annual Report and Business Plan;
- Consider the overview report on key issues and activities relating to Rotherham health economy’s contribution as a statutory partner;
- Agree on the identified areas of risk and future developments and prioritise the way forward;
- Review domestic abuse arrangements in light of recent local SCR’s and the significant health impact living in these circumstances raises.

Background:

Working Together 2010 places a statutory responsibility on Local Safeguarding Children Boards to provide an annual report; the first of these reports is to be published 01 April 2011. Rotherham Local Safeguarding Children Board (RLSCB) have pre-empted this statutory requirement by providing an annual report for 2009/2010 and an accompanying Business Plan 2010 – 2011 to set the direction of travel for partner agencies. It is attached for further information.

Primary Care Trust’s (PCT’s) are responsible for improving the health and wellbeing
of their local population, this responsibility includes children and young people. To achieve this PCT’s are under a legal duty to work with the local authority to assess what kind of health services the local population need (Children Act 2004).

Population figures in 2006 estimated that there were approximately 78,600 children and young people living in Rotherham; this represents 31% of the borough’s total population. This statistic reflects 0 – 24 years as the definition of ‘a young person’ includes Looked After Children (LAC) care leavers, and young people with learning and physical disabilities up to 24 years (Children and Young People’s Plan 2010 – 2013).

It is acknowledged that effective universal services can significantly reduce the escalation of problems if needs are identified and tackled at an early stage (Kennedy 2010). In addition Rotherham is amongst the top 20 most deprived districts in the United Kingdom and therefore has an increased need to focus upon targeted and responsive services (Staying Safe Action Plan 2008). With regard to safeguarding the legal categorisation is recorded as Child in Need (CIN) and Child in Need of Protection Plan (CPP); targeted and responsive services respectively. NHSR alongside retaining effective universal health services for all children must take into consideration the need for targeted and responsive services.

### Children receiving targeted and responsive services as of 01 October 2010

<table>
<thead>
<tr>
<th>Age Profile</th>
<th>CPP</th>
<th>LAC</th>
<th>CPP and LAC</th>
<th>CIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4 years</td>
<td>132</td>
<td>100</td>
<td>8</td>
<td>468</td>
</tr>
<tr>
<td>5 - 15 years</td>
<td>156</td>
<td>235</td>
<td>7</td>
<td>955</td>
</tr>
<tr>
<td>16 -18 years</td>
<td>6</td>
<td>63</td>
<td>1</td>
<td>115</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>294</strong></td>
<td><strong>398</strong></td>
<td><strong>16</strong></td>
<td><strong>1538</strong></td>
</tr>
</tbody>
</table>

* Defined in Key Words Section of report

This report sets out how the health economy works as a partner agency in safeguarding children and highlights areas that NHSR need to consider further.

### Analysis of Risks:

Safeguarding children is a statutory duty which is monitored and reported on by RLSCB with compliance regulated by the Care Quality Commission and the Strategic Health Authority. Non compliance would result in loss of reputation and possible central government involvement.

A key area of risk for NHS trusts in Rotherham is in our ability and capacity to identify and intervene effectively in families where domestic abuse is a welfare issue. For the first time the NHS Operating Framework 2010 – 2011 draws attention to the issue of domestic abuse and its significant impact upon family’s health and welfare. Estimates suggest there is a co-occurrence of domestic abuse against women and child abuse in 52% of cases and that nearly three-quarters of children on the ‘at risk register’ (sic) live in households that endure domestic violence (DoH 2005). All recent local Serious Case Reviews, and specifically Child T, FP1 and FP2 and Family Q demonstrated significant association between domestic abuse and child maltreatment.
Return on Investment:

Universal health services have important roles to play in identifying needs, responding to them early and enlisting people with more targeted or specialist skills where appropriate. For a small number of children they require additional targeted or responsive services, including services from the health economy, to reduce the likelihood and/or impact of possible harm (NSF- children young people and maternity services 2004).

Targeted and responsive safeguarding, in health, is aimed at those children who are identified as being at risk of significant harm* or whose circumstances are detrimental to their wellbeing. These children will have their health, safety and welfare needs addressed by a range of staff with specific skills and knowledge. Universal, health services have a duty to maintain their skills in recognition of abuse and neglect and in subsequent intervention and protection (Healthy Child Programme); we as employers are therefore tasked with the need to ensure that universal services have the capacity and skills to work in partnership with more targeted and specialist services (Working Together 2010).

Failure to identify need early can result in continuous poor outcomes for children with long term implications in the form of poor health outcomes, poor educational achievement, significant mental health problems, increased crime, disorder and substance abuse. Identification of domestic abuse would have a dramatic impact on the health of women and girls; leading cause of morbidity for women aged 19 – 44 and the leading cause of injury and illness for girls and women aged 15 – 44 (Domestic Violence London 2010).

* Defined in Key Words Section of report

Analysis of Key Issues:

All NHS organisations must demonstrate they are meeting their statutory responsibilities (Children Act 2004).

To assure central government that these responsibilities are being undertaken appropriately Local Safeguarding Children Boards were given the governance role to hold local partners to account. RLSCB have improved their governance arrangements and report regularly on compliance.

Section 11, Children Act (2004) places a statutory duty on partner agencies to have arrangements in place to safeguard and promote the welfare of children and young people. At an organisational level, all NHS organisations must comply with the following 8 policy standards of Section 11:

1. Senior management commitment to the importance of safeguarding and promoting children’s welfare
2. A clear statement of the agency’s responsibilities towards children for all staff
3. A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children
4. Service developments that takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families
5. Staff training on safeguarding and promoting the welfare of children for all staff working with or in contact with children and families
6. Safe recruitment procedures in place
7. Effective inter-agency working to safeguard and promote the welfare of children
8. Effective information sharing.
A self-assessment against the policy standards requirements of Section 11 was undertaken by all health trusts in February 2010 and individual action plans produced to address gaps and areas for development. These are monitored via the Safeguarding Health Forum and RLSCB, Quality and Performance Sub Group.

NHSR can demonstrate that they have the necessary designated and named professionals in place with the appropriate level of seniority and experience across the health economy. Job descriptions clearly define their roles and responsibilities.

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Safeguarding Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr John Radford, Director of Public Health and NHSR Board Member</td>
<td>Executive Safeguarding Lead for the health community</td>
</tr>
<tr>
<td>Catherine Hall, Nurse Consultant</td>
<td>Designated Nurse for the health community</td>
</tr>
<tr>
<td>Dr El-Reefee, Consultant Paediatrician</td>
<td>Designated Doctor for the health community</td>
</tr>
<tr>
<td>Dr Ulla Trend, Consultant Paediatrician</td>
<td>Designated Doctor, Looked After Children</td>
</tr>
<tr>
<td>Louise Bishop, Designated Nurse</td>
<td>Designated Nurse, Looked After Children</td>
</tr>
<tr>
<td>Yvonne Weakley, Associate Director Children and Young People Services</td>
<td>Executive Safeguarding Lead Rotherham Community Health Services (RCHS)</td>
</tr>
<tr>
<td>Dr John Radford, Director of Public Health and NHSR Board Member</td>
<td>Named Doctor, RCHS (interim arrangement)</td>
</tr>
<tr>
<td>Kim Porteous, Senior Nurse Advisor</td>
<td>Named Nurse, RCHS</td>
</tr>
<tr>
<td>Jackie Bird, Chief of Quality &amp; Standards / Chief Nurse</td>
<td>Executive Safeguarding Lead Rotherham NHS Hospital Foundation Trust (TRFT)</td>
</tr>
<tr>
<td>Dr E Nagmeldin, Consultant Paediatrician</td>
<td>Named Doctor, TRFT</td>
</tr>
<tr>
<td>Carol Boote, Named Nurse</td>
<td>Named Nurse, TRFT</td>
</tr>
<tr>
<td>Sophia Atkin, Named Midwife</td>
<td>Named Midwife, TRFT</td>
</tr>
<tr>
<td>Deborah Wildgoose, Deputy Nurse Director</td>
<td>Executive Safeguarding Lead Rotherham, Doncaster and South Humber Mental Health Foundation Trust (RDASH)</td>
</tr>
<tr>
<td>Samantha Davies, Named Nurse</td>
<td>Named Nurse RDASH (Secondment)</td>
</tr>
</tbody>
</table>

Safeguarding Policies and Procedures/Board Declaration on Children’s Safeguarding

In July 2009 the Care Quality Commission (CQC) published a document called “The Review of Arrangements in the NHS for Safeguarding Children”. Shortly afterwards the Chief Executive of the NHS, David Nicholson, wrote to leads of all NHS organisations and asked them to take urgent action to ensure that children are safeguarded locally. Boards of NHS Trusts were required to publish a local declaration on their websites.

In order for NHSR to make a public declaration on safeguarding arrangements and for health providers to register with the CQC they undertook a stock take of assurance requirements. NHSR and RCHS stock take revealed a shortfall with regard to Policies and Procedures.
Action Taken

- Updated guidance for Safeguarding the Children of Drug/Alcohol Misusing Parents was launched in November 2009
- One policy and three sets of guidelines were developed, ratified and launched at the beginning of February and are as follows:
  - RCHS Overarching Safeguarding Children’s Policy
  - Co-sleeping and Infant Bed Sharing Guidelines
  - Guidelines for Court Attendance and Statement Writing
  - Practice Guidance on the refusal or Withdrawal from Children’s Health Services
  - NHS Safeguarding Commissioners policy agreed April 2010

All health providers’ in Rotherham declared compliance 2010:

- Rotherham Community Health services (RCHS)
- Rotherham, Doncaster and Humber Mental Health Foundation Trust (RDASH)
- The Rotherham NHS Foundation trust (TRFT)

Safeguarding Children Health Forum

The Safeguarding Children Health Forum has strengthened their governance arrangements with RLSCB, minutes of meetings are shared and attendance from RLSCB Board Manager agreed. Terms of Reference and a regular review of health trusts safeguarding arrangements have all been reinforced to assure NHSR Lead Director of their ongoing commitment to improving service to children and families.

This work has included an audit of attendance at Accident and Emergency by children with non accidental injuries and an audit of mental health staff knowledge acquisition on NICE Guidelines, When to suspect Maltreatment (2009).

Safeguarding Supervision

Local and national Serious Case Reviews (SCRs) continue to highlight the importance of effective safeguarding supervision as crucial for front line practitioners, an assurance of staff competence and a means of targeting services and training appropriately. Supervision is a key performance indicator which is monitored and reported to NHSR Commissioners.

Child Protection supervision is provided in Rotherham to front line health staff. This has at times been ad hoc. RDASH are in the process of employing a full time Named Nurse for Rotherham and a priority area is to consider the supervision of mental health staff. Due to the nature of work in TRFT specialist practitioners provide supervision on specific cases; this is reviewed regularly by the Safeguarding Children Team. RCHS have picked up a number of issues in a recent supervision audit and are actioning these:

- Casework and Child Protection Supervision Procedures are in place and now require dovetailing to identify thresholds for each and to avoid duplication
- 11 managers and 4 nurse advisors attended 2 days supervision training in February 2010 with a final day in September
- The Named Nurse receives monthly supervision from the Nurse Consultant
- Specialist Nurse Advisors and Clinical Team Managers will receive supervision from the Named Nurse
- Supervision contracts have been signed with staff
Casework supervision is now routinely provided to front line staff by Clinical Team Managers who will also monitor child protection plans.

Specialist child protection supervision is now routinely provided by Specialist Nurse Advisors.

Actions that arise from supervision are recorded in the child’s SystmOne record.

The standard of record keeping and practice is reviewed during supervision including whether the views and wishes of C&YP have been considered.

Supervision attendance by Health Visitors and School Nurses is reported monthly to the Head of Service.

Training

All employees require knowledge of safeguarding children so they are clear about their specific responsibility and duty of care. In 2009 NHSR and RCHS were at risk of not achieving compliance with mandatory safeguarding training which resulted in a significant drive to improve attendance and to develop robust systems and processes to prevent future lapses. All provider trusts are now compliant with safeguarding training and the Nurse Consultant for Safeguarding Children is in the process of working with all provider trusts to further develop training. A Safeguarding Training Advisory Group has been established and is Chaired by an NHSR Non Executive Director to drive forward improvements.

Compliance with mandatory training is now being proactively monitored and managed and it is envisaged that a single health learning and development programme will be in place for 2011. This programme will complement Rotherham Local Safeguarding Children Board (LSCB) Multi-agency Training Programme. In acknowledgment of the importance of a well trained workforce a short term group has been set up to consider safeguarding learning and development. The group is Chaired by NHSR Non Executive Director and its plan is to move single agency safeguarding training into a more dynamic and fit for purpose commodity. The ultimate aim is to provide a safeguarding children competency passport to support organisational responsibilities.

GP training in Rotherham has been proactive and well received. Overall attendance at Protected Learning Time (PLT) in May 2009 was 557, with 160 out of 172 GP’s. The session in May was well received and has resulted in the safeguarding health team being invited to facilitate the November 2010 PLT sessions.

Safer Recruitment And Vetting and Barring Scheme

On 12 October 2009, the first phase of the new Vetting and Barring Scheme (VBS) came into force as a requirement under the Safeguarding Vulnerable Groups Act (2006). The key changes are that the previous barred lists (Protection of Children Act, Protection of Vulnerable Adults and List 99) have been replaced by two new lists administered by the Independent Safeguarding Authority (ISA), the ‘Children’s List’ and the ‘Vulnerable Adults List’.

- Employers now have a duty to make referrals to the ISA where they consider a person has either caused harm or poses a risk of harm to children or vulnerable adults.
- Criminal penalties have been put in place for barred individuals who seek to undertake work with vulnerable groups in regulated activity and for any employers who knowingly take them on.
- The eligibility criteria for enhanced Criminal Records Bureau (CRB) disclosures have been extended to include anyone working/volunteering in regulated activity.
- Anyone who applies to work in regulated activity under the new eligibility criteria must apply for an enhanced CRB disclosure. Standard CRB disclosures will not be acceptable after April 2010.
- The NHS is required to check new recruits and staff changing jobs within regulated activity on or after 12 October 2009 where the position involves working with vulnerable adults against the ISA’s ‘Vulnerable Adults’ List. Equally, individuals working in a regulated position with children must obtain full CRB disclosure and check against the ISA ‘Children’s List’ prior to appointment.

All provider trusts declared compliance with this area.

Planned changes to safe recruitment and vetting and barring processes are currently being reviewed by the Coalition Government.

**Serious Case Reviews (SCRs)**

There has been a total of 7 SCRs over recent years; none instigated in 2010.

In addition there has been consideration to holding a SCR discussions on 5 other cases, including “Operation Central” : Operation Central and one of the cases led to independent lessons-learning reviews.

Action Plans from these SCRs have been monitored by NHSR alongside RLSCB and the Strategic Health Authority (SHA). Evidence has been collated and shared by all provider trusts.

The main areas where work has been and is being undertaken includes:

- Competencies of the workforce, with particular reference to authoritative practice and the need for respectful uncertainty (Laming 2009),
- Supervision with particular regard to the challenge and support of staff working with aggression,
- Audits of policy and assessments,
- Development of training and evaluation of learning, with an emphasis on value added learning and development opportunities.
- A real need to take on board and ensure that the voice of the child is heard and recorded as such in all health care deliver.

**Inter-Agency Communication**

Predominately children’s records, in the community, are now electronic unfortunately there are still a number old electronic systems in place within some GP Practices.

Majority of community health staff utilise SystmOne, this will shortly include TRFT being able to have read access to children on SystmOne.

In addition RCHS is in the process of pre-existing paper records all being scanned via CgGold. Any health professional internal or external to RCHS e.g. GPs and RFT with a legitimate reason to view a child’s record will have access to relevant information. This includes information of all children subject to a Child Protection Plan, the national ‘flag’ is utilised on SystmOne so children in need of protection are easily identified to a range of services involved in their care within 1 working day of children being placed on or removed from a child protection plan.
Consideration needs to be given to ‘flagging’ other areas of concern including Looked After Children and domestic abuse. It is estimated that up to 3.5% of emergency department attendances are directly attributed to domestic violence and that 8% of attendees report having experienced domestic abuse (Olive 2007). CQC have recommended that A&E review how they access records to ‘ensure that children and young people can be easily identified if they are already known to social care services’ (Rotherham Announced Inspection Aug 2010). The SystmOne Team are in the process of working with TRFT and nationally to consider a ‘flag system’ for LAC and CIN.

**Safeguarding Children Annual Reports**

RDASH and TRFT provided an annual report to NHSR and the Care Quality Commission (CQC). Both provider trusts highlighted their current position and their planned improvements to children services. Reports have gone via internal governance arrangements and to RLSCB for external scrutiny.

An annual report from RCHS is reported to be in production. An interim report was presented to the Integrated Governance Committee in March 2010 by the Associate Director CYPS.

**Ofsted and CQC Announced Inspection**

Safeguarding and Looked After Children’s Services were inspected by Ofsted and CQC from the 19th – 30th July 2010. The purpose of these inspections is to evaluate the contribution made by all statutory and voluntary services towards ensuring that children and young people are properly safeguarded. The inspection graded the quality of service provision in Rotherham as ‘adequate’.

CQC provide an additional report to the Chief Executive of the commissioning trust. For Rotherham this report included a number of areas were the inspectors recorded the health contribution as good. These included:

- Our ability to improve services,
- Partnership working,
- The links between the Child Death Overview Panel and the Serious Case Review Panel are effective
- The range of high quality multi and single-agency safeguarding training taking place
- Attendance of General Practitioners in safeguarding children training
- The health visitor liaison post, in TRFT, ensures that all children and young people attending A&E are systematically reviewed.
- Electronic flagging of children and young people with child protection plans in RCHS.

2 areas, for health, were identified to be in need of improvement and a multi agency action plan is being progressed.

The inspection outcome contributes to Ofsted’s annual rating of children’s services and to the Council’s Comprehensive Area Assessment (CAA). It is vitally important for the reputation of the Council and Children’s Services that Inspectors were satisfied with the findings. We now need to ensure that the areas highlighted as requiring improvement.
are satisfactorily achieved and that we maintain the other areas.

Conclusion

Rotherham health economy has come a long way in a short period of time and in a time when the media and public spotlight has been placed firmly on our ability to protect children, young people and their families. Section 11 audits and provider trusts annual report provide a level of assurance. However there is no place for complacency, we need to move to the next level and consider:

- Recruitment to RCHS Named Doctor or a GP with Safeguarding leadership responsibilities depending upon RCHS and TRFT organisational developments,
- Impact of safeguarding services delivered e.g. training programmes, supervision,
- Impact of lessons learnt from national and local SCR; in particular how we, as a health service, manage domestic abuse and its significant impact upon health and wellbeing. In contrast to health agencies the police have been tightly managed by the Home Office on reducing violent crimes and keeping people safe, we do work with the police on cases brought to their attention but the low level chronic cases are not being robustly managed. As this area has significant health implications for both the victim and their children we need to take this issue more seriously and systematically
- Developments in CQC, namely the registration of dental practice 2011 and GP Practices from 2012 and how NHSR will manage this development,
- Listening to and taking into account of the voice of children and young people in all our service developments from universal services to high level responsive services. This area was also highlighted in all provider trust Section 11 Audits as being in need of further consideration.

Patient, Public and Stakeholder Involvement:

RLSCB stakeholder involvement has been sought in the production of this report.

Future consideration will need to be given to how we involve the public in our development of safeguarding children services.

Equality Impact:

There is no adverse impact on service users or staff in relation to this report.

Financial Implications:

NHSR makes an annual contribution of £41,556 (2009/10 Prices) to RLCSB (£8,062 of this comes from RCHS).

There is the potential of a cost pressure to ensure that all staff working in provider services with C&YP and vulnerable adults have an up to date Enhanced CRB check and be registered with the ISA. This is difficult to estimate as the Coalition Government are reviewing the whole CRB process.

PCTs commission services from a range of different organisations and hold the
providers of these services to account via contracts. Along with this duty the Care Quality Commission (CQC) as the independent regulator of safety and quality for all health services has from 01 April 2010, expected all NHS trusts and NHS foundation trusts to be registered with them. To date this has been achieved with no financial implications; however the development of SystmOne in A&E and the need to have sick children trained nurses in A&E (as recommended in the Announced Ofsted/CQC Inspection) does have potential cost implications for secondary care providers.

Dental practices and GP practices will be required to register with the CQC, regardless of whether they provide wholly private or wholly NHS services, or a mix of both and will be subject to a consistent set of quality standards. Registration of primary dental care providers will start from 2011 and primary medical care providers from 2012.

Approved by: John Doherty

**Human Resource Implications:**

Co-ordination of a health response to domestic abuse is an unknown quantity at this point in time until a gap analysis of current provision is known. A specific project to consider this area and bridge safeguarding adult and children services should be considered.

There is the potential capacity implication if vetting and barring arrangements come into force for staff working with children and young people and their families and vulnerable adults. The capacity is difficult to estimate as the Coalition Government are reviewing the whole CRB process

Approved by:  

**Procurement:**

N/A

Approved by:

**Key Words:**


* Definitions within the body of the report

**Child in Need** (Section 17 of the Children Act 1989): A child in need is one whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health and development, or that health and development will be significantly impaired, without the provision of services.

**Child in Need of Protection** (Section 47 of the Children Act, 1989): A child in need of child protection is one suffering from or likely to suffer from significant harm.

**Significant Harm:** *This has a particular meaning and establishes a threshold for concern.*
Significant in the context means noteworthy, which may be through presenting seriousness or presenting implication.’ (Polnay 2001)

**Looked After Child (LAC):** This refers to one who is accommodated by the local authority, whether or not a care order has been made. Children in public care may be fostered, in a children's home or otherwise accommodated by the local authority.

**Further Sources of Information:**

- The Children Act (1989 and 2004) plus supporting guidance in Working Together to Safeguard Children (Updated 2010 to reflect findings and recommendations from the inquiry into the death of Baby Peter)
- The Laming Reports (2003, 2009) of inquiries into the deaths of Victoria Climbié in February 2000 and Peter Connelly in August 2007
- CQC Essential Standard, Outcome 7 – Safeguarding people who use services from abuse
- Section 5 of the National Service Framework for Children, Young People and Maternity Services (2004)
- CQC Inspection of PCT’s Guide 2009
Rotherham Safeguarding Children Board

Annual Report 2009 - 2010
&
Business Plan 2010 – 2011
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<td>Purpose and Objectives of Rotherham Local Safeguarding Children Board</td>
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<td>Sub Group Annual Reports – April 2009 – March 2010</td>
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Welcome from the Chair

2009 was a busy year. It has seen the appointment and imminent departure of an Interim Safeguarding Children Board Manager; the departure of the original Independent Chair of the Safeguarding Children Board and my own appointment as the new Independent Chair. It has also seen a realignment of senior management posts in Children’s Services and the consequent appointment of a Director of Safeguarding and Corporate Parenting, also following a period of interim management. The year has also seen the development of a fully revised constitution for the Board. Following OfSTED’s finding in an unannounced inspection that children’s services in Rotherham were “inadequate”, an Improvement Board chaired by the local authority’s Chief Executive, was also established. During the year, first a revised Chapter 8 (Serious Case Reviews) of Working Together 2006 was published, shortly followed by a comprehensive revision and full publication of Working Together 2010 – all this seeking to build on the original publication in the light of a wealth of experience. Three serious case reviews were also completed during 2009, and the action plans arising from them have been implemented.

Alan Hazell
Independent Chair of Rotherham Safeguarding Children Board
May 2010
2 INTRODUCTION

Content of Plan
The Safeguarding Business Plan is a key strategic plan which highlights the priority areas for development over the next year and will be used by the Local Safeguarding children Board as a key monitoring tool to measure effectiveness and progress. It translates national objectives and targets and longer-term local priorities into a working document. The Safeguarding Children Business Plan links to the Children and Young People’s Single Plan and a framework of broader plans. The Plan builds on the Staying Safe section in the Children and Young People’s Single Plan.

Content of Annual Report
One of the innovations within Working Together 2010 is the statutory requirement for Local Safeguarding Children Boards to publish an annual report, and detailed advice is offered on what that report might contain. The first of such reports must be published before 1 April 2011. The business plan therefore takes this Board through to that date, and the annual report for the past year, 2009 – 2010, comes from the sub groups who worked during that period and from the performance indicators shown within this document.
3 ROTHERHAM CHILDREN AND YOUNG PEOPLE IN CONTEXT

Area Assemblies and Wards

There are seven Area Assemblies across the Borough, each one has an average population of 36,000. Rotherham’s Area Assemblies are geographical groupings of three wards, used as the basis for local partnerships made of Councillors, residents and other relevant organisations, including NHS Rotherham and South Yorkshire Police.

Between 1980 and 2004 there were 22 wards in Rotherham, these areas had populations ranging from 8,000 to 17,500. In 2004 these wards were replaced by 21 new wards with an average population of 12,000.

Population

At the most recent population estimates (2006) there were approximately 78,600 Children and Young People living in Rotherham which still represents 31% of the borough’s total population as it did at the 2003 estimate. The gender split for children and young people (0-24 years old) in Rotherham has also remained constant since the model was produced in 2003. The figures for 2005 were 51% male, and 49% female.

Some age groups have reduced as a percentage of the 0-24 population (i.e. 1-4, 5-9 and 10-14) while other groups have increased (15-19 and 20-24) which reflects the general national trend of an aging population with less younger people, however we do know from local birth statistics that Rotherham’s birth numbers had been increasing slightly each year since 2000, from 2527 in the 2000/01 academic year to 3381 in 2006/07; birth rates in 2009/10 averaged 2800.

Ethnicity

The majority of Rotherham’s BME population is concentrated in four central wards; Boston Castle, Rotherham East, Rotherham West and Sitwell, this has not altered between 2005 and 2007. In Rotherham South there is a large and growing BME population, based on school pupil data (2005 compared to 2008). The link between an increase in the birth rate and the growth of the BME population is also shown in 2001 Census data, where Rotherham South has the highest number of people living in families with two or more dependant children, with Rotherham East and Boston Castle wards being the two highest wards overall in terms of both families with two or more children and BME school pupils. More recently, there has been a significant increase in the arrival of EU migrants to the borough. In the school year beginning in September 2008 there were 375 new arrivals of school-age children, 58% (204) were of Roma heritage. In the school year beginning September 2009 there were 375 new arrivals, 69% (259) were of Roma heritage.
Areas of Deprivation

Deprivation in Rotherham is decreasing according to Communities for Local Government. Rotherham was ranked 48th most deprived district in England in the 2000 Index, and is now ranked 68th in the 2007 index; however this is still amongst the top 20% most deprived districts in the United Kingdom.

Within Rotherham there is a great deal of geographical variation to the levels of deprivation. This map shows the areas of greatest deprivation shaded in red.
Rotherham, like many areas across the UK, has a significant number of children and young people living in deprived areas; 14.2% of all Rotherham children live in areas which are within the 10% most deprived nationally (using the Index of Deprivation Affecting Children (IDAC) 2007) and 31% of children who live in low income households live in the most 10% deprived areas nationally.
Population of Children by Category of Risk

The table below details the population of children by category of risk and provides comparison between the National and Rotherham percentage breakdowns.

2009 statistics show that the percentage of local children at risk has increased above the National average across all three main categories of concern; Children in Need, Looked After Children and Children with a Child Protection Plan.

<table>
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<th>2005</th>
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<td></td>
<td>Number</td>
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<td>% of All Childre n</td>
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<td>ONS Mid-Year Population Estimates* (All Children 0-19)</td>
<td>National 13,079,400 47.4%</td>
<td>National 13,064,200 47.5%</td>
<td>National 13,073,600 47.7%</td>
<td>National 13,081,600 48.2%</td>
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<td></td>
<td>Rotherham 63,906 46.8%</td>
<td>Rotherham 63,495 46.9%</td>
<td>Rotherham 63,159 46.8%</td>
<td>Rotherham 62,918 47.3%</td>
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<tr>
<td>Vulnerable Children (aged under 9yrs, from ONS)</td>
<td>National 6,204,800 47.4%</td>
<td>National 6,208,800 47.5%</td>
<td>National 6,237,900 47.7%</td>
<td>National 6,309,800 48.2%</td>
<td># #</td>
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<td>Rotherham 29,928 46.8%</td>
<td>Rotherham 29,754 46.9%</td>
<td>Rotherham 29,541 46.8%</td>
<td>Rotherham 29,767 47.3%</td>
<td># #</td>
</tr>
<tr>
<td>Children in Need (CiN Census)</td>
<td>National 234,700 1.8%</td>
<td>National 234,700 1.8%</td>
<td>National 234,700 1.8%</td>
<td>National 234,700 1.8%</td>
<td>407,800 3.1%</td>
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<td>Rotherham 2,345 3.7%</td>
<td>Rotherham 2,345 3.7%</td>
<td>Rotherham 2,345 3.7%</td>
<td>Rotherham 2,345 3.7%</td>
<td>2,980 4.7%</td>
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<tr>
<td>Looked After Children (National 903 Return)</td>
<td>National 61,000 0.5%</td>
<td>National 60,300 0.5%</td>
<td>National 60,000 0.5%</td>
<td>National 59,400 0.5%</td>
<td>60,900 0.5%</td>
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<td></td>
<td>Rotherham 383 0.6%</td>
<td>Rotherham 310 0.5%</td>
<td>Rotherham 339 0.5%</td>
<td>Rotherham 346 0.5%</td>
<td>406 0.6%</td>
</tr>
<tr>
<td>Children subject to Child Protection Plan (CPR3 Return)</td>
<td>National 25,900 0.2%</td>
<td>National 26,400 0.2%</td>
<td>National 27,900 0.2%</td>
<td>National 29,200 0.2%</td>
<td>34,100 0.3%</td>
</tr>
<tr>
<td></td>
<td>Rotherham 102 0.2%</td>
<td>Rotherham 107 0.2%</td>
<td>Rotherham 145 0.2%</td>
<td>Rotherham 233 0.4%</td>
<td>286 0.5%</td>
</tr>
</tbody>
</table>

*National Population Estimates are for England and Wales
# 2009 ONS Mid-Year population figures not published at time of production. 2008 used as proxy to calculate percentages.
[Update: CYPS Performance & Data Team - March 2010]
4 LEVELS OF SAFEGUARDING

The Staying Safe Action Plan published by the Government in 2008 outlined 3 levels of safeguarding activity set out in the following diagram:

These are defined as:

**Universal safeguarding** – Working to keep all children and young people safe and create safe environments for all children

**Targeted safeguarding** – Some groups of children are more at risk than others, and it is important to target policies and services to these groups, to help keep them safe from harm

**Responsive safeguarding** – Unfortunately, no matter what we do, there will always be some children and young people who suffer harm. We need to respond quickly and appropriately when this happens – supporting children and dealing with those who harm them

Rotherham Local Safeguarding Children Board will plan and report on work in all three areas for the future.
5 PURPOSE AND OBJECTIVES OF ROTHERHAM LOCAL SAFEGUARDING CHILDREN BOARD

4.1 Objectives

The core objectives of the Board (S14 CA 2004) are to:-

- Co-ordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in Rotherham; and
- Ensure the effectiveness of that work.

Safeguarding and promoting the welfare of children is defined in Working Together (WT) 2006 as:-

- Protecting children from maltreatment
- Preventing the impairment of children’s health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- Undertaking that role as to enable children to have optimum life chances and to enter adulthood successfully.

The scope of the Board’s role includes safeguarding and promoting the welfare of children in three broad areas of activity:

- Activity that affects all children and aims to identify and prevent maltreatment, or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care
- Proactive work that aims to target particular groups; and
- Responsive work to protect children who are suffering or at risk of suffering harm.

Section 11 (CA 2004) places a duty on key individuals and bodies to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The application of this duty will vary according to the nature of each agency and its function.

4.2 Functions

The core functions of RSCB, which are defined by The Local Safeguarding Children Boards Regulations 2006, are:-

a) Developing policies and procedures for safeguarding and promoting the welfare of children in Rotherham. These include:-

- Actions to be taken where there are concerns about a child’s safety or welfare, including thresholds for intervention.
- Training of persons who work with children or in services affecting the safety and welfare of children.
- Recruitment and supervision of persons who work with children.
- Investigation of allegations concerning persons working with children.
- Safety and welfare of children who are privately fostered.
- Co-operation with neighbouring Children’s Services Authorities and their Board partners.

b) Communicating to people and bodies in Rotherham the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so.

c) Monitoring and evaluating the effectiveness of what is done by RSCB partners individually and collectively to safeguard and promote the welfare of children, and advising them on ways to improve.

d) Participating in the local planning and commissioning of children’s services to ensure they take into account safeguarding and promoting the welfare of children.

e) Undertaking reviews of cases where a child has died or has been seriously harmed in circumstances where abuse or neglect is known or suspected and advising on lessons that can be learned (Serious Case Reviews), and both managing and progressing recommendations from serious case reviews.

f) Developing procedures for ensuring that there is a co-ordinated response by Board partners and other relevant persons to the unexpected death of a child and collecting and analysing information about all child deaths (Child Death Reviews) with a view to identifying any matters of concern affecting the safety and welfare of children in Rotherham (including any case giving rise to a Serious Case Review) and any general public health or safety concerns arising from such deaths.

The Board may also engage in other activities that contribute to the achievement of its objectives.

Ensuring the effectiveness of RSCB’s work will be undertaken by measuring and reporting the Board’s performance against the objectives of its Business Plan.
The Safeguarding Board has been established since 2005, and has been chaired independently since June 2007. The membership of the Safeguarding Board at 31 March 2010 and attendance at Board meetings in 2009/10 is set out below, along with details of advisors and officers:

There were 4 planned Board meetings during this period: 31 July 2009, 11 September 2009, 4 December 2009 and 19 March 2010.

<table>
<thead>
<tr>
<th>AGENCY</th>
<th>REPRESENTATIVE</th>
<th>31st JULY 2009</th>
<th>11th SEPTEMBER 2009</th>
<th>4th DECEMBER 2009</th>
<th>19th MARCH 2010</th>
<th>BOARD MEMBER / ADVISOR</th>
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<tr>
<td>Independent Chair of RSCB (until July 09)</td>
<td>Judith Dodd</td>
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<td>N/A</td>
<td>N/A</td>
<td>Chair</td>
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</tr>
<tr>
<td>Independent Chair of RSCB (from Sep 09)</td>
<td>Alan Hazell</td>
<td>N/A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Chair</td>
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</tr>
<tr>
<td>Safeguarding Children Unit, CYPS</td>
<td>Viv Woodhead</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>Advisor</td>
<td>2/2</td>
</tr>
<tr>
<td></td>
<td>Catherine Hall (Interim Safeguarding Manager)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tr>
<tr>
<td></td>
<td>Annie Redmond</td>
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<tr>
<td></td>
<td>Phil Morris</td>
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<td>Pam Allen</td>
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<tr>
<td></td>
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<tr>
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<td>John Radford</td>
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<td>11th SEPTEMBER 2009</td>
<td>4th DECEMBER 2009</td>
<td>19th MARCH 2010</td>
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<td>ATTENDANCE TOTAL</td>
</tr>
<tr>
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<td>--------------------------------</td>
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<td>Yvonne Weakley</td>
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<tr>
<td>CAFCASS</td>
<td>Adele Jones</td>
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<tr>
<td>SY Probation</td>
<td>Maryke Turvey</td>
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<td>X</td>
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<td>Rotherham Hospital Trust</td>
<td>Jugnu Mahajan</td>
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<td>Member</td>
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<tr>
<td></td>
<td>Jackie Bird</td>
<td>N/A</td>
<td>N/A</td>
<td>Rep by Carol Boote</td>
<td>✓</td>
<td>Member</td>
<td></td>
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<tr>
<td>RDASH</td>
<td>Tracey Wrench</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>N/A</td>
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<tr>
<td></td>
<td>Deborah Wildgoose</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Neighbourhoods and Adult Services</td>
<td>Shona Macfarlane</td>
<td>✓</td>
<td>✓</td>
<td>Rep by Sam Newton</td>
<td>Rep by Sam Newton</td>
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<td>4/4</td>
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<td>NSPCC</td>
<td>David Radford</td>
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<td>X</td>
<td>X</td>
<td>?</td>
<td>0/?</td>
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<td>Action for Children</td>
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<td>Legal Services</td>
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</tr>
<tr>
<td>Chief Executives Office</td>
<td>Zafar Saleem</td>
<td>✓</td>
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<td>N/A</td>
<td>✓</td>
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<tr>
<td>SY Police</td>
<td>Peter Horner</td>
<td>✓</td>
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<td>N/A</td>
<td>✓</td>
<td>Advisor</td>
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</tr>
<tr>
<td></td>
<td>Simon Palmer</td>
<td>X</td>
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<td>✓</td>
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<td>Schools</td>
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</tr>
<tr>
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<td>David Butler</td>
<td>N/A</td>
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<td>✓</td>
<td>X</td>
<td>Member</td>
<td>1/2</td>
</tr>
</tbody>
</table>
Until July 2008 the Board was supported by Rotherham Safeguarding Children Unit which also managed the child protection conference system and complex strategy meetings, along with Independent Reviewing Officers. Since that date the operational and strategic functions have been separated and the Board is supported by the Strategic Safeguarding Unit which consists of a Safeguarding Children Board Manager, an Assistant Safeguarding Children Board Manager, one Secretary and a part time Child Death Overview Panel Administrator.
### Contacts

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Safeguarding Nature</th>
<th>Dom Violence Clients</th>
<th>Dom Violence Contacts</th>
<th>Sexual Exploitation Clients</th>
<th>Sexual Exploitation Contacts</th>
<th>Other</th>
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<tbody>
<tr>
<td>Apr 05 - Mar 06</td>
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<td>1940</td>
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<td>72</td>
<td>3937</td>
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<td>Apr 07 - Mar 08</td>
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<td>1919</td>
<td>1917</td>
<td>2514</td>
<td>74</td>
<td>80</td>
<td>5415</td>
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<td>Apr 08 - Mar 09</td>
<td>9590</td>
<td>2021</td>
<td>1537</td>
<td>2020</td>
<td>93</td>
<td>117</td>
<td>5432</td>
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<td>Apr 09 - Mar 10</td>
<td>10313</td>
<td>1866</td>
<td>1583</td>
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<td>149</td>
<td>6168</td>
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#### Contacts Apr 05 to Mar 10

- **Other**
- **Sexual Exploitation Contacts**
- **Dom Violence Contacts**
- **Safeguarding Nature**
### Referrals

<table>
<thead>
<tr>
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<th>Dom Violence Clients</th>
<th>Dom Violence Refs</th>
<th>Sexual Exploitation Clients</th>
<th>Sexual Exploitation Refs</th>
<th>Other</th>
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<td>Apr 05 - Mar 06</td>
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<td>1041</td>
<td>155</td>
<td>164</td>
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<td>897</td>
<td>297</td>
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<td>42</td>
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<td>Apr 07 - Mar 08</td>
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<td>1758</td>
<td>2204</td>
<td>89</td>
<td>94</td>
<td>3408</td>
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<td>Apr 08 - Mar 09</td>
<td>3940</td>
<td>1351</td>
<td>638</td>
<td>720</td>
<td>64</td>
<td>68</td>
<td>1801</td>
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<tr>
<td>Apr 09 - Mar 10</td>
<td>3843</td>
<td>1205</td>
<td>642</td>
<td>695</td>
<td>55</td>
<td>58</td>
<td>1885</td>
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#### Referrals Apr 05 to Mar 10

<table>
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<tr>
<th>Period</th>
<th>Number</th>
<th>Other</th>
<th>Sexual Exploitation Refs</th>
<th>Dom Violence Refs</th>
<th>Safeguarding Nature</th>
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<td>Apr 08 - Mar 09</td>
<td>3940</td>
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<td></td>
<td></td>
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<tr>
<td>Apr 09 - Mar 10</td>
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<tr>
<td>Initial Assessments</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>All Completed</td>
<td>Within 7 days</td>
<td>% Within 7 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr 05 - Mar 06</td>
<td>1835</td>
<td>1358</td>
<td>74.01</td>
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</tr>
<tr>
<td>Apr 06 - Mar 07</td>
<td>1905</td>
<td>1529</td>
<td>80.26</td>
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<td>2201</td>
<td>1772</td>
<td>80.51</td>
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<tr>
<td>Apr 08 - Mar 09</td>
<td>2270</td>
<td>1767</td>
<td>77.84</td>
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<tr>
<td>Apr 09 - Mar 10</td>
<td>2306</td>
<td>1722</td>
<td>74.67</td>
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Nationally 71.8% of initial assessments completed 08/09 were completed within timescales
### Initial Assessments Completed

<table>
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<th>Within 7 days</th>
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<td>1835</td>
<td>1358</td>
</tr>
<tr>
<td>Apr 06 - Mar 07</td>
<td>1905</td>
<td>1529</td>
</tr>
<tr>
<td>Apr 07 - Mar 08</td>
<td>2201</td>
<td>1772</td>
</tr>
<tr>
<td>Apr 08 - Mar 09</td>
<td>2270</td>
<td>1767</td>
</tr>
<tr>
<td>Apr 09 - Mar 10</td>
<td>2306</td>
<td>1722</td>
</tr>
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</table>
NI 68 - % of referrals leading to initial assessment

<table>
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<tr>
<th>Apr 05 - Mar 06</th>
<th>Apr 06 - Mar 07</th>
<th>Apr 07 - Mar 08</th>
<th>Apr 08 - Mar 09</th>
<th>Apr 09 - Mar 10</th>
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</thead>
<tbody>
<tr>
<td>58.2</td>
<td>67.1</td>
<td>29.1</td>
<td>57.6</td>
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</table>

CP Enquiries

<table>
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<tr>
<th>Apr 09 - Mar 10</th>
<th>Total Enquiries</th>
<th>Total Clients</th>
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</thead>
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<tr>
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<td>1836</td>
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By source

<table>
<thead>
<tr>
<th>Apr 09 - Mar 10</th>
<th>Health</th>
<th>Education</th>
<th>Police</th>
<th>Locality Services (S/C)</th>
<th>Other Source</th>
<th>Not Recorded</th>
<th>Other</th>
<th>Probation</th>
</tr>
</thead>
</table>
Enquiries by Source Apr 09 - Mar 10

- Health: 54%
- Education: 14%
- Police: 7%
- Locality Services (S/C): 15%
- Other Source: 3%
- Not Recorded: 0%
- Other: 7%
- Probation: 0%

Enquiries by Source Apr 09 - Mar 10

<table>
<thead>
<tr>
<th>Source</th>
<th>Value</th>
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<tbody>
<tr>
<td>Health</td>
<td>1108</td>
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<tr>
<td>Education</td>
<td>291</td>
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<tr>
<td>Police</td>
<td>152</td>
</tr>
<tr>
<td>Locality Services (S/C)</td>
<td>319</td>
</tr>
<tr>
<td>Other Source</td>
<td>59</td>
</tr>
<tr>
<td>Not Recorded</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>136</td>
</tr>
<tr>
<td>Probation</td>
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</table>
Section 47 Enquiries Initiated During Year Ending

<table>
<thead>
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<tr>
<td>As At 31/03/2006</td>
<td>481</td>
</tr>
<tr>
<td>As at 31/03/2007</td>
<td>379</td>
</tr>
<tr>
<td>As at 31/03/2008</td>
<td>432</td>
</tr>
<tr>
<td>As at 31/03/2009</td>
<td>524</td>
</tr>
<tr>
<td>As at 31/03/2010</td>
<td>437</td>
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</table>
Initial Conferences

No. of Initial Conferences Apr 05 to Mar 10

<table>
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<tbody>
<tr>
<td>Rotherham conferences in timescale</td>
<td>68.8</td>
<td>100.0%</td>
<td>96.7</td>
<td>95.7</td>
<td>95.0%</td>
<td>67.50%</td>
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</table>

NB - Unable to provide IPF group comparator and England Info as this is not a national indicator so do not know where this information has come from in the past.
Children made subject of a plan

291 children became subject of a CP Plan

<table>
<thead>
<tr>
<th>Category</th>
<th>Rotherham - % of children in each category as at 31/03/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect</td>
<td>145 (49.8%)</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>41 (14.1%)</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>81 (27.8%)</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>14 (4.8%)</td>
</tr>
<tr>
<td>Multiple Categories</td>
<td>10 (3.4%)</td>
</tr>
</tbody>
</table>

Unallocated Children

Report shows 2 children were unallocated to a qualified worker as at 31/03/10
In Rotherham 78.9% of core assessments in 2009/10 were completed within timescale.

Nationally 78.2% of core assessments in 2008/09 were completed within timescale.
Timeliness of Child Protection

Review Conferences
Nationally 99.1% of Child Protection cases which should have been reviewed during the year 2008/09 were reviewed within timescale
Number of Children with a Child Protection Plan

There were 277 children with a child protection plan at 31/03/2010 which represents 48.9 children per 10,000 in Rotherham (based on ONS population estimates (mid 2008)). Nationally in 2008/09 there were 31 children per 10,000.

