NHS Rotherham

Better Health, Better Lives

Adding Quality and Value

Strategic Plan Refresh
2010 - 2015

Contents

1 Foreword

The NHS has witnessed unprecedented change and improvement since the NHS Plan was published in 2000. Health has improved. Access to services has improved. The number of people receiving treatment has increased. The quality of services has improved. And the way the NHS has worked has also changed.

Rotherham is amongst the most successful health systems in the country, improving enormously during the past decade. We aim to build on this, ensuring that we deliver on all national priorities and pledges, including those in the NHS Constitution.

We have reduced premature deaths, particularly from heart disease; have amongst the best access to GPs and the shortest hospital waiting times; have all but eliminated healthcare acquired infections in hospital; have high quality mental health services and services for people with learning disabilities. These improvements are recognised by local people who consistently report high levels of satisfaction with the local NHS and confidence that we will continue to improve.

Our achievements sit alongside those of our partners: Rotherham Metropolitan Borough Council, which has made huge strides towards better performance; South Yorkshire Police, who continue to provide good services in our borough; the community and voluntary sector, which plays such a crucial role in local life; and the business and commercial sector which is seeking to overcome the economic challenges resulting from the recession to once again be at the heart of a growing economy.

Together, we want to achieve the very best for the people, families and communities of Rotherham. And whilst major improvements have already been made, much remains to be done. We know that good health is cherished by us all – and yet about one third of people in Rotherham report that they suffer from poor health, many from long-term conditions.

Too many women smoke in pregnancy, and too few breastfeed. Not enough of our children receive all their vaccinations. 30% of our children will be overweight or obese by the time they go to secondary school. Sexually transmitted infections are growing. We still have too many adults who suffer heart disease, respiratory disease, diabetes and cancer. Too many people, especially older people, are admitted to hospitals following emergencies. People are still worried about the cleanliness and safety of our hospitals. Too many people die in hospital rather than at home or in a more homely care setting.

The improvements in access to services and hospital waiting times in Rotherham over the last five years have been remarkable and have been delivered at the same time as delivering financial balance. The good performance of Rotherham's NHS, our excellent financial standing and the very good relationships between all partners give us an excellent starting point for the next phase of our strategy.

The strategic context has of course changed. The NHS Constitution provides a valuable and clear framework of rights and responsibilities for us all. In *Good to Great – preventative, people centred, productive* the Government has set out its ambitions for the NHS. The financial outlook is tough as we prepare for the very significant tightening of NHS finances. The NHS Chief Executive has indicated the need to achieve £15 - £20 billion efficiencies and savings nationally over the next five years.

NHS Rotherham's strategy, *Better Health, Better Lives*, was launched in January 2009. This document, *Adding Quality and Value*, refreshes *Better Health, Better Lives*, taking account of the progress we have made during 2009 and the need to secure major quality and efficiency gains. It

has been prepared with input from partners including clinicians, local authority and the public, all of whom have been involved in shaping and challenging this refreshed strategy.

Our goal, vision and values are affirmed.

The progress made with *Better Health, Better Lives* is assessed. The key conclusion is that achieving our life expectancy ambition will be challenging – we need to strengthen action here. We also need to strengthen action to meet children and young people's needs.

Our strategic intelligence review, financial outlook, quality review and efficiency review are summarised. The key conclusions are:

- Ageing population with increasing numbers of long term conditions
- Recession impacting on health and health service finances
- Unsustainable trends of increasing hospital referrals and admissions
- A cumulative gap of £78.6m over four years between projected resources and base case projected costs
- A high performing health community
- A relative lack of information on quality in community services and the potential for better system wide alignment of the quality agenda to improve population outcomes
- Variations between GP practices in cost per patient
- Lack of demonstrable system wide impact of current demand management initiatives
- Over utilisation of acute hospital care which could be addressed by system wide reform and additional community capacity

Our refreshed strategy therefore focuses on:

- strengthening our staying healthy and long term conditions programmes in pursuance of our life expectancy ambition
- strengthening our children and young people's programme
- five major system efficiency programmes: world class primary care; long term conditions, intermediate care and urgent care; GP referrals and planned care; specialised services; improving clinical efficiency
- three key enabling programmes: aligning incentives across the health economy; commissioning for quality; and high impact clinical changes;
- reshaping services and providers to ensure we can sustain high quality service delivery and secure significant efficiency gain
- supporting these programmes and initiatives with our finance, workforce, estates and informatics plans, and by refreshing our organisational development strategy and ensuring that NHS Rotherham itself becomes a productive commissioner.

We will continue to improve public health, put clinical quality at the centre of our commissioning, and modernise services in line with best evidence and public expectations.

We will ensure that investment is made where it is most needed.

We will fundamentally change the shape and configuration of the local NHS, ensuring it can deliver major quality and efficiency gains. Our reconfiguration strategy '*Shaping our Future*' will be agreed by March 2010, consulted upon thereafter and implemented by March 2011.

We will ensure that we secure value for money from all the services and initiatives in which we invest.

By 2015 Rotherham's reshaped health services will be in their fourth year. We will have implemented our whole systems approach to delivering support to people with long term conditions. We will have opened at least three joint service centres with Rotherham Council. We will have modernised our mental health services. Rotherham Hospice will have become our centre of excellence for palliative and end of life care. Smoking in Rotherham will be below the national average, very few women will smoke in pregnancy, most mothers will breastfeed, and thousands of children and adults with have benefited from our obesity services. Older people will enjoy much better care closer to home. And when life comes to its end, many more people will be able to die with their dignity intact, in a place of their choosing.

We believe these and the many other successes we are determined to achieve over the next few years will be greatly cherished and of lasting value. We look forward to working with every one of you to turn this plan in to reality.

ALAN TOLHURST	**ANDY BUCK**	**CHARLES COLLINSON**
Chairman	**Chief Executive**	**Professional Executive Chair**

2 Vision and Values

2.1 Our vision

NHS Rotherham has ambitious plans for the future to make Rotherham a healthier place to live and to ensure that, wherever possible, we diagnose and prevent risks to health before they become serious. We want our NHS to become world class, providing the fair, personal, effective and safe treatment and care we know everyone wants.

We need to raise everyone's aspirations for their own health and their expectations of their health service. We want people to aspire to longer, healthier lives and to want nothing but the best from their health services.

Over the past decade we have been improving and modernising the NHS in Rotherham and have made a number of remarkable improvements including increased life expectancy by nearly two years and halved the number of premature deaths from heart disease and stroke since 1990.

Our vision is *Better Health, Better Lives* for everyone in Rotherham.

We want babies to be born healthy and to have the very best start in life, so that when they start school, children are ready to learn and succeed. Children and young people should be given every opportunity to be fit and active, and be well aware of the risks posed by obesity, smoking, alcohol, sex and drugs.

We want adults to enjoy continued good health, with quick convenient access to excellent services when they are ill. We want to work with people who have a long-term condition, such as diabetes or respiratory disease and we want to support people to manage their health and enable them to access high quality services. This will help to minimise the risks and damage done by these diseases.

When life comes to an end, we want people to be able to choose where they die, and to protect their dignity.

Our NHS is already performing well, and because of the careful management of our finances over the past few years, NHS Rotherham will be able to continue its ambitious and wide ranging programme of health service development and investment launched in 2008. To achieve this, however, we must secure significant efficiency gain from all providers and from the health and care system as a whole. We must also ensure we invest appropriately in new and improved services and facilities and that our investment provides value for money.

Involving our public and patients in planning for the future is very important. During the past few years, the dialogue between the public and the NHS has grown and grown. We know more about what the public want than ever before, which is great news, as it means we are much more able to provide services that meet your needs and aspirations.

Delivering improved health and well being cannot be achieved in isolation. We will work with partners and staff, including GPs, the hospitals and Rotherham Council to deliver seamless services that make the most effective use of the resources available. We have already embarked on some far reaching agreements with Rotherham Council to develop shared facilities for services and, in the case of services for some vulnerable groups such as people with learning disabilities, we have established joint services.

We recognise the importance of working closely with clinicians to deliver high quality, equitable health care. Proactive clinical engagement in strategic planning, service redesign and improving communication across all healthcare interfaces will continue and we will embrace clinical aspirations for health and health services in Rotherham.

NHS Rotherham will lead the reshaping of services and providers to ensure we can sustain high quality service delivery and secure significant efficiency gain. This part of our strategy will see the integration of community services with other parts of the local health economy.

The NHS in Rotherham can do more than improve health and deliver world class health services. We will be using our considerable presence to contribute to Rotherham's future success. We will employ local people, contribute to the wider regeneration of the town, support the thriving voluntary and community sector and contribute to tackling global warming by reducing our carbon footprint.

To achieve our vision we will engage the public and patients as partners, provide better information, advice and support, and encourage self care and "expert patients". Ambitious standards will be set for all services, and we will work with service providers to make sure these standards are achieved.

Director, clinical, programme and contract leaders have been identified for each of our priorities Implementation will be monitored in real-time. The overall progress and priorities of the strategic plan will be reviewed annually at the start of NHS Rotherham Board's Commissioning Cycle. But the most important test of whether we are succeeding is whether the patients, public and stakeholders agree that we are. We will continue to gather public views and opinions, and will use these to inform all that we do.

2.2 Our values

NHS Rotherham has refreshed its values, ensuring that they resonate with staff and reflect our local branding. Our refreshed values are:

Better Health, Better Lives

In everything we do we believe in:

- *Putting People First*
- *Working in Partnership*
- *Continuously Improving Quality of Care*
- *Showing Compassion, Respect and Dignity*
- *Listening and Learning*
- *Taking Responsibility and being Accountable*

We will do this for everyone – the people of Rotherham, patients, service users, carers and the general public, and all staff and partners.

3 *Better Health, Better Lives*

3.1 Development of *Better Health, Better Lives 2008-2012*

In 2008 we developed our strategy *Better Health, Better Lives*, determined that by being clear about our goal, ambitious in our vision and focussed on the most important issues, we will deliver further major improvement over the next five years, so that the NHS in Rotherham will continue to be the envy of many towns and cities in England.

Our vision is *Better Health, Better Lives* for everyone in Rotherham. Successful delivery of the strategy will make a major contribution to the realisation of the Rotherham Community Strategy for the next 5 years. We will make Rotherham a healthier place to live and prevent risks to health before they become serious. We want our NHS to become world class, providing the fair, personal, effective and safe treatment and care we know everyone wants.

Our vision and strategy have been based on extensive stakeholder consultation and as the details of our strategy have been refined we have shared these with our partners.

In the context section of *Better Health, Better Lives* we described in detail what the public, patients and clinicians told us about their aspirations for health services in Rotherham. These insights together with a series of multi-agency health needs assessments and insight into our current performance informed *Better Health, Better Lives*. The other key starting points were:

- *High Quality Care for All*, England's new strategy for the NHS, and *Healthy Ambitions*, the Yorkshire and Humber Health Strategy, provide the framework for all we are trying to achieve.
- Rotherham's Community Strategy and Local Area Agreement set out all partners' ambitions for the borough and the priorities upon which we will focus;

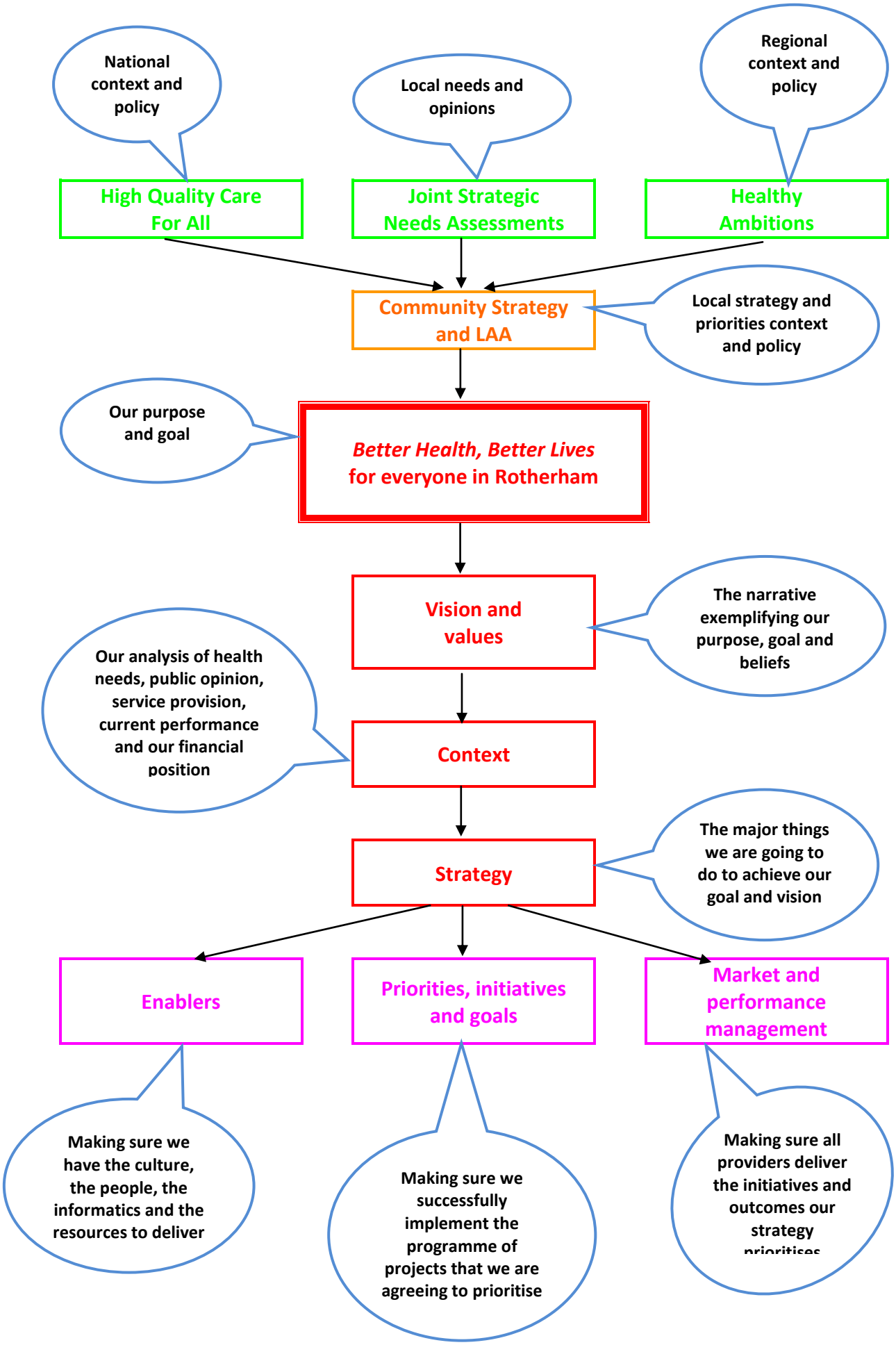
From our in-depth knowledge of the needs of our local population we identified our priority areas and grouped them into those used in *Healthy Ambitions*. We then identified 29 transformational initiatives and the enablers we need to deliver the strategy.

We grouped our **priority areas** as follows:

- First Class Primary Care Services
- Healthy Pregnancy and Birth
- Healthy Childhood
- Staying Healthy
- First Class Services
- Better Services for People with Long Term Conditions
- Better Mental Health
- Better End of Life Care

The journey we took to construct our strategy is described in figure 3.1.

Figure 3.1: The path to Better Health, Better Lives 2000-12



Knowing that we are succeeding and being able to recognise where further improvement is needed is crucial. For each priority area we chose an **outcome measure** with **specific goals** that we will achieve as indicators of our progress to becoming a world-class commissioner.

The ten key outcomes we chose to monitor and assess progress are set out below. The reason for their choice is explained in figure 3.2:

- Reduced health inequalities (measured by the Index of Multiple Deprivation)
- Improved life expectancy
- Increased breastfeeding (measured at 6 weeks)
- Increased childhood immunisation coverage
- Reduced smoking (measured by smoking quitters)
- Reduced ambulatory care sensitive hospital admissions
- Reduced healthcare-acquired infections (measured by clostridium difficile)
- Reduced cardiovascular mortality
- Increased dementia services (measured by the number of assessments)
- Improved choice of end of life care (measured by deaths outside hospital)

Whilst these are our main indicators of success, we also focussed on a wider range of indicators to ensure that the needs and aspirations of Rotherham's people and communities are being met.

Better Health, Better Lives was complemented by our *Financial Plan*, our *Communication and Public Engagement Strategy* and our organisational development strategy *Better Health, Better Lives, Better Delivery,* which set out the substantial organisational development we will make to ensure delivery. In figure 3.3 we summarise our goals, priorities, strategy and outcomes developed in 2008 and the 29 transformational initiatives.

Figure 3.2: 10 Strategic Outcomes and reason for choice

Programme Area	Strategic Outcome	Priority	Reason for Choice
Overall performance	Slope index of inequality	National	Rotherham's slope index of inequality is 9.7 years for men and 5.4 years for women. It has been a long standing borough wide priority to improve this.
	Life Expectancy	National	Life expectancy in Rotherham is lower than the national average and is not increasing as fast as the national average, particularly for males. There are also large variations in life expectancy within Rotherham.
Maternity & Newborn	Infants Breastfed at 6 weeks	Vital Sign B11 LAA	Rotherham has low rates of breastfeeding. Increasing breastfeeding will have a major impact on child health and in the longer term, the health of the overall population.
Children	Immunisation Targets	Vital Sign B10	Rotherham has very poor immunisation coverage. Improving coverage is essential to prevent childhood epidemics. Without action there is a high risk of serious health consequences.
Staying Healthy	Smoking Quitters	Vital Sign B05	Rotherham benchmarks around average for smoking quitters but 500 Rotherham residents still die prematurely each year due to smoking. Further reductions in smoking are essential if NHS Rotherham is to achieve many of its outcomes such as improvements in life expectancy.
Planned Care	Ambulatory Care Sensitive Hospital Admissions	Vital Sign C21	We benchmark poorly on this metric. This means that patients do not always receive care in the setting that is the most appropriate. Providing unnecessary care in hospital is also expensive and reduces the resources available for other NHS Rotherham priorities.
Acute Care	C. Difficile	Vital Sign A03	We benchmark relatively well on this metric. Rotherham's public and patients say that hospital acquired infections are one of their top concerns. Continuing to deliver on this outcome is essential for the reputation of local health services.
Long Term Conditions	CVD Mortality Rate	Vital Sign B02	Rotherham's CVD mortality rates are dropping faster than national rates. Providing comprehensive prevention and treatment is cost effective and will deliver large, quantifiable, health improvements for the people of Rotherham. Continuing to deliver improvements faster than nationally is essential if NHS Rotherham is to meet its life expectancy targets.
Mental Health	Numbers assessed by dementia service	Locally developed	No national benchmarking data are available. Joint strategic needs assessment has identified large and growing unmet needs for dementia patients and their carers.
End of Life	% of deaths not in hospital	Vital Sign C15	We benchmark below average. This means that at present some people in Rotherham do not have full choice over where they receive end of life care.

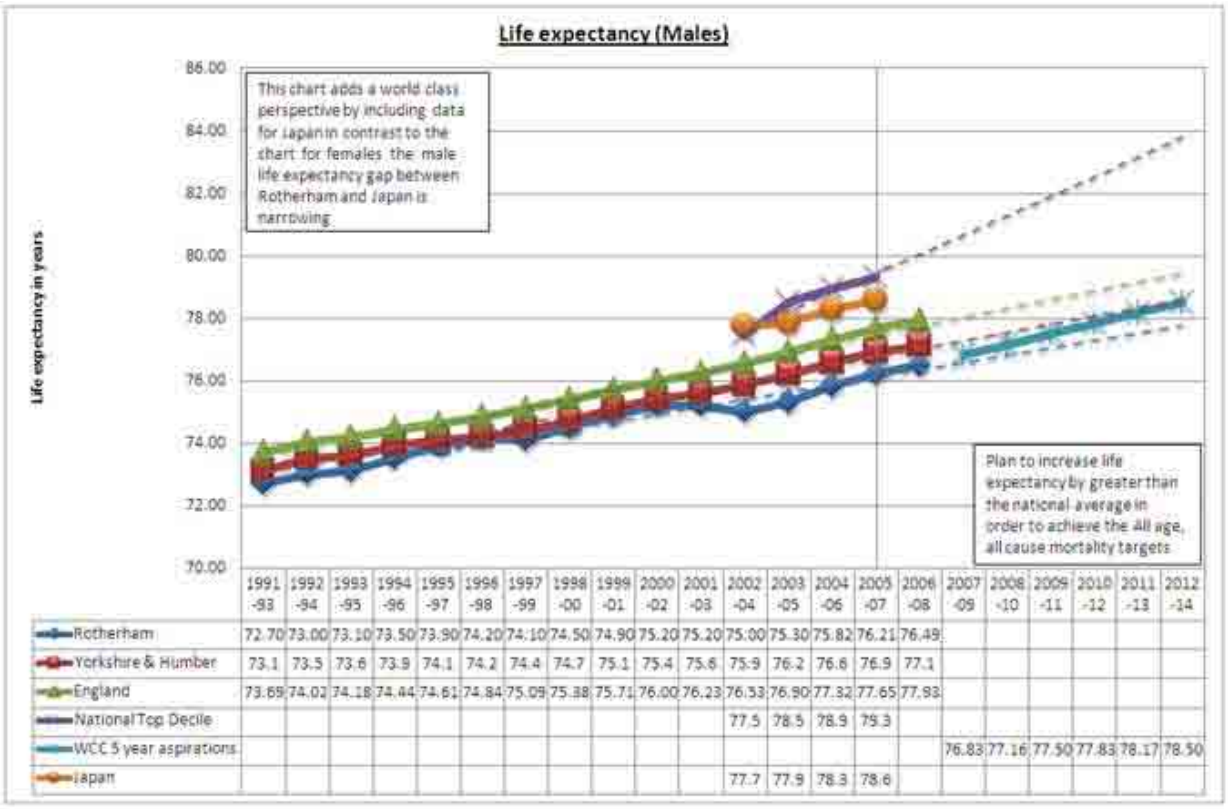
Figure 3.3: Better Health, Better Lives 2008-12 in summary.

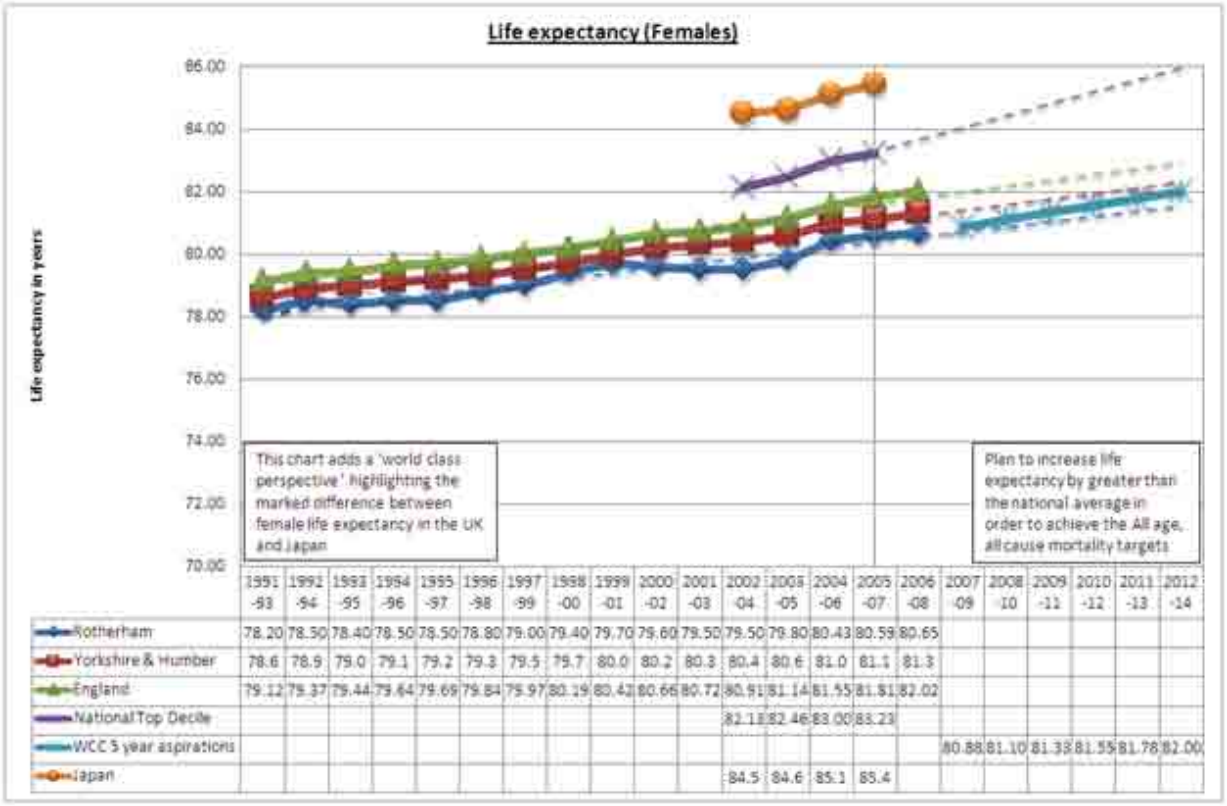
Vision	**Better Health and Better Lives for everyone in Rotherham**			
Priorities and initiatives	Ensuring everyone in Rotherham gets **First Class Primary Care Services** ○ Accessible high quality primary care ○ Effective prescribing – quality and efficacy ○ New and innovative NHS Rotherham Community Health Centre ○ Two new GP practices			
	Healthy Pregnancy and Birth ○ Increasing breastfeeding ○ Reducing smoking in pregnancy ○ Reducing teenage pregnancy	**Healthy Childhood** ○ Improving mental health services ○ Improving services for children with complex needs ○ New programme to reduce childhood obesity ○ Improving childhood immunisation	**Staying Healthy** ○ Reducing smoking ○ Reducing harm from alcohol ○ Improving sexual health ○ New programme to reduce adult obesity ○ Screening for CVD risk	**First class services** - Planned ○ Improving access and choice ○ Reducing the numbers of healthcare acquired infections
	First class services - Acute ○ Implementing robust admission and discharge criteria ○ Commissioning first class stroke services	**Better services for people with Long Term Conditions** ○ Accessible high quality intermediate care ○ Better prevention and treatment of falls ○ Improving diabetic services ○ Implementing the COPD care pathway	**Better Mental Health** ○ Improving mental health promotion ○ Accessible high quality psychological therapies ○ New mental health wards ○ Improving mental health services for older people	**End of Life Care** ○ Improving services and choice for end of life care
Strategy	Leadership and workforce development	Engage with the public and patients	Engage with NHS staff to deliver improvement	Work in partnership with NHS providers, Rotherham Council and Rotherham Partnership
	Finance, IM&T and premises strategies	Supplier development, contract management and performance management	Effective programme and project management	Secure value for money from all our investment
Outcomes	Health inequalities		Life expectancy	
	Immunisation targets	Breastfeeding	Number of assessments for dementia	Clostridium Difficile infections
	Admissions for Ambulatory Care Sensitive Conditions	CVD mortality	Smoking quits	Deaths not in hospital

3.2 Progress with strategic outcomes

3.2.1 Life Expectancy at Birth

National Indicator Life Expectancy
Life expectancy in Rotherham is lower than the national average and is not increasing as fast as the national average, particularly for males. There are also large variations in life expectancy within Rotherham.
Commentary on Progress
In 2008 there were more deaths in Rotherham than in the previous two years. This has had an adverse impact on our progress on life expectancy. We have a comprehensive life expectancy action plan that includes tobacco control, cardiovascular risk screening, better stroke care, effective prescribing, improved diabetic care, reducing obesity, initiatives on infant mortality, screening and excess winter deaths. Many of these initiatives will take several years to have an impact.
Ambition
• Our 2008 trajectory was to improve life expectancy faster than the national average in order to meet the extremely challenging vital sign all age all cause mortality trajectory that we are set as a spearhead PCT. • Our WCC life expectancy ambitions are to increase male life expectancy to 78.5 and female life expectancy to 82 by 2014.
Impact of achieving our ambition
Increasing life expectancy is sufficient reason in itself but it does correlate well with other indicators of well being such as quality of life and social capital.





3.2.2 Health Inequalities

National indicator: slope index of inequality
• The slope index of inequality is a new national outcome measuring long term changes in inequalities in life expectancy within districts. • To calculate the index all the Lower Super Output Areas (LSOAs) in Rotherham (smallest geographical areas for which population data are consistently available) are divided into tenths according to their IMD score (deprivation measures). A graph is then constructed of the life expectancy for each tenth, the index is the slope of this line. It is calculated over a 5 year rolling average. • For males Rotherham's slope index of inequality is 9.7 years (rank 100 out of 152 PCTs). Men in the most deprived tenth of Rotherham live 71.2 years compared to 80.4 in the most affluent tenth. For females Rotherham's slope index is 5.4 years (rank 67 out of 152 PCTS), women in the most deprived tenth live 77.1 years compared to 82.1 in the most affluent tenth.
Commentary on Progress
Data published by the National Information Centre, shows health inequalities in Rotherham have increased from 2003-07 to 2004-08. Previous work in Rotherham looking at changes in geographical inequalities measured by IMD and health outcomes has shown that geographical inequalities are resistant to change partly because of social mobility (individuals whose economic circumstance improve often choose to move neighbourhood). Rotherham has a range of geographically targeted initiatives as a legacy of previous Neighbourhood Renewal Funding and more recent initiatives focussing on the inequalities in central Rotherham.
Ambition
• The national assumption is that it will take 5 to 10 years for significant reductions in geographical inequalities to become apparent. Recessions tend to have the biggest impact on those who are most disadvantaged so it will be a substantial challenge to stop any deterioration in local geographical inequalities as Rotherham emerges from recession. • Our WCC ambition is to ensure there is no increase in local mortality inequalities by 2014.
Impact of achieving our ambition
Tackling health inequalities is sufficient reason in itself but it is also the case that the most deprived areas are the areas where there is most potential to make big improvements in outcomes such as life expectancy, cardiovascular mortality, smoking and breastfeeding.

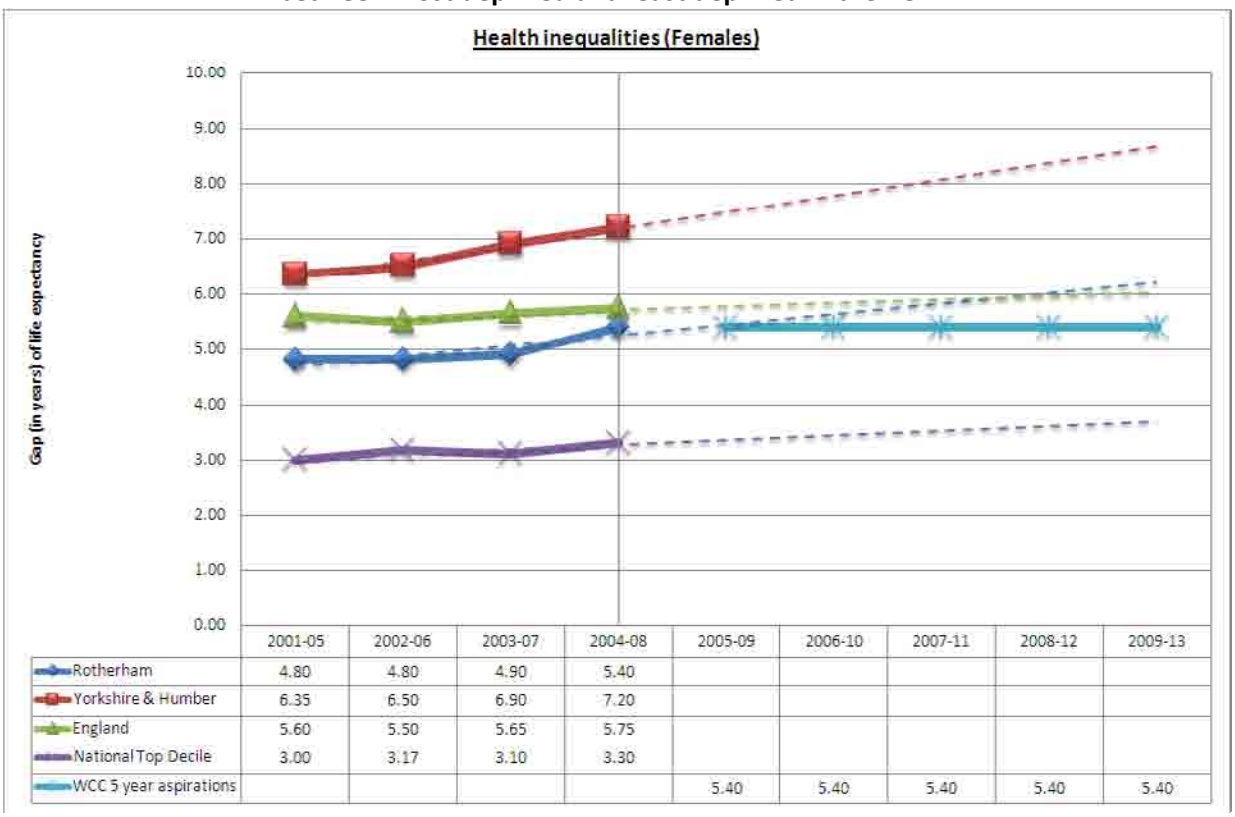
Health Inequalities – male

Slope index of inequalities in life expectancy by deprivation deciles: gap in years of life expectancy between most deprived and least deprived in the PCT

	2001-05	2002-06	2003-07	2004-08	2005-09	2006-10	2007-11	2008-12	2009-13
Rotherham	9.10	9.60	9.30	9.70					
Yorkshire & Humber	9.15	9.85	10.15	10.35					
England	8.40	8.30	8.70	8.60					
National Top Decile	5.74	5.80	5.80	5.70					
WCC 5 year aspirations					9.70	9.70	9.70	9.70	9.70

Health Inequalities – female

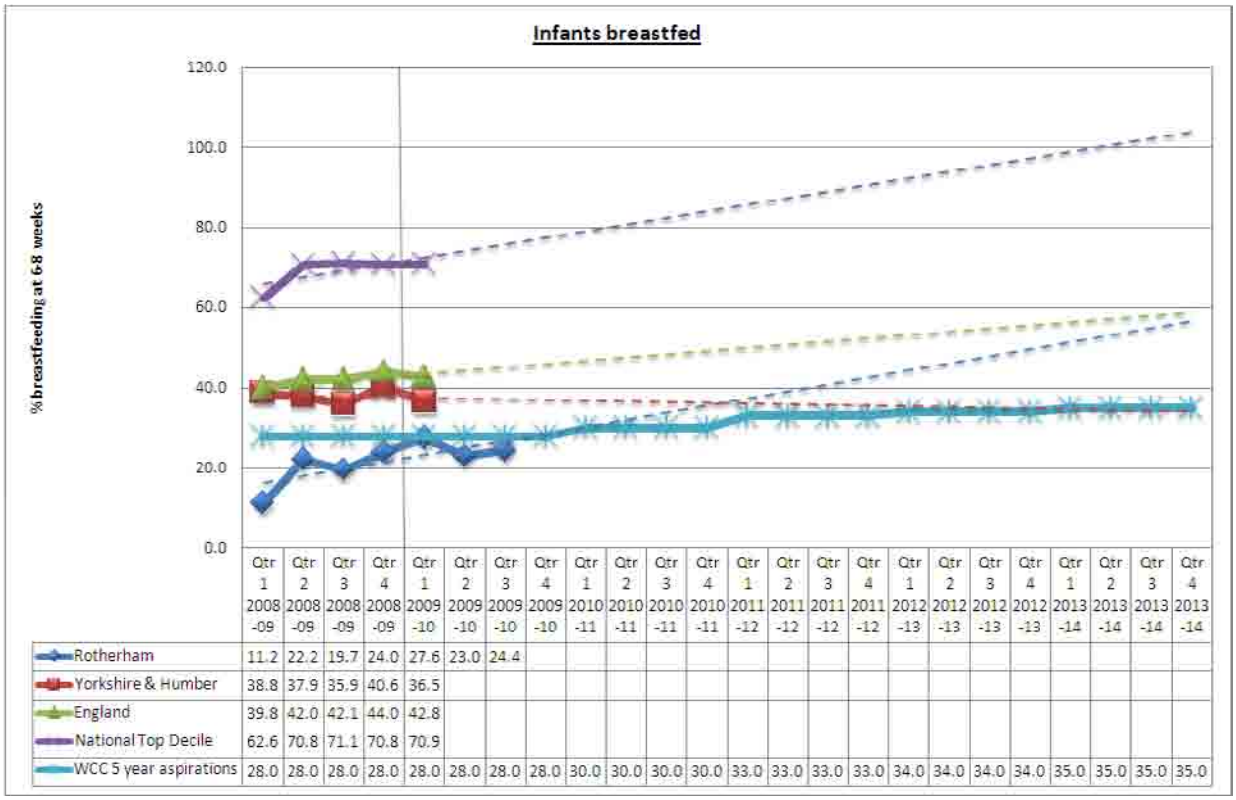
Slope index of inequalities in life expectancy by deprivation deciles: gap in years of life expectancy between most deprived and least deprived in the PCT



	2001-05	2002-06	2003-07	2004-08	2005-09	2006-10	2007-11	2008-12	2009-13
Rotherham	4.80	4.80	4.90	5.40					
Yorkshire & Humber	6.35	6.50	6.90	7.20					
England	5.60	5.50	5.65	5.75					
National Top Decile	3.00	3.17	3.10	3.30					
WCC 5 year aspirations					5.40	5.40	5.40	5.40	5.40

3.2.3 Breastfeeding at 6-8 weeks

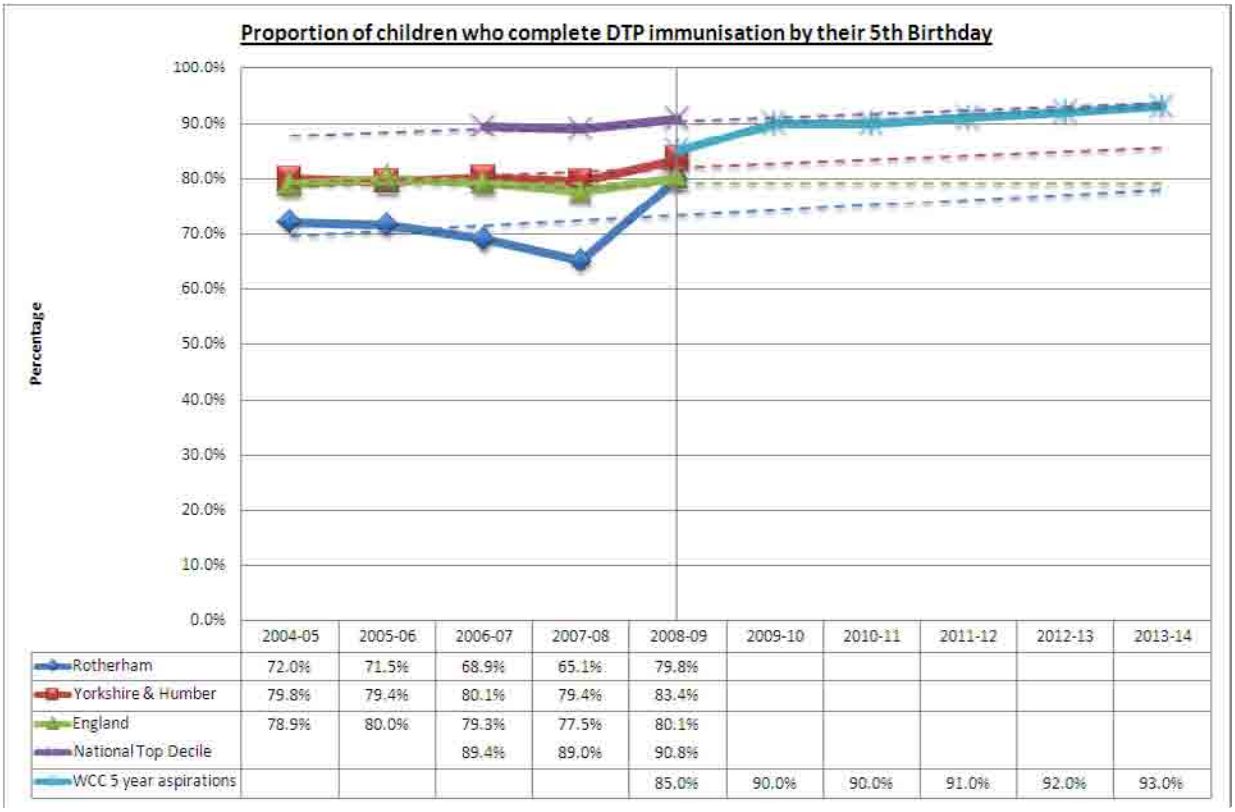
Reason for Choice
Rotherham has low rates of breastfeeding. Increasing breastfeeding at 6 weeks will have a major impact on child health and in the longer term, the health of the overall population.
Commentary on Progress
There is still work required to achieve fully robust data, as well as achieve changes in culture in parents and health workers. Although there appears to have been substantial improvements this year it remains to be seen if this is continued as the data become more robust.
Ambition
• We will increase the number of women who breastfeed to 35% in 2014 • This is a recommitment to the extremely challenging trajectory we set in 2008
Impact of achieving our ambition
• Increasing breastfeeding from 22% to 35% will reduce hospital admissions in children aged under 1 by 5% (225 admissions). • There will also be non quantifiable benefits in reducing childhood obesity.