In Rotherham

131 (47%) on the register were boys
145 (52%) on the register were girls
1 (0.4%) on the register were unborn

No. of Children with a Child Protection Plan

<table>
<thead>
<tr>
<th>Period</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>As At 31/03/2006</td>
<td></td>
</tr>
<tr>
<td>As At 31/03/2007</td>
<td></td>
</tr>
<tr>
<td>As At 31/03/2008</td>
<td></td>
</tr>
<tr>
<td>As At 31/03/2009</td>
<td></td>
</tr>
<tr>
<td>As At 31/03/2010</td>
<td></td>
</tr>
</tbody>
</table>

- Multiple/not recommended
- Emotional abuse
- Sexual abuse
- Physical abuse
- Neglect
<table>
<thead>
<tr>
<th>Category</th>
<th>Rotherham 31/03/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neglect</td>
<td>128 (46%)</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>38 (13.7%)</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>89 (32%)</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>15 (5%)</td>
</tr>
<tr>
<td>Multiple Categories</td>
<td>7 (2.5%)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>No. of children</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>251</td>
<td>91%</td>
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<td>Black</td>
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<tr>
<td>Asian</td>
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<td>1%</td>
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<tr>
<td>Mixed</td>
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<td>3%</td>
</tr>
<tr>
<td>Other/Not recorded</td>
<td>7</td>
<td>2.5%</td>
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</tbody>
</table>

**Looked After Children**

23 of the 277 children with a child protection plan (8%) at 31 March 2010 were also looked after
Cessation of CP Plans by Length of time of plan

As at 31/03/2006
As at 31/03/2007
As at 31/03/2008
As at 31/03/2009
As at 31/03/2010

Period

Number

- 3 years and over
- 2 years but under 3 years
- 1 year but under 2 years
- 6 months but under 1 year
- 3 months but under 6 months
- Under 3 months
Summary of Performance

Explanation of the Performance Monitoring Table
Detailed below is an explanation regarding the different items within the summary performance table.

| Ref | the official reference number. ‘NI’ = National Indicator, ‘BV’ = Best Value performance indicator, LAA and LPI = Local stretch indicators within the 2006-09 Local Area Agreement |
| Definition | The name of the indicator. |
| Good Perf | The direction the performance needs to travel to improve |
| 08/09 Actual | Previous year’s performance |
| 09/10 Target | The current year end target |
| 09/10 Perf | Current Year end or latest available performance |
| On Target | Current years performance against the target set |
| DOT (Yr on Yr) | Direction of travel of performance compared to previous quarter |
| Year to Date | Year To Date. Performance assessment by corporate monitoring system Performance Plus as at December 2008 |
| 09/10 Commentary | If necessary further explanation of performance is summarised here. Examples include details of external influences, seasonal trends or impact of action. This is supplied by indicator managers and approved by directors, additional notes from Performance and Data team may be added to the comments column to aid explanation. |
| Stat. Neigh. | The latest average for our Statistical Neighbour group. Used by Ofsted to assess performance to be a good authority we need to have the majority inline or better than this average. The information in brackets assesses our performance against this average. |
| National | The latest National average. Used by Ofsted to assess performance to be a good authority we need to have the majority inline or better than this average. The information in brackets assesses our performance against this average. |
| 10/11 Target | Future year end targets set by indicator managers. |
| 11/12 Target | }
<table>
<thead>
<tr>
<th>Abbreviations within the table</th>
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<tbody>
<tr>
<td><strong>NI</strong></td>
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<td>PI</td>
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<td>BV</td>
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<td>LAA</td>
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<td>Ref</td>
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<td>NI 59</td>
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<td>NI 60</td>
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<td>NI 64</td>
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<td>NI 65</td>
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<td>NI 67</td>
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<td>NI 68</td>
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Function 1: To review the working practices of the Board and its members with a view to securing the effective operation of LSCB functions and ensuring that all member organisations are effectively engaged (Working Together 2010 paras 3.86 - 3.95)

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<th>Resources</th>
<th>Progress</th>
<th>BRAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish revised constitution that is compliant with Working Together (WT) 2010</td>
<td>All Board members to sign up to the agreed constitution</td>
<td>March 2010</td>
<td>Safeguarding Children Board</td>
<td>Capacity within team. Agency sign up.</td>
<td>RLSCB Development Day 22.02.10. Agreement at RLSCB 19.03.10. COMPLETED</td>
<td>GREEN</td>
</tr>
<tr>
<td>Sub Group Chairs to be agreed</td>
<td>Safeguarding Children Board to agree Sub Group Chairs</td>
<td>March 2010</td>
<td>Safeguarding Children Board Chair</td>
<td>Chair agreement.</td>
<td>RLSCB Development Day 22.02.10. Agreement at RLSCB 19.03.10. COMPLETED</td>
<td>BLUE</td>
</tr>
<tr>
<td>Agree Core Terms of Reference (ToR) for all Sub Groups &amp; plan meeting cycle</td>
<td>All Sub Group Chairs to meet together</td>
<td>March 2010</td>
<td>Safeguarding Children Board Chair</td>
<td>Capacity within team. Agency sign up.</td>
<td>RLSCB Development Day 22.02.10. Agreement at RLSCB 19.03.10. Chairs’ meeting 17.03.10. COMPLETED</td>
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Each Sub Group to confirm its ToR and submit its work plan.

- Learning & Development Complete draft terms of Quarterly meeting Sub Group Chair Staff time and RLSCB agenda RLSCB Development Day GREEN
**Function 1:** To review the working practices of the Board and its members with a view to securing the effective operation of LSCB functions and ensuring that all member organisations are effectively engaged (Working Together 2010 paras 3.86 - 3.95)

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<tr>
<td></td>
<td>reference and work plan.</td>
<td></td>
<td></td>
<td>with admin support</td>
<td>22.02.10.</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Agency sign up.</td>
<td>Agreement at RLSCB 19.03.10.</td>
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<td></td>
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<td></td>
<td>Chairs' meeting 17.03.10.</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Annual report by 1st April each year.</td>
<td></td>
</tr>
<tr>
<td>• Policy &amp; Procedure</td>
<td>Complete draft terms of reference and work plan.</td>
<td>Bi-monthly meeting</td>
<td>Sub Group Chair</td>
<td>Staff time and RLSCB agenda with admin support</td>
<td>RLSCB Development Day 22.02.10.</td>
<td>BLUE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Agency sign up.</td>
<td>Agreement at RLSCB 19.03.10.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Annual Report by 1 April each year.</td>
<td></td>
</tr>
<tr>
<td>• Performance &amp; Quality</td>
<td>Complete draft terms of reference and work plan.</td>
<td>Bi-monthly meeting</td>
<td>Sub Group Chair</td>
<td>Staff time and RLSCB agenda agency sign up.</td>
<td>RLSCB Development Day 22.02.10.</td>
<td></td>
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<td></td>
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</thead>
<tbody>
<tr>
<td>☐ Exploitation</td>
<td>Complete draft terms of reference and work plan.</td>
<td>Quarterly meeting</td>
<td>Sub Group Chair</td>
<td>Staff time and RLSCB agenda with admin support Agency sign up.</td>
<td>RLSCB 19.03.10. Chairs’ meeting 17.03.10. Annual Report by 1 April each year.</td>
<td>AMBER</td>
</tr>
<tr>
<td>☐ Serious Case Review</td>
<td>Complete draft terms of reference and work plan.</td>
<td>Bi-monthly</td>
<td>Sub Group Chair</td>
<td>Staff time and RLSCB agenda with admin support Agency sign up.</td>
<td>RLSCB Development Day 22.02.10. Agreement at RLSCB 19.03.10. Chairs’ meeting 17.03.10. Annual Report by 1 April each year.</td>
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</thead>
<tbody>
<tr>
<td>Child Death Overview</td>
<td>Complete draft terms of reference and work plan.</td>
<td>Quarterly or as required</td>
<td>Sub Group Chair</td>
<td>Staff time and RLSCB agenda with admin support Agency sign up.</td>
<td>RLSCB Development Day 22.02.10. Agreement at RLSCB 19.03.10. Chairs’ meeting 17.03.10. Annual Report by 1 April each year.</td>
<td>BLUE</td>
</tr>
<tr>
<td>Communication and Publicity</td>
<td>Complete draft terms of reference and work plan.</td>
<td>Quarterly or as required</td>
<td>Sub Group Chair</td>
<td>Staff time and RLSCB agenda with admin support Agency sign up.</td>
<td>RLSCB Development Day 22.02.10. Agreement at RLSCB 19.03.10. Chairs’ meeting 17.03.10. Annual Report by 1 April each year.</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Each Sub Group to prepare and submit to the Board a biannual report or as circumstances require.</td>
<td>Schedule for reporting to Board devised</td>
<td>Schedule prepared by 30 May 2010</td>
<td>Assistant Safeguarding Children Board Manager</td>
<td>Staff time and RLSCB agenda with admin support</td>
<td></td>
<td>GREEN</td>
</tr>
<tr>
<td>All Board members to be CRB checked</td>
<td>List of members and date of checks to be compiled &amp; maintained.</td>
<td>30 April 2010</td>
<td>Safeguarding Children Board Manager</td>
<td>Staff time and RLSCB agenda with admin support</td>
<td></td>
<td>GREEN</td>
</tr>
<tr>
<td>Annual audit of Sub Group and Local Safeguarding Children Board effectiveness.</td>
<td>Audit tool to be compiled.</td>
<td>June 2010</td>
<td>Safeguarding Children Board Manager and Assistant Safeguarding Children Board Manager</td>
<td>Capacity. Audit tool. RLSCB sign up.</td>
<td></td>
<td>S11 Self Assessment Audit – Effectiveness Tool. AMBER</td>
</tr>
</tbody>
</table>
### Function 2: To develop policies and procedures for safeguarding and promoting the welfare of children….(Working Together 2010 paras 3.13 – 3.29)

<table>
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</thead>
<tbody>
<tr>
<td>Ensure that safeguarding &amp; child protection procedures are compliant with Working Together to Safeguard Children (WT) 2010.</td>
<td>- Revised procedures agreed by RLSCB and published on web site</td>
<td>November 2010 &amp; rolling programme of review &amp; revision</td>
<td>Policy &amp; Procedures Sub Group Safeguarding Children Board</td>
<td>Sub Group meetings and admin support</td>
<td>Policy &amp; Procedures Sub Group work plan. Policy &amp; Procedures Sub Group regular planned meetings.</td>
<td>GREEN</td>
</tr>
<tr>
<td></td>
<td>- Purchase services of Tri.X for procedure maintenance</td>
<td>30 April 2010</td>
<td>Director, Resources, Policy &amp; Performance, RMBC.</td>
<td>Implementation costs &amp; ongoing maintenance costs</td>
<td>TriX proposal completed.</td>
<td>BLUE</td>
</tr>
<tr>
<td></td>
<td>- Monitoring of compliance with safeguarding children procedures</td>
<td>Biannual reports to Safeguarding Children Board. Periodic Locality Performance Framework reports</td>
<td>Performance &amp; Quality Assurance Sub Group Director, Resources Policy &amp; Performance, RMBC.</td>
<td>RMBC staff time on behalf of RLSCB</td>
<td>TriX agreed at RLSCB 19.03.10.</td>
<td>GREEN</td>
</tr>
<tr>
<td></td>
<td>- Procedure</td>
<td>January 2011</td>
<td>Policy &amp;</td>
<td></td>
<td></td>
<td>GREEN</td>
</tr>
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**Function 2:** To develop policies and procedures for safeguarding and promoting the welfare of children….(Working Together 2010 paras 3.13 – 3.29)

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</tr>
</thead>
<tbody>
<tr>
<td>s to be updated in accordance with WT 2010 guidance</td>
<td></td>
<td></td>
<td>Procedures Sub Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide continuous development of policies and procedures for safeguarding and promoting the welfare of children in line with emerging research, legislative change and Government guidance.</td>
<td>Update associated multi-agency protocols/guidance and publish on website as required</td>
<td>Ongoing</td>
<td>Policy &amp; Procedures Sub Group</td>
<td>Staff time in updating local procedures</td>
<td></td>
<td>GREEN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tri.X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Communications and Publicity Sub Group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each agency responsible for updating procedures and representation on Policy and Procedures Sub Group</td>
<td>Bi-monthly meetings</td>
<td></td>
<td>Individual Agency Representative on Policy &amp; Procedures Sub Group</td>
<td>Staff time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective</td>
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</tr>
<tr>
<td>Review E-safety strategy for Rotherham</td>
<td>• Promote the role of E-safety champion &lt;br&gt; • Publicise E-safety strategy for Rotherham</td>
<td>Bi-monthly meetings</td>
<td>E-safety champion &lt;br&gt; E-safety Special Interest and Communications &amp; Publicity Sub Groups</td>
<td>Staff time. &lt;br&gt; Children and young people time and commitment.</td>
<td>E-Safety Policy. &lt;br&gt; Acceptable Usage Policy. &lt;br&gt; Attendance dates and details of young people attending.</td>
<td>GREEN / BLUE</td>
</tr>
<tr>
<td>Ensure that recruitment and selection policies in partner agencies are “safe”</td>
<td>Review agency selection &amp; recruitment policies to ensure safeguarding</td>
<td>July 2010</td>
<td>Workforce Development Service Manager, CYPS, RMBC. &lt;br&gt; Policy &amp; Procedures Sub Group</td>
<td>Capacity &lt;br&gt; Agency agreement. &lt;br&gt; Section 11 audit.</td>
<td>Section 11 audit completed by agencies March 2010</td>
<td>AMBER</td>
</tr>
</tbody>
</table>
**Function 3:** To communicate to persons and bodies in Rotherham the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so (Working Together 2010 para 3.27)

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</thead>
</table>
| Re launch Communications Special Interest Group as new Sub Group | ● Audit existing publications and schedule of existing publications and ensure regular slots for safeguarding | May 2010 | Appropriate Sub Group members. | Staff time  
Secure space in local media e.g. Rotherham Matters  
Unite Health Matters  
Governor’s Newsletter  
Fostering Newsletter | | |

| | | | | | | **BLUE** |

| | | | | | | | **AMBER** |

● Develop the Safeguarding webpage further
**Function 3:** To communicate to persons and bodies in Rotherham the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so (Working Together 2010 para 3.27)

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<tbody>
<tr>
<td>Publicise new range of Safeguarding Children leaflets</td>
<td>● Review &amp; revise current leaflets &amp; undertake gap analysis</td>
<td></td>
<td>Publishing Officer</td>
<td>Ensure input from Children’s Rights Service &amp; Children’s Information Services</td>
<td></td>
<td>AMBER</td>
</tr>
<tr>
<td></td>
<td>● Prioritise publication of new leaflets</td>
<td></td>
<td>Chair, Communications &amp; Publicity Sub Group</td>
<td>Printing &amp; distribution costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure effective communication strategy and related promotional work around safeguarding.</td>
<td>Continue to develop a range of media to publicise work of the Operational Safeguarding Children Unit and Board, including regular Newsletter.</td>
<td>Safeguarding Children Board newsletter to be published each Spring, Summer &amp; Autumn</td>
<td>Safeguarding Children Board Manager and Operational Safeguarding Children Unit</td>
<td>Communications Special Interest Group</td>
<td></td>
<td>AMBER</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Safeguarding Children Board Manager</td>
<td>Newsletter for agencies and public launched Autumn 2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective</td>
<td>● Include</td>
<td>September 2010</td>
<td>Director of</td>
<td></td>
<td></td>
<td>AMBER</td>
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**Function 3:** To communicate to persons and bodies in Rotherham the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so (Working Together 2010 para 3.27)

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| partnership working with parents, carers, children and young people re consultation and strategy development | Safeguarding Children questions in ‘Audit of Need’  
- Develop consultation opportunities with:  
  - Patient Committee  
  - Youth Cabinet  
  - Voice and Influence  
  - Rights2Rights  
  - Locality Meetings  
  - Rotherham Show (profile)  
- Participation event with children and young people to be developed | November 2010 | Safeguarding Children Board Manager | Resources, Policy & Performance, RMBC | National Takeover Day | AMBER |
Function 3: To communicate to persons and bodies in Rotherham the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so (Working Together 2010 para 3.27)

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<tr>
<td></td>
<td>● Plan audits to measure the impact on individuals, groups and the community</td>
<td>May 2010 November 2010 June 2011 &amp; every 6 months thereafter</td>
<td>Safeguarding Children Board Manager Communications Manager</td>
<td>Funding of external speakers and venue Learning &amp; Development Sub Group time and commitment.</td>
<td>Training event held for Board Members in February 2010. Training on legal aspects May 2010 Further event planned for November 2010 &amp; June 2011</td>
<td>GREEN</td>
</tr>
<tr>
<td>Annual safeguarding conference/trainining event</td>
<td>Arrange and provide Rotherham Safeguarding Children Board events</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Support and promote Anti-Bullying Action Plan | ● Publicise Anti-bullying measures | Regular meetings timetabled with Head of School | Anti-Bullying Officer Risk Management Officer Communication Special Interest Group Head of School | | | AMBER |
**Function 3:** To communicate to persons and bodies in Rotherham the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done, and encouraging them to do so (Working Together 2010 para 3.27)

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<tbody>
<tr>
<td>Agree appropriate avenues of communication between Board &amp; frontline staff</td>
<td>- Explore required level &amp; frequency of information required for various partner agencies</td>
<td>31 August 2010</td>
<td>Communication Special Interest Group</td>
<td>Staff time and capacity.</td>
<td>Planned implementation programme for learning and development around national and local serious case reviews.</td>
<td><strong>GREEN</strong></td>
</tr>
<tr>
<td>Further Develop advice and support for Designated Members of Staff across all</td>
<td>Develop forum for the sharing of information, good practice, and update of legislation and</td>
<td>Meetings held termly beginning Autumn Term 2009</td>
<td>Senior Safeguarding Officer/Safeguarding Officer</td>
<td>Income generated from delivery of training</td>
<td>Two meetings held - very well received planned to continue current frequency – to be reviewed.</td>
<td><strong>GREEN</strong></td>
</tr>
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<td>educational services</td>
<td>guidance</td>
<td></td>
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**Function 4:** Produce and publish an annual report on the effectiveness of safeguarding in Rotherham (Working Together paras 3.34 - 3.39)

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<tbody>
<tr>
<td>Provide information re policy &amp; procedures for safe recruitment of staff</td>
<td>Review agency selection &amp; recruitment policies to ensure safeguarding</td>
<td>July 2010</td>
<td>Workforce Development Service Manager, CYPS, RMBC. Policy &amp; Procedures Sub Group</td>
<td>Section 11 audit.</td>
<td></td>
<td>AMBER</td>
</tr>
<tr>
<td>Report on single &amp; multi agency training on safeguarding and promoting children’s welfare</td>
<td>• Audit partner training needs • Review admin support for RLSCB joint training</td>
<td>Bi-annual reports to Board</td>
<td>Learning &amp; Development Sub Group</td>
<td>Section 11 audit.</td>
<td></td>
<td>AMBER</td>
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### Function 4: Produce and publish an annual report on the effectiveness of safeguarding in Rotherham (Working Together paras 3.34 - 3.39)

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<td>Evidence the impact of any SCR recommendations &amp; highlight uncompleted actions</td>
</tr>
<tr>
<td>State lessons learned from CDOP to prevent child deaths</td>
</tr>
<tr>
<td>List progress on priority issues</td>
</tr>
<tr>
<td>Provide comment &amp; challenge on work of the Children’s Trust Board</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Planned Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Update collated SCR recommendations &amp; highlight uncompleted actions</td>
</tr>
<tr>
<td>Review &amp; revise action plans resulting from lessons learned</td>
</tr>
<tr>
<td>Consider progress achieved &amp; barriers met</td>
</tr>
<tr>
<td>Meetings to consider safeguarding aspects of Children &amp; Young People’s Plan and other Children’s Trust initiatives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Milestones and Deadlines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bi-annual reports to Board</td>
</tr>
<tr>
<td>Bi-annual reports to Board</td>
</tr>
<tr>
<td>September 2010; March 2011; 6 monthly thereafter</td>
</tr>
<tr>
<td>Regular diaried meetings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Person Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Chair for specific cases, RLSCB Serious Case Review Sub Group</td>
</tr>
<tr>
<td>Child Death Overview Panel</td>
</tr>
<tr>
<td>Independent Chair, Safeguarding Children Board</td>
</tr>
<tr>
<td>Independent Chair, LSCB Chair, Children and Young People’s Trust Board Strategic Director, Children &amp; Young People’s</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resources</th>
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</thead>
<tbody>
<tr>
<td>Annual Report to RLSCB 04.12.09</td>
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<table>
<thead>
<tr>
<th>Progress</th>
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<tbody>
<tr>
<td>AMBER</td>
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<tr>
<td>(but review)</td>
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<td>GREEN</td>
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<td>GREEN</td>
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<tr>
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<tbody>
<tr>
<td>AMBER</td>
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</table>
### Function 4: Produce and publish an annual report on the effectiveness of safeguarding in Rotherham (Working Together paras 3.34 - 3.39)

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Publish Annual Report by 1 April each year</td>
<td>Include draft report on March Board meeting agenda</td>
<td>April 2011</td>
<td>Independent Chair, LSCB Safeguarding Children Board Manager</td>
<td>Services, RMBC</td>
<td></td>
<td>GREEN</td>
</tr>
</tbody>
</table>
**Function 5:** To monitor and evaluate the effectiveness of what is done by the Local Authority and Board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve (Working Together 2010 paras 3.28 – 3.33)

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</thead>
<tbody>
<tr>
<td>Individual agencies’ compliance with statutory responsibilities</td>
<td>Review and update section 11 audits for all Board members</td>
<td>March 2010</td>
<td>Assistant Safeguarding Board Manager</td>
<td>Assistant Safeguarding Board Manager time</td>
<td>Completed Report to RSCB 19.03.10 and updates at subsequent meetings.</td>
<td>AMBER</td>
</tr>
<tr>
<td>Improve effectiveness of RLSCB</td>
<td>Review &amp; update Board audit undertaken on Development day 22 Feb 2010</td>
<td>September 2010</td>
<td>Chair, Safeguarding Children Board &amp; its members</td>
<td></td>
<td></td>
<td>GREEN</td>
</tr>
<tr>
<td>Effective performance management and quality assurance systems which ensure safe single and interagency practice</td>
<td>Review local quality assurance and auditing process systems</td>
<td>July 2010</td>
<td>Operational Safeguarding Unit management</td>
<td>Staff time</td>
<td>Performance management system to be adapted and implemented across communities.</td>
<td>AMBER</td>
</tr>
<tr>
<td>Contribute to development of integrated services to ensure new arrangements continue to safeguard and promote the welfare of children and advise them on ways to improve</td>
<td>Develop and review criteria Review the impact of new integrated arrangements Multi agency learning community meetings to be held during 2010</td>
<td></td>
<td>Strategic Director, Children &amp; Young People’s Services</td>
<td></td>
<td></td>
<td>AMBER</td>
</tr>
<tr>
<td>Action</td>
<td>Responsible Party</td>
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</tr>
<tr>
<td>Promote welfare of children</td>
<td>• Report findings to Board</td>
<td></td>
<td></td>
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<tr>
<td>Review national guidance and publications and ensure that action</td>
<td>On-going</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>or learning required takes place</td>
<td>Safeguarding Children Board Manager Chair, Communication Special Interest Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation of standards in respect of safe recruitment and</td>
<td>Assistant Safeguarding Children Board Manager Safeguarding Recruitment Group (Education)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>supervision of staff for all agencies.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor compliance with standards by agencies &amp; organizations</td>
<td>November 2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review Rotherham’s parenting strategy</td>
<td>• Review collaboration between adult and children services to safeguard children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approval Date</td>
<td>RMBC Director of Community Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approval Date</td>
<td>Strategic Leader (Attendance &amp; Parenting) appointed in February 2008</td>
<td></td>
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Notes:
- GREEN indicates completion.
- AMBER indicates action required.
| Endorse the Safe & Well Guidance and Prevention & Early Intervention Strategy on their launch | Ensure all RLSCB Members are fully aware of launch and of Guidance/Strategy | Launch 22 April, 2010 RLSCB Members to ensure staff are fully aware of documents June 2010 | Safeguarding Children Board members | Safe and Well report discussed and ratified at RLSCB Policy and Procedures Sub Group Feb 2010 Approved by Children and Young People’s Trust Board (date?) February 2010. Prevent and Early Intervention Strategy approved at Children and Young People’s Trust Board on 21 April, 2010. | BLUE |
**Function 6:** To participate in the local planning and commissioning of children’s services to ensure that they take safeguarding and promoting the welfare of children into account (Working Together 2010 paras 3.40 & 3.41)

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| In-house or commissioned services are assessed as safe for children to use and meet agreed standards in relation to safe organisations | ● Safeguarding is included in the Commissioning Checklist contained in the CYPS Commissioning Framework  
● The Safeguarding Children Unit and the Commissioning Team to collaborate to ensure that all commissioned services safeguard and promote welfare of the children using them  
● IROs to contact the Commissioning Team if there | Director of Resources, Planning and Performance  
Operational Safeguarding Unit Manager, RMBC  
Protection and Planning Officers | | | | AMBER |
**Function 6:** To participate in the local planning and commissioning of children’s services to ensure that they take safeguarding and promoting the welfare of children into account (Working Together 2010 paras 3.40 & 3.41)

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<tr>
<td>need for children’s services to be commissioning in line with the report</td>
<td>● LSCB to work in consultation with the Children and Young People’s Trust Board to agree strategic approaches to understanding needs and the effectiveness of current services</td>
<td>Initial formal consultation with RLSCB re CYPP March 2010</td>
<td></td>
<td></td>
<td></td>
<td>AMBER</td>
</tr>
<tr>
<td>need for children’s services to be commissioning in line with the report</td>
<td>● LSCB to agree arrangements for ensuring that priorities for change are delivered through Children’s Trust partners</td>
<td>Joint meeting of Children and Young People’s Trust Board and RLSCB members to agree CYPP</td>
<td></td>
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<td></td>
<td>and Young People’s Trust Board approaches to understanding the impact of specialist services on outcomes for CYP &amp; F</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
| Develop services for children and young people affected by domestic abuse/violence | Reduce the impact of domestic abuse by:  
  - Reviewing the impact of the inter-agency guidance and arrangements in respect of domestic abuse  
  - Reducing repeat incidents of domestic abuse | September 2010  
  Review annually | Strategic Director, Children & Young People’s Services | | | RED |
| | | | PPU Manager | | | |
**Function 6:** To participate in the local planning and commissioning of children’s services to ensure that they take safeguarding and promoting the welfare of children into account (Working Together 2010 paras 3.40 & 3.41)

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<tr>
<td></td>
<td>homicides relating to Domestic Violence</td>
<td>September 2010</td>
<td>South Yorkshire Police Domestic Violence Co-ordinator/ Voluntary Sector LSCB representative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increasing the level of awareness of impact on children and their families, around domestic abuse/violence.</td>
<td></td>
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<tr>
<td></td>
<td>Work with locality teams, schools, the Police, Neighbourhood and Voluntary Sector services to ensure consistent and effective action in support of children and their families suffering from domestic abuse</td>
<td></td>
<td></td>
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**Function 6:** To participate in the local planning and commissioning of children’s services to ensure that they take safeguarding and promoting the welfare of children into account (Working Together 2010 paras 3.40 & 3.41)

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<tbody>
<tr>
<td>Consultation with C&amp; YP</td>
<td>In conjunction with partners, consult with children young people and their families on safeguarding priorities.</td>
<td>Develop consultation strategy by September 2010. Examine existing and recent consultation outcomes from RLSCB member agencies.</td>
<td>LSCB Assistant Manager</td>
<td></td>
<td></td>
<td>AMBER</td>
</tr>
</tbody>
</table>
**Function 7:** To collect and analyse information about the deaths of all children in the Borough of Rotherham with a view to identifying:

i) any matters of concern affecting the safety and welfare of children in Rotherham, including any case giving rise to the need for a Serious Case Review;

ii) any general public health or safety concerns arising from the deaths of children (Working Together 2010 para 3.42 & Chapter 7)

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</table>
| Effective local procedures for the conduct of Child Death Reviews | • Review arrangements in line with statutory guidance  
• Provide Annual Report to RLSCB | June 2010  
December 2010 | Chair, Child Death Overview Sub Group | Staff time; additional administrative costs | Statistical data collected for 2009-10 | GREEN |
| Dissemination of lessons from Child Death Overview Panel | • Publicise lessons learned  
• Audit impact on the reduction of preventable deaths  
• Ensure audit trail for decisions | December 2010 | Communications & Publicity Sub Group | Executive summary published | AMBER |
Function 7: To collect and analyse information about the deaths of all children in the Borough of Rotherham with a view to identifying:

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<tr>
<td>re referral to SCR Sub Group</td>
<td></td>
<td></td>
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</tbody>
</table>
**Function 8:** to put in place procedures for ensuring that there is a co-ordinated response by the Local Authority, their Board Partners and other relevant persons to an unexpected death of a child (Working Together 2010 Chapter 7)

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</thead>
<tbody>
<tr>
<td>Local procedures are effective for rapid response to the unexpected death of a child.</td>
<td>Procedures reviewed</td>
<td>June 2010</td>
<td>Rapid Response Lead</td>
<td>Staff capacity.</td>
<td></td>
<td>GREEN</td>
</tr>
<tr>
<td>• Compare second year’s operation with initial year of operation</td>
<td>October 2010</td>
<td>Rapid Response Lead and CDOP Administrator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Function 9:** to undertake reviews of cases where abuse or neglect of a child is known or suspected, a child has died or has been seriously harmed, and there is cause for concern as to the way in which the local authority, their Board partners or other relevant persons have worked together to safeguard the child  (Working Together 2010 para 3.44 & Chapter 8)

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</table>
| Serious Case Reviews completed in accordance with statutory guidance | SCR Procedure to be reviewed & revised.  
Handbook for practitioners.  
Training of Senior Managers in training staff to undertake writing IMRs. This training is now to be provided twice a year in Rotherham. | Procedures developed March 2009  
February 2010 | Assistant Safeguarding Children Board Manager.  
Operational Safeguarding Children Unit | Working Together to Safeguard Children December 2009.  
Ofsted grade descriptors. | Procedures developed.  
Training undertaken Dates ? Nos.? | GREEN |
**Function 9:** to undertake reviews of cases where abuse or neglect of a child is known or suspected, a child has died or has been seriously harmed, and there is cause for concern as to the way in which the local authority, their Board partners or other relevant persons have worked together to safeguard the child  (Working Together 2010 para 3.44 & Chapter 8)

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| Improved practice as a result of implementing the recommendations from Serious Case Reviews completed in 2009-10. | ● Publish Executive Summaries on the Safeguarding webpage  
● Further publicise availability of information re learning outcomes  
● Training - Develop specific agency learning sets in addition to multi-agency arrangements  
● Monitor the | First of 3 completed Executive Summaries to be published March 2010. Second due to be published May 2010  
March 2010 & ongoing Protected Learning Time for GPs to consider learning from SCRs - ongoing Quarterly reports to Safeguarding Children Board | Safeguarding Board Manager  
Communications Manager  
Operational Safeguarding Children Unit  
Safeguarding Children Board Manager  
Safeguarding Children Board Manager and Operational Safeguarding Children Manager  
Assistant Safeguarding Children Board Manager  
Safeguarding Children Board Manager | Capacity and staff knowledge and skills of SCR lessons | AMBER / GREEN |
**Function 9:** to undertake reviews of cases where abuse or neglect of a child is known or suspected, a child has died or has been seriously harmed, and there is cause for concern as to the way in which the local authority, their Board partners or other relevant persons have worked together to safeguard the child (Working Together 2010 para 3.44 & Chapter 8)

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<tbody>
<tr>
<td></td>
<td>implementation of action plans within agreed timescales</td>
<td>Deliver a series of events to disseminate and reinforce key common messages from cases completed in 2008 - 2010</td>
<td>Children Manager Two trained trainers for IMRs.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Function 10:** to engage in any other activity that facilitates, or is conducive to, the fulfilment of Rotherham Local Safeguarding Children Board’s objectives (Working Together 2010 para 3.45).

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<tr>
<td>Needs of Black and Minority Ethnic communities in Rotherham are addressed effectively</td>
<td>Publish safeguarding guidance for madressahs and other faith groups</td>
<td>December 2009</td>
<td>Assistant Manager, Safeguarding Unit, Equalities and Diversity Manager</td>
<td></td>
<td></td>
<td>AMBER / GREEN</td>
</tr>
<tr>
<td>Reduction in the number of children experiencing, or at risk of, sexual exploitation</td>
<td>RLSCB to monitor via Annual Report.</td>
<td></td>
<td>Assistant Manager, Safeguarding Children Unit, RMBC, Chair, Exploitation Sub Group</td>
<td>Sexual Exploitation Forum</td>
<td></td>
<td>AMBER</td>
</tr>
<tr>
<td>Empower children with disabilities to participate in Child Protection Conferences and Looked After Children Reviews</td>
<td>Develop further communication methods to facilitate participation in reviews etc</td>
<td>IROs in Rotherham seek to meet with all children prior to reviews and seek their participation as appropriate. Advocacy and Independent Visitor scheme developing</td>
<td>Assistant Manager (Safeguarding)</td>
<td>Children’s’ Rights Service time</td>
<td></td>
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<td>To review all single agency training and quality assure through a Safeguarding Board accreditation scheme</td>
<td>Audit by Training Sub-committee</td>
<td>On going</td>
<td>Safeguarding Children Unit Manager</td>
<td>Capacity of agencies. Capacity of Learning and Development Sub Group</td>
<td>March 2010 health economy undertaking of Task and Finish Group into the feasibility of a Health Economy Training Strategy.</td>
<td>AMBER</td>
</tr>
<tr>
<td>Audit the impact of training in relation to improved outcomes for children.</td>
<td>Embed audit activity into work of Safeguarding Children Unit</td>
<td></td>
<td>Service Manager Safeguarding Unit Multi-agency Trainer</td>
<td></td>
<td></td>
<td>AMBER</td>
</tr>
<tr>
<td>Act as a responsible authority in terms of the Gambling Act 2005 Act as a responsible authority in terms</td>
<td>Publicise the Act and the responsibility to protect children and vulnerable people</td>
<td>December 2009 – planning meeting held in December 2009</td>
<td>Communications Manager Senior Licensing Officer</td>
<td></td>
<td>Further action planned for January 2009. Communication Manager to update</td>
<td>RED</td>
</tr>
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<td>of the Gambling Act 2005</td>
<td>To develop further local systems to ensure that: 1. Licensed premises (Licensees) are provided with a best practice framework for activity where children and young people may be present. 2. To ensure that any Licensee not adhering to conditions or placing children and young people at risk of harm.</td>
<td>Develop a protocol for gathering and analysing intelligence on Licensed premises and Licencees in the Rotherham area. Sept 2010. Develop materials to support Licensees in respect of their responsibilities to C&amp;YP under the licensing Act 2003.</td>
<td>Safeguarding Children Board Manager</td>
<td>Officer time.</td>
<td>RLSCB is an integral and active participant in the local responsible authorities meetings. Has contributed to the revocation of a License where young people were being placed at risk of harm.</td>
<td>AMBER</td>
</tr>
<tr>
<td>Licensing Act RLSCB as one of the responsible authorities in Rotherham.</td>
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<td>Induction for LSCB Members</td>
<td>Develop a programme of induction for new LSCB members to enable them to fulfil their role.</td>
<td>Induction programme in place for September 2010.</td>
<td>Assistant Manager, LSCB</td>
<td>Officer time</td>
<td>Person specification and responsibilities contained in the new constitution.</td>
<td>AMBER</td>
</tr>
<tr>
<td>Develop Board members’ resources to execute its functions more effectively</td>
<td>Assess the priorities for development of RLSCB Board members’ skills, knowledge and influence</td>
<td>Agenda for Development Day Nov 2010</td>
<td>Chair, Learning &amp; Development Sub Group</td>
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SUB GROUP ANNUAL REPORTS – APRIL 2009 – MARCH 2010

Policy and Procedures Sub Group
The Policies and Procedures Sub Group has developed a work plan for all relevant RLSCB documents, and ensures they are kept up-to-date. This is done through consultation with relevant stakeholders. Once the Policy and Procedures Sub Group is satisfied the document has been appropriately updated, it is brought to the RLSCB for ratification. We then notify the Training Sub Group, who look to ensure appropriate refresh or new training is available. Having up-to-date policies and procedures means our staff and volunteers are acting in the best interests for the safeguarding of children, young people and their families in Rotherham.

Attendance:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Representative</th>
<th>Member / Advisor</th>
<th>Number of times attended</th>
<th>Total number of possible attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYPS</td>
<td>Joyce Thacker (Chair)</td>
<td>Member</td>
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<tr>
<td></td>
<td>Angie Heal</td>
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<tr>
<td></td>
<td>Catherine Hall</td>
<td>Advisor</td>
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<td></td>
<td>Carole Pattinson</td>
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<td></td>
<td>Viv Woodhead</td>
<td>Member</td>
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<tr>
<td>Rotherham Hospital Trust</td>
<td>Carole Boote (Deputy)</td>
<td>Advisor</td>
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<tr>
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<td>Sherif El-Refee</td>
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<td>5</td>
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<tr>
<td>Neighbourhoods and Adult Services</td>
<td>Cherryl Henry</td>
<td>Member</td>
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<tr>
<td>Young People &amp; Families Voluntary Sector Consortium</td>
<td>Kerry Albiston</td>
<td>Member</td>
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<tr>
<td>Rotherham Community Health Services</td>
<td>Kim Porteous</td>
<td>Member</td>
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<tr>
<td>Probation</td>
<td>May Lubienski</td>
<td>Member</td>
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<tr>
<td>RDASH</td>
<td>Tracey Wrench</td>
<td>Member</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>South Yorkshire Police</td>
<td>Simon Palmer (Vice Chair)</td>
<td>Member</td>
<td>3</td>
<td>5</td>
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</tbody>
</table>
Significant Achievements:

- Increase in agency contribution and involvement since RLSCB Member commenced as Chair and dedicated administrative support.
- Distribution list to enable tracking of consultation and alert to published documents.
- Documents updated and approved:
  - Protocol for Safeguarding Children in whom Illness is Fabricated or Induced
  - Safeguarding Children who may have been Trafficked from Abroad
  - Safeguarding Young Women who may be at risk of abuse through Female Genital Mutilation
  - Children and Young People who Harm Others
  - Guidance for Madrassahs, Mosques and Supplementary Schools
  - Flow Chart - What is a Policy/Guidance/Protocol
  - Abuse of Disabled Children
  - South Yorkshire Runaways Joint Protocol Procedure
  - Safeguarding Children of Drug Misusing Parents
  - Safeguarding Children and Young People from Forced Marriage
  - Safeguarding Children and Young People from Honour Based Violence
  - Safeguarding Children and Young People Involved in Organised or Multiple Abuse and other Complex Investigations
  - Managing People who Pose a Risk (PPR) to Children and Young People
  - Safeguarding Children and Young People from Sexual Exploitation
  - Forced Marriage
  - Complex Abuse Protocols
  - Safe and Well Protocol/Practice Guidance

- Documents awaiting approval at RLSCB:
  - Private Fostering
  - Under 16 Pregnancy Protocol

Outstanding Objectives:

Documents requiring update and approval:

- Organised Abuse
Effectiveness of Multi Agency Working:

- **What worked well** - There is a dedicated core of members who commit to taking the work of the Sub Group forward. The temporary appointment of a Policy Development Officer has been crucial to the success in updating several out of date protocols.

- **What could have worked better and how** - Membership will be reviewed, as attendance for some agencies is not what is expected. All agencies were written to at the start of the year to confirm their nominated representative but this has not been sufficient in securing regular commitment to the work.

**Conclusion:**

This has been a particularly busy year, with much achieved. The work of the sub group has been more effective with the additional resource to update procedures. It is pleasing that the RLSCB has committed to the purchase of additional resource to support the update of policies.
E-Safety Sub Group

The e-safety sub group is a multi-agency group which comes together to share good practice (and resources wherever possible) across the different partners, the work being primarily focussed around internet safety and how we can protect our children and young people when they are online in council settings, but also giving them the skills to understand risks to the dangers into which they may put themselves.

The e-safety strategy (approved by RLSCB in December 2008) uses the Becta PIES model: Policies, Infrastructure, Education and Standards. This forms the work plan for the group.
The group continues to engage with children and young people and makes it a priority that the times and venues chosen enable children and young people from across the Borough to attend and be part of any discussions / presentations, and to make sure that their voices are heard

Attendance:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Representative</th>
<th>Number of times attended</th>
<th>Total number of possible attendances</th>
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<tbody>
<tr>
<td>CYPS</td>
<td>Sue Wilson (Chair)</td>
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<td>Sue Shelley</td>
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<td>Catherine Hall</td>
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<td>James Keeley</td>
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<td>Tom Ormerod</td>
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<td></td>
<td>Steve Pearson</td>
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<tr>
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<td>Sue Horton</td>
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<tr>
<td></td>
<td>Barrie Morgan</td>
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<tr>
<td></td>
<td>Sarah Hughes</td>
<td>1</td>
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</tr>
<tr>
<td>Environment &amp; Development (Library Services)</td>
<td>Angella Parker</td>
<td>1</td>
<td>3</td>
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<tr>
<td></td>
<td>Wendy Darby</td>
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<td>Keith Swannick</td>
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<tr>
<td>YHGFL Foundation</td>
<td>Andy Brookes</td>
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<tr>
<td>Winterhill CLC</td>
<td>Gill Batson</td>
<td>3</td>
<td>5</td>
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<tr>
<td>Youth Offending Service</td>
<td>Paul Grimwood</td>
<td>1</td>
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<tr>
<td>South Yorkshire Police</td>
<td>Paul Gray</td>
<td>2</td>
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</tr>
<tr>
<td>Rawmarsh Thorogate Primary School</td>
<td>John Barnett</td>
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Significant Achievements
• Continue to engage with young people at all meetings
• Draft Acceptable Use Policies prepared and being consulted on with young people (these shared with schools and other settings in the New Year.
• Attendance and sharing of good practice from Regional e-safety events
• Internet safety day awareness raising.

Outstanding Objectives:
• Incident Monitoring not yet developed
• Audit Framework not yet developed

Effectiveness of Multi Agency Working:
• What worked well -
  Sharing of information, training and resources

• What could have worked better and how -
  Dedicated resources and budget
  Dedicated officer leading on e-safety

Conclusion:
The members of the group are all very keen and work well together, sharing ideas, training sessions and resources. However, e-safety is not anyone’s main role and purpose, and it is an addition to most people’s responsibilities. (unlike Sheffield, e.g., who have a dedicated officer) It is sometimes difficult to ensure that the work is sufficiently prioritised when, although very important, ends up as an “add on” to staff workload.
## Serious Case Review Sub Group

### Attendance:

<table>
<thead>
<tr>
<th>Agency</th>
<th>Representative</th>
<th>Member / Advisor</th>
<th>Number of times attended</th>
<th>Total number of possible attendances</th>
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</thead>
<tbody>
<tr>
<td>Independent Safeguarding Children Board to August 2009</td>
<td>Judith Dodd</td>
<td>Chair</td>
<td>1</td>
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<tr>
<td>Nurse Consultant Safeguarding Children/Interim Safeguarding Children Board Manager (Chair from June 2009)</td>
<td>Catherine Hall</td>
<td>Chair</td>
<td>1 as Nurse Consultant</td>
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<tr>
<td></td>
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<td>9 as RLSCB Manager</td>
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<tr>
<td>Social Care</td>
<td>Pam Allen</td>
<td>Member</td>
<td>4</td>
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</tr>
<tr>
<td></td>
<td>Lyn Burns</td>
<td>Member</td>
<td>4 (1 as Chair)</td>
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</tr>
<tr>
<td>Education Services</td>
<td>Tom Kelly</td>
<td>Member</td>
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<tr>
<td>CAFCASS</td>
<td>Adele Jones</td>
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<td>RDASH</td>
<td>Tracey Wrench</td>
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<td>Deborah Wildgoose</td>
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<tr>
<td>South Yorkshire Probation Trust</td>
<td>Ruth Holmes</td>
<td>Member</td>
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<td>Maryke Turvey</td>
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<tr>
<td>Rotherham NHS Hospital Foundation Trust</td>
<td>Sherif El-Refee / Sanjay Suri</td>
<td>Member</td>
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<td>Eisawl Nagmeldin</td>
<td>Member</td>
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<td>South Yorkshire Police</td>
<td>Dave Pickett</td>
<td>Representative</td>
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<td>Helen Smith</td>
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<td>Pete Horner</td>
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<tr>
<td>NHS Rotherham</td>
<td>John Radford</td>
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<td>Rotherham Community Health Services</td>
<td>Yvonne Weakley</td>
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<td>Legal Services, RMBC</td>
<td>Frances Jeffries</td>
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<td>Beckie Marjoram</td>
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<tr>
<td>Robin Williams</td>
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<tr>
<td>Operational Safeguarding Children Unit</td>
<td>Viv Woodhead</td>
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<td>Annie Redmond</td>
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<td>1 (rep Pam Allen)</td>
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<td>Community Services, CYPS</td>
<td>Simon Perry</td>
<td>Advisor</td>
<td>1 (rep Pam Allen)</td>
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<td>Rotherham Safeguarding Children Board</td>
<td>Sheila Hall</td>
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<td></td>
<td>Phil Morris</td>
<td>Advisor</td>
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In addition to attendance at 10 Standing Panels recorded in the above table, the following meetings also took place:
- 3 Special Panels (2 on 15.05.09 and 1 on 18.01.10)
- 1 meeting to discuss the Serious Case Review Action Plans (24.03.10)

**Significant Achievements:**

In a challenging year, agencies in Rotherham worked hard to review and satisfactorily completed further review of an SCR graded by Ofsted as unsatisfactory. Also 3 SCRs were completed and submitted to Ofsted in August and September 2009. Four cases referred to the Serious Case Review Sub Group within this period did not lead to a Serious Case Review being undertaken.

Chairing arrangements of the SCR panel were also a challenge, including the departure in March of the Safeguarding Children Board Manager and the commissioning of an Interim Board Manager in May 2009. An Assistant Safeguarding Board Manager was appointed in October 2009 to concentrate on serious case reviews.

**Outstanding Objectives:**

- Complete the 3 remaining action plans
- Further support agencies in developing their evidence databases
- Further consider and develop themed work with regard to SCR recommendations both nationally and locally
- Ensure that the process is quality assured throughout
Effectiveness of Multi Agency Working:

- **What worked well -**
  The panels have continued to work well; meeting attendance was good for all agencies and in particular from NHS Rotherham, Police and CYPS Social Care;
  Advice being on hand at each meeting from CYPS Legal services has proved and continues to prove invaluable;
  having a template to record SCR panel discussions on individual cases.

- **What could have worked better and how:**
  Acceptance that the previous SCR process was not fit for purpose and commitment by agencies and the Safeguarding Children Board that a new robust process was required. This included the purchase, by NHS Rotherham, of a Chronolator. The Chronolator is a commercial product that supports agencies in the development of a chronology - this will save administration time and ensure that a chronology is available in a usable format.