	Qtr 1 2008 -09	Qtr 2 2008 -09	Qtr 3 2008 -09	Qtr 4 2008 -09	Qtr 1 2009 -10	Qtr 2 2009 -10	Qtr 3 2009 -10	Qtr 4 2009 -10	Qtr 1 2010 -11	Qtr 2 2010 -11	Qtr 3 2010 -11	Qtr 4 2010 -11	Qtr 1 2011 -12	Qtr 2 2011 -12	Qtr 3 2011 -12	Qtr 4 2011 -12	Qtr 1 2012 -13	Qtr 2 2012 -13	Qtr 3 2012 -13	Qtr 4 2012 -13	Qtr 1 2013 -14	Qtr 2 2013 -14	Qtr 3 2013 -14	Qtr 4 2013 -14
Rotherham	11.2	22.2	19.7	24.0	27.6	23.0	24.4																	
Yorkshire & Humber	38.8	37.9	35.9	40.6	36.5																			
England	39.8	42.0	42.1	44.0	42.8																			
National Top Decile	62.6	70.8	71.1	70.8	70.9																			
WCC 5 year aspirations	28.0	28.0	28.0	28.0	28.0	28.0	28.0	28.0	30.0	30.0	30.0	30.0	33.0	33.0	33.0	33.0	34.0	34.0	34.0	34.0	35.0	35.0	35.0	35.0

3.2.4 Percentage of children immunised by their 5th birthday (DTP boosters)

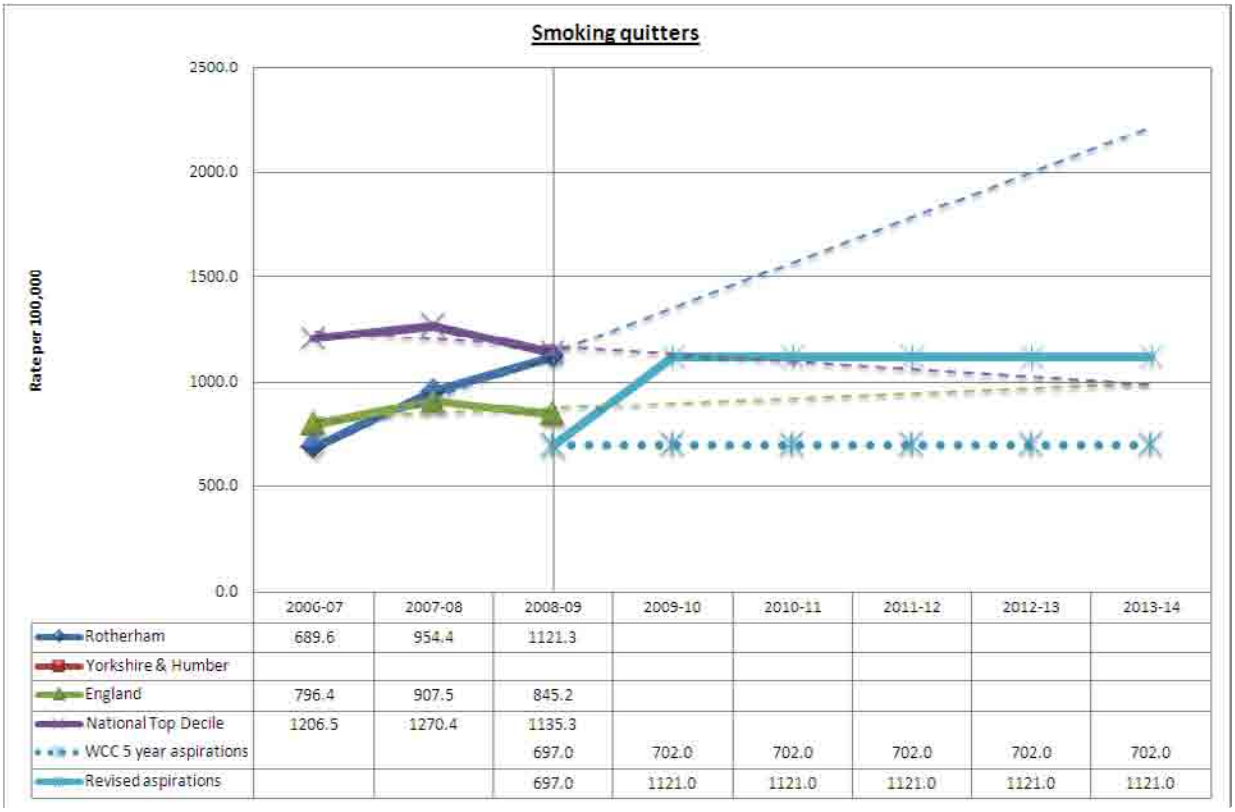
Reason for Choice
Rotherham has very poor immunisation coverage. Improving coverage is essential to prevent childhood epidemics. Without action there is a high risk of serious health consequences.
Commentary on Progress
We have made substantial progress in tackling Rotherham's historically low immunisation rates. Successful implementation of the plan for a locally enhanced service for immunisation will be necessary to improve coverage above 90%.
Ambition
• Pre school immunisation coverage will be 93% in 2014. • This is a recommitment of our 2008 trajectory which is well above the current national top decile.
Impact of achieving our ambition
The impact will be to minimise the risks of serious outbreaks of diseases such as measles which would otherwise have a dramatic impact on life expectancy.



	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Rotherham	72.0%	71.5%	68.9%	65.1%	79.8%					
Yorkshire & Humber	79.8%	79.4%	80.1%	79.4%	83.4%					
England	78.9%	80.0%	79.3%	77.5%	80.1%					
National Top Decile			89.4%	89.0%	90.8%					
WCC 5 year aspirations					85.0%	90.0%	90.0%	91.0%	92.0%	93.0%

3.2.5 Smoking Quitters

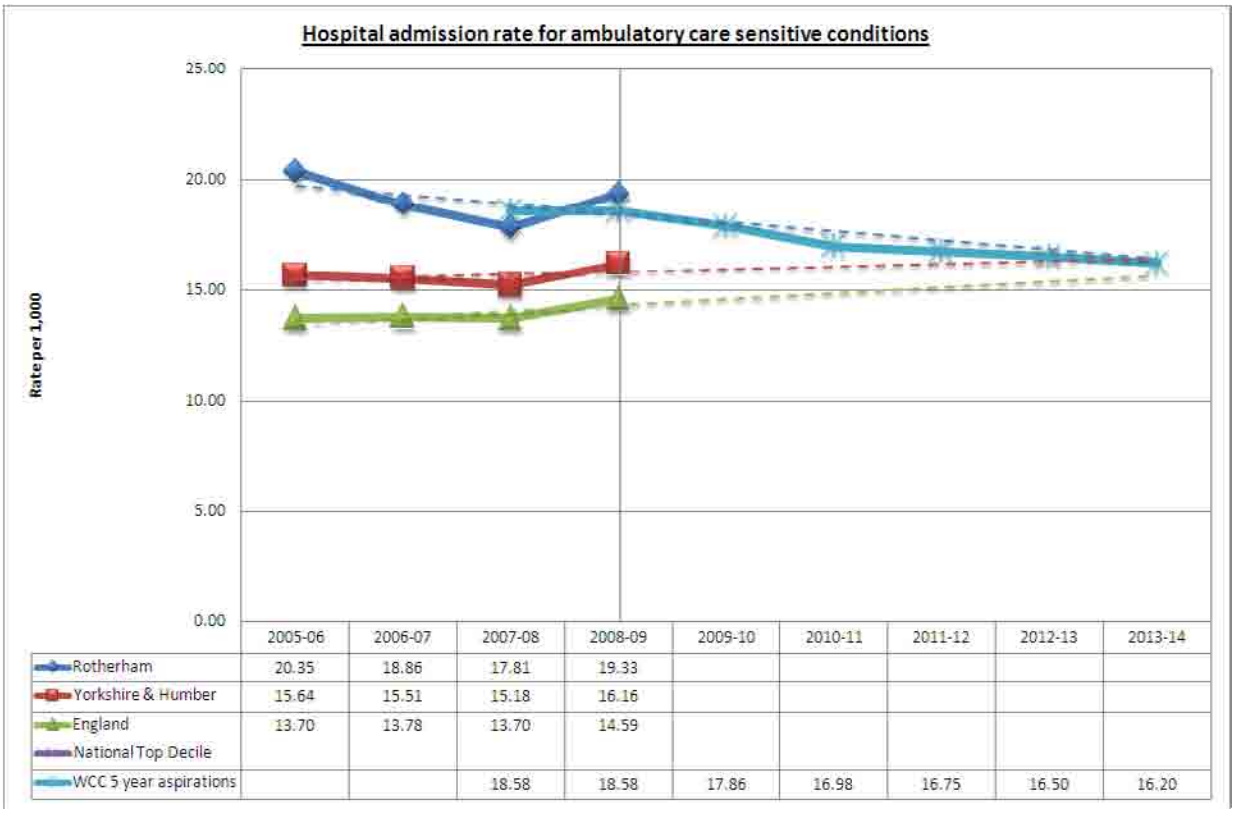
Reason for Choice
500 Rotherham residents still die prematurely each year due to smoking. Further reductions in smoking are essential if NHS Rotherham is to achieve many of its outcomes such as improvements in life expectancy
Commentary on Progress
Rotherham exceeded its vital signs trajectory in 2008/9 and was in the top decile for performance per 100,000.
Ambition
• We will help more than 2500 people to quit smoking each year for the next 5 years • Maintaining this top decile performance will be extremely challenging because of the impact of the recession and the fact that because smoking prevalence is falling, remaining smokers find it increasing difficult to quit.
Impact of achieving our ambition
After allowing for 70% relapse rate each quitter will live an additional 3 years. Over time this will have a dramatic impact on life expectancy in Rotherham. There will also be an impact on hospital admission rates both for the smokers and their families.



	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Rotherham	689.6	954.4	1121.3					
Yorkshire & Humber								
England	796.4	907.5	845.2					
National Top Decile	1206.5	1270.4	1135.3					
WCC 5 year aspirations			697.0	702.0	702.0	702.0	702.0	702.0
Revised aspirations			697.0	1121.0	1121.0	1121.0	1121.0	1121.0

3.2.6 Emergency ambulatory care sensitive admissions

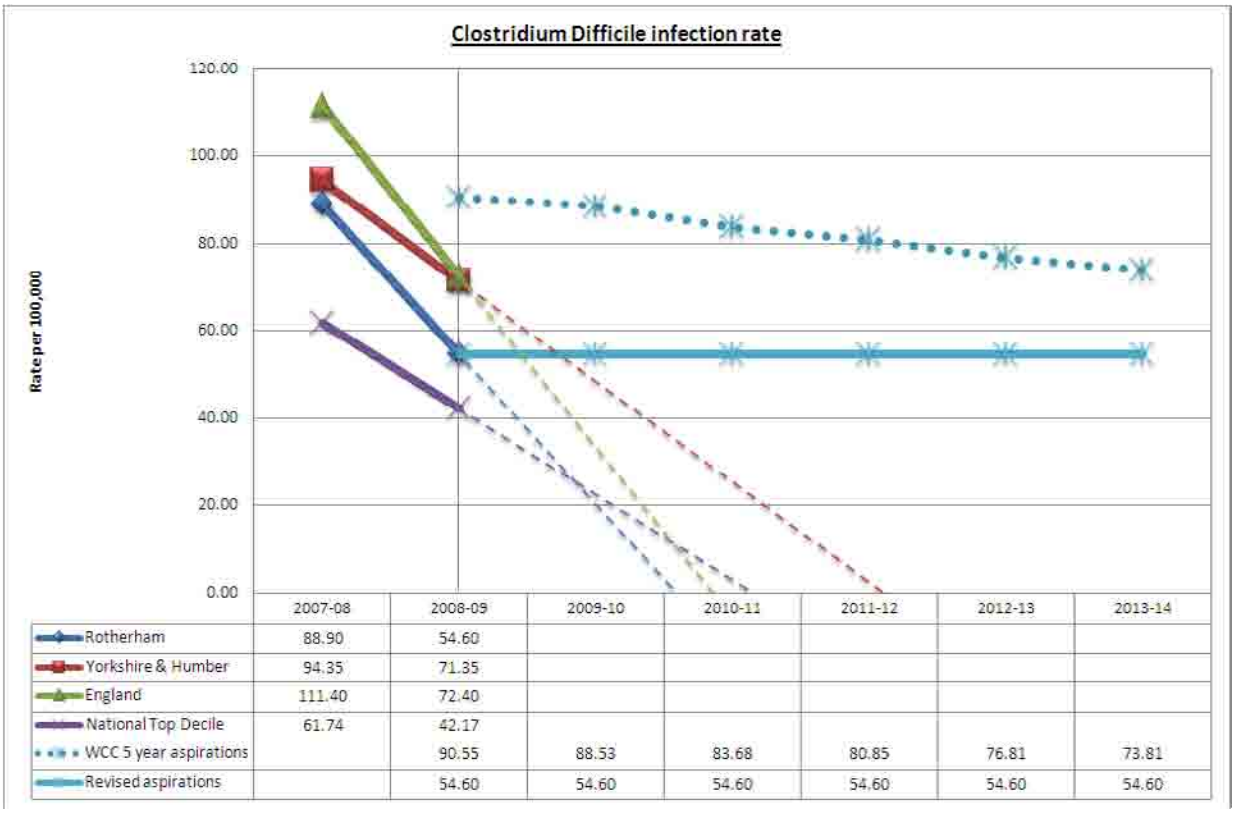
Reason for Choice
We benchmark poorly on Ambulatory Care Sensitive Condition (ACSC) admissions. This means that patients do not always receive care in a setting that is the most appropriate. Providing unnecessary care in hospital is also expensive and reduces the resources available for other NHS Rotherham priorities.
Commentary on Progress
ACS admissions went up in 2008/9. Transformational initiatives to address this include interQual.
Ambition
• We will reduce the number of ACS condition admissions by 10% by 2014 • The trajectory is extremely challenging given an ageing population and long term trends towards increased use of hospitals.
Impact of achieving our ambition
• ACSC admissions will decrease from 4600 to 4200 / year by 2014. • This will reduce ACSC costs by £750,000 / year.



	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Rotherham	20.35	18.86	17.81	19.33					
Yorkshire & Humber	15.64	15.51	15.18	16.16					
England	13.70	13.78	13.70	14.59					
National Top Decile									
WCC 5 year aspirations			18.58	18.58	17.86	16.98	16.75	16.50	16.20

3.2.7 Clostridium Difficile infection

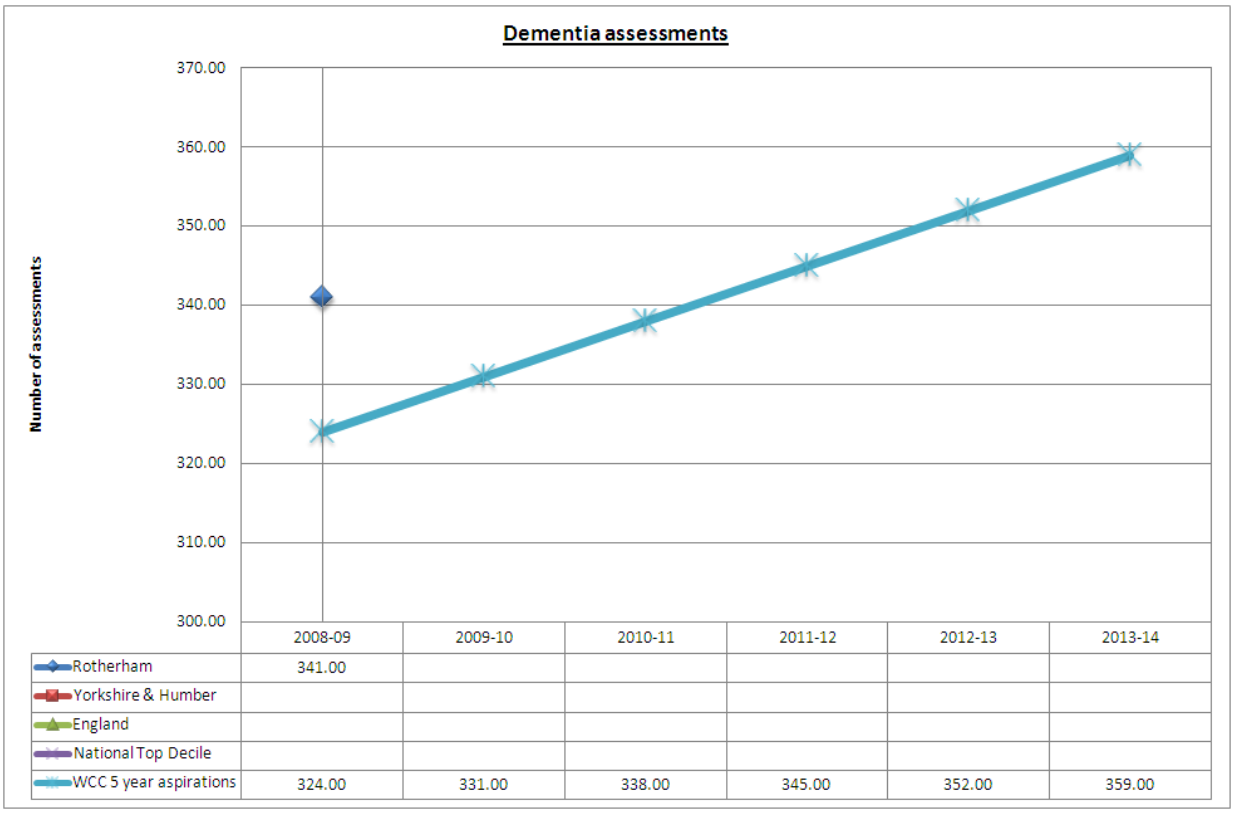
Reason for Choice
We benchmark relatively well on this metric. Rotherham's public and patients say that hospital acquired infections are one of their top concerns. Continuing to deliver on this outcome is essential for the reputation of local health services.
Commentary on Progress
NHS Rotherham's rate of hospital acquired infections continues to decline and is well below the national average.
Ambition
• We will sustain the dramatic reduction in C Difficile rates. • Rotherham has preformed well in excess of its existing vital sign trajectory.
Impact of achieving our ambition
• Confidence and satisfaction with NHS. • Mitigate the risk of an increase in admissions.



	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
Rotherham	88.90	54.60					
Yorkshire & Humber	94.35	71.35					
England	111.40	72.40					
National Top Decile	61.74	42.17					
WCC 5 year aspirations		90.55	88.53	83.68	80.85	76.81	73.81
Revised aspirations		54.60	54.60	54.60	54.60	54.60	54.60

3.2.8 Dementia assessments

Reason for Choice
The Joint Strategic Needs Assessment identified large and growing unmet needs for dementia service patients and their carers.
Commentary on Progress
Our new dementia service achieved its trajectory in 2008/09. We will ensure the service retains the capacity to make increasing numbers of new patient assessments, whilst looking after an increasing caseload of existing patients.
Ambition
• NHS Rotherham will maintain its 2008 commitment to assessing around 350 new patients a year. • This is a local commitment as there is no suitable WCC metric for dementia
Impact of achieving our ambition
• Providing the new capacity will go a long way to meeting current unmet need and future demands. • It will also decrease costs that would otherwise occur from emergency admissions and care home placements.



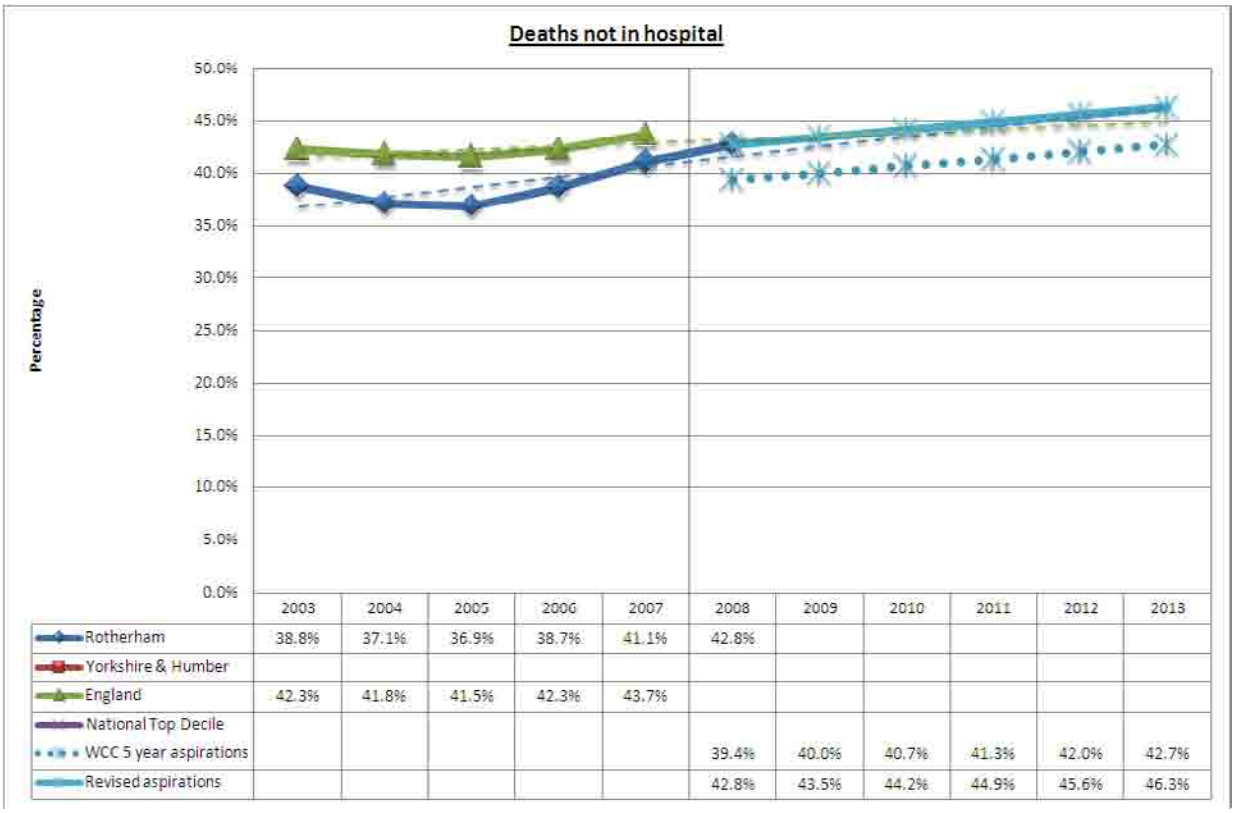
3.2.9 Cardiovascular Disease (CVD) mortality rate

Reason for Choice
Rotherham's CVD mortality rates are dropping faster than national rates. Providing comprehensive prevention and treatment is cost effective and will deliver large, quantifiable, health improvements for the people of Rotherham. Continuing to deliver improvements faster than nationally is essential if NHS Rotherham is to meet its life expectancy targets.
Commentary on Progress
Our long term progress on CVD is extremely good. In 2008 there was an increase in numbers of CVD deaths. This makes our initiatives to implement comprehensive CVD screening (NHS Health Check) and effective prescribing for people with CVD especially important.
Ambition
• Premature cardiovascular deaths will continue to fall and will be nearly half their current level in 2014. • We will maintain the challenging commitment we made in 2008.
Impact of achieving our ambition
• Years of life lost due to cardiovascular disease will be halved by 2014. • This will make a substantial contribution to improving life expectancy .

	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13
Rotherham	100.74	90.35	83.84	81.58					
Yorkshire & Humber	99.11	92.14	88.26	82.80					
England	97.09	88.41	83.84	74.80					
National Top Decile	70.98	65.88	65.42						
WCC 5 year aspirations					66.30	59.50	54.50	50.40	46.80

3.2.10 Percentage of deaths not in hospital

Reason for Choice
We benchmark below average. This means that at present some people in Rotherham do not have full choice over where they receive end of life care.
Commentary on Progress
2008 data shows we made some progress on this outcome.
Ambition
• We will increase the proportion of people who die outside hospital to 46% by 2014. • This is an increase from the commitment we made in 2008. It is challenging because the age at which people die is getting higher and long term societal trends are for more deaths to occur in hospital.
Impact of achieving our ambition
• More patients and families will have real choice of EOL care. • By 2014 there will be 86 less deaths per year in hospitals. This will not result in an overall cost saving but will make available £293,000 for re-investment in community care.



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Rotherham	38.8%	37.1%	36.9%	38.7%	41.1%	42.8%					
Yorkshire & Humber											
England	42.3%	41.8%	41.5%	42.3%	43.7%						
National Top Decile											
WCC 5 year aspirations						39.4%	40.0%	40.7%	41.3%	42.0%	42.7%
Revised aspirations						42.8%	43.5%	44.2%	44.9%	45.6%	46.3%

3.3 Transformational initiatives

In 2008 we identified 29 transformational initiatives that formed the focus of our strategy (figure 3.4). These initiatives were chosen on the basis of: health impact; clinical quality impact; public, patient, clinician and partner opinions; and achievability. The following pages provide a summary for each priority area. All our investments, split by programme area, are detailed in section 7.

Figure 3.4: Transformational initiatives

Priority Area	TI Number in Annex B(BH,BL):	Transformational Initiative
First Class Primary Care Services	TI :1 TI: 2 TI: 3 TI: 4	• Accessible high quality primary care • Effective prescribing • New and innovative Community Health Centre (RCHC) • Two new GP practices
Healthy Pregnancy & Birth	TI: 5 TI: 6 TI: 7	• Increasing breastfeeding • Reducing smoking in pregnancy • Reducing teenage pregnancy
Healthy Childhood	TI: 8 TI: 9 TI: 10 TI: 11	• Improving services for the emotional and mental health needs of all children and young people • Improving services to support children with complex and continuing health care needs • New and innovative programme to reduce childhood obesity • Dramatically improving childhood immunisation coverage
Staying Healthy	TI: 12 TI: 13 TI: 14 TI: 15 TI: 16	• Reducing smoking • Reducing harm from alcohol • Improving sexual health • New and innovative programme to reduce adult obesity • Screening for cardiovascular risk
First Class Services	TI: 17 TI: 18 TI: 19 TI: 20	• Implementing robust admission and discharge criteria • Reducing the numbers of healthcare acquired infections • Improving access and choice • Commissioning first class stroke services
Better services for people with Long Term Conditions	TI: 21 TI: 22 TI: 23 TI: 24	• Accessible high quality intermediate care services • Better prevention and treatment of falls • Improving diabetic services • Implementing the chronic obstructive pulmonary disease care pathway
Better Mental Health	TI: 25 TI: 26 TI: 27 TI:28	• Improving mental health promotion • Accessible high quality psychological therapies • New mental health wards to enable modern therapeutic care • Improving mental health services for older people
End of Life Care	TI: 29	• Improving services and choice for end of life care

3.3.1 First Class Primary Care Services

'Primary care – the services provided by our local GPs, dentist, pharmacists and opticians, are the bedrock of the NHS. They are the services we most often turn to for advice, treatment and care. In fact, over nine in ten contacts with the NHS are with primary care services. In Rotherham we have good primary care services but we want them to become world class'.

By 2012:

- all GPs will be providing services to new, ambitious standards that will ensure that everyone gets consistently high quality care
- access to GPs will have been made easier, with many GPs offering appointments in the early morning, early evening and at weekends
- information on the quality and accessibility of all Rotherham GPs will be easily available to the public, patients and NHS Rotherham
- everyone will be able to use a single telephone number to access urgent care services, including walk in centres and GP out of hours services at any time of the day.
- we will have invested in the development of first class premises for primary care services. This will include the new centres in Maltby (opened September 2008), Aston, Rawmarsh, Wath and Brinsworth all to open over the next 5 years. In addition, we will have substantially improved many of the remaining GP practices around Rotherham.
- we will commission two new GP practices, one in the NHS Rotherham Community Health Centre (RCHC) and one in the Wath and Brampton communities.
- everyone in Rotherham will be able to use the new NHS RCHC facility in the town centre, which will provide a wide range of primary and community health services, and a 12 hour a day, 7 day a week, walk in service for minor ailments and injuries
- we will increase the number of dentists working in Rotherham by 12, making it easier for people to get routine and emergency treatment
- community pharmacists will provide a wider range of advice and support including help to quit smoking and medicine reviews.

We identified the following initiatives to help us achieve these goals:

Goal	Progress	
Accessible high quality primary care	Delivery ●	Substantial progress with access to primary care. GP quality accounts published with evidence of some high quality practices but substantial variation. Review of all LESs underway. Programme of ophthalmic practice visits commenced.
	Impact ●	93% of GPs are open for all core hours covering 98% of the population. 67% of GPs serving 85% of the population offer extended hours. 3 new pharmacies opened (2 are 100 hours). Above average performance on disease registers, QOF and patient survey
Effective prescribing	Delivery ●	Effective prescribing team, innovative schemes for dietetics and continence. All practices have been benchmarked against 17 KPIs in Rotherham prescribing quilt. Expansion of Community Pharmacy Minor Ailment Scheme
	Impact ●	Prescribing cost growth is one of the lowest in the North of England. At the same time, there has been an increase in prescribing of effective treatments such as statins.
New and innovative community health centre	Delivery ●	Rotherham Community Health Centre opened January 2009. Diagnostics service commenced February 2009. Extended "Walk-in" including Out of Hours commenced June 2009.
	Impact ●	The Walk In Centre is popular but to date there has been little resulting reduction in A&E usage, suggesting that the centre is addressing previously unmet need. Uptake of diagnostics has been slow but is improving.
Two new GP practices	Delivery ●	The new Chantry Bridge Medical Practice commenced June 2009 and the new Brampton medical practice commenced August 2009.
	Impact ●	Numbers of people choosing to register with the two new practices was initially slower than predicted (50% at Chantry Bridge and 60% at Brampton) but is now increasing.

How will we measure our success?

Our first class primary care services goals are:

Each GP practice in Rotherham will show a year on year improvement in world class commissioning outcome measures measured at practice population level (after allowing for random variations in small practices)

By 2012 the range in outcomes between GP practices in Rotherham will have been reduced by the practices that currently have the lowest achievements improving faster than the average.

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- GP Single Assessment Review metrics
- Patient reported measures of GP access in Vital Signs (6 measures)
- Identified prevalence of key QOF conditions such as hypertension, COPD and diabetes compared to expected prevalence and national benchmarks *(HA metric)*
- A series of metrics on the effectiveness and cost effectiveness of prescribing
- 4 hour maximum wait in A&E (as a metric to measure the impact of the RCHC)
- Maximum 6 week wait for diagnostics
- For all GP metrics we will show both year on year improvements and a reduction in unexplained variation between practices

3.3.2 Healthy Pregnancy and Birth

'We all want the best possible health. Good health begins during pregnancy, birth and in the first weeks and months of life.'

By 2012:

- all our providers will be able to demonstrate to their patients and to NHS Rotherham that all pregnant women receive high quality care
- all pregnant women who smoke will be supported to stop and to breastfeed their babies
- all pregnant women will have a named midwife, who will help them to manage their pregnancy and make the right choices about where and how to give birth
- vulnerable women and their babies will receive special help, to ensure they also have the best possible pregnancy, birth and start to life, including neonatal services for premature babies and babies born with special needs

We identified the following initiatives to help us achieve these goals:

Goal	Progress	
Increasing breastfeeding	Delivery ●	Implementation of UNICEF Baby Friendly Initiative, increased targeted community midwifery home visiting, 24 hour breastfeeding helpline, peer support, 'Be a Star' campaign, increased antenatal and postnatal support workers and introduction of a breast pump loan scheme.
	Impact ●	Slow progress in addressing data quality issues but now starting to improve. 6-8 week recording coverage is poor at 75% and prevalence is low at 23%. Initiation rates are steady at 57-58%.
Reducing smoking in pregnancy	Delivery ●	CO monitors for all community midwives, introduction of 'smoke free homes' scheme, launch of smoking in pregnancy campaign, updated service specifications for proactive stop smoking service, health visiting and maternity services, implementation of incentive scheme, funding for 2 specialist smoking cessation midwives.
	Impact ●	Smoking in pregnancy rates have deteriorated over the past 12 months.

Goal	Progress	
Reducing teenage pregnancy	Delivery ●	Initiative milestones have been met with increased access to LARC, better access to contraceptive advice following termination, care pathway for under 18's, implementation of an overall brand for young peoples sexual health, roll-out of the 'S word' sexual health campaign, Maltby Linx Young Women's Project received Regional health and social care award and is being rolled out
	Impact ●	Teenage conception rates remain consistently and significantly above target.

How will we measure our success?

Our healthy pregnancy and birth goal is:

By 2012 more than one third of mothers will breastfeed for at least 6 weeks after delivery.

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- Early access for women to maternity services *(HA metric)*
- Percentage of low birth weight babies *(HA metric)*
- Percentage of mothers known to be smoking at time of delivery *(HA metric)*
- Under 18 conception rates

3.3.3 Healthy Childhood

'We all want good health to continue during childhood. In Rotherham we are giving great priority to further improvements to children and young people's services, all aimed at helping children stay healthy, be safe, achieve their potential, enjoy economic well being and make a useful contribution.'

By 2012:

- all providers of services to Rotherham's children will be able to show to their patients, parents and to NHS Rotherham that all Rotherham's children receive high quality services
- all children will be offered help to keep their weight under control, with better diets and more physical activity
- all our services for children, young people and their families will be better coordinated, so that instead of having to look to many different services for help, parents, children and young people will be able to get help from one unified service that will be able to help direct individuals to the most appropriate assistance.
- children and young people who have mental health problems will get quicker, easier access to better services
- children with complex needs and disabled children will also get better services at home, at school and in hospital

We identified the following initiatives to help us achieve these goals:

Goal	Progress	
Improve services for the emotional and mental health needs of children and young people	Delivery ●	Increased capacity of CAMHS via single Point of Access , enhanced Tier 3 capacity including delivery up to age 18. New referral to treatment standard of 6 weeks. Enhanced Tier 2 provision to deliver a range of mental health training to 317 staff (schools, GP's, health visitors, school nurses), Tier 2 CAMHS will have a worker in each of the 7 neighbourhood areas by Jan 2010.
	Impact ●	Performance against Vital Sign plans is good. All measures are being achieved or exceeded.

Goal	Progress	
Improve services to support children with complex and continuing health care needs	Delivery ●	Children's Complex Health Care now offers a bereavement and rapid discharge service. Bluebell Wood Hospice provision commissioned from October 2009. New process for approving, purchasing, tracking and storing specialist equipment. Allocated funding for 'Aiming High' short break.
	Impact ●	The six week target for specialist equipment is generally being met. The impact of the rapid discharge service and the numbers accessing the new short breaks service is not yet known.
New and innovative programme to reduce childhood obesity	Delivery ●	Over 80 children have attended Carnegie weight management residential camp, this year 53 children lost over 53 stone between them. Carnegie Clubs deliver 12 week programmes for overweight children and families. Tier 3 multi-disciplinary team is now operational (Rotherham Institute for Obesity).
	Impact ●	Early indications show active referral and positive outcome data. The National Child Measurement Programme data shows improved performance in 2008/9 for both Reception and Year 6.
Dramatically improve childhood immunisation rates	Delivery ●	Reporting processes have been streamlined, individual GP performance metrics developed, MMR campaign and signposting within Children's Centres, quality performance incorporated within contract review. A longer term strategy to allow sustainable progress has not yet been implemented.
	Impact ●	4 of the 6 targets have now been met or exceeded and both targets that are not met are improving.

How will we measure our success?

Our healthy childhood goal is:

By 2012 more than 9 in 10 five year olds will have full immunisation coverage

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- All immunisation trajectories in Vital Signs (8 measures)
- Child and adolescent mental health measures in Vital Signs (4 measures)
- Percentage of children in reception year recorded as obese
- Percentage of children in year 6 recorded as obese

3.3.4 Staying Healthy

'Staying healthy as we become adults, and throughout adulthood, is crucial to our quality of life and to our life expectancy. There is overwhelming evidence that smoking and obesity cause serious illnesses such as diabetes, heart disease and cancer.'

By 2012:

- all services we commission will be able to demonstrate to NHS Rotherham how they are contributing to people staying healthy as well as providing services for ill patients
- everyone who smokes will be encouraged and supported to quit
- everyone who is overweight will have access to advice about how to lose weight
- people who have a drink problem will have better advice and support to reduce their drinking
- people who misuse drugs will continue to have access to a range of advice and treatment
- people will better understand the risks to good sexual health, and many more people will be screened for sexually transmitted diseases
- everyone who is at risk of heart disease or stroke will be offered preventative treatment with cholesterol busting drugs
- a wider range of screening programmes will be on offer for cancer and heart disease

We identified the following initiatives to help us achieve these goals:

Goal	Progress	
Reduce smoking	Delivery ●	Establishment of Tobacco Control Alliance, exceptional compliance rates to the smoke free law (99%), expansion of smoke free homes programme, 2 high level campaigns on counterfeit and smuggled tobacco, increased capacity in Stop Smoking service, referral pathways extended through choose and book, schools, colleges and self referral, Nicotine Replacement Therapy available free of charge, implementation of stop smoking toolkit in primary and secondary care and GP LES.
	Impact ●	The number of smoking quitters is consistently well above target.
Reduce harm from alcohol	Delivery ●	23 practices now operating the new Alcohol in Primary Care Scheme, screening patients alcohol consumption and providing services for those with identified problems. Quicker access to secondary care where needed.
	Impact ●	Significant number of Rotherham population have access to identification and brief advice surrounding risky alcohol consumption. Waiting times within primary care services remain less than three weeks with 40-50 referrals into the service per month, 75% of these referrals have not accessed treatment services before. The service supports the long term impact of reduction in alcohol related hospital admissions
Improve sexual health	Delivery ●	Review of sexual health strategy and services (incorporating needs analysis) to commence Jan 2010 with intention of improving quality of services and achieving value for money. Increased access to contraception services within broader settings.
	Impact ●	Chlamydia screening is on target. Access to GUM (offered within 48 hours) is consistently at 100% but the percentage seen within 48 hours is relatively low at 86%. New cases of gonorrhoea are consistently and significantly above target.
New and innovative programme to reduce adult obesity	Delivery ●	Reshape Rotherham , Tier 2 intervention for overweight adults, operational since September 09. Tier 3 multidisciplinary team now operational delivered by Rotherham Institute for Obesity. Tier 4 bariatric surgery for morbidly obese adults commissioned sub-regionally.
	Impact ●	Early indications show active referral and positive outcome data. GP recording of BMI does not meet the national recommendation of 56%.
Screening for cardiovascular risk	Delivery ●	CVD screening programme established through a GP LES, together with increased capacity in lifestyle change programmes (weight management, physical activity, stop smoking).
	Impact ●	6,075 people have been screened (9% Rotherham average) to date, however, there have been some discrepancies with data collection and indications show that this figure will notably increase.

How will we measure our success?

Our staying healthy goals are:

By 2012 Rotherham will have maintained its improved position on Index of Multiple Deprivation

By 2012 life expectancy in Rotherham will have improved faster than the national rate so that NHS Rotherham will meet challenging vital sign trajectories for all age, all cause mortality.

By 2012 life expectancy in the Rotherham Neighbourhood Renewal Strategy Target area will have increased faster than the Rotherham average.

We will support people to quit smoking so that less than one in 5 people in Rotherham smoke by 2012.

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- We will report key health outcomes for Rotherham NRS target areas so we can show improvements in the most deprived 25% of Rotherham
- We will develop a metric that reliably triangulates available data on smoking prevalence

- Obesity status of GP registered population aged 16 and over *(HA metric)*
- Sexual health targets for chlamydia, gonorrhoea and access to GUM
- Number of GP practices delivering alcohol related treatment
- Rate of hospital admissions for alcohol related harm *(HA metric)*
- CVD mortality rate
- Cervical and breast cancer screening coverage rates
- Cancer mortality rate

3.3.5 First Class Services

'When we become more seriously ill, we want fast access to effective and safe health services.'

By 2012:

- all service providers will be able to demonstrate to their patients and to NHS Rotherham that they provide high quality care to all patients
- all hospital treatment will begin within 10 weeks of referral by a GP
- people with life threatening emergencies (for example, following a major accident, a heart attack or a stroke) will be taken directly to specialist services that can very quickly provide the best possible life saving treatment
- our hospitals will be guaranteed to be clean and infection rates will be reduced to the lowest possible levels
- we will work even more closely with other NHS organisations to ensure specialist resources are available when needed
- we will continue to invest in Yorkshire Ambulance Service to ensure patients have faster access to emergency services when needed.

We identified the following initiatives to help us achieve these goals:

Goal	Progress	
Reducing numbers of healthcare acquired infections	Delivery ●	C Diff rates reported at GP practice level
	Impact ●	Rate continues to decline and is well below the national average.
Improving access and choice	Delivery ●	Work with GP practices and other services to ensure promotion of the choice agenda.
	Impact ●	Target already met for March 2010 with 95% of patients being able to go to their hospital of choice. Recall of choice was 60% an increase of 13% since March 2009. Awareness of choice was 68% the same as in March 2008. Choose and Book performance is comparatively good.
Implementing robust admission and discharge criteria	Delivery ●	InterQual pilot phase concluded September 2009 and is now implemented within the Rotherham Foundation Trust. Implementation extended further to cover A&E, paediatrics, community matrons and Breathing Space. Results show that many patients should be in alternative care settings
	Impact ●	Information from the project will further improve hospital efficiency. More ambitious commissioning plans are required to achieve full impact across the system.
Commissioning first class stroke services	Delivery ●	Full redesign of stroke pathway and development of a 24/7 hyperacute stroke service. 12 hour thrombolysis service delivered.
	Impact ●	The CVD mortality rate continues to decrease.

How will we measure our success?

Our first class services goals are:

By 2012 hospital admissions for ambulatory care sensitive diagnoses will have decreased by 10%

By 2012 Clostridium Difficile infections will have been dramatically reduced so that Rotherham rates will be in the lowest 10% nationally

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- Number of cases of MRSA
- Ambulance response times
- Thrombolysis call to needle time
- 18 week waits for admitted and non-admitted care
- Patient reported measure of choice of hospital in Vital Signs
- Stroke deaths within 30 days
- Proportion of Transient Ischemic Attack (TIAs) scanned and treated within 24 hours
- Proportion who spend at least 90% of their time on a stroke unit
- Delayed transfers of care
- Surgical admission rates for 5 surgical procedures
- Emergency bed days

3.3.6 Better Services for People with Long Term Conditions

'Despite much improved prevention and excellent primary care and hospital services, many people will still get long term conditions such as heart disease and diabetes, and we need to make sure that we provide excellent services for people with these conditions.'

By 2012:

- all service providers will be able to demonstrate to their patients and to NHS Rotherham that they provide high quality care to all patients
- We want to offer patients far better information, advice and support. We aim to make sure patients have every opportunity to care for themselves, are well informed about their condition and have the confidence to manage it themselves, supported by health professionals who treat their patients as partners.
- We will continue to improve prevention and treatment for cancer, heart disease and respiratory disease. Particular priority will be given to improving stroke services and services for people with diabetes. We will make sure that the national standards for services for people with neurological conditions are met in Rotherham.
- We will work with our partners to support people to manage their conditions and get back into employment where possible.
- People with long term conditions often rely on a wide range of generic care services – services like intermediate care, community matrons and case management. These will continue to expand.
- We appreciate the important role played by carers in supporting people with long-term conditions and we will invest further in supporting carers in that role.
- We will work with social care partners to develop single assessment, integrated care plans and personal health budgets.

We identified the following initiatives to help us achieve these goals:

Goal	Progress	
Accessible high quality intermediate care services	Delivery ●	A strategic review of intermediate care services has been completed.
	Impact ●	The strategic review highlights a substantial need for service redesign - reconfiguration, investment and disinvestment.
Better prevention and treatment of falls	Delivery ●	Implementation of a 3 tier 'pilot' falls prevention service based on National standards and guidelines. Service includes a specialist 12 week rolling programme of falls rehabilitation and will train front-line health and social care staff to identify those most at risk of falling.
	Impact Not yet known	This service commences autumn 2009. The impact will be reviewed in early 2010.
Improving diabetic services	Delivery ●	Benchmarking of GP performance has been undertaken. Prescribing and management guidelines have been reviewed. Increased take up of structured patient education and retinal screening. LES for insulin initiation in development. However, there are still opportunities for more radical service redesign.
	Impact ●	Performance is good against the reduction in HbA1c metric.
Implementing the chronic pulmonary disease services	Delivery ●	Breathing Space pilot has run from May 2007 for day patients and rehabilitation, and from October 2008 for inpatient and respite.
	Impact ●	Full evaluation is due December 2009. Early indication shows that whilst it has been popular with patients, there has been little impact on hospital admission rates.

How will we measure our success?

Our long term condition goals are:

By 2012 we will have maintained our above average performance on cardiovascular mortality so that deaths will be well below the national average.

By 2012 cardiovascular mortality in the Rotherham Neighbourhood Renewal Strategy Target area will have increased faster than the Rotherham average.

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- Patients on diabetes registers with HBA1c reading 7.5 or less
- Diabetic retinopathy screening
- Patient reported outcome measures (PROMs) and quality adjusted life years gained (QALYs) for COPD patients
- Hospital admissions for COPD related conditions

3.3.7 Better Mental Health

'At some point in our lives, many of us will have a mental health problem, which for some people can be very serious. As people live longer, more elderly people are at risk of depression or dementia.'