**Conclusion:**

This has been a difficult as well as challenging year for SCR. Chapter 8 of Working Together has been re-written and Rotherham has endeavoured to keep abreast of changes. We continue to strive to ensure that SCRs in Rotherham have made a difference to the lives of children in the borough.

Individual SCR Panels will be set up for each case and the new post of Assistant Safeguarding Board Manager will ensure that each agency is given the support and challenge it requires. RLSCB has reviewed its Constitution and more transparent terms of reference are being agreed for a SCR Sub Group to oversee the local and national SCR agenda.

Lord Laming found that the existing safeguarding and child protection agencies/workers were too focussed on processes and timescales and not focussed enough on outcomes and multi agency working. This was the finding of a recent LSCB report into the last 7 SCRs. To address this, RLSCB recommended that a task and finish group consider the themes identified from this review.
Child Death Overview Panel (CDOP)

Name of the Chair: John Radford
Designation of the Chair: Director of Public Health

Purpose of the Sub Group
Each death of a child is a tragedy for his or her family, and subsequent inquiries should keep an appropriate balance between forensic and medical requirements and the family’s need for support. CDOP is a statutory requirement that reports to the Local Safeguarding Children Board.

Attendance

<table>
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<tr>
<th>AGENCY</th>
<th>REPRESENTATIVE</th>
<th>NUMBER OF TIMES ATTENDED</th>
<th>TOTAL NUMBER OF TIMES THAT COULD HAVE BEEN ATTENDED</th>
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<tr>
<td>NHS Rotherham</td>
<td>John Radford</td>
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<td>RCHS</td>
<td>Kim Porteous</td>
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<tr>
<td>RLSCB</td>
<td>Catherine Hall</td>
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<td>CYPS</td>
<td>Annie Redmond</td>
<td>5</td>
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<td>Pam Allen/Lyn Burns</td>
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<tr>
<td>Rotherham Hospital Trust</td>
<td>Peter Macfarlane</td>
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<td>SYP</td>
<td>Dave Pickett</td>
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<td>HMC</td>
<td>Sarah Grainger/ Kevin Keen</td>
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<td>RMBC Equalities</td>
<td>Zafar Saleem</td>
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<td>Bluebell Wood</td>
<td>Varies</td>
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<tr>
<td>YAS</td>
<td>David Blain</td>
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**Résumé of the year 01.04.09 to 31.03.10**

Rotherham Local Safeguarding Board believes that all childhood deaths deserve a thorough investigation into the circumstances and factors leading up to that death.

**Background and work of the Panel**

Within England there are two interrelated processes for reviewing child deaths (either of which can trigger a serious case review):

- a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child
- an overview of all child deaths (under 18 years) in the Local Safeguarding Children's Board (LSCB) area(s), undertaken by a panel.

Child Death Overview Panels are responsible for reviewing information on all child deaths, and are accountable to the LSCB Chair. Child Death Overview Panels may serve more than one LCSB. In South Yorkshire one Panel has been established for each LSCB. These Panels meet collectively every ¾ months to review regional variances.

**Significant Achievements**

The CDOP report records the number of deaths reviewed in Rotherham as:

- Total number of deaths = 27
- Unexpected Deaths = 10
- Expected Deaths = 17
Deaths subject to Serious Case Review = 1

Key lessons for Rotherham included:

1. **Unsafe sleeping arrangements**
   Co-sleeping with an adult, whether on a bed or a sofa, is a recognised risk factor for sudden infant death. The risk of overlaying is increased if the adult is alcohol or drug intoxicated.

   NHS Rotherham mounted a multi agency campaign to re-iterate the message about safe sleeping to all health and social care professionals and parents. Rotherham health economy developed a Co Sleeping and Bed Sharing Policy to support practitioners in Rotherham delivering the same message to parents and carers.

2. **The impact of alcohol or drugs**
   The involvement of alcohol or drugs in either the carers for young children or in young adults is of serious concern. It is an observation that NHS, Social Care, the Police and society accept and tolerate heavy alcohol use and we underestimate the risk that it poses to children and young adults.

   Further work needs to be undertaken to ensure that the known risks are given a higher profile generally, and that targeted services are provided to social groups most at risk.

**Outstanding Objectives**

Changes in Provision of Services:

a. NHS Rotherham should explore the possibility of an outreach paediatric cardiac ultrasound service to Rotherham rather than transferring the baby in an emergency ambulance to Sheffield.

b. When a child dies and the death is not due to obvious trauma or deliberate violence the body should be transported to Accident and Emergency for appropriate blood, tissue and biological samples to be taken to assist in the medical investigation of the death.

**Effectiveness of Multi Agency Working**

Out of the deaths reviewed there were 5 deaths in young adults aged 14-17. All were male. 4 of the 5 were due to either accidents or accidental self poisoning. In one of the deaths, drug ingestion may have been a co-incidental finding.
One young man died of anaphylaxis following accidental ingestion of a known allergen. It is difficult to know how such a tragic event could be avoided. However the Panel believed that GP’s should be encouraged to ensure that young adults undergo regular training in the use of the Epipen (self administered adrenalin treatment). In addition the need to summon help immediately when an anaphylactic reaction is suspected was re-iterated generally.

4 of the deaths involved the use of alcohol and or illicit drugs. Drug and alcohol services, in Rotherham, have been invited to attend LSCB Sub Groups to ensure that their expertise is utilised appropriately.

It was considered by the Panel that teenagers, and teenage boys in particular, are risk takers to some degree, and the use of illegal substances is a known and common risk.

**Conclusion**

An update to Chapter 7 of *Working Together to Safeguard Children* became statute on the 01 April 2010. Rotherham Child Death Overview Panel (CDOP) is ensuring that they are compliant with developments to this service. Part of this compliance has been to review and develop the Terms of Reference of CDOP and implement a work plan that is open to scrutiny by the Local Safeguarding Children Board.

Families should be treated with sensitivity, discretion and respect at all times, and professionals should approach their enquiries with an open mind. This is out of respect for the child and family, and to fulfil statutory requirements. Agencies in Rotherham now need to consider how they take account of how they work with families and continually strive to improve their services. Rotherham CDOP plan to review this.
NHS Rotherham

NHS Rotherham Board: 15th November 2010

Performance Reporting Framework

Contact Details:

<table>
<thead>
<tr>
<th>Lead Director:</th>
<th>Dr Robin Carlisle</th>
<th>Lead Officer:</th>
<th>Linda Hurst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Director of Intelligence &amp; Performance</td>
<td>Title:</td>
<td>Head of Performance</td>
</tr>
</tbody>
</table>

Purpose:

To agree a streamlined approach to the organisation’s performance reporting arrangements, whilst maintaining a robust and transparent performance framework.

Recommendations:

To approve revised performance reporting arrangements for NHS Rotherham, as detailed in this report, with effect from November 2010.

Background:

A Performance Management Framework was approved by the NHS Rotherham Board in April 2010.

Since April, the external performance assessment arrangements have changed significantly. Nationally, the WCC and CQC assessments have discontinued but regionally, the Single Assurance and Accountability Process (SAAP) has been introduced. The White Paper proposal for an NHS Outcomes Framework is yet to be finalised.

As a result of these changes, together with the increasing requirement for efficiency, the performance reporting arrangements have been revisited and a revised approach is suggested.

Analysis of Risks:

The Performance Management Framework is referenced in the Corporate Risk Assurance Framework, reference 2i(iii).

Return on Investment:

No additional investment is expected from the proposed changes to the Performance Management Framework.

The benefits that would accrue to the organisation include;

a) Achievement of key corporate performance indicators
b) Achievement of key health related performance strategies such Local Area Agreement, Quality Innovation Productivity and Prevention (QIPP), SAAP, Commissioning for Quality and Innovation (CQUIN)
Analysis of Key Issues:

The Performance Management Framework agreed in April requires that the Professional Executive and the Board receive a sub-set of selected key targets with associated indicators. At the time, the selection of the sub-set of indicators was based on the following criteria:

- Significant outliers
- Local Area Agreement (LAA) targets
- 10 World Class Commissioning (WCC) health outcomes
- Care Quality Commission (CQC) Existing Commitments and National Priorities
- National Vital Signs
- SHA priority areas
- Prioritised health impact indicators

Responsibility for the performance monitoring of indicators not reported to PE and Board, was delegated to the Management Executive (ME) and the Performance Team.

As a result of the changes to the external assessment agenda detailed above, it is proposed that the performance reporting arrangements should be amended as follows:-

1. The sub-set of indicators submitted to PE and Board to be restricted to reflect the current performance agenda i.e:
   - LAA markers
   - Key health outcomes (the former 10 WCC outcomes)
   - Key local priorities

   This will result in a considerable reduction in the number of metrics reported via the Performance Report to PE and Board. A schedule of the proposed sub-set is attached to this report as Appendix A. On the whole, these are metrics where monitoring data is available routinely either monthly or quarterly. For Mental Health, national indicators are under development and additional metrics around this programme area will be added to the Performance Report, when possible.

2. A number of metrics can only be updated on an annual basis e.g. mortality rates. A further set of metrics will therefore be submitted to PE/Board annually in December with updated information on these metrics:-

   Primary Care – self reported experience of patients and users  
   GP QOF achievement  
   Outcome of GP Annual Contract Review process  
   Infant mortality rate  
   Low birth weight babies  
   Childhood obesity levels – Reception year  
   Cancer mortality rate  
   Stroke mortality per 100,000 population  
   CHD mortality rate  
   Mortality rate from suicide and injury of undetermined intent
3. The full schedule of performance metrics will continue to be monitored by the Director of Intelligence & Performance and specifically, by the Performance Team. Management of underperformance will follow the Escalation Policy, which was attached to the Performance Framework agreed in April. The process is intended to incorporate some flexibility and where necessary, specific performance metrics will be added to/removed from the Performance Report, to reflect changing priorities for management intervention.

Monitoring will continue to be based around the Performance Plus performance management tool. Performance Plus is widely available to PE/Board members and NHS Rotherham managers and the full schedule of metrics is therefore open to scrutiny at any time.

4. Following a review of the metrics currently monitored by the Performance Team, a small number of metrics will be removed from the system, as they no longer form part of the organisation’s core performance requirements. These are metrics that are not within the SAAP process and are unlikely to form part of the NHS Outcomes Framework.

Patient, Public and Stakeholder Involvement:
Board performance reports are public documents. Key targets are communicated with the public and partners through individual programmes and projects.

Equality Impact:
Many of the programmes and outcomes in the NHS Rotherham’s strategy address inequalities. At a high level, the health outcome measures on life expectancy and inequalities show the degree to which NHS Rotherham is being successful in improving outcomes for people with lowest life expectancy. The Performance Framework gives assurances that such inequalities are being monitored and managed.

Financial Implications:
No additional financial implications are expected.
Approved by: Chris Edwards

Human Resource Implications:
No additional staffing implications are expected. The revision to the framework supports the prioritisation of commissioning time on key performance areas.
Approved by: Peter Smith

Procurement:
Not applicable
Approved by: Doug Hershaw

Key Words:
Performance Framework, Local Area Agreement, Vital Signs, World Class Commissioning, Care Quality Commission, Quality Innovation Productivity and Prevention (QIPP), Single Assurance & Accountability Process (SAAP), Commissioning for Quality and Innovation (CQUIN), Use of Resources.
### Further Sources of Information:

<table>
<thead>
<tr>
<th>Source</th>
<th>Date</th>
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<tbody>
<tr>
<td>NHS Rotherham Performance Management Framework April 2010</td>
<td></td>
</tr>
<tr>
<td>Liberating the NHS: Transparency in outcomes – a framework for the NHS (A consultation on proposals) July 2010</td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>Driver</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------</td>
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<tr>
<td>Low cost prescribing for lipid modifications (%)</td>
<td>Local Priority</td>
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### Healthy Pregnancy and Birth

<table>
<thead>
<tr>
<th>Measure</th>
<th>Driver</th>
<th>Performance Type</th>
<th>Programme Manager/Operational Lead</th>
<th>Periodicity</th>
<th>Latest Update</th>
<th>Actual/Predicted</th>
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<th>Plan to Date</th>
<th>Cumulative Variance</th>
<th>Status</th>
<th>Direction</th>
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<tr>
<td>Infants breastfed at 6-8 weeks-prevalence (%)</td>
<td>Health Outcome/LAA</td>
<td>Bigger is Better</td>
<td>Anna Jones</td>
<td>Quarterly</td>
<td>Sep-10</td>
<td>A</td>
<td>26.56</td>
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<td>Infants for whom breastfeeding status is recorded at 6-8 weeks-coverage (%)</td>
<td>LAA</td>
<td>Bigger is Better</td>
<td>Anna Jones</td>
<td>Quarterly</td>
<td>Sep-10</td>
<td>A</td>
<td>98.06</td>
<td>95.00</td>
<td>3.06</td>
<td>⭐️</td>
<td>⬆️</td>
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<tr>
<td>Women known to be smokers at time of delivery (%)</td>
<td>Local Priority</td>
<td>Smaller is Better</td>
<td>Alison Iff</td>
<td>Quarterly</td>
<td>Sep-10</td>
<td>A</td>
<td>22.46</td>
<td>23.00</td>
<td>0.45</td>
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<td>Teenage conception among girls aged under 18 (Rate per 1000 females)</td>
<td>LAA</td>
<td>Smaller is Better</td>
<td>Mel Simmonds</td>
<td>Quarterly</td>
<td>Jun-09</td>
<td>A</td>
<td>42.40</td>
<td>41.20</td>
<td>1.20</td>
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<td>12 week access to maternity services (% mothers assessed by a midwife within 12 weeks)</td>
<td>Local Priority</td>
<td>Bigger is Better</td>
<td>Sarah Whittle</td>
<td>Quarterly</td>
<td>Sep-10</td>
<td>Pr</td>
<td>95.60</td>
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### Healthy Childhood

<table>
<thead>
<tr>
<th>Measure</th>
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<th>Actual/Predicted</th>
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<th>Plan to Date</th>
<th>Cumulative Variance</th>
<th>Status</th>
<th>Direction</th>
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<tbody>
<tr>
<td>Children aged 5 who have been immunised for diptheria, tetanus, polio and pertussis (DTaP/IPV) (%)</td>
<td>Health Outcome</td>
<td>Bigger is Better</td>
<td>Kathy Wakefield</td>
<td>YTD</td>
<td>Sep-10</td>
<td>A</td>
<td>90.00</td>
<td>90.00</td>
<td>0.00</td>
<td>⭐️</td>
<td>⬆️</td>
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<tr>
<td>Childhood obesity in year 6 (% with height and weight recorded who are obese)</td>
<td>LAA</td>
<td>Smaller is Better</td>
<td>Gill Harrison</td>
<td>Annual</td>
<td>Mar-09</td>
<td>A</td>
<td>19.05</td>
<td>18.00</td>
<td>1.00</td>
<td>⬆️</td>
<td>⬆️</td>
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<tr>
<td>Children and young people’s participation in high quality PE and sport (%)</td>
<td>LAA</td>
<td>Bigger is Better</td>
<td>Sarah Whittle</td>
<td>Annual</td>
<td>Mar-10</td>
<td>A</td>
<td>85.00</td>
<td>81.00</td>
<td>4.00</td>
<td>⭐️</td>
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### Staying Healthy

<table>
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<th>Actual/Predicted</th>
<th>Performance to Date</th>
<th>Plan to Date</th>
<th>Variance</th>
<th>Status</th>
<th>Direction</th>
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<tbody>
<tr>
<td>Life expectancy at time of birth—Comparison with national average: Male (Years)</td>
<td>Health Outcome</td>
<td>Bigger is Better</td>
<td>Joanna Saunders</td>
<td>3yr rolling average</td>
<td>Jan-08 A</td>
<td>76.50</td>
<td>77.96</td>
<td>-1.46</td>
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<tr>
<td>Life expectancy at time of birth—Comparison with national average: Female (Years)</td>
<td>Health Outcome</td>
<td>Bigger is Better</td>
<td>Joanna Saunders</td>
<td>3yr rolling average</td>
<td>Jan-08 A</td>
<td>80.70</td>
<td>82.11</td>
<td>-1.41</td>
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<tr>
<td>Smoking prevalence (Number of quitters per 100,000 population)</td>
<td>Health Outcome</td>
<td>Bigger is Better</td>
<td>Alison Iliff</td>
<td>Monthly</td>
<td>Aug-10 Pr</td>
<td>1049</td>
<td>674</td>
<td>375</td>
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<td>Hospital admissions for alcohol related harm (Rate per 100,000 population)</td>
<td>Local Priority</td>
<td>Smaller is Better</td>
<td>Anne Charlesworth</td>
<td>Annual</td>
<td>Mar-10 Pr</td>
<td>1898</td>
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### Planned Care

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<th>Plan to Date</th>
<th>Variance</th>
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<tr>
<td>18 weeks Referral to Treatment for Admitted patients (%)</td>
<td>Local Priority</td>
<td>Bigger is Better</td>
<td>Keith Boughen</td>
<td>Monthly</td>
<td>Aug-10 A</td>
<td>97.65</td>
<td>90.00</td>
<td>7.65</td>
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<tr>
<td>All cancers: two week wait from referral to appointment (%)</td>
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<td>Bigger is Better</td>
<td>Keith Boughen</td>
<td>Monthly</td>
<td>Aug-10 A</td>
<td>95.40</td>
<td>93.00</td>
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<tr>
<td>Hospital Standardised Mortality Ratio</td>
<td>Local Priority</td>
<td>Smaller is Better</td>
<td>Gail Palmer</td>
<td>Quarterly</td>
<td>Mar-10 A</td>
<td>91.70</td>
<td>100.00</td>
<td>-8.30</td>
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<td>C-difficile: Commissioner target (Number)</td>
<td>Health Outcome</td>
<td>Smaller is Better</td>
<td>Kathy Wakefield</td>
<td>Monthly</td>
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<td>47</td>
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### Long Term Conditions, Intermediate Care and Urgent Care

<table>
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<th>Programme Manager/Operational Lead</th>
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<th>Actual/Predicted</th>
<th>Performance to Date</th>
<th>Plan to Date</th>
<th>Cumulative Variance</th>
<th>Status</th>
<th>Direction</th>
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<tbody>
<tr>
<td>Patients who have a TIA and are scanned and treated within 24 hours (as a % of the number of patients admitted with a TIA)</td>
<td>Local Priority</td>
<td>Bigger is Better</td>
<td>Dominic Blaydon</td>
<td>Quarterly</td>
<td>Sep-10</td>
<td>A</td>
<td>57.14</td>
<td>56.25</td>
<td>0.89</td>
<td>⭐</td>
<td>⬤</td>
</tr>
<tr>
<td>Emergency readmission rates; non elective; within 28 days of discharge (%)</td>
<td>Local Priority</td>
<td>Smaller is Better</td>
<td>Dominic Blaydon</td>
<td>Quarterly</td>
<td>Mar-10</td>
<td>A</td>
<td>6.80</td>
<td>5.50</td>
<td>1.30</td>
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<td>🔴</td>
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<tr>
<td>Hospital admissions for ambulatory care sensitive conditions against vital sign plan (Rate per 1000 population)</td>
<td>Health Outcome</td>
<td>Smaller is Better</td>
<td>Dominic Blaydon</td>
<td>Quarterly</td>
<td>Jun-10</td>
<td>A</td>
<td>5.24</td>
<td>4.24</td>
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<tr>
<td>CVD mortality (Rate per 100,000 directly age standardised)</td>
<td>Health Outcome</td>
<td>Smaller is Better</td>
<td>Jo Abbott</td>
<td>Annual</td>
<td>Dec-09</td>
<td>A</td>
<td>80.32</td>
<td>65.10</td>
<td>15.22</td>
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<td>🔴</td>
</tr>
<tr>
<td>People supported to live independently through social services (Rate per 100,000)</td>
<td>LAA</td>
<td>Bigger is Better</td>
<td>Dominic Blaydon</td>
<td>Quarterly</td>
<td>Jun-10</td>
<td>A</td>
<td>2364.93</td>
<td>2559.25</td>
<td>-194.32</td>
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<td>Carers receiving a 'carers break' or a specific carers' service (% of clients receiving community based services)</td>
<td>LAA</td>
<td>Bigger is Better</td>
<td>Dominic Blaydon</td>
<td>Quarterly</td>
<td>Jun-10</td>
<td>A</td>
<td>8.77</td>
<td>30.00</td>
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<td>Achieving independence for older people through rehabilitation/intermediate care (%)</td>
<td>LAA</td>
<td>Bigger is Better</td>
<td>Shiv Bhurton</td>
<td>Quarterly</td>
<td>Jun-10</td>
<td>A</td>
<td>82.10</td>
<td>81.72</td>
<td>0.38</td>
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### Mental Health

<table>
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<th>Periodicity</th>
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<th>Performance to Date</th>
<th>Plan to Date</th>
<th>Cumulative Variance</th>
<th>Status</th>
<th>Direction</th>
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</thead>
<tbody>
<tr>
<td>Access to crisis resolution (Number of home treatment episodes)</td>
<td>Local Priority</td>
<td>Bigger is Better</td>
<td>Kate Tufnell</td>
<td>Monthly</td>
<td>Sep-10</td>
<td>A</td>
<td>338</td>
<td>271</td>
<td>67</td>
<td>⭐</td>
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<tr>
<td>Dementia assessments carried out by the memory service (Number)</td>
<td>Health Outcome</td>
<td>Bigger is Better</td>
<td>Dominic Blaydon</td>
<td>Monthly</td>
<td>Jul-10</td>
<td>A</td>
<td>173</td>
<td>167</td>
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### End of Life Care

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<th>Actual/Predicted</th>
<th>Performance to Date</th>
<th>Plan to Date</th>
<th>Cumulative Variance</th>
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<tbody>
<tr>
<td>Deaths not in hospital (%)</td>
<td>Health Outcome</td>
<td>Bigger is Better</td>
<td>Gail Palmer</td>
<td>Quarterly</td>
<td>Jun-10</td>
<td>A</td>
<td>44.60</td>
<td>40.00</td>
<td>4.60</td>
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</table>
Finance Performance Report – for the Period Ended 30th September 2010

The first section of this report details the financial position as at 30th September 2010 for the first six months of the financial year. The latter section provides information on key performance indicators in contract service specifications.

1. Resource and Cash Limits

1.1. Revenue Resource Limits

NHS Rotherham has been notified of a Revenue Resource Limit allocation of £449.59m with a further forecast allocation of £12.16m making a total of £461.75m. This includes recurrent allocations of £448m and £13m non-recurrent additions. The attached operating cost statement shows a forecast underspend of £1.14m after six months and a forecast end of year surplus of £2.2m is anticipated.

The forecast surplus of £2.2m is in line with financial plans. Achievement of control totals on spending will be managed through use of reserves.

Hospital and Community Services have a forecast overspend of £1.39m. It should be noted that there are significant financial risks inherent within Payment by Results (PbR) agreements and these are being monitored closely. Part of this pressure is as a result of increases in non elective activity at Rotherham Foundation Trust. Audit work has been undertaken to better understand the reasons for these increases in non elective admissions.

Our prescribing performance is positive and the forecast is that prescribing will deliver to plan and QIPP savings will be achieved. This takes account of the risks of “M Drugs” which are being closely monitored.

Rotherham Community Health Services are reporting an underspend of £0.20m as at 30th September and forecasting a year end underspend of £0.13m.

Substantial funds have been set aside in the Operational Plan for the full year cost of Continuing Care. The latest forecasts indicate that these resources will be insufficient and an overspend of £4.18m is forecast. This area of expenditure is very high risk and is being monitored at individual patient level.

NHS Rotherham faces additional financial risks in 2010/11. These include potential redundancy costs and changes to expected allocations resulting from the actions of central government.

1.2. Capital Resource Limit

We are anticipating a forecast Capital Resource Limit (CRL) of £1.23m of which £0.50m has been completed as at the end of September. £0.23m of the capital spend will be funded through capital receipts as planned. The remaining plans are expected to be completed before the end of the financial year. As previously discussed, there has been some uncertainty regarding the Rawmarsh investment (NHSR share £3.8m) from RMBC – this has been confirmed as back on track by RMBC therefore our assumption is that this will be completed in 2010/11.
1.3. Cash Limit

NHS Rotherham is expecting to receive a cash limit allocation of £461.0m for the financial year. At the end of September drawings were £215.25m or 47% of the cash limit. A profile of cash drawings is shown below:

![Cash Drawings Graph]

1.4. Balance Sheet

The Balance Sheet at 30th September 2010 shows:

<table>
<thead>
<tr>
<th>Category</th>
<th>2010</th>
<th>2011</th>
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</thead>
<tbody>
<tr>
<td>Cash and cash equivalents</td>
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<tr>
<td>Non Current Assets Held for Sale</td>
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<td>0</td>
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<tr>
<td><strong>Total Current Assets</strong></td>
<td>7610</td>
<td>5826</td>
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<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td>16587</td>
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<td><strong>CURRENT LIABILITIES</strong></td>
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</tr>
<tr>
<td>Trade &amp; Other Payables</td>
<td>-21414</td>
<td>-26918</td>
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<tr>
<td>Provisions</td>
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<td>-93</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
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<td>-27011</td>
</tr>
<tr>
<td><strong>NET CURRENT ASSETS/(LIABILITIES)</strong></td>
<td>-13915</td>
<td>-21185</td>
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<tr>
<td><strong>NON CURRENT LIABILITIES</strong></td>
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<tr>
<td>Provisions for Liabilities and Charges</td>
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<tr>
<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
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<td><strong>TAXPAYERS EQUITY</strong></td>
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<tr>
<td>General Fund</td>
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<td>-8250</td>
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<td>Revaluation reserve</td>
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<td>3093</td>
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<tr>
<td><strong>Total</strong></td>
<td>2541</td>
<td>-5157</td>
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</tbody>
</table>
1.5. Run Rate

The run rate is a measure of monthly financial performance. The purpose of monitoring the run rate is to give an early warning of monthly expenditure exceeding income. The two charts below show the Run Rate Monthly Surplus Chart and the Run Rate Monthly Expenditure Chart.

1.5.1. Run Rate Monthly Surplus Chart

In 2010/11 NHS Rotherham (NHSR) are planning for a £2.2m surplus, which equates to £183.3m surplus per month. Where the monthly surplus is consistently above the plan surplus line, then NHSR are on course to achieve the financial plan. For NHS Rotherham to remain within its Revenue Resource limit then the monthly surplus needs to be consistently above the break even line.

1.5.2. Run Rate Monthly Expenditure Chart

NHS Rotherham anticipates a Revenue Resource Limit (total allocation) of £461.0 million which equates to £38.4 million per month. To achieve its statutory duty, monthly expenditure needs to be consistently below this line. A further useful run rate indicator is monthly performance against the recurrent allocation. The NHSR recurrent allocation is £448.2million or £37.3 million per month. To be in recurrent financial balance NHSR monthly expenditure needs to be consistently below the recurrent allocation line.
2. Public Sector Payments Policy

Public sector organisations are expected to achieve a target of 100% in terms of both the number of bills paid and the value of bills paid within 30 days. Achievement of 95% is regarded as acceptable performance. In the period to 30th September 2010 NHS Rotherham has achieved an average of 99% compliance on the value of bills paid and an average of 97% against the number of bills paid.

3. Full Cost Recovery

NHS Rotherham intends to achieve full cost recovery in relation to its provider functions during the financial year to 31st March 2011.

4. Management Costs

We have planned to decrease management costs by at least £1.36 million in 2010/11. We expect to achieve this by continuing to release vacant posts through an ongoing vacancy freeze. In addition to this, we have now approved the release of 25 posts resulting in savings of £1.2m. Further work is required by Rotherham Community Health Services (RCHS) to ensure further reductions are identified.

An update of performance to date is provided below:

<table>
<thead>
<tr>
<th></th>
<th>FOT</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>1,139,458</td>
<td>607,854</td>
</tr>
<tr>
<td>Finance</td>
<td>1,491,158</td>
<td>781,889</td>
</tr>
<tr>
<td>Strategic Planning</td>
<td>1,117,843</td>
<td>576,241</td>
</tr>
<tr>
<td>IM &amp; T</td>
<td>1,072,816</td>
<td>552,713</td>
</tr>
<tr>
<td>Human Resources</td>
<td>296,990</td>
<td>145,436</td>
</tr>
<tr>
<td>Public Health</td>
<td>135,425</td>
<td>79,263</td>
</tr>
<tr>
<td>Subcontracted Costs</td>
<td>811,243</td>
<td>405,622</td>
</tr>
<tr>
<td>RCHS</td>
<td>3,670,819</td>
<td>1,890,639</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9,735,751</strong></td>
<td><strong>5,039,657</strong></td>
</tr>
</tbody>
</table>

FOT YTD

Envelope in year 1 Commissioner & Provider 9,779,000  
Distance from Target -43,249  

Envelope in Year 1 Commissioner 6,317,000  
Distance from Target -252,068  

Envelope in Year 1 Provider 3,462,000  
Distance from Target 208,819
<table>
<thead>
<tr>
<th>Description</th>
<th>Year to Date</th>
<th>Forecast Outturn</th>
<th>Year to Date</th>
<th>Forecast Outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Rotherham Operating Cost Statement Period Ended 30 September 2010</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1 Hospital &amp; Community Health Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Rotherham NHS Foundation Trust</td>
<td>112</td>
<td>0</td>
<td>6,652</td>
<td>66,597</td>
</tr>
<tr>
<td>b) Sheffield Teaching Hospitals NHS FT</td>
<td>(140)</td>
<td>0</td>
<td>(12,377)</td>
<td>(12,294)</td>
</tr>
<tr>
<td>c) Rotherham, Doncaster &amp; South Humber MHFT</td>
<td>0</td>
<td>0</td>
<td>(12,803)</td>
<td>0</td>
</tr>
<tr>
<td>d) Doncaster &amp; Basfossilw Hospitals NHS FT</td>
<td>0</td>
<td>0</td>
<td>(5,919)</td>
<td>(5,803)</td>
</tr>
<tr>
<td>e) Specialised Commissioning Group</td>
<td>0</td>
<td>0</td>
<td>(18,403)</td>
<td>(18,402)</td>
</tr>
<tr>
<td>g) Other</td>
<td>564</td>
<td>786</td>
<td>(12,547)</td>
<td>13,120 (757)</td>
</tr>
<tr>
<td>h) Internal PCT Service Level Agreement Expenditure</td>
<td>0</td>
<td>0</td>
<td>15,316</td>
<td>15,316</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>544</td>
<td>786</td>
<td>143,892</td>
<td>146,335</td>
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<tr>
<td><strong>2 Primary Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) PMS &amp; GMS</td>
<td>(69)</td>
<td>(41)</td>
<td>14,297</td>
<td>14,269 (28)</td>
</tr>
<tr>
<td>b) Prescribing</td>
<td>(421)</td>
<td>(454)</td>
<td>21,843</td>
<td>21,550 (293)</td>
</tr>
<tr>
<td>c) Dental (PDS &amp; nGDS)</td>
<td>0</td>
<td>0</td>
<td>5,706</td>
<td>5,706</td>
</tr>
<tr>
<td>d) Pharmacy</td>
<td>(33)</td>
<td>93</td>
<td>4,172</td>
<td>4,096 (76)</td>
</tr>
<tr>
<td>e) Out of Hours</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f) Other Commissioned Primary Care Services</td>
<td>0</td>
<td>0</td>
<td>5,641</td>
<td>5,669 (28)</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>(523)</td>
<td>(402)</td>
<td>51,659</td>
<td>51,290 (369)</td>
</tr>
<tr>
<td><strong>3 Corporate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Chief Executive &amp; Modernisation</td>
<td>(44)</td>
<td>(79)</td>
<td>1,445</td>
<td>1,392 (52)</td>
</tr>
<tr>
<td>b) Finance, Contracting &amp; Procurement</td>
<td>(71)</td>
<td>(104)</td>
<td>2,416</td>
<td>2,367 (49)</td>
</tr>
<tr>
<td>c) Intelligence &amp; Performance</td>
<td>(80)</td>
<td>(181)</td>
<td>1,526</td>
<td>1,411 (114)</td>
</tr>
<tr>
<td>d) HR, OD &amp; Corporate Governance</td>
<td>(13)</td>
<td>(23)</td>
<td>457</td>
<td>440 (17)</td>
</tr>
<tr>
<td>e) Public Health</td>
<td>(100)</td>
<td>(221)</td>
<td>2,473</td>
<td>2,343 (129)</td>
</tr>
<tr>
<td>f) Strategic Planning &amp; Development</td>
<td>(54)</td>
<td>(132)</td>
<td>3,199</td>
<td>3,131 (67)</td>
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<tr>
<td>g) Provider Internal Recharges</td>
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<td>0</td>
<td>(2,009)</td>
<td>(2,009)</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>(362)</td>
<td>(641)</td>
<td>9,504</td>
<td>9,074 (430)</td>
</tr>
<tr>
<td><strong>4 Partnership</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) RMBC (inc Sec.28)</td>
<td>20</td>
<td>20</td>
<td>1,065</td>
<td>1,085 (20)</td>
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<tr>
<td>b) Continuing Care &amp; Free Nursing Care</td>
<td>1,580</td>
<td>3,792</td>
<td>5,177</td>
<td>7,073 1,896 (36.6)</td>
</tr>
<tr>
<td>c) Learning Disabilities - Commissioned and Pooled Budgets</td>
<td>(114)</td>
<td>(196)</td>
<td>1,791</td>
<td>1,642 (149)</td>
</tr>
<tr>
<td>d) Learning Disabilities Commissioned by RMBC</td>
<td>0</td>
<td>0</td>
<td>6,402</td>
<td>6,402</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>1,486</td>
<td>3,616</td>
<td>14,435</td>
<td>16,202 1,767 (30)</td>
</tr>
<tr>
<td><strong>5 Provision of Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Provider Services</td>
<td>(101)</td>
<td>(308)</td>
<td>9,678</td>
<td>9,516 (162)</td>
</tr>
<tr>
<td>b) Support</td>
<td>95</td>
<td>461</td>
<td>1,313</td>
<td>1,441 (130)</td>
</tr>
<tr>
<td>c) Childhood Services</td>
<td>(46)</td>
<td>(64)</td>
<td>4,424</td>
<td>4,289 (135)</td>
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<tr>
<td>d) Corporate - Provision of Services</td>
<td>(40)</td>
<td>(89)</td>
<td>232</td>
<td>196 (36)</td>
</tr>
<tr>
<td>e) Internal PCT Service Level Agreement Income</td>
<td>0</td>
<td>0</td>
<td>(15,316)</td>
<td>(15,316)</td>
</tr>
<tr>
<td>f) Commissioner Internal Recharges</td>
<td>0</td>
<td>0</td>
<td>2,009</td>
<td>2,009</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>(92)</td>
<td>0</td>
<td>2,340</td>
<td>2,137 (203) (10)</td>
</tr>
<tr>
<td><strong>6 Reserves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Reserves</td>
<td>(2,003)</td>
<td>(5,559)</td>
<td>2,348</td>
<td>0 (2,348) n/a</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td>(2,003)</td>
<td>(5,559)</td>
<td>2,348</td>
<td>0 (2,348) n/a</td>
</tr>
<tr>
<td><strong>7 Grand Total</strong></td>
<td>(950)</td>
<td>(2,200)</td>
<td>224,178</td>
<td>223,038 1,140 (0.5)</td>
</tr>
<tr>
<td><strong>Last Month’s Variances</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub Total</td>
<td></td>
<td></td>
<td>(950)</td>
<td>(2,200)</td>
</tr>
<tr>
<td><strong>Operating Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub Total</td>
<td></td>
<td></td>
<td>224,178</td>
<td>223,038 (1,140)</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td></td>
<td></td>
<td>462,061</td>
<td>459,861 (2,200)</td>
</tr>
</tbody>
</table>

This section provides information on the key performance indicators outlined in the service specifications, in order to proactively manage the contract.

THE ROTHERHAM NHS FOUNDATION TRUST

1. Overview of Performance

The areas to report for August 2010 are as follows:

1.1. GP and Other Referrals

The number of GP referrals at the end of Quarter 1 was 11,757, a decrease of 3.4% against the same period in 2009/10. The number of “Other” Referrals to the end of Quarter 1 was 4,610, a decrease of 11.8% against the same period in 2009/10. However, an analysis of referrals since Quarter 1 2006/7 continues to show an upward trend, which is reflected in a 2% increase in GP referrals from Quarter 4 2009/10 to Quarter 1 2010/11.

1.2. 18 week Referral to Treatment and Data Completeness

Currently Rotherham admitted patients enjoy a 99% 18 week referral to treatment against a target of 90% and for non-admitted patients the 18 week referral to treatment is 99% against a target of 95%. There are no issues with data completeness.

1.3. Cancer Waiting Times

Since the new monitoring methodology was implemented in Quarter 4 2008/09 the Trust has performed well and at the end of July 2010 all the national targets for cancer waits are being achieved, except the 2 week wait for Breast which was 87.9% against a target of 93% (actual numbers are one month behind in reporting).

1.4. Accident and Emergency

The cumulative performance to the end of August was 98.95%.

2. Commissioning for Quality and Innovation (CQUIN)

The regional indicators will be reported on a quarterly basis through the SHA. Performance is to be reported quarterly and will include percentage achievement of CQUIN measures in addition to areas of underachievement. Quarter 1 data is still awaiting validation and will be reported in December.

The local scheme has been co-ordinated by NHS Rotherham on behalf of other local commissioners and constitutes 0.7% of the contract value. The indicators focus on smoking in pregnancy, breastfeeding, improving care of children with diabetes, reducing emergency readmissions, timeliness and quality of patient letters, and health promotion.

Last month the only outstanding local indicators were emergency re-admissions and outpatient letters. An audit of 50 sets of case-notes has highlighted a number of issues in regard to emergency re-admissions and the impact of this is currently being analysed.

The audit to establish the baseline for timeliness and quality of the outpatient letters confirmed poor performance and this target is subject to further discussions. We expect both of these issues will be resolved in time for the next report.
3. Overview of Financial Performance

An analysis of the latest financial position has highlighted some risks. The latest position which is shown in the September Operating Cost Statement has identified a £70,000 overspend which when projected to a year end forecast results in an over-spend of £478,000.

The detailed analysis shows a significant overspend on non-elective activity of approximately £700,000 however 70% of that is clawed back as part of the Payment by Results threshold arrangements. Further overspends in excluded drugs, chemotherapy and GP direct access have been masked by under-sPENDS in critical care and rehabilitation medicine. It would be reasonable to note here that both critical care and rehab medicine are low volume, high cost services and small fluctuations in numbers could have a significant financial impact. NHS Rotherham is working with the Trust to discuss these risks and to ensure delivery of a breakeven position at the year-end.

4. Derogation

The Trust continues to make progress towards European Working Time Directive for derogated rotaS. It is anticipated that, whilst the workforce numbers remain dynamic, the reduced working hours will be delivered within the July 2011 timeframe.

5. Quality Assurance Visits

NHS Rotherham’s clinical guardians are developing a process for quality assurance visits to our main providers. This follows earlier visits made by NHS Rotherham to the Obstetric Unit Delivery Suite and Antenatal Ward, and the Care of the Elderly Unit, Stroke Unit and a Medical Ward which gave the visiting team assurance of the quality of care delivered in these areas.
### The Rotherham NHS Foundation Trust Balanced Scorecard Description 2010/11 (Actual)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Indicator</th>
<th>TARGET</th>
<th>Apr-10</th>
<th>May-10</th>
<th>Jun-10</th>
<th>Jul-10</th>
<th>Aug-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to GUM Clinics - Patients offered an appointment within 48hrs of contacting a service</td>
<td>CQC</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Access to GUM Clinics - Patients seen within 48hrs of contacting a service</td>
<td></td>
<td>85%</td>
<td>86.5%</td>
<td>89.7%</td>
<td>87.2%</td>
<td>89.1%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Clostridium Difficile Infection - Local target of 42 set with NHS Rotherham: RFT</td>
<td></td>
<td>42</td>
<td>9</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Clostridium Difficile Infection - Local target of 42 set with NHS Rotherham: Community</td>
<td></td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>11</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>MRSA - Annual target of 3 is for NHS Rotherham, Monitor and CQC.</td>
<td></td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Breastfeeding Initiation (within the first 48hrs of birth)</td>
<td></td>
<td>58%</td>
<td>64.8%</td>
<td>51.8%</td>
<td>55.6%</td>
<td>60.8%</td>
<td>55.7%</td>
</tr>
<tr>
<td>Admitted patients seen within 18 weeks from referral</td>
<td></td>
<td>90%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Non-admitted patients seen within 18 weeks from referral</td>
<td></td>
<td>95%</td>
<td>99%</td>
<td>98%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Waiting times for for the 15 Key diagnostic tests - To ensure patients do not wait in excess of 6 weeks</td>
<td></td>
<td>100%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Waiting times for Pathology diagnostic tests - to ensure patients do not wait in excess of 6 weeks</td>
<td></td>
<td>100%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Percentage of patients waiting less than 4 hours in A&amp;E</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting times for Rapid Access Chest Pain Clinic - Percentage of patients with new onset chest pain thought to be angina seen in a RACPC within 2 weeks of referral.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancelled Operations - Percentage of patients not given a binding date within 28 days of their cancelled operation</td>
<td></td>
<td>0.8%</td>
<td>1.00%</td>
<td>0.91%</td>
<td>0.89%</td>
<td>0.84%</td>
<td></td>
</tr>
<tr>
<td>Cancer: Two week waits (All) - Percentage of patients seen within two weeks of urgent GP referral for suspected cancer for outpatient appointment with a specialist.</td>
<td></td>
<td>93%</td>
<td>95.3%</td>
<td>97.4%</td>
<td>95.1%</td>
<td>94.3%</td>
<td>Not Available</td>
</tr>
<tr>
<td>Cancer: 2 week wait (Breast) - Proportion of patients with Breast symptoms, not suspected of cancer, referred to a specialist who are seen within two weeks of referral</td>
<td></td>
<td>93%</td>
<td>87.5%</td>
<td>94.9%</td>
<td>94.1%</td>
<td>87.9%</td>
<td>Not Available</td>
</tr>
<tr>
<td>Cancer: 31 Days diagnosis to treatment - Percentage of patients beginning treatment within 31 days of a cancer diagnosis.</td>
<td></td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>Not Available</td>
</tr>
<tr>
<td>Cancer: 62 Days GP urgent referral to treatment - Percentage of patients treated within 62 days of referral.</td>
<td></td>
<td>85%</td>
<td>94.7%</td>
<td>90.8%</td>
<td>94.4%</td>
<td>96.2%</td>
<td>Not Available</td>
</tr>
<tr>
<td>Cancer: 62 Day Consultant Upgrade - Percentage of patients treated within 2 months of Consultant Upgrade. Performance monitoring in preparation of targets being set in 2011/12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer: 31 day 2nd or Sub Treatment (Surgery) - Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment</td>
<td></td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
<td>93.3%</td>
<td>100%</td>
<td>Not Available</td>
</tr>
<tr>
<td>Cancer: 31 day 2nd or Sub Treatment (Chemotherapy) - Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment</td>
<td></td>
<td>98%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>Not Available</td>
</tr>
<tr>
<td>Cancer: 62 day Screening Program - Proportion of patients with suspected cancer detected through national screening programmes or by hospital specialists who wait less than 62 days from referral to treatment.</td>
<td></td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
<td>94.1%</td>
<td>100%</td>
<td>Not Available</td>
</tr>
<tr>
<td>Maternity 12 weeks assessment- Percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy.</td>
<td></td>
<td>75%</td>
<td>84%</td>
<td>84%</td>
<td>93%</td>
<td>91%</td>
<td>86%</td>
</tr>
<tr>
<td>Implementation of Stroke Strategy - Percentage of patients who spend at least 90% of their time on a stroke unit. The agreed annual target of 80% is required for NHS Rotherham by quarter 4 2010/11.</td>
<td></td>
<td>80%</td>
<td>82.4%</td>
<td>76.0%</td>
<td>90.9%</td>
<td>78.3%</td>
<td>75.0%</td>
</tr>
<tr>
<td>TIA’s 24hrs- percentage of higher risk TIA cases who are treated within 24 hours of first contact with any healthcare professional. This target only applies to non-admitted patients. The agreed annual target of 60% is required for NHS Rotherham by quarter 4 2010/11.</td>
<td></td>
<td>60%</td>
<td>33.3%</td>
<td>40.0%</td>
<td>55.6%</td>
<td>33.3%</td>
<td>61.5%</td>
</tr>
</tbody>
</table>

Data Source: RFT

(Data robust Apr10 - Jun10)
1. Overview of Performance

The areas to report for August 2010 are as follows:

1.1. GP and Other Referrals
The number of GP referrals from NHS Rotherham in Quarter 1 of 2010/11 was 162, which is an 8% decrease against the same period in 2009/10. Other referrals are showing an increase in Quarter 1 of 29.5% at 246, compared to the same period in the previous year.

1.2. Admitted and Non-Admitted 18 Weeks
The Trust remains contractually bound to deliver the standard for “Oral Surgery” and “Other”. In August, the Trust achieved the target for non-admitted pathways (95%) and for admitted Oral Surgery (90%). However, for “Other” admitted pathways the Trust underachieved at 88.74%. The Trust position on 18 weeks remains very challenging with the numbers of patients from all Primary Care Trusts waiting on admitted pathways increasing by approximately 30% (discounting Ophthalmology) since November 2009.

1.3. Outpatients and Inpatients Waiting
This information is no longer provided by the Trust for individual Primary Care Trusts following the issue of national guidance.

1.4. Cancer Waiting Times
At the end of August 2010 the Trust has achieved 95.65% against a target of 93% for 2 week waits and 100% against a target of 96% for 31 Day Waits.

1.5. Accident and Emergency
The Trust achieved 98.9% compliance against the contractual maximum 4 hour wait target of 98% in August 2010 and 98.79% year-to-date.

1.6. Key Performance Indicators
There was one reportable case of Clostridium Difficile in August 2010, this remains within the trajectory for the year.

The Trust has now agreed a ceiling of one case of MRSA bacteraemia in 2010/11. There were no cases in August and none in the year to date.

1.7. CQUIN
The Trust submitted data for key collaborative and specialist CQUINs in September covering the first quarter of the year and as such will receive payment for these. Work continues to clarify the CQUIN relating to specialist services which concerns refusals for access to Paediatric Intensive Care Unit (PICU) beds. The final wording on the CQUINs for the patient survey and new to follow-up ratios has still to be finalised.

2. Overview of Financial Performance

The Contract for 2010/11 is agreed and awaiting signature. The position at the month end shows an over-performance against plan, which at present is forecasted to continue giving a year end position of £510,000 over-performance. The main over-performance is in planned care, particularly Trauma & Orthopaedics, Paediatric Surgery and Ear, Nose and Throat.
THE SHEFFIELD TEACHING HOSPITALS FOUNDATION TRUST

1. Overview of Performance

The areas to report for August 2010 are as follows:

1.1. GP and Other Referrals
    GP referrals continue to increase year on year but have slowed compared to previous months. Year-to-date referrals as at the end of August are showing a 2% increase against the previous year. Other referrals are showing a 7% increase.

1.2. Admitted and Non-Admitted 18 Weeks
    The Trust achieved both the admitted and non-admitted targets.

1.3. Outpatients and Inpatients Waiting
    The total number of outpatients waiting at the end of August was 1056 which is an increase of 9% compared to the same period in 2009/10. The total number waiting for an inpatient spell at the end of August is 472, which is 4% lower than the same period in 2009/10.

1.4. Cancer Waiting Times
    The Trust is currently meeting all the cancer targets as at the end of August.

1.5. Accident and Emergency
    Performance against the 4 hour target was exactly on target at 98%.

2. Overview of Financial Performance

As at the end of August, Elective activity is under-performing against plan, most significantly in Orthopaedics. Non-Elective activity is showing over-performance against the plan, with significant areas being General Surgery, Obstetrics and Diabetes. This is offset against the Non-Elective threshold. Outpatient activity is also over performing against plan in areas such as Medical Ophthalmology, Nephrology and Neurology, but this is offset by adjustments for Outpatient follow-up reduction initiatives. The forecast outturn shows an under-performance of £500,000 on the Cost and Volume contract, whereas the Cost Per Case Drugs contract is over-performing by £553,000. The overall year end position is forecast at £53,000 over-performing.
ROtherham Community Health Services

1. Overview of Performance

The areas to report for August 2010 are as follows:

1.1. GP and Other Referrals
Based on referrals to the end of August, GP and Other Referrals for 2010/11 are expected to show an increase of 4.7% in comparison to 2009/10.

1.2. Admitted and Non-Admitted 18 Weeks and Data Completeness
Two patients breached the 18 week referral to treatment in Podiatric Surgery but these were attributed to patient choice. All other relevant non-admitted patients (Orthopaedic Triage, Primary Ear Care, Learning Disabilities and Community Geriatrician) continue to be seen and treated within 18 weeks of referral.

Rotherham Community Health Services is continuing with an initiative to improve the reporting of activity and overall data quality stands at 96.48% in July. This is a slight reduction over the previous month, but the provider is still 0.15% above target.

1.3. Outpatients Waiting
Waiting times for most services are within 6 weeks, but there are areas where higher waiting times are being experienced. These include Minor Surgery, Domiciliary Podiatry, Community Dental, Physiotherapy Domiciliary, Adult Learning Disabilities Communication, Wheelchair Service, Mental Health Counsellor and Children’s Occupational Therapy. These areas are being investigated.

1.4. Key Performance Indicators
Work is still ongoing to improve the scope and reporting of key performance indicators for all specifications. This is being undertaken as part of the move towards vertical integration.

2. CQUIN

The local indicators account for 1% of the contract value and are continuing to show mixed performance. Quarter 2 data shows achievement in the areas of Data Quality, Child Obesity, under 18 conception rates and reduction in ambulatory care sensitive admissions. Others areas need further work by the Provider.

The regional indicators will be reported on a quarterly basis through the SHA and constitute 0.5% of the contract value. Quarter One data has now been received and used to inform targets for the remaining three quarters of the year. It was agreed with the provider to pay 100% of monetary value for Quarter 1 based on data collection due to the delay in agreement of all CQUIN measures.

3. Overview of Financial Performance

The contract is funded through a block payment. NHS Rotherham has indicated to Rotherham Community Health Services that it should manage any operational variations (changes in referrals and service developments which are provider driven) within the financial block. Only where NHS Rotherham specifically commissions a new, or addition, to a service will there be any financial implications.
YORKSHIRE AMBULANCE SERVICE (YAS)

1. Overview of Performance

The areas to report for August 2010 are as follows:

1.1. **Category A (8 minute)**
Cumulative performance to the end August was 76.6% for YAS as a whole and 78.7% for NHS Rotherham, against the national target of 75%.

1.2. **Category B (19 minute)**
Cumulative performance to the end of August was 94.7% for YAS as a whole and 96.5% for NHS Rotherham, against the national target of 95%.

1.3. **Performance Management**
YAS continues to perform well for the year to-date against the national targets and is also performing well compared to other ambulance trusts. However YAS has indicated that it considers the Cat B target to be a challenge for the year end position.

YAS are still following an Operational Improvement Plan (OIP) and are generally performing well against these targets.

1.4. **2010/11 Contract**
The Strategic Health Authority has required commissioners to allocate funding into a ’risk reserve’, to be used in the event that YAS are on target to meet Category A and B targets for the year, but are facing financial issues. YAS are currently indicating that they do not anticipate having to access this reserve.

2. **CQUIN**
Payment for Quarter One has been approved.

3. **Overview of Financial Performance**

Actual activity for Rotherham is almost in line with the indicative plan. There is currently very minimal risk of any extra payments being required as part of the ‘cost and volume’ arrangement.
DONCASTER AND BASSETLAW NHS FOUNDATION TRUST

1. Overview of Performance

The latest report for August 2010 is as follows:

1.1 Referrals
The Trust continues to experience problems resolving the Patient Administration System issues to produce the required activity data. An interim position for Quarter 1 2010/11 has been agreed between NHS Doncaster and the Trust, which shows referrals overall have increased by 8.5% (this position excludes Ophthalmology due to inaccuracies which could not be corrected manually). Broken down GP referrals have increased by 3.9%, Consultant to Consultant referrals by 17.9% and Other referrals by 15.4%. Regular system updates are being provided by the Trust until data flow is resumed.

1.2 Admitted and Non-Admitted 18 week RTT and Data Completeness
All targets were achieved and are at green, with achievement well above the national target.

1.3 Cancer Waiting Times
In July all targets have been achieved.

1.4 Accident and Emergency 4 Hour Wait
The performance for August was rated green at 98.62%.

2. Overview of Financial Performance

Current position at the month end is £116,000 under-performance, with provisional indication that this position will continue to the year-end.
1. Overview of Performance

The areas to report for August 2010 are as follows:

1.1. GP and Other Referrals
The number of GP referrals from Rotherham in Quarter 1 of 2010/11 was 101, an increase of 9.7% against the same period in 2009/10. Other referrals have increased by 44.6%, with 81 being referred from Rotherham in Quarter 1 of 2010/11 compared to the same period last year. Overall there has been an increase of 22.9% year-on-year.

1.2. Admitted and Non-Admitted 18 Weeks
All targets were achieved for the Trust. Achievement is above the national target of 90% for admitted at 96.60% and 99.04% for non-admitted against a target of 95%.

1.3. Outpatients and Inpatients Waiting
Trust wide, the number of inpatients waiting longer than 26 weeks is green at 0% against target of 0%. The number of outpatients waiting longer than 13 weeks is currently amber at 0.45% against a target of 0%.

1.4. Cancer Waiting Times
The Cancer waiting times for August 2010 are as follows:-
   - 14 Days Two Week Wait stands at 97% against a 93% target
   - 31 Days Referral to Diagnosis stands at 100% against a 96% target
   - 62 Days Referral to Treatment stands at 90% against an 85% target

1.5. Accident and Emergency
The validated position at the end of August is 98.1% against a 98% target.

1.6. Diabetic Retinopathy
The latest position is 74% of patients have been offered screening against a 95% national target, 75% of patients were screened. Due to the problems encountered throughout 2009/10 it is not anticipated that these figures will rise significantly until at least December 2010 due to the targets being on a rolling 12 month basis.

1.7. Key Performance Indicators
The latest position on the Key Performance Indicators for August 2010 is:-
   - Genito-Urinary Medicine 48 hour access offered 100% of patients an appointment
   - MRSA has a cumulative actual of 0 against an annual target of 1
   - Clostridium Difficile has a cumulative actual of 19 against an annual target of 47

2. Overview of Financial Performance

The Contract for 2010/11 has been agreed at a value of £1,878,000. Current position at month end is £36,000 under-performance, with provisional indication at year-end of a position of £10,000 under-performance.
1. Overview of Performance

The areas to report for August 2010 are as follows:

KPIs

1.1. Number of patients on Care Programme Approach (CPA) discharged from psychiatric care who were followed up within 7 days of discharge
   100% of patients were followed up in August.

1.2. Crisis Resolution and Home Treatment Team
   The total number of people receiving treatment episodes for August was 271.

1.3. Early Intervention in Psychosis Service
   The service in August has a caseload of 139 which is 17 above target. The service accepted 2 new cases in August.

1.4. Assertive Outreach Service
   The number of people receiving the service is reported as achieving target and currently stands at 108.

1.5. 28 Day Re-Admissions
   There were 2 re-admissions to report in August due to patients being discharged to RFT for medical care.

1.6 Number of people under 16 and 18 admitted to an Inpatient Ward
   There were no admissions to report in August.

2. CQUIN

Both the regional Strategic Health Authority and local CQUIN schemes have been agreed and are signed up to. The regional CQUIN scheme equates to 0.5% of the contract value covering seven indicators. The indicators focus upon improving access to services, improving Black, Minority and Ethnic outcomes, achieving better practice in relation to nutrition and pressure ulcers, meeting the needs of people with a learning disability, and developing pathways and jointly working in dementia care.

The local scheme has been coordinated by NHS Rotherham on behalf of other local commissioners and constitutes 1% of the contract value. The indicators focus upon improving access to services for older adults, service user satisfaction, preparation for introduction of Payment by Result and promoting healthy living.

3. Overview of Financial Performance

NHS Rotherham signed the new NHS Standard Mental Health and Learning Disability Service Contract on 31 March 2010, of which NHS Barnsley is an Associate Commissioner. The value of the 2010/11 contract is £27.1M. As the contract is managed within a block funding arrangement, the financial risk is minimal.
1. Overview of Performance

The areas to report for August 2010 are as follows:

1.1 Walk-In Centre
- The Walk-In Centre experienced 82% of the expected number of attendances per month, against a target of 75%.
- All other targets have been achieved and there were no breaches of the 4 hour attendance in August.
- 100% of non-urgent cases were seen within 40 minutes of registration.

1.2 Out-of-Hours Service
This is a joint service with NHS Barnsley. The Out-of-Hours service is performance managed on the 15 National Quality Standards and 6 local targets. In August the service continued to report a “red” on the category of “Attendance in 120 Minutes”. A query has been raised by NHS Rotherham in relation to this issue.

1.3 Diagnostic Centre - GP and Other Referrals
Overall activity for the 4 modalities (x-ray, ultrasound, echo and dexa) saw a small decrease at 68% in August compared to July.

Against a target of 90%, the capacity utilisation for all modalities in August was as follows:-
- **X-Ray** – 67% of contracted capacity was utilised, which is the same as July.
- **Ultrasound** – 77% of contracted capacity was utilised, a decrease of 12% from July.
- **Echo** – Remains low at 34%, but has increased from 31% in July. This modality continues to be problematic and Care UK has approached NHS Rotherham to suggest a reduction in service by one day per week after a programme of promotion.
- **Dexa** – 82% of contracted capacity was used, which is an increase of 3% from July.
- **MRI** – 80% of activity was utilised, equating to 69 patients being examined which is a reduction of 30 patients from July’s levels.

**Key Performance Indicators – Annual Targets**
- Activity indicators are below the 90% target but improvement has been seen through the year.
- Overall activity for all modalities (including MRI activity) is currently under target at 72% compared to the target of 90%.
- 104 patients (10%) completed the patient satisfaction survey, reporting a score of “excellent” for the diagnostics service

2. Overview of Financial Performance

- The Out-of-Hours Service is managed within a block contract and this is currently performing on target.
- The Walk-In Service is managed on a cost per case or minimum guarantee basis. This is on target to surpass the minimum guarantee but is within budget.
- The GP Practice is managed on a cost per registered patient or minimum guarantee. It is on target for minimum guarantee.
- The Diagnostic Centre income guarantee for the second year is 75% of base costs.
PRIMARY CARE SERVICES

1. General Medical Services – GPs

- 78% of Practices are engaged in Extended Hours. This gives 88% of NHS Rotherham’s population coverage.
- The Annual Commissioning Reviews began in April 2010 with 17 Practices having had their review, no reviews were undertaken in August 2010.
- The GP Practice at Rotherham Primary Care Centre entered its second year of the contract on 1st June with a target of 2,400 registrations by 31st May 2011. At the end of August the Practice had 471 patients registered which gives an 80.37% shortfall against target.
- Brampton Primary Care Medical Centre now has 928 patients registered at the end of August 2010 which is an increase of 113 on the last reporting period; their target is to have 3,000 registered patients by the end of September 2010.

2. General Dental Services

- The total number of Practices currently accepting new patients is 15.
- The Dental Reference Service carries out Dental Practice visits and report back to the Dental Advisor at NHS Rotherham.
- The end-of-year reports show that 10 Dental Practices have achieved less than 96% of their annual UDA activity. Accordingly, this issue will be raised at the individual Practices concerned.

3. General Pharmacy Services

- The ‘Pharmacy First Scheme’ is a minor ailments service where you can receive advice and/or medicines for common less serious illnesses from a community pharmacy, without having to make an appointment with your GP. The total number accredited to offer this scheme is 30 out of 59 eligible Pharmacies. The number of illnesses covered by the scheme is 23.
- Annual visits are to be arranged when pre-visit questionnaires have been returned from the Pharmacies for 2010/2011. The Medicines Management Team accompany NHS Rotherham on visits.
- The Pharmaceutical Needs Assessment document is now completed in draft form and has been checked by the solicitors against regulation. The Stakeholder Consultation commenced 23 August 2010 and will end on 21st November 2010. The final document must be signed off by the Trust Board by February 2011.

4. General Optometric Services

- The second trawl of visits are taking place, the Practices have been RAG rated as follows:-
  o Green Practices are fully compliant with the contract and do not require a further visit until 2013.
  o Amber Practices are to have a short visit to cover previous action plans.
  o Red Practices are to have a yearly visit until they have had a consistent approach to their action plans.
Performance data aligns to SHA QIPP Tracker as at the end of September 2010
The implementation of NHS Rotherham’s Strategic Plan (Adding Quality & Value) is based on the organisation’s ability to achieve significant efficiency savings, specifically in 7 programme areas i.e.

- Primary Care and Prescribing
- Long Term Conditions & Urgent Care
- Clinical Efficiency
- Planned Care
- Specialised Services
- Corporate Budgets
- Management Costs

Detailed information on the metrics and milestones associated with each of these efficiency programmes has been submitted in previous months and reports will now concentrate on the overview position, with key metrics for demand-led projects in graphical format.

The summary below gives an overview of performance against the target savings for each programme and highlights any shortfalls. As at September 2010, NHS Rotherham is on track to achieve the planned efficiency savings, with an overall overachievement of £3,500. Two programmes are showing as underachieving i.e.:

- Specialised Services, where savings over and above the £125,000 reported for the end of June will not materialise until 2011/12.
- Management Costs, where the SHA QIPP Tracker requires the plan to reflect the original plan of £1,441,000 from earlier in the year, although this has now been revised locally to £1,354,000. From a local perspective, this efficiency programme is on track.

Nevertheless, overachievement of savings in the Prescribing, Primary Care and Corporate Budgets programmes have more than offset the underachieving programmes.

### Programme Area Efficiencies

<table>
<thead>
<tr>
<th>Programme Area</th>
<th>Efficiencies</th>
<th>Target annual savings £</th>
<th>Target savings as at September £</th>
<th>Actual savings to September £</th>
<th>Shortfall/ surplus as at September £</th>
<th>Forecast end of year savings £</th>
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<td></td>
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The Prescribing Efficiency Programme requires recurrent savings of at least £1,703,000 in 2010/11. It is intended that this will be generated by interventions in 4 areas:

- Project 1 - Reduction in prescribing expenditure (target £300,000 savings)
- Project 2 - Management of new drugs and use of specialist drugs (target savings £1,403,000)

Only Project 1 (prescribing expenditure) is demand related and subject to influence. Performance against the achievement of the target savings of £300,000 is shown below. It is anticipated that savings will exceed the target and are likely to reach £400,000 by the year end. Performance as at the end of August shows an overachievement of £41,600.

The Long Term Conditions & Urgent Care Efficiency Programme requires a £500,000 recurrent saving in 2010/11, with increasing efficiency requirements in future years until 2013/14. The main long term efficiency programme to address the increase in non-elective expenditure is through vertical integration as part of the “Shaping Our Future” arrangements. However this will not impact until 2011. Meanwhile, in 2010/11, it is intended that the required £500,000 will be generated non-recurrently by the decommissioning of specific services.

The main demand-related metric relates to non-elective activity. Performance to the end of June shows that non-elective activity is significantly above contract and indeed, is in line with the “do nothing” scenario.
The Clinical Efficiency Programme requires a £3,000,000 recurrent saving in 2010/11 and additional recurrent savings of £2m from 2011/12 to 2013/14. It is intended that this will be generated by interventions in the following areas:

- **Project 1** - Reduction in the rate of 5 Low Clinical Value (LCV) procedures (target savings £350,000)
- **Project 2** - Introduction of a 60% local tariff with RFT for procedures planned and not carried out (target savings £150,000)
- **Project 3** - Redesign of pathways and treatment thresholds for 5 priority specialties, resulting in a reduction in both outpatient appointments and inpatient procedures (target savings £2m)
- **Project 3.4** - Introduction of a local composite tariff with RFT for first/follow-up appointments (target savings £500,000)

Performance against the main demand-related metrics (elective inpatient/day cases and first outpatients) is given below. This shows that, although elective inpatient activity is below contract plan, the case mix is such that the cumulative cost to the end of June is above the contracted value. First outpatient activity is below the historical trend but above the efficiency plan level.

**Project 4.1: Metric (a) Expenditure on elective inpatient/day case activity (£)**

<table>
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<th>Month</th>
<th>Do Nothing Scenario</th>
<th>With Interventions (£2 Million Reduction from Contracted)</th>
<th>Contracted Activity</th>
<th>Actual</th>
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**Project 4.1: Metric (c) First outpatient activity levels**
NHS Rotherham

Board; 15 November 2010

Update on clinical referrals and the planned-care efficiency programme

Contact Details:

<table>
<thead>
<tr>
<th>Lead Director:</th>
<th>Robin Carlisle</th>
<th>Lead Officer:</th>
<th>Insert Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Director of Intelligence and performance</td>
<td>Title:</td>
<td>Insert job title</td>
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Purpose:

To update the board on the clinical referrals efficiency programme and the 6 monthly review of the Clinical Referral Management Committee.

Recommendations:

The Board is asked to:

1. Note the financial risks associated with the clinical referral efficiency programme

2. Agree that resources to support the workstreams associated with this efficiency programme are given high priority in discussions about priorities for the proposed GP commissioning executive and in the current NHS Rotherham re-organisation

3. Agree that the Clinical Referral Management Committee (CRMC) gives more emphasis to facilitating educational dialogue with practices in addition to work on care pathway re-design and that this is integrated with dialogue through PBC, Annual Contact Reviews and Protected Learning Time.

4. Agree that an alternative forum, to the CRMC, be developed for clinical discussions about evidence-based commissioning; procedures of limited clinical value, and region-wide referral thresholds work. The CRMC should only discuss these areas where they overlap with its own work programme.

5. Note that the CRMC may need to incorporate changes of membership, to that listed in the ToR, in order to reflect developments in local GP leadership and the reducing management structure of NHS Rotherham.

Background:

NHS Rotherham’s financial plan assumes £2M efficiency saving from clinical referral management in 2010/11 and for each of the following 3 years.
The CRMC is a joint committee of NHS Rotherham and Rotherham Foundation Trust (RFT). The approach taken is of dialogue between GPs and consultants leading to improved feedback from consultants to GPs, peer review between GPs and more efficient care pathways.

Key components include:

- Specific work programmes on 5 prioritised specialities (see enclosure)
- For dermatology there is a proposal for time limited outpatient clinics to be held in targeted practices as part of an overall programme of increased dialogue between GPs and consultants
- Dialogue with all 150 GPs about referral variations – to date this has been limited to email and one Protected Learning Time (PLT) event. Dialogue also occurs through Practice-Based Commissioning (PBC) and to a limited extent through the annual contract review.
- Work on generic issues
  - a proposed common referral proforma to facilitate consultant to GP feedback,
  - improving ways of getting clinical advice without referral,
  - improving ways of getting urgent and immediate appointments rather than admissions.

There are also related areas such as procedures of limited clinical value and regional work on clinical thresholds and evidenced-based commissioning that are not in the current Terms of Reference of the CRMC.

The Director of Intelligence & Performance took over the leadership of this efficiency programme from the Director of Public Health in October. This is until a dedicated GP leader for this key area can be identified. Dedicated NHS Rotherham project officers will be identified to facilitate this work as part of the current organisational re-structure. There are key relationships with PBC, the annual contract review process and PLT events.

The Terms of Reference (ToR) for the Clinical Referrals Management Committee (CRMC) and summaries of work to date are included as enclosures.

**Analysis of Risks:**

The rise in clinical referrals is one of the key financial challenges. It will not be mitigated without clinical leadership and widespread adoption by 150 GPs.

**Return on Investment:**

This is an efficiency programme seeking to reduce the anticipated financial consequences of increasing outpatient referrals and subsequent elective activity by £2M per year.

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1 These summaries were produced for other than the Board and make use of acronyms that would be readily understood by their intended audiences. There has been an attempt to explain all abbreviations – in not within those papers then via this fronting report
Analysis of Key Issues:

Trends

79% of all NHS Rotherham outpatients - subject to Payment By results (PBR) - take place at RFT, 56% of all first outpatients are GP referred, and Rotherham has outpatient rates substantially higher than the national average - although this can be explained to some extent by higher than average morbidity.

Chart 1 shows trends in first outpatients for all providers for NHS Rotherham patients. There was a 16% increase in first outpatient activity in the period between 2007/8 and 2009/10 (2.5% of this was a one off increase due to changes in recording of activity by midwives). Most other PCTs have seen similar steep rises in recent referral activity. There are long standing reasons for increasing referrals such as rising public expectations and national guidance such as from NICE (which often recommends that best practice is to get a specialist opinion), however the reason for the step change in 2007/8 has never been fully understood and could be related to more complete data recording and supplier induced demand as a result of PBR and shortened waiting times.

Chart 1 shows actual and predicted trends and an ‘affordable trajectory’ that is reflected in NHS Rotherham’s financial plan. The savings from the efficiency programme will be realised if referrals (and consequent elective activity) rise at the rate that is in the financial plan. Data from the five months of 2010 suggest that the steep rise of the last two years might have started to ease, but there are still considerable long term risks in this area.

1) NHS Rotherham first outpatients (actual and predicted) as a percentage of 2009/10 activity
Chart 2 shows monthly GP referrals to RFT from all PCTs up to September 2010. Although it is too soon to be certain there is some evidence than the extreme growth in referrals up until April 2010 has begun to flatten out. If this turns out to be sustained it has occurred too soon to be attributed to the efficiency programme but is important for the financial future of the NHS in Rotherham.

2) RFT total GP Referrals - Moving Annual Totals

Evidence

All PCTs are attempting to curb a rise in clinical referrals. Yet there is no compelling evidence pointing to a proven way forward. The recent Kings Fund report summarises evidence in this area and approaches being taken by PCTs. The report gives strong support to Rotherham’s approach of using a cross organisational, educational approach - building clinical consensus and re-aligning incentives. The report and its implications are summarised in the attached paper by Sarah Lever. NHS Rotherham is also visiting 4 other health communities to learn from their approaches to clinical leadership in this area. These visits will have been completed by mid November.

Below is a list of strengths and issues from the first six months work of the clinical referral efficiency programme.

Strengths of Rotherham’s current approach

Dissemination of benchmarking and trend information to all clinicians (see further sources of information).

Work initiated on all 5 priority areas (diabetes, trauma & orthopaedics, ophthalmology, dermatology, gynaecology) with input on each from at least two GPs plus consultants and other clinical staff. (see attachment).

Emerging methodology on a process for initiating work streams (starting with Rapid Improvement Events).
A proposal for semi structured referral templates to enable better consultant to GP feedback and the possibility of collecting speciality level information for educational feedback.

Generic ENT guidelines disseminated along with tonsillectomy guidelines from the Scottish Intercollegiate Guidelines Network,

Guidance on arrangement for urgent referrals by each speciality and discussions on each speciality’s handling of urgent and immediate referrals.

**Issues with Rotherham's current approach**

**Project issues** (ie easily resolvable)

Underestimated the time required to produce proposals/options and the time to implement options.

Lack of identified NHS Rotherham project support staff

Difficulty in recruiting GPs beyond core group, partially because of lack of NHS Rotherham project management to encourage involvement and ensure mutually convenient times for meetings.

Work involving RCHS (eg the diabetes and orthopaedics care pathways) is more complex than would be usually the case because of the proposed changes in leadership from Shaping our Future.

**Fundamental issues**

The proposal to introduce a more standardised referral template for some specialities to facilitate consultant to GP feedback is unpopular with some GPs. A PBC survey is being undertaken to more accurately access the range of GP opinion in this area.

Increased dialogue with all 150 GPS is required. Whilst this is partially a question of identifying the resources (particularly GPs to facilitate peer discussion), there is also a question of message. An analogy is often made with prescribing advisers but prescribing advisers have very specific discussions with GPs. They do not say ‘you have high prescribing costs’ they say ‘you benchmark high on drug X, have you considered a switch to drug Y which studies have shown to be more cost effective? ’. Categorical suggestions are harder to identify in referral situations where clinical decisions are finely nuanced. The dermatology and gynaecology workstreams incorporate audit to encourage meaningful learning for GPs.

RFT senior management is committed to the process of curbing the rise in referrals and has communicated this to all clinical leaders. However in the same way that many GPs are most concerned about ensuring good access to patients who need referral, it requires a significant culture change among secondary care clinicians to change mindsets from business models based on increasing throughput and numbers.

Both the GP community and hospital consultants are enthusiastic about improving access to outpatient consultations in the community setting. However for this to be affordable it has to be combined with educational consultant to GP feedback otherwise improving access risks creating an unaffordable increase in referrals.

RFT has ambitious plans to market private cosmetic dermatology services. NHS Rotherham needs to understand what the impact of such plans will have on demand for...
NHS referrals.

Secondary care outpatient information is only collected at speciality level, reason for referral and diagnosis are not routinely recorded, and information is only available by practice rather than by individual GP. Potential solutions are major investment in primary care information systems or requesting additional data collection or audits from primary or secondary care.

**Patient, Public and Stakeholder Involvement:**

None

**Equality Impact:**

None

**Financial Implications:**

A non recurrent budget of £250K is available to backfill GP and consultant time. Currently this is under-spent and so has been reduced to £80K. The wider financial implications are covered in the ‘key issues’ section.

Approved by: Chris Edwards

**Human Resource Implications:**

NHS project management for clinical referrals is being considered as part of the current re-structuring. There are implications for general practice with regards to the time required to extensively engage in this programme and there is a substantial cultural challenge for both primary and secondary care clinicians to assume full responsibility for this agenda.

Approved by: Pauline Fryer

**Procurement:**

Issues may arise depending on the proposals from individual work streams.

Approved by: Chris Edwards

**Key Words:**

Referrals, QIPP, efficiency

**Further Sources of Information:**

CRMC Update on current workstreams (attached)

Managing referrals paper by Sarah Lever to CRMT August 2008 (attached)

ToR CRMC (attached)

NHS Rotherham First Outpatient Activity Trends and Variation, July 2010


Referral management: lessons for success Kings Fund 2010

http://www.kingsfund.org.uk/publications/referral_management.htm
Clinical Referrals Management Committee Update October 2010.

There are currently 5 speciality workstreams:

1. **Diabetes** - Rapid Improvement Event (RIE) has been held and action plan developed. This includes standardised model for annual review, use of diabetic retinopathy database to identify clinical responsibility for annual review, consistency of care for all cases on DN caseload and streamlining referrals between podiatry and orthotics. Anticipated ‘go live’ date for proposals is 1st April 2011.

   | Commissioning lead: | Nagpal Hoysal |
   | RFT lead            | Andy Irvine, Lorraine Watson |
   | GPs involved        | Jason Page, Neil Thorman, Alison Ogden, Theo Barragry, Bernard Everett |
   | Consultants involved| Solomon Muzulu, Bernard Franke, Shariff El-Reefee, Abdel Hatiz |
   | Progress document   | YES |
   | Who holds           | Nagpal Hoysal |
   | Go live             | 1 April 2011 |

2. **Trauma and Orthopaedics** - RIE event had taken place and proposed a programme of GP education and feedback plus service redesign with a one stop service for physio and OT alongside consultant-led service.
   - Issues to be considered - how does this fit with current ortho triage
   - How will therapy-led service work and how will different levels of service be paid for?
   - How will the service control the growth in referrals

   Work is on-going with four sub groups:
   1) Education and referral information.
   2) Referral triage.
   3) One-stop shops.
   4) Staffing requirements.

   | Commissioning lead: | Charles Collinson |
   | RFT lead            | Suzanne Stubbs, Rachael Lewis, Clinical Lead for Orthopaedic Triaging |
   | GPs involved        | Julie Kitlowski, Charles Collinson, David Plews, Steve Burns and Rowan Kenny |
   | Consultants involved| Ian Carmichael |
   | Progress document   | YES |
   | Who holds           | Suzanne Stubbs (Sue Howard) |
   | Go live             | 1 April 2011 |

3. **Ophthalmology** - RIE event has been held. Currently working on an options plan, including possible triage of direct referrals from optometrists and community triage clinic. Update due first week December 2010.
4. **Dermatology** - RIE event being planned. The working group is looking at a possible ‘one stop’ clinic in the community (they currently run a similar clinic in Doncaster). Also more effective feedback to GPs. A proposal for a prospective audit of current referrals followed by fixed term outpatient clinics in high referring practices starting from January 2011 is being worked up as part of a wider plan of educational feedback from consultants to GPs.

5. **Gynaecology** - Management of vaginal Bleeding. Main actions. 1) Audit of current referrals against the existing but not publicised care pathway. 2) Sharing audit with GPs and identification of best means of disseminating information to 150 GPs – includes PLT events in 2011. 3) looking at the number of hysteroscopies carried out as out-patient and day case at RFT and scoping the possibilities of a one stop approach.

In addition to the speciality work streams the committee has been discussing:

- **Guidance regarding how to get urgent clinical advice and urgent outpatient appointments from different specialities.** A draft of this has been produced and once all specialities are included will be sent out to GPs.
- Proposal for a **Generic standardised referral proforma** – to aid consultant to GP feedback, for RFT to better anticipate the likely management required and be aware of investigations already carried out.
- How to provide useful feedback to GPs on ways in which the growth in referrals can be kept to affordable levels. A series of **visits to PCTs with different models of GP led referral management** was to be completed by 3 November.
Managing Referrals

Sarah Lever, 16 August, 2010

The Clinical Referrals Management Committee (CRMC) has asked that evidence of best practice and lessons learnt from other health economies in implementing referral management initiatives is collated to support its work. The purpose of this paper is to:

- Set out the current policies and incentives in place in Rotherham;
- Explore what the literature tells us about the relative success or otherwise of referral management initiatives;
- Suggest a way forward for NHS Rotherham, highlighting those PCTs which are reputed to have contained referrals in addition to ongoing work which NHSR could draw from in undertaking its work.

Summary

Rotherham established the Clinical Referrals Management Committee to contain the unsustainable rise in referrals. Existing policies and incentives are in place: NHS Rotherham does not commission procedures in line with the NORCOM policy, and an Individual Funding Requests policy is in place for consideration of these. A local PBC incentive is in operation to encourage general practices to manage demand.


Its findings showed that whilst some initiatives have improved the quality of referrals, which may have longer term cost saving implications, they may not have reduced referrals. Indeed the research showed that those PCTs actively engaged in referral management initiatives were no more likely than others to have curtailed demand. The research showed that most effective strategy for managing referrals was likely to:

- be linked to clear referral criteria and evidence based guidelines
- include peer review and audit and involve a system which enabled and used feedback from hospital consultants.

Passive dissemination of clinical guidelines had no influence on referral behaviour. The use of incentives has altered referral behaviour however those which encourage blanket reductions in referrals could also reduce those which are clinically appropriate.
The report stresses the importance of a whole system approach both with respect to managing demand and engaging clinicians from primary and secondary care and community services. It also highlights the potential for increased demand which can result from initiative to manage referrals and the inherent clinical risk involved in the handover of patients from one clinician to another.

Work is ongoing across Yorkshire and the Humber to develop evidenced based commissioning policies. It also includes work to develop referral thresholds across a range of conditions. NHS Rotherham is engaged with this work and should ensure that the outcomes are implemented through the CRMC.

NHS Cumbria, NHS Redbridge and NHS East Riding of Yorkshire have adopted approaches endorsed by the King’s Fund research either in whole or in part. NHS Rotherham should work with these PCTs to understand the details of their approach and the materials developed to support their initiatives which could be utilised by Rotherham.

In taking forward its work to contain referrals, NHSR should consider:

- co-production with PBC and RFT;
- the procedures of limited clinical value and pathways suggested by RFT and practice based commissioners, where referrals could be reduced and/or where primary care practitioners would welcome feedback from secondary care colleagues;
- how access to the most up-to-date guidelines and protocols can be maintained, for example through web-based facilities: Some PCTs have endorsed the use of Map of Medicine through which access to evidence based pathways is free of charge. The tool can be adapted to include local policies and pathways;
- how practices can be supported in reducing referrals for example, through mentoring and peer review involving secondary clinicians.
- how practices can be supported to improve referral practice, and more targeted interventions be made where necessary;
- improving access to informal specialist advice for example by telephone or email to remove the need for referral, and how the availability of such facilities can be publicised across the heath community. Successful examples are already in place: In paediatrics a consultant is available from 9am to 5pm to offer advice to GPs and similar examples include general surgery and oral maxillo-facial surgery (OMFS). There is an advice box available via Choose and Book but this is not often utilised.
• encouraging GPs to ensure all investigations have been carried out prior to referral

• how less costly interventions can be made with the appropriate reduction in capacity elsewhere in the system;

• how incentives can be aligned across the system, and how contracting can be used to ensure that the benefits of referrals management initiatives can be utilised;

• creating greater consistency in the way that clinical triage works, making greater use of guidelines.

• how benchmarking data by specialty will be collected and disseminated for use in challenging referral practices;

• resource requirements from the PCT.

**Referrals Management in Rotherham**

The CRMC was formed to reduce the unsustainable growth in referrals, in the first instance around 5 pathways: Trauma and Orthopaedics, Diabetes, Ophthalmology, Dermatology and Gynaecology. It has added to its terms of reference the five procedures of limited clinical value and welcomed the suggestion that each of the clinical support units at RFT suggest two pathways in which the number of referrals could be reduced; Dizziness is one pathway which has already been suggested. However some concerns have been raised about the scope of the CRMC and whether it should complete its initial remit before extending its work beyond the five original pathways.

• **PBC Local Incentive Scheme**

NHS Rotherham has an incentive scheme in place to improve the care of patients in primary care and reduce costs in secondary care. Practices receive 70% of savings against forecast budgets for payment by results activity if the PCT as a whole comes under budget.

• **Use of clinical guidelines and exceptional case panel**

NHS Rotherham does not commission procedures which fall outside those agreed by NORCOM; These include those that the North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium do not commission except in exceptional circumstances. These have superseded NHSR’s local policy, “Effective and Appropriate Healthcare” which was last updated in 2006. An individual funding requests policy is in place for consideration of these.
Referrals Management, Lessons for success

The King’s Fund has recently published *Referrals Management, Lessons for success*, a review of referral management initiatives which have been adopted by PCTs to reduce costs and improve quality by reducing inappropriate referrals.

A range of strategies were employed by the PCTs involved in the study: These included clinical referrals management centres, triage and assessment centres, incentivising GPs financially and the use of clinical guidelines.

The research showed that PCTs known to be actively involved in initiatives to reduce referrals were no more likely than other PCTs to achieve this. Despite half of the PCTs involved in the review believing that they had curtailed demand, an analysis of performance data did not confirm those perceptions. The report also raises concerns that some initiatives could undermine quality by misdirecting referrals in the absence of clinical information or delaying access to specialists.

Approaches to referrals management

NHS Rotherham has engaged with a number of PCTs which are reputed to have contained referrals: These have employed some of the initiatives covered by the King’s Fund report. NHS Redbridge, NHS Cumbria, NHS Sommerset and NHS East Riding of Yorkshire have shared details of their schemes and the materials they have developed to support them.

Unsurprisingly, informal conversations with those PCTs echoed many of the findings the King’s Fund Report. As most of the PCTs we have talked to have implemented their Schemes in the last year it is not possible to evidence whether they have had the desired impact. The majority believed that they were having an effect.

This section of the paper explores differing approaches to referrals management. Their strengths and weaknesses, taken from the King’s Fund research are shown in Table 1.

- **Referrals management centres**

  Referrals Management Centres were adopted by 50% of PCTs involved in the King’s Fund research. They have been established to triage all referrals from GPs to consultants and sometimes consultant to consultant referrals. Their role is to:

  - assess the completeness and adequacy of the referrals;
  - seek further information from GPs if necessary;
  - reject referrals for excluded or low priority procedures;
  - divert referrals to alternative clinical assessment or two tier services.
There has been no systematic evaluation of the effectiveness of referrals management centres and there is little available literature. A series of Welsh pilot sites were established in 05/06. An evaluation of those raised concerns and did not result in the roll out across Wales because the overall costs would outweigh the benefit unless they were focused solely on areas where quality issues were known to exist.

Anecdotal evidence from Sheffield and Barnsley concerning the effectiveness of their RMCs is in line with these findings. Both PCTs felt that these centres were an additional administrative layer having little additional benefit.

- **Clinical triage and assessment**

Clinical assessment and treatment services or clinical assessment services are growing rapidly – all of the PCTs engaged in the King’s fund research had some form of these. These work on the basis that patients will be seen by the service and diverted from specialist services.

Triage has been shown to be successful in diverting patients to out of hospital services (CRG Research, Cardiff University) however whilst high levels of patient satisfaction are reported with these, the initiatives have stimulated additional demand – in North Wales, musculoskeletal referrals doubled over 18 months.

Where triage is by way of second opinion from a GP, unnecessary referrals have been reduced. The provision of a physiotherapy service alongside a general practice has also improved the proportion of referrals reaching the appropriate place.

Because investments in these services has been made without disinvestment in secondary care services, there has been no reduction in demand for more specialist care and costs have not been reduced.
High quality and regular feedback loops in the referrals process have been shown to be effective in improving the quality of referrals and referring patients to community services in place of hospital referrals. Feedback received from consultants around the need for the referral, content of the referral letter and expectations of the consultant with respect to the management of the patient in primary care prior to referral has been effective in driving up the quality of referrals and has been popular with GPs.

In one example, where a weekly practice-level review of referrals was undertaken and supplemented by 6 weekly cluster meetings which included consultant feedback resulted in a 30% reduction in hospital referrals (patients were referred to community services instead). Variation in referral rates was reduced, the
awareness of referral guidelines was increased, the quality of referral letters was improved along with the work undertaken in general practice prior to referral.

Where programmes of GP education involving workshops or outreach visits, led by specialists have been run on an ad hoc basis, the success rate has been mixed.

- **Clinical Guidelines**

The dissemination of clinical guidelines in conjunction with peer and/or specialist review and/or other aids for example (proformas or standardised letters and risk factor checklists) have proved successful in influencing referral thresholds, timelines, letter content and pre-referral management.

Structured referral sheets which prompt GPs to conduct certain pre-referral checks or treatments have been effective in altering referral behaviour but these may be limited to single conditions only. The research reported the number of completed structured sheets was less than half.

Where guidelines are disseminated passively, the quality of referrals has not improved and if any benefits have been realised, they have been short term.

- **Financial incentives**

PCTs have adopted a range of financial incentives to manage referrals. Financial incentives have been proven to alter behaviour although those which incentivise an overall reduction in referrals may reduce those which are appropriate as well as those that are inappropriate.

- **Benchmarking data**

It is well documented that there is considerable variation in referral practice within areas and across practices. Access to good quality data to enable benchmarking of referral information by specialty is vital to enable differences in referral practice to be identified and challenged.

- **Specialty or comprehensive approach to referrals management**

There was no consensus amongst the participants in the King’s Fund research as to whether a comprehensive or more targeted (specialty based) approach to referral management was best.

The report draws the following conclusions:

- Any intervention in referrals needs to consider the context in which the referral is made;
- Changing referral behaviour will require a major change management initiative requiring strong clinical leadership from primary and secondary care;
• Any referrals management strategy must recognise the inherent clinical risks present during hand over from one clinician to another and mitigate against those;

• Strategies to reduce inappropriate referrals could uncover inappropriate non referrals which will improve quality but limit the potential for reducing demand;

• Blanket financial incentives to reduce referrals numbers should not be introduced;

• Reducing referrals from one source can be negated if all referral routes are not considered in a demand management initiative;

• A whole system strategy is required to manage demand, with active collaboration between primary, secondary and community services.

Where are the interventions endorsed by the King’s Fund research being applied?

• Yorkshire and the Humber wide work

Work is ongoing across Yorkshire and the Humber to establish a single process for developing, quality assuring implementing and monitoring evidence-based commissioning policies – this is being led by Ailsa Claire.

Other work, led by Jan Sobieraj, is being carried out by the SHA Planned Care Board to develop and agree thresholds across a range of conditions. The Board is focused on high value service areas with wide variation: examples include primary hip and knee replacements, tonsillectomy and wisdom teeth extraction.

• NHS Cumbria

NHS Cumbria endorses the use of Map of Medicine, a web based tool which includes over 350 evidence-based pathways across a range of specialties. It has developed an evidence-based referrals policy which includes a comprehensive set of clinical guidelines and referral templates which it disseminates to general practices.

It incentivises practices to engage in referral management activity including peer review through a LES. It also resources each practice with a clinical interface manager who acts as a conduit for information and a link to the PCT. The focus of its scheme on improving the quality of care has enabled clinical engagement which has been pivotal to encouraging changes in clinical behaviour.

NHS Cumbria has developed a LES to incentivise GP involvement in its scheme. It includes payment for regular protected meetings with the locality and within the practice to discuss referrals, monthly peer discussion (which can be at PLT),
other lead GPs and the referral support locality co-ordinator. An element of payment is for data quality and analysis to inform those meetings and identify progress. Submission of an annual plan identifying three areas for improvement is also a part of the LES. Practices must adopt the referral letter template and in-house ideas following clinical debates.

- **NHS Redbridge**

NHS Redbridge implemented a process for managing referrals in October, 2010. The PCT has been divided into groups of practices which are aligned with the PBC clusters (known as polysystems). The Professional Executive Committee has been disbanded and the PCT has used the monies to establish a Clinical Commissioning Board and to employ a clinical director and management lead in each PBC cluster. The initiative took around six months to take effect but since February, the PCT report seeing a dramatic slow down in referrals (awaiting evidence). The PCT has taken a specialty by specialty approach, similar to that taken by NHS Rotherham CRMC to managing referrals, basing their approach on the application of clinical guidelines. A clinical advisory service has been set up which screens referrals and gives access to expert clinical advice. Some general practices have been sceptical about the messages relayed by the clinical directors because of their employment by the PCT.

- **NHS East Riding of Yorkshire**

East Riding of Yorkshire has developed a LES to encourage a reduction in referrals by financially rewarding:

- A blanket reductions in referrals;
- Attendance at meetings to review referrals and prescribing behaviour;
- Educating local GPs
- Reviewing intelligence reports; clinical guidelines and information about local care pathways

A PBC development fund is divided up on a fair shares basis by list size and is deemed essential to enable the PBC groups to act quickly to try out new ways of working before committing to a full pathway redesign process.

The first month’s data has shown that the number of referrals has gone down although reductions across the patch have been varied. Those practices with which the PCT has good relationships have engaged in the scheme to a greater extent. It is too soon to say whether the incentive scheme will work as implementation is very recent.
NHS Somerset

NHS Somerset has an information system called RISC which is reputed to provide close to real time information about referrals and activity levels. The PCT has a referrals/bookings management centre and they established a database system within that centre. They input detailed referrals data into this system and it looks like it also matches to subsequent hospital activity. This gives them real time referral data and also links in the other monitoring data from Trusts, which we would already get.

This would require investment in software, implementation of a database somewhere and a resource to populate/manage the database. It would also be some duplicate entry of data into the RMC database and the Trust if it gets referred on.

Conclusion and Next Steps

The King’s Fund Report suggests that the most effective strategies for managing referrals are likely to:

- include peer review and audit and involve a system which enabled and used feedback from hospital consultants.
- be linked to clear referral criteria and evidence-based guidelines.

NHS Rotherham is to take forward a programme of visits to PCTs which are known to have adopted initiatives in line with the Kings Fund Research. These should begin with NHS Cumbria, NHS Redbridge and NHS East Riding of Yorkshire.