By 2012:

- all service providers will be able to demonstrate to their patients and to NHS Rotherham that they provide high quality care to all patients
- we will deliver high quality mental health promotion in addition to high quality services
- double the number of counsellors working in GP practices
- make sure everyone who needs it can access "psychological therapies"
- invest in a wider range of community services, providing more early intervention and home based support and treatment
- invest in new wards for adults who need to be admitted for psychiatric care.

We identified the following initiatives to help us achieve these goals:

Goal	Progress	
Improving mental health promotion	Delivery ●	Mental Health First Aid delivered to 171 front line staff, work with over 40 employers to improve their working practice in relation to mental health, 70 employers in contact with 'mind your own business', 2 stress control groups run through year and a health trainer pilot established at a GP practice
	Impact ●	Whilst many employers have embraced the initiative addressing a change in attitude to mental health will be a long term objective.
Accessible high quality Psychological Therapies	Delivery ●	New services are fully staffed and reporting commenced in October 2009. A project plan is being developed with the SHA on future delivery. Work is underway on the agreement of clinical pathways and referral thresholds across the services.
	Impact Not yet known	Population impact will be assessed in early 2010.
New mental health wards to enable modern therapeutic care	Delivery ●	Planning permission granted August 2009, building commenced October 2009, a number of consultation events in conjunction with local partners have taken place, quarterly public forums established September 2009.
	Impact Not yet known	Impact will be assessed in early 2010.
Improving mental health services for older people	Delivery ●	OPMH service transferred to new base October 2009. New community based service model. Rationalisation of inpatient and residential services. Pilot for specialist domiciliary enabling and support service commissioned from Crossroads began April 2009.
	Impact ●	Memory Service referral rate exceeding expectations (507 against a target of 350). Memory Service review (April 09) showed good performance and carer satisfaction. MH Liaison Team has received 340 referrals in the first 4 months.

How will we measure our success?

Our better mental health goal is:

By 2012 1700 people will have received a full memory service assessment

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- Suicide rate
- Access to psychological therapies
- Patient experience of mental health services

3.3.8 End of Life Care

'All our lives will come to an end. Dying in comfort and dignity and in the place of our choosing is important to us all'.

By 2012:

- more people will be able to die in the place of their choosing, which will mean more dying at home and at a hospice, and fewer in hospital
- more community palliative care will be available, giving more people the opportunity to be cared for and to die at home
- Rotherham's hospice will have been expanded to provide more beds
- Appropriate support will be available for carers.

We identified the following initiatives to help us achieve these goals:

Goal	Progress	
Improving services and choice for end of life care	Delivery ●	Implementation of Gold Standard Framework in care homes and GP practices, increased bed capacity at Rotherham hospice.
	Impact ●	Deaths outside hospital and deaths at home increased between 2007 and 2008 but the most recent data shows a reduction indicating that achieving this ambition will be challenging.

How will we measure our success?

Our end of life care goal is:

By 2012 we will have reduced the proportion of people dying in acute hospitals to the current national average. This means that an extra 100 people a year will die in a more appropriate setting.

3.3.9 Summary of progress with transformational initiatives

Figure 3.4 summarises our progress with each transformational initiatives. We have given two ratings to our progress, a rating of whether delivery in on track according to the milestones we set at the onset of *Better Health, Better Lives* and a rating of whether our initiatives are starting to show an impact on outcome measures.

All our ambitions, priorities and initiatives are led by responsible directors and programme managers. We have introduced Performance Plus, an IT based system, to support programme and project management, and we have assessed progress with all our ambitions, priorities and initiatives.

Figure 3.4 Summary of our progress with each transformational initiatives.

Primary Care	**D**	**I**
Accessible high quality primary care	🟡	🟡
Effective prescribing	🟢	🟢
Community Health Centre	🟢	🟡
Two new GP practices	🟢	🟡
Maternity and Newborn	**D**	**I**
Increasing breastfeeding	🟡	🔴
Reducing smoking in pregnancy	🟡	🔴
Reducing teenage pregnancy	🟢	🔴
Children and Young People	**D**	**I**
Mental Health	🟢	🟢
Complex and continuing healthcare needs	🟢	🟡
Childhood obesity	🟢	🟡
Immunisation rates	🟡	🟡
Staying Healthy	**D**	**I**
Reduce smoking	🟢	🟢
Reduce harm from alcohol	🔴	🔴
Improve sexual health	🟢	🟡
Adult obesity	🟢	🟡
Screening for cardiovascular risk	🟡	🟡

First Class Services - Planned Care	**D**	**I**
Healthcare acquired infections	🟢	🟢
Improving access and choice	🟢	🟡
First Class Services – Urgent Care	**D**	**I**
Admission and discharge criteria	🟢	🟡
Long Term Conditions	**D**	**I**
Intermediate care services	🟢	🟡
Better prevention and treatment of falls	🟡	
Improving diabetic services	🟡	🟡
Chronic pulmonary disease services	🟡	🟡
Stroke services	🟡	🟡
Mental Health	**D**	**I**
Improving mental health promotion	🟡	🟡
Psychological therapies	🟡	
New mental health wards	🟢	
Mental health services for older people	🟢	🟢
End of Life Care	**D**	**I**
End of life care	🟡	🟡

D	Delivery	
I	Impact	Note: blank cell indicates impact not yet known

3.4 Becoming a world class, productive commissioner

3.4.1 Focus on strategy and priorities

We are focusing corporate effort on delivering *Better Health, Better Lives.* Our Board, Professional Executive, Management Executive and staff are all committed to its successful delivery, and to realising its goal and vision.

3.4.2 Leadership and Governance

We have strengthened our leadership of the NHS and our governance arrangements:

Leadership

- We have confirmed and acted upon our role as leader of the NHS and commissioner of all Rotherham's health services.
- We have successfully rebranded ourselves as NHS Rotherham.

- We have embedded our refreshed values, which guide all that we do and will ensure that we always put people first.
- We have continued our Board and PE development programme.

Governance
- We have strengthened governance – the NHS Rotherham Board focusing on commissioning, our new Governance, Quality and Risk committee focusing on quality and risk, the successful internal separation of our provider arm Rotherham Community Health Services.

Clinical Leadership and Engagement
- We have an effective Professional Executive which has representation from adult and children's services and secondary care as well as community and primary care.
- We have relaunched practice based commissioning, with a new borough wide committee whose chair also sits on our Professional Executive; numerous new initiatives have been taken as a result.
- We have identified clinical leaders for all our priorities and initiatives.
- The Rotherham Clinical Board, which brings together NHS Rotherham, GPs, Rotherham NHS Foundation Trust and Rotherham Community Health Services, provides clinical leadership for change and improvement across care and organisational boundaries.
- We have appointed clinical guardians for all our major providers.

Management
- We have strengthened our Management Executive with the appointment of new Directors of Finance and Contracting, and Intelligence and Performance
- Programme managers have been appointed to lead our priorities and initiatives.
- Contract managers lead the interface with all our providers.
- We have completed the first phase of world class commissioning management development.
- We have an active development programme and approach for all our commissioning staff.

3.4.3 Engagement, partnership and clinical engagement

- An Assistant Director of External Relations has been appointed to lead our communication and public engagement priorities and initiatives.
- We have strengthened engagement with the public and patients, and with clinicians; we have strengthened partnership with other public bodies, stakeholders and providers:

Informing patients and the public
- Rotherham News is the Rotherham Partnerships new monthly paper, in which we are key partners.
- We launched our now state of the art website in early 2010.

Engaging patients and the public
- We have undertaken an extensive programme of engagement at community events and locations, including over 6,000 contacts at the Rotherham Show, resulting in powerful feedback on how people see us and the services we commission.
- "Andy on the Road" – programme of attendance by our chief executive at community groups.
- Health small grants scheme – grants of up to £500 awarded to community organisations through our Health Network (a voluntary group).
- Work with partners on a variety of activities, including a DVD for carers, and joint engagement events for older people and BME communities among others.
- Continued support to many user groups, for example, we have just been working to refresh "Cancer Action Rotherham". This is now being acknowledged as leading the area in how we have structured engagement in cancer services.

- We are building a wealth of quantitative data through the use of touch screen devices, and balancing this through roadshows and promoting Patient Opinion to collect qualitative data and patient stories.
- We have developed strong media relations and have set an annual programme of communications activities.

Social marketing

NHS Rotherham has invested considerable resources into a number of social marketing programmes which are already showing positive results. Examples include;

- The *S-word* which was developed to increase awareness of sexual health issues among young people.
- A number of social marketing programmes to address the issue of smoking in specific demographics including smoking in pregnancy, smoking in the Asian community and smoking from a GP perspective.
- *Be a Star*, a national breast feeding programme, delivered locally by primary care trusts. The campaign focused on women aged between 18-25 years from areas of social deprivation.

Working with our partners

- The Rotherham Partnership, of which we are key members, has continued to lead improvement across the Borough.
- We have positive links with Rotherham Metropolitan Borough Council, with whom we have coterminous borders.
- We have robust joint commissioning arrangements in place which encompass pooled budgets, joint service centres and jointly funded staff.

3.4.4 Delivery System

We have redesigned our delivery system, focusing on strengthening matrix management, programme management and contract management. We have also implemented a gateway process for investment (including disinvestment) planning and decision making. The prioritisation criteria are:

- We have formalised our delivery system, which is based on a "single team" principle and ascribes clear roles to all commissioning staff.
- At the heart of the delivery system are matrix working, programme managers and contract managers, supported by ongoing organisational development and staff development at all levels, see figure 3.5.
- Programme managers are responsible for the:

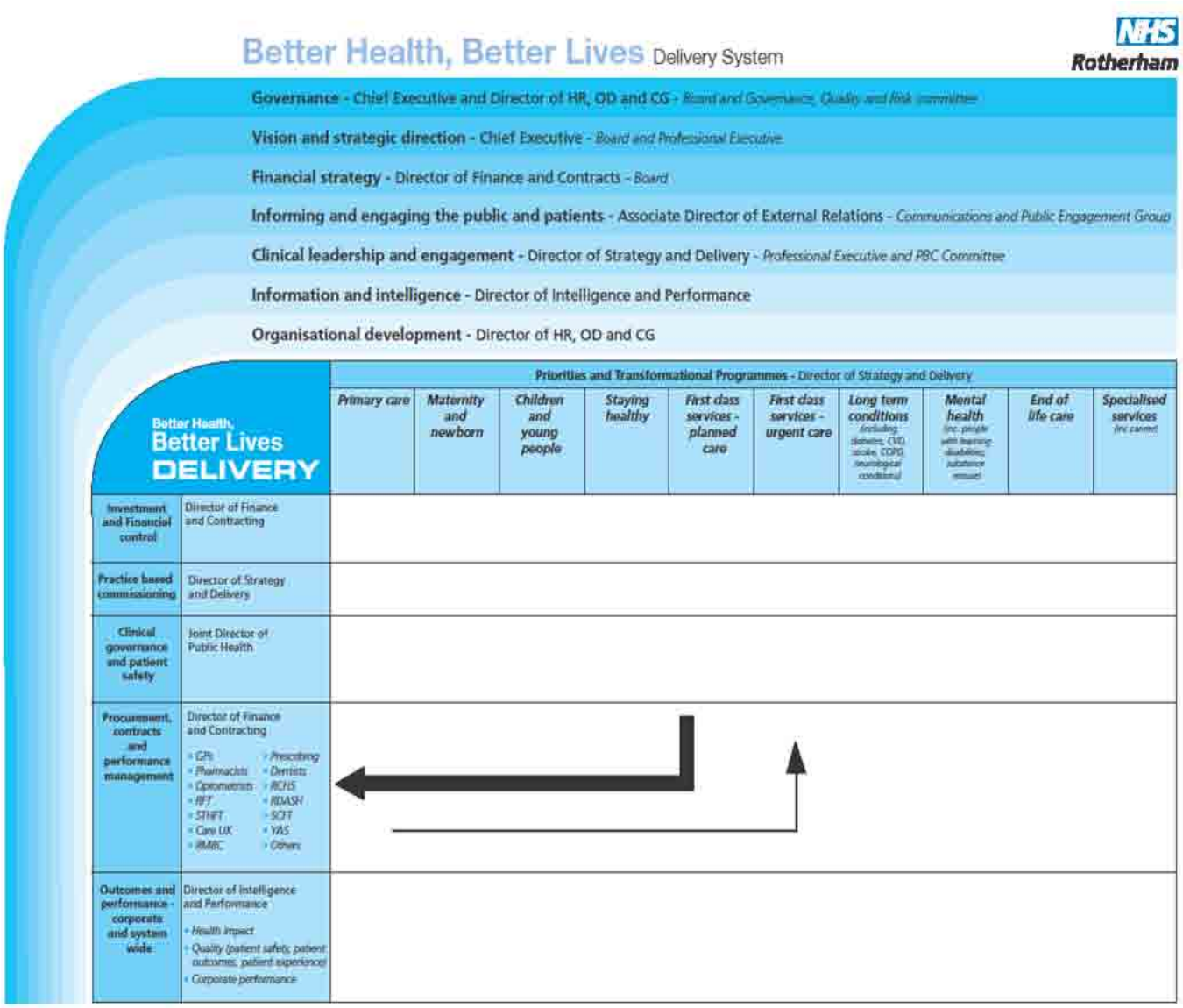
> '*overall strategic responsibility and leadership for planning, determining and leading the implementation of all activity and services required for each programme, and to work in partnership with lead clinicians and contract managers for each of the transformational initiatives to ensure that all the major outcomes identified in Better Health, Better Lives are achieved*'

- Contract managers are responsible for the;

> '*overall development, negotiation, monitoring and performance management of all healthcare contracts to ensure maximum health gain for available resources'*

- We have appointed clinical guardians for each major provider (or group of providers) who will be responsible for leading commissioning for quality.

Figure 3.5: Better Health, Better Lives Delivery System



3.4.5 Prioritisation Criteria

We have introduced the following criteria to guide decision making about investment and disinvestment.

Evidence of need

- Number of people with capacity to benefit.
- Quality and capacity of existing services.
- Rotherham's comparative outcomes in this area.

Health impact

- Strength of evidence that the proposal will bring about health gain - hierarchy of evidence from authoritative national guidance (e.g. NICE), high quality randomised controlled trials to other evidence.
- Amount of health gain in terms of extending life or increasing quality of life.

Impact on health inequalities

- Impact on health inequalities within Rotherham.
- Impact on health inequalities between Rotherham and the national average.

Cost and cost effectiveness

- Total cost of proposal.
- Relationship between cost and health impact - ideally in terms of cost per QALY or life years.

Affordability and timing

- Overall cost in relationship to spend on this programme area and total NHSR spend.
- Timing of spend and timing of benefits.

Public opinion

- Evidence of demand and acceptability.

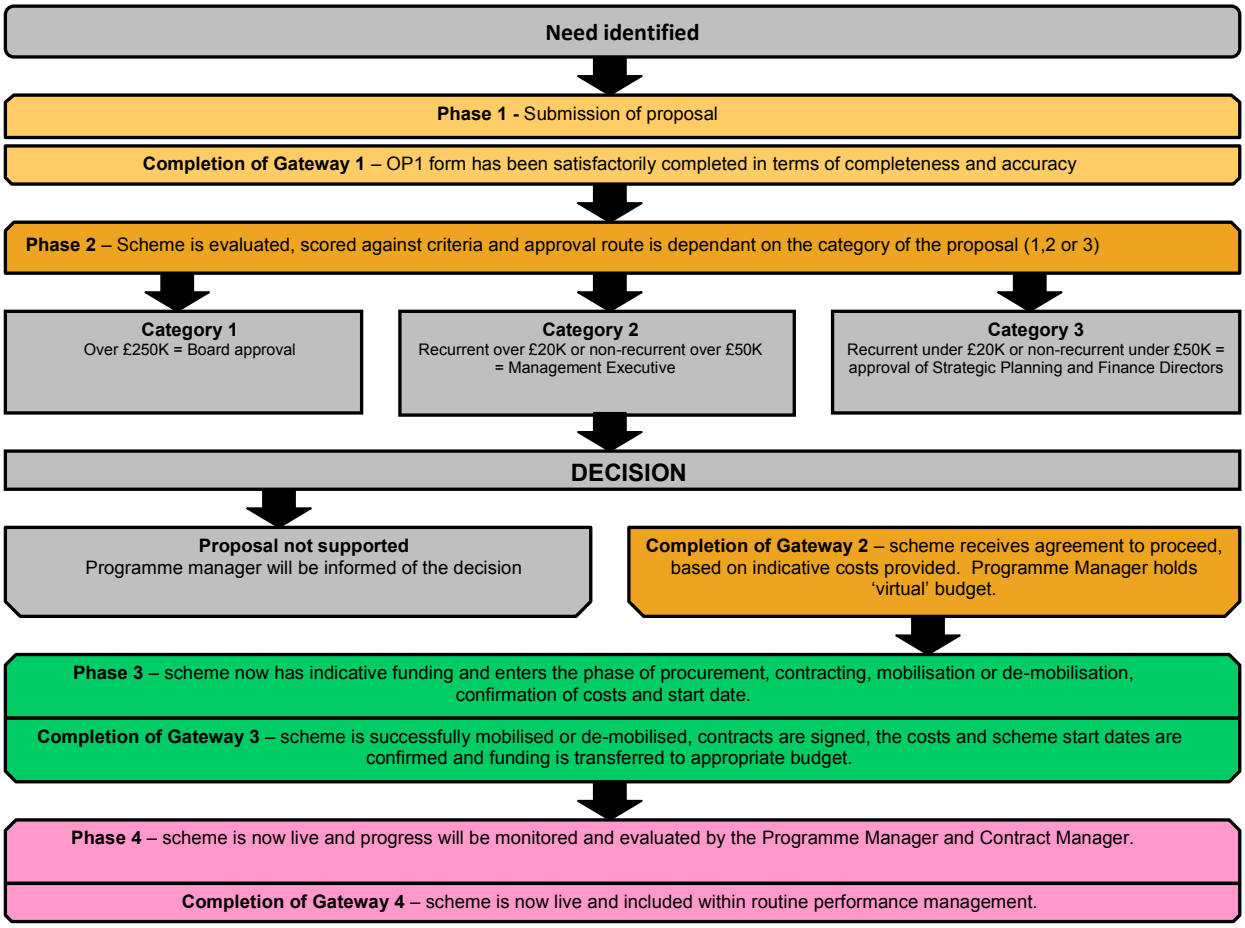
Fit with strategy

- National policy.
- NHSR Strategic plan, *Better Health, Better Lives*.
- Partners strategy e.g. RMBC.

3.4.6 Gateway decision process

We have introduced a Gateway Decision Process to guide all decision making, as illustrated in figure 3.6.

Figure 3.6: Gateway Decision Process



3.4.6 Market Development and Management

We have been proactive in developing and managing the healthcare market. In the last twelve months we have undertaken procurement exercises in several major service areas including:

- Out of Hours
- Obesity Services
- General Practice
- Dental Services
- Pharmacy Services
- Diagnostics

This has led to new providers entering the market in Rotherham, for example, Care UK, dental practitioners and pharmacists.

A key element of these procurements has been the establishment and implementation of a robust performance management regime in relation to each of these contracts.

We have strengthened management of existing contracts: an increasingly assertive approach to GP contract management; robust management of the contract with Rotherham Community Health Services; sustaining our high standard of contract management with foundation trusts.

3.4.7 Financial Discipline and Control

We have introduced five rules to strengthen financial discipline and control:

1. All current investment will be reviewed to ensure it offers value for money.

2. No new investment will be made that increases our recurrent exposure.

3. All new improvement must demonstrate a significant contribution to improving prevention, quality and efficiency.

And internally:

4. No vacancies arising amongst the commissioning workforce will be filled without approval by the Management Executive.

5. No changes to the grade of existing posts or staff will be made unless these are demonstratably affordable within allocated directorate budgets, and managers will ensure staff work within their agreed grades.

We have strengthened financial reporting to include the monthly "run rate" for expenditure and underlying surplus.

3.4.8 Risk Management

We have strengthened risk management, controls and assurance, which is aligned to *Better Health, Better Lives*, which has enabled us to identify the key risks to successful delivery of the strategy. The following key risks were identified for *Better Health, Better Lives*. The additional risks identified from the *Adding Quality and Value* work and the proposed mitigating actions are shown in section 8, figure 8.2:

- Programme management and deliverability
- Finance risks
- Public and patient engagement and changing public behaviours
- Cultural change (staff)
- Effective partnership working
- Information management
- Workforce skills
- Ability to maintain local services
- Clinical engagement
- Procurement challenges

3.5 Progress with *Better Health, Better Lives* Summary

Overall, we have made a good start to implementing *Better Health Better Lives*. It is important to remember that we have assessed progress just a year after agreeing a five year strategy.

Most of our initiatives are making good progress; we need to ensure that this is the case for all of them.

Our assessment of progress towards our ambitions shows that achieving our life expectancy target will be challenging therefore we need to strengthen action here. We must also strengthen action to meet children and young people's needs.

We have significantly strengthened governance, leadership and our delivery system.

Figure 3.7 highlights some of NHS Rotherham's successes during 2009.

Figure 3.7: 2009 A Year of Success

January	• **NHS Rotherham launches new five year strategy for health – *Better Health, Better Lives*.** • **Rotherham Community Health Centre opens its doors to patients bringing a range of health services all under one roof.**
February	• NHS Rotherham **performed well** against a range of standards in the **World Class Commissioning Framework** and was one of the top performers across the Yorkshire and Humber region**.** • NHS Rotherham launched this year's **residential weight management programme** aimed at children aged between 8-17 years who want to lose weight and make long lasting change to their lifestyles. Last year's cohort lost a massive 53 stones in weight. • New mums to be across Rotherham celebrated the launch of the new service offering **direct access to a midwife**. Self referral into the local midwifery service is a choice that will speed up and enable earlier access to maternity services and support healthy pregnancies.
March	• NHS Rotherham was yet again declared an excellent place to work in the results of the national **NHS Staff Survey** • Outstanding staff from NHS Rotherham were honoured for their hard work at this year's **Chairman's Awards**.
April	• Plans for mental health services in Rotherham which will see the **modernisation and improvement of services for adults and older people**, have been given the green light after a three month public consultation. A new state of the art, purpose built Older People's Unit at Rotherham Hospital and a new Psychiatric Intensive Care Unit at Swallownest Court are being developed.

May	• **The NHS Constitution** was launched in Rotherham. • **NHS Rotherham** celebrated the shortest waiting times since NHS records began with the average wait for patients being six or seven weeks – an achievement which was unimaginable 10 years ago. • A radical programme to offer **incentives for pregnant smokers** launched and attracts national media coverage. • NHS Rotherham received **praise from the NHS Chief Executive David Nicholson** for the work on tackling obesity in Yorkshire and the Humber.
June	• NHS Rotherham celebrated after winning two awards at the regional **Health & Social Care Awards**. The Rotherham Obesity Model and Health Weight Commissioning Framework won the 'Excellence in Commissioning' award, and the 'Success in Partnership Working' award went to the Maltby Linx Young Women's Project, led by NHS Rotherham and Rotherham Metropolitan Borough Council. • Three services based at Rotherham Community Health Centre under the management of Care UK launched enhanced patient services. A new GP practice - **Chantry Bridge Medical Practice; Diagnostic Services** commenced and the **Walk-in Centre** extended its hours opening every day of the year except Christmas day.
July	• NHS Rotherham unveiled the new state of the art **Brampton Primary Care Medical Centre** in Rotherham with the help of local MP John Healey. The practice has been built in response to consultation with local people who given the extra housing developments and increasing numbers of people living in the area, felt that that additional local health services were needed.
August	• The Mayor of Rotherham Shaukat Ali opened the new **pharmacy** situated in Rotherham Community Health Centre. The state of the art pharmacy is open until 10pm every day, 365 days a year and is dedicated to enhancing the patient experience, offering three private consultation rooms, a patient information area including a touch screen health-point displaying local health information and a large LCD TV screen showing Life Channel. • The launch of the **S-Word** – NHS Rotherham's new sexual health campaign took place amid a backdrop of Hollywood glamour. The launch included the premiere of a new viral video to highlight sexual health issues with young people. Teenagers from Rotherham starred in the movie themed campaign, which uses iconic films such as PS I Love You, Mission Impossible and The Bourne Trilogy imagery and play on words to convey NHS Rotherham's sexual health messages. • NHS Rotherham signed up to the social networking site **Twitter** to help local people, staff and patients keep up to date with all its latest health news.
September	• As part of the Obesity Strategy, NHS Rotherham launched the '**Carnegie Clubs'** - a 12 week weight loss programme aimed at young people aged between 8-17years, who are overweight. • Young mums from across Rotherham helped to launch a new campaign to highlight the benefits of breast feeding. **'Be A Star'** is dedicated to increasing the number of young Rotherham mums who choose to breastfeed by using images of real women.
October	• NHS Rotherham was rated 'good' for delivering value for money and high quality services for patients in the latest **Annual Health Check**. For the third year running, NHS Rotherham is consistently one of the best performing primary care trusts in the country according to national performance ratings released by the Care Quality Commission.
November	• NHS Rotherham launched the **Rotherham Institute for Obesity (RIO**), a unique and specialist centre for the management of obesity, and an integral part of the obesity strategy led by specialist GP Matt Capehorn. The opening received positive media coverage from across the region. • November saw the official opening of **Rotherham Community Health Centre** with the three Rotherham MP's jointly performing the opening ceremony. The centre opened to the public in January 2009 to provide a wide range of existing and new health services, all under one roof.
December	• NHS Rotherham launched places for the pioneering Carnegie Club programme which starts in January. Members who have just completed the latest 12 week programme have had huge success, making significant lifestyle and behaviour changes in an attempt to achieve a healthy weight. • Finally, preparations were being made for the launch of **NHS Rotherham's new internet site** in January. The site which has already been hailed as 'one to watch' with an innovative new design (designed in-house) and first class functionality and usability.

4 Intelligence

4.1 Introduction

NHS Rotherham undertook an in-depth contextual analysis to inform *Better Health, Better Lives* which was described in detail in annex A of *Better Health, Better Lives*.

To inform the refresh of *Better Health, Better Lives,* we have undertaken a further strategic intelligence review, financial outlook analysis, efficiency review and quality review.

4.2 *Better Health, Better Lives* contextual analysis

The contextual analysis:

- synthesised the numerous joint strategic needs assessments undertaken in Rotherham during the past three years. We have therefore identified the critical health needs in the borough;

- similarly synthesised the insights of patients and the public, including those derived from formal patient surveys and those obtained from many consultation and engagement activities. We therefore identified the critical local patient and public opinions;

- analysed current service provision, including the provider landscape, activity commissioned and clinical quality;

- reviewed current performance against national and local priorities and targets, including WCC outcomes and our 29 transformational initiatives;

- reviewed our financial position specifically in light of the economic downturn.

The outcome of this analysis was the identification of our strategic priorities. The analysis also informed our organisational development and communications strategies.

Five contextual issues were of over-riding importance:

- NHS Rotherham is very ambitious as our goal – *Better Health, Better Lives for everyone in Rotherham* – makes clear; our ambition is matched by that of our partners;

- the scale of health need in Rotherham remains considerable, and long term sustainable improvement will require action to address a wide range of priorities and to address inequalities across the borough;

- NHS Rotherham's previous positive financial position means that we have had the opportunity to invest in the action needed to address all these priorities; this refreshed strategy builds on those investments and identifies opportunities to disinvest whilst still delivering our overall vision;

- patients and the public in Rotherham are generally positive about the local NHS, but this may mask relatively low aspirations and expectations;

- as we have already delivered a generally very positive position in relation to access, choice, waiting times and activity levels, supported by robust contracts and assertive performance management, we now have the opportunity to focus our strategy on the most critical health needs and on improving the quality of care and treatment.

4.3 Strategic Intelligence Review (SIR)

We have completed our strategic intelligence review for 2009/10 which is published as annex A to this refreshed strategy.

The SIR covers demographics, health needs, insights from public, patients, clinicians and local partners, provider landscape with high level market analysis, activity trend analysis and performance review. It builds on the comprehensive contextual analysis published as annex A to *Better Health, Better Lives.*

The SIR has been considered in detail by our Professional Executive and Board, and approved by the Board. The SIR summary is included here, followed by a summary of activity trends and the main points our revised strategy must address.

4.3.1 Population Demographics and health needs

Rotherham has a history of deprivation and disadvantage, as demonstrated by the national Index of Multiple Deprivation (IMD). However, in recent years we have begun to see significant overall improvement, although the health and disability IMD domains have seen little improvement. This is particularly so for the most disadvantaged communities. Rotherham's life expectancy although improving, remains below the national average.

Maternal, infant and childhood health give quite considerable cause for concern, with smoking in pregnancy and low birth weight being above the national average and breastfeeding rates below national average. Our immunisation rate is unacceptably low.

Staying healthy is a challenge for many people and families in Rotherham. Whilst smoking prevalence has fallen, it remains the biggest single cause of premature mortality. Obesity amongst children and adults has become almost as serious a problem. Obesity and lack of physical activity will eventually overtake smoking as the biggest lifestyle factor causing ill health.

The population is ageing (e.g. numbers of over 85s will increase by 80% by 2025). As a consequence, more people will have long term health conditions (e.g. numbers of people with dementia will increase by more than a third by 2025).

Numbers of people from black and minority ethnic communities (BME) will rise. These communities will continue to have a younger age profile, with the numbers of BME children increasing sharply, however, the number of BME elders will also increase.

Cancers, cardiovascular disease and accidents are the top cause of excess life lost in Rotherham, although significant improvements have been made to cardiovascular disease rates. Diabetes is also a significant problem.

The number of people with social care needs will increase by a quarter over the next 10 years. High numbers of people in Rotherham are receiving incapacity benefits. Mental ill health is the biggest cause of morbidity and incapacity.

4.3.2 Insights from public, patients, clinicians and local partners in 2008/09

The NHS in Rotherham is well regarded by local people and patients. In recent surveys, satisfaction rates in Rotherham are routinely found to be in the top 20% regionally and nationally. This may, however, mask relatively low expectations and aspirations.

Local people want to see further improvements in access to primary care and to dental services. They want staff attitudes to be consistently positive – and expect to be treated with dignity and respect at all times. They believe the patient experience at accident and emergency services should be better.

People want more information – about health promotion and about health services themselves.

Local people want local services to be protected, and want more services closer to home, including community mental health services. They want better alcohol services, and more radical approaches to drug misuse.

People want a greater choice of palliative and end of life care.

Over the past 12 months feedback has been overridingly positive, particularly in terms of improved access and new services. Issues where concerns have been raised include:

- Getting better information about new and changing services
- Cleanliness and concerns about hospital acquired infection
- Better staff communication and attitudes
- Quicker appointments and better telephone access
- Levels of funding and staffing
- Better signage in new premises

4.3.3 Insights from clinicians

Whilst public aspirations are mainly for improved access, clinicians are strong advocates for driving forward further improvements in quality.

Benchmarking has made clinicians aware that there are marked variations in clinical quality between general practices and given increasing insights into variations in resource usage and equity issues.

Clinicians advocate a greater role for community pharmacy, for services closer to peoples' homes and for strong links between general practice and community services.

Clinicians make the case for better care pathways (for example for mental health, diabetes and stroke) and for better communication across interfaces.

There is a strong desire to improve clinical information systems so that it is easier to demonstrate quality of care. This applies to all sectors but in particular to community care.

4.3.4 Service provision

The intelligence review includes a high level analysis of the health care market and NHS Rotherham will work with providers to produce quality reports on key services during 2009/10.

The biggest change in service provision in the last 12 months has been the opening of the new town centre Rotherham Community Health Centre, where most community services are now located. This includes a new community diagnostics service, and a 7 day a week walk in centre. We have also commissioned two new GP practices.

There continues to be a dramatic reduction in hospital waiting times, but substantially higher rates of hospital admissions than the national average.

The most important trend is a rapid increase in numbers of people seen for both first and follow up hospital appointments – this is not sustainable given likely future levels of NHS funding.

Provider Landscape

Rotherham people have access to comprehensive primary, secondary and tertiary care within a ten mile radius. About 90% of Rotherham people live within one mile of a GP surgery and community pharmacy. Access to dental care is not as good. Rotherham's hospital provides full secondary care services, and almost all tertiary services are no further away than Sheffield. The local private sector market is stable with some growth.

In line with the previous strategy the provider landscape has changed and improved, we now have additional GP and GDP (dentist) capacity in some communities; additional orthodontist; a new mental health service model with more community based services. We also have much improved inpatient accommodation and increased hospice capacity currently in the process of construction.

Activity commissioned

NHS Rotherham has made very considerable progress towards commissioning a stable and affordable level of activity from all providers which is sufficient to meet local need and meet waiting time targets.

The key activity issues are:

- Insufficient, but improving, data and intelligence about community services activity and waiting times;
- gradual growth in mental health activity, which the underlying growth in dementia will see sustained;
- broadly stable secondary care activity which is within affordable limits;
- relatively high non-elective activity.

Clinical quality

Primary care services in Rotherham are all of an acceptable standard and some achieve consistently high quality, as demonstrated by annual performance reviews and by analysis of prescribing, QOF and QUEST. Immunisation and screening rates give cause for concern. There is also very considerable variation between primary care providers.

Community health services in Rotherham comply with the national Standards for Better Health. Mental health services comply with the national Standards for Better Health, and are rated excellent by the Healthcare Commission.

Hospital services are similarly compliant with all rated good or excellent. Rotherham Foundation Trust's MRSA and Clostridium Difficile rates are amongst the lowest in England. More detailed analysis of quality metrics indicates no major cause for concern, but equally scope for further improvement.

The tertiary services used by Rotherham people are of a high standard. Good progress has been made in implementing cancer Improving Outcomes Guidance (IOGs). Specialised drugs and treatments are the subject of clinical policies agreed with neighbouring PCTs. The Trent Neonatal Survey has highlighted some concerns about neonatal service configuration.

The NHS Rotherham organisational development plan '*Better Health, Better Lives, Better Delivery*' identifies seven key strategic objectives. The underpinning action plan includes actions to maximise the effectiveness of clinical leaders in the commissioning process and to further develop practice based commissioning.

The Board now receives, in addition to routine reports on provider cost activity, a developing report on quality. Clinical Guardians are now in place for all contracts and programme areas have an identified clinical lead.

4.3.5 Current Performance and Performance Risks

NHS Rotherham was one of the best performing PCTs in the 2008 World Class Commissioning round and was rated good for both quality of commissioning and financial management by the Care Quality Commission for 2008/09. Our major foundation trust providers have similar excellent or good Care Quality Commission ratings. However, Yorkshire Ambulance Service is rated weak for quality of services and good for financial management.

We performance manage the delivery of the initiatives set out in *Better Health, Better Lives,* via our contracts with our key providers and detailed community wide performance against 48 national 'vital sign' targets. Detailed results are in the appendices of the SIR. Figure 4.1 shows commissioned activity and key trends.

Two significant additional risks to delivery have emerged since the publication of *Better Health, Better Lives:* the impact of the economic recession on health and future heath service funding, and the potential impact on health and health services of the H1N1 flu pandemic. Achieving our strategic objectives whilst managing these issues is our biggest challenge.

Figure 4.1: Commissioned Activity and key trends

Category	Annual number (per 1000 registered patients)	Annual Change (over last 4 years)	Benchmark (Comparative position and comparative trend)
GP Contacts	5300	3% ↑	•Numbers from national data
GP OOH Contacts	100	0% change	•No benchmarking information
District Nurse Contacts (inc OOH)	750	1% ↓	•Data quality issues makes trend unclear •No robust benchmarking information
Prescribing Costs	£158,670	0.1% ↓	•Costs around regional average •Cost growth lower than SHA
Ambulance A and B incidents	90	2% ↑	•Rate of increase is lower than national average
Diagnostic Tests	260	4% ↑	•Activity is 20% less than comparator (NHS Doncaster) •Rate of increase is 7% less than comparator
A&E Attendances	250	2% ↑	•17% lower attendance rate than comparator (NHS Doncaster) •Rate of increase is 1% above comparators annual increase
Mental Health Occupied Bed Days	210	6% ↓	•No robust benchmarking information
First Hospital Outpatients	350	5% ↑	•Activity is 10% above national average •Recent increase in rate in line with national increases
Follow-up Hospital Outpatients	1040	8% ↑	•Activity is 25% above national average •Recent increase in line with national increases
Elective Hospital Inpatients (inc day cases)	220	6% ↑	•Activity is 20% above national average standardised rates •Trend parallels national trend
Non-Elective Hospital Inpatients	160	4% ↑	•Activity is 30% above national average standardised rates •Trend parallels national trend

4.3.6 Strategic Intelligence Review Summary

- An ageing population with increasing numbers of people with long term conditions such as dementia.
- Key maternity and children's issues including breastfeeding, smoking in pregnancy, obesity and safeguarding.
- The needs of people from black and minority ethnic communities.
- The impact of the recession on population health and on NHS finances.
- A competitive health market which has improved access, delivered shorter waiting times and health service activity levels.
- Unsustainable increases in hospital referrals and hospital admissions.

4.4 Financial Outlook

4.4.1 Financial Outlook

NHS Rotherham has completed an in depth assessment of our current financial position. Our financial strategy is summarised in section 7.1 of this plan, and in the accompanying detailed financial templates.

Our financial standing is very positive. We have met our statutory financial duties in all seven years since we were established, and in the past two years have delivered a surplus. We have £19.4 million lodged with the Yorkshire and the Humber Strategic Investment Fund (SIF), which we assume will be available in full. Our use of resources, as assessed by the Audit Commission, is rated as "good". We therefore have a very robust financial platform to underpin this strategy.

In 2009/10 we will invest £433million (£420m recurrent and £13m non recurrent), which equates to about £1695 per person in Rotherham. Our principal investments are GP services (£39m, 9%), prescribing (£43m, 10%) acute hospital services (£218m, 50%), mental health services (£34m, 8%), and community health services (£38m, 9%). ` Our forecast outturn for 2009/10 is a surplus of £2.1m, which is consistent with the control total set for us by NHS Yorkshire and the Humber. We expect to meet all other financial duties.

Our capital investment in 2009/10 will be £7.4million. Our principal capital investments will be setting up the new Rotherham Community Health Centre infrastructure and the implementation of the TPP Community IT system. Also included are Capital grants for CAMHs services, Rawmarsh Joint Service Centre and GP Premises grants. We will meet our capital expenditure duties.

4.4.2 Assumptions

We have built a financial model for 2010 – 2015 based on a series of assumptions about resources, inflation, demography and activity. The model has enabled us to project the "resource gap" for 2010 – 2015. It is these gaps that our revised strategy must overcome.

Assumptions – resources and inflation

2010/11

- PCT allocations 5.5%
- Net tariff uplift 0% (inflation 3.5%; efficiency 3.5%)
- CQUIN 1% (plus 0.5 % already in baselines, total uplift 1.5%)
- GP prescribing 5%
- GMS and PMS 0.5%
- Dental 0%

2011/12 to 2014/15

- PCT allocations 'Flat real' (an uplift to cover inflation plus an element of growth funding)
- Net tariff uplift -2% (2.5% inflation, 4.5% efficiency)
- CQUIN 1%
- GP prescribing 5%
- GMS and PMS 0.5%
- Dental 0%

Assumptions – demography and activity

2011/12 to 2014/15

- Population – 0.6% annual increase
- Older people – over 65s 3% annual increase
- GP referrals – 6% annual increase
- 999 calls – 2% annual increase
- A&E attendances – 2% annual increase
- Non elective admissions – 4% annual increase

Our financial model makes a £7.8m provision for these pressures in 2010/11, and £5m per annum thereafter.

4.4.3 Building the financial model

We have built our financial model using these assumptions and scenarios. We have made provision for new investment in essential service improvements. The model provides the 'base case' – it describes the resources gap we will face should we take no additional action to manage the expected financial challenge we face. The base case model is illustrated in figure 4.2:

Figure 4.2: Base Case Financial Model

	2009/10	2010/11	2011/12	2012/13	2013/14
Growth in allocations to NHSR	6%	5.5%	1%	1%	1%
Inflation Levels (set by DH)					
Tariff Inflation	4.7%	3.5%	2.5%	2.5%	2.5%
Efficiency Savings	-3%	-3.5%	-4.5%	-4.5%	-4.5%
Net Tariff inflation	1.7%	0%	-2%	-2%	-2%
Quality Payment (CQUIN)	0.5%	1%	1%	1%	1%
Prescribing	8%	5%	5%	5%	5%
PMS/GMS	2%	0.5%	0.5%	0.5%	0.5%
Dentistry	2%	0%	0%	0%	0%
Demand Pressures					
Activity/Demand Pressures (Recurrent)	£5m	£7.8m	£5m	£5m	£5m
Required Surplus					
Non Recurrent surplus	£2.1m	£2.2m	£2.2m	£2.2m	£2.2m
Recurrent or 'underlying' Surplus	£2.5m	£8.8m	£8.8m	£8.8m	£8.8m
Investment Plans					
Investment Plan (Recurrent)	£14.7m	£7.2m	£2.2m	£2.2m	£2.2m
Investment Plan (Non Recurrent)	£2.4m	£12.7m	£12.7m	£13.7m	£6.6m
Contingency Levels					
Recurrent Contingency	£2.1m	£2.2m	£2.2m	£2.2m	£2.2m
Non Recurrent Contingency	£0m	£2.2m	£2.2m	£2.2m	£2.2m

If all these assumptions are correct then in order to manage within our resource limit we will need to secure efficiency savings as follows:

Efficiency Savings					
Provider efficiency	£-11.7m	£-13.1m	£-15.4m	£-15.2m	£-15.0m
System efficiency	£0m	£-5.5m	£-3.5m	£-3.7m	£-4.8m
Management efficiency	£0m	£-0.8m	£-0.8m	£-0.8m	£0m
Total Efficiency Savings	**£-11.7m**	**£-19.4m**	**£-19.7m**	**£-19.7m**	**£-19.8m**

4.4.4 Financial Model Risks

The risks associated with the base case financial model are fourfold.

First, the model assumes that the financial allocations to the NHS announced in the Pre Budget Report 2009 and the NHS Operating Framework for 2010/11 will not be changed. This may not be the case following the 2010 general election.

Second, the model assumes given rates of increase in demand and activity. Whilst these assumptions are considered realistic, greater increases in underlying need and demand, GP prescribing, GP referrals and hospital activity, and changes in patients' expectations would in turn increase the level of efficiency savings required to secure financial balance. The NHS may also feel the impact of financial constraints in other parts of the public sector, in particular local government. It is probable that reductions in central budgets held by the DH will increase pressure on locally held NHS budgets.

Third, achieving financial balance will be dependent on securing major efficiency gains. The providers from whom we commission services will have to deliver efficiencies totaling £58.7m by 2013/14. Additional system efficiencies of £17.5m will also be required, together with a cut in NHS Rotherham management costs of £2.4m.

Fourth, implementing the fundamental changes needed to the way services are organised and delivered will itself incur non recurrent costs – change management costs, possible redundancy costs and so on. We will need to ensure that these are indeed non-recurrent costs, and work closely with providers to minimise the employment risk, ensure essential skills are retained and cover any unavoidable costs in our financial plans.