In taking forward this work, NHSR should consider:

- co-production with PBC and RFT;
- the procedures of limited clinical value and pathways suggested by RFT and practice based commissioners, where referrals could be reduced and/or where primary care practitioners would welcome feedback from secondary care colleagues;
- how access to the most up-to-date guidelines and protocols can be maintained, for example through web-based facilities: Some PCTs have endorsed the use of Map of Medicine through which access to evidence-based pathways is free of charge. The tool can be adapted to include local policies and pathways;
- how practices can be supported in reducing referrals for example, through mentoring and peer review involving secondary clinicians.
how practices can be supported to improve referral practice, and more targeted interventions be made where necessary;

improving access to informal specialist advice for example by telephone or email to remove the need for referral, and how the availability of such facilities can be publicised across the health community. Successful examples are already in place: In paediatrics a consultant is available from 9am to 5pm to offer advice to GPs and similar examples include general surgery and OMFS. There is an advice box available via Choose and Book but this is not often utilised.

encouraging GPs to ensure all investigations have been carried out prior to referral

how less costly interventions can be made with the appropriate reduction in capacity elsewhere in the system;

how incentives can be aligned across the system, and how contracting can be used to ensure that the benefits of referrals management initiatives can be utilised;

creating greater consistency in the way that clinical triage works, making greater use of guidelines.

how benchmarking data by specialty will be collected and disseminated for use in challenging referral practices;

resource requirements from the PCT.
TERMS OF REFERENCE Clinical Referral Management Committee

Contact Details:

<table>
<thead>
<tr>
<th>Lead Director/ Clinician:</th>
<th>John Radford</th>
<th>Lead Officer:</th>
<th>Keith Boughen</th>
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<tr>
<td>Title:</td>
<td>Director of Public Health</td>
<td>Title:</td>
<td>Associate Director</td>
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Purpose:

To develop the appropriate and more efficient clinical management of patients whose condition may have required referral to hospital.

To operate to reduce the costs of care in the context of the NHS financial circumstances.

To take action to change system pathways will require financial risk taking by the health community. No risks will be taken with regard to patient safety.

Responsibilities:

To ensure the efficient use of resources in relation to the flow of patients.

To ensure patients have access to appropriate diagnostic skills, clinical investigation and chronic disease management.

To ensure National performance targets are not breached.

To make all members of the health community aware of the financial consequences of this project.

To advise NHS Rotherham when an NHS Trust or Independent Contractor fails to participate in the program of work.

To establish programs of work for structural, clinical and process change to short timescales to deliver the primary purpose.

Ensure systems of clinical and activity data recording are accurate and timely.

To engage the health community in the clinical pathways.

To improve the quality of referrals as this is more cost efficient.

Principles

- Improve the quality of care
- Reduce waste.
- Clinical cost effectiveness.
- Implementation of NICE Guidance.
- Support clinical performance review
- Establish a learning environment which supports whole system clinical excellence.
- Supports all clinicians in evidence for appraisal.
- Regular reporting on system performance.
- To improve consistency and reduce variation in quality of referrals.
- To develop alternative appropriate effective pathways where necessary.
- It is not about cutting costs but improving efficiency.
- Savings will be recycled into healthcare.

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<tr>
<td>Director Of Public Health, NHSR</td>
</tr>
<tr>
<td>The Deputy Chair will be either, RFT CMO, NHSR Medical Director/GP, or GP/Professional Executive Chair.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Composition of group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Public Health NHSR</td>
</tr>
<tr>
<td>Director of Finance NHSR</td>
</tr>
<tr>
<td>Director of IT and Intelligence, NHSR</td>
</tr>
<tr>
<td>Chief of Rotherham Hospital</td>
</tr>
<tr>
<td>Rotherham FT Divisional Manager</td>
</tr>
<tr>
<td>Rotherham FT Chief Medical Officer</td>
</tr>
<tr>
<td>LMC Representative</td>
</tr>
<tr>
<td>Medical Director NHSR</td>
</tr>
<tr>
<td>Professional Executive Chairman NHSR</td>
</tr>
<tr>
<td>GP Member/Rotherham PBC Group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>In Attendance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Rotherham Program Leads</td>
</tr>
<tr>
<td>Rotherham Foundation Trust Business Managers</td>
</tr>
<tr>
<td>Director of Service Improvement, RFT</td>
</tr>
<tr>
<td>RDASH Representative</td>
</tr>
<tr>
<td>RCHS Representative</td>
</tr>
<tr>
<td>Relevant Clinicians associated with the projects</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deputising:</th>
</tr>
</thead>
<tbody>
<tr>
<td>As appropriate</td>
</tr>
</tbody>
</table>
Quorum:
Two members from RFT, two members from NHSR and two members from Primary Care.

Accountability:
To NHS Rotherham CE and RFT CE

Frequency of meetings:
2 Weekly

Order of business:

Agenda deadlines:

Minutes:
NHS Rotherham

Administration:
The minutes should go to the RFT Corporate Management Team, Clinical Policy Board, and the Professional Executive.

Attendance:

Review Date:
April 2011

Membership List
John Radford, Director of Public Health NHSR
Chris Edwards, Director of Finance NHSR
Robin Carlisle, Director of IT and Intelligence, NHSR
Matthew Lowry, Chief of Rotherham Hospital
Alison Grundy, Rotherham FT Divisional Manager
Walid, Al-Wali, Rotherham FT Chief Medical Officer
LMC Representative
David Plews, Medical Director NHSR
Charles Collinson, Professional Executive Chairman NHSR
Ian Turner, GP Member/Rotherham PBC Group
Workforce Assurance Update Report for NHS Rotherham Main Providers

November 2010

Key Points

- Significant improvements in sickness absence of provider organisations
- Average pay lower than in comparator organisations, particularly in RDASH.
- Leaver rate stabilises after general increases last year
## Contents

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<thead>
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<th>Page</th>
<th>Title</th>
</tr>
</thead>
<tbody>
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<td>Introduction</td>
</tr>
<tr>
<td>4</td>
<td>Comparison of sickness absence rates of Rotherham NHS organisation staff to other organisations</td>
</tr>
<tr>
<td>5</td>
<td>Comparison of average earnings of Rotherham NHS organisation staff to other organisations</td>
</tr>
<tr>
<td>6</td>
<td>Comparison of leaver rate and stability of Rotherham NHS organisation staff to other organisations - Nursing</td>
</tr>
<tr>
<td>7</td>
<td>Comparison of leaver rate and stability of Rotherham NHS organisation staff to other organisations – Allied Health Professionals</td>
</tr>
<tr>
<td>8</td>
<td>Appendix – QIPP workforce metrics August 2010</td>
</tr>
</tbody>
</table>
Introduction

This report is provides an update on a number of key indicators relating to workforce to assist NHSR to carry out its assurance role in relation to its main providers.

It is anticipated that in future workforce assurance indicators will be integrated with the main performance reports for providers and not separately in this present format.

Comparator organisations

This report compares local providers to other local groups as follows:-

Rotherham Foundation Trust is described as a small acute Trust. The only other Trust in Yorkshire and Humberside described as such is Barnsley Hospital Foundation Trust and therefore any reference to other small acute Trusts in Yorkshire & Humber refers to Barnsley FT.

NHS Rotherham (Rotherham PCT) is compared to the average of the following Yorkshire & Humberside group:-

Sheffield PCT
Barnsley PCT
Bradford & Airedale PCT
Doncaster PCT
Kirklees PCT
Wakefield PCT
Calderdale PCT
Leeds PCT
N. Lincs PCT
E. Riding PCT
North Yorkshire and York PCT
Hull PCT

RDASH is compared to the average of the following Yorkshire & Humberside group:-

South West Yorkshire MH
Leeds Partnership MH
Hull MH

South Yorkshire Ambulance Service NHS Trust is compared only to the national average for Ambulance Services
Comparative sickness absence rates by organisation type

<table>
<thead>
<tr>
<th>Organisation Type</th>
<th>2008</th>
<th>2009</th>
<th>2010 to June</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham FT</td>
<td>5.65%</td>
<td>4.63%</td>
<td>4.39%</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber Small Acute (Barnsley)</td>
<td>5.09%</td>
<td>4.65%</td>
<td>4.10%</td>
</tr>
<tr>
<td>All Small Acute</td>
<td>4.23%</td>
<td>4.17%</td>
<td>3.95%</td>
</tr>
<tr>
<td>Rotherham PCT</td>
<td>5.11%</td>
<td>4.65%</td>
<td>4.05%</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber PCT</td>
<td>4.75%</td>
<td>4.46%</td>
<td>4.41%</td>
</tr>
<tr>
<td>All PCTs</td>
<td>4.51%</td>
<td>4.37%</td>
<td>4.25%</td>
</tr>
<tr>
<td>RDASH</td>
<td>6.48%</td>
<td>5.95%</td>
<td>5.43%</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber MH</td>
<td>5.90%</td>
<td>5.51%</td>
<td>5.40%</td>
</tr>
<tr>
<td>All MH</td>
<td>5.40%</td>
<td>5.20%</td>
<td>4.98%</td>
</tr>
<tr>
<td>Yorkshire Ambulance</td>
<td>6.27%</td>
<td>5.68%</td>
<td>5.82%</td>
</tr>
<tr>
<td>All Ambulance Services</td>
<td>5.92%</td>
<td>5.67%</td>
<td>5.85%</td>
</tr>
</tbody>
</table>

The sickness absence calculation is the total time lost through sickness absence as a percentage total work time available.

Sickness absence performance in Rotherham organisations shows a significant improvement in the first quarter of 2010, except for the Yorkshire Ambulance Service. Rotherham PCT fell below national average levels.

There is no significant variance between YAS and its comparators with significant improvement/convergence between 2007 and 2009.

Source: NHS I-view
Comparative average earnings trends by organisation type – Basic Pay

<table>
<thead>
<tr>
<th></th>
<th>2008 mid yr</th>
<th>2009 mid yr</th>
<th>2010 to Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham FT</td>
<td>£31,100</td>
<td>£32,300</td>
<td>£32,700</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber Small Acute (Barnsley)</td>
<td>£31,500</td>
<td>£32,200</td>
<td>£32,700</td>
</tr>
<tr>
<td>All Small Acute</td>
<td>£32,300</td>
<td>£33,200</td>
<td>£34,000</td>
</tr>
<tr>
<td>Rotherham PCT</td>
<td>£27,400</td>
<td>£28,300</td>
<td>£29,100</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber PCT</td>
<td>£28,900</td>
<td>£29,300</td>
<td>£30,000</td>
</tr>
<tr>
<td>All PCTs with MH</td>
<td>£29,400</td>
<td>£30,100</td>
<td>£30,800</td>
</tr>
<tr>
<td>RDASH</td>
<td>£26,200</td>
<td>£27,000</td>
<td>£27,500</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber MH</td>
<td>£28,900</td>
<td>£29,800</td>
<td>£30,400</td>
</tr>
<tr>
<td>All MH</td>
<td>£31,200</td>
<td>£32,000</td>
<td>£32,800</td>
</tr>
<tr>
<td>Yorkshire Ambulance</td>
<td>£31,400</td>
<td>£31,900</td>
<td>£30,500</td>
</tr>
<tr>
<td>All Ambulance Services</td>
<td>£31,000</td>
<td>£32,000</td>
<td>£31,800</td>
</tr>
</tbody>
</table>

The average basic pay calculation is the total basic salary bill divided by the whole time equivalent workforce numbers.

Although average basic pay has increased at the same rate in Rotherham compared to those in each sector, average basic pay in Rotherham remains below both Regional and National levels. This is particularly significant in RDASH, which may be as a result of a larger proportion of staff in band 2 than average. YAS average labour costs are below those of the comparator.

Source: NHS I-view
Comparative leaver rate by organisations – Qualified Nursing Staff

<table>
<thead>
<tr>
<th></th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>12 months to Jun 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham FT</td>
<td>3.95%</td>
<td>8.29%</td>
<td>7.46%</td>
<td>6.63%</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber Small Acute av. (Barnsley)</td>
<td>9.29%</td>
<td>9.00%</td>
<td>8.38%</td>
<td>7.37%</td>
</tr>
<tr>
<td>Total average NHS Small Acute</td>
<td>7.33%</td>
<td>10.07%</td>
<td>9.54%</td>
<td>9.40%</td>
</tr>
<tr>
<td>Rotherham PCT</td>
<td>4.84%</td>
<td>9.89%</td>
<td>11.54%</td>
<td>19.15%</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber PCTs average</td>
<td>6.26%</td>
<td>9.42%</td>
<td>9.28%</td>
<td>15.21%</td>
</tr>
<tr>
<td>Total average NHS PCTs</td>
<td>9.05%</td>
<td>12.55%</td>
<td>10.86%</td>
<td>12.62%</td>
</tr>
<tr>
<td>RDASH</td>
<td>4.06%</td>
<td>8.17%</td>
<td>10.21%</td>
<td>10.46%</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber MH average</td>
<td>5.55%</td>
<td>8.56%</td>
<td>9.18%</td>
<td>8.70%</td>
</tr>
<tr>
<td>Total average NHS MH</td>
<td>9.29%</td>
<td>10.35%</td>
<td>9.89%</td>
<td>10.33%</td>
</tr>
</tbody>
</table>

The qualified nursing leaver rate in all sectors appears to have risen sharply in 2008/09 and has continued to rise in Rotherham PCT and RDASH despite a national downturn.

High levels of turnover may indicate pressures in the workforce and capacity problems for the provider.

Source: NHS I-view
Comparative leaver rate by organisations – Allied Health Professionals

The Allied Health Professional leaver rate has risen particularly sharply amongst staff employed in Mental Health Trusts within the past three years. A similar rise was seen in small acute Trusts and PCTs although this stabilised in the last year.

Source: NHS I-view
## QIPP Metrics: Workforce

### Appendix 1 – QIPP Metrics

<table>
<thead>
<tr>
<th>WP1: PCT total payroll (millions £)</th>
<th>WP2: PCT total staff in Pool by organisation (number)</th>
<th>WP3: PCT annualised Av Basis Pay per FTE (Thousands £)</th>
<th>WP4: PCT sickness Absence rates (%)</th>
<th>WP5: PCT turnover using FTE (%)</th>
<th>WP6: PCT ratio of Clinical to Non-clinical staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fife</strong></td>
<td>Bergamini</td>
<td>11.4</td>
<td>2,125</td>
<td>28.4</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>Birmingham</strong></td>
<td>Birmingham</td>
<td>16.2</td>
<td>2,349</td>
<td>28.6</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Bolton</strong></td>
<td>Wigan &amp; Leigh</td>
<td>9.5</td>
<td>1,461</td>
<td>28.4</td>
<td>4.3</td>
</tr>
<tr>
<td><strong>Bradford &amp; Airedale</strong></td>
<td>29.3</td>
<td>1,038</td>
<td>-0.4%</td>
<td>28.3</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>Kingston upon Hull</strong></td>
<td>5.0</td>
<td>1,239</td>
<td>0.6%</td>
<td>28.4</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Leeds</strong></td>
<td>32.3</td>
<td>3,130</td>
<td>-1.4%</td>
<td>29.1</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>N Lincolnshire</strong></td>
<td>5.6</td>
<td>3,591</td>
<td>0.6%</td>
<td>28.1</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>N Yorkshire &amp; York</strong></td>
<td>27.2</td>
<td>1,425</td>
<td>0.3%</td>
<td>28.1</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Wakefield</strong></td>
<td>10.2</td>
<td>2,100</td>
<td>0.4%</td>
<td>28.1</td>
<td>5.2</td>
</tr>
</tbody>
</table>

### Appendix 1 – QIPP Metrics

<table>
<thead>
<tr>
<th>WP7: Acute trust total payroll (millions £)</th>
<th>WP8: Acute trust total staff in Pool by organisation (number)</th>
<th>WP9: Acute trust annualised Av Basis Pay per FTE (Thousands £)</th>
<th>WP10: Acute trust sickness Absence rates (%)</th>
<th>WP11: Acute trust turnover using FTE (%)</th>
<th>WP12: Acute trust ratio of Clinical to Non-clinical staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alfreds NHS Trust</strong></td>
<td>11.2</td>
<td>2,226</td>
<td>0.8%</td>
<td>27.3</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>Barnsley Hospital NHS FT</strong></td>
<td>18.7</td>
<td>2,394</td>
<td>-0.3%</td>
<td>28.0</td>
<td>4.0</td>
</tr>
<tr>
<td><strong>Bradford Teaching Hosp NHS FT</strong></td>
<td>36.8</td>
<td>4,171</td>
<td>0.6%</td>
<td>27.7</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>Calderdale &amp; Huddersfield NHS FT</strong></td>
<td>40.0</td>
<td>5,028</td>
<td>0.4%</td>
<td>27.1</td>
<td>4.6</td>
</tr>
<tr>
<td><strong>Doncaster &amp; Rotherham NHS FT</strong></td>
<td>45.0</td>
<td>6,309</td>
<td>0.7%</td>
<td>26.3</td>
<td>4.6</td>
</tr>
<tr>
<td><strong>Harrogate &amp; District NHS FT</strong></td>
<td>16.5</td>
<td>1,956</td>
<td>-0.4%</td>
<td>27.7</td>
<td>4.0</td>
</tr>
<tr>
<td><strong>Hull &amp; East Yorks NHS Trust</strong></td>
<td>97.0</td>
<td>7,076</td>
<td>0.3%</td>
<td>27.2</td>
<td>5.0</td>
</tr>
<tr>
<td><strong>Leeds Teaching Hosp NHS Trust</strong></td>
<td>111.6</td>
<td>13,821</td>
<td>-0.7%</td>
<td>27.7</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>Mid Yorkshire Hosp NHS Trust</strong></td>
<td>50.2</td>
<td>5,720</td>
<td>0.5%</td>
<td>26.7</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>N LINcolnshire &amp; Goole Hosp NHS FT</strong></td>
<td>38.9</td>
<td>5,320</td>
<td>1.0%</td>
<td>26.9</td>
<td>4.6</td>
</tr>
<tr>
<td><strong>Stourbridge &amp; NEC Orc NHS Trust</strong></td>
<td>14.6</td>
<td>1,821</td>
<td>0.3%</td>
<td>26.6</td>
<td>5.8</td>
</tr>
<tr>
<td><strong>Sheffield Children’s NHS FT</strong></td>
<td>15.9</td>
<td>1,800</td>
<td>0.3%</td>
<td>30.3</td>
<td>4.3</td>
</tr>
<tr>
<td><strong>Sheffield Teaching Hosp NHS FT</strong></td>
<td>36.0</td>
<td>1,228</td>
<td>0.4%</td>
<td>26.9</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>The Rotherham NHS FT</strong></td>
<td>23.0</td>
<td>2,911</td>
<td>3.3%</td>
<td>27.6</td>
<td>5.5</td>
</tr>
<tr>
<td><strong>York Hosp NHS FT</strong></td>
<td>30.3</td>
<td>3,663</td>
<td>0.7%</td>
<td>27.2</td>
<td>4.4</td>
</tr>
</tbody>
</table>

### Notes
- Indicator increased
- Indicator remained the same
- Indicator decreased
Commissioning Staff & Commissioner Hosted Shared Services *

July–September 2010 quarter

*Shared services include Commissioner hosted functions in Human Resources & Organisational Development, Financial Services, Intelligence & Performance, Public Health and Chief Executive’s Office.

This report excludes Provider hosted shared services. Due to small numbers of staff involved PALS and Health Advice Centre, part of NHSRCommissioner, are included with shared services.

Although the Provider/Commissioner split had not taken place at the beginning of the period, this report projects the reconfigured organisation structure back to April 2009.

Key Points

- 26 posts have been identified for voluntary redundancy and/or early retirement from September 2010 to June 2011. (Table 1 Staff in post)
- Continuing reduction in sickness absence rate (Table 2 Sickness Absence)
- Huge reduction in agency costs in 2010/11 to date (Table 6 Agency Costs)
1. STAFF IN POST and TURNOVER RATE

### FTE Staff in post 30 September 2010 (Head Count in brackets)

<table>
<thead>
<tr>
<th>Area</th>
<th>Management Cost posts</th>
<th>Non-Management Cost posts</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Execs Office + directors</td>
<td>16.15 (20)</td>
<td>7.00 (7)</td>
<td>23.15 (27)</td>
</tr>
<tr>
<td>Finance &amp; Contracting</td>
<td>42.49 (52)</td>
<td>3.38 (6)</td>
<td>45.87 (56)</td>
</tr>
<tr>
<td>Public Health &amp; Strategy</td>
<td>15.93 (20)</td>
<td>53.18 (72)</td>
<td>69.12 (93)</td>
</tr>
<tr>
<td>Strategy, Dev &amp; Planning</td>
<td>31.69 (37)</td>
<td>10.93 (13)</td>
<td>40.62 (48)</td>
</tr>
<tr>
<td>Intelligence &amp; Performance</td>
<td>30.45 (58)</td>
<td>0.00 (0)</td>
<td>30.45 (58)</td>
</tr>
<tr>
<td>Workforce/OD &amp; Governance + Risk Man &amp; HA Centre</td>
<td>8.68 (14)</td>
<td>5.4 (7)</td>
<td>14.08 (21)</td>
</tr>
<tr>
<td>External Funded</td>
<td>0.00 (0)</td>
<td>7.00 (7)</td>
<td>7.00 (7)</td>
</tr>
<tr>
<td>Commissioner &amp; Support Total</td>
<td>145.39 (201)</td>
<td>89.72 (113)</td>
<td>230.29 (310)</td>
</tr>
</tbody>
</table>

**Source:** Management Costs Forecast 2010/2011. This includes only the element of the post that remains in Commissioning Services and discounts any parts of the post that report to Provider Services.

### Leaver Rate June to September 2010

<table>
<thead>
<tr>
<th></th>
<th>Leavers</th>
<th>Head Count % Leaver</th>
<th>FTE % Leaver</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-June 2010</td>
<td>9</td>
<td>3.05%</td>
<td>3.03%</td>
</tr>
<tr>
<td>July-Sept 2010</td>
<td>14</td>
<td>3.99%</td>
<td>4.08%</td>
</tr>
</tbody>
</table>

Leaver Rate displayed as a quarterly figure to discern any patterns as a result of redundancies.

---

### Key Points:
- 26 posts identified for voluntary redundancy and/or early retirement from September to June 2011.

### Actions:
- Robust vacancy, grading and cost controls are in place.
- The quarterly leaver rate has increased in the past quarter, before any redundancies have taken place.
2. SICKNESS ABSENCE

Sickness Rates to 30th September 2010

<table>
<thead>
<tr>
<th>Area</th>
<th>Last Quarter</th>
<th>12 months to date</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioner &amp; Support Total</td>
<td>3.19%</td>
<td>2.88%</td>
<td>3.25%</td>
</tr>
<tr>
<td>Chief Exec Office</td>
<td>0.75%</td>
<td>0.96%</td>
<td>0.95%</td>
</tr>
<tr>
<td>Finance &amp; Contracting</td>
<td>3.97%</td>
<td>3.22%</td>
<td>3.40%</td>
</tr>
<tr>
<td>Public Health &amp; Strategy</td>
<td>1.75%</td>
<td>2.65%</td>
<td>3.84%</td>
</tr>
<tr>
<td>Strategy, Dev &amp; Planning</td>
<td>4.21%</td>
<td>3.96%</td>
<td>3.44%</td>
</tr>
<tr>
<td>Intelligence &amp; Performance</td>
<td>3.51%</td>
<td>2.13%</td>
<td>1.38%</td>
</tr>
<tr>
<td>Workforce/OD &amp; Governance + Risk Man &amp; HA Centre</td>
<td>3.98%</td>
<td>3.19%</td>
<td>2.80%</td>
</tr>
</tbody>
</table>

Key Points:

- Small fall in sickness absence overall with rates decreasing in some areas and increasing in others.

Planned actions:

- In light of the Operating Framework requirement for savings in management costs, all short and long term absence is being reviewed with a regular monthly report being made to managers and directors who were supported by HR to take appropriate action in individual cases where staff have hit sickness absence trigger points.
- The Board has recently agreed a 3% target for sickness absence. NHSR is on course at the moment albeit with the winter months to come.
3. INCIDENTS INVOLVING STAFF

All Personal Accidents to 30th Sep 2010

<table>
<thead>
<tr>
<th>Area</th>
<th>2010-11 to date</th>
<th>Serious 2009/10</th>
<th>Serious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Strat Planning</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shared Services</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

All Violent Incidents

<table>
<thead>
<tr>
<th>Area</th>
<th>2010-11 to date</th>
<th>Serious 2009/10</th>
<th>Serious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Strat Planning</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Shared Services</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Serious incidents are classified as red and amber using the PCT guidance matrix on classification of incidents. All red and amber incidents must be investigated further and appropriate action taken to minimize the possibility of further occurrence.

Key Points:

- There were only 3 recorded personal accidents involving Commissioner staff this quarter, none of them serious in nature.
- There have been no violent incidents in 2010/11 to date involving commissioner staff.

Planned actions:

- Health and Safety policies and guidance to be reviewed to reflect arrangements for the commissioner from April 2011.
### Ethnic Group Monitoring

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Staff in post</th>
<th>Local pop. 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>276</td>
<td>238.10 95.94</td>
</tr>
<tr>
<td>White Irish</td>
<td>3</td>
<td>1.06 0.43</td>
</tr>
<tr>
<td>White Other</td>
<td>5</td>
<td>1.31 0.53</td>
</tr>
<tr>
<td>Mixed White/Black Caribbean</td>
<td>0</td>
<td>0.35 0.14</td>
</tr>
<tr>
<td>Mixed White/Black African</td>
<td>0</td>
<td>0.10 0.04</td>
</tr>
<tr>
<td>Mixed White/Asian</td>
<td>2</td>
<td>0.49 0.20</td>
</tr>
<tr>
<td>Other mixed background</td>
<td>0</td>
<td>0.27 0.11</td>
</tr>
<tr>
<td>Indian</td>
<td>3</td>
<td>0.50 0.20</td>
</tr>
<tr>
<td>Pakistani</td>
<td>7</td>
<td>4.70 1.89</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0</td>
<td>0.03 0.01</td>
</tr>
<tr>
<td>Other Asian background</td>
<td>0</td>
<td>0.30 0.12</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1</td>
<td>0.18 0.07</td>
</tr>
<tr>
<td>Black African</td>
<td>2</td>
<td>0.18 0.07</td>
</tr>
<tr>
<td>Other Black background</td>
<td>1</td>
<td>0.04 0.02</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>0.30 0.12</td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>1</td>
<td>0.27 0.11</td>
</tr>
<tr>
<td>Total White</td>
<td>284</td>
<td>240.47 96.89</td>
</tr>
<tr>
<td>Total Non-White</td>
<td>18</td>
<td>7.71 3.11</td>
</tr>
<tr>
<td>Undefined/Not stated</td>
<td>2</td>
<td>-          -</td>
</tr>
<tr>
<td>Total</td>
<td>304</td>
<td>248.18 100.00</td>
</tr>
</tbody>
</table>

### Key Points:
- Overall staff Ethnicity matches local population with higher percentage of non-white staff compared to local population.
- There is a small underrepresentation in some groups, including Pakistani, although actual numbers are small.

### Planned actions:
- A single Equality Scheme, to replace existing stand-alone Race, Disability and Gender Equality Schemes, was approved by board in March 2010, and the associated action plan was approved in May 2010.
3b. DIVERSITY MONITORING STAFF IN POST – Age, Gender and Disability

### Age Group

<table>
<thead>
<tr>
<th>Age Group (at 30th Sept 2010)</th>
<th>Staff in post</th>
<th>Local pop. 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>1</td>
<td>0.33</td>
</tr>
<tr>
<td>20-24</td>
<td>8</td>
<td>2.63</td>
</tr>
<tr>
<td>25-29</td>
<td>28</td>
<td>9.21</td>
</tr>
<tr>
<td>30-34</td>
<td>32</td>
<td>10.53</td>
</tr>
<tr>
<td>35-39</td>
<td>46</td>
<td>15.13</td>
</tr>
<tr>
<td>40-44</td>
<td>49</td>
<td>16.12</td>
</tr>
<tr>
<td>45-49</td>
<td>48</td>
<td>15.79</td>
</tr>
<tr>
<td>50-54</td>
<td>59</td>
<td>19.40</td>
</tr>
<tr>
<td>55-59</td>
<td>22</td>
<td>7.24</td>
</tr>
<tr>
<td>60-64</td>
<td>8</td>
<td>2.63</td>
</tr>
<tr>
<td>65+</td>
<td>3</td>
<td>0.99</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>304</strong></td>
<td><strong>1.00</strong></td>
</tr>
</tbody>
</table>

### Gender

<table>
<thead>
<tr>
<th>Gender (at 30th Sept 2010)</th>
<th>Staff in post</th>
<th>Local pop. 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>87</td>
<td>28.62</td>
</tr>
<tr>
<td>Female</td>
<td>217</td>
<td>71.38</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>304</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

### Disability

<table>
<thead>
<tr>
<th>Disability (at 30th Sept 2010)</th>
<th>Staff in post</th>
<th>Local pop. 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability/Limiting long-term illness</td>
<td>16</td>
<td>5.26</td>
</tr>
<tr>
<td>Not declared/No</td>
<td>288</td>
<td>94.74</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>304</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

Includes all staff with substantive contracts

---

**Key Points:**

- Majority of Commissioner & Shared Services staff in 36-54 age band, with under-representation below 20 and over 60.
- Males under-represented by a large amount, not dissimilar to the NHS as a whole (75.4% female, 24.6% female nationally at Feb 2010).
- Small under-representation of disabled persons in workforce.

**Planned actions:**

- Age discrimination legislation and related employment policies support the employment of an older workforce.
- Advertisements for NHSR jobs encourage applications from disabled persons.
4. EMPLOYEE RELATIONS ACTIVITY

Commissioner and Shared Services 2007 – 2010 to date

<table>
<thead>
<tr>
<th>Action</th>
<th>2008</th>
<th>2009</th>
<th>2010 to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disciplinary procedures</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Bullying &amp; Harassment</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Grievances</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ill-health retirements &amp;</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>resignations *</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Expanded to include ill-health resignations

Key Points:
- 2 disciplinary procedures commenced in September 2010 concerning IT processes.

5. LEARNING AND DEVELOPMENT

Commissioner & Shared Services Welcome Induction compliance update

<table>
<thead>
<tr>
<th>Oct-Dec 09</th>
<th>Nov-Dec 09</th>
<th>% Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>7</td>
<td>70%</td>
</tr>
<tr>
<td>11</td>
<td>9</td>
<td>82%</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>80%</td>
</tr>
</tbody>
</table>

Key Points:
- This will be the final report on Induction attendance as no new starters are anticipated in Commissioning from now on. Anyone who does so will receive an informal induction from the Learning & Development Department.
- Local Inductions appear to have been carried out less frequently than Welcome Inductions, although this may be because they are not being recorded appropriately on ESR as per the written procedure on the web page. This has been, and will continue to be followed up with managers and ESR Self-Service users.

Commissioner & Shared Services Local Induction compliance update

<table>
<thead>
<tr>
<th>Oct-Dec 09</th>
<th>Nov-Dec 09</th>
<th>% Recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>4</td>
<td>40%</td>
</tr>
<tr>
<td>11</td>
<td>5</td>
<td>45%</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>10%</td>
</tr>
</tbody>
</table>

No new starters
6. AGENCY COSTS

**Commissioner spend**

<table>
<thead>
<tr>
<th>Account</th>
<th>Total spend 09/10</th>
<th>Apr-Sep 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>T/P Project Dev Officer - Admin &amp; Clerical</td>
<td>£11,955.70</td>
<td>£54.70</td>
</tr>
<tr>
<td>Chief Executive – Medical Recharge</td>
<td>£450.00</td>
<td>-</td>
</tr>
<tr>
<td>Corporate Business Finance A&amp;C</td>
<td>£6,795.89</td>
<td>-</td>
</tr>
<tr>
<td>Financial Services A&amp;C</td>
<td>£7,074.36</td>
<td>-</td>
</tr>
<tr>
<td>HR Directorate A&amp;C</td>
<td>£5,904.38</td>
<td>-</td>
</tr>
<tr>
<td>IM&amp;T Policy &amp; Op. services A&amp;C</td>
<td>£91,606.63</td>
<td>£16,707.73</td>
</tr>
<tr>
<td>IM&amp;T Strategy &amp; Dev A&amp;C</td>
<td>£114,903.80</td>
<td>£7977.36</td>
</tr>
<tr>
<td>IM&amp;T Education, Training &amp; Dev. A&amp;C</td>
<td>£3,990.00</td>
<td>-</td>
</tr>
<tr>
<td>IM&amp;T Application &amp; Development</td>
<td>£2355.00</td>
<td>-</td>
</tr>
<tr>
<td>FACT Information A&amp;C</td>
<td>£725.33</td>
<td>-</td>
</tr>
<tr>
<td>Public Health/Health Promotion</td>
<td>£25,757.19</td>
<td>£1182.87</td>
</tr>
<tr>
<td>Clinical Effectiveness medical</td>
<td>£225.00</td>
<td>-</td>
</tr>
<tr>
<td>Director of Dental Public Health</td>
<td>£10,624.60</td>
<td>-</td>
</tr>
<tr>
<td>PH Prescribing Agency</td>
<td>£2,276.40</td>
<td>-</td>
</tr>
<tr>
<td>Strategic Planning &amp; Development A&amp;C</td>
<td>£16,458.62</td>
<td>-</td>
</tr>
<tr>
<td>Strategic Planning Programmes A&amp;C</td>
<td>£199.40</td>
<td>-</td>
</tr>
<tr>
<td>Medical Adviser</td>
<td>£12,960.00</td>
<td>£3240.00</td>
</tr>
<tr>
<td>Drug Strategy Team A&amp;C</td>
<td>£21,239.72</td>
<td>£258.57</td>
</tr>
<tr>
<td><strong>Total to Date</strong></td>
<td><strong>£333,147.02</strong></td>
<td><strong>£31,776.30</strong></td>
</tr>
</tbody>
</table>

**Key Points:**

- This half-year has seen a vast reduction in agency costs from previous periods.
- A 30% Reduction in Agency spend by 2012/14 is a requirement of the Operating Framework along with a need to ensure that external management consultancy is only used when there are no other options. These costs should therefore be reduced in line with other management costs, although in some cases this might be counter-productive to reducing recurrent management costs.
# NHS Rotherham

**Board 15 November 2010**

**Pharmacy Services Available over the Lunchtime Period in the Rotherham area**

<table>
<thead>
<tr>
<th>Contact Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lead Director:</strong> Kath Atkinson</td>
</tr>
<tr>
<td><strong>Title:</strong> Director of Strategic Planning</td>
</tr>
</tbody>
</table>

## Purpose:

To inform the NHS Rotherham Board of pharmacy services during the lunchtime period in the Rotherham area. Details are given at Appendix 1.

## Recommendations:

The NHS Rotherham Board is requested to note the availability of pharmacy services during the lunchtime period in the Rotherham area.

## Background:

A patient recently highlighted a problem regarding being unable to get a prescription dispensed in a neighbouring PCT area over the lunchtime period. As a result NHS Rotherham requested every pharmacy in its area to provide details of whether they closed over lunch-time, and signposting arrangements in the event of a closure.

## Analysis of Risks:

It is essential that patients with urgent prescriptions are able to have them dispensed in a timely manner without having to travel too far to access pharmaceutical services. All geographical areas are covered with the exception of Thorpe Hesley, Greasbrough, Canklow, Stag, Thrybergh and Kilnhurst. In these cases, patients are signposted to the next nearest open pharmacy.

## Return on Investment:

Availability of pharmacy services is paramount in maintaining the health of the population of Rotherham.

## Analysis of Key Issues:

From the exercise carried out it was noted that 33 out of the 57 (i.e.58%) the pharmacies in the NHS Rotherham area do not close over lunchtime. Of those that do close, an indication of the next nearest pharmacy which is open is posted on the door. Clear signposting arrangements are in place for those pharmacies which do have a lunch-break.
<table>
<thead>
<tr>
<th><strong>Patient, Public and Stakeholder Involvement:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients are affected by the availability of pharmacy services. If patients make NHS Rotherham aware of potential problems, they can be investigated and resolved expediently</td>
</tr>
<tr>
<td><strong>Equality Impact:</strong></td>
</tr>
<tr>
<td>NHS Rotherham has a diverse number of independent and multiple pharmacies</td>
</tr>
<tr>
<td><strong>Financial Implications:</strong></td>
</tr>
<tr>
<td>There are no financial implications for the PCT associated with pharmacy lunchtime openings / closures</td>
</tr>
<tr>
<td>Approved by: John Doherty</td>
</tr>
<tr>
<td><strong>Human Resource Implications:</strong></td>
</tr>
<tr>
<td>Staffing associated with pharmacy lunch-time openings is the responsibility of the pharmacist</td>
</tr>
<tr>
<td>Approved by: Peter Smith</td>
</tr>
<tr>
<td><strong>Procurement:</strong></td>
</tr>
<tr>
<td>There are no formal procurement exercises associated with lunch-time openings</td>
</tr>
<tr>
<td>Approved by: Doug Hershaw</td>
</tr>
<tr>
<td><strong>Key Words:</strong></td>
</tr>
</tbody>
</table>
| Pharmacy Panel applications  
The National Health Service (Pharmaceutical Services) Regulations 2005, Information for Primary Care Trusts revised 2009  
Necessary and Expedient  
Choice and Competition |
| **Further Sources of Information:** |
| The National Health Service (Pharmaceutical Services) Regulations 2005, Information for Primary Care Trusts revised 2009 |
## Appendix 1

**NHS Rotherham**

**Mapping of Pharmacy Lunchtimes**

### Town Centre

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Location</th>
<th>Lunch Break</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicx</td>
<td>RCHC</td>
<td>No lunch break</td>
</tr>
<tr>
<td>Boots</td>
<td>Howard Street</td>
<td>Half hour break</td>
</tr>
<tr>
<td>Cryer</td>
<td>Kenneth Street</td>
<td>No lunch break</td>
</tr>
<tr>
<td>Lloyds</td>
<td>Doncaster Gate</td>
<td>No lunch break</td>
</tr>
<tr>
<td>Superdrug</td>
<td>The Cascades</td>
<td>No lunch break</td>
</tr>
<tr>
<td>Tesco</td>
<td>Forge Island</td>
<td>No lunch break</td>
</tr>
<tr>
<td>Vantage</td>
<td>Howard Street</td>
<td>No lunch break</td>
</tr>
</tbody>
</table>

### Eastwood / Dalton

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Location</th>
<th>Lunch Break</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asda</td>
<td>Aldwarke Road</td>
<td>1pm – 2pm</td>
</tr>
<tr>
<td>Rowlands</td>
<td>York Road</td>
<td>No lunch break</td>
</tr>
<tr>
<td>Lloyds</td>
<td>Dalton</td>
<td>No lunch break</td>
</tr>
</tbody>
</table>

### Thorpe Hesley

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Location</th>
<th>Lunch Break</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-operative</td>
<td>Sough Hall Avenue</td>
<td>1pm – 2pm Signpost on to next nearest open pharmacy</td>
</tr>
</tbody>
</table>

### Clifton

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Location</th>
<th>Lunch Break</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lloyds</td>
<td>Doncaster Road</td>
<td>No lunch break</td>
</tr>
<tr>
<td>Lloyds</td>
<td>Badsley Moor Lane</td>
<td>No lunch break</td>
</tr>
</tbody>
</table>

### Greasbrough

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Location</th>
<th>Lunch Break</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lloyds</td>
<td>Fenton Road</td>
<td>12noon – 1pm Signpost on to next nearest open pharmacy</td>
</tr>
</tbody>
</table>

### Kimberworth

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Location</th>
<th>Lunch Break</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lloyds</td>
<td>Kimberworth Park</td>
<td>2pm – 2.30pm</td>
</tr>
<tr>
<td>Lloyds</td>
<td>Kimberworth Road</td>
<td>1pm – 2pm</td>
</tr>
<tr>
<td>Winterhill</td>
<td>Fellowsfield Way</td>
<td>No lunch break</td>
</tr>
</tbody>
</table>

### Canklow

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Location</th>
<th>Lunch Break</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherchem</td>
<td>Canklow Road</td>
<td>1pm – 2pm Signpost on to next nearest open pharmacy</td>
</tr>
</tbody>
</table>

### Stag

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Location</th>
<th>Lunch Break</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Local Boots</td>
<td>Herringthorpe Valley Road</td>
<td>1pm – 2pm Signpost on to next nearest open pharmacy</td>
</tr>
</tbody>
</table>

### Broom

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Location</th>
<th>Lunch Break</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whitworths</td>
<td>Broom Lane</td>
<td>12.45pm – 2.15pm</td>
</tr>
<tr>
<td>Whitworths</td>
<td>Broom Valley</td>
<td>1pm – 2.15pm</td>
</tr>
<tr>
<td>Location</td>
<td>Pharmacy</td>
<td>Opening Hours</td>
</tr>
<tr>
<td>----------</td>
<td>----------</td>
<td>---------------</td>
</tr>
<tr>
<td>Whiston</td>
<td>Brookside</td>
<td>Whiston</td>
</tr>
<tr>
<td>Treeton / Catcliffe / Brinsworth</td>
<td>Cohens</td>
<td>Treeton</td>
</tr>
<tr>
<td></td>
<td>Weldricks</td>
<td>Brinsworth</td>
</tr>
<tr>
<td></td>
<td>Weldricks</td>
<td>Catcliffe</td>
</tr>
<tr>
<td>Wickersley / Ravenfield</td>
<td>Co-operative</td>
<td>Wickersley HC</td>
</tr>
<tr>
<td></td>
<td>Co-operative</td>
<td>Bawtry Road</td>
</tr>
<tr>
<td></td>
<td>Co-operative</td>
<td>Ravenfield</td>
</tr>
<tr>
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<tr>
<td></td>
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<td>Dinnington / Laughton Common</td>
<td>Lloyds</td>
<td>New Street</td>
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<td>Laughton Road</td>
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<td>Maltby</td>
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<td>Laburnum Parade</td>
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<td>Maltby HC</td>
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<tr>
<td></td>
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<tr>
<td>Aston / Swallownest</td>
<td>Lloyds</td>
<td>Hepworth Drive</td>
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<tr>
<td>Kiveton Park / Wales</td>
<td>Lloyds</td>
<td>Wales Road</td>
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<td></td>
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<td>Wales</td>
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<tr>
<td>Parkgate Retail World</td>
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<td></td>
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<tr>
<td>Boots</td>
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<tr>
<td>Stadium Way</td>
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<tr>
<td>Half hour break between 1pm and 2pm</td>
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<td>Morrisons</td>
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<tr>
<td>Stadium Way</td>
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<table>
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<tr>
<td>Weldricks</td>
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<tr>
<td>Claypit Lane</td>
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<tr>
<td>1pm – 2pm</td>
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<tr>
<td>Weldricks</td>
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<td>Thorogate</td>
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<tr>
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<tr>
<td>Vantage</td>
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<tr>
<td>Bellows Road</td>
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<td>Morrisons</td>
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<td>Cortonwood</td>
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<td>Co-operative</td>
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<tr>
<td>Park Lane</td>
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<td>1pm – 2pm</td>
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<tr>
<td>Signpost on to next nearest open pharmacy</td>
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<td>Church Street</td>
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<td>Tesco</td>
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<tr>
<td>Biscay Way</td>
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<tr>
<td>Highthorn Road</td>
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<td>1pm – 2pm</td>
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<td>Signpost on to next nearest open pharmacy</td>
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<tr>
<td>Crown Street</td>
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<tr>
<td>12.30pm – 1.30pm</td>
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<td>Weldricks</td>
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<tr>
<td>Church Street</td>
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Title of Meeting: AUDIT COMMITTEE
Time: 9.30am
Date: Thursday 9 September 2010
Venue: Cedar Room, G.02
Reference: JG/CE/wac
Chairman: Mr John Gomersall

Present
John Gomersall, and Rekha Kapoor

Attending
Chris Edwards Director of Finance & Contracting
John Pannell Audit Manager, Audit Commission
Jonathan Idle Head of Internal Audit, SYNDAS
Kate Pilling Audit Manager, SYNDAS
Pauline Fryer Director of OD, Workforce & Governance
Alan Tenanty Board Secretary
Wendy Commons Minute Taker

39/10 APOLOGIES
Damian Murray, Mark Bishop, Stephen Wood

40/10 MINUTES OF MEETING HELD ON 3 JUNE 2010
The minutes of the meeting held on 3 June 2010 were accepted as a true and accurate record subject a small amendment to note the title of the correct title of the Governance, Quality and Risk Committee.

41/10 MATTERS ARISING
30/10 – John Gomersall advised that following Mark Bishop’s work with NHSR Communications Team an article had been placed in the local paper highlighting fraud issues.

42/10 EXTERNAL AUDIT PROGRESS REPORT
John Pannell reported that all audit fieldwork on the 2009/10 audit plan had been completed. The Annual Audit Letter for 2009/10 was being prepared and would be presented at the next meeting.

John advised members of the proposed new approach to local value for money audit work that would apply from 2010/11. In future auditors would give their statutory value for money conclusion based on the PCT’s arrangements in place to secure economy, efficiency and effectiveness. These changes reflect the PCTs duty to improve efficiency and productivity and cut costs over the next three years. Auditors would therefore be planning their VFM audit work programme based on a local audit risk assessment. It was noted that this new approach would mean a reduction in audit fees from 2011/12.

Members thanked John Pannell for setting out future arrangements and noted external audit progress.
43/10  **ANNUAL GOVERNANCE REPORT**

John Pannell presented the final version of the 2009/10 Annual Governance Report which had been presented to the Audit Committee in June.

Members noted the conclusion of the audit and the results of audit work for 2009/10.

44/10  **REVIEW OF INTERNAL AUDIT**

John Pannell presented the audit report undertaken to provide an independent review of the internal audit service provided to NHS Rotherham by South Yorkshire and North Derbyshire Audit Service (SYNDAS). The review assessed compliance with IA operational standards and focussed on audit strategy, management of audit assignments, due professional care, reporting and quality assurance based on the 2009/10 internal audit plan.

Members noted the results of the review indicated that SYNDAS were meeting the operational NHS Internal Audit Standards in all areas except Quality Assurance. However, the level of performance represented an improvement from the position found in the 2007 review.

Members acknowledged the improvements made in internal audit and noted the outcome of the report.