4.4.5 Financial Outlook Summary

- Our financial outlook is built on a series of assumptions drawn from the pre-budget report, NHS Operating Framework and other national advice, and local assessment of need and demand.
- The financial outlook identifies the need for efficiency gain and other measures to cover a £78.6m cumulative gap over four years between projected resources and base case requirements.
- Further changes to NHS allocations and/or to demand and activity would increase this pressure.

Whilst NHS Rotherham enters this period of unprecedented financial constraint from a very sound position, the challenge remains a very considerable one, with many attendant risks.

4.5 Quality Review

4.5.1 Introduction

We have undertaken an assessment of the quality of healthcare in Rotherham. This includes taking account of the Care Quality Commission's Annual Health Check, the GP quality account we have published, critical appraisal of initial quality accounts published by foundation trusts and other providers, and progress with CQUIN.

4.5.2 Annual Health Check

The annual health check for Rotherham is extremely positive. Taken together, the results are, with the important exception of Yorkshire Ambulance Service, as good as anywhere in England. Figure 4.3 shows the CQC Annual Health Check 2008/09 for NHS Rotherham and its major providers.

We have also taken account of Rotherham's Comprehensive Area Assessment, and the reports published by Ofsted and the CQC about children's and adults' services in Rotherham. This assessment has enabled us to identify priorities for quality improvement.

Figure 4.3: CQC annual health check 2008/09

Organisation	Quality of Services	Financial management
NHS Rotherham	Good	Good
Rotherham Foundation Trust	Excellent	Excellent
Rotherham, Doncaster and South Humber Foundation Trust	Excellent	Excellent
Sheffield Teaching Hospitals Foundation Trust	Good	Excellent
Sheffield Children's Foundation Trust	Good	Excellent
Yorkshire Ambulance Service	Weak	Good

4.5.3 GP quality accounts

What are NHS Rotherham GP Quality Accounts?

- Detailed series of benchmarked information which are publically available.
- Include needs analysis, £ per patient, and a wide range of output measures including *Better Health, Better Lives* outcomes expressed at individual practice level.
- Forms the intelligence for our well established contract review process.

What is the overall picture of GP quality and quality improvement in Rotherham?

- Above average performance in long term condition case finding building on a long history of targeted CVD work (YHPHO CVD mortality reductions predictions are the biggest in the North of England).
- High achievement on QOF for most practices.
- The vast majority of practices have decreased inappropriate exception reporting on QOF.
- Sustained progress towards much more cost effective prescribing over the last 5 years (prescribing cost growth the lowest in the North of England).
- Above average public perception scores on the majority of questions in the MORI survey (93% overall satisfaction).
- Good overall performance in specific initiatives such as increasing statin prescribing to people on disease registers.

But there is substantial variation in most areas

- 28 out of 39 practices have satisfactory assessment for all 6 components of their contract review, 11 do not.
- 3 practices have been 'managed out' in 2008/9.
- The Rotherham Good Medical Practice Panel considered 8 cases in 2008 including one that was passed to the police and one who was removed from practicing.
- There are substantial unexplained variation in most key areas including resource usage where there is potential for system wide quality and efficiency savings.

4.5.4 Dentists, pharmacists, optometrists and the independent sector

- Our quality review of dentists, pharmacists and optometrists shows some quality improvement initiatives but we have a less comprehensive grasp of the whole picture than for general practices and foundation trusts.
- There has been a high profile SUI in dentistry which has required strong NHS Rotherham action.
- Adult safeguarding procedures received a positive rating by the Care Quality Commission. SUIs in 2 independent nursing homes have been detected and investigated using adult safeguarding and NHS Rotherham governance procedures.
- Barlborough NHS Treatment Centre produces a robust quality report including commentary from an appointed clinical guardian.
- Our new services with Care UK (GP practice, walk in centre, GP out of hours and community diagnostics) all have robust KPIs covering a range of quality indicators.

4.5.5 Community services quality

Community health services are diverse and meet a wide range of needs for both adults and children. They include services provided by community nurses and therapists in a number of venues, many of which we provided alongside social care.
The information available about community services is generally poor compared with that available about primary care and hospital services. This means that it is not easy to analyse activity levels, quality, efficiency and hence value for money, nor is benchmarking with other services easy.

For the services commissioned from RCHS this is gradually changing as the benefits of the data and information generated from the new electronic clinical record, SystmOne, begin to be realised. For services for which contracts have recently been let, this is less problematic as we have required providers to supply the data and information we need. Notwithstanding these issues, we know that:

- access is generally satisfactory, with long waiting times having been cut significantly in the past eighteen months.
- activity levels are generally in line with contracts.
- patient safety is good, with good infection control and few serious incidents.
- patient experience, as indicated by PALS enquiries, complaints and other feedback, is generally good, but with some significant examples of poor experience.

However, we do have some serious concerns about the quality and effectiveness of some key services, including health visiting and district nursing. The key gaps in our intelligence relate to patient outcomes, efficiency and value for money.

4.5.6 Foundation Trusts Quality Accounts

In 2009 all NHS Rotherham's main acute hospital and mental health providers produced quality accounts (including RFT, RDASH, SCH, STHFT, DBHFT, BHFT). A key challenge for quality accounts is how to best present to the public the increasing amount of information that is available on how Rotherham's health providers benchmark on clinical quality and on progress with quality improvement.

This section summarises key messages from RFT and RDASH quality accounts in 2009 and sets out how NHS Rotherham will work with providers to continue to improve quality and make this information more publically accessible.

RFT and RDASH quality accounts in 2009
RFT's 2009 quality account concentrated on reporting initiatives and outcomes in four top priority areas.

- Hospital standardised mortality rates. These fell by 7% from 2008 to 2009, they now benchmark at exactly the national average and the trust plans to reduce them by a further 7% by April 2010.
- Between 2008 and 2009 RFT's patient satisfaction in the national inpatient survey improved substantially. In 2008 RFT was in the bottom 20% for one question and in the top 20% for 13 questions. In 2009 RFT was not in the bottom 20% for any questions and in the top 20% for 19 questions. The trust prioritises increasing reported satisfaction still further in 2010.
- The number of falls in hospital. These have remained constant over the last 4 years and are planned to be reduced by 40% in 2009/10.
- Hospital acquired pressure ulcers which are planned to be reduced by 50% in 2009/10.

RDASH reported a wider range of outcome measures and compliance with national initiatives and standards. Achievements in 2009 include:

- Achieved excellent CQC rating for 3 successive years and is fully compliant with CQC patient focus requirements
- 100% follow up of patients within 7 days of discharge
- Substantial reductions in waiting times for specialist services

NHS Rotherham's future approach to quality account
As part of our overall approach to commissioning for quality we will develop a common quality dashboard for all providers. This will include the 3 Darzi domains of effectiveness, safety and experience, incorporate the CQUIN metrics discussed later in section 5.3.1, include additional patient reported outcomes measures and patient reported experience measures, learning from serious untoward incidents and never events.

The quality dashboard will be aligned with the key *Adding Quality and Value* metrics and be the basis of quality reports discussed at provider quality meetings and provide board assurance for all providers. We will work with providers and with Monitor about how best to make this additional information publically available in Quality accounts to add to the information already available on NHS Choices and in publications such as Dr Foster Good Hospital Guide.

4.5.7 Comprehensive Area Assessment (CAA)

Rotherham's first CAA was published in December 2009. Amongst the key issues it highlighted are:

- The need for sustained effort to support skills and the economy.
- The weak Ofsted rating for children's services, which results primarily from the findings of an unannounced inspection of children's social care services, but which also highlights concerns about achieving well and staying healthy.
- The excellent CQC rating for adult services.

The Rotherham Partnership is giving top priority to resolving the concerns about children's services.

4.5.8 Quality review Summary

- On the basis of external assessments we are one of the best performing health communities in England.
- We have a robust picture of the quality of GP services – overall quality is above the national (and world) average and is improving BUT there is substantial variation and we have had to deal with cases of unacceptable practice in the past year.
- Our quality reviews of other independent providers are less comprehensive – there have been important SUIs in dentistry and in 2 independent care homes in the past year.
- Our quality review of community services is also less complete owing to a relative paucity of data; the information we have available indicates relatively good quality.
- Rotherham's CAA highlighted serious concerns about aspects of children's services.
- We have substantially increased our emphasis on quality in 2009. Contract managers now work with clinical guardians and are supported by inputs from programme managers, head of public and patient engagement and from practice based commissioners when negotiating contracts and monitoring performance.
- Foundation trusts quality reports show substantial quality improvements in 2008/9 in terms of reduced standardised hospital mortality rates and improvements in patient reported experience. We are working with them to get the biggest possible impact from implementing CQUIN and to achieve system wide alignment of additional quality initiatives.

4.6 Efficiency review

We have undertaken an initial analysis of all our investment to identify scope for efficiency gain, drawing on data and information that is already available. This includes programme budgets, Better Care, Better Value indicators and prescribing. We have grouped the analysis into five themes:

- GPs
- Prescribing
- Programme Budgets
- Hospital Services – emergency
- Hospital Services - planned.

This has enabled us to identify priority issues for further investigation and action.

4.6.1 General Practice

We have undertaken a new analysis of efficiency at general practice level. Practices' cost per weighted patient varies significantly, which suggests potential scope for efficiency gain. We have built upon this to identify the quality and efficiency improvements that might be obtained. Figure 4.4 illustrates this, showing expenditure per patient, with median and lower quartile lines for total expenditure. The cost saving, should all practices above the median spend the median value, would be **£5.4m.** The cost saving, should all practices above the lower quartile spend the lower quartile value, would be **£10.8m.**

GP variations – key indicators

We have assessed GPs performance against a suite of key indicators. The resulting dashboard, figure 4.5, shows a number of key areas such as access, resource utilisation and clinical effectiveness.

There is a level of variation between different practices. This analysis will underpin commissioning of GPs for 2010/11 onwards.

GP variations – secondary care activity (RFT)

We have analysed secondary care activity (first out patient, elective, non elective and A&E) delivered at RFT for each general practice; this is illustrated in figures 4.6 and 4.7. Potential savings are achieved if each practice reduces their expenditure to the mean average or lowest median quartile (for Rotherham). Practices on the periphery of the borough have a distorted position against their peers as a significant proportion of their activity may go to other providers e.g. Dinnington patients going to Bassetlaw hospital. *These additional data will be included in further versions of this analysis.*

The practices highlighted in green are the practices which would generate the biggest savings by moving to the average or lowest quartile. List size is a fundamental determinant.

Those practices who do not have a value illustrates that they are below either the mean average or median lowest quartile spend per 1000 patients. Potential savings made by moving to mean average would be **£9.1m**. Potential savings made by moving to the median lower quartile would be **£19.9m**.

Figure 4.4: GP Practices: Expenditure by patient

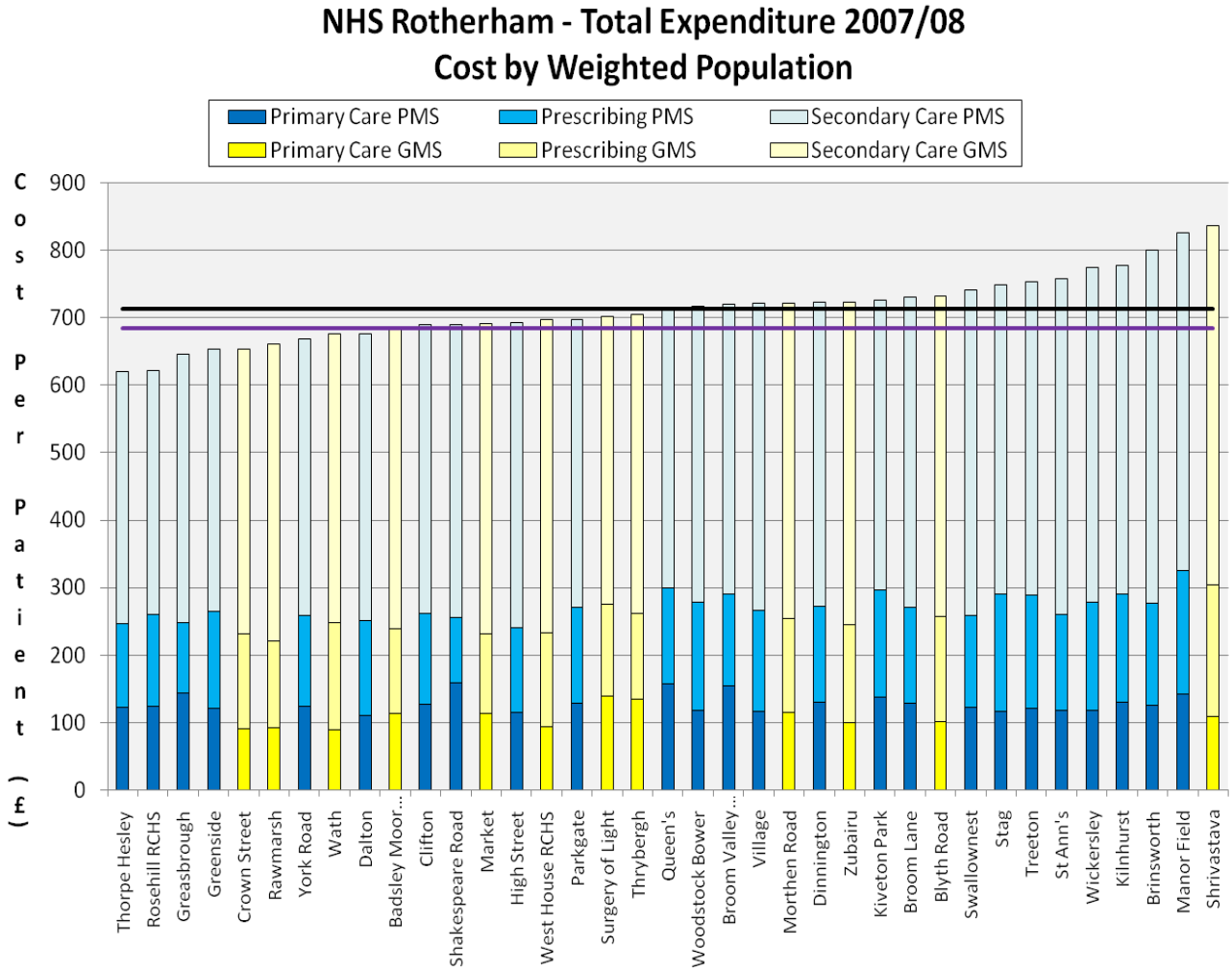


Figure 4.5: GP variations – key indicators

Priority	48hrs & Advanced Access (%)	WIC (weighted per 1,000)	Core Hours	[illegible]	[illegible]	[illegible]	Reduce hospital admissions and reliance on other care services	Children don't get life threatening and debilitating diseases	Early identification of life threatening cancers	Cost Per Patient GMS/PMS	Provision of Local Enhanced services	Choose & Book Uptake (min 60% max 90%)	Paperlight
Financial Benefit	Reduce reliance on OOHs and A&E	Redirection of patients from A&E	Reduce OOH's and A&E attendances	Cost effective prescribing	Managing chronic disease					Ensure value for money (benchmark) reduce practice variation	Reduction in the number of Secondary Care outpatient appointments	Reduction in DNAs and failed appointments	Better administrative procedures
Patient Benefit	Ensure patient access in Primary Care when required	Care in an appropriate setting/place	Access to appointments in Primary Care	Reduces risk of heart attack and strokes	Better quality of life		Better quality of life	Better quality of healthier life	Better quality of life	Ensure high quality services	Reduce inequalities. Ensure access to care in an appropriate setting/place	Choice of provider and time of appointment	Electronic patient medical records
Proposed Action	Should be 100%	Benchmarking A&E/WIC attendances by Practice	Core Hours funding Benchmarking A&E attendances by Practice			Influenza Uptake (%) Under 65 & at risk 1 Sep 08 to 31 Jan 09	Influenza Uptake (%) 65 and over 1 Sep 08 to 31 Jan 09	Compare PMS "block" payments with actual performance		Benchmarking done for last 2 yrs, further erosion of MPIG in GMS, use of (discretionary payments	Review of Enhanced Services ongoing.		
Practice	**2008 2009**	**2008 2009**	**Nov 09**	**2008 2009**	**2008 2009**	**Sept 08 - Jan 09**	**Sept 08 - Jan 09**	**Quarter Ending June 09**	**Jan - Dec 2008**	**2008 2009**	**Nov 09**	**2008 2009**	**Nov 09**
Dadsley Moor Lane	86	[illegible]	[illegible]	74	97.0%	55.90	[illegible]	[illegible]	76.2	658.80	[illegible]	73	[illegible]
Blyth Road	97	23.21	Yes	78	99.2%	66.10	79.60	98%	85.19	774.99	17	76	Yes
Brinsworth	77	27.66	Yes	74	97.7%	50.80	[illegible]	93%	79.1	[illegible]	18	55	Yes
Broom Lane	88	37.40	Yes	74	96.9%	50.80	76.60	95%	79.15	771.08	18	71	Yes
Broom Valley Road	93	[illegible]	Yes	83	98.8%	60.80	78.90	89%	[illegible]	[illegible]	[illegible]	86	[illegible]
Canklow Road RCHS	86	39.08	Yes	87	[illegible]	71.10	79.70	92%	[illegible]	700.82	[illegible]	86	[illegible]
Clifton	81	[illegible]	Yes	72	95.0%	52.00	78.20	[illegible]	74.21	735.58	19	86	Yes
Crown Street	90	6.79	Yes	76	96.0%	62.80	72.30	96%	83.86	730.80	19	74	Yes
Dalton	95	30.07	Yes	76	[illegible]	60.20	77.50	91%	76.76	745.22	16	65	[illegible]
Dinnington	[illegible]	8.68	Yes	[illegible]	93.8%	51.10	77.30	82%	77.4	730.29	17	66	Yes
Gate RCHS	95	39.66	Yes	82	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	12	68	[illegible]
Greasbrough	99	23.44	Yes	96	[illegible]	[illegible]	73.80	96%	77.69	671.93	17	82	[illegible]
Greenside	99	27.70	Yes	89	99.1%	49.90	77.50	98%	82.98	647.08	19	93	Yes
High Street	81	31.45	Yes	70	94.8%	60.90	81.30	95%	83.55	751.54	13	88	Yes
Kilnhurst	96	22.15	Yes	[illegible]	99.2%	49.20	77.80	96%	77.19	766.45	13	[illegible]	Yes
Kiveton Park	92	4.61	Yes	[illegible]	96.5%	57.30	81.60	96%	77.69	777.10	18	86	Yes
Manor Field	87	18.64	Yes	73	99.3%	54.60	79.20	99%	80.89	759.78	16	[illegible]	Yes
Market	95	7.01	Yes	78	98.4%	64.80	83.80	98%	81.76	737.10	19	[illegible]	[illegible]
Morthem Road	[illegible]	40.97	Yes	74	97.3%	45.10	72.30	97%	86.1	730.66	22	[illegible]	Yes
Parkgate	82	27.56	Yes	74	96.4%	[illegible]	[illegible]	97%	77.23	750.90	11	66	[illegible]
Queen's	79	18.76	Yes	[illegible]	98.1%	[illegible]	81.30	[illegible]	80.05	[illegible]	15	79	Yes
Rawmarsh	96	22.65	Yes	86	98.0%	[illegible]	[illegible]	96%	79.65	698.28	16	64	Yes
Rosehill RCHS	[illegible]	24.75	Yes	81	94.1%	[illegible]	[illegible]	94%	[illegible]	699.93	[illegible]	52	[illegible]
Shakespeare Road	[illegible]	[illegible]	Yes	80	96.3%	57.40	78.20	[illegible]	[illegible]	716.16	16	100	Yes
Shrivastava	[illegible]	17.76	Yes	[illegible]	97.0%	57.50	73.10	92%	84.58	[illegible]	14	51	Yes
St Ann's	[illegible]	[illegible]	Yes	76	95.2%	48.50	76.80	[illegible]	[illegible]	780.05	10	[illegible]	Yes
Stag	82	[illegible]	Yes	[illegible]	95.4%	47.90	77.00	96%	82.61	767.14	16	62	[illegible]
Surgery of Light	95	21.07	Yes	72	99.8%	57.10	74.30	100%	79.67	663.51	13	70	[illegible]
Swallownest	[illegible]	12.48	Yes	78	95.7%	53.00	81.90	98%	79.01	781.00	15	[illegible]	Yes
Thorpe Hesley	95	24.65	Yes	[illegible]	99.0%	46.60	[illegible]	100%	78.34	662.10	[illegible]	[illegible]	Yes
Thrybergh	97	40.09	[illegible]	71	99.1%	61.50	82.10	100%	82.57	714.50	13	75	[illegible]
Treeton	[illegible]	20.18	Yes	70	94.7%	[illegible]	78.30	93%	76.68	[illegible]	14	79	Yes
Village	82	16.02	Yes	78	97.4%	59.30	78.00	93%	76.2	772.33	18	87	Yes
Wath	94	2.76	Yes	77	[illegible]	54.00	72.30	92%	77.75	[illegible]	[illegible]	93	[illegible]
West House RCHS	100	5.26	Yes	78	[illegible]	[illegible]	[illegible]	91%	[illegible]	751.36	[illegible]	100	[illegible]
Wickersley	86	38.90	Yes	72	95.8%	75.80	75.10	94%	80.11	766.29	15	76	Yes
Woodstock Bower	83	[illegible]	Yes	75	[illegible]	49.20	75.50	[illegible]	75.72	776.51	10	74	Yes
York Road	91	[illegible]	Yes	72	97.6%	50.20	72.20	[illegible]	[illegible]	698.26	17	86	Yes
Zubairu	76	25.23	Yes	78	[illegible]	81.90	80.40	93%	89.91	725.59	[illegible]	[illegible]	[illegible]
Target	85.79	28.34	37	73	94%	75	75	90%	80%	751.03		Min 60% Max 90%	74
Financial Benefit			**£42.43K**				**£50.60K**				**£14.15K**		

4.6: Out Patient Attendances at RFT by practice. Savings based on moving everyone to average or lower quartile shown (green indicates practices that would generate biggest savings)

Practice	Cardiology		Dermatology		T & O		ENT		Opthalmology		Obstetrics		Gynae		Others		Savings	
	Savings moving everyone to average	Savings moving everyone to lower qtrile	Savings moving everyone to average	Savings moving everyone to lower qtrile	Savings moving everyone to average	Savings moving everyone to lower qtrile	Savings moving everyone to average	Savings moving everyone to lower qtrile	Savings moving everyone to average	Savings moving everyone to lower qtrile	Savings moving everyone to average	Savings moving everyone to lower qtrile	Savings moving everyone to average	Savings moving everyone to lower qtrile	Savings moving everyone to average	Savings moving everyone to lower qtrile	Average	Lower Quartile
Badsley Moor Lane			520	1850		1687	2465	3290			2597	3587	3372	3945	5410	16234	14364	30592
Blyth Road		298	8765	11959	10053	16559	3615	5597	2214	3837	2164	4541		93	30261	56256	57073	99140
Brampton											29	50					29	50
Brinsworth	1533	3661	2556	6559	1924	10078	91	2575		454		2305	520	2244		29772	6623	57647
Broom Lane	5241	8794				6410		1	2787	6183		4340		2526		41189	8028	69443
Broom Valley Road			146	1158		1320	457	1085		92	1275	2028			1482	9714	3361	15396
Canklow Road RCHS											1312	1978		35			1312	2012
Chantry Bridge					9	61					42	61					51	122
Clifton		1110	378	7247	622	14611		3636		2186	3689	8802	713	3670	4200	60099	9603	101360
Crown Street		2000	4170	9273	10001	20395	4220	7387		2429			4130	6328	21621	63155	44143	110967
Dalton		226		1056		1259			524	1084	476	1296	1008	1482		8042	2008	14445
Dinnington		898	6676	17828	20611	43325		6204		483	4491	12792				64270	31778	145799
Gate RCHS			529	1286			1267	1737			5057	5621	134	460	3692	9856	10679	18960
Greasbrough	2307	3251									1231	2553		448			3539	6251
Greenside	1869	3281				840				837						3594	1869	8552
High Street	1838	4029	4943	9065		6142		451	2225	4320		2494	1748	3522	1149	34694	11903	64718
Kilnhurst		1580	1377	5157		7586		2017	2256	4178			1148	2775	23520	54283	28302	77576
Kiveton Park				5739	7803	19794		910	860	3852		3049	2503	5038		39354	11165	77734
Manor Field		182			1994	7952	175	1990		1068	1364	3542	4252	5512		20015	7785	40261
Market				1263				1526				803				11956	0	15548
Morthen Road	2397	5543	7257	13175		7526	4558	8230		2307		1497	2153	4701	31156	79321	47520	122300
Parkgate		1450						1277		458	159	2612	1643	3062			1803	8860
Queen's	982	1518		228		0	1124	1749			710	1460	49	483	1941	10142	4806	15580
Rawmarsh				1022		4321		666		153			369	1293		14607	369	22061
Rosehill RCHS		576		502		1713		533									0	3324
Shakespeare Road		520		2				613			10354	12132	63	1091			10417	14357
Shrivastava	433	1282		1554	569	3822			1710	2522			725	1413	5302	18302	8740	28895
St Ann's	2298	7284	13932	23310		13948	7523	13341	13076	17843	4851	11831	3274	7313	100347	176671	145302	271540
Stag	1548	4762		4673		11616	9012	12763	7764	10837					50193	99395	68518	144046
Surgery Of Light		119		26										143			0	288
Swallownest	10785	15276	3256	11702	8401	25606		2733	2640	6933		2288		736		65817	25082	131091
Thorpe Hesley	2408	4099				4648		1439		301		233		1181		11190	2408	23091
Thrybergh	122	501		272	2305	3757				70	16	547	1437	1744			3880	6891
Treeton		272		1635		6442		1103			2681	5070	2215	3597		20759	4896	38879
Village		1066		2175		6818		1538	1506	3240		1794				8617	1506	25248
Wath			1503	2626	5273	7561	1855	2552	1674	2245		644	1006	1490	11966	21108	23276	38224
West House RCHS			4023	4914	759	2573		86	1728	2181					2225	9477	8734	19231
Wickersley	1100	3014	3052	6653	629	7964	976	3211	1781	3611			4497	6048	9668	38978	21703	69480
Woodstock Bower		1511			1229	14047				1767		4320		1642		36858	1229	60145
York Road		7								188	1271	3359					1271	3553
Zubairu			599	1466	3574	5339	733	1271		50	701	1346	702	1075	2987	10039	9296	20585
Range of savings	34863	78108	63682	155374	75755	285722	38073	91510	42744	85707	44469	108969	37659	75090	307122	1143762	644368	2024242

Figure 4.7: A&E, non-elective and elective activity at RFT by practice. Savings based on moving everyone to average or lower quartile show (green indicates practices that would generate biggest savings)

Practice	A & E Attendances		Non-Electives		Electives	
	Savings moving everyone to average	Savings moving everyone to lower qtrile	Savings moving everyone to average	Savings moving everyone to lower qtrile	Savings moving everyone to average	Savings moving everyone to lower qtrile
Badsley Moor Lane	36584	10229	109173	204701		19990
Blyth Road	16068	15803		191191	49377	152173
Brinsworth	2848	64122				124051
Broom Lane	17769	41640	526155	1006166	105741	320811
Broom Valley Road		33792	69947	142597	14214	46765
Canklow Road RCHS	32275	45162	47451	111722		
Clifton	47661	27503	255137	748499	199856	420909
Crown Street		20122		55871		
Dalton	13210	19350	70154	149270		35211
Dinnington		106336				
Gate RCHS	28906		46989	101390		
Greasbrough	9071		140069	267579		34158
Greenside		20077		89618	39226	124709
High Street	915		218433	514503	177614	310270
Kilnhurst		15896	335027	606537	190484	312134
Kiveton Park		242400				
Manor Field	18692	0	181736	391882	75909	170066
Market				119375		10885
Morthen Road		91967		209337	109638	300110
Parkgate	20384	38893	333611	570307	37689	143742
Queen's	9261	93898				
Rawmarsh	5498		39496	193748	113170	182283
Rosehill RCHS		38047		85519	21116	64346
Shakespeare Road	78496	395		135053		
Shrivastava	9819		272669	387401	88287	139693
St Ann's	181905	22459	1544133	2217762	474807	776629
Stag				113212	320349	514918
Surgery Of Light	5611	36672			19900	42938
Swallownest		28673				
Thorpe Hesley		15761		81633	9618	112002
Thrybergh	11203	18439		45353	8990	31942
Treeton	18189	10639	108639	339176		3866
Village		20315	181504	426541	98567	208356
Wath			46187	126871		18875
West House RCHS		20522			53685	82362
Wickersley		9423		194084	153620	269528
Woodstock Bower	65741		364994	817039	181402	383942
York Road	46026	60876	275237	476737		84750
Zubairu	12849	37564	12752	74996	19125	47014
Total	688981	1206974	5179492	11195670	2562384	5489427

4.6.2 Prescribing

We have a positive track record of improving prescribing efficiency, including several highly innovative schemes such as our dietetic and incontinence product prescribing schemes which have secured external praise. Our indicative prescribing budgets are weighted according to practice need using local practice disease registers.

Our prescribing cost growth has been one of the lowest in the North of England over the last 4 years and we have assessed the scope for further efficiency gain

The NHS Institute's Better Care, Better Value indicators, see figure 4.8, suggest potential gain of about £800K in two areas. Our prescribing quilt, figure 4.9, focuses on 18 prescribing indicators, three of these are the Better Care, Better Value indicators (columns 2, 3 and 4 on the quilt), 11 indicators gives benchmarking information on a series of initiatives aimed to improve life expectancy (columns 4 to 15) and the final 3 indicators benchmark community antibiotic prescribing which is important in reducing health care acquired infections.

The quilt will be extended to include new indicators and is used by practices and NHS Rotherham's prescribing team to increase the effectiveness and cost effectiveness of each practices prescribing.

Figure 4.8: Better Care, Better Value - prescribing

Indicator (Q4 2008/09)	Rank (of 152)	Rating	Productivity Opportunity
% low cost statins (Q1 2008/09)	100	72.9%	£464,216
% low cost PPI	146	81.9%	£330,966
% low cost ACEI	23	75.0%	£0

(The ratings show the current % of low cost drugs that are prescribed in Rotherham. The productivity opportunity is the cost savings if Rotherham were to be in the national best quartile for statins, lipids and PPIs.)

Figure 4.9: NHS Rotherham Prescribing Quilt 2009/10

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Practice	Practice Budget 2008/09	A2RA Qtr 4 2008/09	PPI Qtr 4 2008/09	Statins Qtr 4 2008/09	CHD % on a Statin	HF % on a Statin	AF % on a Statin	Diabetes % on a Statin	COPD % on a Statin	SMI % on a Statin	Hypertension % on a Statin	AF % on an anticoagulant	% of T2DM patients on metformin	% heart failure pts titrated AceSartanRI	% heart failure pts on titrated Beta Blocker	Antibacterials All Items per Starpu Qtr 3 2008/09	Antibacterials Cefalosporin Items per Starpu Qtr 3 2008/09	Antibacterials Quinolone Items per Starpu Qtr 3 2008/09
Badsley Moor Lane	£378,424	82.9%	91.9%	73.4%	87.5%	80.0%	86.7%	88.4%	57.1%	44.4%	64.6%	26.7%	75.0%	33.3%	8.3%	247	0.5	0.5
Blyth Road	£920,800	70.9%	85.9%	81.8%	76.9%	64.9%	55.7%	80.8%	48.7%	40.0%	58.6%	51.9%	48.3%	15.8%	1.8%	337	51.8	15.4
Brinsworth	£1,114,307	77.0%	80.5%	76.3%	83.5%	50.9%	50.0%	76.6%	44.5%	13.0%	52.6%	53.4%	50.8%	30.2%	3.8%	251	10.3	7.4
Broom Lane	£2,008,775	74.6%	82.5%	74.2%	88.2%	73.4%	63.5%	85.8%	50.5%	23.7%	55.3%	49.2%	61.3%	30.9%	11.7%	210	8.5	4.3
Broom Valley Road	£333,109	84.1%	79.5%	85.0%	89.6%	64.7%	77.8%	88.8%	73.1%	38.5%	80.3%	63.0%	82.7%	23.5%	0.0%	184	0.6	2.9
Canklow Road RCHS	£232,068	72.9%	89.4%	90.1%	88.9%	83.3%	66.7%	88.7%	60.0%	15.8%	75.6%	100.0%	83.0%	41.7%	0.0%	306	4.7	2.0
Clifton	£2,024,190	75.5%	81.8%	74.3%	87.5%	74.0%	60.6%	82.9%	53.8%	27.9%	63.5%	45.1%	69.5%	38.5%	11.5%	183	8.1	3.7
Crown Street	£1,690,930	68.0%	91.1%	78.4%	93.3%	71.4%	63.4%	93.3%	49.1%	32.7%	51.9%	57.2%	71.0%	33.3%	1.6%	172	4.2	2.2
Dalton	£325,506	84.4%	89.4%	77.5%	90.1%	81.3%	46.4%	93.0%	62.9%	13.3%	76.1%	35.7%	73.8%	11.1%	0.0%	244	12.8	3.5
Dinnington	£3,216,137	74.9%	80.0%	66.3%	84.9%	65.5%	63.2%	81.6%	47.2%	20.7%	54.5%	52.8%	54.9%	17.4%	1.8%	250	8.6	4.1
Gate RCHS	£117,045	90.7%	92.5%	78.5%	69.2%	0.0%	0.0%	47.6%	25.0%	7.1%	32.1%	0.0%	71.4%	0.0%	0.0%	175	7.6	4.2
Greasborough	£489,377	83.8%	87.7%	97.8%	80.0%	53.3%	59.5%	74.8%	61.6%	26.7%	65.3%	52.4%	78.1%	13.3%	0.0%	161	9.7	1.4
Greenside	£842,536	80.0%	91.9%	88.8%	83.6%	56.1%	51.3%	84.7%	52.2%	23.1%	59.4%	52.6%	78.7%	38.6%	7.0%	254	12.7	2.7
High Street	£1,152,560	73.3%	83.3%	72.7%	86.1%	75.4%	20.3%	85.4%	49.6%	18.2%	54.6%	53.4%	65.8%	35.8%	6.0%	189	13.1	2.0
Kilnhurst	£1,270,646	75.5%	85.7%	69.3%	93.6%	84.5%	72.6%	92.7%	56.7%	74.5%	66.6%	60.4%	75.1%	37.9%	3.4%	183	13.7	2.2
Kiveton Park	£1,795,764	66.8%	93.7%	65.3%	85.1%	67.4%	59.5%	91.2%	66.9%	44.4%	61.0%	44.1%	59.7%	27.1%	6.8%	197	17.5	3.0
Manor Field	£925,276	74.2%	86.8%	74.6%	91.6%	75.4%	70.6%	86.5%	54.7%	20.5%	63.2%	76.5%	72.4%	31.8%	10.6%	188	3.7	3.9
Market	£1,303,332	77.4%	94.2%	80.5%	83.4%	60.0%	54.5%	75.7%	38.9%	14.3%	40.4%	44.7%	78.1%	22.8%	7.0%	146	5.6	3.6
Morthen Road	£1,627,116	72.5%	79.7%	76.3%	87.0%	73.4%	64.1%	81.1%	49.8%	35.2%	55.3%	49.7%	80.1%	26.6%	7.8%	209	11.4	4.3
Parkgate	£1,074,490	76.7%	84.1%	76.7%	85.8%	73.2%	58.3%	87.7%	51.8%	20.0%	64.9%	39.6%	72.2%	22.9%	4.3%	268	6.2	3.6
Queen's	£302,050	72.1%	86.8%	72.4%	79.5%	86.4%	63.2%	76.8%	46.5%	25.0%	62.1%	21.1%	70.7%	26.1%	4.3%	230	0.6	4.9
Rawmarsh	£651,490	73.5%	78.0%	86.8%	81.4%	62.2%	49.0%	75.9%	42.5%	8.7%	50.8%	51.0%	58.9%	40.5%	10.8%	294	9.0	6.1
Rosehill RCHS	£429,961	77.4%	81.3%	66.7%	83.9%	88.9%	72.0%	82.1%	47.1%	36.4%	73.1%	56.0%	64.0%	22.2%	0.0%	165	5.3	4.4
Shakespear Road	£503,788	73.6%	90.9%	81.6%	94.9%	91.3%	84.6%	85.4%	65.3%	30.3%	67.6%	46.2%	78.9%	30.4%	4.3%	335	32.1	1.3
Shrivastava	£657,875	83.9%	74.2%	73.0%	90.5%	80.6%	75.5%	87.9%	69.3%	50.0%	74.3%	67.9%	79.5%	17.1%	0.0%	168	6.3	6.7
St Ann's	£2,984,419	76.2%	87.0%	79.6%	86.3%	76.3%	59.1%	90.1%	54.5%	27.9%	66.3%	43.2%	55.0%	37.4%	14.4%	185	15.9	2.1
Stag	£1,976,550	66.5%	84.0%	65.0%	84.6%	56.8%	55.6%	80.5%	46.4%	25.3%	91.2%	50.2%	50.5%	17.5%	6.2%	274	13.4	10.6
Surgery Of Light	£186,135	76.5%	89.6%	75.3%	88.0%	66.7%	73.3%	83.7%	63.0%	42.9%	66.4%	33.3%	71.0%	18.2%	0.0%	282	1.8	2.8
Swallownest	£2,490,869	77.8%	89.2%	78.3%	85.8%	67.2%	56.2%	79.8%	43.8%	20.2%	54.3%	50.6%	60.4%	31.0%	10.3%	217	16.3	2.8
Thorpe Hesley	£898,379	75.7%	85.5%	78.7%	90.2%	75.0%	76.7%	87.1%	49.3%	18.2%	53.5%	46.6%	71.8%	15.9%	2.3%	200	3.6	4.0
Thrybergh	£200,761	86.4%	82.7%	73.4%	98.0%	100.0%	100.0%	94.0%	67.9%	45.5%	85.2%	63.6%	87.5%	42.9%	0.0%	196	3.5	12.2
Treeton	£925,800	72.5%	76.1%	73.8%	81.4%	65.2%	59.4%	83.7%	47.8%	23.7%	53.2%	49.5%	72.4%	22.2%	4.4%	313	16.6	15.6
Village	£1,076,979	75.4%	89.3%	78.5%	89.4%	77.4%	65.2%	81.9%	51.3%	19.6%	58.8%	45.2%	61.3%	31.1%	11.5%	167	6.8	2.6
Wath	£420,437	73.7%	85.1%	78.4%	85.9%	64.7%	65.4%	82.1%	48.9%	33.3%	69.0%	34.6%	50.5%	29.4%	5.9%	148	6.3	1.1
West House RCHS	£337,651	69.8%	81.4%	78.3%	66.4%	43.9%	63.2%	73.8%	53.8%	57.1%	54.5%	26.3%	69.2%	18.0%	0.0%	176	0.0	6.0
Wickersley	£1,114,165	70.3%	86.1%	74.7%	82.9%	66.3%	65.7%	82.1%	56.9%	24.1%	66.4%	38.4%	53.0%	13.5%	0.0%	257	19.3	7.0
Woodstock Bower	£2,142,785	77.2%	81.4%	76.2%	80.3%	57.3%	44.8%	80.1%	42.4%	20.0%	54.4%	46.8%	57.5%	22.9%	7.3%	190	10.9	2.3
York Road	£877,107	85.6%	86.5%	72.5%	93.9%	68.5%	63.1%	92.0%	53.4%	37.8%	75.8%	84.6%	55.6%	27.5%	5.9%	253	8.4	2.2
Zubairu	£240,760	83.5%	86.5%	85.1%	75.3%	50.0%	53.3%	73.2%	57.9%	42.9%	65.8%	26.7%	66.7%	10.0%	0.0%	253	3.7	1.5
PCT Median		75.5%	85.9%	76.3%	85.9%	68.5%	63.2%	83.7%	51.8%	25.3%	63.2%	49.5%	70.7%	26.6%	4.3%	209	8.4	3.6
PCT Mean		75.3%	85.0%	75.7%	85.5%	68.5%	61.3%	83.1%	52.9%	29.3%	62.5%	48.5%	67.6%	27.1%	6.8%	265	11.66	4.3
		0.2%	0.9%	0.7%	0.4%	0.0%	1.9%	0.6%	-1.1%	-4.0%	0.7%	1.0%	3.1%	-0.5%	-2.5%	-56	-3.2	-0.7

4.6.3 Programme Budgets

Programme budget information is provided nationally based on PCT returns. It reports on PCT expenditure within 22 programmes. NHS Rotherham data is shown in figure 4.10 below. The three areas of relatively highest spend have changed since last year, although both Infectious Diseases and Problems of Vision were relatively high spenders last year also.

Differences in service configuration between PCTs, particularly with regards to services shared with other bodies, can significantly affect how funding is allocated. This can contribute to the variations seen below, social care needs being a particular example of this.

Figure 4.10: Expenditure by programme compared to other PCTs (£ per head 2008/09)

Programme	Rank	NHSR £ per head	NHSR £ per head 2007/08	ONS Cluster £ per head	Similar PCT £ per head (Barnsley)	Yorks & Humber SHA £ per head	National £ per head	Variance from ONS Cluster	Variance from ONS Cluster 2007/08
Infectious Diseases	44	23	19	17	19	18	23	39%	19%
Problems of Vision	6	43	38	33	27	34	33	30%	18%
Problems of Hearing	26	11	8	9	13	9	8	21%	-8%
Problems of Genito Urinary System	24	82	65	71	81	74	74	16%	2%
Problems of Respiratory System	7	98	76	87	94	89	78	13%	3%
Problems due to Trauma and Injuries	43	70	74	63	91	64	64	11%	22%
Dental Problems	33	71	60	64	56	69	62	10%	8%
Conditions of Neonates	64	18	17	16	16	16	17	9%	27%
Cancers and Tumours	50	101	78	96	119	97	95	5%	-6%
Problems of Gastro Intestinal System	34	86	81	84	95	85	78	2%	0%
Maternity and Reproductive Health	94	58	56	57	63	55	60	1%	-2%
Problems of the Skin	69	32	33	33	45	33	32	-3%	13%
Problems of Learning Disability	74	55	66	59	38	49	56	-6%	51%
Problems of Circulation	86	126	121	134	117	144	130	-6%	-6%
Adverse effects and poisoning	81	18	12	19	21	17	18	-9%	-17%
Mental Health Disorders	110	168	148	184	233	192	191	-9%	6%
Neurological	103	62	52	68	68	70	68	-9%	-10%
Disorders of the Blood	97	17	18	19	25	18	19	-10%	5%
Endocrine, Nutritional and Metabolic	112	38	37	44	52	42	43	-14%	2%
Healthy Individuals	78	34	30	41	50	34	36	-16%	16%
Problems of Musculo Skeletal System	115	68	68	85	111	72	80	-20%	-14%
Social Care Needs	141	8	27	42	201	54	37	-80%	-26%
Total		**1287**	**1362**	**1326**	**1635**	**1336**	**1303**		

4.6.4 Hospital Services

Rotherham's health care system includes an over reliance on urgent hospital admissions with insufficient alternatives to hospital care.

Better Care, Better Value indicators

The NHS Institute's BCBV indicators show that Rotherham ranks 140 out of 152 PCTs for weighted emergency admission rates and 144 out of 152 for elective surgical procedures for the five marginally effective procedures defined by the CMO.