45/10  **USE OF RESOURCES 2009/10**

John Pannell presented NHS Rotherham’s Use of Resources assessment report. This concluded how well the PCT is managing and using its resources to deliver value for money and better and sustainable outcomes for local people. Members noted that NHS Rotherham’s themed scores were:

- Managing Finances: 3
- Governing the Business: 3
- Managing Resources: 2

John reported that, whilst the overall scores achieved remained the same as last year, progress had been made particularly in relation to the Workforce Planning part of the Managing Resources theme. However, with the introduction of a further review area to this theme - use of natural resources, the PCT had not had sufficient time in which to progress their action plan resulting in a score of one which had brought down the overall score in this area.

Chris Edwards confirmed a working group had been put in place to take forward a programme of issues.

John Gomersall advised that he would report the use of resources scores in his report to NHSR Board.
Members noted the report and were reassured that NHSR Officers were working towards addressing the improvements recommended.

**46/10 INTERNAL AUDIT PROGRESS REPORT**

Kate Pilling reported that 13 Audits had been completed since previously reporting. Kate drew attention to three audits that had been given an audit grade of D. Firstly Kate referred to the TPP SystmOne audit. Members were asked to note that the PCT had asked auditors to undertake this audit and had fully embraced the recommendations. Auditors had also been asked to return in November to chart progress made. Kate would provide a verbal update on this return visit in December.

Chris Edwards highlighted that NHS Rotherham had piloted the TPP System and were identifying issues for later users which were being corrected but were still ahead of others across the country.

Kate Pilling commended NHSR in their approach to working with Auditors on the issues identified.

Members went on to discuss the Payroll audit which had also been rated D. Kate explained that auditors had been unable to locate the files at RFT. The reason given at the time was that the Payroll department had moved offices. It was noted that the move had taken in September 2009 which was before the audit commenced in 2010. Auditors understood that the issue had since been resolved. A follow up of the payroll audit had been scheduled into the 2011/11 plan where the issues and actions taken would be reviewed.

The HR Recruitment audit had been rated D. Kate highlighted that the 09/10 review had taken place prior to the change in government which had resulted in a vacancy freeze in NHS Rotherham thereby rendering some of the recommendations now irrelevant. It was noted that this had been reflected in the action plan completion dates.

Kate reported that the audit plan was on course for completion within the days allocated.

Members noted that the majority of performance indicators were being achieved. Two new indicators had been added this year in relation to counter fraud. Discussion followed relating to counter fraud and John Gomersall suggested it may help to add an indicator to the commissioning reviews with GPs to gauge their awareness of how to raise fraud/corruption issues.

Members received and noted the Internal Audit Progress report.

**47/10 OUTSTANDING AUDIT RECOMMENDATIONS**

Kate Pilling informed members that there were no ‘red’ audit recommendations outstanding which was acknowledged was due to increased follow up by the Director of Finance to ensure officers responded. The Audit Committee acknowledged a positive stepped
change in responses in the past year.

Discussion followed regarding the appropriateness of resetting the target date for completion of audit actions where a risk had been rated as high. It was agreed that, in these cases, managers would be asked to justify and operational reason for the completion delay with a senior manager/Director asked to endorse.

Discussion followed regarding transferring of some services to other organisations. It was agreed that where possible, NHSR would ensure actions were completed or alternatively highlight the risks to receiving organisations.

Pauline Fryer advised that there had recently been a large increase in the number of Freedom of Information requests. NHS Rotherham were considering how to deal with the burden and reviewing the current process.

48/10 COUNTER FRAUD PROGRESS REPORT

Jonathan Idle presented the report for information. He highlighted that discussions taking place to review the process for investigations to ensure efficiency in the current climate and focus attention appropriately. Chris Edwards advised members that counter fraud was exempt from management costs.

Members received and noted the report.

49/10 AUDIT COMMITTEE HANDBOOK

Jonathan Idle advised members of the key issues arising from the revision of the NHS Audit Committee Handbook. He reported that the requirement for all NHS organisations to have an Audit Committee remained unchanged, the basic underlying principles that govern its roles and responsibilities remained the same.

Members noted that the self assessment had been revised and agreed to review a copy of it at the next meeting.

JI/JG

50/10 FUTURE GOVERNANCE ARRANGEMENTS AND MEETING DATES

Members were advised of the proposal to merge the Audit Committee with the Governance, Quality and Risk Committee to form a new Audit and Assurance Committee. Members noted that the inaugural meeting date of the new Audit & Assurance Committee would take place on 20th October 2010 and selected 9th December 2010 as their preferred option for the final Committee of 2010. Dates for 2011 would be agreed following the inaugural committee.

JG/WAC

51/10 AUDIT & ASSURANCE COMMITTEE DRAFT TERMS OF REFERENCE

John Gomersall presented the draft terms of reference for the new Audit & Assurance Committee. It was noted that the Chair of the Committee would be John Gomersall. Following discussion, members felt that an aspiration would be to include a GP in the full membership but
Action

JP/JI

52/10 ACCOUNTING TREATMENT OF REDUCED MANAGEMENT COSTS

Chris Edwards explained to the Committee that NHS Rotherham had asked Internal & External Audit to comment on their approach to reducing managing costs. The measures taken had been to impose strict controls on recruitment as well as offering part-time working, sabbaticals and the purchase of additional annual leave. Recently a voluntary redundancy scheme had been introduced. Chris advised that 24 expressions had been progressed to Remuneration and Terms of Service Committee for approval by Board in September. Four of the applications required SHA approval.

Members noted the response from the Audit Commission provided by John Pannell.

Confirmation of approval by way of the minutes from NHSR Board and Remuneration & Terms of Service Committee would be forwarded to John Pannell for information.

53/10 REVIEW OF YORKSHIRE & HUMBER SPECIALISED COMMISSIONING GROUP

Members noted the contents of the 2009/10 audit report undertaken by Audit Commission on behalf of the 14 Primary Care Trusts in the Consortium. It was acknowledged that the report provided reassurance for NHSR that arrangements were in place for audit and actions progressed.

Chris Edwards confirmed that the Specialised Commissioning Group provided management cost detail to each Primary Care Trust member.

54/10 PAYMENT BY RESULTS DATA ASSURANCE FRAMEWORK – INPATIENT AUDIT

John Pannell presented the above audit report that had been completed and issued in February 2010. It had been funded by NHS Rotherham and completed at Rotherham Foundation Trust. John advised that as in previous years a major part of the audit had been a substantive review of the accuracy of coding for a sample of 300 episodes of treatment. Testing had identified a low error rate of 4.3%. Members were reassured that coding arrangements were good but noted a couple of areas in the action plan still being progressed.

Chris Edwards advised that discharge letters had been included in CQUIN this year which would help further improve quality.

Audit Committee received and noted the report.
World Class Commissioning Panel Report

Members received the final report from the WCC assessment produced in May 2010 for assurance. Chris Edwards referred to the ‘amber’ rating for ‘sustainable financial position under different financial scenarios’ which had been challenged. This result was felt to have resulted from the way questions had been posed.

Audit Committee received the report and noted that there would be no further WCC assessments undertaken following recent government changes and White Paper announcements.

Transforming Community Services (TCS) Update

Chris Edwards gave an update on progress in relation to TCS. He advised that offer documents had been forwarded to receiving organisations in July. A key area was noted in relation to unaligned staff deciding where their future would be. Final proposals were due to be presented to the Shaping our Future Programme Board on 8th October with transfers expected to take place between 1 January 2011 and 31 March 2011. It was acknowledged that this was an ambitious timeframe.

Some of the governance and risk management issues were considered:

a. The risk register would be shared with External & Internal Audit Colleagues and discussions with them when best to involve their skills in this process.

b. John Gomersall felt it would be helpful to spend time at the December meeting to look at the risks in more detail and review them, with Auditors, to provide assurance.

c. It was agreed that the agenda from the Audit Committee and the Governance, Quality & Risk Committee needed to be reviewed to ensure they were merged and managed in line with the assurance cycle. A meeting would be arranged for NHSR Officers to review accordingly.

Audit Committee Self Assessment

John Gomersall tabled a copy of the Audit Committee Self Assessment that had been completed by members of the Audit Committee as routinely undertaken annually.

John highlighted some key areas where further progress could be noted since the completion of the assessment:

It was noted that the Chairman of the Audit Committee was providing a written report to NHSR Board;

the Committee had considered the role of ‘Company Secretary’ but were satisfied with the present arrangements for secretarial support;

the merging of the Audit and Governance, Quality & Risk Committees would provide better assurance for governing risk;
Members acknowledged the progress made in relation to follow up actions to Auditors which had been an area where they felt timeliness could be improved; private discussions were held with External Audit and good, open relationships existed with Auditors.

Discussion followed in relation to the costs of the Committee and putting a value on these and whether they were appropriate to the perceived costs and benefits. Jonathan Idle agreed to consider this area and advise the Committee accordingly.

Jonathan Idle indicated that the Audit Committee Handbook was in the process of being reviewed. This included a revised Audit Committee Self Assessment checklist which Jonathan would forward to the Chair as some other areas for consideration had been added.

**UPDATE ON WORK WITH OTHER AUDIT COMMITTEES**

John Gomersall advised that he had attended a Joint Audit Committee held with RMBC to discuss Joint Service Centres and review the action plan from the recent report. It was acknowledged as an effective use of both Auditors and Audit Committee Members' time and John had been assured by the process. A regional Joint Audit Event was in the process of being planned.

A Rotherham Joint Audit Committee which included RMBC, Fire Service etc was planned for early October to look at sharing and the wider Rotherham picture.

John would also be meeting with the Chair of RMBC Audit Committee and the Directors of Finance at the end of September.

Jonathan Idle advised that SYNDAS were in the process of organising an audit event to take place in November. Invitations would follow.

**MINUTES OF GOVERNANCE, QUALITY AND RISK COMMITTEE**

Rekha Kapoor presented the minutes from the meetings held on 30 June 2010 and 18 August 2010. She highlighted that Dr David Plews had recently joined the Committee which had focussed members on clinical engagement issues. Rekha felt it important that this focus continued on the new Audit and Assurance Committee to provide assurance.

It was noted that the confidential section included detailed names in the minutes. Discussion followed regarding whether names should be changed to initials. Although it was acknowledged as important to disclose information to enable Committees to hold their discussions, it was agreed that this issue needed to be further discussed.

**ANY OTHER BUSINESS**

Following a recent government paper detailing the abolition of the Audit Commission after December 2012, John Pannell reassured members that work was underway in considering options for the continuation of the
audit practice in the future. In the meantime, the Audit Commission were committed to continuing to deliver quality service to its clients.

61/10 DATE AND TIME OF NEXT MEETING

For clarification – Meetings of Audit and Assurance Committee will be held on:

- **Weds 20 October 2010** at 12.30pm in Willow Rm 2.03
- **Thurs 9 December 2010** at 9.30am in Willow Rm 2.03
Yorkshire and the Humber Specialised Commissioning Group
Board Meeting - 24th September 2010

Decision Summary for PCT Boards

1. Policies:

**SCG 71/10**

General Commissioning Policies for Medicines and Treatments

*The following four policies were approved for adoption by the SCG:*-

(a) **Imatinib** for the adjuvant treatment of gastrointestinal stromal tumours - To be not routinely funded, in accordance with **NICE TA 196**

(b) **Capcitabine** for the treatment of advanced gastric cancer - To be routinely funded in accordance with **NICE TA191**

(c) **Rituximab** for the treatment of relapsed or refractory chronic lymphocytic leukaemia - To be routinely funded in accordance with **NICE TA193**

(d) **Gefitinib** for the first-line treatment of locally advanced or metastatic non-small-cell lung cancer - Update to regional policy 08/10 to reflect recently published **NICE TA192**

**SCG 72/10**

Evidenced-Based Commissioning (EBC) - Policies

*The following policies were approved for adoption by the SCG (category 2 in the EBC list)*

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<tr>
<th>Ref</th>
<th>Name</th>
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<tr>
<td>17/10</td>
<td>Armour Thyroid (thyroid tablets USP, Forrest Pharmaceuticals) and other non – UK licensed products - (Hypothyroidism)</td>
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<td>18/10</td>
<td>Bevacizumab (Avastin, Roche) – (Metastatic Colorectal Cancer)</td>
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<td>19/10</td>
<td>Botulinum toxin type A (botox, Allergan; and all other brands) – (Hyperhidrosis)</td>
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<td>20/10</td>
<td>Botulinum toxin A (Available as Botox (allergen), Vistabel (Allergen), Dysport (lipsen), Xeomin (Merz pharma), Azzalure (Gelderma) – (Overactive Bladder)</td>
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<td>Botulinum toxin type A (Available as Botox (Allergen), Vistabel (Allergen), Dysport (lipsen), Xeomin (Merz pharma), Azzalure (Gelderma) – (Prophylaxis of Migraine)</td>
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<td>22/10</td>
<td>Botulinum toxin A (Available as Botox (Allergen), Vistabel (Allergen), Dysport (lipsen), Xeomin (Merz pharma), Azzalure (Gelderma Ltd) – (Anal Tissues)</td>
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<td>23/10</td>
<td>Cetuximab (Erbitux, Merck) – (Metastatic Colorectal Cancer)</td>
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<td>24/10</td>
<td>Co-careldopa 2000mg/500mg intestinal gel for administration via PEG tube – (Parkinson's Disease)</td>
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<td>25/10</td>
<td>Penile Prostheses – (Erectile Dysfunction)</td>
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<td>Gemcitabine IV infusion (Gemzar, Eli Lilly) Capecitabine 150mg or 500mg tablets (Xeloda, Roche) – (Pancreatic Cancer)</td>
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<tr>
<td>27/10</td>
<td>Infliximab – (Hidradenitis Supportiva)</td>
</tr>
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</table>
28/10  Mecasermin (Increlex, Ipsen) – (Growth Failure)
29/10  Rituximab – (SLE)
30/10  Sacral Nerve Stimulation [SNS] (Sacral Nerve Neuromodulation) – (Urinary retention/urinary urge incontinence/faecal incontinence/chronic constipation)
31/10  Spinal Cord Stimulation (neuromodulation) – (Intractable Chronic Pain)

(b)  The following policies were approved for adoption by the constituent PCTs of the Yorkshire & the Humber SCG unless a PCT is able to inform the SCG why they should not adopt a specific policy (category 3 in the EBC list).

- Mecasermin 4mg or 8mg tablets (Increlex, Ipsen) – (Growth Failure)
- Rituximab – (SLE)
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- Spinal Cord Stimulation (neuromodulation) – (Intractable Chronic Pain)
Yorkshire and the Humber Specialised Commissioning Group

Minutes of the meeting held on
Friday, 24 September 2010
Sandal Rugby Club

Present:
Ailsa Claire Chief Executive (Chair) NHS Barnsley
Steve Wainwright Director of Strategy & Contracting NHS Barnsley
Steve Hackett Director of Finance NHS Barnsley
Annette Laban Chief Executive NHS Doncaster
Andy Buck Chief Executive NHS Rotherham
Jan Sobieraj Chief Executive NHS Sheffield
Ann Ballarini Director of Strategy & Commissioning NHS Wakefield
Carol McKenna Director of Commissioning NHS Kirklees
Jayne Brown Chief Executive NHS North Yorkshire & York
Simon Morriss Chief Executive NHS Bradford & Airedale
John Lawlor Chief Executive NHS Leeds
Debbie Graham Director of Business Intelligence NHS Calderdale
Ivan Ellul Chief Executive NHS East Riding
Julia Mizon Assistant Director – Contracting and Performance NHS Hull
Caroline Briggs Director of Strategic Commissioning & Development NHS North Lincolnshire
Sue Rogerson Director of Collaborative Commissioning North East Lincolnshire Care Trust Plus

In Attendance:
Cathy Edwards Director Yorkshire & the Humber SCG
Kevin Smith Medical Advisor Yorkshire & the Humber SCG
Lisa Marriott Assistant Director of Commissioning Yorkshire & the Humber SCG
Frances Carey Deputy Director of Finance Yorkshire & the Humber SCG
Paul McManus Lead Pharmacy Advisor Yorkshire & the Humber SCG – from item 49/10
Laura Sherburn Deputy Director of Commissioning – Specialised Services Yorkshire & the Humber SCG
Pia Clinton- Asst Director of Commissioning – Specialised Services Yorkshire & the Humber SCG
Tarestad Specialised Services
Ged McCann Associate Director of Commissioning – Specialist Mental Health Yorkshire & the Humber SCG
Paul Crompton Business Manager Yorkshire & the Humber SCG

SCG Apologies
62/10
Maddy Ruff Director of Commissioning NHS Hull
Graham Wardman Director of Performance NHS Calderdale
Declarations of Interest

There were no declarations of interest.

Minutes of the Meeting held on Friday 23rd July 2010

The minutes of the meeting held on the 23rd July 2010 were accepted as a true and accurate record.

Matters Arising

(a) Paediatric Critical Care Services

The meeting was informed that there was an improving position with regard to this matter. The five PICU beds at Sheffield had re-opened on the 2nd August and the middle grade training staff rota was much improved. EMBRACE was now providing full cover with effect from the beginning of September. However, there was still some risk in the system with regard to consultant staffing.

(b) Paediatric Standards

The exercise for undertaking a stock-take against the standards was now in progress and due to be completed by the 31st October. Mid Yorkshire and Harrogate hospitals had yet to nominate a representative for this. The results from the exercise would be reported to the SCG Board meeting in November.

(c) Paediatric Cardiac Surgery Update

Cathy Edwards gave a briefing on the background to the article which had appeared in last week’s ‘Sunday Telegraph’ newspaper in relation to paediatric cardiac surgery. The article had been developed following a statistical analysis of the Central Cardiac Audit Database (CCAD) information looking at the expected and actual deaths at Oxford between 2000 and 2008. Using similar data from across the country, three other centres were identified as potential areas for concern, one of which was Leeds.


There had been problems at Leeds in the middle period with regard to one particular procedure, but these had been addressed, and the latter period clearly evidenced an improvement.

The national SCT in conjunction with Sir Ian Kennedy were now
considering requesting further information from each of the three providers regarding their mortality and morbidity meetings; both the process and the clinical outcomes. This information would enable assurance to be provided to both the public and the NHS about the standard of current services. This information would also feed into the ongoing review of paediatric cardiac surgery.

Kevin Smith stated that he had reviewed the Leeds data from 2008 onwards and the processes that were now in place. He had been able to provide the national SCT with reassurance that Leeds had very good processes in place that would immediately register any abnormalities in outcomes. Leeds was not in the same position as Oxford.

Cathy Edwards highlighted that the matter needed very careful management.

It was noted that public consultation on the full review would not start until early 2011.

It was agreed that a position statement and briefing note be circulated to PCTs for information and to ensure a consistent position. Enquiries regarding the matter should be directed to Cathy Edwards.

(d) Neonatal Task Force Implementation

It was reported that progress was being made with regard to neonatal surgery and intensive care in Sheffield where currently there were two Trusts involved with provision. There had been a discussion involving the two Trusts where it had been agreed that it was not practical or deliverable to consider moving one of the services to colocate with the other. However it had been agreed to review the standard of care provided in neonatal surgery at Sheffield Children’s Hospital to ensure consistency with the main neonatal services in Sheffield Teaching Hospitals Foundation Trust.

SCG 66/10 Financial Plan 2010/11 – 2011/12 Update on Progress

Frances Carey presented a summary of the report to the meeting.

The last 2010/2011 financial plan paper presented to the Board was in May 2010 at which point the financial plan was signed off subject to finalisation and agreement of contract values.

The financial plan was split into 2 elements, financial values for those elements that needed to be placed into contracts from the 1 April 2010 and financial values for those elements where the cost related to in year growth predictions.

The SCT recommendation was that the growth horizon scanning funding
would be required in 2010/2011 however as the timing of these investments were not known this was at the discretion and risk of the PCTs as to whether funding was set aside for these elements.

At the time of writing the report all secure services and all but a few of the national contracts were signed. A number of local contracts were agreed and contract documentation sent out for signature. An update on the main local contracts was attached. The situation with regards the SCG element mirrored the issues facing PCTs for the non specialised elements of the contracts.

A reconciliation of the original financial plan to the 2010/11 actual financial plan would be presented to the SCG Board meeting in October.

With regard to the 2011/12 financial plan, baseline information and horizon scanning information would be forwarded to PCTs next week.

A confirm and challenge event was being held with PCTs in October. There was a discussion on the correct percentage to include for efficiency savings, the SHA figure of 3.5% appeared to have been modified and the actual figure being used by PCTs was above this figure.

It was reported that providers of services had been forwarded a letter in August 2010, requesting that they use the correct YDD2 codes when recording SCG activity and costs. Only one provider to date was complying fully. It was the intention to forward a further letter indicating that PCTs/SCG would use the appropriate clauses in the contract to withhold part of the contract payments if the correct coding for SCG activity was not used.

It was agreed that the contents of the report be noted and the proposed actions with regard to ensuring that providers used the correct coding system be approved.

SCG 67/10 QIPP Programme Report

Laura Sherburn presented a summary of the QIPP programme and the first set of reports.

The SCG QIPP Programme was signed off in May 2010. The SHA undertook a subsequent review of the QIPP Programme in July 2010, and it was agreed that monitoring reports should be in place from September onwards. An SCG Programme Manager role has been sourced from the Commercial Procurement Collaborative. The reporting format was based on the salient elements of the SHA QIPP tracker used by PCTs. The Chief Executive sponsors for each project identified in May continued in these roles, and receive detailed briefings on the progress of their project from the SCT on a regular basis.

This first report contained details of all risks and milestones identified for the
19 SCG QIPP Projects, and an overall financial summary by project.

The original SHA reports were completed in May 2010 and since then there had been various events that had changed the scope and outcome of some of the QIPP Projects, these changes were identified in the milestones and risks in the report.

A brief summary of the most significant changes & risks were as follows:

(i) The morbid obesity surgical services project originally identified that a saving between £0-800k would be made in 2010/11. This would now not be achieved, as it was based on 7 PCTs currently operating different criteria to move to the current regional criteria in-year. These PCTs were now opting to make one move to the new regional criteria which were being developed within this overall project over a longer time frame.

(ii) The fertility project price negotiations had been completed however, the restrictions surrounding the agreement within the LTHT contract not to re-visit non-PbR prices in 2010-11, meant that the savings of £470k could not be realised in 2010/11.

(iii) The specialist mental health project had been delayed due to recruitment issues with NHS Barnsley host.

(iv) The finance resource to support the QIPP Programme agreed by SCG Board in July had not yet been identified, and as a result, the financial input to the projects to date had been compromised. This would not be sustainable as the projects were taken forward.

The principle for calculating individual monthly savings per PCT per project had been circulated for comment to the SCG Finance Network Group and Performance Monitoring Sub Group. The figures would be submitted via the individual PCT trackers to the SHA.

Concern was expressed about the slippage in the QIPP projects. It was agreed that there was a need to review the overall QIPP Programme, from a strategic perspective, to ensure appropriate focus and priorities. North Yorkshire and York PCT volunteered to assist in the review process.

It was agreed that:

(a) The QIPP programme summary, financial summary and 19 project highlight reports be noted

(b) The reports for submission to the SHA be approved

(c) A report be submitted to the October SCG Board following a further review of the programme to reduce/eliminate the slippage.

Laura Sherburn /
Low Secure Services Update

Ged McCann presented a report on low secure services and the activity commissioned on behalf of the Yorkshire & the Humber SCG. Information was provided for each PCT. The focus of the report was to draw attention to the patient pathway specifically at the interface between secure care and local mental health services. The information in the report was to assist individual PCTs in identifying opportunities to reduce the need for secure care, or reduce length of stay.

The secure services pathway was dependent on the whole patient pathway for it to work efficiently as a lack of local services would cause delays and extend the length of stay in secure care. To monitor the patient pathway the SCT had introduced standard pathway criteria which was in use across the secure services and case managers with Yorkshire & the Humber. The criteria attempted to classify a patient at all stages along their pathway and monthly reviews of all patient allowed the SCT to quantify delays and identify areas to improve efficiency.

A number of ‘bottlenecks’ in the pathway were identified in the report.

The report also went on to identify the specific issues in individual PCTs relating to the pathway.

It was agreed that the report be noted and that individual PCTs use the information to inform the approach to low secure services.

Low Secure Risk Share Update

It was agreed that this item be deferred to the next SCG Board meeting in October.

Pilot PIPE at HMP Hull

Ged McCann presented a report on the establishment of a pilot scheme at HMP Hull.

The National Personality Disorder Policy Team, which works cross departmentally between the DH and the Ministry of Justice (MoJ), had published a draft strategy for individuals with Personality Disorder (PD) and ‘high harm’ behaviour. The strategy proposed two parallel pathways for this population; one in health the other in the criminal justice system. The central tenet of the strategy was that those individuals with PD and ‘high harm behaviour’ should be treated within the prison system and only be transferred into the health system when there were co-morbidities (such as psychotic illness, autistic spectrum disorder or learning disability).
The strategy proposed the establishment of PD treatment centres within the prison estate within each region to underpin existing dangerous and severe PD (DSPD) provision and that those treatment centres should be supported by Psychologically Informed Planned Environments (PIPEs) within each region. Action was now being taken to establish a small number of pilots on both the male and female prison estate. The Secure Services Team had submitted an expression of interest. The application had been successful and HMP Hull would be establishing one of these pilot sites by the end of the year.

The development was essentially a prison venture but SCG would have oversight and would ensure that the service linked with the programme of PD focussed services in the region. The successful establishment of regional treatment centres and PIPEs within the prison estate would have significant implications for the secure hospital system which could see a substantial reduction in the number of men referred for specialist treatment.

It was agreed that the report and developments be noted.

**General Commissioning Policies for Medicines and Treatments**

The following four policies were proposed for adoption by the SCG:-

(a) *Imatinib* for the adjuvant treatment of gastrointestinal stromal tumours - To be not routinely funded, in accordance with NICE TA 196

(b) *Capecitabine* for the treatment of advanced gastric cancer - To be routinely funded in accordance with NICE TA191

(c) *Rituximab* for the treatment of relapsed or refractory chronic lymphocytic leukaemia - To be routinely funded in accordance with NICE TA193

(d) *Gefitinib* for the first-line treatment of locally advanced or metastatic non-small-cell lung cancer - Update to regional policy 08/10 to reflect recently published NICE TA192

The following notes for commissioners were provided:-

(a) Clarification of NICE TA 190 – pemetrexed for maintenance treatment of non-small cell lung cancer

The three cancer networks had identified different levels of use of pemetrexed in line with NICE TA 190.

These differences would be explored in an on-going review of cancer network treatment regimens being undertaken by the SCG Pharmacist Advisor and lead pharmacists for the three cancer networks.

Paul McManus
(b) **Review of regional policy 10/09 (rituximab for severe (refractory) rheumatoid arthritis)**

In view of changes to national policy in accordance with NICE TA 195, a review of regional policy 10/09 was proposed, to be facilitated by the Regional Policy Sub-Group.

Commissioners would need to be aware of the implications of NICE TA 195, which increased treatment options for patients with severe rheumatoid arthritis, and, in particular, recommended that abatement, which had previously not been supported by NICE, may be used in certain circumstances.

(c) **Imatinib for adjuvant treatment of gastrointestinal stromal tumours**

Commissioners were reminded that Imatinib was already funded, in accordance with NICE TA 86 (October 2004) for gastro-intestinal tumours that could not be removed surgically. This more recent appraisal related to use after surgery, which should not be funded.

(d) **Patient access scheme for gefitinib**

Commissioners were asked to note the patient access scheme for gefitinib and ensure that systems were in place to avoid payment for patients who discontinue therapy within the first 3 months.

It was agreed that:

(i) the key points for commissioners be noted;

(ii) the general policies for Imatinib, Capecitabine, Rituximab and Gefitinib as detailed in the report be approved for adoption; and

(iii) These policies be made available to the public in accordance with directions from the Secretary of State

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**SCG 72/10 Evidenced-Based Commissioning (EBC)**

The Evidence-Based Commissioning programme aims to support collaborative development by PCTs, using the SCG mechanisms. In conjunction with providers and clinical networks, a single process to quality assure, implement and monitor Evidence Based Commissioning policies for non-specialised drugs and interventions had been developed. It aims to deliver consistent written statements and policies, in accordance with directions from the Secretary of State (April 2009), for publication by PCTs. The group also horizon scans for potential future topics. By utilising this collaborative approach, it aims to ensure transparency and consistency, while sharing capacity and cost saving across the region.
The EBC programme links closely to the aims and objectives of the Regional Policy Sub-Group, and shares the same decision-making framework. However, it has a different focus, both in terms of the range of treatments considered, and the process for policy development. While the RPSG looks to prospectively develop policies for specialised or cancer medicines (and other areas of collaboration subject to agreement of SCG), EBC focuses on non-specialised treatments and, in its initial stages, provides a mechanism for PCTs to share existing commissioning policies that have been developed elsewhere in the region.

In the medium to long term, EBC will link with the RPSG to provide quality assurance. Until the RPSG is fully functional, SCG had asked that the first wave of EBC policies are developed using the regional policy template which will then be reviewed by a sub-group of the RPSG, and proposed to SCG via the Clinical Standards Sub-Group.

The EBC programme was divided into a number of waves of policy.

Wave one started with a stock-take of all PCT commissioning policies in the region. The author PCT was invited to review their policy, to ensure that it was still relevant, accurate, and reflected current evidence, and convert it into the regional policy template. These standardised policies were then submitted to the project team for review.

Policies were then scrutinised by a sub-group of the RPSG, who sought assurance that there had been the clinical input to the development of policies and they had been equality impact assessed.

The report set out a list of policies which were categorised as follows:

- Policies previously agreed by the SCG
- Policies recommended for adoption by SCG
- Policies recommended for the SCG – Primary Care Interface
- Policies requiring further work prior to recommendation
- Policies that were not recommended for adoption

In terms of the implementation much of this would be via local PCT processes, excepting these that relate to cancer drugs. The critical element was the need for consistency across the region and the need to avoid inappropriate use of the Individual Funding request (IFR) process).

It was agreed:

(a) In respect of the policies set out in the first two categories (pages 5-9 of the report), excepting the policies for Functional Electrical Stimulation (FES), hyperbaric oxygen therapy (HBOT) and occipital nerve stimulation (ONS) be approved for adoption as regional policies;
(b) In respect of the policies set out in category three (pages 10-12 of the report) that these be adopted by the constituent PCTs of the Yorkshire & the Humber SCG, unless a PCT was able to inform the SCG why they should not adopt a specific policy;

(c) That SCG Board members be circulated a note on the implementation procedures, including the uses of comparative information and benchmarking; and

(d) That appreciation be expressed to Paul McManus and the PCTs who had assisted in the development of the policies.

**Interim Cancer Drugs Fund**

The Secretary of State for Health had recently announced plans to establish a Cancer Drugs Fund from April 2011 to improve patient access to cancer drugs prior to the anticipated reform of arrangements for the pricing of branded medicines from 2014. Further details on this fund would be available in October following publication of the Comprehensive Spending Review. However, an interim fund of £50M had been identified from DH central budgets to provide in-year funding for cancer drugs from October 2010 to March 2011. This interim funding would be allocated at a regional level, based on weighted capitation, and made available through Strategic Health Authorities (SHA). The allocation for Yorkshire and the Humber SHA was expected to be around £5.3M.

The SHA Medical Director, Professor Chris Welsh, was leading arrangements for the distribution of the Interim Cancer Drugs Fund in Yorkshire and the Humber, in collaboration with YHSCG and the three cancer networks in the region. The SHA was proposing that operational management of the fund was undertaken by the Specialised Commissioning Team, with an appropriate increase in capacity.

Early estimates of the potential demands on the interim fund suggested that there may not be sufficient to fund all patients whose clinician was recommending treatment with a medicine that was not currently funded by the local NHS. The SHA therefore intended to work with local cancer clinicians to agree which treatments, not currently funded by the local NHS, should be priorities for the fund. Some contingency would also need to be agreed to fund treatments for rarer cancers and ‘off-label’ use of cancer medicines that were less easy to anticipate.

Professor Welsh had written to all cancer clinicians in the region explaining the fund and asking for support in its administration. In addition representatives from YHSHA, YHSCG and the three cancer networks had recently met to agree clinical involvement in deciding which treatments would be covered by the fund.

The Chair advised the meeting that the national Specialised Commissioning
Team had identified an underspend in 2010 and the share for Yorkshire and Humber would be £2m. It was felt appropriate that this be kept in reserve to help mitigate against the risks associated with the fund; particularly the associated treatment costs which were not covered by the Cancer Drug Fund.

It was anticipated that the clinical panel would take 6 weeks to identify the priority list, including patient numbers and activity.

Discussion identified that communication issues were critical to this matter. It was suggested that training for PCT chairs and Non-Executive Directors regarding the Interim Cancer Drug Fund would be required.

It was agreed:

(a) To note the proposed draft regional arrangements for the Interim Cancer Drug Fund and to support the direction of travel set out; and

(b) To endorse the need for PCTs and acute Trusts to establish procedures for the monitoring of the use of the fund and associated activity costs.

Reimbursement of Living Donor Expenses Policy

A report was presented to the meeting which advised that Department of Health Guidance states that reimbursement of living donor expenses is permitted, although the NHS is not legally obliged to do so. However, as renal transplantation is the most cost effective treatment for end stage renal failure (ESRF), payment of donor expenses incurred was justified.

The purpose of the discretionary reimbursement was to ensure that loss of earnings or other financial disincentives did not act as a constraint on individuals wishing to act as a live transplant donor.

Currently there were inconsistencies within the Yorkshire & the Humber region regarding reimbursement of living donor expenses.

The Yorkshire & the Humber Renal Network were therefore recommending the following:

(i) Consistency across NHS Trusts and Primary Care Trusts in the reimbursement of living donor expenses

(ii) Reimbursement of reasonable individual claims as outlined in the policy document

(iii) An agreed policy for reimbursement

(iv) An agreed claims process

It was agreed that the recommendation of the Renal Network relating to the
reimbursement of Living Donor Expenses be approved.

### Yorkshire & the Humber SCG Annual Report 2009/10

The final version of the Yorkshire & the Humber SCG Annual Report 2009/10 was presented to the meeting. A copy of the report would be put on the Y&H SCG website. PCTs were required to present the report to their Board meetings.

It was agreed that:

(a) The final version of the Y&H SCG Annual Report be approved and that this be placed on the web-site.

(b) The report be presented to PCTs Boards

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<th>SCG 75/10</th>
<th>SHA Review of SCG</th>
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<td>A letter from the Yorkshire and Humber Strategic Health Authority was presented to the meeting. The review took place on the 15th July 2010 and the main focus of the review had been the SCG commissioning strategy and the proposed SCG QIPP programme. The letter highlighted that the SCG had made many improvements over the last year and that the SCG QIPP programme would only be delivered if PCTs were actively involved in the process. It was agreed that the letter from the Y&amp;H SHA regarding the review of the SCG be noted.</td>
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<th>SCG 76/10</th>
<th>Exception Performance Report (to June 30th 2010)</th>
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<td>The exception performance report for the period up to the 30th June 2010 was presented to the meeting. The position at the end of June showed an underspend of £1.2m but there were a number of outstanding issues relating to contract baselines which needed to be resolved. The year end forecast was showing an overspend of £5.5m. Work was already in progress on challenging the position and obtaining a more accurate forecast. It was agreed that the exception report for the period up to the 30th June 2010 be noted.</td>
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<th>SCG 77/10</th>
<th>Risk Management of the Sheffield Teaching Hospitals Contract 2010/11</th>
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<td>Further to the Performance Monitoring Sub Group meeting on 16th August 2010, a report was presented to the meeting setting out the issues that caused a significant variance from the projected spend for 2009/10 and the</td>
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additional risks to the contract identified in respect of the Sheffield Teaching Hospitals contract. The report went on to set out the agreed actions to mitigate against a recurrence of the problem in 2010/11.

It was agreed that the contents of the report be noted and the proposed actions were endorsed.

**SCG Acute CQUINs Scheme Quarter 1 Results**

The SCG Acute CQUINs Scheme 2010-11 was endorsed by SCG at Board on 26th March 2010 and subsequently approved by the YHSHA. Following discussion with providers in an open Clinical Standards Sub-Group (CSSG) meeting a consensus version of the scheme, agreed by CSSG members, was endorsed by SCG on 28th May 2010.

There had been considerable work done in Q1 to ensure the indicators were fit for purpose, leading to some revisions to the schedule. Given these changes, and to ensure that improvement trajectories were based on the most robust data, it was therefore proposed that Q2 submissions would set baselines for all 7 indicators.

A revised schedule of the indicators was attached to the report setting out the changes.

It was made clear where narrative reports would be submitted to supplement the raw data.

It was also made clear that for those indicators where Q1 submission was not required, the principle of payment in Q1 was agreed only subject to submission in Q2; should submission of Q2 not be achieved, then Q1 payment would be repaid to commissioners.

The following revisions to indicators were proposed:

- **Indicator 1 (Lung Cancer):** it was proposed to go back to quarterly reporting of real-time data, instead of using published annual reports

- **Indicator 2 (BMT):** emphasis on learning from significant events rather than accrued rates

- **Indicators 3 & 4 (NIC & PIC):** improved definitions of indicators 3a and 3b were proposed, together with an agreed comprehensive indicator for both 3c and 4 which recognised the importance of network-level action

- **Indicator 5 (Cardiac):** improved definitions were proposed

The CSSG would continue work on the approval of baselines and setting of trajectories, throughout the coming months.
Learning from the experience of the short lead-in time for the 2010-11 scheme, it was recognised that work on the SCG Acute CQUINS scheme for 2011-12 must begin early. Therefore it was proposed that the CSSG would start to consider the priority areas for 2011-12 at their meeting in October, and, using the learning from this year, start to build up next year's scheme.

It was agreed that:

(a) The recommendations and revisions proposed by the CSSG in relation to the SCG Acute CQUIN scheme be approved;

(b) Q1 payments to all providers in respect of all indicators as per the schedule of CQUIN indicators be approved; and

(c) The planned work of the CSSG be noted

Action

Kevin Smith

SCG 80/10

Strengthening SCG Board Governance Arrangements

A report was presented to the meeting which set out the following information:

At the SCG Board meeting on 28 May it was agreed that a range of proposals to strengthen the SCG Board governance would be circulated for consideration by PCT Boards and PCT Executive Teams. The proposals included:

- Updating the Establishment Agreement to incorporate Version 3 of the Specialised Services National Definition Set (SSNDS), and an appendix clearly listing non-specialised areas for SCG Board collaboration

- Amending the Scheme of Delegation to delegate decisions relating to commissioning policy to SCG Board

- Strengthening the role of the SCG Patient and Public Involvement (PPI) Steering Group in providing assurance to SCG Board

- Incorporating non-executive challenge to SCG Board

- Changing the Chair of the Clinical Standards Sub-Group (CSSG)

Feedback had been received from the constituent PCT Boards on the proposals and these were sent out in an appendix to the report. The feedback had been incorporated in the recommendations and revised documentation that was presented for approval:

- Yorkshire and the Humber SCG Establishment Agreement
- Yorkshire and the Humber SCG Scheme of Reservation and Delegation
- Development/Adoption of Commissioning Policies – Clarification on level of Delegation
A discussion followed on the issue of transparency in the decision making process and the need for PCTs to adopt the SCG minutes at their Board meetings.

In conclusion it was agreed that:

(a) The revised Establishment Agreement which incorporated SSNDS version 3 and a list of non-specialised areas for collaboration be approved;

(b) The revised Scheme of Delegation incorporating the development/adoption of commissioning policies – clarification on the level of delegation, be approved;

(c) The PPI Steering Group terms of reference be amended as recommended in the report;

(d) Implementation of non-executive involvement be suspended;

(e) Nominations for a new Chair of the CSSG be considered later in the agenda;

(f) The revised terms of reference of the Sub-Groups be considered; and

(g) The minutes from the SCG Board meetings be presented to PCT Board meetings for adoption and that these minutes would be prefixed by a summary of the decisions.

Laura Sherburn

Action

Specialised Services National Definition Set – Update

A report was presented to the meeting setting out the implications of adopting the use of the Specialised Services National Definitions Set (SSNDS) 3rd Edition. The report summarised the major changes from the 2nd Edition:

- Removal of four definitions (14 HIV; 21 Learning Disabilities; 25 Pathology; 20 Hyperbaric Oxygen);

- Addition of three definitions (36 Metabolic Disorders; 37 Ophthalmology; 38 Haemoglobinopathy);

- Updates of other definitions with clearer descriptions of what elements of service require specialised commissioning;

- Removes elements of four definitions where number of providers exceeds 50 nationally (4 Fertility Treatments; 14 Angioplasty; 26 Almost all Adult Rheumatology; 30 much Vascular Surgery).

The report outlined key areas where the SCG currently commissions
services, which have been removed from the 3rd Edition definitions, but still merit regional commissioning.

It was agreed that:-

- The 3rd Edition of the Specialised Services National Definition Set be adopted as part of the Y&H SCG Establishment Agreement;

- The Y&H SCG continues to commission services which have been removed from the SSNDS which continue to merit regional commissioning (IVF Treatments; HIV, Principal Treatment Centres only; and Vascular Surgery & Interventional Radiology).

**SCG 82/10 Revised/Update Terms of Reference**

The following revised/updated terms of reference were presented to the meeting:-

(a) Clinical Standards Sub Group  
(b) Designation Sub Group  
(c) Performance Monitoring Sub Group  
(d) Regional Policy Sub Group

It was noted that a new chair of the Clinical Standards Sub Group was required.

It was agreed that:-

(a) The revised terms of reference for the Clinical Standards, Designation, Performance Monitoring and Regional Policy Sub Groups be approved; and

(b) John Lawlor be appointed as the Chair of the Clinical Standards Sub Group.

**SCG 83/10 Minutes of the Designation Sub Group**

The minutes of the Designation Sub Group meeting held on the 3rd August 2010 were presented to the meeting.

It was agreed that the minutes of the Designation Sub Group meeting held on the 3rd August 2010 be received.

**SCG 84/10 Minutes of the Performance Monitoring Sub Group**

The minutes of the Performance Monitoring Sub Group meeting held on the 16th August 2010 were presented to the meeting.

It was agreed that the minutes of the Performance Monitoring Sub Group
meeting held on the 16th August 2010 be received.

SCG 85/10  
Minutes of the Yorkshire Neonatal Network Board

The minutes of the Yorkshire Neonatal Network Board meeting held on the 15th April were presented to the meeting.

It was agreed that the minutes of the Yorkshire Neonatal Network Board meeting held on the 15th April 2010 be received.

SCG 86/10  
Minutes of the North Trent Neonatal Network Steering Group

The minutes of the North Trent Neonatal Network Steering Group meetings held on the 21st April and 16th June 2010 were presented to the meeting.

It was agreed that the minutes of the North Trent Neonatal Network Steering Group meetings held on the 21st April and 16th June 2010 be received.

SCG 87/10  
Minutes of the North Trent Neonatal Clinical Sub Group

The minutes of the North Trent Neonatal Clinical Sub Group meetings held on the 11th May and 9th July 2010 were presented to the meeting.

It was agreed that the minutes of the North Trent Neonatal Clinical Sub Group meetings held on the 11th May and 9th July 2010 be received.

SCG 88/10  
Minutes of the Yorkshire & Humber Renal Strategy Group

The minutes of the Yorkshire & Humber Renal Strategy Group meeting held on the 28th June 2010 were presented to the meeting.

It was agreed that the minutes of the Yorkshire & Humber Renal Strategy Group meeting held on the 28th June 2010 be received.

SCG 89/10  
Draft Minutes of the Congenital Cardiac Network Board

The draft minutes of the Congenital Cardiac Network Board meeting held on the 8th September 2010 were presented to the meeting.

It was agreed that the draft minutes of the Congenital Cardiac Network Board meeting held on the 8th September 2010 be received.

The meeting was advised that a Chair of the Congenital Cardiac Network was required.

It was agreed that Jayne Brown be appointed as the Chair of the Congenital Cardiac Network.
Y&H SCG Board Meeting Dates 2011

The proposed dates for the Y&H SCG Board meetings in 2011 were presented to the meeting.

It was agreed that the dates and times set out for the SCG Board meetings in 2011 be approved.

Any Other Business

There were no other items of business.

Date and Time of Next Meeting

Friday 22nd October 2010, 9am – 12:30pm at Sandal Rugby Club, Wakefield
NHS ROTHERHAM

Minutes of the Professional Executive of NHS Rotherham held on
6 October 2010 in the Elm Room, Oak House

Present:  
Dr R C A Collinson (Chairman)  
Dr R Brynes  
Mr A Buck  
Mr P Chapman  
Dr J Coates  
Mr C Eades  
Mr M Foster  
Dr J Kitlowski  
Dr P Macfarlane  
Mrs J Pearson  
Dr J Radford  
Mrs G South  
Dr D Tooth  
Dr I Turner  

In Attendance:  
Mrs K S Atkinson, Director of Strategic Planning  
Dr R Carlisle, Director of Intelligence and Performance  
Mrs Keely Firth, Deputy Director of Finance for Mr Edwards  
Mrs P Fryer, Director of OD, Workforce and Governance  
Dr D Plews, Medical Director  
Mrs D Smith, Children’s Services for Mrs Thacker  
Mr A Tenany, Board Secretary  

(Item 199-201/10) Ms J Abbott, Public Health Consultant for Dr Radford  
(Item 191/10) Mr Ian Jerams, Rotherham, Doncaster and South Humber Mental Health Foundation Trust  

(Item 199-201/10) Dr Hannah Jordan, Public Health trainee  
(Item 190/10) Mrs A Kilner, Joint Commissioning Manager  
(Item 198/10) Dr Sarah Lever, Deputy Director of Contracting  
(Item 192/10) Ms Jenny Lingrell, Rotherham Metropolitan Borough Council  
(Item 186/10) Mr Jason Punyer, Prescribing Support Pharmacist  
(Item 191/10) Mrs K Tufnell, Programme Manager for Mental Health  
(Item 191/10) Ms Cath Williams, Rotherham, Doncaster and South Humber Mental Health Foundation Trust  

* First part of meeting only

182/10 Apologies for absence

Apologies were received from Dr Burns, Mr Edwards, Mr Hamstead, Mrs Thacker, Mrs Topliss and Mrs Wright.