Indicator (Q4 2008/09)	Rank (of 152)	Rating	Productivity Opportunity
Emergency Admissions (ACS)	140	142.2	£5,952,000
Outpatient Referrals	93	117.9	£720,000
Surgical Threshold	144	127.5	£905,000

The ratings are a needs weighted standardised ratio. For example, the ACS ratio means that Rotherham's admissions are 42% above weighted average. The productivity gain is the amount saved if Rotherham's activity were at the lowest national quartile.

For ACS admissions this would mean reducing annual costs from £8,522,863 to £2,570,863. Even if this dramatic transformation were to be achieved *there would be some significant compensatory increase in costs for alternative elective and non hospital care.*

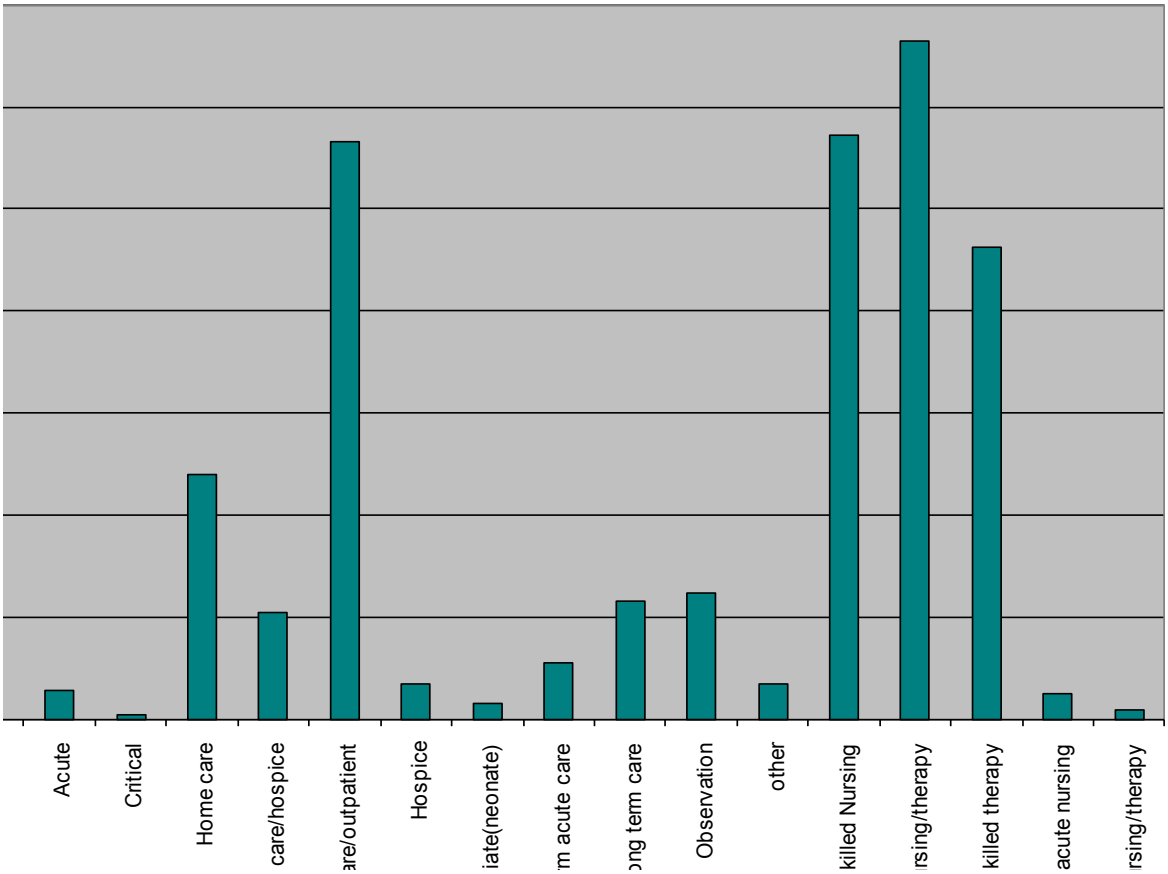
For 5 surgical threshold conditions (myringotomy, hysterectomy, low back pain surgery, tonsillectomy and D&C) the savings would involve decreasing current costs from £1,989,445 to £1,084,445. Again there would be some compensatory costs for alternative treatments.

InterQual

Our InterQual project collects information about people currently in hospital using standard enquiry tools. 70% of all bed days are occupied by people who should ideally be in an alternative level of care. Some of the findings of this project can be implemented immediately, for example, some people currently receiving hospital care who could be looked after at home. Other findings require commissioning alternative capacity led by skilled nurses and skilled therapists. Figure 4.11 shows urgent care InterQual analysis.

Figure 4.11: Urgent care - InterQual analysis

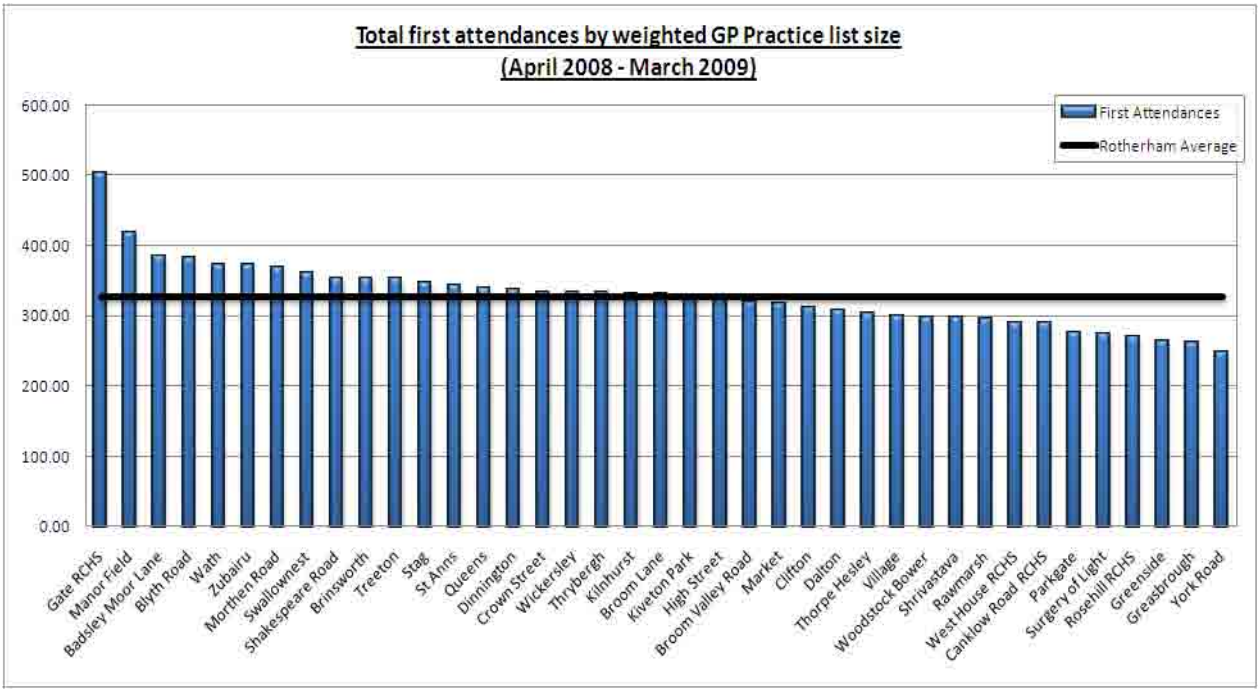
Rotherham Foundation Trust's trust wide audit of 513 patients showed 70% of adults and 78% of children did not meet interQual criteria for their speciality beds. This graph shows the number of days of alternative levels of care these patients would require. In total there are 3054 variance days. The equivalent of 101 beds. Savings depend on the costs of providing alternative care.



GP referral, out patients and elective activity

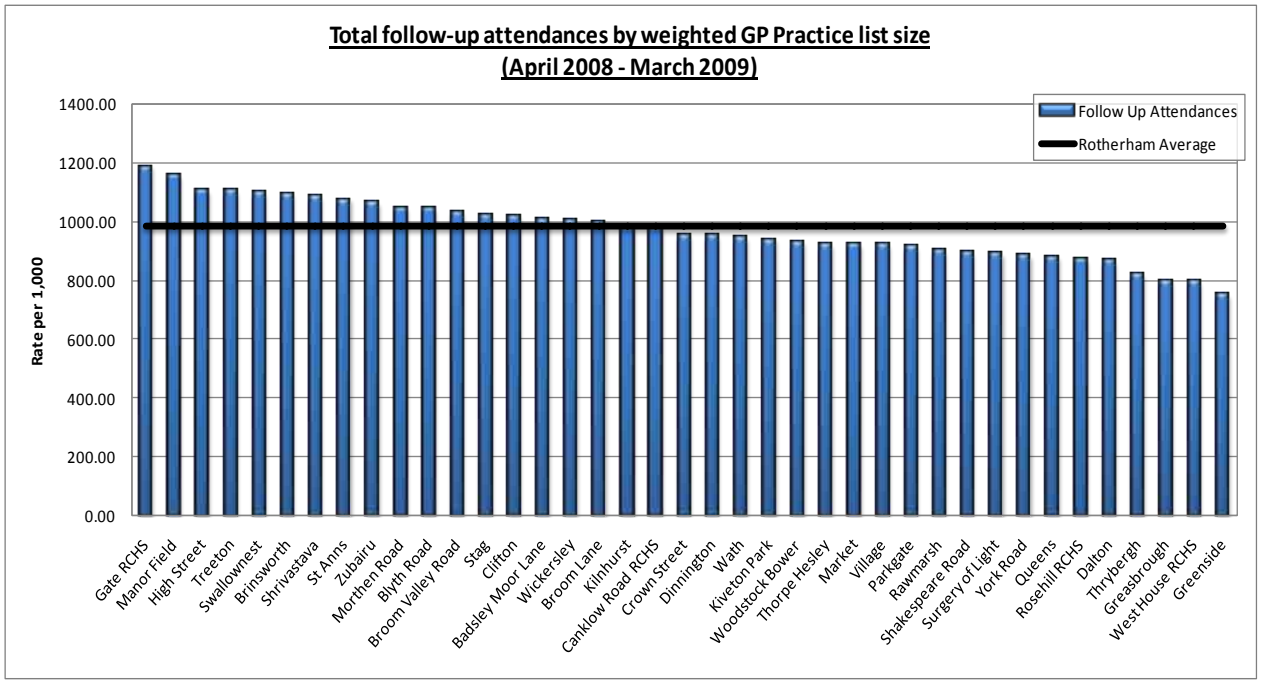
Like other health communities there has been a sharp recent increase in GP referrals. First outpatient appointments increased by 11% in 2008/9. Figure 4.12 shows GP referrals for planned care. Rotherham is 93rd highest out of **152** PCTs for weighted GP first referral rates. Rates are rising at 5% a year and there is a near two-fold difference between practices within Rotherham.

Figure 4.12: GP First referral rates



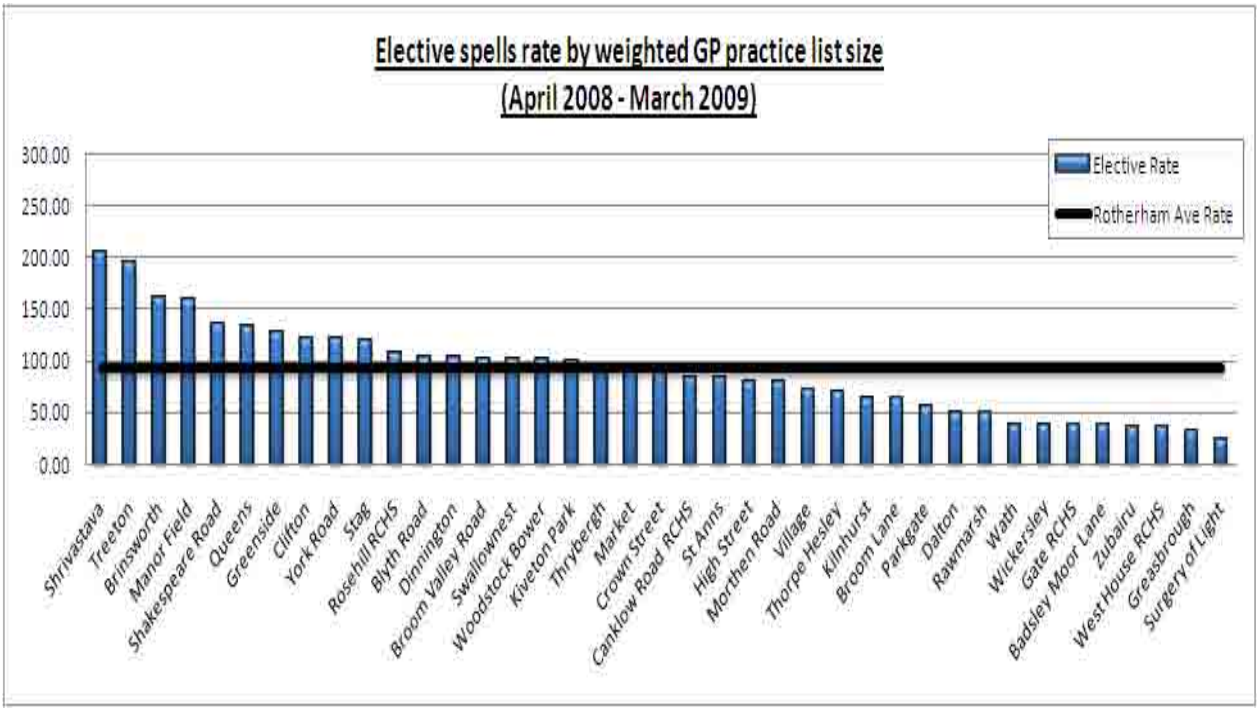
Rotherham's weighted rate of follow-up appointments, see figure 4.13, is 30% above the national average, rates are going up by 8% a year and there is more than 50% variation between practices.

Figure 4.13: Follow-up attendance



Rates of elective spells, see figure 4.14, are 25% above weighted national average, they are increasing by 6% per year and there is four-fold variation between Rotherham practices.

Figure 4.14: Elective Spells



4.6.5 Efficiency review summary

Our efficiency review highlights the major efficiency opportunities in Rotherham:

- Scope for rationalising GP incentive payments and enhanced services.
- Substantial variation in cost per patient between general practices.
- Fragmentation and lack of demonstrable system wide impact of current demand management initiatives such as community matrons, CARATS and Breathing Space.
- Hospital costs that are rising faster than primary and community care costs.
- InterQual shows substantial avoidable utilisation of inpatient hospital care especially for ACS conditions.
- Above average rates of re-admissions and follow ups.
- Potential for greater use of technology for better community management and inter-hospital communication (e.g. stroke).

4.7 Intelligence Summary

Strategic intelligence review

- Ageing population with increasing numbers of long term conditions.
- Recession impacting on health and health service finances.
- Unsustainable trends of increasing hospital referrals and admissions.

Financial outlook

- A cumulative gap of £92m over four years between projected resources and base case projected costs.

Quality review

- A high performing health community.
- Variations in quality between GP, a relative lack of information on quality in community services and the potential for better system wide alignment of the quality agenda to improve population outcome.

Efficiency review

- Variations between GP practices in cost per patient.
- Lack of demonstrable system wide impact of current demand management initiatives.
- Over utilisation of acute hospital care which could be addressed by system wide reform and additional community capacity.

5 Priorities, initiatives and efficiency programmes

5.1 Introduction

In *Adding Quality and Value* we have reaffirmed the goal, vision, values, priorities and transformational initiatives described in *Better Health, Better Lives.* We have assessed progress in 2009, and have analysed intelligence, including about quality, efficiency and the financial outlook.

The very good performance of Rotherham's NHS, our sound financial position and the excellent relations within our health economy mean we have a positive platform upon which build. *Adding Quality and Value* seeks to achieve this by:

- protecting and sustaining the major improvements made in the past decade to health and to health services.
- delivering the priorities and outcomes set out in *Better Health Better Lives.*
- securing major improvements to quality and efficiency
- reshaping the local NHS to ensure that we have the right configuration of services and providers.

5.2 Priorities

Better Health, Better Lives focused on 8 priorities. In *Adding Quality and Value* we are making one change to this, to recognise the critical interdependence between long term conditions, intermediate care and urgent care, and the need for coordinated action to secure the major quality and efficiency improvements our intelligence review suggests is achievable for these services.

The revised priorities – each of which forms a discrete programme - are therefore:

- First Class Primary Care
- Healthy Pregnancy and Birth
- Healthy Childhood
- Staying Healthy
- First Class Planned Care
- Long Term Conditions , Intermediate Care and Urgent Care
- Better Mental Health
- End of Life Care

For all eight priorities, we have refreshed the 29 *Better Health, Better Lives* transformational initiatives, taking account of the progress reported in section 3.3.

In addition, three of the priorities will make a major contribution to efficiency gain. These are:

- First Class Primary Care
- First Class Planned Care
- Long Term Conditions , Intermediate Care and Urgent Care

5.3 Transformational initiatives and efficiency programmes

5.3.1 First Class Primary Care

Rotherham benefits from generally good primary care. Access and extended hours are good. QOF achievement is above the national average. Prescribing is good. Many practices have been supported to improve their premises. We have made positive progress towards our aim of having fewer practices with less than 5,500 patients.,

Efficiency opportunity – First Class Primary Care

Our analysis of GPs suggests that if all GPs offered good access to high quality primary care, achieved upper quartile prescribing performance, and achieved average or better referral rates, system wide efficiency would be generated.

We will achieve this by:

- Ensuring all practices abide by core and extended hours requirements.
- Maintain the focus on efficiency and quality of prescribing.
- Continuing our programme to reduce the number of single handed GPs, including securing long term solutions for the practices managed by RCHS.
- Reviewing and rationalising local enhanced services.
- Identifying at practice level the critical changes to performance and activity we wish to secure, focusing on prescribing, referrals and urgent care.
- Renegotiating all PMS contracts to take account of these critical changes.
- Linking future uplifts of GP remuneration to guaranteed minimum standards in service delivery.
- Remunerating GPs for actual childhood vaccination and immunisation and cervical cytology performance.
- Offering incentives tailored to the priorities at each practice.
- Aligning our annual commissioning reviews of each practice to focus on the key priorities for each practice.
- Continuing to take a robust approach to GPs who give cause for concern.

We estimate the value of this efficiency opportunity over the next four years to be between £1m and £3m (excluding the costs of hospital services).

We have refreshed our transformational initiatives to focus on securing this efficiency gain.

Transformational initiatives

- Accessible and responsive high quality primary care
- Quality and efficiency priorities for individual practices
- Effective prescribing
- Renegotiate all PMS contracts

5.3.2 Healthy Pregnancy and Birth

We will retain our focus on ensuring that we promote good health during pregnancy and the first months of life. Encouraging new mums to adopt healthy lifestyles and to breastfeed remains at the heart of this initiative. The improvements required in this area are cultural and long term. We are therefore maintaining the initiatives identified in *Better Health, Better Lives.*

Transformational initiatives

- Increasing breastfeeding
- Reducing smoking in pregnancy
- Reducing teenage pregnancy

5.3.3 Healthy Childhood

We have used the information from our analysis of need and consultation exercises to inform our local priority setting. All the transformational initiatives are carried forward from *Better Health, Better Lives*, with a stronger focus on delivery. The first three initiatives focus on the service improvements required to ensure children are given the opportunity to live as healthy a life as possible. The fourth reflects the ongoing work to integrate services with the local authority. The changes proposed to community services give an added impetus to this work and will require us to resolve any outstanding issues and implement by 2011. There is basic agreement between the two authorities on the vision and shape of the services. The outstanding issues relate more to the organizational framework and employment options. This will be a key piece of work to resolve as we work towards transforming community services.

Transformational initiatives

- Better mental health services and services for children with complex health needs
- Reduce childhood obesity
- Improve vaccination and immunisation rates
- Integrate services with Rotherham Council

5.3.4 Staying Healthy

We have had an extensive life expectancy and prevention programme underway for many years. This was strengthened in 2007. The outcome of our review of progress is five fold:

- We have identified the need to fully integrate the life expectancy plan into *Better Health, Better Lives*.
- We have agreed a revised set of life expectancy initiatives.
- Some of these are of major strategic performance as they overlap with the long term conditions, intermediate care and urgent care efficiency programme, and so require a major refresh.
- Others require a more modest refresh, or further investigation.
- We have identified priorities for social marketing.

Figure 5.1 summarises the position reached. Our refreshed transformational initiatives reflect this.

Transformational initiatives

- Reduce the number of smokers
- Improve primary care services for alcohol misusers
- Improve access to sexual health services
- Reduce adult obesity
- Follow up people identified at risk through the NHS Health Check

Figure 5.1: Strategy to improve life expectancy

Initiative	*Programme*	*Status*		*Refresh*	*Comment*	*Social marketing*
Alcohol	Staying Healthy	🔴	🔴	YES	Priorities to review investment and preventative and treatment services. Major health benefits to be gained	None
Smoking	Staying Healthy	🟢	🟡	NO	Anticipate achievement of smoking cessation target in Qtr 4 (2009-10) but targets continue to be challenging.	Yes. Need to continue.
Obesity	Staying Healthy	🟢	🔴	NO	Continue to monitor and develop newly commissioned services. Need to expand whole population work.	None
Winter deaths	Staying Healthy	🟢	🔴	YES	Need to analyse re co-morbidities. Further discussions needed with RMBC around wider determinants .	None
Accidents	Staying Healthy	🟡	🔴	YES	Further discussion needed with partners. Lead RMBC	None
Screening	Staying Healthy	🟡	🟡	YES	Some programmes achieving targets. Continued performance and inequalities in uptake issues.	Yes. Need to continue.
Early presentation	Staying Healthy	🟡	🟡	YES	NTCN post (1 yr) to support reduction in inequalities and promote screening and uptake of services.	No. Funding needed
NHS health check	Staying Healthy	🟡	🟡	NO	Initial review indicates uptake good. Continued marketing will see uptake increase.	Yes. Need to continue.
Long term conditions	Long Term Conditions	🟢	🔴	YES	Review of impact on Life Expectancy needed. Prescribing reviews a priority.	None
Diabetes	Long Term Conditions	🟢	🔴	YES	Good case finding. Need to promote self management, education and services to reduce risk of complications.	None currently
CVD	Long Term Conditions	🟢	🔴	YES	High hospital admissions. Review of heart failure outcomes needed. AF and Prescribing work good but needs accelerated review. Health Check opportunities.	None
Stroke	Long Term Conditions	🟢	🔴	NO	Good progress with Action Plan. Need to monitor future performance.	None
Cancer	Planned Care	🟡	🔴	YES	Priorities to look at treatments commissioned for Rotherham patients and to review investment.	No. Needs to develop.
Respiratory disease	Long Term Conditions	🟡	🔴	YES	Breathing Space Evaluation (Dec 2009). Review of activity to follow and inform service development	None
Mental health	Mental Health	🟢	🔴	YES	Preventative work under review. Learning Disability work good. Need to prioritise support for people with mental health problems. Major impact on health outcomes	No Local
Infant mortality	Maternity and Children	🟢	🔴	YES	Infant Mortality Action Plan being refreshed. Currently updating the Children and Young Peoples Plan across local authority and health.	Yes. Need to continue

5.3.5 First Class Planned Care

Rotherham has achieved the waiting time targets for elective care. The key challenge now is to maintain this, whilst ensuring that all referrals and planned care activity is cost effective.

Efficiency opportunity – GP referrals

GP referrals to outpatients services have risen significantly during the past 18 months. The level they have now reached if converted into elective activity is economically unsustainable. First to follow up outpatient ratios are relatively high.

We therefore need to exert control over referrals and planned care activity rates. Our options for doing this include:

- Set referral targets for GPs, supported by incentives, as part of a wider 'excellence in referrals' programme.
- Set treatment thresholds for high volume procedures.
- Develop a referral management or advice scheme.
- Consider options for primary care triage schemes.
- Set first to follow up thresholds at Rotherham Foundation Trust.

Following further analysis on type and source of referral, we will develop with clinicians a programme to manage referrals at clinically effective and affordable levels.

We estimate the value of this efficiency opportunity over the next four years to be between £4m and £10m.

Efficiency opportunity – Specialised services

We invest £32m in specialized services through the Yorkshire and the Humber Specialised Commissioning Group, of which we are one of 14 PCT members.

The SCG is developing a region wide strategy which complement each PCT's local strategy. The SCG strategy will include a comprehensive focus on productivity and efficiency, seeking to ensure appropriate treatment thresholds, activity controls and price controls, and effective performance and contract management.

We make a comprehensive contribution to the SCG, and will continue to do so.

We estimate the value of this efficiency opportunity over the next four years to be between £1m and £3m.

Efficiency opportunity – Improve clinical efficiency

We presently invest in services or procedures that are ineffective – services which have no or very little clinical benefit. Some of these services have already been identified nationally; some will be identified via the Yorkshire and the Humber SCG; others will need to be identified by local reviews. We will decommission these services. Options under consideration include:

National:

- Five less effective surgical procedures recommended by the CMO

Specialised services:

- Stricter application of criteria for individual treatment requests
- Stricter application of cost per QALY thresholds for marginally cost effective NICE approved treatments such as third line cancer drugs
- Stricter controls on specific services, for example IVF

Local:

- Some GP locally enhanced services
- Potential duplication in community service provision
- Criteria for some high volume elective activity
- Patient transport services

We estimate the value of this efficiency opportunity over the next four years to be between £1m and £3m.

We have refreshed our transformational initiatives to focus on these three efficiency opportunities and to ensure that we maintain and improve upon Rotherham's excellent performance in reducing healthcare acquired infections.

Transformational initiatives

- Implement a referral management / advisory programme
- Secure efficiency from specialised services (via SCG)
- Increase clinical efficiency
- Manage and reduce healthcare acquired infections

5.3.6 Long Term Conditions, Intermediate Care and Urgent Care

Efficiency opportunity- Long Term Conditions, Intermediate Care and Urgent Care

Considerable NHS expenditure is accounted for by patients with long term conditions requiring urgent care.

Our intelligence review shows that there are major potential efficiencies to be obtained by radically improving the management of long term conditions, supported by much improved intermediate levels of care, and hence reduced utilisation of unplanned, urgent and emergency care.

We must ensure that all parts of the long term conditions, intermediate care and urgent care system work effectively and efficiently in themselves. For example, we must secure improvements to the ambulance service, which does not perform well. We are undertaking, with Rotherham Foundation Trust, an assessment of emergency services, using the National Support Team toolkit. This will help to ensure that A&E and emergency admissions work smoothly.

We aim to achieve long term conditions care pathways and service models, and a supporting organisational infrastructure, which:

- Place the needs of people with long term conditions and frail older people at the heart of service delivery.
- Provide personalised services tailored to individual patients and carers needs.
- Achieve much better outcomes for less investment, and hence better value for money.
- Provide care closer to home, with a radical reduction in emergency hospital activity without a compensating rise in planned hospital activity.
- Provide seamless care pathways for the major long term conditions – cardio vascular disease, diabetes, respiratory disease – and for frail older people.

- Are inclusive of patients with dementia, with a highly effective interface to the services for older people we commission from RDASH.
- Provide high quality support for carers.
- Include a highly effective interface with social services.
- Have an effective interface with specialist palliative and end of life care services.
- Create whole system leadership and engagement – clinical, professional and managerial.
- Are based on a high standard of evidence.
- Make excellent use of innovative technologies and care processes, including self care and telecare.
- Deliver 10 – 20% efficiency gain over four years from the total investment made in long term conditions, intermediate care and urgent care services.
- Have an efficient and reasonable distribution of risk which will ensure the viability of commissioners and providers, acting together in the best interests of patients and the population, hence making best possible use of the NHS Rotherham resources.
- Have long term sustainability.

We estimate the value of this efficiency opportunity over the next four years to be between £3m and £12m.

Realising the potential quality and efficiency gain is our greatest opportunity, most important priority and greatest challenge. To succeed, we will fundamentally reshape major parts of the NHS in Rotherham, our approach to which is described in section 6 on developing the provider landscape and market management. We have refreshed our transformational initiatives accordingly.

Transformational initiatives

1. System wide redesign of care pathways for long term conditions
2. Commission alternative levels of care closer to home
3. Reconfigure intermediate care

5.3.7 Better Mental Health Services

Building on the work undertaken in 2009/10, the mental health programme will continue to improve the delivery of both mental health promotion and secondary care services. We will work with our key provider RDASH to implement New Horizons across all services. The major capital scheme to reprovide all inpatient accommodation is a key feature of the service improvements and will be accompanied by an ongoing drive to improve health promotion, deliver personalised care and focus on the wider inclusion agenda.

Transformational initiatives

- Improve mental health promotion
- Commission new wards and day patient services

5.3.8 End of Life Care

We have a wide range of quality multi agency services for people at the end of life. However we know that too many people in Rotherham still are not able to die in the place of their choosing. The initiatives that we put in place last year are beginning to take effect. In addition to system changes which ensure patient care is appropriately coordinated, many of the initiatives are about changing attitudes to death amongst both the public and professionals. We acknowledge this is more than a one year programme and will therefore continue with the initiatives established in 2009. The

implications of our work to transform community services will enable us to work more closely with the hospice and primary care to deliver more comprehensive and coordinated care.

Transformational initiatives

- Improve services and choice for end of life care
- Review and extend the Rotherham Hospice Service
- Re-commission an enhanced hospice at home service
- Implement the Gold Standard Framework across Rotherham

5.4 Enabling Programmes

In order to deliver on these challenging initiatives we have identified three priority enabling programmes:

- Commissioning for quality
- Aligning Incentives
- High Impact Clinical Changes

5.4.1 Commissioning for Quality

We have an ever increasing grip on the quality of services that we commission and the way we hold providers to account.

With regard to general practice we have developed a robust single assessment process based on six standards each with a set of criteria that evolve on an annual basis. The assessment process is challenging and includes non executive directors taking part in assessment visits. A wide range of NHS Rotherham staff, including programme managers, contribute to gathering the information in advance of the assessment. Rotherham practices perform well on the national quality and outcomes framework in terms of outcomes, case finding and reducing inappropriate exception reporting. For the last two years we have included £ per patient metric in the review to challenge practices on their efficiency.

Better Community Services sets ambitious plans to improve the reporting of quality outcome measures from community providers. We have developed a robust range of metrics which are reported monthly, these include information on activity, performance against key targets, data quality and clinical quality.

All our major providers including Foundation Trusts and independent sector providers are required to produce monthly performance reports and explain performance at contract meetings. We have strengthened the way this is reported to Board and Board performance reports now have a monthly section on performance against contract with separate sections for each major provider or set of providers.

NHS Rotherham has produced and has made publically available GP quality accounts which summarise our current assessment of the quality of general practice across Rotherham and give benchmarking information on a wide range of performance information for all 41 Rotherham general practices.

All local NHS Foundation Trusts produced quality reports in 09/10 (the content is discussed in Section 4.4.5 later in this document). The quality reports have been discussed at NHS Rotherham Board and trusts have been given feedback on content for 2010/11 including how the reports should align with the outcome measures and initiatives in *Adding Quality and Value*.

In addition to commissioning for quality, we have a robust approach to system wide clinical governance through our Governance, Quality and Risk Committee which scrutinizes serious untoward incidents in our providers. We report high profile SUIs early to Board and keep Board members directly aware of progress with investigations.

We will strengthen our approach to commissioning for quality in three additional ways in 2010:

- The first class primary care initiative (detailed in annex B). This consists of 4 initiatives to improve the quality of primary care; accessible and responsive high quality primary care (T1), renewed focus on reviews and priorities for individual practices (T2), effective prescribing (T3) and renegotiating all PMS contacts (T4).

- Clinical guardians – we have identified 4 NHS Rotherham staff as clinical guardians. They will work with our 4 contract leads for General Practice, Community Health Services, RDASH and RNHSFT to further shift the emphasis at performance meetings towards clinical quality. For example for RNHSFT we will have a separate quality performance meeting that will: receive a provider quality report based mainly on CQUINS; discuss any other aspects of measured quality that has come to light including intelligence from NHS Rotherham's Clinical benchmarking system; discuss any soft intelligence that has come to light; and discuss information from the provider on data quality and human resource issues.

- CQUINS – for RCHS and Foundation trusts we will set local quality metrics with challenging stretch targets. For acute providers CQUINS will be an additional quality payment of 1.5% made up of 0.3% national indicators, 0.5% regional and 0.7% local indicators.

5.4.2 Aligning Incentives

We presently have a range of incentive schemes to encourage and reward providers for improved performance. These include:

GPs: locally enhanced services (£3m); QOF (£5m); practice based commissioning (£1m).

GDPs: access and quality scheme (£900k)

CQUIN: quality markers at RFT, RDASH and RCHS (£1.25m)

RFT: A&E waiting times (£800k); infection rates (£500k)

These incentive schemes have tended to be developed separately and, in some cases, by focusing on specific performance concerns. We therefore wish to align incentives to the *Better Health, Better Lives* priorities, and to our efficiency programmes. We will also need to ensure that incentives, penalties and risks are designed to optimise the likelihood of our long term conditions, intermediate care and urgent care programmes delivering major efficiency gain.

We will therefore review all current incentives and negotiate revised incentives (and, where appropriate, penalties) for 2010/11 and again for 2011/12 onwards.

5.4.3 High Impact Clinical Changes

We have extensive clinical involvement in service and system re-design initiatives. However clinicians' biggest impacts on outcomes, safety and efficiency are through their day-to-day clinical decisions on the advice, diagnostic tests, treatments and referrals they make.

A key part of the implementation of *Adding Quality and Value* is enabling clinicians to be fully empowered to deliver increasing quality and be responsible for cost effectivness. We will do this by widespread dissemination of key strategic issues including value for money throughout all providers in Rotherham and by re-stating and co-coordinating the roles of the key multiagency high level groups concerned with clinical leadership.

Currently there are 4 Rotherham wide groups concerned with high level clinical change:

- The Professional Executive
- The Clinical Board,
- Rotherham Practice Based Commissioning Group
- The Area Prescribing Committee

We are adding a further group:

- The Clinical Referral Committee.

The roles of the groups will be restated in the context of *Adding Quality and Value*, the organisational changes in community services set out in Shaping the Future and NHS Rotherham's future as a commissioner only organisation. The Professional Executive already includes clinicians from RNHSFT and RCHS will be expanded to include clinicians from RDASH. The Clinical Board will be renamed the Clinical Quality Board and will also include clinicians from RDASH. The new Clinical Referral Committee will lead clinical effective and cost effective referral management in a similar way to the way we are already delivering cost effective prescribing.

All five groups will concentrate of four agreed high impact clinical change programmes.

1 Maximise prevention opportunities: clinicians throughout the system signposting people to existing prevention care pathways.

Delivered by:

- being a major role of the Clinical Quality Board (and other high level clinical groups)
- Programme lead for Staying Healthy to produce material on existing care pathways using a *Making Every Contact Count* methodology
- Dissemination campaign to clinicians across Rotherham
- Equity audit programme to establish where existing referrals into prevention care pathways originate and feedback to clinicians and clinical groups who don't make every contact count

2 Keeping referrals to agreed and affordable limits:

Delivered by:

- The Clinical Referrals Committee working with clinicians across Rotherham including engaging through the Professional Executive, Rotherham Practice Based Commissioning group and Clinical Board.
- The Committee will have a budget to free up clinical time and invest in behavioural and educational resources

- Work to a set of principles including: right care, right setting, right place; clinical effectiveness; cost effectiveness; establishing a learning environment and supporting re-validation
- Strategic actions will include; *working with patients* (frequent users) ; *working with referring clinicians* (including benchmarking, disseminating locally credible advice and direct face to face discussions with outliers); *working with consultants* (encouraging active feedback, harnessing expertise as educational resources and developing tele and e consultations as alternatives to outpatients); *working with care pathway design and incentives* (including clinical leadership and prioritisation of care pathway re-design, triage schemes, and incentivising the provision of advice rather than face to face consultations).

3 Timely and effective clinician to clinician communication: e-referrals, advice, discharge summaries, results, information available on urgent care, GP OOH and A&E, information on safeguarding.

Delivered by:
- Clinical communication being a major role of the Clinical Quality Board (and other high level clinical groups)
- IT aspects addressed through Rotherham IM&T strategy overseen by Rotherham IM &T Board

4 Transforming major care pathways starting with diabetes: in addition to all existing care pathway improvement projects, Rotherham health community will prioritise one pathway, at any one time, to make rapid, high profile system wide improvements.

This will be a rolling programme and when progress has been made another pathway will be chosen. The criteria used to choose subsequent pathways will be;
- Number of patients on pathway,
- Strength of evidence for quality or efficiency improvement from the current position in Rotherham
- Feasibility of delivery

Delivered by:
- Being a major role for all high level groups in Rotherham

6 Reshaping services and providers

6.1 Introduction

Implementation of *Adding Quality and Value* requires fundamental changes to the capacity, capability, culture and configuration of local and regional NHS services and providers. The key market development issues include:

- General practices: continued reduction in the number of single handed and small practices; resolving long term future for practices managed by RCHS.

- Community services: integration of children's services; integration of long term conditions, intermediate care services with hospital services; future governance and management of Rotherham Hospice; long term future for all other community services.

- Secondary care: integration of hospital services with community based long term conditions and intermediate care services; substantial downsizing of local hospital capacity; outcome of sub regional review of care for the acutely ill child and paediatric surgery.

- Tertiary care: implications of SCG strategy.

- Other services: potential downsizing and realignment of patient transport services.

The key market management issues include:

- General practices: PMS contract renegotiation; more assertive contract and performance management, linked to thresholds and targets for overall cost footprint.

- Long term conditions, intermediate care and urgent care: introduction of potentially radically changed contracts, payment terms etc for community and hospital services.

- Secondary care: introduction of controls on referrals, out patient and elective activity; potential introduction of tariff type contracts for mental health services

- Other services: continued use of procurement and other tools to secure improved efficiency and outcomes

6.2 Better Community Services

Better Community Services, our strategy for transforming community services, was agreed in October 2009. It is a companion strategy to *Adding Quality and Value*. *Better Community Services* established a clear commissioning policy for community services, and set our commissioning intentions. In *Shaping our Future* we will set out our detailed proposals for the organisational structure for community services. *Shaping our Future* will be agreed by the end of March 2010 and consulted upon thereafter.

The current service configuration provides real quality for patients accessing all parts of the service, however major efficiency and quality gains can still be achieved by further streamlining the patient pathway. We believe this will best be achieved by a greater integration of services.

We therefore intend to commission a fundamentally changed model of community and hospital health care. This will see the existing community health services provider cease to exist. The

services it provides have been grouped in accordance with the eight priorities in this strategy, and proposals are being developed for the integration of these services with other parts of the local NHS. These proposals will the subject of formal consultation during 2010, and, subject to the outcome of consultation, implementation by March 2011.

The proposals, in outline, are summarized in section 6.3.

6.3 *Shaping our Future*

Chapter three of our Strategic Intelligence Review (annex A) provides a detailed market analysis of the provider landscape using five key indicators:

- Quality: how good is the service?
- Choice: is there anywhere to go if the service is poor?
- Switching: do people switch providers in practice?
- Concentration: is the current service concentrated in the hands of the few?
- Rivalry: how easy is it for new providers to offer services?

The implementation of *Shaping our Future* will lead to changes in the Rotherham provider landscape. Specifically we are likely to see the two major providers, Rotherham Foundation Trust and Rotherham, Doncaster and South Humber Foundation Trust, develop more community based services.

We have concluded that in order to find solutions which best meet the needs of the Rotherham community we must commission more integrated delivery of services able to provide care closer to home, with improved quality and efficiency and sustainable in the medium to long term.
We believe this will be best achieved by integrating community health services with other existing local health and care services.

NHS Rotherham will therefore cease to have a provider arm and Rotherham Community Health Services (RCHS) would, in its present organisational form, cease to exist. RCHS will be replaced with new arrangements as part of an overall plan for the future shape of the NHS in Rotherham. The new arrangements must protect and improve services for patients and the wider community and must protect, wherever possible, the interests of staff.

We have begun to consider what specific arrangements might be suitable for the services presently provided by RCHS. We have done this by focusing on each part of RCHS, and considering the options open to us. The initial conclusions we have reached are as follows:

General practices: RCHS presently manages four practices. One of these, in Wath, will close by the end of March 2010 as the GP is retiring. We are already procuring a new provider for the Canklow practice. We need to find long term solutions for the Rosehill and Gate practices.

Children and young people's services: We need to reach a final decision about whether to fully integrate children and young people's community health services with Rotherham Council's services, or whether to retain some or all of these services within an NHS organisation with a joint working arrangement with the Council. The transfer of staff to the preferred organisation would then be necessary.

Staying healthy: We need to find a suitable long term solution for the staying healthy services provided by RCHS. This might be with one of the local foundation trusts, although other options may be possible.

Planned care services: We are considering integrating these services with those run by Rotherham Foundation Trust, which would mean transferring staff to the Foundation Trust, or whether other options may be better for all or some of these services.

Long term conditions, intermediate care and urgent care services: We are considering integrating these services with those run by Rotherham Foundation Trust, which would mean transferring staff to the Foundation Trust.

Mental health services: We need to find a suitable long term solution for the primary care based mental health services provided by RCHS. This might be one of the local Foundation Trusts or another healthcare provider.

Learning disability services: We need to find a suitable long term solution for the specialist health services provided by RCHS for people with learning disabilities. We also need to find a solution for the staff who work in the residential homes run by South Yorkshire Housing Association.

Palliative and end of life care services: We are considering integrating these services fully with the Rotherham Hospice.

Finalising these proposals, consulting on them, and implementing the resulting decisions is a major strategic priority for 2010/11. We intend to take maximum advantage of our good performance, positive financial position and good relationships to make these very important changes ahead of the major financial challenge we face. The changes will be a key part of our strategy to secure far greater quality and efficiency from all our investment.

We will continue to focus as well on other priority market development issues:

- Reducing the number of single handed and small practices
- Working closely with Rotherham Council to ensure the quality of residential care
- Working with other PCTs to determine the future of the regional ISTC
- Using procurement where appropriate to secure new providers and improved performance
- Responding to the challenges facing district general hospitals as a consequence of national and regional work on developing specialist responses to paediatrics, stroke, cardiac and major trauma

7 Resources

7.1 Financial plan

This strategy is supported by our financial plan, which is summarised here and exemplified in detail in the accompanying finance templates.

7.1.1 Principles

The key principles underpinning our financial plan are to:

- Enable the delivery of Better Health, Better Lives
- Maintain financial balance
- Achieve statutory financial duties
- Generate a modest surplus each year
- Invest at least 2% of total recurrent resources non-recurrently
- Promote and secure efficiency and value for money
- Maximise the funds available for investment in healthcare
- Cover financial risks appropriately

7.1.2 Growth, inflation and demographic assumptions

Our base case financial plan assumes:

- 5.5% recurrent growth in 2010/11 (£22.6m)
- 1% recurrent growth in 2011/12 and 2012/13 (£4.4m each year).

Our inflation assumptions are:

- Net 0% increase in tariff and non tariff services from 2010/11
- 5% increase in prescribing expenditure.
- 0.5% increase in primary care.
- 0% uplift in Dental services.

We have assumed that Rotherham's population will rise by 0.6% a year to 2014/15. This increase has been factored into the forecast demand for services, and hence into expenditure forecasts.