183/10 Declaration of Pecuniary or Non-Pecuniary Interests

a) 186/10 Flu Vaccination Programme

Drs Brynes, Collinson, Kitlowski, Plews, Tooth and Turner declared an interest in the above item.

b) 187/10 Shaping Our Future

Drs Brynes, Collinson, Kitlowski, Plews, Tooth and Turner declared an interest in the above item - as did Mr Chapman, Mrs J Pearson and Mrs South.
c) 191/10 Mental Health Service Configuration

Dr Coates declared an interest in the above item.

c) 208/10 White Paper

Drs Brynes, Collinson, Kitlowski, Plews, Tooth and Turner declared an interest in the above item

184/10 Minutes

The minutes of the Professional Executive meeting held on 1 September 2010 were confirmed as a correct record, subject to the following amendment:

Dr Tooth had not been present and his name should be listed under “Apologies”.

185/10 Matters Arising

a) 178/10 Fluticasone

Asthma management guidelines had just been issued by the Medicines Management Team. The NHS Rotherham publicity arrangements (nb mouse mats) were noted.

b) 161/10 Magnetic Resonance Imaging – Direct Access Service

The fact-finding on the impact of direct access on patient management continued. The Practice-Based Commissioning Group supported continuation of the service and wished to identify other services to decommission instead.

186/10 Flu Vaccination Programme

Mr Punyer described an arrangement by which pharmacists would be involved in a pilot to try and vaccinate hard-to-reach people – as such people may visit a pharmacy more than their GP.

The PE supported the pilot starting in January, subject to it being compliant with Standing Orders and Standing Financial Instructions.

187/10 Shaping Our Future - update

Mr Buck reported that following an extensive consultation with staff, the Board had approved proposed organisational destinations for the various elements of Rotherham Community Health Services. Negotiations on the transfer of services / staff continued with the prospective hosts and approval had to be obtained from (different) third parties.
Mrs Atkinson explained that officers had reviewed NHS Rotherham’s priorities and transformational initiatives. The agenda paper showed proposed alterations to priorities. The PE noted the revised list and recommended that the Board adopt them for 2011/12.

Mrs Firth presented the performance report on contracts and finance, drawing attention to the following:-

a) Continuing Health Care was experiencing a surge in expenditure and today’s report contained an analysis of this. A full report would be brought to the next meeting.

b) Data on the secondary care contracts was showing the activity position at one-third through the year and some differences against targets had already emerged.

c) The Rotherham Foundation Trust contract provisions about discharge letters were not being met: some clawback of funding may result. Dr Macfarlane explained that individual departments had not received additional funding to achieve the (worthy) provisions.

Dr Tooth observed that the average cost of A&E attendances and of planned admissions had risen and he queried if this was a real phenomenon or an example of coding drift.

**Action: Director of Intelligence and Performance / Director of Finance and Contracting**

Dr Kitlowski explained that the marketing of CareUK’s general practice also encouraged the use of its walk-in centre. The consequence was that patients’ use of the centre was sometimes not a reflection of their own practice’s availability to them.

Mrs Kilner introduced an interim mortality audit report on patients with a learning disability. It was noted that the audits had uncovered some examples of very good care. The case history of six patients was being investigated more intensively and this was encountering issues of record keeping and storage. Next steps would be decided by Dr Collinson, Dr Radford and Mr Buck.

**Action: Director of Public Health**

An agenda paper supported a presentation by Mr Jerams on the plan to change how secondary mental health care was delivered. The model proposed by Rotherham, Doncaster and South Humber Mental Health Foundation Trust (RDasH) had a projected start date of February 2011 and was already operational in Doncaster.

Points of note in a lengthy discussion included:-

a) No changes were planned in the working of the primary care mental health teams.
b) An “access team” would direct patients to one of four specialist teams. Rotherham, Doncaster and South Humber Mental Health Foundation Trust was not expecting much movement (i.e. double handling) between the community therapies team and the intensive community therapies team.

c) Target (maximum) turnaround times for referral to assessment included 48 hours for “urgent” and 14 days for “routine”. Patient categories were defined by referrers.

d) Outpatient follow-up appointments would be far fewer and this should allow GPs to have better access to a consultant opinion on new problems. Mrs Pearson reported her positive experience of obtaining a consultant opinion, instead of a referral to the consultant.

e) Patients would be (largely) seen as close to their homes as is the case now.

f) The ceasing of hospital outpatient attendances may lead to more domiciliary care by the community mental health teams.

g) Drug monitoring (especially the use of lithium) was always a challenge. Good communication of changes would be vital.

Outcome measures would be used to determine the success, or otherwise, of the changes: these would be shared with the PE before February 2011.

**Action: Mental Health Programme Lead**

The PE noted the planned changes. Mr Jerams stressed that the detail of arrangements was still open to change in response to views received. It was agreed (later in this meeting) that views on the proposals would be obtained from GPs in order to present to Mr Jerams.

**Action: Director of Strategic Planning**

### 192/10 Children and Young People’s Action Plan

Ms Jenny Lingrell was welcomed to the meeting and explained that whilst a plan was no longer a statutory requirement, the local Children’s Trust Board had completed production of the one underway and now wished to use it – subject to some scaling down in response to expected cuts in public expenditure.

The content of the action plan(s) were noted. Mr Buck stressed the importance of maintaining a partnership between health agencies and the Rotherham Metropolitan Borough Council. Ian Kennedy’s report would be brought to a future PE

**Action: Chief Executive**

### 193/10 SHA Single Assurance and Accountability Process (SAAP)

Dr Carlisle introduced an agenda paper.¹

¹ Replacement sheets for the last three pages of statistics were tabled.
The PE noted:-

a) the establishment of a SAAP by the Strategic Health Authority (SHA). GP members of the PE queried this use of time for SHA and NHSR officers;

b) the initial assessment of NHS Rotherham performance under the SAAP;

c) the actions being taken to clarify the metrics being assessed in the SAAP;

d) the planned “deep dive” meeting of SHA and NHS Rotherham directors to be held in November, and

e) the need for ongoing reporting arrangements locally.

194/10 Performance Report - Vital Signs

Dr Carlisle introduced a report on NHS Rotherham performance across the range of vital signs. The PE noted the performance and the actions proposed where performance was below the national average.

195/10 Performance Report - Quality and Health Gain Targets

Dr Carlisle presented the performance report on quality and health targets.

196/10 Performance Report – Efficiency Programmes

Dr Carlisle presented the report on attainment of improved efficiency. Whilst there had been good progress on containing prescribing costs, work on referrals management was not yet having any impact.

197/10 Practice-Based Commissioning (PBC) - LIS out-turn and Annual Report

Dr Tooth introduced the 2009-10 annual report on PBC. A key feature of the year had been the improved engagement of clinicians in the processes. The PE noted the outturn and congratulated Dr Tooth on what had been a successful year.

198/10 Rotherham, Doncaster and South Humber Mental Health Foundation Trust - performance report

The content of the report dated July 2010 was noted by the PE.

The report’s format had been designed only recently, but would need alteration in the light of the planned changes to the organisation of services. See 191/10 above. Dr Lever noted some observations about format. Dr Tooth would discuss, with PBC colleagues, their understanding of the current performance baseline.

Action: Dr Tooth, Deputy Director of Contracting
199/10  Coronary Heart Disease Health Equity Audit

Dr Jordan introduced the NHS Rotherham Health Equity Audit of July 2010. The report showed the practice by practice data on a large number of measures.

The PE congratulated the authors of the report and noted the following findings and recommendations:

a) Over the next decade maintain the momentum of progress and work on closing the gap between the most deprived areas and the rest of Rotherham.

b) Continue with 3-yearly equity audits to benchmark progress and feedback to GPs - encouraging practices to develop their own action plans and audit against them.

c) Continue providing feedback on prescribing practices to GPs, with the prescribing team visiting GPs to provide support around prescribing.

d) Continue to develop lifestyle initiatives in the areas of obesity, alcohol, smoking cessation and physical activity.

e) Provide information to the Clinical Referrals Management Group (CRMC).

The PE congratulated the authors of the report. The report would be circulated to every practice. It would also be offered to the Practice-Based Commissioning group and the Clinical Referrals Management Committee.

Action: Director of Public Health

Information on the uptake of the current CVD risk screening programme was requested in order to assist decisions about the likely closure of that programme.

Action: Director of Public Health

200/10  Keeping Warm in Later Life (KWILLT) - interim report

Ms Abbott introduced a report on the KWILLT initiative and drew attention to the interest from the international research community. The PE received the update and supported implementation of the interim findings in the planning for winter 2010/1.

201/10  Local Research - Annual Report

The PE noted the Research Governance Annual Report of 2010 and congratulated all those involved in the good progress over the last twelve months.

202/10  Clinical Referrals Management Committee

The minutes of the Clinical Referrals Management Committee meeting held on 18 August 2010 were received and noted.
203/10  Governance, Quality and Risk Committee

The (unadopted) minutes of the Governance, Quality and Risk Committee meeting held on 18 August 2010 were noted.

204/10  Medicines Management Committee

The minutes of the Medicines Management Committee meeting held on 18 August 2010 were received and noted.

205/10  NORCOM

a) The (unadopted) minutes of the joint meeting of NORCOM held on 10 September 2010 were noted.

b) The (unadopted) minutes of the commissioner-only meeting of NORCOM held on 10 September 2010 were noted.

206/10  Practice-based Commissioning Group

The (unadopted) minutes of the Practice-based Commissioning Group’s meeting held on 28 July 2010 were noted.

It was noted that the statements in item 17.5 (community nursing services) were not meant to imply that the nurses were to be employed by general medical practices.

207/10  Yorkshire and the Humber Specialised Commissioning Group (SCG)

The (unadopted) minutes of the Yorkshire and the Humber SCG meeting held on 23 July 2010 were noted.

Item 41/10f (Evidence-Based Commissioning) alluded to the large number of policies, for medicines and treatments, that would need approval at the SCG’s September meeting. The attention of the health community would be drawn to these approvals and the PE would consider their scope.

Action: Director of Strategic Planning

208/10  White Paper – update

Mr Buck reported that the consultation period on the White Paper proposals had just ended (and that on its supporting papers was about to end). NHS Rotherham had submitted a response to the White Paper consultation and a copy was circulated.

A listing\(^2\) of what PCTs are statutorily required to do was circulated.

The Protected Learning Time events in September had seen a discussion of proposals for GP-led commissioning. \textit{See next minute.}

\(^2\) prepared by the NHS Confederation
209/10  GP-led commissioning

It was clear that the government would be giving GPs a lead role in commissioning. To that end, proposals about enhancing their role within Rotherham in the meantime had been developed. An agenda paper presented proposals – with suggestions for the identification and nurturing of those GPs that might lead future commissioning. Mr Buck stressed that the proposals were still under discussion and that they were not an attempt to set up a GP commissioning consortium.

GP-led commissioning could be fostered by refashioning the PE into a “GP Commissioning Executive” (GPCE) that would replace the PE and the Practice-Based Commissioning group. ³ The GPCE might include eight GP and six non-GP clinicians and would be supported by a “GP reference group”. The PCT continued to be statutorily responsible for commissioning and thus the selection of members for the GPCE would involve Mr Buck and Mr Tolhurst.

A lengthy discussion led to the PE expressing support for the proposals. The need for local authority input to the GPCE was acknowledged and would be incorporated in the next iteration of the proposals.

Action: Chief Executive

210/10  Future Agenda Items

November 2010
CVD screening (2011 funding) (JR)
Cancer Network performance report (KA)
Lifestyle survey, primary school age children (JT)

211/10  Date, Time and Venue of Next Meeting

The Professional Executive’s next meeting was scheduled to take place on 3 November 2010 at 1.00 pm at Oak House, Moorhead Way, Bramley, Rotherham.

³ and would use the existing budgets for their infrastructure
NHS Rotherham Community Health Services

Minutes of the Rotherham Community Health Services (RCHS) Committee
held on
Wednesday 6\textsuperscript{th} October 2010 in Meeting Room 4, RCHC

Present :
Mr R Stonebridge, Non-Executive Director (Chair)
Mrs S Lockwood, LAY Member
Mrs K Henderson, Managing Director

Co-opted member:
Mrs J Dalton, Staff side representative

In Attendance :
Mrs L Watson, Associate Director Adult Services
Mrs Y Weakley, Associate Director Children & Young People’s Services
Mr B Chico, Head of Business and Informatics RCHS
Mr P Ferrie, HR Manager (representing Ms Bralsford)
Mrs K Firth, Deputy Director of Finance (representing Mr Edwards)
Mrs Y Jackson, Committee Secretary

140/10 Apologies

Apologies were received from Mrs P Wade Non-Executive Director, Mr A Irvine, Chief of Community Services, RFT, Mr C Edwards, Director of Finance and Contracting and Ms J Bralsford, Associate Director of HR & OD

141/10 Declaration of Pecuniary or Non-Pecuniary Interests

There were no declarations of interest.

142/10 Minutes of the previous meeting

The minutes of the RCHS Committee meeting held on Wednesday 1\textsuperscript{st} September 2010 were confirmed as a correct record.

143/10 Matters arising

121/10 Serious Case Review – Highfield Executive Summary

Mrs Henderson reported that she had met with Dr J Radford, Mr A Buck and Mrs S Cassin to discuss the issues raised at the previous Committee Meeting. Following this meeting Dr Radford had written to Mrs Cantrill outlining concerns in relation to the draft report.
### Managing Directors Report

Mrs Henderson presented the Managing Director’s report informing the Committee about current issues. Attention was drawn to the following:-

The Trust Board’s decision around “Shaping Our Future” Future Form was highlighted. Mr Stonebridge asked who the members were on the Service Integration Committee. Mrs Henderson reported that the committee was chaired by Mr A Irvine, and included Directors from the RFT, along with herself and Mr Chico from RCHS. The committee is now changing its focus from Due Diligence to the Transactional Process. Mr Stonebridge suggested that members of the RCHS Committee should meet with Trust Board members from RFT, DASH and the Hospice to discuss what the services would look like. Mrs Henderson to discuss with Mrs Wade on her return from holiday and organise these meetings.

**Action: Mrs Henderson**

Mrs Henderson also reported that the Clinical Transformation Forum had received a progress update in relation to three clinical teams who were currently piloting Relationship Based Care and Productive Community Services. This is the only National pilot in terms of Community Health Services. The Clinical Transformation Forum had been impressed by the progress to date and early benefits being realised.

### Safeguarding Action Plan – Looked After Children

Mrs Weakley presented this paper and reported that the Inspection had been focused on the Local Authority Services, but that Health had also been included. As a result of the Inspection 2 actions had been assigned to Health with regards to issues around Safeguarding Children in the Accident and Emergency Department. One issue was around A&E not having access to SystmOne – this issue was in the process of being resolved by the installation of SystmOne into A&E, and a training programme being undertaken by staff. The second issue was around A&E not having a Paediatric Nurse resource on a 24 hour basis. Mr Stonebridge asked whether commissioning were aware of this lack of paediatric nurse cover. Mrs Weakley confirmed that Mrs Whittle was aware and responsibility for both actions were identified as NHSR Commissioners and TRFT.

It was agreed that Mrs Weakley would provide an up to date action plan, which included updates from the LA and partners.

**Action: Mrs Weakley**

### Safeguarding Adults Annual Report

Mrs Henderson presented this paper and reported that the report was brought to the Committee as part of the Assurance Process. Mrs Henderson reported that Mrs Angela Shaw, Head of Patient Safety was a member of the Safeguarding Adults Board.
The committee received this report.

<table>
<thead>
<tr>
<th>147/10</th>
<th>Policies for approval</th>
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<tbody>
<tr>
<td>Mrs Henderson reported that all these policies had been through the relevant meetings and were here for final approval. Mr Stonebridge suggested that in future that a summary of which meetings the policies had been through, and highlight any issues, instead of the whole policy having to be presented. The committee agreed.</td>
<td></td>
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<tr>
<td>IPC 2 Standard Infection Control Precautions</td>
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<tr>
<td>The committee approved this policy.</td>
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<td>IPC 3 Sharps Policy</td>
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<td>The committee approved this policy.</td>
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<tr>
<td>IPC 5 Hand Hygiene</td>
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<td>The committee approved this policy.</td>
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<td>IPC 12 Decontamination</td>
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<td>The committee approved this policy.</td>
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<tr>
<td>RCHS 31 Oxygen Policy</td>
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<td>The committee approved this policy.</td>
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<tr>
<td>RCHS 29 Never Events</td>
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<tr>
<td>The committee approved this policy.</td>
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<tr>
<th>148/10</th>
<th>Performance Monitoring Report</th>
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<tr>
<td>Mr Chico presented the performance report for Rotherham Community Health Services. This showed the position on activity, waiting times and finance.</td>
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<tr>
<td>Attention was drawn to the following:-</td>
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<tr>
<td>The financial position has improved to a forecast of breakeven.</td>
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<tr>
<td>The Capital Budget for 2011/12 has been allocated in full for investment in digital pens that support mobile working.</td>
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<td>The activity for 2010/11 is outperforming the annual plan by 12.8%. It has been discussed with NHSR that the 2011/12 annual plan will reflect outturn in 2010/11. This is subject to resolving some services which are overspending and over performing.</td>
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<tr>
<td>CRES – work now completed and forecasting that the CRES will be achieved in full. Mrs Firth stated that the due diligence process for Shaping our Future would provide assurance for the committee regarding budgets to be transferred to other organisations but may inherently expose issues which could result in further efficiency requirements to be resolved in 2010/11.</td>
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<tr>
<td>CQUINS – RCHS are forecasting 75% achievement of CQUINS in 2010/11.</td>
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</table>
Negotiations around local CQUINS have been finalised, but the Regional CQUINS are still to be finalised. Mrs Weakley highlighted that the Antenatal goal was always going to be difficult as the information regarding expectant mothers was not being received on a regular basis from the RFT. Mrs Henderson asked that this issue be raised with Mrs S Whittle and Mrs J Bird.

**Action: Mrs Weakley**

Capital Resource – Mr Chico to ask Mr Chapman do submit an update on Digital Pens to the IGC.

**Action: Mr Chico**

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<thead>
<tr>
<th>149/10</th>
<th>Update on Mandatory Training</th>
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<tr>
<td>This item was to be deferred to the next meeting.</td>
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<thead>
<tr>
<th>150/10</th>
<th>Integrated Governance Committee</th>
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<tbody>
<tr>
<td>The minutes of the Integrated Governance Committee dated 22\textsuperscript{nd} July 2010 were received for information.</td>
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<thead>
<tr>
<th>151/10</th>
<th>Core Management Team</th>
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<tbody>
<tr>
<td>The minutes of the Core Management Team dated 27\textsuperscript{th} July 2010 were received for information.</td>
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<thead>
<tr>
<th>152/10</th>
<th>Core Management Team</th>
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<tbody>
<tr>
<td>The minutes of the Core Management Team dated 25\textsuperscript{th} August 2010 were received for information.</td>
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<tr>
<th>153/10</th>
<th>The Gate Social Enterprise Project Board</th>
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<tr>
<td>The minutes of the Gate Social Enterprise Project Board dated 6\textsuperscript{th} August 2010 were received for information.</td>
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<thead>
<tr>
<th>154/10</th>
<th>Any Other Business</th>
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<tbody>
<tr>
<td>Hospice Patients</td>
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<tr>
<td>Mrs Henderson reported that Hospice In-Patients had now been temporarily relocated to Breathing Space and this was being carefully monitored.</td>
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<tr>
<td>155/10</td>
<td>Date, Time and Venue of Next Meeting</td>
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<td></td>
<td>The next meeting of the Rotherham Community Health Services Committee is scheduled to take place on Wednesday 3\textsuperscript{rd} November 2010 at 09:30 am in Meeting Room 4 at Rotherham Community Health Centre, Greasbrough Road, Rotherham S60 1RY.</td>
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NORCOM
North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium

(Joint Meeting)
10.30am on Friday, 8 October 2010
In the Boardroom, NHS Sheffield

Present:
Andy Buck NHS Rotherham (Chair)
Annette Laban NHS Doncaster
Steve Hackett NHS Barnsley
Steve Wainwright NHS Barnsley
Jan Sobieraj NHS Sheffield
Felicity Cox NHS Bassetlaw
Jill Turner Doncaster & Bassetlaw Hospitals
Chris Linacre Sheffield Teaching Hospitals
Mike Pinkerton Rotherham Hospitals
Tracey Bray East Midlands Specialised Commissioning Group
David Peverell Barnsley Hospital
Steven Swift Chesterfield Royal Hospital

In Attendance:
Cathy Edwards Yorkshire & the Humber Specialised Commissioning Group
Clare Hillitt North Trent Network of Cardiac Care
Kim Fell North Trent Cancer Network
Kim Cox Yorkshire & the Humber Specialised Commissioning Group
Fiona Jorden Commissioning of Screening Services (item 7)
Jacky Mason Commissioning of Screening Services (item 7)

1 Apologies
Chris Sharratt Sheffield Children’s Hospital
Pia Clinton-Tarestad Yorkshire & the Humber Specialised Commissioning Group
Paul Thefault East Midlands Specialised Commissioning Group
Lisa Bromley NHS Bassetlaw
Ailsa Claire NHS Barnsley

2 Minutes of the meeting held on 10 September 2010

The minute for item 6 relating to Stroke in-hours thrombolysis, was amended to read ‘...as work in progress.’ Otherwise the minutes of the meeting held on 10 September 2010 were accepted as a true and accurate record.

3 Matters Arising

(a) Pediatric Services

It was reported that the stocktake against service standards was progressing well. NORCOM was reminded that, in addition to a report of the stocktake, there would be a report on activity across Yorkshire & the Humber and a third report on workforce issues.
These reports would be taken to the SCG Board in November and would then be shared with other appropriate forums for discussion.

Cathy Edwards also confirmed that the EMBRACE service was now fully operational.

(b) Stroke Services

There was nothing further to report.

(c) Vascular Services

The recommendations and impact statement from the vascular services review had been discussed at the SHA Chief Executives meeting. There had been no challenge to the recommendations in the impact statement and it had been confirmed that all the necessary steps had been actioned.

The full report would be taken to the October SCG Board for a decision following which there would be a formal SCG-wide consultation on the proposals.

4 Cancer Services

(a) Service Changes

(i) Breast Screening Update

The executives, from the four provider Trusts, had recently met and a new approach had been agreed upon. There would be four accountable outlets that would work collaboratively together to provide a single “networked” service – through a provider collaboration.

There was general support for the proposal at the Cancer Board. A number of issues would need to be addressed urgently. The provider collaboration would need to formulate a single “networked” proposal with a clear action plan for implementing a single service and delivering the service specification.

NORCOM noted that the detail of the service specification, in terms of outcomes and targets remained unchanged, though there was a provider view regarding whether all the requirements could be delivered within the current cost envelope.

Once the significant issues had been addressed, there would be a need to assess what could be delivered, at what cost and over what time period. There would also be a need for an assessment of the provider governance arrangements and whether they were fit for purpose.
(ii) Children & Young People

NORCOM received an update report sent previously with the agenda. Implementation of the Improving Outcomes Guidance (IOG) was proceeding according to plan.

It was noted that when the IOG was first published there was a proposal around numbers of patients required to enable a service to be viable this being 80 new patients per year. Sheffield Children's had staffed services sufficient for up to 65-70 patients.

The peer review measures had translated the 80 patients to a minimum requirement. The outcome of the peer review of Sheffield Children’s suggested that it would be unreasonable for the Trust to be required to staff for up to 80 patients when current staffing was adequate. Increasing the staffing for 80 patients would cost an extra £150k and would be unnecessary. However in these circumstances Sheffield Children’s would not meet the peer review standards.

It was noted that there was significant variation in activity between years and that there was a need to see the most up to date figures and the average over a number of years not just in one year.

It was noted that this position would be reported to the October SCG meeting and that Kim Fell would be discussing the issue with the National Cancer Action Team.

(iii) Urology

In 2007 NORCOM had decided that treatment of complex urological cancers would be centralised at Sheffield Teaching Hospitals to comply with Improving Outcomes Guidance. At the recent Peer Review Internal Validation panels held at each of the trusts, it had become apparent that the national recommendations in the management of renal cancers requiring specialist management were not being met.

A paper was presented which detailed an action plan for resolving the issues by January 2011. The action plan was agreed with progress to be reported to the November NORCOM meeting.

It was noted that any contractual issues would also need to be resolved.

There was also a need to consider the learning from this issue about monitoring compliance with IOG requirements.
(iv) **Radiotherapy Update**

An update was provided on progress to date and the paper outlined a number of next steps.

The waiting times were being met for 31 day subsequent treatments for radiotherapy. To date however, the expected projected out-turn number of fractions for 2010/11 was currently estimated at 51,093 which was a significant reduction on 2009/10 position (54,418) and the planned growth position.

Commissioners requested that funding be reviewed, in view of the projected under performance.

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(b) **Interim Cancer Drugs Fund (ICDF)**

A process was now in place for administering the ICDF. There would be a need for minor revisions to the process following the publication in November of the revised guidance on the policy based approach. PCTs were requested to ensure timely consideration of requests for funding.

(c) **Local Operational Plan (LOP)**

NORCOM noted the cancer priorities for the LOP, which included a list of drugs expected to be approved by NICE. It was recognised that all the priorities would need to be assessed against QIPP.

PCT contract leads were being notified of 2010/11 slippages

It was reported that the Myeloma XI trial work had been reviewed and there were no excess treatment costs associated with it. The network was now intending to progress this and take part in the trial. The PCTs approved participation in the trial.

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5 **Critical Care PbR Update**

The paper regarding the risks of implementing the new tariff was deferred to the next meeting. Collection of information on prices, costs and activity in each provider was in progress.

The Network was developing a set of consistent quality standards for use next year. There was a need to agree a process for implementing consistent quality standards and prices across the whole network.

It was noted that the network task was to support the implementation of a common currency not a common price. There would need to be further discussions regarding whether there should be a NORCOM-wide risk share. It was agreed that this would be a standing agenda item from now on.

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Kim Fell

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Phil Mettam
6 East Midlands and South Yorkshire Congenital Anomalies Register

The meeting discussed whether the contract for the congenital anomalies register should be renewed. It was noted that other parts of the country do not have an equivalent register. The information presented in the paper informing the discussion showed that the register was rarely used and, when it was used, it was not for commissioning purposes.

The meeting recommended that the contract should not be renewed. There was a need to develop a plan that accounted for the consequences of not renewing the contract.

Laura Sherburn

7 Screening Services

(a) General Update

The meeting received the update sent previously with the agenda.

The significant improvement in cervical screening reporting was noted. All PCTs were on target to achieve the 14 day turn around by December 2010 with the exception of Bassetlaw. However performance in Bassetlaw was improving.

It was reported that the abdominal aortic aneurysm (AAA) screening programme implementation date was October 2012 with screening commencing in April 2013.

(b) Performance report

The screening services performance report was received and noted.

(c) Risk Register

The risk register report was received.

8 Clinical Networks Update

(a) Cancer

The Cancer Network update report was received.

(b) Cardiac

The Cardiac Network update report was received.

There had been significant discussion regarding phase 4 of rehabilitation. It had been agreed to address the issue on a patch basis.

Jan Sobieraj explained that the Care Quality Commission (CQC) would be coming to measure call to balloon time. It was noted that call to balloon time data was already available however there was variation between PCTs that would need to be addressed locally.
(c) **Neonatal**

The Neonatal Network update report was received.

(d) **Stroke**

The Stroke Project Update report was received.

Chris Linacre noted that Sheffield Teaching Hospitals had some concerns regarding the proposed operation of out of hours telemedicine. It was noted that the principle of an in hours service supported by out of hours telemedicine had already been agreed. However options for models of service delivery and the timeline for implementation had yet to be modelled and agreed.

Sarah Halstead

9 **Any Other Business**

There was no other business.

10 **Date and time of next meeting**

Friday 12 November 2010, Room 4, RED Centre, Doncaster.
NORCOM
North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium

12.00pm to 2.00pm

Friday, 8 October 2010
In the Boardroom NHS Sheffield

COMMISSIONER ONLY MEETING

Present:
Andy Buck  
NHS Rotherham (Chair)
Jackie Pederson  
NHS Doncaster
Steve Wainwright  
NHS Barnsley
Jan Sobieraj  
NHS Sheffield
Phil Mettam  
NHS Bassetlaw
Tracey Bray  
East Midlands Specialised Commissioning Group

In Attendance:
Cathy Edwards  
Yorkshire & the Humber Specialised Commissioning Group
Kim Cox  
Yorkshire & the Humber Specialised Commissioning Group
Kim Fell  
North Trent Cancer Network
Claire Hillitt  
North Trent Network of Cardiac Care

1 Apologies

Annette Laban  
NHS Doncaster
Paul Thefault  
East Midlands Specialised Commissioning Group
Lisa Bromley  
NHS Bassetlaw
Pia Clinton-Tarestad  
Yorkshire & the Humber Specialised Commissioning Group

2 Minutes of the meeting held on 10 September 2010

The minutes of the meeting held on 10 July 2010 were accepted as a true and accurate record.

3 Matters Arising

(a) Vascular Services Review

There was nothing further to report

(b) Conditions Management Programme

The decommissioning process was progressing as planned. All staff had been put at risk. Some had already left and found alternative employment. A formal paper reporting progress would be brought to the November meeting.  

(c) Interim Cancer Drugs Fund

There was nothing further to report

Steve Wainwright
(d) **Cervical Screening**

There was nothing further to report

(e) **AAA Screening**

It was agreed that the decision to implement AAA screening would be communicated to the Strategic Health Authority. 

**Withdrawal of Financial Risk Share Agreement – Derbyshire County**

Cathy Edwards reported that she had received a letter from Derbyshire County PCT formally requesting withdrawing from all remaining financial risk shares from 1 April 2011.

Derbyshire County contributed approximately £8.2m to the risk share. This primarily related to cancer drugs and renal services.

It was agreed that there was a need for further work to identify and understand the financial and service risks associated with Derbyshire County withdrawing from the risk share. Of particular concern was the fact that renal services were commissioned on a network basis.

**Critical Care PbR Update**

Further to the discussion at the joint meeting it was recognised that the implementation of a national tariff would have a significant impact. The critical care units across the patch were known to be very different to each other and the costs associated with implementing PbR would be very different. In addition, there may be some clinical governance issues that require clarification.

It was recognised that there was a need to determine ways to monitor compliance with existing protocols and standards. A progress report would be brought to the November meeting.

**PTS Update**

An update on the South Yorkshire Patient Transport Service (PTS) contracting collaboration and proposed procurement for a South Yorkshire screening/booking service and South Yorkshire Renal PTS service was received.

The screening/booking service was proceeding as planned and expected to deliver a new triage service from 1 April 2011.

The renal procurement was progressing but would not be completed for 1 April 2011.

There remained an outstanding funding query between NHS Sheffield and NHS Doncaster that needed to be resolved before the Yorkshire Ambulance Services contract could be signed.
7 Commissioning Contingency and Transformation Programme

The required documentation had been sent to the SHA by 1 October. There had been no response so far. It was agreed that the overall strategy would be for PCTs to manage their own issues initially and then progress to bilateral/trilateral discussions if necessary. Any out-of-NORCOM solutions would be a last resort.

The next stage would be to consider which functions needed to be available to support GP commissioning. This would be followed by determination of the form Practice Based Consortiums would need to adopt in order to deliver the required functions. It was agreed that Andy Buck would contact Ailsa Claire to discuss the timing of the second stage. Andy Buck

8 Clinical Networks – discussion paper

The meeting received a paper produced by NEYCOM which considered the future functions of networks, the form they might take and how this could be commissioned.

It was agreed that the approach was helpful and that a similar paper should be produced that related to NORCOM networks. Cathy Edwards

It was noted that in some areas key network staff had been offered and had accepted redundancy. This presented a significant risk to business continuity in these areas

9 Collaborative Work Programme

The meeting briefly discussed each of the elements of the collaborative work programme. There were no areas of concern. All

10 Any Other Business

There was no other business

11 Date and time of next meeting:

Friday 12 November, Room 4, RED Centre, Doncaster
NHS Rotherham

Board 15 November 2010

Feedback from the Audit and Quality Assurance Committee

Contact Details:

<table>
<thead>
<tr>
<th>Lead Director:</th>
<th>John Gomersall</th>
<th>Lead Officer:</th>
<th>Chris Edwards</th>
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<tbody>
<tr>
<td>Title:</td>
<td>Audit &amp; Quality Assurance Committee Chairman</td>
<td>Title:</td>
<td>Director of Finance, Contracting &amp; Procurement</td>
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Purpose:

1. To advise the Board of the proposed work programme of the new Audit & Quality Assurance (AQA) Committee
2. To update the Board on the areas of assurance examined at the inaugural meeting held on 20 October 2010

Recommendations:

1. To note the update from the inaugural Audit and Quality Assurance Committee provided by the Chairman
2. To receive and note the contents of the Annual Audit Letter by the Audit Commission

Background:

Arrangements for the new Audit & Quality Assurance Committee bringing together the work of the Audit Committee and Governance, Quality & Risk Committee were agreed at the Board meeting on 18 October 2010.

The intention was to combine the work on assurance undertaken in both the previous committees and the statutory functions of the Audit Committee to give a comprehensive overview of the governance processes of the organisation.

The first meeting of this new committee was held on 21 October 2010 and arrangements have planned for bi-monthly meetings for the next year.

Analysis of Risks:

The format of the meeting has been approved by both internal audit and the Audit Commission. The assurance level the Board receives should not decrease as a result of this change in governance arrangements.
Return on Investment:
The Committee have made a positive start on bringing together all the assurance processes necessary for the governance of NHS Rotherham. This will be a learning curve for many of the staff, auditors and clinicians who will be involved in parts of the framework with which they may be unfamiliar but ultimately this will provide a sound basis not only for providing the board the assurances they seek but also for helping to shape the agenda for governance arrangements associated with the proposed reforms of the NHS.

Analysis of Key Issues:
At the inaugural meeting, the Committee spent some time determining the processes necessary to integrate the agendas of the previous committees and ensuring continuity of outstanding items from both.

In addition, the Annual Audit Letter from the District Audit provided assurances in relation to the audit of financial statements and the arrangements NHS Rotherham has in place to achieve value for money in its use of resources. The Committee were assured by the positive comments but noted that one area for improvement was performance on environmental issues within the organisation. A copy of the Annual Audit Letter is attached.

It was pleasing to welcome three GP’s who were attending to observe the work of the new Committee which it was felt would be enhanced by GP membership. The benefits of their clinical input were evidenced during a discussion of the Annual Audit Letter relating to coding of both inpatient and outpatient cost at Rotherham Foundation Trust which was part of a national audit. GP representatives would also gain a better understanding of the governance and assurance issues they may need to address in proposed future NHS reforms.

Following on from the Board discussion in October, the Committee also looked in detail at the efficiency programme and agreed that the fullest detail of this should be a regular item on the agenda. It was suggested that AQA Committee should review the full report but that summary reports should continue to be presented to the full Board.

There was a constructive discussion about the approach to be taken to examining the risk register that mirrored some of the previous discussions at the Board. It was agreed that further work was needed to ensure the register is fully populated with data and action plans as well as clearer indication of progress/regression on items. It was felt that the present documentation did not highlight key issues sufficiently. Work on improvements to the register was commissioned and would be re-examined early in the new year.

Similarly the Committee discussed the presentation of clinical governance work. It was agreed that, in the first instance, the Committee would benefit from all the current processes being mapped, similar to the mapping of external scrutiny processes presented by Robin Carlisle.

Patient, Public and Stakeholder Involvement:
n/a
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<th><strong>Financial Implications:</strong></th>
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<tr>
<td>There are no financial implications caused by the change in the meeting format. The Board will continue to receive the same level of assurance on financial governance arrangements.</td>
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<tr>
<td>Annual Audit Letter, Risk Register</td>
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The Audit Commission is an independent watchdog, driving economy, efficiency and effectiveness in local public services to deliver better outcomes for everyone.

Our work across local government, health, housing, community safety and fire and rescue services means that we have a unique perspective. We promote value for money for taxpayers, auditing the £200 billion spent by 11,000 local public bodies.

As a force for improvement, we work in partnership to assess local public services and make practical recommendations for promoting a better quality of life for local people.
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- Accounting Practice and financial reporting

### Use of resources
- Use of resources (UoR) judgements
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### Payment by Results (PbR)
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### Current and future challenges
- Equity and excellence: Liberating the NHS
- Economic downturn
- Transforming Community Health Services

### Closing remarks

### Appendix 1  Audit fees

### Appendix 2  Use of resources and value for money conclusion

### Appendix 3  Glossary
Key messages

This report summarises the findings from my 2009/10 audit. My audit comprises two elements:

- the audit of your financial statements (pages 4 and 5); and
- my assessment of your arrangements to achieve value for money in your use of resources (pages 6 to 9).

No additional recommendations are made in this report.

Audit opinion and financial statements

1 I issued an unqualified report on the financial statements on 10 June 2010. The accounts and working papers, including those needed for the new IFRS requirements, were well prepared.

Value for money

2 The PCT is generally managing resources well. Scores of 3 ('performing well') were achieved for the arrangements applied in the Managing finances and Governing the business themes. The Managing resources theme was scored at level 2 ('adequate').

3 This latter score was necessary due to the natural resources key line of enquiry (KLOE), being scored at level 1 ('not meeting minimum standards'). This score reflects my view that the PCT's understanding and quantification of its use of natural resources is incomplete at present with arrangements to manage risk and reduce environmental impact still being at an early stage.

4 These findings resulted in my issuing a qualified (except for) conclusion stating the PCT had adequate arrangements to secure economy, efficiency and effectiveness in its use of resources, except that it did not put in place arrangements for making effective use of natural resources.

5 Areas for improvement have been identified to PCT management who have undertaken to take improvement action.
Audit fees

6 The audit fee for 2009/10 of £174,200 (including Payment by Results fee of £33,400), remains the same as in my fee letter of April 2009. A more detailed analysis of the fee is shown at Appendix 1.
The Primary Care Trust's financial statements and annual governance statement are important means by which the PCT accounts for its stewardship of public funds.

Significant issues arising from the audit

7 I issued an unqualified opinion on the financial statements on 10 June 2010.

8 No matters of a material nature arose and there were only a few amendments made as a result of the audit of the financial statements. None of these changes affected the achievement of your financial duties or the reported financial performance.

9 International financial reporting standards (IFRS) were introduced across the NHS from 2009/10. This required the restatement of the previous year's accounts. The PCT has handled this change well with revised figures prepared accurately. Minor changes only were agreed as necessary to meet the new IFRS reporting requirements.

Significant weaknesses in internal control

10 My review of internal control arrangements highlighted some control issues where it was necessary to bring the matters identified to the attention of the Audit Committee. As indicated in Table 1 below PCT management has responded promptly to address the recommendations made.

<table>
<thead>
<tr>
<th>Control issue</th>
<th>PCT response</th>
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<tr>
<td>Separation of duties - Two of the senior officers within financial services</td>
<td>System access rights have been restricted.</td>
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<td>were found to have Purchase Ledger system access rights which empowered them</td>
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<td>to input ledger invoices, send out approval requests and also to approve</td>
<td></td>
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<td>invoices.</td>
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</table>
Control issue

PCT Non NHS Income - income from non NHS sources found not to be generally regulated by service level agreements being based on historical budget information. As such the PCT is not able to demonstrate that the income earned is appropriate for the services provided.

PCT response

Through implementation of the 'Shaping Our Future' strategy a full review of all income sources is to be undertaken.

Payroll nominal roll - Review identified that one of the key system checks in place is the validation by budget holders of a nominal roll report and subsequent vetting of the budget holder response by management accounts staff. No record was being maintained to evidence the completion of this check or of any remedial action taken as a result of it.

Monthly validation being undertaken with budget holders. Finance to verify twice yearly that checks have been completed with any variations acted on.

Provider overhead costs - The allocation of indirect and overhead costs between Commissioning and Provider functions is done in a basic manner as it is an internal transfer of resources. With the prospect of provider services transferring to third party organisations in the next 12 months there is a need for review of how costs are apportioned to ensure that, in advance of transfer, an equitable allocation is achieved.

A full review of all direct and indirect costs associated with Provider Services is being completed in 2010/11.

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Statement on Internal Control (SIC)

11 None of the above matters was sufficiently serious to merit further disclosure within the Statement on Internal Control (SIC).

12 Review of the SIC statement confirmed that it was consistent with my knowledge of the PCT’s arrangements. The disclosures made were also in accordance with the format required by the Department of Health.

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Accounting Practice and financial reporting

13 I considered the qualitative aspects of your financial reporting.

14 In my view the overall quality of the statements presented for audit and the working papers produced to support the financial statements has been of a good standard.
Use of resources

I considered how well the PCT is managing and using its resources to deliver value for money and better and sustainable outcomes for local people, and gave a scored use of resources judgement.
I also assessed whether the PCT put in place adequate corporate arrangements for securing economy, efficiency and effectiveness in its use of resources. This is known as the value for money (VFM) conclusion.

Use of resources (UoR) judgements

15 In forming my scored use of resources judgements, I have used the methodology set out in the use of resources framework. Judgements have been made for each key line of enquiry (KLOE) using the Audit Commission’s current four point scale from 1 to 4, with 4 being the highest. Level 1 represents a failure to meet the minimum requirements at level 2.

16 I have also taken into account, where appropriate, findings from previous value for money conclusion assessments (updating these for any changes or improvements) and any other relevant audit work.

17 The PCT’s use of resources theme scores are shown in Table 2 below. The key findings and conclusions for the three themes and the underlying KLOE, are summarised in Appendix 2.

<table>
<thead>
<tr>
<th>Use of resources theme</th>
<th>Scored judgement</th>
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<tbody>
<tr>
<td>Managing finances</td>
<td>3</td>
</tr>
<tr>
<td>Governing the business</td>
<td>3</td>
</tr>
<tr>
<td>Managing resources</td>
<td>2</td>
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18 Although the theme scores are unchanged this year, improvements have continued to be made, particularly in Workforce Planning arrangements where progress is evident in the following key areas:

- staff skill gaps being addressed;
- business processes being re-engineered to improve service delivery and achieve cost improvements; and
- stronger management action being taken to address sickness absence.

19 I was only able to assess the Managing resources theme at level 2 this year. This score was necessary due to the natural resources key line of enquiry (KLOE), which was reviewed for the first time during 2009/10, being scored at level 1. This score reflects my view that the PCT's understanding and quantification of its use of natural resources is incomplete at present with arrangements to manage risk and reduce environmental impact still being at an early stage. This finding is not uncommon within the PCT sector.

20 I have reported to management on the need to develop arrangements to regulate the use of natural resources. Management have agreed to take action in the following areas:

- Energy efficiency - improve the understanding of energy usage across the PCT estate in order to provide a baseline for setting future targets for reducing the PCT's use of energy, waste and water and to pinpoint where action is required.
- Travel and transport plan - emergent plan needs to be informed by a clear understanding of current transport activity and associated emissions. Planned actions need to define responsibilities, timescales and resource needs.
- Information technology (IT) - a need exists to review current energy consumption within IT so that clear targets for improvement can be set.
- Carbon reduction - plan needs to be revisited to ensure that it:
  - meets the requirements of the Good Corporate Citizen toolkit http://www.corporatecitizen.nhs.uk;
  - is informed by analysis of local rather than national carbon reduction performance; and
  - defines performance targets and monitoring arrangements.
- Staff awareness - in place of current ad-hoc initiatives a planned and sustained campaign should be initiated to raise staff awareness of sustainability issues.

VFM conclusion

21 I assessed your arrangements to secure economy, efficiency and effectiveness in your use of resources against criteria specified by the Audit Commission. For 2009/10 my VFM conclusion has been drawn from:

- the World Class Commissioning (WCC) assurance framework;
- findings from my Use of Resources (UoR) work in 2009/10, as reported above; and
- other risk based work (see next sub-section).
World-Class Commissioning (WCC)

22 The PCT has once again performed well in its WCC assessment. This review comments favourably on the PCT’s strategic, governance and financial arrangements reflecting that the PCT is ‘strong and well positioned for success’. As such these findings are consistent with those arising from my UoR work.

23 The strengths identified will be of critical importance as the PCT responds to the financial challenges and wider change agenda that has now been set.

Other risk-based work - Review of Internal Audit

24 In support of my VFM work I reviewed the operation of the PCT's internal audit function relative to the standards set by the Department of Health. The internal audit service is an important part of the PCT's internal control environment and a key source of assurance for the annual Statement on Internal Control (SIC).

25 My review found that the internal audit service is meeting the NHS Internal Audit Operational Standards in all areas except Quality Assurance. This level of performance represents an improvement over the position found in our previous review in 2007.

26 Improvement action in this area has been agreed with the Chief Internal Auditor and endorsed by PCT management.

Summary assessment

27 Following my assessment of PCT performance against the VFM criteria requirements, summarised in Appendix 2, I issued an qualified (except for) conclusion stating the PCT had adequate arrangements to secure economy, efficiency and effectiveness in its use of resources, except that it did not put in place arrangements for making effective use of natural resources.

Approach to local value for money work from 2010/11

28 Given the scale of pressures facing public bodies in the current economic climate, the Audit Commission has been reviewing its work programme for 2010/11 onwards. This review has included discussions with key stakeholders of possible options for a new approach to local value for money (VFM) audit work. The Commission aims to introduce a new, more targeted and better value approach to our local VFM audit work.

29 My work will be based on a reduced number of reporting criteria, specified by the Commission, concentrating on:
   ■ securing financial resilience; and
   ■ prioritising resources within tighter budgets.
I will determine a local programme of VFM audit work based on my audit risk assessment, informed by these criteria and my statutory responsibilities. I will no longer be required to provide an annual scored judgement relating to my local VFM audit work. Instead I will report the results of all my local VFM audit work and the key messages for the PCT in my annual report to those charged with governance and in my annual audit letter.
Payment by Results (PbR)

31 Under the PbR data quality assurance framework the Audit Commission has carried out inpatient clinical coding audits, outpatient data quality audits and the continuation of national benchmarking information and analysis at NHS Trusts and NHS Foundation Trusts.