7.1.3 Strategic investment fund

We will receive the return of £19.4m from the Strategic Investment Fund over the next three years: £6.2m in 2010/11; £6.1m in 2011/12; £7.1m in 2012/13. These funds are non recurrent and will therefore be invested to secure quality and efficiency improvement, and not for recurrent purposes.

7.1.4 Commissioning assumptions and interventions

The outcome of the national negotiations about GP contracts will be factored into the plan when they are fully known following advice from the Doctors and Dentists Review Body (DDRB).

Prescribing costs have been forecast net of planned interventions, for example to reduce expenditure on proton pump inhibitors, bronchodilators and anti-depressants. It is assumed that recent very low prescribing growth rates will not continue, and that Category M prices will start to rise again.

GP referrals are assumed to grow at 6% per annum. This assumption is based on past trends and forecast growth in demand.

A&E activity is assumed to grow at 2% per annum. Non-elective admissions are assumed to grow at 4% per annum, but with a lower rate of cost growth. This assumption takes account of further developments in community and intermediate care services, including the introduction of Interqual, improvements to intermediate care service utilisation and the extension of the walk in centre.

The impact of the potential introduction of payment by results for mental health and community services is as yet unknown. We have assumed this will be cost neutral, but have highlighted this as a potential risk.

We are preparing firm proposals for the long term future of our provider services, which are expected to see all these services integrated with other local providers. The financial plan makes provision for the costs associated with making these changes, which will make a significant medium term contribution to efficiency gain.

7.1.5 Planned annual position

We will plan for an annual 0.5% surplus and will allow an annual 1% contingency. Our forecast summary income and expenditure for the five years from 2009/10 is as follows:

Figure 7.1: Forecast income and expenditure position of NHS Rotherham

	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000
Income	433,611	461,115	460,866	466,231	463,539
Expenditure	431,506	458,915	458,666	464,031	461,339
Surplus	**2,105**	**2,200**	**2,200**	**2,200**	**2,200**

The significant growth in income includes assumed annual uplifts and the planned return of the funds lodged with the Strategic Investment Fund. Our detailed forecast income position is as follows:

Figure 7.2: Detailed income analysis

	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000
Recurrent Baseline Allocation	409,555	432,141	436,463	440,827	445,236
Non Rec. Allocations each year	10,808	16,105	16,105	16,105	16,105
Other Non Rec. Allocations	7,251	4,564	(2)	(1)	(2)
Strategic Inv. Fund Repayment	4,400	6,200	6,100	7,100	0
Surplus b/fwd	1,597	2,100	2,200	2,200	2,200
Total	**433,611**	**461,115**	**460,866**	**466,231**	**463,539**

This is matched by annual expenditure projections inclusive of investment in transformational initiatives. Our detailed annual forecast expenditure position is as follows:

Figure 7.3: Detailed expenditure analysis

	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000
Primary and community care	138,999	150,288	147,701	151,187	154,901
Mental health, learning disability and continuing care	55,090	55,972	55,366	54,894	53,945
Non specialised acute care	192,394	195,399	198,969	202,032	201,922
Specialised acute care	26,089	30,380	30,078	30,464	30,884
Other	18,934	22,476	22,152	21,054	15,287
Contingency	-	4,400	4,400	4,400	4,400
Total	**431,506**	**458,915**	**458,666**	**464,031**	**461,339**

The forecast annual outturn position is therefore as follows:

Figure 7.4: Underlying position

	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000	£000
Recurrent surplus /deficit(-)	2,505	8,800	8,800	8,800	8,800
Non recurrent surplus/deficit (-)	-400	-6,600	-6,600	-6,600	-6,600
Net surplus	**2,105**	**2,200**	**2,200**	**2,200**	**2,200**

We are presently forecasting that our 2009/10 outturn will be in accordance with this plan.

7.1.6 Investment in new developments

In support of Better Health, Better Lives we invested £17.1m in 2009/10 in our 29 transformational initiatives. The level of investment was set by assessing health needs and considering clinical solutions. A further £7.2m is to be invested in 2010/11 to complete this programme, and a further £12.7m will be invested non recurrently. The following table summarises this new investment:

Figure 7.5: Recurrent and non-recurrent Investment Plan (2009/10 to 2012/13)

New Recurrent Investments	2010/11	2011/12	*2012/13*	2013/14
	£000	£000	£000	£000
Primary Care	257	0	0	0
Maternity and Newborn Care	0	0	0	0
Children's Health	419	0	0	0
Staying Healthy	180	1,100	1,100	1,100
Planned Care	900	0	0	0
Long Term Conditions/urgent care	3515	1,100	1,100	1,100
Mental Health	1743	0	0	0
End of Life	0	0	0	0
Enabling Strategies	186	0	0	0
Total	**7,200**	**2,200**	**2,200**	**2,200**

New non recurrent Investments	2010/11	2011/12	2012/13	2013/14
	£000	£000	£000	£000
Primary Care and Community IT	1,000	1,000	1,000	1,000
Shaping our Future Implementation	3,500	3,500	3,500	0
Management Efficiency/Exit Costs	2,000	2,000	2,000	0
Capital Investments (revenue to capital transfer)	1,000	2,000	2,000	2,000
Dementia Services Modernisation.	500	500	500	0
Referrals Management Pilot	500	500	500	500
Telehealth	1,000	1,000	1,000	1,000
Hospice Modernisation Costs	1,000	0	0	0
Long Term Conditions Modernisation	1,100	1,100	1,600	1,000
Staying Healthy Initiatives	1,100	1,100	1,600	1,100
Total	**12,700**	**12,700**	**13,700**	**6,600**

Transformational initiatives

The approval and delivery process for all new investment, including our transformational initiatives, requires clarity and agreement about the outputs and outcomes to be secured from each investment prior to funds being released for investment. This therefore allows an assessment to be made of the expected return on investment, and hence of value for money. Metrics are then agreed against which each initiative will be monitored and evaluated. This is a developing process which is more advanced for some initiatives than for others. Further information about this is given for each initiative in annex B to this plan, which includes a detailed section for each of the initiatives.

7.1.7 Efficiency requirements

Securing the planned underlying position, and releasing funds for continued investment in service development will require significant efficiency gain. Figure 7.6 summarises this requirement, and the three principal sources of efficiency gain

Figure 7.6: Efficiency requirement (2010/10 to 2013/14)

Efficiency requirement	2010/11	2011/12	2012/13	2013/14	Total
	£000	£000	£000	£000	£000
Provider efficiency	13,100	15,400	15,200	15,000	58,700
System efficiency	5,500	3,500	3,700	4,800	17,500
Management efficiency	800	800	800	0	2,400
Total	**19,400**	**19,700**	**19,700**	**19,800**	**78,600**

7.1.8 Provider efficiency

The provider efficiency requirement is being transferred to providers via a 3.5% efficiency in the uplift in tariff and non-tariff contract values. Providers are able to earn up to 1.5% income via the CQUIN programme (0.3% from nationally set requirements, 0.5% from regional requirements, and 0.7% from local requirements). Of this 1.5%, 1% represents an increase in income due to 0.5% being allocated non-recurrently in 2009/10. Providers face a very considerable challenge if they are to release the required level of efficiency. We will be working very closely with all providers to ensure these efficiencies are delivered.

7.1.9 System efficiency

The system efficiency requirement will be secured primarily from the major efficiency opportunities described in the refreshed strategy. In addition, we expect our life expectancy programme to

contribute to efficiency gain. A further contribution will be made by controlling corporate budgets. Our intended system efficiency gains are:

Figure 7.7: System efficiency gains

System efficiency gain	2010/11	2011/12	2012/13	2013/14	Total
	£000	£000	£000	£000	£000
First class primary care	500	0	0	0	500
Long term conditions, intermediate care and urgent care	500	1,000	1,700	2,800	6,000
GP referral management	2,500	2,000	2,000	2,000	8,500
Specialised services	500	500	0	0	1,000
Improve clinical efficiency	500	0	0	0	500
Corporate budgets	1,000	0	0	0	1,000
Total	**5,500**	**3,500**	**3,700**	**4,800**	**17,500**

First class primary care efficiencies will be primarily secured from sustaining our excellent track record of securing cost effective prescribing from GPs. We also expect to secure efficiencies from our review of locally enhanced services and PMS contracts.

Long term conditions, intermediate care and urgent care efficiencies will be secured by fundamentally restructuring service provision to focus on greater prevention, care closer to home, reduced admissions to hospital, shorter length of stay, timely discharge and fewer readmissions. *Shaping our Future*, our strategy for integrating community and hospital services, and the extended role we expect many GPs to play in long term conditions management will make a major contribution to achieving this.

GP referrals management efficiencies will be achieved by working with GPs and RFT to control referrals and subsequent hospital activity within affordable limits. This will include action to control first to follow up ratios and introduce agreed clinical thresholds for treatment.

Specialised services efficiencies will be achieved by continuing to play an active part in the Yorkshire and the Humber SCG's strategy to control investment.

Improving clinical efficiency will be achieved by a wide range of measures, including decommissioning ineffective services.

Corporate budgets efficiency will be achieved by reviewing and reducing all corporate budgets.

7.1.10 Management efficiency

The management efficiency requirement will be secured by controlling and reducing NHS Rotherham's management costs. Our refreshed organisational development plan describes the approach we will take to reducing management costs.

Our indicative targets for management cost reduction are:

	2010/11	Full Year Effect
	£000	£000
Vacancy control	300	450
Flexible working	100	150
Exit Costs	200	300
RCHS transfers	200	300
TOTAL	**800**	**1,200**

Management cost reduction targets for future years will depend on how much of the reduction is achieved in 2010/11, and the outcome of the restructuring of community services.

7.1.11 Capital investment

We are continuing to modernize our premises and improve access for patients. Our assumed operational capital is £1.13m. During 2009/10 we have seen the commissioning of the new NHS Rotherham Community Health Centre followed by the decommissioning of Doncaster Gate Hospital and its subsequent sale.

In primary care, the policy of establishing customer service centres will continue. This will include the new centre in Maltby (opened September 2008) and new centres in Aston, Rawmarsh, Dalton and Treeton. All are expected to open over the next five year period.

NHS Rotherham will use its operational capital to maintain the existing estate, to develop its infrastructure and also modernize its IT systems in line with Connecting for Health. Where necessary it will bid for strategic capital as well as exploring alternative funding sources.

Figure 7.9: Capital Plan – proposed strategic capital investments

Proposed Strategic Capital Investments	2009/10	2010/11	2011/12	2012/13	2013/14
	£000	**£000**	**£000**	**£000**	**£000**
CAMHS	2,400	0	0	0	0
Rawmarsh Joint Service Centre	1,850	3,850	0	0	0
Dalton Joint Service Centre	0	0	2,100	0	0
Treeton Joint Service Centre	0	0	0	2,000	0
Dinnington Joint Service Centre	0	0	0	3,000	0
Other Joint Service Centres	0	0	0	0	7,000
Total	**4,250**	**3,850**	**2,100**	**5,100**	**7,000**

7.1.12 Securing value for money

Our approach to securing value for money is three fold:

- Ensuring that we can secure quantified return on investment from all our transformational initiatives;
- Developing a comprehensive approach to identifying, analysing and optimising the return on investment secured from all our investment.
- Ensuring that we sustain and build upon our existing programme of demand management and efficiency savings.

7.1.13 Financial risks and contingency

We have assessed the critical financial risks we anticipate over the next four years. These are summarised in figure 7.10 and are incorporated into our overall risk assessment (figure 8.2).

Figure 7.10: Critical financial risks

Risk Description	Mitigation
Implementation of HRG4.	The impact of HRG4 on our contracts in 2009/10 saw an increase in costs. This is expected to have a reduced effect in 2010/11 as the initial impact is now understood.
Implementation of a mental health tariff.	Membership of the local and regional groups working on the mental health tariff to give an early indication of the effects.
Implementation of a community tariff.	Moving the community services block contract to an activity basis with local prices. This is expected to be cost neutral and contracts will need to be designed to minimise risk.
Increased Prescribing Costs arising from increase in Category M and new drugs coming onto the market.	Informed prescribing team able to implement actions at GP practice level to reduce the effects of increasing costs and volumes.
Achievement of annual 3.5% efficiency savings on Internal Provider Services and the Corporate Directorates in 2010/11.	Monthly review of efficiency savings made to enable early remedial actions to be taken.
Incorrect acute activity assumptions.	Joint planning with the main acute provider ensures realistic assumptions are being made. Efficiency action plans to be developed before the start of each year.
Increases in GP referrals.	GP referrals are increasing at 9% a year. We intend to set up a referrals management unit to keep this growth under control.
Savings in the financial plans aren't realised.	The financial plan assumes system efficiency and management efficiency savings. If these savings aren't realised or take longer than planned to be fully realised we have contingencies in place to manage in the short term.
Cost overruns on new projects and investments.	Governance arrangements appropriate to the size and complexity of the projects are in place. A contingency is also in place to be used for unforeseen cost overruns.
Changes in the economic environment leading to higher than expected inflation or lower than expected allocations	Strong governance arrangements are in place in order to re prioritise developments or establish cost saving measures, such as vacancy freezes, if required. We have also planned using an 'upside' and 'downside' scenario to plan for changes in our planning assumptions.

7.1.14 Balance sheet

The balance sheet has no major movements over the period of the plan except for an increasing general fund reflecting the planned annual surplus. There will be a few adjustments to the estate including transactions concerning GP premises to facilitate market changes. There are also some planned minor improvements and sales of existing premises.

7.1.15 Cash flow

Cash allocations are assumed to be directly related to the revenue and capital resource limits adjusted for non cash items such as capital charges. The return of Strategic Investment Funds is assumed to be backed by equivalent cash allocations.

7.2 Workforce

The continued implementation of *Better Health, Better Lives* and *Adding Quality and Value* has major workforce implications.

We have continued to manage system wide and cross organisational employment risk via the Rotherham Workforce Collaborative to assess the quality, sustainability and deliverability of the summation of provider workforce plans across the local health economy. We have produced our second iteration of the health economy wide workforce risk assessment, cross referenced to clinical pathways, to provide the assurance that service plans are achievable and the necessary action is being taken for high level risks.

The risk assessment process has allowed us to work with providers to seek assurance of the achievement of key workforce policies and targets, e.g. 18 week referral to treatment, Working Time Directive and Maternity Matters.

We will continue to work collaboratively with other PCTs, the SHA and local providers to develop shared improvement goals and cross-boundary working and to introduce key workforce metrics to drive quality improvement.

We will continue to exercise due diligence in awarding contracts, taking key workforce criteria into account to ensure the quality, sustainability and deliverability of our commissioning plans.

Cross boundary working around the Swine Flu Pandemic produced a Memorandum of Understanding signed by all South Yorkshire NHS and Local Authority organisations to share resources around the region at the advanced stages of a pandemic. This agreement will apply equally to other emergency planning situations.

Through joint working with all our main providers at the Rotherham Workforce Collaborative, chaired by the NHS Rotherham Director of OD, Workforce and Governance, we have agreed a set of workforce metrics which will inform the contract and monitoring arrangements, support the achievement of World Class Commissioning competencies, be utilised in procurement activity and provide assurance to the NHSR Board.

In response to the NHS Operating Framework 2010/11, we will reach an early decision about the future of Rotherham Community Health Services, our provider arm. The intention is to shift the workforce to support the optimum management of need – acute, intermediate, community, primary care - by integrating community services with existing providers to align with patient pathways. This will improve quality and efficient use of resources, productivity and service integration.

To enable this system wide organisational change to take place we will develop, in partnership with providers, a system wide workforce development strategy and vision for the local health economy, identifying the key strategic health and social care workforce implications of our commissioning strategies. This will include:

- Local labour market issues to inform the change management process and education investment priorities.
- Introducing new ways of working at system wide, service and individual role levels.
- Focusing on productivity/efficiency/LEAN initiatives.
- Rising to significant leadership challenges, with new skill and behavioural implications.
- Leading cultural change – focusing minds on quality, use of resources and hence ”better for less”.
- Making greater use of outsourcing/shared services/economies of scale.

- Meeting increased skills/training needs –"fresh eyes", innovation, unblocking behaviours/systems, managing large scale change; managing capacity.

We will reduce our management costs by 30% by 2012/13 and have already introduced restrictions on any pay affecting changes, including recruitment. These changes will be managed sensitively, in partnership with our internally separated provider in order to protect the interests of staff and ensure that we can retain the right skills and capacity in the right place to continue to deliver on this strategy.

We will continue to participate and invest in local education, training and employment initiatives to improve the health and well-being of the local population. The NHSR Director of OD, Workforce and Governance is an active member of the Rotherham Work and Skills Board and we have recruited ten apprentices from the local population.

7.3 Informatics

The Rotherham IM and T Board has developed a comprehensive IM & T strategy to support the delivery of *Adding Quality and Value*.

Currently NHS IT services are provided by 4 main organisations, RNHSFT, RMBC, RDASH and NHS Rotherham (which provides services for RCHS and independent providers including GPs). Rotherham has chosen not to opt for a fully integrated IT solution and this means that for the foreseeable future there will be four main IT systems covering: acute hospital care, community care, mental health and social care. A key issue is increasing the interoperability between these systems to add quality and value.

Three strategic considerations underpin the IT strategy:

- *Adding Quality and Value* (which includes delivering the IT contribution to the QIPP agenda)
- Shaping the Future – the shape of the future provision of IT services will be reviewed as soon as the future organisational form of community services in Rotherham is decided.
- Delivering benefits from national initiatives where they fit with local priorities

There are 8 main themes in Rotherham's NHS IT strategy:

1 Clinical data quality and patient safety

This is the paramount consideration to enable both quality and value.

2 Robust Information Governance

We will maintain our robust information governance arrangements including using the National Information Governance Toolkit to assure our performance.

3 Improved information for managers and commissioners

RFT and RDASH have data warehouses that provide management and performance information for their services. A similar solution will be developed for GP and community services and will integrate information across the system. From a commissioning perspective, GP information and the Child Health System are particularly important as they cover the entire Rotherham population.

Integration of GP and hospital information will enable better stratification of patients at risk of hospital admission and so help deliver the strategic objective of more patients to be managed in the community. Robust information on children is essential for safeguarding.

4 Interoperability between the major IT systems

Key benefits are: improved clinical safety when patients are admitted and discharged, safer prescribing, safer and more efficient access to test results, safer and more efficient urgent care, safer services for children especially communication around safeguarding, better integration of care for long term conditions and end of life, and enabling single assessment of adults for health and social care.

5 GP system rationalization

Currently Rotherham GPs use 3 different IT systems only one of which is integrated with other community clinicians. NHS Rotherham's Professional Executive recognizes the major patient benefits that will result from integrated GP and community IT systems and NHS Rotherham will explore all ways in which the benefits of GP/ community IT integration can be achieved.

6 IT systems that support system wide efficiency

During the period of this strategy we will identify and deploy technologies that support efficiencies across the healthcare system. Key initiatives that we have already identified as potential efficiency drivers are:

- **InterQual**: the use of this clinical decision tool will enable more efficient urgent care and allow more patients to be cared for in the community.

- **RFTs Electronic Patient Record: s**uccessful delivery of the new EPR will enable safer and more efficient hospital care as well as early system wide benefits from improved discharge communication.

- **Increased access to SystmOne:** the availability of read only SystmOne records in key parts of the hospital such as A&E, pharmacy and children wards will improve patient safety. The use of SystmOne in out of hours care and integration with GP records will improve patient safety and decrease unnecessary admissions.

- **Telemedicine:** we will develop telemedicine solutions starting with inter-hospital communication for acute stroke patients, telemedicine for end of life patients and diabetic e-consultations.

7 More efficient IT services

Includes rationalising existing services and considering the efficiency opportunities from shared services. Decommissioning legacy systems and considering whether NHS mail offers efficiency savings.

8 National initiatives

We will roll out SystmOne to the Out of Hours Service, the Walk in centre and for community bed management. We will implement Electronic Prescription transfer and the first phase of the national Summary Care Record project in 2010. We will consider how to gain local value from Map of Medicine.

7.4 Estates

NHS Rotherham's Care Premises Strategy was reaffirmed by the Board in 2009. We will continue implementation of the primary care premises and facilities strategy agreed in 2003, which focuses on a hub and spoke model aligned with Rotherham Council's service strategies, creatively taking advantage of funding opportunities where possible.

We have continued to develop an integrated approach to estate strategy developments and facilities, particularly with the Council, to improve the provision of one stop integrated and joined up services in the community for local people and co-location of staff providing joint services with the Council.

The joint service centre at Maltby opened in September 2009, Aston will complete in July 2010 and Rawmarsh the following year. These new centres develop affordable facilities at a neighbourhood level which support the movement of accessible and appropriate services from secondary to primary care and improve access and address health inequalities.

NHS Rotherham will continue in the role of landlord for many community premises. We will ensure the systematic improvement of all premises to better meet the need of patients and users, reflecting and supporting new ways of working and improving the working environment for staff.

We will improve the efficiency of the estate by clearly identifying premises that can be rationalised or declared surplus, thereby reducing backlog maintenance, improving the utilisation of premises and reducing our carbon footprint. In 2010 we envisage the closure and disposal of surplus accommodation in Dinnington, Kimberworth, Brinsworth and Swallownest.

In the next 5 years we will:

- Open, with Rotherham Council, joint service centres at Swallownest and Rawmarsh.
- Support the upgrade of primary care services in at least a further two areas.
- Continue the development of high quality joint children's centres, including a major capital development at Kimberworth to serve children with complex needs.
- Sign and act upon the concordat for carbon reduction.

8 Delivery

We recognise that the ambition and the scale of the changes we wish to deliver during the next five years means that we must continue to strengthen our delivery capacity and capability. We have therefore reflected on our recent achievements and have undertaken a SWOT analysis of our delivery capability, see figure 8.1. We have used this analysis to identify the major risks to delivery of the strategy, see section 8.2, and how we will monitor performance is set out in section 8.4. The key aspects of our financial plan are summarised in section 7.1. Delivering this ambitious strategy is a major challenge. How we will address this is set out in our organisational development plan *Better Health, Better Lives, Better Delivery*, summarised at section 8.6.

8.1 Past delivery performance

NHS Rotherham has an excellent track record of delivery. Below is a list of areas where we have delivered significant change over the last four years, additionally in figure 3.7 we have set out '2009 - A year of success':

- Improved access to community mental health care
- Community geriatricians
- Redesign of communications and public and patient engagement
- Rotherham Community Health Centre – new build to include new diagnostics, walk-in service, new GP, out of hours – Opened on time and within budget
- Achievement of waiting times for 18 weeks
- Reduction in waiting times at A&E
- Improvements in primary care access
- New GP practice premises at Anston
- New Joint Service Centre at Maltby
- Reduction in CVD mortality
- Redesign of urgent care
- Redesign of orthopaedic triage
- Review and improvements in intermediate care services
- Innovative programme of obesity services for adults and children
- Extension of Expert Patient Programme – including young disabled and carers
- Co location of staff in children's services – moving towards full integration
- Single Point of Access for Children and Young Peoples Mental Health Services
- Award winning children's complex care team
- Award winning Citizens' Juries
- Significant improvement in GP Out of Hours service

Figure 8.1: SWOT analysis delivery capability

Strengths	Weaknesses
Substantially improved waiting times and access - secondary care waiting times have been dramatically reduced, strong plans are in place for improving primary care access. These achievements give a strong foundation for commissioning for improved outcomes **Established Commissioning Function** • Good knowledge of the local area and key players • Established commissioning team, early internal separation of commissioning and provider established the focus on commissioning (evidenced by outcome of Fitness for Purpose) • Established Organisational Development department with significant investment in leadership development e.g. Leading an Empowered Organisation (LEO), Directors of the Future, World Class Commissioning Master classes • Previous investment in Board development e.g. Finnamore **Matrix working -** All NHS Rotherham see commissioning as their business. Function not seen to be vested in one department or individual **Significant clinical input** • 8 Practice Based Commissioning neighbourhoods • Clinical Board established with clinicians from primary and secondary care • Professional Executive active and clinically driven • Established Prescribing Committee has delivered significant improvement in both prescribing practice and cost **Collaborative working arrangements** • NHS Rotherham are key players in Yorkshire and Humber Specialised Commissioning Group • Joint appointments with RMBC - Director of Public Health, commissioning officers • Coterminous boundaries allow us to respond quickly e.g. floods in 2007 • Local Strategic Partnership – NHSR Chief Executive chairs Chief Executives group • Strong links with community sector, MP's and local media. • Strong relationships with GPs and Local Medical Committee. **Established contracting arrangements with all main providers** • FT community -all local acute hospitals and Mental Health Trusts are FTs • Legally binding contracts in place with all FTs. • All contracts in line with DoH best practice • Building a significant portfolio of external procurements: Rotherham Community Health Centre, Pharmacy, Obesity service, Dental **Public and Patient Engagement -** History of community engagement e.g. Citizens Juries, Health network, Patients' Opinion, database of information **Financial position –** NHS Rotherham has achieved financial balance every year since establishment in 2002 **Delivery** • Extensive experience of delivering large, complex projects e.g. Breathing Space, Joint Service Centres, Learning & Development Centre, Rotherham Community Health Centre • A good record of delivery of targets e.g. Choice, 18 weeks **Culture of PCT** • Acknowledged as learning organisation with a positive external and internal reputation as employer evidenced by the staff survey and good recruitment and retention of staff	**Finance** • NHS Rotherham will see a significant reduction in availability of recurrent funding , this will challenge the new criteria agreed by Board to oversee all development/disinvestment proposals. • NHS Rotherham will have a significant non recurrent allocation which will need to be used effectively to pump prime change. **Appraisal of projects and decommissioning of services** **Matrix working** • Potential for lack of clarity of roles or disjointed working **Celebrating Success** Potential to miss opportunities by failing to celebrate success **Information** Community information not adequate to make robust commissioning decisions and restricts the ability to capacity plan and potential impact on transformation agenda. **Public aspiration** – the public and service users currently rate most commissioned services highly/above average but we cannot be sure if this is related to low health aspirations/expectations.

Opportunities	Threats
Finance • Strong financial position • Non recurrent opportunity **InterQual** • Will provide consistent admission and discharge criteria across the community **Information** • New systems being implemented across the community will improve intelligence **Ambulatory Care Sensitive Admissions** • Improving ACS rates of admission will free up resources **Benchmarking** • Make further use of benchmarking both clinical and financial to improve commissioning decisions • Using regional and national networks to keep up to date with best practice • Expand the usage of the Strategic Intelligence Review **Rotherham Renaissance** • Will put town and employers in stronger position to recruit. **Potential for improvement** • High health needs and inequalities provide opportunities to make a real difference.	**Financial position** • Large non recurrent reserve • Risk of slippage on schemes • Financial implications of NICE guidance • National economic downturn • Impact of changes to continuing care thresholds **Reconfigurations** • Potential for provider changes - e.g. small providers having to change as a consequence of national drive for larger catchment areas e.g. A&E • Implication of European Working Time Directive • Potential for Board priorities to be distorted if involved in service reconfiguration **Small PCT** • Critical mass needed for some services to be commissioned may mean service has to be collaboratively commissioned even where this may not be NHS Rotherham preference e.g. ambulance • Potential to lose experienced staff to large PCTs • May not always be able to attract staff in terms of available / optimum use of national pay flexibilities. **Capacity** Existing capacity stretched to deliver expanding performance and will need to manage management costs **Patient choice** • Swamping local services • Contracting and procurement becomes more complex **Matrix working** Potential for lack of clarity of roles and overlap **Established team** Potential for over reliance on key individuals and implications if they leave. **Information systems** • Information systems, specifically TPP and MARACIS, unable to provide minimum information to meet statutory requirements **Changes to national tariff** • Mental health and community tariff a potential financial risk **National "must be dones"** • overtake local needs and organisation becomes target driven • Procurement – impact on timescales and costs **Increasing public procurements** • Leave organisation open to legal challenge • Change of national policy e.g. linked to change of government **Public aspiration** • Low aspirations of Rotherham people for their own health may constrain the achievement of our vision. **Intermediate care –** potential lack of sufficient infrastructure to deliver future demand for services (we expect position to change as a result of the implementation of InterQual) **Cultural Change** • Delivering smoking, breast feeding, sexual health and diet involves substantial cultural change. • Other cultural forces will be at work which are not under NHS Rotherham's control e.g. social forces affecting population behaviours (drinking behaviours, new drugs etc) and changes in market forces (private sector competition)

8.2 Risk management

A risk assessment has been undertaken of all the key initiatives within the strategy by lead managers, a strategic analysis by lead directors, and taking into account past delivery/performance. The most significant risks to the delivery/implementation of the initiatives have been identified and categorised (figure 8.2). Our risk mitigation analysis has been revised and updated to incorporate all the major significant risks and actioned to deliver the strategy.

Figure 8.2: Risk assessment of all key initiatives.

	Key Initiatives	Likelihood	Severity	Mitigating actions	Lead	Estimated financial impact
A	**Project Management and Deliverability including capacity** • Capacity to manage total range of initiatives and deliver on all project outcomes • Empowerment of key leaders, including clinicians. • Not robustly monitoring commissioning and contracting plans.	Med	High	• Established a robust project management framework across all initiatives including appropriate capacity to support the projects. • Extended performance management including customising reports in Performance Plus so that early remedial action can be taken if necessary. • Further refine and monitor the metrics that best fit the aims of each initiative. • Extended clinical leadership • NHS Rotherham Risk assessment frame work identifies and addresses all key project risks. • Strengthening of matrix working, particularly in terms of programme and contract managers • Ongoing prioritisation of our ME in light of reduced capacity (management costs)	**Director of SP&D**	£20m £10-20m £50m
B	**Financial Risk** • Changes in the economic environment leading to higher than expected inflation or lower than expected allocations • Managing disinvestments and efficiency including management costs • Use of resources and investment scrutiny • Prioritisation • Long term planning • Incorrect activity assumptions. • Cost overruns on new projects and investments • Achievement of an annual 3.5% efficiency savings on Internal Provider Services and the Corporate Directorates. • Increased Prescribing Costs arising from increase • Costs of implementing TCS • Potential to overspend on individual placements • Implementation of a mental health tariff.	Med	High	• Monthly review of efficiency saving made to date to enable early remedial actions to be taken. • The impact of *Shaping our Future* on the wider health community to identify strategic changes which will deliver more cost effective services. • Management costs Reduction Strategy including prioritisation of resources, tighter staffing/vacancy controls and collaborative working. • Joint planning with the main acute provider ensures realistic assumptions are being made. Efficiency action plans to be developed before the start of each year • Implemented prioritisation criteria and rules for investment and disinvestment • Joint work with key stakeholders across the health community identifying changes which will deliver more cost effective services and risk sharing arrangements. • Careful consideration to be given to the cost of different possible models. • Governance arrangements appropriate to the size and complexity of the projects are in place. A contingency is also in place to be used for unforeseen cost overruns. • Strong governance arrangements are in place in order to re prioritise developments or establish cost saving measures as required. • Strategy reflects need for an overall change in risk arrangements with providers. • Informed prescribing team able to implement actions at GP practice level to reduce the effects of increasing costs and volumes. • Community wide discussions taking place to identify options and to agree and focus on	**Director of Finance & Contract**	£2.5m £10-20m £2.4m £0m £0m £0m £1m £0m £0m £0m £5m £0m £3m

	Key Initiatives	Likeli hood	Seve rity	Mitigating actions	Lead	Estimated financial impact
				preferred model. • Robust arrangements for continuing care and PAG. • Membership of the local and regional groups working on the mental health tariff to give an early indication of the effects with close working with RDASH to understand implications of tariff.		£0m
C	**Patient and Public Engagement/patient expectations** • Failure to raise NHS Rotherham's public profile • Failure to raise the public's expectation for good health. • Failure to shape public opinion on smoking and obesity. • Public disengage as a result of impact of potential service reductions.	**Med**	**Med**	• Implementation of the previous Patient and Public Engagement Strategy and Action Plan, and the new Communication and Public Engagement Strategy including good marketing/consultation when changes to services mean a fundamental shift away from tradition; (see OD & HR Plan Goal c).	**Assistant Director External Relations**	N/A
D	**Cultural Change (staff)** • Staff failing to engage with the new agenda • Staff commitment through difficult changes including workforce reductions	**High**	**Med**	• See Organisational Development and HR Plan for NHSR staff – (Goal d,e,g,h) • Support cultural changes across all providers, through commissioning and partnership arrangements. • Securing effective ownership via robust engagement, communication and leadership behaviours across partners and providers.	**CEO & Directors of OD, WF & Gov/ SP&D, Fin & Cont/ PH/ Intell & Perf**	N/A
E	**Effective Partnership Working and System Wide Risk Management** • Failure to deliver Community Strategy. • Failure to deliver LAA targets. • Failure to realise major partnership projects. • Impact of economic downturn on all partners. • Retention of clinical ownership through difficult changes. • Whole system risk management approach to avoid inappropriate transference of cost and risk behaviours	**Med**	**High**	• See Organisational Development and HR Plan (goal a,b,& f re Partnership working and Clinical Engagement section , goal b & f) • Maintain regular dialogue / communication channels • Concordat being developed	**Chief Executive**	£10-20m
F	**Information Management** • Information is not available for good decision making and accurate monitoring. • Information is not interpreted correctly. • Staff are not appropriately skilled to use data and information. • Failure of major IT projects in major providers such as RFT Electronic Patient Record and InterQual	**Med**	**Med**	• Information strategy and plans to cover these risks. • Development of information skills . • Investments in new systems and training in their use. • Harnessing IT to deliver new ways of working. • New director with focus on data quality and intelligence. • Management through project boards and if necessary mitigation by switching providers	**Director of Intell & Perf**	£5-10m
G	**Workforce Skills** • Including recruitment, retention and development of essential skills in commissioning, and recruitment, retention, deployment and development across all providers. • Retention of skilled staff in economic downturn. • Failure to develop leadership capacity and capability	**Low**	**Med**	• Commissioners – see OD and HR Plan – Goal d, e & g) • Other providers - Risk Assurance of providers workforce approach / strategy including contracting discussions and HR leads discussions. • Innovation, quality, re-design, unblocking barriers, managing large scale change skills; and delivering workforce efficiencies/new ways of working (see OD and HR plan goal a, d, e & g) • Retention of essential skills via ME prioritisation process	**Director of OD, WF & Gov**	N/A

	Key Initiatives	Likeli hood	Seve rity	Mitigating actions	Lead	Estimated financial impact
H	**Ability to maintain local services** • Maintenance of sustainable locally available primary, acute, community, secondary, specialist and tertiary services. • Future arrangements for children's services and in particular safeguarding arrangements. • Not developing fit for purpose premises to deliver high quality services	Med	High	• Commissioners – continue robust local stakeholder discussions and planning, including NORCOM. • Ensure the development of a sustainable model for RCHS, working with RMBC to ensure effective arrangements. • Partnership working and development of comprehensive Estates Strategy/CIAMS with key stakeholders	Chief Executive	£1-5m
I	**Clinical Engagement** • Maintenance and enhancement of PBC. • Robust clinical engagement across all stages of commissioning activity.	Low	Med	• Ensure clinical engagement in all aspects of commissioning including engagement of secondary care clinicians. • Extended clinical leadership and engagement • Clarified PBC and PE role and leadership (see OD and HR Plan – Goal b & f)	CEO / Chair of Professional Executive	N/A
J	**Procurement** • Risk of litigation. • Non delivery of contract activity or quality. • Implementing 'NHS preferred provider' whilst securing world class services. • Ensuring effective focus on quality and use of resources.	Low	Med	• Development of clear contract specifications. • Robust and transparent procurement processes, and new procurement team. • Performance Management of Contracts. • Directorate of Intelligence established and implementation of quality framework across all providers.	Director of Finance & Cont/ PH / SP&D/ Intell & Perf	£1-5m
K	**Emergency Preparedness** • Ability to respond to emergency situations e.g. Swine Flu. • Emergency situations impacting on business continuity.	Med	Med	• Robust continuity management. • Impact on focus/priorities • Capacity management	Director of Public Health	£1m

8.3 Equality Impact Assessment

Better Health, Better Lives is designed to reduce health inequality and ensure that the needs of all parts of our increasingly diverse community are met. *Adding Quality and Value* seeks to build upon this. To understand the health of our population and where there are unjustifiable inequalities in health, we have used the information from our joint strategic needs assessment and strategic intelligence review, as described in section 4. We have then looked at this through the spectrum of equality and diversity legislation and identified some of the key areas of inequality:

Life Expectancy

- Life expectancy varies by 9.7 years for men and 5.4 years for women between different parts of the Borough.
- Females in Rotherham aged under 75 are more likely to die from cancer compared to men.
- People with a learning disability are 2.5 times more likely to have health problems than other people and 4 times as many die of preventable diseases.

Primary Care

- There is higher smoking prevalence amongst Pakistani males and the Irish community.
- Overweight and obesity are more common in lower socioeconomic and socially disadvantaged groups, particularly among women. Women's obesity prevalence is far lower in managerial and professional households (18.7%) than in households with routine or semi-routine occupations (29.1%).
- In 2007, 795 asylum seekers were living in Rotherham; asylum seekers are likely to present increased levels of diseases such as tuberculosis, HIV and the physical and psychological effects of war and torture.

Long Term Conditions, Intermediate Care and Urgent Care

- 2008 Lifestyle Survey shows that 35% of the population consider themselves to have a long term condition; this increases to 39% of respondents in areas of deprivation.
- Rotherham's population is ageing, and we have many people with life limiting illnesses looked after in the community. This has substantial implications for carers and the provision of health and social care.
- African Caribbean and South Asian communities have a higher prevalence of Type 2 diabetes (4 times higher in African Caribbean and 6 times higher in South Asian).

GP referrals and planned Care

- In Rotherham people of South Asian origin are more likely to be admitted to hospital with cardiac complaints and receive cardiac interventions (heart bypass and angioplasty) than the population average, once age differences in the populations are adjusted for.
- The BME community in Rotherham had twice the rate of hospital admissions for congestive heart failure (CHF) between 2000 and 2005 than for the general population. The Pakistani community had two and a half times the rate of hospital admissions for this condition compared to the general population.

As a result, some of the key goals of *Adding Quality and Value* are directed to tackling these particular areas:

- ***Life expectancy****:* we will continue to ensure that all parts of our life expectancy programme reach people and communities in particular need, including black and ethnic minority communities and people with mental health problems and disabilities.

- ***Primary care****:* this programme seeks to ensure that everyone in Rotherham can access high quality care; this is the foundation to tackling health inequality, and is particularly important for specific groups of patients, for example people with learning disabilities and mental health problems.

- ***Long term conditions, intermediate care and urgent care****:* this programme aims to radically change and improve the services provided for people with long term conditions and frail older people; we will take action to ensure that this is achieved; specific action will be needed to ensure this programme is inclusive of older people with dementia and people from black and ethnic minority communities.

- ***GP referrals and planned care****:* this programme will seek to reduce variation – but we must ensure that this is not achieved at the expense of patients whose aspirations and expectations are relatively low.

We believe therefore that our strategy can demonstrably help to reduce inequalities in health and we will monitor progress through:

- An equality impact assessment on *Adding Quality and Value*.
- Refreshing the equality impact assessments already completed on all transformational initiatives.
- Ensuring that equality impact assessments are completed for new workstreams and new transformational initiatives.
- Ongoing monitoring of the life expectancy and prevention programme (now integrated within the staying healthy programme, see section 5.3)
- Continued performance monitoring of our transformational initiatives.
- Future monitoring of patient experience and satisfaction metrics across equality streams (reliant on data being available from providers).

8.4 Performance management

8.4.1 Monitoring outcomes

NHS Rotherham has a performance framework that sets out its approach to monitoring outcomes and initiatives and its approach to escalation where there is underperformance. NHS Rotherham keeps under surveillance around 200 performance metrics (such as Vital Signs and LAA targets). Overall performance is kept under review at the monthly External Assessment Group which has representation from all directorates and the Local Authority. This group co-ordinates performance for all key external assessments including World Class Commissioning, Care Quality Commission Periodic Review, SHA performance framework (healthy Ambitions), Audit Commission Use of Resources, Local Area Agreement and Comprehensive Area Assessment. The Professional Executive and the Board receive a sub-set of 38 selected key targets with associated indicators at their monthly meetings (see Board papers for details). The sub-set is selected on the following criteria:

- 10 World Class Commissioning health outcomes
- LAA targets
- CQC Periodic Review metrics
- National priority areas
- Prioritised health impact indicators
- Healthy Ambitions
- Significant outliers

The sub-set will vary from year to year as priorities and performance change. Reporting at all levels of the organisation is categorised into *Better Health, Better Lives* priorities.

A commercial performance management software package (Performance Plus) is a key part of performance management. This is a web-based system that allows all PCT commissioners much easier access to outcomes data and allows reports to be easily customised for different commissioning groups.

8.4.2 World class commissioning outcomes

Figure 8.3 at the end of this section shows the NHS Rotherham's World Class Commissioning Score Card for 2008/09, with benchmarking against 10 high level outcomes. Figure 8.4 shows the updated scorecard as at January 2010. Reasons for selecting the outcomes are discussed in section 3.1. As well as using this organisational level score card, we also provide reports for the 10 outcome measures at individual GP practice population level to increase individual primary care clinicians ownership of Rotherham wide initiatives.

Figure 8.5 at the end of this section shows the extent of the improvements we will make for the 10 high level outcomes. In some cases the first 3 years trajectories reflect the challenging targets we are committed to meeting as part of the Local Area Agreement and NHS Vital Signs. These have been extended to 2012/13 using predictive processes and local knowledge of the extent of the challenge. Where no Vital Signs apply, local trajectories have been agreed, based on historical performance, benchmarking data and our aspirations for the future. Figure 8.6 shows the relationship between NHS Rotherham priority areas and transformational initiatives to World Class Commissioning outcome measures.

8.4.3 Monitoring initiatives

To successfully deliver World Class Commissioning, groups working on individual priority areas and transformational initiatives need easy access to key outcome metrics. This will be delivered by

customising reports in Performance Plus. A key challenge for each initiative will be to further refine the metrics that best fit the aims of the initiative. This will involve the use of some local metrics. However, comparisons with other health communities can only be done easily using nationally available metrics. In the strategy section of this document the metrics that are currently being used for each individual initiative are described. The second table at the end of this section summarises some of the nationally available metrics we use for the initiatives and priority areas – this table will be further refined as World Class Commissioning progresses. For all Healthy Ambitions areas that have been selected as *Adding Quality and Value* initiatives the metrics used to assess performance include the regionally agreed Healthy Ambition metrics.

Responsibility for each milestone and metric is clearly set out in the performance framework. Responsibility for refining the existing milestones for each initiative and for monitoring progress against them lies with named leads. Any performance issues are escalated to programme leads and directors as set out in the performance framework. All milestones and metrics are available throughout the organisation in Performance Plus and individuals can customise their view to show the metrics they are responsible for. Performance Plus also makes clear the inter-relationships between different initiatives and outcome measures.

An organisational overview of progress against initiatives is also necessary for prioritising and risk managing the delivery of the multiple initiatives set out in this strategy.

8.4.4 Monitoring providers

Monthly performance meetings are held with all main secondary and community care providers. Provider scorecards are available for main providers and will be incorporated into the performance management framework.

In primary care, Single Assessment Reviews are held with each practice annually, covering all contractual and performance issues, dental six month review against contract and pharmacy annual review. We have produced Rotherham GP quality accounts with GP providers, which summarise GP practice performance on a wide range of metrics.

8.4.5 Performance Clinics

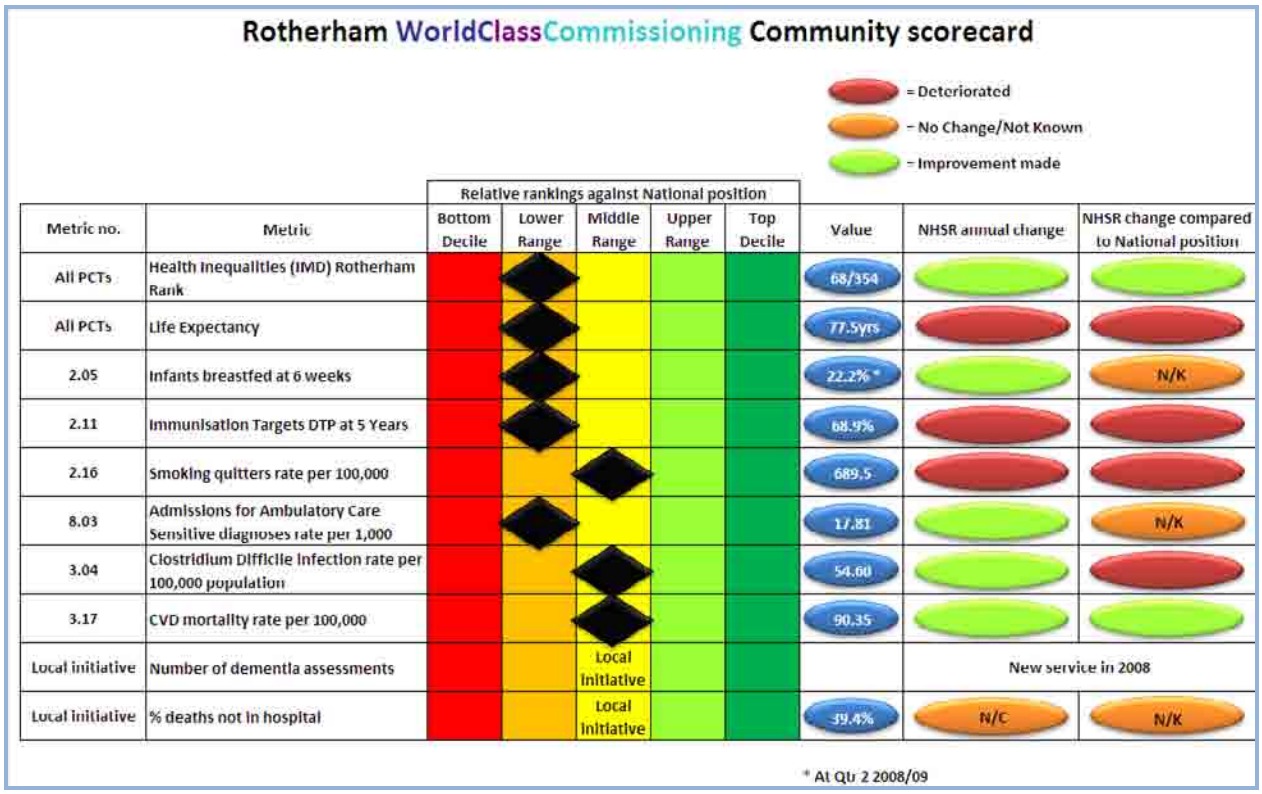
Significant areas of underachievement are addressed via the establishment of a performance clinic for the indicator concerned. Clinics held include:

- Health inequalities
- Childhood immunisation and vaccination
- Infant breastfeeding
- Chlamydia screening
- Smoking quit rates

8.4.6 Monitoring Impact on Inequalities

Quarterly inequalities reports will be produced for each inequalities performance clinic. These reports will include a mixture of process measures of progress in delivering the NHS Rotherham Inequalities Action Plan and outcome measures. To monitor progress on closing the health inequalities gap within Rotherham, relevant outcome measures such as mortality rates will continue to be reported for Rotherham Neighbourhood Renewal Strategy target area as well as for Rotherham overall.

Figure 8.3: NHS Rotherham's World Class Commissioning Score Card for 2008/09



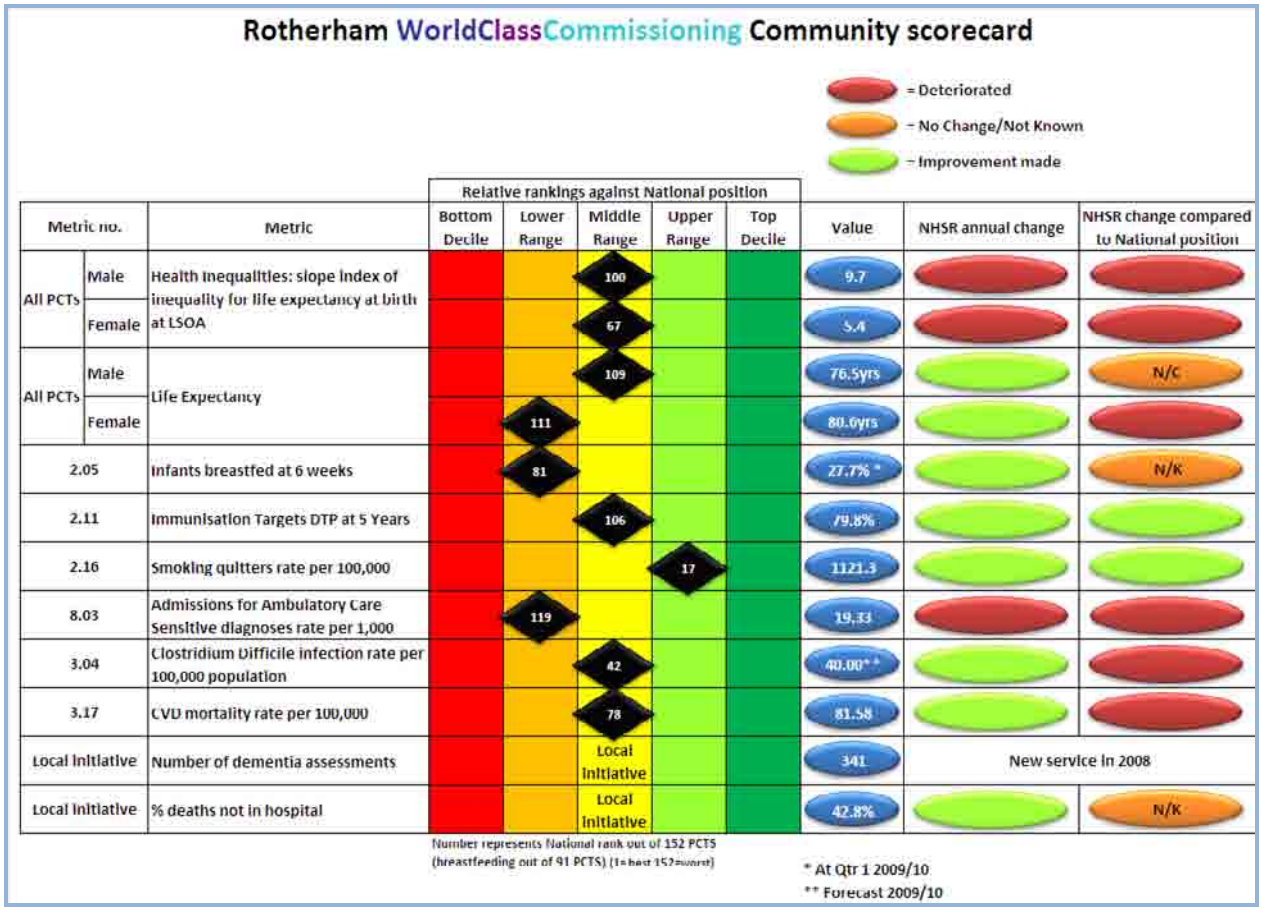
Rotherham WorldClassCommissioning Community scorecard

= Deteriorated
= No Change/Not Known
= Improvement made

Metric no.	Metric	Relative rankings against National position: Bottom Decile	Lower Range	Middle Range	Upper Range	Top Decile	Value	NHSR annual change	NHSR change compared to National position
All PCTs	Health Inequalities (IMD) Rotherham Rank		◆				68/354		
All PCTs	Life Expectancy		◆				77.5yrs		
2.05	Infants breastfed at 6 weeks		◆				22.2% *		N/K
2.11	Immunisation Targets DTP at 5 Years		◆				68.9%		
2.16	Smoking quitters rate per 100,000			◆			689.5		
8.03	Admissions for Ambulatory Care Sensitive diagnoses rate per 1,000		◆				17.81		N/K
3.04	Clostridium Difficile infection rate per 100,000 population			◆			54.60		
3.17	CVD mortality rate per 100,000			◆			90.35		
Local Initiative	Number of dementia assessments			Local Initiative				New service in 2008	
Local Initiative	% deaths not in hospital			Local Initiative			39.4%	N/C	N/K

* At Qu 2 2008/09

Figure 8.4: NHS Rotherham's World Class Commissioning Score Card – Updated January 2010



Rotherham WorldClassCommissioning Community scorecard

= Deteriorated
= No Change/Not Known
= Improvement made

Metric no.		Metric	Relative rankings against National position: Bottom Decile	Lower Range	Middle Range	Upper Range	Top Decile	Value	NHSR annual change	NHSR change compared to National position
All PCTs	Male	Health Inequalities: slope index of inequality for life expectancy at birth at LSOA			100			9.7		
	Female				67			5.4		
All PCTs	Male	Life Expectancy			109			76.5yrs		N/C
	Female			111				80.6yrs		
2.05		Infants breastfed at 6 weeks		81				27.7% *		N/K
2.11		Immunisation Targets DTP at 5 Years			106			79.8%		
2.16		Smoking quitters rate per 100,000				17		1121.3		
8.03		Admissions for Ambulatory Care Sensitive diagnoses rate per 1,000		119				19.33		
3.04		Clostridium Difficile infection rate per 100,000 population			42			40.00**		
3.17		CVD mortality rate per 100,000			78			81.58		
Local Initiative		Number of dementia assessments			Local Initiative			341	New service in 2008	
Local Initiative		% deaths not in hospital			Local Initiative			42.8%		N/K

Number represents National rank out of 152 PCTS (breastfeeding out of 91 PCTS) (1= best 152=worst)

* At Qtr 1 2009/10
** Forecast 2009/10

Figure 8.5: Trajectories for 10 high level outcomes.

Metric no.		Vital Sign	Metric	2008/09		2009/10		2010/11		2011/12		2012/13	
All PCTs	Benchmarking data available		Health Inequalities	M 9.7	F 5.4	M 9.7	F 5.4	M 9.7	F 5.4	M 9.7	F 5.4	M 9.7	F 5.4
All PCTs		VSB 01	Life Expectancy (male & female)	Plan to increase life expectancy by greater than the national average in order to achieve the All age, all cause mortality targets below									
		(Proxy)	All Age All Cause Mortality (male & female)	M 723	F 534	M 691	F 519	M 660	F 505	M 631	F 491	M 603	F 477
2.05		VSB 11	Infants breastfed at 6 weeks	28%		30% 28%(Vsign refresh)		32% 30%(V.Sign Refresh)		33%		34%	
2.11		VSB 10	Immunisation Targets DTP at 5 Years	80%		85%		90%		91%		92%	
2.16		VSB 05	Smoking quitters rate per 100,000 (LAA Stretch Target used)	697		697		697 702(V.Sign Refresh)		702		702	
8.03		VSC 21	Rate of admissions for Ambulatory Care Sensitive diagnoses per 100,000 population	1858		1786		1698		1675		1650	
3.04		VSA 03	Clostridium Difficile infections – Commissioner	224		217		207 172(V.Sign Refresh)		130		130	
3.17		VSB 02	CVD mortality rate per 100,000	65.1		59.4		54.1		50		47	
	Benchmarking data not available		Number of dementia assessments	324		331		338		345		352	
3.24	Benchmarking data available	VSC 15	% Deaths not in hospital	39.4		40		40.7		41.3		42	

	Agreed Vital Signs trajectory

Figure 8.6: Relationship between NHS Rotherham priority areas and TIs to WCC outcome measures (shown in yellow)

Transformational Initiative	Outcome Measures: High level WCC outcomes in yellow
First Class Primary Care - General	• Single Assessment Review process • 10 WCC Health Outcome measures at GP practice level
1 Accessible and responsive high quality primary care	• Patient reported measures of GP access in Vital Signs (6 measures) • % GPs offering extended opening • Patients receiving NHS primary dental services • Cost per patient
2 Quality and efficiency priorities for individual practices	• Key QOF indicators
3 Effective prescribing	• Productivity metrics such as low cost statins, PPI and ace inhibitors
4 Renegotiate all PMS contracts	• Revised local QOF indicators
Healthy Pregnancy and Birth – General	• Early access for women to maternity services (by 12 weeks & 6 days) • Mortality rate per 1,000 live births • Low birth weight babies
5 Increasing breastfeeding	• % mothers initiating breastfeeding
	• % mothers breastfeeding at 6 weeks
6 Reducing smoking in pregnancy	• % mothers known to be smoking at time of delivery
7 Reducing Teenage Pregnancy	• Under 18 conception rate
Healthy Childhood - General	• Infant mortality, sexual health metrics
8 Better mental health services and services for children with complex needs	• CAMHS measures in Vital Signs (4 measures) • Metrics to be developed to include access to specialist equipment, access to short break provision
9 Reduce childhood obesity	• % in reception recorded as obese • % in Year 6 recorded as obese
10 Improve vaccination and immunisation rates	• Immunisation trajectories in Vital Signs for DTP,HiB/MenC, MMR and PCV (8 measures)
11 Integrate services with RMBC	• To be confirmed
Staying Healthy - General	• Life expectancy rates - males/females/all • Health Inequalities - Deprivation Index score
12 Reducing number of smokers	• Smoking quit rate
	• Smoking status among population aged 16 and over • CO validated quit rate
13 Improve primary care services for alcohol misusers	• No of GP practices delivering alcohol treatment in the management of problematic drinking • Rate of hospital admissions for alcohol related harm per 100,000 population
14 Improving access to sexual health services	• Sexual health targets for chlamydia, gonorrhoea and access to GUM
15 Reduce adult obesity	• Obesity status on GP registered population aged 16 and over
	• % adults who are obese (BMI>30)
16 Follow up people identified at risk through the NHS Health Check	• CVD Mortality rate
	• Numbers of over 40s who have had risk assessments
First Class Services - General	• Ambulance response times • Patient survey
17 Implementing a referral management/advisory programme	• Delayed transfers of care
	• Hospital admission rates for ambulatory care sensitive conditions
	• Surgical admission rates for 5 surgical procedures
	• Emergency bed days
18 Secure efficiency from specialised services	• Rate of decrease in SCG spend
19 Increase clinical efficiency	• Hospital admission rates for ambulatory care sensitive conditions
	• Surgical admission rates for 5 surgical procedures
	• Emergency bed days
20 Manage and reduce HCAIs	• Number of cases of MRSA
	• Incidence of C. Difficile
Long Term Conditions, Intermediate Care and Urgent Care - General	• CVD Mortality rate
	• All age all cause mortality rate
21 System wide redesign of care pathways for long term conditions	• Emergency bed days
22 Commission alternative levels of care closer to home	• Hospital admission rates for ambulatory care sensitive conditions
	• Emergency bed days
	• Reduced length of stay
23 Reconfigure intermediate care	• Emergency bed days
Better Mental Health - General	• Suicide rate, Number of people using mental health services in employment
24 Improve mental health promotion	• Reduced mental health prescribing
25 Commission new wards and day patient services	• New and refurbished MH ward facilities
End of Life Care	
26 Improve services and choice for end of life care	• Proportion of deaths not in hospital
	• Deaths at home
27 Review and extend the Rotherham Hospice service	• Proportion of deaths not in hospital
28 Re-commission an enhanced hospice at home service	• Proportion of deaths not in hospital
29 Implement the Gold Standard Framework across Rotherham	• Proportion of deaths not in hospital
	• Deaths at home
	• % GP practices using the Gold Standard Framework
Efficiency Programmes	
1 First Class Primary Care	• Patient reported measures of GP access in Vital Signs (6 measures) • % GPs offering extended opening • Patients receiving NHS primary dental services • Cost per patient
2 First Class Planned Care – GP referrals	• GP referrals
3 First Class Planned Care – Specialised Services	• Rate of decrease in SCG spend
4 First Class Planned Care – Increase clinical efficiency	• Surgical admission rates for 5 surgical procedures
5 Long Term Conditions, Intermediate Care and Urgent Care	• Emergency bed days

8.5 Communications and engagement

8.5.1 Introduction

Effective communications and engagement with public, patients, partners and staff are key enablers to the delivery of our strategy, *Better Health, Better Lives* and its sequel *Adding Quality and Value.* We are starting from a strong position which has given us a firm platform in which to strengthen our work in this area. Our focus will be to reinforce our role as local leaders of the NHS, engage in a way that gathers unique insights into the needs of our population in order to ensure services are planned and delivered around their needs and high quality information to enable people to better manage their own health and make informed choices about their healthcare. Reputation audits have told us that the NHS Rotherham brand is well recognised and highly regarded by our local communities; 91% of Rotherham residents who attended the Rotherham show had heard of NHS Rotherham. We now need to take this to the next level to ensure that NHS Rotherham forges the way forward in improving the aspirations for good health in our local communities.

Communications and engagement with our staff is also a priority as without their engagement and commitment we will be unable to achieve the health and financial challenges facing us. Our local media relations are excellent, developed through strong values of mutual trust and probity which has led to good levels of media coverage and balanced negative coverage. In the last twelve months we have revitalised the Communications and Engagement Committee; a committee of the Board chaired by a non executive director. The Committee is responsible for overseeing the delivery and evaluation of the communications and engagement strategy and ensure it is undertaken in line with local priorities and statutory and legal requirements.

8.5.2 NHS Constitution

NHS Rotherham welcomed the publication of the NHS Constitution last year and has already made significant progress in embedding and sometimes exceeding the requirements laid down within the rights, pledges and responsibilities. For example, Rotherham has developed a local referral to treatment target with its neighbouring foundation trust which means that on average, many patients do not wait longer than 10 weeks for treatment. Local surveys also tell us that an increasing number of Rotherham patients are having a say in which hospital they attend for treatment with 95% of patients stating they attended the hospital of their choice. Following consultation on new patient rights we are confident that the views expressed by both staff and the public will inform policy at a national level. NHS Rotherham has recently refreshed their own 'values' which complement the staff rights and pledges in the Constitution and are integral to the new Staff Charter and Good Staff Management Guide. The Board and Professional Executive are fully engaged with the principles within the NHS Constitution and the legal duty to 'have regard to' and have expressed their full support in fulfilling their responsibilities for embedding the Constitution locally.

8.5.3 Patient and Public Engagement

NHS Rotherham is in a fortunate position with a strong patient and public engagement function who have developed excellent relationships with patients and the public through the interface with a diverse range of local community and voluntary groups including health networks, the LINk and Rotherham Older People's Experience of Services (ROPES). Through this work, we gain a wealth of valuable insight which informs the planning and delivery of health services across the borough.

ROPES were involved in the planning and delivery of services at the new Rotherham Community Health Centre. Following extensive consultation additional interior and exterior signage to improve way-finding was installed

and cold water drinking fountains were placed in eleven locations throughout the building. A hearing loop system was also installed in the main reception area as well as portable loops for each service area.

Rotherham Cancer Service User Forum needed support to meet the needs of current cancer patients and services, and to be effective in raising the concerns of those affected by cancer. We provided funding, support and direction to refresh the group and to create a brand new website. This enabled them to reach a wider group of people and raise awareness of cancer services.

People told us that they were having difficulty using the Choose and Book system. We made sure that people can book using a variety of methods including the telephone and internet with support from Practice staff. At the Citizen's Jury, people told us that they wanted more community based services such a memory clinics. We responded by establishing a memory service for those people with early memory loss.

Younger people told us that they wanted one brand for sexual health services. Using insight from young people we developed a new brand called S-word using themes from iconic films to get important sexual health messages across to the target population.

We have recently refreshed our communications and engagement strategy and aim to progress further work to continue to systematically embed engagement into the commissioning cycle.

8.5.4 Social marketing

It is acknowledged that Rotherham has significant health challenges right across the health and social care spectrum. Positively impacting on the health of the population requires insight and intelligence to understand the motivations and attitudes that compel people to behave in a particular way. Good quality research ensures that interventions are relevant, targeted, timely and cost effective. NHS Rotherham has invested considerable resources into a number of social marketing programmes which are already showing positive results. Examples include;

- The S-word, conceived to increase awareness of sexual health issues among young people. Insight from young people across Rotherham informed the campaign to ensure that delivery would resonate with the target audience. A campaign was developed using popular film imagery and supporting video using viral marketing techniques. To date, the video has received 4000 hits on You Tube and over 67,000 hits to the dedicated website. Attendance at services and STI rates will be evaluated around the first anniversary of the programme launch.

- Smoking is a public health priority and a major contributor to health inequalities across Rotherham. NHS Rotherham has commissioned a number of social marketing programmes to address the issue of smoking in specific demographics including smoking in pregnancy, smoking in the Asian community and smoking from a GP perspective. World Class Commissioning performance data will help to evaluate the success of the programmes.

- Be a Star is a national breast feeding programme delivered locally by primary care trusts. The campaign focused on women aged between 18-25 years from areas of social deprivation and included elements of market research and insight. The use of social marketing highlighted local barriers and incentives that influence the decision to initiate or continue breastfeeding and the preferences for support. This research along with pre-testing of the campaign imagery then informed the development of promotional resources. The imagery was relevant to the target group and is set to become a motivating factor in the decision to breastfeed. World Class Commissioning performance data will help to evaluate the success of the programme.

8.6 Organisational development

Delivering this strategic plan represents a considerable challenge. We are fortunate to start from a strong position. Our current assessment of our competency as commissioners is summarised in the separate world class commissioning (WCC) competency self assessment. Our strategic organisation and development goals have been discussed and agreed by the NHS Rotherham Board and a detailed action plan is set out in our organisational development plan, *Better Health, Better Lives, Better Delivery.* This section summarises the key parts of the organisation development action plan.

Sources have included:

- A comprehensive review of the 2009 WCC assessment results.
- A series of internal assessments of remaining gaps against the full eleven WCC competencies (as revised in September 2009), involving the Board, Professional Executive, 70 commissioning staff and clinical leaders.
- These assessments have been supported by external benchmarking, networking and collaboration and Newchurch development work with the Board and commissioning staff.
- A risk assessment of each transformational initiative by lead directors and programme managers.
- Our 2009 Strategic Intellligence Review, including patient and public feedback.
- Strategic Planning Board and Professional Executive timeout.
- Structured 1 to 1 discussions with the Chief Executive and directors.
- Discussions with practice based commissioning and other GP leaders about the strategic challenges.
- 2009 Rotherham Workforce Risk Assessment and development planning and associated discussions with the Rotherham Workforce Collaborative and human resources leads.
- Development workshops with over 70 commissioning staff.
- A review of progress against, and learning from, previous organisational development initiatives.
- Our updated risk analysis and review of planned mitigation.
- Previous formal assessments including Strategic Health Authority reviews and team development.
- Feedback and discussions with Joint Staff Consultation and Negotiating Committee and other staff partnership arrangements.
- Feedback from other partners and providers.
- Consideration of organisational development and workforce implications arising from “High Quality Care for All”, “Healthy Ambitions, “A High Quality Workforce”, the NHS Constitution, ‘NHS 2010-11 from good to great’, the Operating Framework 2010/11, and other government policy, organisational development and management material.
- Our updated SWOT analysis.

We have identified nine key strategic organisational development and human resource objectives, see below, and areas for development which need to be addressed to enable the achievement of our strategic plan. Action plans have been developed to support the objectives and are set out in Appendix 2 of *Better Health, Better Lives, Better Delivery*. Progress against these plans will be reviewed as part of the performance management arrangements for the delivery of the strategic plan including review by the Management Executive and the Board. The strategic organisational development and human resource objectives are as follows:

1 Transformational Leadership

To continue to develop leadership skills and behaviours which maintain a firm hold on our goal, vision, values and priorities, including the need for major efficiency gain, whilst empowering, motivating and engaging

managers, clinicians, staff and partners to deliver and innovate; embedding and nurturing expanded clinical leadership; resisting centralising control; and holding our nerve in the face of challenge.

2 Clinical Engagement

To secure robust clinical engagement and ownership of the drive to improve quality, including the reduction of costs and inefficiencies at an individual practitioner level and embedding our high impact clinical changes; to secure clinical leadership for the major quality and efficiency reforms across the Rotherham health care system; including our extended clinical leadership and engagement arrangements, including our Professional Executive and practice based commissioners.

3 Patient and Public Engagement

To ensure systematic extensive, open and honest public engagement to inform and influence service improvement and efficiency and secure a mandate for major changes; to influence lifestyle behaviours via segmented social marketing and prioritisation, and to continue to enhance our public profile and reputation.

4 Further Embed the NHS Rotherham Vision, Culture and Values

To ensure we hold true to our values and vision, and support the case for the NHS and the NHS Constitution, via extensive staff partnership and engagement; to support understanding and ownership of the challenges ahead, the drive for high quality at reduced cost and to facilitate associated cultural change.

5 Become a Productive Commissioner with Significantly Reduced Management Costs

Ensure that we make optimal use of our commissioning workforce through the adoption of productive working approaches, prioritisation of resources and capacity, retention of essential skills, collaborative arrangements to share scarce skills, and downsizing to achieve the 30% cut in management costs required over the next four years.

6 Effective External Partnerships

Develop whole system concordats for major efficiency and quality initiatives, and the alignment of incentives; and continue to enhance partnership working with Rotherham Council, the Rotherham Partnership, practice based commissioners, providers and other PCTs (including via the Specialised Commissioning Group).

7 Develop Critical Commissioning Skills and Capacity for Major Change

To further enhance critical commissioning skills to influence behavioural change and underpinning beliefs to release “better for less” innovation across the system and all providers, to lead major transformational change and to embed a rigorous approach to commissioning for quality and to investment and disinvestment prioritisation.

8 Employer of Choice

To continue to develop our reputation as an employer of choice whilst reducing our staffing workforce, by increasing our focus on deploying and nurturing talent, staff development, support, wellbeing and appreciation. To work with Rotherham providers to manage and reduce employment risk and to enhance service quality through assurance of the NHS constitution staff pledges and other workforce quality metrics.

9 Delivery Systems

Continue to strengthen our intelligence and programme management, and prioritisation processes to ensure we focus, track and deliver on improved health outcomes and quality; harness IT to drive efficiencies, and secure an optimum return on a reduced level of investment.

Better Health, Better Lives, Better Delivery includes a comprehensive action plan addressing all these objectives. These include actions to take forward our major system efficiency programmes, the alignment of incentives across the health community; commissioning for quality, and our high impact clinical services; and our plans to become a productive commissioner with reduced management costs.

9 Conclusion and summary

Adding Quality and Value refreshes *Better Health, Better Lives*. It is accompanied by two annexes: annex A is our Strategic Intelligence Review and annex B provides in-depth information on priority areas and transformational initiatives. It is supported by our organisational development strategy *Better Health, Better Lives, Better Delivery*, our Communication and Engagement Strategy and our Financial Plan. In figure 9.1 we summarise our goals, priorities, outcomes and our refreshed strategy and 29 transformational initiatives.

***Adding Quality and Value*: Summary**

Our goal is *better health, better lives* for everyone in Rotherham

We want babies to be born healthy and to have the very best start in life, so that when they start school, children are ready to learn and succeed.

Children and young people should be given every opportunity to be fit and active, and be well aware of the risks posed by obesity, smoking, alcohol, sex and drugs. We want adults to enjoy continued good health, with quick convenient access to excellent services when they are ill.

We want to work with people who have a long-term condition, such as diabetes or respiratory disease and we want to support people to manage their health and enable them to access high quality services. This will help to minimise the risks and damage done by these diseases.

When life comes to an end, we want people to be able to choose where they die, and to protect their dignity.

We are committed to this goal and vision, to the ambitions set in Better Health, Better Lives, and to the initiatives already underway.

Progress review

- Overall, we have made a good start to implementing Better Health Better Lives
- It is important to remember that we have assessed progress just nine months after agreeing what is a five year strategy
- Our assessment of progress towards our ambitions shows that achieving our life expectancy target will be challenging – we need to strengthen action here
- We have also identified the need to strengthen action in relation to children
- Most of our initiatives are making good progress; we need to ensure that this is the case for all of them
- We have significantly strengthened governance, leadership and our delivery system

Intelligence review

Strategic intelligence review

- Ageing population with increasing numbers of long term conditions.
- Recession impacting on health and health service finances
- Unsustainable trends of increasing hospital referrals and admissions

Financial outlook

- A cumulative gap of £78.6m over four years between projected resources and base case projected costs.

Quality review

- A high performing health community
- Variations in quality between GPs, a relative lack of information on quality in community services and the potential for better system wide alignment of the quality agenda to improve population outcomes

Efficiency review

- Variations between GP practices in cost per patient
- Lack of demonstrable system wide impact of current demand management initiatives
- Over utilisation of acute hospital care which could be addressed by system wide reform and additional community capacity

Strategy

Our strategy, therefore:

First, deliver *Better Health, Better Lives*:

- Complete delivery of the 29 initiatives
- Refresh our strategy to improve life expectancy
- Refresh our strategy to meet children's needs

Second, focus on five major system efficiency programmes:

- World class primary care
- Long term conditions, intermediate care and urgent care
- GP referrals and planned care
- Specialised services
- Improve clinical efficiency

Third, add three key enabling programmes

- Aligning incentives across the health economy
- Commissioning for quality
- High impact clinical changes

Fourth, implement *Shaping our Future*, our strategy to reshape the local NHS market to align providers and their services to this strategy.

Fifth, support these programmes and initiatives by aligning our finance, workforce, estates and informatics programmes to our strategy, and by sustained organisational development to ensure NHS Rotherham becomes a productive, world class commissioner, with reduced management costs.

The outcome is *Adding Quality and Value*.

We will continue to demonstrate commitment and determination in the pursuit of our goal and vision, the implementation of our strategy and the delivery of Better Health, Better Lives for everyone in Rotherham.

Figure 9.1: Better Health, Better Lives: Adding Quality and Value 2010- 2015 in summary.

Vision	***Better Health, Better Lives*: *Adding Quality and Value***			
Priorities and Initiatives	**First Class Primary Care Services** ➢ Accessible and responsive high quality primary care ➢ Quality and efficiency priorities for individual practices ➢ Effective prescribing ➢ Renegotiate all PMS contracts	**Healthy Pregnancy and Birth** ➢ Increasing breastfeeding ➢ Reducing smoking in pregnancy ➢ Reducing teenage pregnancy	**Healthy Childhood** ➢ Better mental health services and services for children with complex health needs ➢ Reduce childhood obesity ➢ Improve vaccination and immunisation rates ➢ Integrate services with Rotherham Council	**Staying Healthy** ➢ Reduce numbers of smokers ➢ Improve primary care services for alcohol misusers ➢ Improve access to sexual health services ➢ Reduce adult obesity ➢ Follow up people identified at risk through the NHS Health Check
	First Class Services: Planned Care ➢ Implement a referral management / advisory programme ➢ Secure efficiency from specialised services (via SCG) ➢ Increase clinical efficiency ➢ Manage and reduce HAI's	**Long Term Conditions, Intermediate Care and Urgent Care** ➢ System wide redesign of care pathways for long term conditions ➢ Commission alternative levels of care closer to home ➢ Reconfigure intermediate care	**Better Mental Health Services** ➢ Improve mental health promotion ➢ Commission new wards and day patient services	**End of Life Care** ➢ Improve services and choice for end of life care ➢ Review and extend the Rotherham Hospice service ➢ Re-commission an enhanced hospice at home services ➢ Implement the gold standard framework across Rotherham
Strategy	Leadership and workforce development	Engage with the public and patients	Engage with NHS staff to deliver improvement	Work in partnership with NHS providers, Rotherham Council and Rotherham Partnership
	Shaping our Future	Aligning Incentives	Commissioning for Quality	High Impact Clinical Changes
	Finance, IM&T and estates strategies	Market development, contract management and performance management	Effective programme and project management	Secure value for money from all our investment
Ambition and Outcomes	Health inequalities		Life expectancy	
	Immunisation targets	Breastfeeding	Number of assessments for dementia *(local)*	Clostridium Difficile infections
	Admissions for Ambulatory Care Sensitive Conditions	CVD mortality	Smoking quits	Deaths not in hospital

Better Health, Better Lives: Adding Quality and Value

Annex B

Contents

Introduction

NHS Rotherham's Strategy *Better Health, Better Lives* was launched in January 2009 and clearly set our vision and strategy for health and for health services; the strategy has been revisited in light of the current economic climate.

The financial downturn radically changes the environment in which we must seek to deliver our strategy.

The challenge we have set ourselves is to:

- Protect and sustain the major improvements made in the past decade to health and to health services
- Deliver the priorities and outcomes set out in Better Health, Better Lives
- Secure major improvements to quality and efficiency

Better Health, Better Lives: Adding Quality and Value reports on the progress we have made towards implementation of our strategy, summarises our Strategic Intelligence Review and analyses the financial outlook. It then goes on to describe the new and augmented initiatives we will take to rise to our new challenge.

Building on the previous sections (strategy and annex A) this document, annex B, provides a detailed account of our priority areas and transformational initiatives.

Figure 1.1 summarises how we have refocused our priority areas and transformational initiatives. It shows those set out in *Better Health, Better Lives* and their progression to *Better Health, Better Lives: Adding Quality and Value*.

Figure 1.2 summarises our refreshed strategy '*Better Health, Better Lives: Adding Quality and Value'*.

Figure 1.3 shows how Healthy Ambitions are being taken forward within '*Better Health, Better Lives: Adding Quality and Value'*.

Figure 1.1: Priority Areas and Transformational Initiatives: *From Better Health, Better Lives to Adding Quality and Value*

BH, BL **Priority Area**	***BH, BL: AQAV*** **Priority Area**	***Better Health, Better Lives*** **Transformational Initiatives**	**How the Transformational Initiatives have been changed in Adding Quality and Value**	***Better Health, Better Live : Adding Quality and Value*** **Transformational Initiatives**
First Class Primary Care	**First Class Primary Care Services**	1. Accessible high quality primary care 2. Effective Prescribing 3. New and innovative Community Health Centre (RCHC) 4. Two new GP practices	**1 and 2** - updated but primarily unchanged **3 and 4** - no longer TI, ongoing performance management **New :** • Renegotiate all PMS contracts • Renewed focus on annual commissioning reviews and priorities for individual practices	1. Accessible and responsive high quality primary care 2. Quality and efficiency priorities for individual practices 3. Effective prescribing 4. Renegotiate all PMS contracts
Healthy Pregnancy & Birth	**Healthy Pregnancy & Birth**	5. Increasing breastfeeding 6. Reducing smoking in pregnancy 7. Reducing teenage pregnancy	**5,6 and 7** - updated but primarily unchanged	5. Increasing breastfeeding 6. Reducing smoking in pregnancy 7. Reducing teenage pregnancy
Healthy Childhood	**Healthy Childhood**	8. Improving services for the emotional and mental health needs of all children and young people 9. Improving services to support children with complex and continuing health care needs 10. New and innovative programme to reduce childhood obesity 11. Dramatically improving childhood immunisation coverage	**8 and9** have been merged and updated to become : • Improve services specifically designated to support Children and Young People (C&YP) with Mental Health problems and also improve services designated to meet the needs of those C&YP with Complex Healthcare Needs. Co-locate specific specialised teams to enhance access and quality of these services. **10 and 11 –** updated but primarily unchanged **New :** • Integrated services more closely with RMBC	8. Better mental health services and services for children with complex health needs 9. Reduce childhood obesity 10. Improve vaccination and immunisation rates 11. Integrate services with RMBC
Staying Healthy	**Staying Healthy**	12. Reducing smoking 13. Reducing harm from alcohol 14. Improving sexual health 15. New and innovative programme to reduce adult obesity 16. Screening for Cardiovascular risk	**12, 14 and 15** – updated but primarily unchanged **13 and 16** – significantly updated	12. Reduce numbers of smokers 13. Improve primary care services for alcohol misusers 14. Improve access to sexual health services 15. Reduce adult obesity 16. Follow up people identified at risk through the NHS Health Check
First Class Services	**First Class Services: planned care**	17. Implementing robust admission and discharge criteria 18. Reducing the numbers of HCAI 19. Improving access and choice	**17 and 18** – updated but primarily unchanged **19** - no longer TI, ongoing performance management **New :** • Secure efficiency from specialised services (via SCG)	17. Implement a referral management / advisory programme 18. Secure efficiency from specialised services (via SCG) 19. Increase clinical efficiency 20. Manage and reduce HAI's
Better services for people with Long Term Conditions	**Long Term Conditions, Intermediate Care and Emergency Care**	20. Accessible high quality intermediate care services 21. Better prevention and treatment of falls 22. Improving diabetic services 23. Implementing the chronic obstructive pulmonary disease care pathway 24. Commissioning first class stroke services	Significant re-focus - LTC expanded to include IC and Urgent Care - **TIs 20 - 24** will be picked up under the **new** TIs : • Implement a system wide efficiency programme including whole system pathways for long term conditions • Commission whole system reform based on the outcomes of Interqual to provide alternative levels of care closer to home • Establish a central hub for intermediate care and reconfigure the service so that it acts as a vehicle to prevent avoidable hospital admissions	21. System wide redesign of care pathways for long term conditions 22. Commission alternative levels of care closer to home 23. Reconfigure intermediate care
Better Mental Health	**Better Mental Health Services**	25. Improving mental health promotion 26. Accessible high quality psychological therapies 27. New MH wards to enable modern therapeutic care 28. Improving mental health services for older people	**25 –** updated but primarily unchanged **26 and 28 –** no longer TI, ongoing performance management **27 –** updated but primarily unchanged	24. Improve mental health promotion 25. Commission new wards and day patient services
End of Life Care	**End of Life Care**	29. Improving services and choice for end of life care	**29** – this has been segmented into the following 3 TIs : • Improve services and choice for end of life care • Review and extend the Rotherham Hospice Service • Re-commission an enhanced hospice at home service • Implement the gold Standard Framework across Rotherham	26. Improve services and choice for end of life care 27. Review and extend the Rotherham Hospice service 28. Re-commission an enhanced hospice at home services 29. Implement the gold standard framework across Rotherham

Figure 1.2: Summary of our refreshed strategy 'Better Health, Better Lives: Adding Quality and Value'.

Vision	Better Health, Better Lives: Adding Quality and Value			
Priorities and Initiatives	**First Class Primary care Services** ➢ Accessible and responsive high quality primary care ➢ Quality and efficiency priorities for individual practices ➢ Effective prescribing ➢ Renegotiate all PMS contracts	**Healthy Pregnancy and Birth** ➢ Increasing breastfeeding ➢ Reducing smoking in pregnancy ➢ Reducing teenage pregnancy	**Healthy Childhood** ➢ Better mental health services and services for children with complex health needs ➢ Reduce childhood obesity ➢ Improve vaccination and immunisation rates ➢ Integrate services with RMBC	**Staying Healthy** ➢ Reduce numbers of smokers ➢ Improve primary care services for alcohol misusers ➢ Improve access to sexual health services ➢ Reduce adult obesity ➢ Follow up people identified at risk through the NHS Health Check
	First Class Services: Planned Care ➢ Implement a referral management / advisory programme ➢ Secure efficiency from specialised services (via SCG) ➢ Increase clinical efficiency ➢ Manage and reduce HAI's	**Long Term Conditions, Intermediate Care and Urgent Care** ➢ System wide redesign of care pathways for long term conditions ➢ Commission alternative levels of care closer to home ➢ Reconfigure intermediate care	**Better Mental Health Services** ➢ Improve mental health promotion ➢ Commission new wards and day patient services	**End of Life Care** ➢ Improve services and choice for end of life care ➢ Review and extend the Rotherham Hospice service ➢ Re-commission an enhanced hospice at home services ➢ Implement the gold standard framework across Rotherham
Strategy	Leadership and workforce development	Engage with the public and patients	Engage with NHS staff to deliver improvement	Work in partnership with NHS providers, Rotherham Council and Rotherham Partnership
	Shaping our Future	Aligning Incentives	Commissioning for Quality	High impact Clinical changes
	Finance, IM&T and estates strategies	Market development, contract management and performance management	Effective programme and project management	Secure value for money from all our investment
Ambition and Outcomes	Health inequalities		Life expectancy	
	Immunisation targets	Breastfeeding	Number of assessments for dementia *(local)*	Clostridium Difficile infections
	Admissions for Ambulatory Care Sensitive Conditions	CVD mortality	Smoking quits	Deaths not in hospital

Figure 1.3: How Healthy Ambitions is taken forward within NHS Rotherham's Strategic Plan

Healthy Ambition Recommendation	In NHSR Plan Explicit	In NHSR Plan Implicit	Location within NHSR Plan: Annex B	Delivered through NHSR normal contracting route	Delivered via SCG
Maternity and newborn care					
Latest national guidance strongly backed by local clinicians		√			
Increase the levels of consultant staffing cover inline with Royal College guidance		√			
Action to improve performance on breastfeeding	√		section 1.2		
Action to reduce smoking in pregnancy	√		section 1.2		
Improve the quality and consistency of information for pregnant women	√		section 1.2		
Prioritise midwifery time to women who need it most	√		section 1.2		
Children's Services					
The development of comprehensive children's primary care teams	√		section 1.3		
Improved paediatric expertise in primary care	√				
A single phone line for advice on children				√	
A series of summits for our regional experts to improve the care of children with asthma and diabetes					
Routine planned surgery for children to take place as locally as possible, specialist and emergency surgery to be concentrated where it will improve outcomes					√
Support for the recommendations in a number of other areas as they affect children (e.g. urgent care, planned care, staying healthy etc)	√	√	section 1.3		
Staying Healthy					
Alcohol: Improve screening and identification of people with alcohol problems; offer tiered support services; use influence to reduce availability of cheap alcohol	√		section 1.4		
Obesity - every area to commission local weight management services; areas to work together to commission bariatric surgery where this is the best for morbidly obese people; programme of local work with partners on good policy and skills for adults; improve opportunities for active leisure	√		section 1.4		
Tobacco - Commission free nicotine replacement therapy; Systematically use every NHS opportunity to encourage and support giving up smoking	√		section 1.4		
Recommend investment switch from treatment to prevention	√		section 1.4		
Planned Care					
Improve access to diagnostic services	√		section 1.1		
Better communication between GPs and hospital doctors		√		√	
More procedures completed as day cases and fewer patients needing to stay overnight in hospital				√	
Make sure we have appropriate specialist cover for intensive care					√
Some specialist care in non-hospital settings, beginning with diabetes and some lung conditions	√		section 1.5		
Explore potential for home monitoring of some conditions	√		section 1.5		

Healthy Ambition Recommendation	In NHSR Plan Explicit	In NHSR Plan Implicit	Location within NHSR Plan: Annex B	Delivered through NHSR normal contracting route	Delivered via SCG
Acute Care					
A wider range of services to avoid having to go to A&E (pharmacies, extended primary care, urgent care centres)	√		section 1.1		
Better support to look after yourself, including a self-care manual	√		section 1.6		
A single telephone number for local urgent care and out of hours care	√		section 1.1		
Guidance for ambulance services to take people immediately to the best location					√
Experienced staff making decisions at the door of all A&E departments		√			
Long Term Conditions					
Personal care plans agreed annually with patients to manage their long term conditions	√		section 1.6		
Actively identify people in the community at risk from long term conditions and reduce their risk of needing hospital admission	√		section 1.6		
More support for people to manage their own conditions	√		section 1.6		
Better co-ordination of care	√		section 1.6		
Better use of new technology to help self-care	√		section 1.6		
Focus of prevention of problems	√		section 1.6		
Mental Health					
Help when it is needed – no queues		√			
The adoption of a vision for mental health 'to live free from discrimination, disability and poverty'	√		section 1.7		
A single access point to ensure you get the right support quickly		√			
Investment in community mental health services to ensure capacity meets demand	√		section 1.7		
Mental health teams attached to GP practices	√		section 1.7		
Modernized dementia services	√		section 1.7		
End of Life					
Every NHS area to develop a better range of services for people nearing the end of their lives	√		section 1.8		
Clinical teams caring for patients, their families and carers should deliver agreed standards of care	√		section 1.8		
Each area to establish a single care co-coordinator	√		section 1.8		
Every patient should have access to a 'key worker' contact through their practice	√		section 1.8		
Advanced care planning should happen everywhere	√		section 1.8		
End of life care to form part of training and education for NHS staff	√		section 1.8		
Create a more open climate to discuss the end of life care	√		section 1.8		

1.1 First Class Primary Care Services

'Primary care – the services provided by our local GPs, dentists and pharmacists and opticians, are the bedrock of the NHS. They are the services we most often turn to for advice, treatment and care. In fact, over nine in ten contacts with the NHS are with primary care services. In Rotherham we have good primary care services but we want them to become world class.'