32 PCTs will have received regular reports on the results of this work at their main provider trusts and national updates directly from the Commission.

The Payment by Results (PbR) system

33 The aim of Payment by Results (PbR) is to provide a fair, transparent, rules-based system for paying trusts, rewarding efficiency and quality. It does this by paying a nationally set price or tariff for each procedure, classified by Healthcare Resource Group (HRG).

34 Payment by results requires good quality data on costs and clinical activity to be available.
- The Department of Health (DH) needs reliable cost and activity data in order to set a fair, accurate tariff.
- Trusts need good quality activity data for billing purposes and accurate knowledge of their costs.
- PCTs make payments based on information from trusts and so need to know that data is correct and fair in terms of activity volume and case-mix.

35 In 2009/10, we undertook reviews of inpatient and outpatient data at all local acute hospital provider trusts including The Rotherham NHS Foundation Trust, your main acute hospital service provider.

36 We discussed and agreed reports with the relevant trust and the host commissioning PCT, requesting that reports be shared with other significant commissioning PCTs. Local reports are also available for download on the PbR assurance portal and we publish all results from the audits on the Audit Commission website http://www.audit-commission.gov.uk/nationalstudies/health/pbr/pages/default.aspx.

37 The data reviewed not only affects payments made by the PCT, but also underpins healthcare commissioning in your area. Therefore, the PCT should ensure that it builds into contract management arrangements all issues identified from the audits.

38 Implementation of recommendations should be followed up at contract monitoring meetings with providers. The PCT should also regularly use the PbR National Benchmarker to identify further issues with provider data and performance.
Inpatient clinical coding audit

Qualified clinical coding auditors have audited the PbR processes at all acute trusts. Results for The Rotherham NHS Foundation Trust and other significant local providers are summarised in Figure 1. Due to the targeted nature of these audits and the small sample of activity examined, these results should not be extrapolated beyond the actual sample.

Figure 1: HRG, procedure and diagnosis error rates respectively for Rotherham Primary Care Trust’s main providers

The main chart to comment upon is the HRG error rate (left hand side chart) as it has most impact on the financial outcomes. The error rate found in 2009/10 is slightly higher than 2008/09 but this is consistent with regional and national results and is not unexpected as it was the first year that the HRG 4 tariff was examined. The error rate at the Rotherham NHS Foundation Trust was well below the regional and national average. Further details of the results nationally are available in the Audit Commission report - ‘Improving data quality in the NHS’ (August 2010).
Outpatients

41 The outpatient audits reviewed provider data quality arrangements using a scored assessment against Key Lines of Enquiry (KLOEs) and then 150 key outpatient data items per provider were tested back to source documentation.

42 Figure 2 below shows a wide variation in your provider error rates ranging from 1.33 per cent to 14.67 per cent although the national variation is even greater. The main cause of error was recording incorrectly whether the appointment was a first or follow up attendance. Other causes of error included the incorrect treatment function or incorrect procedure. Again further details are included in the recent national report.

Figure 2: Percentage of outpatient attendances with one or more errors that affect price

Payment by results in 2010/11

43 In response to the feedback from our consultation in 2009, the PbR audit framework will become risk based and focus on areas which need to improve the most. For 2010/11, we will focus inpatient and outpatient audits on the worst performing trusts and independent sector providers who contract with the NHS. The programme will also be more commissioner-focused. We will develop a framework for identifying financial risks of provider data quality and review local contract management arrangements. We will also move into reviewing the quality of costing information by reviewing reference cost submissions at all acute trusts.
Current and future challenges

**Equity and excellence: Liberating the NHS**

The NHS White Paper - Equity and excellence: Liberating the NHS (July 2010), sets out the Government’s long-term vision for the future of the NHS.

**Organisational change**

The Government is committed to ensuring that patients are put at the heart of the NHS through the devolution of power and responsibility for commissioning services to the healthcare professionals closest to patients. Arising from this decision, PCTs are to be abolished by April 2013 with responsibility for the commissioning of most NHS services being assumed by GPs and their practice teams working in consortia.

In terms of NHS financing there is a commitment to increase healthcare spending in real terms in each year of this Parliament. There is an equal determination to achieve £20 billion of efficiency savings by 2014 for reinvestment in front-line services. This latter ambition will require NHS management costs to be reduced by more than 45 per cent over the next four years.

**Managing the transition**

Outgoing PCTs have a critical role to play in managing the transition to the new arrangements. In the short term imperatives are to:

- restructure management arrangements to secure recurrent savings in management costs; and
- work more closely with GPs to agree the size of consortia/consortium to be established and prepare the new administration so that it operates in 'shadow form' from 2011/12.

We will continue to monitor developments and discuss any audit implications with management. During 2010/11 we will focus particularly on the drive to reduce management costs and the accounting implications that stem from this action.

**Economic downturn**

Although the UK economy is now officially moving out of recession the economic downturn continues to have a very significant impact on public finances generally and the bodies that manage them.
Current financial health

For the PCT, funding levels look to be assured for 2010/11 with growth in financial allocations to be maintained at around 6 per cent per annum. Reports on financial performance so far in 2010/11 indicate strong pressure on the continuing care budget due to higher demand for placements. Increased levels of spending in this area are currently reported as being containable from reserves. The PCT will need however to closely monitor its financial position throughout the remainder of the year to ensure delivery of the desired operational and financial outcomes.

Longer term financial prospects

Beyond 2010/11, there is, as indicated above, an assurance that overall funding of the NHS will increase in real terms. Allocations for 2011/12 will not however be known until spending plans are announced in the Spending Review this autumn.

The emphasis on delivering greater efficiency in the use of resources comes at a time when management costs are being drastically reduced and so is likely to present a major challenge to the PCT.

In accordance with our VFM conclusion responsibilities from 2010/11 we will consider the PCT’s financial health as well as its ongoing prioritisation of resources.

Transforming Community Health Services

In its vision for primary and community care the Department of Health (DH) made a public commitment to creating modern, responsive community health services which are delivered to a consistently high standard.

Transfer of functions

In order to create an environment in which the desired improvements can be achieved PCT’s were required to review their organisational structures during 2009 to create an internal separation from their operational provider services and establish a contractual relationship for the delivery of services. Having achieved an internal separation of functions PCTs are now required to make arrangements for all community services to transfer to other organisations for them to manage. The transfer of functions is necessary by April 2011.

Management action

Progress is being made in line with the timetable prescribed. Extensive discussions have taken place with potential providers and staff to develop proposals for the transfer and future management of services. The principles of transfer are now agreed and a formal consultation process with stakeholders is underway. Proposals remain subject to scrutiny by the strategic health authority, the national competition panel and Monitor (due diligence review for foundation trusts wishing to take on services).
57 We will continue to track the progress being made towards achieving the transfer of services with attention given to the terms of transfer and associated governance and accounting issues.
Closing remarks

58 I have discussed and agreed this letter with the Chief Executive and the Director of Finance. I will present this letter at the Audit and Assurance Committee on 20 October 2010 and will provide copies to all Board members.

59 Further detailed findings, conclusions and recommendations in the areas covered by our audit are included in the reports issued to the PCT during the year.

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<td>April 2009</td>
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<tr>
<td>Payment by Results</td>
<td></td>
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<tr>
<td>■ Inpatients – The Rotherham NHS FT</td>
<td>February 2010</td>
</tr>
<tr>
<td>■ Outpatients – The Rotherham NHS FT</td>
<td>March 2010</td>
</tr>
<tr>
<td>Annual governance report</td>
<td>June 2010</td>
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<tr>
<td>Audit opinions and certificate</td>
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</tr>
<tr>
<td>Review of Internal Audit</td>
<td>August 2010</td>
</tr>
<tr>
<td>Use of resources</td>
<td>August 2010</td>
</tr>
<tr>
<td>Annual Audit Letter</td>
<td>October 2010</td>
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</table>

60 The PCT has taken a positive and constructive approach to our audit. I wish to thank the PCT staff for their support and co-operation during the audit.

Damian Murray
District Auditor
October 2010
Appendix 1  Audit fees

The analysis below shows that we contained our audit fee within the totals agreed with you via the 2009/10 Audit Plan.

<table>
<thead>
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<th></th>
<th>Actual £</th>
<th>Proposed £</th>
<th>Variance £</th>
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<td>Financial statements and annual governance statement</td>
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<tr>
<td>Use of Resources/VFM Conclusion</td>
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<tr>
<td>Total</td>
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This table shows the score and conclusion for each key line of enquiry.

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<tr>
<th>Themes (in bold) and key lines of enquiry</th>
<th>Use of resources score</th>
<th>Adequate arrangements for the value for money conclusion</th>
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<tr>
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<td>Planning for financial health</td>
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</tr>
<tr>
<td>Understanding costs and achieving efficiencies</td>
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<td>Governing the business</td>
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<td>Not applicable</td>
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<td>Workforce planning</td>
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</table>
Appendix 3  Glossary

Statement on Internal Control

Public bodies must provide assurance that they are properly managing and controlling their money, time and people. The Statement on Internal Control (SIC) is an important document for communicating these assurances to Parliament and citizens.

The SIC is the means by which the Chief Executive Officer declares his or her approach to and responsibility for, risk management, internal control and corporate governance. It is also used to highlight weaknesses which exist in the internal control system within the organisation. It forms part of the Annual Report and Accounts.

Audit opinion

On completion of the audit of the accounts, auditors must give their opinion on the financial statements, including:

- whether they give a true and fair view of the financial position of the audited body and its spending and income for the year in question;
- whether they have been prepared properly, following the relevant accounting rules; and
- for local probation boards, primary care trusts and strategic health authorities, on the regularity of their spending and income.

Financial statements

The annual accounts and accompanying notes.

Qualified/unqualified opinions

Statement of whether or not the auditor has some reservations or concerns.

Value for money conclusion

The auditor’s conclusion on whether the audited body has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of money, people and time.
The Statement of Responsibilities of Auditors and Audited Bodies issued by the Audit Commission explains the respective responsibilities of auditors and of the audited body. Reports prepared by appointed auditors are addressed to non-executive directors, members or officers. They are prepared for the sole use of the audited body. Auditors accept no responsibility to:

- any director/member or officer in their individual capacity; or
- any third party.

Audit Commission
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www.audit-commission.gov.uk

October 2010
Yorkshire and the Humber Specialised Commissioning Group
Board Meeting – 22 October 2010

Decision Summary for PCT Boards

1. Strategy and Direction

SCG 97/10 Vascular Services Review

It was agreed that:

(c) subject to SHA approval all the recommendations set out in the Vascular Services Review be publicly consulted upon.

SCG 98/10 Vascular Services Review – Communications and Engagement Plan

It was agreed that:

(b) a report on the outcome of the consultation be submitted to the SCG Board meeting in February 2011.

2. Policy

Nothing to report.

3 Governance

Nothing to report.
YORKSHIRE AND THE HUMBER SPECIALISED
COMMISSIONING GROUP

Minutes of the meeting held on
Friday, 22 October 2010
In the Chevet Suite, Sandal Rugby Club, Wakefield

Present:

Ailsa Claire  Chief Executive (Chair)  NHS Barnsley
Steve Wainwright  Deputy Chief Executive  NHS Barnsley
Annette Laban  Chief Executive  NHS Doncaster
Andy Buck  Chief Executive  NHS Rotherham
Sarah Lever  Deputy Director of Contracting  NHS Sheffield
Ian Atkinson  Director of Performance & Delivery  NHS Sheffield
Ann Ballarini  Director of Strategy & Commissioning  NHS Wakefield
Carol McKenna  Director of Commissioning  NHS Kirklees
Jayne Brown  Chief Executive  NHS North Yorkshire & York
Simon Morrirt  Chief Executive  NHS Bradford & Airedale
Debbie Graham  Director of Business Intelligence  NHS Calderdale
Julia Mizon  Assistant Director – Contracting and Performance  NHS Hull
Caroline Briggs  Director of Strategic Commissioning & Development  NHS North Lincolnshire
Sue Rogerson  Director of Collaborative Commissioning  North East Lincolnshire Care Trust Plus
Rob Webster  Chief Executive  NHS Calderdale

In Attendance:

Cathy Edwards  Director  Yorkshire & the Humber SCG
Kevin Smith  Medical Advisor  Yorkshire & the Humber SCG
Lisa Marriott  Assistant Director of Commissioning  Yorkshire & the Humber SCG
Frances Carey  Deputy Director of Finance  Yorkshire & the Humber SCG
Laura Sherburn  Deputy Director of Commissioning – Specialised Services  Yorkshire & the Humber SCG
Pia Clinton-Tarestad  Asst Director of Commissioning – Specialised Services  Yorkshire & the Humber SCG
Ged McCann  Associate Director of Commissioning – Specialist Mental Health  Yorkshire & the Humber SCG
Paul Crompton  Business Manager  Yorkshire & the Humber SCG
Chas Newstead  Clinical Lead Renal Network  Leeds Teaching Hospitals
Chris Welsh  Medical Director  NHS Yorkshire & the Humber

SCG Apologies

Ivan Ellul  Chief Executive  NHS East Riding
Jan Sobieraj  Chief Executive  NHS Sheffield
Steve Hackett  Director of Finance  NHS Barnsley
Andy Buck  Chief Executive  NHS Rotherham
Maddy Ruff  Director of Commissioning  NHS Hull
Declarations of Interest

There were no declarations of interest.

Minutes of the meeting held on Friday 24 September 2010

The minutes of the meeting held on 24 September were accepted as a true and accurate record.

The meeting confirmed that the format of the ‘Decision Summary for PCT Boards’ was useful.

Matters Arising

(a) **Paediatric Cardiac Surgery**

Cathy Edwards gave an update on the situation in respect of Paediatric Cardiac Surgery.

The National Specialised Commissioning Team had issued a briefing note, a copy of which had been circulated with the agenda for the meeting.

In view of the availability of new information a mortality review group had been established to review the higher than expected level of mortality in paediatric cardiac surgery at three centres. In respect of Leeds Teaching Hospitals this would relate specifically to the procedures of tetralogy repair which were undertaken between April 2003 and March 2006. This review would take place in October and the findings would be presented to Sir Ian Kennedy’s Expert Panel in December. The Joint Committee of PCTs would be agreeing the recommendations for public consultation in December taking into account all the review findings including the findings of the mortality review group.

The public consultation on paediatric cardiac surgery would take place from January 2011 for fifteen weeks.

The options for consultation would be based on achieving ‘viable clinical networks’.

**It was agreed:** that the update on paediatric cardiac surgery be noted.

(b) **Pilot PIPE at HMP Hull**

Ged McCann gave a brief update on the pilot Psychologically Informed Patient Environments (PIPE) initiative at HMP Hull.

**It was agreed:** that the update on the pilot PIPE at HMP Hull be noted.

(c) **QIPP and Evidence Based Commissioning (EBC)**
In response to a question relating to the costing of EBC initiatives in the QIPP programme, it was advised that the impact could only be assessed on an individual PCT basis.

**Vascular Services Review**

A report was presented to the meeting setting out the recommendations from the review of vascular services.

The review had considered a number of options for providing resilient vascular services across the region. There was no ‘one size fits all’ solution. Vascular services also had links with a range of other services and this needed to be carefully considered.

A detailed impact assessment setting out a range of options had been shared with all stakeholders in January 2010 and responses received back. Significant work had then undertaken at a sub-regional level to seek and reach consensus on the best fit locally. From this, a preferred option for each sub-regional had been identified.

The report was accompanied by an impact assessment of options to deliver the vascular designation standards and a full list of the documentation that was considered during the review.

The concept of partnership working had emerged as an overarching theme from the sub-regional discussions, driven by the acknowledgement that significant changes to clinical practice and workforce within vascular services were anticipated over the next 5-10 years and a partnership over a larger population may be better placed to respond to these changes. As a result of these discussions, all of the preferred service models involved partnership across two or more existing providers of vascular services.

The proposed model for North & East Yorkshire and Humberside was a single service with two collaborating centres in Hull and York, with some elective non arterial surgery being carried out at Harrogate, Scarborough, Scunthorpe and Grimsby, along with local outpatient clinics.

The proposed model for West Yorkshire Central was a single service with all vascular emergencies and major elective vascular arterial surgery carried out on the Leeds General Infirmary site, with outpatients, day cases, intermediate cases (including renal access) and ward attendees continuing to take place at Mid Yorkshire hospitals, through a unified partnership of the existing clinical teams.

The proposed model for West Yorkshire West was a single service with two collaborating centres for all levels of care in Bradford and Calderdale and Huddersfield, with outpatient and day case activity continuing to be provided in Airedale. Out of hours care would alternate on a weekly basis between Bradford Royal Infirmary and Huddersfield Royal Infirmary.

The proposed model for South Yorkshire and Bassetlaw was a single service with two collaborating centres in Doncaster and
Sheffield delivering elective and emergency care levels 2 and 3 activities across both sites, with some non arterial surgery and outpatient clinics continuing to be carried out in Barnsley, Rotherham and Bassetlaw. Complex level 4 cases would continue to be undertaken at Sheffield Hospital.

It was noted that the recommendations set out in the review would impact on existing contracts.

The report highlighted a number of overarching risks and proposed mitigation for these.

In terms of implementing the report it was recommended that a regional public consultation exercise be undertaken and that interim designation of vascular services would take place in June 2011 with full designation the following year in June 2012. The report also identified the data collection and performance targets that should be incorporated into new contracts.

The draft recommendations of the Office of Government Commerce (OGC) Gateway Review were also presented to the meeting, these focused on implementation, planning, risk management, consultation and workforce planning.

The National Clinical Advisory Team (NCAT) review was also referred to, which commented on the following: the risks associated with partnerships; the need to scrutinize and hold to account partnerships; issues around recruitment and retention; the low volume of patients in some areas and the proposed number of centres.

The SCG was content that the proposed approach, met the service requirements had cross organisational support and was built on strong clinical, patient and public engagement. The need for strong local commissioner support was regarded as essential.

It was agreed:

(a) that the recommendations from the OGC Gateway Review were supported.

(b) The NCAT Review comments were noted.

(c) that subject to SHA approval all the recommendations set out in the Vascular Services Review be publicly consulted upon.

SCG 98/10 Vascular Services Review – Communications and Engagement Plan

The Communications and Engagement Plan for the Vascular Services Review was presented to the meeting. The plan had been developed through the Patient and Public Involvement (PPI) Steering Group.

The SCG would co-ordinate the media element, arrange sub regional events and support PCTs. A press release would be
made on the 25 October 2010.

The consultation documentation had been prepared. The outstanding information from PCTs should be provided to the SCG by 26 October 2010.

**It was agreed:**

(a) that the Communication and Engagement Plan for the Vascular Services Review be approved;

(b) that a report on the outcome of the consultation be submitted to the SCG Board meeting in February 2011.

In conclusion it was agreed that Pia Clinton-Tarestad should be congratulated on the quality of the work in the Vascular Services Review.

**SCG 99/10 Cancer Services Improving Outcomes Guidance (IOG) Updates**

Three reports on cancer services IOG updates were presented to the meeting.

(a) **Brain/CNS**

There were a number of risks to compliance with the Brain/CNS IOG. Failure to recruit to key posts had been an issue for all three cancer networks, although it was hoped that these posts would be in place by December 2010.

Good progress had been made to achieving IOG compliance within NTCN and YCN since the last update in December 2009. Progress in HYCCN had been limited, primarily as commissioners and providers had been unable to identify the investment required to make continued progress. This would impact upon the level and quality of services for patients.

(b) **Sarcoma**

It was anticipated that the services in place in Leeds and Sheffield would comply with the Sarcoma IOG. The services in Hull, however, could not become compliant as they do not meet the minimum numbers required. The Cancer Action Team had reaffirmed that any Centre carrying out surgery must undertake a minimum of 100 cases on site. Actions were being taken at Chief Executive level to consider this service within the overall strategic context of Hull as a Cancer Centre.

(c) **Children & Young People (CYP)**

It was anticipated that the Principal Treatment Centres in Leeds and Sheffield would comply with the CYP IOG, however there was a residual risk that shared care agreements would not be in place in time. There was also a risk to compliance within the shared care hospitals, which
would need to be assessed through local planning and commissioning processes.

The lack of a paediatric oncology consultant within HEY posed a critical risk to IOG compliance and the level and quality of patient care. The appointment to this post was being actively pursued.

The SCG was performing reasonably well against the Peer Review commissioning measures for children's cancer, but further work was required before the Hull Peer Review, which would take place in 2011.

**It was agreed:**

(a) that the update reports on all the Cancer Services IOGs be noted and

(b) that in respect of Brain/CNS and Sarcoma a further report be made to the November SCG Board meeting setting out the NEYCOM analysis of the issues in the context of Hull's strategic position as a Cancer Centre and an action plan on how these matters would be addressed.

**SCG 100/10 Draft Child and Adolescent Mental Health Services (CAMHs) Tier 4 Service Strategy and Commissioning Framework**

A report was presented to the meeting on the draft CAMHs tier 4 Service Strategy and Commissioning Framework.

The strategy set out the commissioning intentions for the future design and delivery of CAMHS tier 4 services in Yorkshire and Humber, and the principles underpinning these intentions. The scope of the strategy covered the elements of the CAMHS care pathway that deliver highly specialised Tier 4 services, the majority of which are currently inpatient services, to which patients are admitted on an overnight stay basis, for intensive specialist input and treatment. However, some configurations of Tier 4 services include out-reach and/or day-case services, depending on how community services are designed to interface with the specialised element of the pathway.

The commissioning of tier 4 services on a Yorkshire and Humber basis provided the opportunity to address inequalities of service access and offered a framework for a more strategic approach to service development and delivery.

The development of the strategy had been as a consequence of the work of the CAMHs tier 4 Regional Strategy Group which was formed in June 2009. It had been developed with input from and involvement of commissioners, service providers, clinicians, and patients and carers.

The review work had identified a number of issues which would need to be addressed, including: inconsistent thresholds for admission; inconsistent service models and standards; lack of data on services and funding; and inconsistent commissioning arrangements.
The proposed regional strategy would be the enabler in ensuring local, regional and national drivers would be addressed.

The next phase of work required was to undertake some detailed modelling and analysis, to gain greater understanding of the capacity that the strategic tier 4 model would need to provide, taking into account the impact of current and future tier 3 services. This was a significant piece of work and was required before it would be possible to commission the right levels of tier 4 services. There was already evidence that investment in some local tier 3 services had had an impact on reducing tier 4 demand. However, the current situation was made more complex by the approaching reductions in tier 3 spend in various localities in Y&H, and this needed to be fully understood before the service strategy could be implemented.

There was general support for the direction of travel outlined in the strategy.

The Commissioning Framework report set out three options for the commissioning of CAMHs Tier 4 services:

1. Work with current providers to deliver the entirety of the regional service strategy using the entirety of the financial envelope available without a tender process.

2. Serve notice on current contracts and run tender designation process for the entirety of new service delivery.

3. Maintain current contracts and work with current providers; use spot purchase expenditure to tender for services to eradicate out of region placements and align local contracts with this.

There was a discussion which highlighted that an approach had been developed in secure mental health, which could help with a consistent approach to providers.

It was agreed:

(a) that a final decision on the draft CAMHs Tier 4 Service Strategy be deferred to the next meeting of the SCG Board; and

(b) that a further paper on the proposed commissioning approach be presented to the next meeting of the SCG Board for consideration alongside the draft CAMHs tier 4 Service Strategy.

Laura Sherburn
/Ged McCann

SCG 101/10

Draft Financial Plan 2011-12

A paper was presented to the meeting which set out progress in developing the SCG Financial Plan for the current year and following three years to 2013/14, including the position in terms of contract baselines in 2010/11.

A comparison of current 2010/11 baselines to the final 2010/11
financial plan by PCT was also provided, together with a summary of the SCG Financial Plan, and for each PCT for the next three years.

Horizon scanning has also been reviewed and the information gathered had been used as the basis of the “Confirm and Challenge” event on 20 October, which was organised by the SCT and attended by PCT representatives.

The following themes emerged from the meeting.

(1) A regional discussion was required to agree a consistent approach to reviewing of non-PbR baselines across the acute provider organisations.

(2) A discussion was required to agree a consistent approach to taking forward the PbR principles for 2011-12, and whether this should be led on a sub-regional or regional basis.

(3) Commitment was required from SCG Board to implement appropriate risk shares for selected services in 2011-12, with agreement that individual PCT impacts would be accepted as part of the collective benefit.

(4) It was imperative that each of the three sub-regional fora robustly consider strategic commissioning issues, to ensure that commissioning decisions are taken with full understanding of the whole-system impact.

A discussion followed and a gap was identified between SCG decisions and the Contracting Consortia. Strategic commissioning discussions which had an impact across the whole region, did not always take place at the sub-regional level. It was also noted that the South Yorkshire PCTs had undertaken a lot of work on PbR/non-PbR issues and they intended to share this with other PCTs.

It was agreed:

(a) that Rotherham PCT would arrange a workshop for other PCTs, at the earliest opportunity to agree a consistent approach to reviewing non PbR baselines across the acute provider organisations;  

(b) that the SHA workshop on the 18 November be asked to consider the issue of establishing a consistent approach to PbR principles for 2011-12 and whether this should be led on a sub-regional or regional basis;

(c) that the background work for establishing risk shares for blood and marrow transplants (BMT) and blood products be commenced; and

(d) that the three sub-regional consortia be asked to submit issues that have a regional impact to the SCG Board prior to decisions being taken.
A report was presented to the meeting in respect of the SCG CQUINs scheme 2011-12.

Local SCGs were responsible for agreeing a CQUIN scheme with each provider of specialised services in their area, related to the contract value associated with those services.

The Clinical Standards Sub Group (CSSG) would lead the process of CQUIN development for 2011-12. The timetable for development included the following milestones:

**October:** Agree process for identifying priorities for Goals.

**November:** Agree priorities and invite proposals for Indicators.

**December:** Test draft long list of indicators with provider CQUIN leads (including information and finance leads) and with commissioner contract leads.

**January:** Agree final scheme for inclusion in contract negotiations with providers.

The process would need to work within the parameters set by YHSHA, take into account decisions of the NSCG, and be open to review once new guidance was published. Two schemes would be developed – one for acute and one for secure mental health.

It was proposed that a number of additional areas were included in the 2011-12 CQUIN scheme:

- Neurosciences;
- Haemophilia;
- Vascular; and
- Cystic Fibrosis.

The CSSG meeting on 14th October had agreed the following criteria to be used to prioritise goals/services for development of indicators for the acute scheme:

- Identified issue with clinical quality;
- Significant capacity to benefit from inclusion in CQUIN scheme;
- Overall service value-associated nominal CQUIN value; and
- Builds on progress made in 2010-11.

The CSSG also asked that a scheme be developed for Secure Mental Health and CAMHs Tier 4.

**It was agreed:**

(a) the timescales for the production of the 2011-12 scheme be noted;

(b) that the intention to develop a separate scheme for Secure Mental Health and CAMHs Tier 4 be noted; and

(c) that the draft criteria for prioritising goals be noted.

Kevin Smith
Interim Cancer Drug Fund (ICDF)

An update report on the Interim Cancer Drug Fund was presented to the meeting.

A policy for administration of the Interim Cancer Drug Fund (ICDF) had been developed by NHS Yorkshire and the Humber on the basis of legal advice from Beachcroft, and in collaboration with YHSCG and the three cancer networks in the region, and a copy was attached for information.

A service level agreement between YH SHA and YHSCG for administration of the fund was nearing completion. In addition, work was ongoing with finance and contract teams to agree payment for medicines to be funded from the ICDF and associated activity costs. Local cancer clinicians and networks would advise the SHA of their priorities for medicines to be funded from the ICDF by mid-November 2010. PCTs were involved in developing those priorities based on existing NHS funding arrangements. Until local priorities for the ICDF were established, funding requests would be considered by an SHA-led panel on an individual patient basis.

It was noted that a national cancer drug fund would continue in 2011-12. In preparation for next year there would need to be progress on three linked pieces of work. Firstly, there would need to be a full assessment of the current position in each network; secondly a consistent set of policies across Yorkshire & the Humber and thirdly prioritisation of drugs that fall outside of the policies.

It was agreed: that the update on the Interim Cancer Drug Fund be noted.  

Mitral Clip Devices Update

An update report on the mitral clip device was presented to the meeting.

At the SCG Board meeting on 23rd July 2010, it had been agreed that, alongside noting the commissioning statement on mitral clips "information and feedback was required on the outcome of cases where this treatment had been approved, and that this be presented at the October 2010 meeting of the SCG Board."

HEYT advise that they had performed 15 procedures in total, one from this region, since July 2010. Apart from 2 cases (one death and one revised procedure) all the patients were in ongoing follow-up in HEYT or in a local hospital.

The Trust and local commissioners were continuing to discuss the development of a service specification and to work on costings.

It was agreed: that the update report on the mitral clip device be noted.
The Exception Performance Report for the four months ending 31 July 2010 was presented to the meeting.

The year end forecast was showing an overspend of £5.9m.

**It was agreed:** that the Exception Performance Report for the period up to 31 July 2010 be noted.  

**SCG QIPP Programme**

An update report in respect of the QIPP Programme was presented to the meeting.

It had been agreed at the last SCG Board meeting that the submission for October 2010 would only include the risks and milestones identified for the 19 SCG QIPP Projects that were new or still highly relevant for the month of October, together with the overall financial summary.

The report identified the most significant changes and risks.

**It was agreed:**

(a) that the contents of the QIPP programme summary, financial summary and 19 project highlight reports be noted;

(b) that the report be approved for submission to the SHA; and

(c) that a business case relating to fertility at the LTHT be submitted to the November SCG Board meeting.

**Cardiac Surgery – Nuffield**

A verbal update on cardiac surgery (Nuffield) was given to the meeting.

**It was agreed:** that the matter be progressed though the WYCOM meeting.

**Low Secure Risk Share Update**

A report was presented to the meeting together with a revised proposal from NHS Sheffield which provided an update on the matter.

Following the last SCG meeting NHS Sheffield had made a further proposal in relation to withdrawing from the risk share arrangements for low secure services and proposing some “rules”, in the absence of any formally agreed processes around withdrawal.

A lengthy discussion followed which focused around the following key criteria:

- Did the proposals fundamentally affect the risk pool
- Did the proposals affect other PCTs
- What were the current protocols regarding leaving the risk share
• What would be the impact on forward planning

It was felt that there would now be a need to develop a more formal agreement in terms of risk share arrangements. There was also a need to ensure risk share arrangements were appropriately incentivised.

The members of the low secure risk share agreement were asked to give their views on the NHS Sheffield proposal.

NHS Sheffield indicated that they would pursue additional options around risk share including the opportunity to cap organisational risk.

**It was agreed:**

(a) that the NHS Sheffield proposals in respect of the low secure risk share not be accepted and

(b) that a further report be made to the SCG Board on future changes to SCG risk share arrangements, for all risk shares, including an evaluation of the proposals around risk capping.

**Audit Commission Recommendations – Update**

A report setting out the progress in delivering the recommendations of the Audit Commission report on the review of the Y&H SCG 2009/10 and in relation to risk share arrangements was presented to the meeting.

**It was agreed:**

(a) That progress in delivering the recommendations of the Audit Commission report on the review of the Y&H SCG be noted; and

(b) That the existing risk share arrangements noted within the audit recommendations from NHS Barnsley’s annual governance report be approved.

**Risk Assurance Framework**

In July 2010 the Board agreed a risk management process for SCG. It was agreed that the SCG Board would receive a quarterly assurance framework, highlighting all SCG risks with the potential to directly impact upon the delivery of either SCG’s or NHS Barnsley’s strategic objectives.

A fully inclusive risk register was now held centrally by the Specialised Commissioning Team (SCT). The SCT executive team had brought all risks from this register with a residual score of 20 or over to the Board’s attention, as per the enclosed Risk Exception Report.

It had been agreed that NHS Barnsley, as host PCT, would review the corporate SCG risks only within their Audit and Risk Management Committees, as it was only the corporate ones that affected NHS Barnsley uniquely in its capacity as host. These
were considered at the meeting of NHS Barnsley’s Audit Committee on 27th September. No specific risks were reported to SCT as directly impacting on NHS Barnsley strategic objectives.

**It was agreed:**

(a) that the contents of the Risk Exception Report be noted; and

(b) that the content and format of the Risk Exception Report be approved.

**SCG 111/10**

**Draft Minutes of the Designation Sub Group**

The draft minutes of the Designation Sub Group meeting held on 5 October 2010 were presented to the meeting.

**It was agreed:** that the draft minutes of the Designation Sub Group meeting held on 5 October 2010 be received.

**SCG 112/10**

**Minutes of the Performance Monitoring Sub Group**

The minutes of the Performance Monitoring Sub Group meeting held on 13 September 2010 were presented to the meeting.

**It was agreed:** that the minutes of the Performance Monitoring Sub Group meeting held on 13 September 2010 be received.

**SCG 113/10**

**Minutes of the Clinical Standards Sub Group**

The minutes of the Clinical Standards Sub Group meeting held on the 9 September 2010 were presented to the meeting.

**It was agreed:** that the minutes of the Clinical Standards Sub Group meeting held on the 9 September 2010 be received.

**SCG 114/10**

**Minutes of the Regional Policy Sub Group**

The minutes of the Regional Policy Sub Group meeting held on the 6 July 2010 were presented to the meeting.

**It was agreed:** that the minutes of the Regional Policy Sub Group meeting held on the 6 July 2010 be received.

**SCG 115/10**

**Draft Minutes of the Regional Policy Sub Group**

The draft minutes of the Regional Policy Sub Group meeting held on the 29 September 2010 were presented to the meeting.

**It was agreed:** that the draft minutes of the Regional Policy Sub Group meeting held on the 29 September 2010 be received.

**SCG 116/10**

**Minutes of the North Trent Neonatal Network Steering Group**

The minutes of the North Trent Neonatal Network Steering Group meeting held on the 11 August 2010 were presented to the meeting.
It was agreed: that the minutes of the North Trent Neonatal Network Steering Group meeting held on the 11 August 2010 be received.

Laura Sherburn

SCG
117/10
Minutes of the Yorkshire Neonatal Network Board
The minutes of the Yorkshire Neonatal Network Board meeting held on the 16 July 2010 were presented to the meeting.

It was agreed: that the minutes of the Yorkshire Neonatal Network Board meeting held on the 16 July 2010 be received.

Alison Gibbs

SCG
118/10
Draft Minutes of the Yorkshire & Humber Renal Strategy Group
The draft minutes of the Yorkshire & Humber Renal Strategy Group meeting held on the 6 September 2010 were presented to the meeting.

It was agreed: that the draft minutes of the Yorkshire & Humber Renal Strategy Group meeting held on the 6 September 2010 be received.

Jackie Parr

SCG
119/10
Minutes of the Forensic Catchment Group
The minutes of the Forensic Catchment Group meeting held on the 9 June 2010 were presented to the meeting.

It was agreed that the minutes of the Forensic Catchment Group meeting held on the 9 June 2010 be received.

Ged McCann

SCG
120/10
Draft Minutes of the Forensic Catchment Group
The draft minutes of the Forensic Catchment Group meeting held on the 3 September 2010 were presented to the meeting.

It was agreed that the draft minutes of the Forensic Catchment Group meeting held on the 3 September 2010 be received.

Ged McCann

SCG
121/10
Service Development Proposal – Specialist Centre for Stammering Children for the North of England, Speech Therapy Service
A report on the development of services for stammering children was presented to the meeting.

This service development proposal had been produced in response to an agreement in principle by PCT Chief Executives across Yorkshire and Humber to support the development of a Centre of Excellence for children and young people who require access to expert, evidence based, stammering support.

The Centre would provide:

- High quality expert intensive therapy based on agreed pathways and criteria for referral to centre, either in groups or individually
- Education and training to support local service provision,
recruitment and retention
• Clinical supervision to local services
• Research (grant funded)

It was agreed:

(a) that continued discussion take place with the Association for Research into Stammering in Childhood around funding and support;

(b) that a host provider be identified; and (c) that agreement in principle to on-going financial support be indicated.

Simon Morritt

SCG 122/10
Any Other Business
There were no items of other business.

SCG 123/10
Date of Next Meeting
9.00am on Friday, 26 November 2010 in the Board Room at NHS Kirklees.
NHS Rotherham

NHS Board November

The Medical Profession (Responsible Officers) Regulations 2010

Contact Details:

<table>
<thead>
<tr>
<th>Lead Director:</th>
<th>Dr John Radford</th>
<th>Lead Officer:</th>
<th>Dr David J Plews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title:</td>
<td>Director of Public Health</td>
<td>Title:</td>
<td>Medical Director</td>
</tr>
</tbody>
</table>

Purpose:

To inform the Board of the “Health Care and Associated Professions, Doctors, The Medical Profession (Responsible Officers) Regulations 2010” which come into force on 1st January 2011.

Recommendations:

The Board receives the legislation [ ref #1] and guidance [2].

Background:

The Board discussed the Responsible Officer role in September 2009 and endorsed the appointment of Dr David J Plews as NHSR’s Responsible Officer [3]. The development of the Responsible officer role is part of the programme of reforms set out in the White Paper Trust, Assurance and Safety [4].

The Responsible Officer role will ensure:

- doctors who provide care continue to be safe
- doctors are properly supported and managed in sustaining and, where necessary, raising their professional standards
- doctors who fall short of the professional standards expected, are identified and appropriate remedial, performance and regulatory actions are taken to safeguard patients
- increase public and professional confidence in the regulation of doctors

The Responsible Officer will play a crucial role in medical revalidation. The processes for medical revalidation are still being explored by a number of pilots (which NHSR is involved in). There is no date for implementation for medical revalidation as yet, but April 2013 is a possibility.

Under the legislation designated NHS bodies have a duty to appoint a Responsible Officer.

Under the legislation designated NHS bodies have a duty to provide the responsible officer with sufficient funds and resources necessary for them to be able to discharge their responsibilities.

The guidance states that the Responsible Officer must be a doctor registered with the GMC with a licence to practice. The responsible officer will be expected to have the competencies laid out in the Department of Health Document “A Competency
Framework for Responsible Officers”. This document has not been published yet. Previous guidance has indicated that the Responsible Officer role may be the designated bodies’ Medical Director.

### Analysis of Risks:

It is a statutory requirement to appoint a Responsible Officer for the 1st January 2011. It is a statutory requirement to adequately resource the Responsible Officer in their role.

### Return on Investment:

No extra funds are needed. Even within the current shrinking management resources there are currently no extra funds or resource required. This may change in the future. The Pathfinder Revalidation Pilot is currently leading to extra work and expenses of the nominated Responsible Officer, but this is being covered by the Pilot budget.

### Analysis of Key Issues:

NHSR must appoint a Responsible Officer for the 1st January 2011.

### Patient, Public and Stakeholder Involvement:

The responsible officer role has been specifically created in increase public and professional confidence in the medical profession and the care they deliver.

### Equality Impact:

N/a

### Financial Implications:

None, at this time.

Approved by: Chris Edwards

### Human Resource Implications:

The RO role is a “bolt-on” function in the absence of any other guidance. No extra remuneration or resource is provided by the DH hence the legislation mandating organisations to find anything needed from within current allocations. Currently no extra resource is actually needed. There is no start date for revalidation. When it does, the full resource issue for Rotherham GPs will then be down to GP Commissioners.

Approved by: Pauline Fryer

### Procurement:

N/a

Approved by:

### Key Words:

Responsible officer, revalidation
Further Sources of Information:

[1] The Medical Profession (Responsible Officers) Regulations 2010  

[2] The Role of the Responsible Officer  


NHS Rotherham Board  15 November 2010

Community Pharmacy Applications for the period 1 March 2010 – 31 August 2010

Contact Details:

<table>
<thead>
<tr>
<th>Lead Director:</th>
<th>Kath Atkinson</th>
<th>Title:</th>
<th>Director of Strategic Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Officer:</td>
<td>Keith Stamp</td>
<td>Title:</td>
<td>Programme Lead: Primary Care</td>
</tr>
</tbody>
</table>

Purpose:

To update the NHS Rotherham Board on the number and type of community pharmacy applications, which have been received and processed by the Local Pharmacy Panel during the period 1 March 2010 – 31 August 2010. Details of the applications are given at Appendix 1.

Recommendations:

The NHS Rotherham Board is requested to endorse the decisions made by the Pharmacy Panel during the period 1 March 2010 – 31 August 2010.

Background:

The Pharmacy Panel receives and determines the applications for inclusion in the Rotherham Pharmaceutical List. All applications are dealt with in accordance with “The NHS (Pharmaceutical Services) Regulations 2005, Information for Primary Care Trusts – revised 2009”.

Analysis of Risks:

It is essential that NHS Rotherham acts with utmost probity when making decisions on applications. Failure to observe the Regulations could result in determinations being successfully challenged by way of judicial review on the grounds of procedural irregularity, with all the resultant expense and delay that such proceedings inevitably involve.

Return on Investment:

The approval of these pharmacies has secured the adequate provision of pharmaceutical services in neighbourhoods of identified need.

Analysis of Key Issues:

During the period 1 March 2010 – 31 August 2010, the Pharmacy Panel received the following:

a) One application to Minor Relocate over 500 metres was granted but did not relocate within the prescribed 9 months, therefore the application failed

b) One application to Minor Relocate under 500 metres was granted and the relocation took place on 21 June 2010

c) One Preliminary Consent for a Wholly Mail Order (exempted site) pharmacy was
granted and has been converted to a full application and must open by February 2011

d) Two Preliminary Consents were granted, but were subsequently appealed to the FHSAU, one is still with the FHSAU, but the other had the appeal dismissed and must submit a full consent application by 12 February 2011

<table>
<thead>
<tr>
<th>Patient, Public and Stakeholder Involvement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>In determining the pharmacy applications, the Pharmacy Panel has consulted with all interested parties, which consist of all pharmacies in Rotherham, LINk Rotherham, Local Community Groups, Local Pharmacy and Medical Committees and, where appropriate, the Parish Council. The consultation period is 45 days for interested parties to make representations.</td>
</tr>
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<table>
<thead>
<tr>
<th>Equality Impact:</th>
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<tbody>
<tr>
<td>Decisions on applications are based on whether it is “necessary or expedient”, and, where appropriate, the “choice and competition” assessment to grant the application to secure an adequate provision of pharmaceutical service in a particular neighbourhood of Rotherham.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Financial Implications:</th>
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<tbody>
<tr>
<td>On 1 April 2010, the pharmacy global sum was devolved from the Department of Health to PCTs. This means that NHS Rotherham became responsible for funding pharmacy establishment payments. Every Pharmacy which exists within PCT boundaries will be entitled to an annual Establishment payment of between £23,278 - £25,100 depending on the numbers of items dispensed.</td>
</tr>
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| Approved by: John Doherty |

<table>
<thead>
<tr>
<th>Human Resource Implications:</th>
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<tbody>
<tr>
<td>There are no NHS Rotherham staffing changes. The approved pharmacy applications will lead to an overall increase in the number of pharmacists and dispensing staff working in the Rotherham area.</td>
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| Approved by: Peter Smith |

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<thead>
<tr>
<th>Procurement:</th>
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<tr>
<td>There are no formal procurement exercises associated with these applications, however NHS Rotherham may direct and reimburse pharmacies to provide certain services.</td>
</tr>
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| Approved by: Doug Hershaw |

<table>
<thead>
<tr>
<th>Key Words:</th>
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<tbody>
<tr>
<td>Pharmacy Panel applications</td>
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<tr>
<td>The National Health Service (Pharmaceutical Services) Regulations 2005, Information for Primary Care Trusts revised 2009</td>
</tr>
<tr>
<td>Necessary and Expedient</td>
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<tr>
<td>Choice and Competition</td>
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</tbody>
</table>
### Further Sources of Information:

<table>
<thead>
<tr>
<th>The National Health Service (Pharmaceutical Services) Regulations 2005, Information for Primary Care Trusts revised 2009</th>
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### NHS ROTHERHAM

**COMMUNITY PHARMACY APPLICATIONS FOR THE PERIOD**

**1 MARCH 2010 – 31 AUGUST 2010**

<table>
<thead>
<tr>
<th>Type of Application</th>
<th>Applicant</th>
<th>Site</th>
<th>Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor Relocation over 500 metres</td>
<td>Knollbeck Pharmacy</td>
<td>Brampton Medical Centre</td>
<td>Granted by the Pharmacy Panel</td>
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<td></td>
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<td>Did not relocate within time allowed</td>
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<td></td>
<td></td>
<td></td>
<td>Application failed</td>
</tr>
<tr>
<td>Minor Relocation under 500 metres</td>
<td>Lloyds Pharmacy</td>
<td>Aston-cum-Aughton Services Centre</td>
<td>Granted by the Pharmacy Panel</td>
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<td></td>
<td></td>
<td></td>
<td>Relocated from Hepworth Drive 21 June 2010</td>
</tr>
<tr>
<td>Preliminary Consent Wholly Mail Order</td>
<td>Rotherham Direct Pharmacy</td>
<td>Shakespeare Road Eastwood</td>
<td>Granted by the Pharmacy Panel</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Must submit a Full Consent application by 19 October 2010</td>
</tr>
<tr>
<td>Preliminary Consent New Premises</td>
<td>Pharmacare Solutions</td>
<td>Harthill Village</td>
<td>Granted by the Pharmacy Panel</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Appeal with the FHSAU</td>
</tr>
<tr>
<td>Preliminary Consent New Premises</td>
<td>Weldricks Pharmacy</td>
<td>The Pastures Todwick</td>
<td>Granted by the Pharmacy Panel</td>
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<td></td>
<td></td>
<td></td>
<td>Appealed to FHSAU</td>
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<td></td>
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<td>FHSAU upheld the Pharmacy Panel decision</td>
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<td></td>
<td></td>
<td></td>
<td>Must submit a Full Consent Application by 12 February 2011</td>
</tr>
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*ends*