Introduction
We have identified four transformational initiatives relating mainly to improving general practice services:

TI: 1 Accessible and responsive high quality primary care
TI: 2 Quality and efficiency priorities for individual practices
TI: 3 Effective prescribing
TI: 4 Re-negotiate all PMS contracts

This introduction sets out our overall vision for providing world class primary care and mentions specifically improving GP services and premises, improving primary care services for people with learning disability, and improving dental, pharmacy and ophthalmic services.

Improving GP services
In five years time everyone who lives in Rotherham will have first class GP services. We will achieve this by focussing on five key areas for improvement:

- Quality
- Access
- Wider range of services
- Choice
- Premises

These improvements will be the route by which NHS Rotherham delivers the primary care challenges set out in *High Quality Care for All* and *Healthy Ambitions*. The primary care transformational initiative sections explain how we will improve quality and access across all practices. One component of this is building on the major new investments in Rotherham Community Health Centre and the procurement of two new practices as a catalyst to improve quality and access across all general practices.

We will encourage all our GP practices to extend the range of services they deliver, including providing more preventative services such as smoking cessation, cardiovascular risk advice, advice on diet, exercise and weight management (details are in the Staying Healthy section 1.4 of this document). We will also encourage practices to provide more services for people with long term conditions, such as diabetes, in primary care thus reducing the number of patients who receive long term condition management from hospitals (details are in the better Long Term Conditions section 1.6).

We will ensure the people of Rotherham are able to exercise real choice over which GP they wish to register with. To achieve this we will change the way GP services are organised and provided. The age profile of GPs in Rotherham indicates that a number of GPs may retire in the next five years. Many new GPs coming into practice prefer to work in larger practices where a greater range of services are available. By 2012 we expect that most practices will have at least 5,500 patients. This means that, as the opportunity arises (for example when GPs retire), we will look to develop multi-handed practices. The result will be fewer practices, all offering a wider range of services.
Out of 41 general practices, 21 have a practice population over 5,500. We are working with the remaining 20 practices towards reaching practice populations of over 5,500. However, of the 20 practices:

- Two are new GP practices, Brampton and Chantry Bridge, set up in 2009 where the list size is still under development.
- Two practices are working towards potential partnership merges.
- One practice, the Gate, was set up to meet the needs of asylum seekers and migrants and therefore the nature of the practice population is such that ever reaching a population of 5,500 is highly unlikely.
- One practice will be recommissioned under an APMS agreement.
- One practice list is being freely dispersed.

Improving Primary Care Premises
Modern, fit for purpose premises are an important enabler of high quality services. Working with Rotherham Council, NHS Rotherham has invested in integrated service centres for out of hospital health care and Council services. These co-locate Community, Mental Health, GP Practice and other health services with Council services such as housing, adult services and libraries. This supports the shift of care from hospital into communities and towards upstream public health services. The first integrated service centre, Maltby Customer Services Centre, is located in one of our more deprived areas opened in September 2008, with Swallownest following in the summer of 2010 and Rawmarsh in 2011.

We are also making substantial investments in stand alone GP premises. Major premises extensions have been delivered in Kimberworth Park and Swinton and we are currently reviewing other proposals. Two new GP practices have opened under the delivering equitable access programme. Further developments are planned at Brinsworth, Broom and Wath.

In 2010 we will undertake a fundamental review of contracts including QOF for PMS practices, working with practices to ensure alignment of incentives across the healthcare economy (see TI 4).

Primary care services for people with learning disability
Nationally, the Independent Inquiry *Health Care for All* has shown high levels of unmet medical needs among people with learning disabilities. In Rotherham, programme budgeting information shows that we spend £6.5m on services for people with learning disability (35% above the national average). Rotherham's specialist services have been highly commended by the Health Care Commission in their recent audit of specialist inpatient provision. Nevertheless, we are determined that the primary health care needs of people with learning disability should be fully met with a particular emphasis on health promotion and screening in order to address the diagnostic shadowing issue highlighted in the HNA section. A health subgroup of the Learning Disability Partnership Board has been set up which will build on the primary care QoF Learning Disability registers to ensure that the health care services and outcomes received by people with Learning Disability are at least as good as those received by the overall population.

General Dental Services
NHS Rotherham is committed to developing and expanding local NHS dental services. The ratio of one wte dentist to every 3000 people is the lowest in South Yorkshire. In 2009 we commissioned two new general dental practices; one to serve the population of Maltby; and one in the town centre with a focus to take patients from the East Herringthorpe and Eastwood areas. Existing practices have also increased their appointment capacity in the Rotherham area.

Key dental service priorities identified in the local dental public health strategy are as follows;

- To increase the dental service provision in the Eastwood, Wath and Swinton areas of Rotherham
- To increase the dental workforce by retaining dentists who have completed the Vocational Training Scheme.
- To increase the provision of domiciliary care
- To review the difference in payment levels between GDS and PDS practices
- To seek to increase endodontic provision by appointing dentists with specialist interest

In 2008/09 we invested an additional £1.2m to expand the local primary care dental workforce by an additional four dentists and retain four dental vocational trainees. The provision of domiciliary care was increased. In 2009/10 a further £600k has been used to retain four further dental vocational trainees and to develop orthodontic services.

In January 2010 a new orthodontic practice was commissioned in the town centre.

In 2009 we introduced a new local dental contract to focus on Quality, Access and Prevention. Quality in dental practice is currently assured by clinical governance visits by the General Dental Practice Advisor.

General Pharmaceutical Services
NHS Rotherham had already taken steps consistent with the "*Pharmacy in England: Building on strengths – delivering the future*" in advance of its publication. These included commissioning the following Local Enhanced Services from pharmacists:

- NRT / Smoking Cessation
- Minor Ailments
- Supervised Administration
- Needle and syringe exchange
- Palliative Care Formulary
- Out of Hours

We have a Community Pharmacy Assessment Framework with a programme of visits by the trust pharmacy advisor to determine priority areas and ensure that the requirements of the pharmacy contract are being met.

Our plans are for pharmacies to offer increasingly convenient access to medication and a wider range of other health services close to people's homes:

- Become "healthy living centres" promoting health and well-being and helping people take better care of themselves
- Being the first port of call for people with minor ailments – saving every GP up to the equivalent of one hour per day
- Provide support for people with long term conditions, especially those starting out on a new course of treatment
- Commission further Local Enhanced Services already provided by pharmacists, such as: Emergency Hormonal Contraception, Vascular Risk Assessment, Managing Long Term Conditions, Early Detection of Cancer
- Take a pivotal role in medicines management in a 'flu pandemic'
- Increase number of pharmacists offering quality Medicines Use Reviews
- Ensure that the NHS Rotherham Pharmacy Needs Assessment is regularly updated to address any gaps in the provision of pharmaceutical services.

We now have four community pharmacies providing a 100 hour service, these are situation in Wath, the Town Centre, Thurcroft and Brinsworth.

General Ophthalmic Services
New regulations published in August 2008 place Ophthalmic Practitioners on the same footing as General Medical Practitioners and General Dental Practitioners working under a formal contract rather than Terms of Service. NHS Rotherham will maximize the opportunity this brings and will create a coherent framework for the commissioning of services locally, over and above basic sight testing services.

Contracts will be divided into those providing mandatory services, those providing additional services and those providing both.

NHS Rotherham has recently appointed an Optometric Advisor, and we will:

- Expand the role of opticians in managing eye care and promoting eye health, for instance by helping to manage the care of people with Glaucoma
- We will assess the quality of the service provided by local opticians by the end of 2010.
- Individual practice visits will be carried out by the Optometric Advisor.

How will we measure our success?

Our first class primary care services goals are:

- *Each GP practice in Rotherham will show a year on year improvement in world class commissioning outcome measures measured at practice population level (after allowing for random variations in small practices)*

- *By 2012 the range in outcomes between GP practices in Rotherham will have been reduced by the practices that currently have the lowest achievements improving faster than the average.*

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- GP Single Assessment Review metrics
- Patient reported measures of GP access in Vital Signs (6 measures)
- *Identified prevalence of key QOF conditions such as hypertension, COPD and diabetes compared to expected prevalence and national benchmarks (HA Metric)*
- A series of metrics on the effectiveness and cost effectiveness of prescribing
- 4 hour maximum wait in A&E (as a metric to measure the impact of the RCHC)
- Maximum 6 week wait for diagnostics
- For all GP metrics we will show both year on year improvements and a reduction in unexplained variation between practices

Transformational Initiative: Accessible and responsive high quality primary care (TI: 1)

Where we are now
Quality – overall the standard of primary care in Rotherham is good (see clinical quality, section 10, of the health needs assessment). However there are a small number of practices who consistently score poorly across a range of metrics. **Access** – in April 2008 only 3 out of 39 practices were open for all core hours (defined as 8-6.30 Monday to Friday). This situation is improving quickly and over half of all practices were open for all core hours by September 2008. In December 2009 39 out of 41 practices (i.e. 95%) are open for all core hours. This covers 98.5% of the Rotherham population. We will ensure that patients' access to primary care is improved on as measured by the results of the GP National patient access survey.We will continue to ensure that patients have access to extended hours in the evening and at the weekend. The availability of these services will be subject to the local needs but where a practice does not offer this service, the PCT commissioned other services through two new practices.
Where we will be in 5 years
Quality – the quality of care delivered by all NHS Rotherham practices will improve each year, by 2012 all practices will be delivering high quality care and the information that demonstrates this will be easily and clearly available to patients and to commissioners. **Access** – all practices will be open for all core hours, patients will have easy access to primary care when they are ill on a 24/7 basis, patients will have the choice of being able to book routine appointments outside core hours.
Impact on health and other services
Improved primary care quality and access is key to improving the health of Rotherham patients and will result in better quality of life and improved life expectancy. This will be because of more systematic access to health promoting interventions such as early mental health interventions, smoking cessation services, cardiovascular risk assessment

and cancer screening services. More accurate diagnosis of important conditions and higher quality management of long-term conditions will also lead to health benefits.
In the short term improving quality and access in primary care will increase the appropriate demand for health promotion services and the need for long-term disease management for example by increasing referrals to smoking and obesity services and by identifying more people with diabetes and at cardiovascular risk.

In the medium term this initiative will decrease the number of people who would otherwise require hospital admission for serious complications. The long term impact on health care demand is difficult to quantify because increasing life expectancy brings with it implications for increased demand for some care of the elderly services such as dementia.

How we will make sure that the initiative will impact on the people who most need it?

NHS Rotherham has a well established equity audit programme. We routinely attribute IMD scores to practices and also categorise practices according to the number of patients they have in Rotherham Neighbourhood Renewal Target Area. We will continue to monitor the relationship of key primary care metrics such as smoking cessation and screening uptake rates against deprivation scores and take actions to address inequalities.

Finance

Currently NHS Rotherham spends £76m on primary care services (including prescribing). Much of this transformational imitative is about delivering consistent value for money for all patients from this resource.

There is additional funding of £650K is available recurrently and a further £111K in the operating plan to improve access through the extended hours LES.

Quality improvements are being incentivised through the PBC LES, the total annual funding is £940K. Some components of the funding are for attention to secondary care and prescribing budgets, other components are directly for access and quality initiatives (currently the use of Choose and Book and 3 prescribing quality initiatives from the PCTs life expectancy plan; statins for CVD risk, metformin in diabetes and warfarin in atrial fibrillation).

How we will get there

Quality and access improvements will be delivered through developing our existing Substantive Annual Reviews (SAR). Currently all practices are assessed against 6 quality standards. We use a multi- directorate approach to improving quality with the intelligent use of information to produce time limited action plans. There is a rolling programme of assessment with criteria changing annually to address different priority areas. An important part of SAR is asking practices to explain their per-patient costs (both for primary care spend and secondary care costs). There is currently substantial variation between costs and practices are asked to explain this, either in terms of better outcomes or increased need.
We have developed a balanced score card of primary care metrics. This will be further developed to include all 10 NHS Rotherham World Class Commissioning outcomes expressed at practice population level, together with locally generated practice information and information from the SHA primary care information project. The primary care balanced scorecard has been piloted in 08/09 SAR.
Improvements in access will be delivered by SAR, by encouraging practices to respond to consumer demand, by the example set by the new practice procurement initiatives, and by putting access criteria into all new contracts as opportunities arise.
Key milestones for this initiative:

- January 95% of all practices open for all core hours covering 98.51% of the Rotherham population.
- The balanced scorecard template has been agreed and the scoring mechanism will be ratified at the end of March 2010.

How we will measure improvement

Improvements in overall quality will be tracked by the SAR and balanced score card using all 10 WCC outcome measures - some are particularly relevant to primary care such as by practice immunisation rates, smoking quitters, ambulatory care sensitive admissions and mortality rates, but all have some relevance to primary care for example healthcare acquired infections are associated with primary care antibiotic prescribing.

In addition to the World Class Commissioning outcomes we use a range of other metrics including cost per patient. We will see an improvement in process measures such as immunisation rates quickly with impacts on admission rates and mortality over a longer time period.

As well as delivering an overall increase in quality, we will quickly see a reduction in current variation in quality between practices as a result of support, challenge and assertive action for practices who are outliers on quality metrics.

Communication Plan (include patient, clinical and stakeholder input)		
• GP practices opening times will be shown on the NHS choices website • Practices will be asked to ensure that their practice leaflet is kept up to date on a regular basis		
LEAD MANAGER	**LEAD DIRECTOR**	**LEAD CLINICIAN**
Keith Stamp	**Kath Atkinson**	**Charles Collinson, Mark Hamstead, Mike Foster**

Transformational Initiative: Quality and efficiency priorities for individual practices (TI: 2)

Where we are now
We already have a comprehensive annual review process that is designed to stimulate and support improvement in patient care. We have undertaken a new analysis of efficiency at general practice level and assessed GPs performance against a suite of key indicators.
Where we will be in 5 years
The level of variation in performance, quality and cost between practices will have been reduced.
How do we get there
Minimum standards and individual key priority areas will be identified for each GP practice. We will work with PBC and the LMC to develop world class practices able to offer a wider range of services and rewarded by an increase in these services within their responsibility.
How we will make sure that the initiative will impact on the people who most need it?
Improved primary care quality and ensuring value for money is key to improving the health of Rotherham patients and will result in better quality of life and improved life expectancy.
Finance
Currently NHS Rotherham spends £76m on primary care services (including prescribing). Much of this transformational imitative is about delivering consistent value for money for all patients from this resource. The practices' cost per weighted patient varies significantly, which suggests that there is potential scope for efficiency gain. There are potential savings to be made should all practices achieve median value and lower quartile value spends in their expenditure.
How we will get there
In the contracting rounds assessors will robustly challenge practices where there is disappointing progress against agreed priorities.
How we will measure improvement
Improvements in overall quality will be monitored by the Annual Commissioning Review (ACR) process and by using the Quality accounts which measures resource utilisation, clinical effectiveness, prevention and access. Their purpose is to promote benchmarking between practices and help define what World Class Primary Care means for Rotherham. When published they will also help patients and their carers make better informed choices about health care. The current ACR process requires the delivery of a minimum of 3 service improvements not linked to additional remuneration. The aspects of fairer funding of GP services will also ensure that future uplifts of remuneration are based on the principle that there is a need to guarantee minimum standards in service delivery.
Communication Plan (include patient, clinical and stakeholder input)
The LMC will be consulted on the principles of fairer funding for GP services. The quality accounts have been finalised and are available to stakeholders via the NHS Rotherham intranet.

LEAD MANAGER	**LEAD DIRECTOR**	**LEAD CLINICIAN**
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Transformational Initiative: Effective Prescribing (TI: 3)

Where we are now
NHS Rotherham's primary care prescribing costs are £41m. This budget requires active management to maximise health benefits, to increase safety and to ensure efficient use of resources.

Practice prescribing budgets are set by an innovative formula which is based on the actual practice prevalence of conditions for the majority of BNF categories. This makes resource allocation more accurate and also incentivises case finding.

Prescribing data is linked with clinical data (QOF /admissions data) to ensure that whilst prescribing costs are controlled, the quality of prescribing is not compromised.NHS Rotherham's recent track record on minimising ineffective prescribing is good. Cost growth has been below the North of England average for the last two years and in 06/07 was the lowest in the whole North of England.
We have a good track record on managing the introduction of new drugs in conjunction with secondary and tertiary health care providers. In 07/08 we had the lowest expenditure on recently introduced new drugs in Y&H.

The nutrition expenditure part of GP prescribing budget has been devolved to dieticians. This ensures that financial and clinical responsibility rests with the most appropriate health professional. In 2009 we are now funding 4.4 community dieticians from money which has been released from expenditure on nutritional supplements. Last year Nationally the expenditure on nutritional supplements increased by 13.5% where as in Rotherham expenditure decreased by 16.8%. NHS Rotherham now spends less on nutritional supplements than it did in 2003/04. The model has proved so successful that it has been applied to continence products and that scheme has received a National Award. Plans are underway to apply a modified business model to wound care.

Where we will be in 5 years

- Prescribing cost growth will not exceed the national and SHA average.
- The small number of practices who are currently outliers on a multiple prescribing quality indicators will be prescribing in line with their peers. .
- There will be more consistent uptake of prescribing interventions that are associated with proven reductions in mortality and\or reduce event rates (such as stains and aspirin for cardiovascular risk, beta-blockers in heart failure, metformin in diabetes).
- Prescribing performance indicators will be included into health care providers contracts as part of performance management to deliver cost effective prescribing across care pathways.
- There will be better devolvement of prescribing budgets to ensure that clinical and financial responsibility reside together e.g. continence and stoma products and wound care.
- Greater incorporation of quality indicators into prescribing analysis to ensure prescribing is not just cost effective but is also delivering high quality health care.
- Pharmaceutical care to be incorporated into an ever-increasing number of care pathways.
- Improved interactions with nursing\residential homes to deliver quality medicine management
- More quality assured clinical services commissioned from community pharmacists.

Impact on health and other services

Health Impact.
Improved medicines management improves patients' quality of life, control over their condition and life expectancy. Ensuring cost effective, evidence-based prescribing releases financial resources to support other health care initiatives. In some therapeutic classes there is a 20-fold difference in costs between clinically equivalent treatments.

Impact on other services
Increasing appropriate prescribing and increased safety in prescribing will lead to decreased hospital admissions.

How we will make sure that the initiative will impact on the people who most need it?

Monitoring prescribing data together with clinical quality indicators and admissions data is a powerful way of demonstrating that patients are receiving effective health care. We will ensure that NHS Rotherham's equity audit programme includes key prescribing quality markers.

Finance

The addition of £400,000 into the 2008/9 operating plan specifically for statins and aspirin for people on disease registers who are at cardiovascular risk is an example of specifically targeted additional prescribing expenditure to achieve a specific health outcome.

How we will get there

- NHS Rotherham has an integrated Prescribing Support Team which provides both a commissioning function and support to NHS Rotherham Community Services. This team will continue to improve prescribing in Rotherham.
- The commissioning role of the prescribing support team will be strengthened so that more prescribing quality indicators are included into health care provider contracts
- Practices that consistently fail to achieve prescribing outcome measures will receive support, challenge and assertive action to ensure their patients are not disadvantaged.
- NHS Rotherham will realise the potential of commissioning further prescribing support to work within directly

provided services in roles traditionally undertaken by other health care providers e.g. prescribing pharmacists.

- We will further devolve the prescribing budget, eg in the areas of continence, stoma and wound care.
- We will develop additional incentives to improve coverage of prescribing initiatives where there is strong evidence of improved health outcomes.

How we will measure improvement

Clinical measures

We will continue to use and develop a comprehensive range of prescribing quality indicators, including national productivity metrics, regional comparators and locally generated metrics to measure concordance with agreed standards.

Prescribing performance will continue to be measured every quarter in key therapeutic areas and compared to QOF prevalence data and admissions data. Practices whose performance gives cause for concern with be offered advice and support, if improvements are not made this will be addressed through the SAR (see quality and access transformational initiative).

Financial measures

Prescribing costs will be kept within allocated budgets each year with a cost growth that does not exceed the North of England average. Unexplained prescribing cost variations between practices will be reduced.

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Transformational Initiative: Renegotiate all PMS contracts (TI: 4)

Where we are now

There is a wide range of investment between PMS practices and particularly when this is compared to GMS practices. At the lower end the £ per weighted patient is £79.88 and at the higher end it is £124.67 In some cases there are clear quality and broader health system benefits from the additional investment. In other cases the additional benefits are less clear. We will aim to understand these variations and ensure that contracts are delivering value for money.

Where we will be in 5 years

The variation in spend in our PMS contracts will have been reduced.

How do we get there

We will refresh the Quality and Outcome framework for PMS practices and we will develop additional quality indicators to be included in contracts. Clear practice objectives will be set which are Specific, Measureable, Achievable, Relevant and Timely (SMART). Future remuneration will be more closely aligned to the delivery of actual performance in areas such as cervical cytology and childhood vaccination and immunisation.

How we will make sure that the initiative will impact on the people who most need it?

The QOF was introduced in 2004 as part of the GMS contract and is a voluntary incentive scheme for GP practices, rewarding them for how well they care for patients across specific disease areas.

PMS practices are eligible to engage in the QOF. The QOF gives an indication of the overall achievement of a practice through a points system. Practices aim to deliver high quality care across a range of areas for which they score points. Put simply the higher the score, the higher the financial reward for the practice. The final payment is adjusted to take account of the practice list size and prevalence.

The refresh of the QOF will determine the development of new indicators and recommend for example whether existing indicators should continue to be part of the QOF. For example where the activity being measured has become part of standard management practice, there would be no longer a need to provide a financial incentive.

Finance

The new quality improvements will be incentivised by using existing funding from the recycled QOF and PBC LES.

How we will get there

We will use the opportunity to negotiate higher quality/performance standards so that “added value” of PMS can be demonstrated. We will introduce key performance indicators (KPIs) within the PMS contract.

How we will measure improvement

The variance in spend in PMS contracts will have been reduced. The achievement of PMS objectives will have been demonstrated and where necessary refocused. The review of PMS contracts will lead to the reduction in health inequalities.

Communication Plan (include patient, clinical and stakeholder input)

Any changes to the QOF will be discussed with the LMC.

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1.2 Healthy Pregnancy and Birth

'We all want the best possible health. Good health begins during pregnancy, birth and in the first weeks and months of life'

Introduction
We have identified three transformational initiatives relating mainly to improving healthy pregnancy and birth:

TI: 5 Increasing breastfeeding
TI: 6 Reducing Smoking in Pregnancy
TI: 7 Reducing Teenage Pregnancy

This introduction sets out our overall vision for providing world class maternity services and mentions specifically improving antenatal and postnatal care (Maternity Matters), improving access to midwives, informed and greater choice and better maternal mental health.
The vision for Rotherham's Maternity service is to ensure women have easy access to supportive high quality maternity services, designed around individual needs and the needs of their babies, reducing infant mortality and ensuring infants get the best possible start in life. Our priority is to provide a choice of safe, high quality care for all women and their partners, to enable pregnancy and birth to be as safe and satisfying as possible for both mother and baby, and to support new parents in a confident start to family life.

Maternity Matters highlight the importance of improving outcomes for more vulnerable and disadvantaged families. Infant mortality rates are higher in more deprived areas, both across the country and in Rotherham.

Over the last year NHS Rotherham has made a number of improvements to maternity services and we plan to make even more to ensure that we are providing safe, high quality care for all.

Ante-natal care
2009 brought true our commitment of direct referral to a midwife, to ensure that women and their partners are able to access services for the first time, not only via the GP practice, but also ringing a midwife direct if they preferred. This has been achieved through joint working with the local authority's families' information service and is the first free phone telephone number to be launched in Yorkshire and Humber.

A review of antenatal education has taken place and we plan to start a revised programme of antenatal classes to be delivered across Rotherham during 2010, to ensure that all women and their partners receive this essential education. Classes will be running during the day and also at weekends to really give parents the choice of how to access classes and they will be running from a number of children centres across Rotherham and at the local hospital, more than doubling current resources.

Over the next year we plan to revise the current documentation provided to women and their partners utilising the maternity forums established to ensure that the steer is taken from patients as well as clinicians.
To promote continuity of care, we also aim to ensure that all women have an antenatal visit from their local health visitor.

Women who smoke during pregnancy remain a priority and whilst many investments have been made in this area there is still work to be done. We have revised the current pathway for women who smoke during pregnancy and plan to implement and review this during 2010.

Staffing
To ensure that we have the right staff, in the right place, at the right time to improve health outcomes, 2009 saw the recruitment of 6 community midwifery support workers. We are currently undertaking a further review of staff, to ensure that skill mixes are at an appropriate level. To date, Rotherham is one of the best areas across Yorkshire and Humber for staffing levels. Only by increasing capacity within community and on wards can we start to provide more tailored care to families.

Labour
Over the last year we have worked hard to promote birth options to women and their partners to ensure that 'parents to be' have a choice, not only of location, but also type of birth. The last year has seen a record number of women choosing to have their babies at home. Water births were also an option in 2009 with women being able to choose to deliver in a home birthing pool.

Whilst much has been achieved in just a year, there is still much work to undertake. During 2010, we will have the opening of Rotherham's first birthing pool on the labour ward for women who choose to have their baby in hospital but would like a water birth.

Postnatal Care
We need to support further, our breastfeeding mums, increasing their support mechanisms through peer support and supporting more places in Rotherham to be breastfeeding friendly. Over the last year we have worked hard to ensure that all breast feeding mums are visited every day for the first 5 days by a midwife and over the next year we are planning to expand this support for up to 8 weeks through a mixture of support workers and peer supporters.

2010 will see seamless care between midwifery and health visiting services, to ensure that women and families have better continuity of care as they travel along the pathway.

NHS Rotherham will continue to support mums and dads to be better parents thought closer working with the local authority and aiming to run postnatal parenting groups. We have asked parents what they would like to see in a new parents group and plan to action this by 2011.

Maternity Services Liaison Committee
We have successfully commissioned a maternity service liaison committee (MSLC) from the voluntary sector and commissioners and clinicians have been meeting with service users on a regular basis to ensure that service changes meet the needs of Rotherham women. 2010 will see an expansion of the MSLC, to house forums within a number of children centres across the district. This will ensure that a wider number of women's views are heard when commissioning services.

Maternal Mental Health
A review of maternal mental health services has taken place and actions will be taken forward over the coming year, starting with a pilot to provide support to mothers within children centres antenatally and postnatally.

High impact priorities for children and young people *(see section 1.3 for high impact priorities 2 -4)*
We have used all of the information from our analysis of need, results from consultation and surveys together with a visioning exercise and local intelligence to inform our priority setting, details below of how we will achieve each priority:

1. To halt the rise in infant mortalities – achieved by:
- Implementing the Infant Mortality Action Plan
- Reducing the rate of women that smoke in pregnancy
- Increase breastfeeding initiation and maintenance rates via training and support
- Providing information and education on the importance of eating a healthy diet,

- Ensuring full uptake of immunisation programmes available to women in the preconception period and to babies, children and young people.

How will we measure our success?

Our healthy pregnancy and birth goals are:

By 2011 we will reduce smoking in pregnancy to 15% and, where possible, reduce the numbers of partners and families who are smoking.

By 2012 more than one third of mothers will breastfeed for at least 6 weeks after delivery.

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- *Percentage of mothers initiating breastfeeding (HA Metric)*
- *Early access for women to maternity services (HA Metric)*
- *Percentage of low birth weight babies (HA Metric)*
- *Percentage of mothers known to be smoking at time of delivery (HA Metric)*
- Under 18 conception rates

Transformational Initiative: Increasing Breastfeeding (TI: 5)

Where we are now?

Rotherham has around 3,500 births a year, of these approximately 3,000 births are at Rotherham NHS Foundation Trust (RFT). Currently the breastfeeding initiation rate at RFT is 58% in Quarter 2 (2009/10) which is a 5% rise from 53.9% in 2007/8.

Of those women who begin breastfeeding, we know that a large number stop within the first 2 weeks. The National Infant Feeding Survey in 2005 showed an increase in breastfeeding initiation rates from 76% in 2005 to 69% in 2000. The standardised figures show the greatest increase in breastfeeding initiation between 2000 and 2005 was in England and Wales, an increase from 62% to 67%. The prevalence and duration of breastfeeding also increased across the UK with the greatest increases seen in older mothers, mothers from higher socioeconomic groups and mothers with higher educational profiles (SACN, 2008).

Rotherham has historically struggled to increase breastfeeding rates and our performance has placed us within the lower half of the Region's performance table. We need to increase breastfeeding in line with regional and national averages and achieve the Vital Sign targets set by the Department of Health from initiation through to 6-8 wks. The Vital Signs target has been aligned with the Local Area Agreement target, giving it priority status in both the LA and the LSP.

The RFT and NHS Rotherham are working in partnership to achieve UNICEF Baby Friendly Accreditation in both Hospital and Community settings. We obtained our certificate of commitment in October 2008 and submitted our stage 1 application in December 2009.

Where we will be in 5 years

- All women and families will be presented with up to date, evidence based information to help them make informed choices about breastfeeding.
- All women and families will be supported to successfully initiate breastfeeding and breastfeed for as long as they want to.
- All staff working with pregnant and/or new mums will be trained to be able to effectively support mothers with successful positioning to prevent breastfeeding problems.

Our aim is to achieve UNICEF Baby Friendly Accreditation by September 2011, meaning that women will be supported in breastfeeding following recognised standards and be encouraged to breastfeed on the hospital ward and in the community. We want to make breastfeeding the norm and to work with businesses and community settings to implement breastfeeding policies and empower women to feel they have the right to choose to breastfeed in public areas.

Impact on health and other services

Increasing breastfeeding rates reduces the risk of a number of illnesses for mother and infant. Infants who are breastfed are less likely to develop gastroenteritis, asthma and other respiratory illnesses, otitis media and urinary tract infections, and in the longer term are less likely to have high blood pressure or be diabetic or obese. Mothers who breastfeed are less likely to develop breast or ovarian cancer, and are better equipped to return to their pre pregnancy weight and therefore less likely to have the additional risks associated with obesity.
The NICE costing report details how a 10% increase in breastfeeding rates achieved by UNICEF Baby Friendly Accreditation will result in savings in the cost of treating gastroenteritis and asthma to name a few. Increasing breastfeeding rates would reduce the incidence of otitis media by 28% and admissions to Hospital for gastroenteritis by 6.4%. In reality the cost savings will be much higher than detailed in the report as breastfeeding protects both mothers and babies from a wide range of common illnesses, and cost savings will continue year after year as the costs of maintaining accreditation fall.

How we will make sure that the initiative will impact on the people who most need it?

We will revisit the Health Equity Audit early in 2010 to ensure progress is being made in the most deprived and needy areas and we will target additional resources into these areas. This audit will look at breastfeeding at initiation, 10-14 days and 6-8 weeks. We are working to improve data recording in order to gain a full and accurate picture for Rotherham and the impact of targeted initiatives.

Finance

NHS Rotherham has committed over £350,000 to ensure that breastfeeding rates improve in the future. This money has enabled the employment of an Infant Feeding Coordinator and Infant Feeding Project Worker, purchased breast pumps for all Children's Centres to develop a breast pump loan scheme, will fund the implementation of UNICEF Baby Friendly and an additional 6 support workers covering the antenatal and postnatal support. Further funding will be sought to support the breastfeeding peer support agenda and a social marketing campaign targeting young mums.

How we will get there

- We have set local trajectories to March 2011 looking to increase our initiation rate to 60% and our 6-8 weeks to 32% by 2011.
- NHS Rotherham and the RFT are implementing UNICEF Baby Friendly Standards and have action plans to support their delivery.
- All Health Professionals will be trained to give Breastfeeding support and information in line with UNICEF Baby Friendly Accreditation Standards.

To ensure that the right messages are going out to women we commissioned a social marketing campaign, to review current breastfeeding services and to develop a social marketing approach to service delivery for both breastfeeding and smoking in pregnancy. It is essential that we understand how messages are received by the population so we can allocate resources to have the greatest impact. The research from this campaign will inform the development of a 'chatmag' that is being developed and will be distributed early in 2010/11. Training has also been provided to front line staff and focussed on how to verbally communicate messages to achieve positive results.

We have also commissioned the Be A Star social marketing campaign targeting women aged 18-25 years and their 'influencers' from areas of social deprivation. National and local research suggests that women in this group are less likely to initiate breastfeeding and will stop breastfeeding if they experience difficulties. The insight report collated from local research highlighted local barriers and incentives that influence the decision to initiate and continue breastfeeding and their preferences for support. The research along with pre-testing of the campaign imagery then informed the development of promotional resources. As the imagery is relevant to the target group the materials are set to become a motivating factor in the decision to breastfeed. The campaign was launched in July 2009 and a range of materials are and will continue to distributed in the antenatal and early postnatal period. The campaign will be formally evaluated in 2010/11.

Additional support workers have been recruited to provide additional and intensive breastfeeding support for all women needing support in the early postnatal period (up to 8 weeks). We will work with Children's Centres and Health Visiting teams to increase their roles in providing support to women. We recognise the role of peer supporters and aim to utilise these services effectively developing a robust peer support service across the Borough. We are currently strengthening the peer support service by working with Rotherham Metropolitan Borough Council's Children's Centre Network to increase the number of peer supporters and peer support trainers. In addition to the development of community based peer support we have commissioned a paid peer worker for the postnatal ward at Rotherham Foundation Trust maternity Unit to be in post in 2010. This worker will support the critical transition from hospital to community and to provide the necessary continuity of support. It will also deliver against the NICE recommendation that all women have contact with a peer supporter within the first 48 hours of discharge from hospital care.

The Breastfeeding Friendly Rotherham award scheme will be implemented in 2010 to support mothers to identify premises across the Rotherham district where they will be supported to breastfeed their baby and will outline the minimum standard of services provided by each venue. The initiative will support women to overcome a barrier to breastfeeding and will promote breastfeeding as the normal way for babies to be fed supporting the normalising of breastfeeding in Rotherham.

How we will measure improvement

- ***Vital Signs Target for Breastfeeding at 6-8 weeks****. By April 2011 32% of infants will be receiving some breast milk.
- Achieving UNICEF Baby Friendly Accreditation by Sept 2011.

We will re-establish the Breastfeeding Strategy Group to monitor and progress activity within Rotherham. The draft Breastfeeding Strategy will be completed by November 2008. We have established an Infant Feeding Group within NHS Rotherham to progress activity against the UNICEF Baby Friendly Action Plan and the Breastfeeding Strategy.

We have local trajectories for breastfeeding initiation and 6-8 week targets, and we have targets within local Service Specifications that will be measured and monitored on a quarterly basis. All services being set up have robust outcome and process measures e.g. contacts and outcomes.

Communication Plan (include patient, clinical and stakeholder input)

We have consulted fully with all stakeholders, including, RFT (midwifery), RCHS, Children's Centres, RMBC, Voluntary Sector (GROW) Primary Care, lead Clinicians and also Pregnant Women and young mothers.
We have carried out a social marketing Campaign to ensure the right messages were being put over to young mothers.
A number of Surveys have been carried out (Nationally, Regionally and also Locally) a full Equality Impact Assessment has also been undertaken.

We have a Strategic Maternity Partnership with a wide membership across all agencies. We also have a very proactive MSLC in Rotherham.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Anna Jones	**John Radford**	**Jane Pearson**

Transformational Initiative: Reducing Smoking in Pregnancy (TI: 6)

Where we are now

Yorkshire and Humber Smoking in Pregnancy rates are rising whereas England rates are decreasing (DH, 2006). Rotherham has the lowest percentage of mothers who do not smoke during pregnancy in the Yorkshire and Humber region (YHPHO, 2006). Smoking rates in pregnancy have stayed at around 25% in Rotherham for the last few years.

Infant mortality rates continue to be above the Rotherham and Yorkshire and Humber average and low birth weight rates are projected to rise. Rotherham is one of the 43 areas where we have more than 20 infant deaths in the Routine and Manual Classes over a three year period (2002-04). Smoking in pregnancy is known to be linked to deprivation and age of mother. Therefore we need to target our resources and promotion at these groups to make the biggest health gains.

NHS Rotherham has struggled to reduce smoking rates in pregnancy for a number of years. We have recently increased the capacity of the Stop Smoking Service by 2 WTE maternity specialists and one specialised advisor.

Where we will be in 5 years

We aim reduce smoking in pregnancy to 15% by 2011 and where possible reduce the numbers of partners and families who are smoking.

- All women and families will be presented with up to date, evidence based information to encourage them to give up smoking during pregnancy.
- All women and families will be supported to quit and followed up to encourage maintaining their quit
- All staff working with pregnant and/or new mums will be trained to be able to effectively support mothers with quitting and maintaining smokefree status.
- A variety of settings are used to promote and encourage women to stop smoking during pregnancy.

Impact on health and other services

Smoking in pregnancy is a cause of ill health for the mother and the baby. Babies of mothers who smoke during pregnancy are more likely to be born prematurely, twice as likely to be of low birth weight and three times as likely to die from a sudden unexpected death, and infant mortalities are increased by 40%. There are also the associated

smoking health risks for the mother.

Increasing the Smoking Cessation support available to women during pregnancy and the postnatal period to ensure more women are seen and supported to quit smoking would directly influence the smoking in pregnancy targets and indirectly affect the low birth weight rates and infant mortality target and rates (through relapse prevention in the postnatal period).

The savings from women stopping smoking during pregnancy are difficult to calculate as there are many illnesses to both mother and infant that can be prevented if a woman stops smoking during pregnancy and stays smokefree in the postnatal period. The Department of Health have estimated that £4 is saved on potential treatment for every £1 spent on preventative interventions for smoking in pregnancy due to the benefits to mother and infant (DH, 2006)

How we will make sure that the initiative will impact on the people who most need it?

We are targeting additional resources into these areas, e.g. support workers, and over the next 5 years we aim to have undertaken a robust smoking health equity audit to measure the outcomes of the current interventions and identify further areas for improvement.

Finance

2 Smoking Cessation Specialist Midwives and 1 specialist advisor provide smoking cessation support to all pregnant women and new mothers. These posts are also responsible for the development of the service and training of staff including GPs Health Visitors, Midwives and Children's Centre staff.

How we will get there

Permanent smoking cessation is difficult for many women to achieve and relapse is common, particularly in the post natal period. We know that, of the women who stop during pregnancy many restart soon after, increasing their infant's risk of mortality. To achieve a reduction of women smoking during pregnancy, all women who smoke at booking will be referred into a specialist pathway as a high risk pregnancy. Women can expect 1:1 support from a specialist stop smoking midwife antenatally and up to 1 month postnatally with additional support from a support worker. After this time frame, if a woman and her family still require support this will be via the generic stop smoking service.

For some women in Rotherham stopping smoking during pregnancy is not high on their priority list, however, focus groups undertaken in 2009, have shown that as soon as women see their baby at the first scan, they want to access support there and then. To ensure that we can support this cohort of women, 2010 will see a specialist stop smoking service at the antenatal clinic.

- We have set local trajectories to March 2011 to decrease our smoking in pregnancy rate to 15%
- All Health Professionals will be trained in Smoking Cessation by the specialist midwife in line with best practice standards.
- Smokefree Homes scheme will be implemented in partnership with the voluntary sector.

To ensure that the right messages are going out to women we commissioned a social marketing campaign, which involved local women providing the answers on how to target messages to them. Action is now in place to focus on both breastfeeding and smoking in pregnancy. It is essential that we understand how messages are received by the population so we can allocate resources to have the greatest impact. This learning will be used in the delivery of other maternity messages around preconception care and healthy eating. The social marketing campaign will also provide training to front line staff. The training will focus on how to verbally communicate messages to achieve positive results.

Further work is needed with healthcare professional (GPs, Health Visitors and Midwives) to ensure they have up to date knowledge and the skills to discuss the issue of smoking with women and families. We will increase the provision of smoking cessation in community settings and work with Children's Centres to provide both awareness of the risks associated with smoking in pregnancy and support to quitters.

Additional support workers have been recruited to provide increased smoking cessation support for vulnerable groups, but we recognise that all women need to be supported during this time. We will work with Children Centres' and health visiting teams to increase their roles in providing support to women and families.

Over the next 5 years we aim to have undertaken a robust smoking Health Equity Audit to measure the outcomes of the current interventions and identify further areas for improvement. It is widely accepted that partners, family members and friends have a key influencing role and need to be supported to stop smoking where possible.

Therefore work completed in pregnancy and in the postnatal period will be linked to the Smoking Cessation Service priorities and to initiatives like 'Smokefree Homes'.

How we will measure improvement

Reduce the smoking in pregnancy rates in Rotherham to 15% in line with 2010 Smoking Kills target, (Department of Health, 1998).
We have set local quarterly trajectories and will measure our process by collecting information and performance clinics and meetings. We also have targets within local Service Specifications that will be measured and monitored on a quarterly basis. Services being set up have robust outcome and process measures e.g. contacts and outcomes.

Communication Plan (include patient, clinical and stakeholder input)

At all stages during the proposed changes to services delivery, Stakeholders, service providers and service users are involved. Examples of this includes the Social Marketing Campaign that was implemented 2009

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Alison Iliffe	**John Radford**	**Jane Pearson**

Transformational Initiative: Reducing Teenage Pregnancy (TI: 7)

Where are we now?

In 2000 Rotherham's Teenage Pregnancy Strategy was launched, with the aim of reducing under-18 conception rates by 50% from the 1998 baseline by 2010 and to increase to 60% the proportion of teenage mothers in education, employment or training. For the first five years of the strategy the overall trajectory for under 18 conception rates for Rotherham was downward, with a 2005 final year rate of 49.5 (per 1000 girls aged 15-17), and an overall rate reduction of 12.5% from the 1998 baseline. In 2008 the release of the Borough's 2006 statistics showed an increase in the number of conceptions and in the rate (to 53.9 per thousand): this only represented a reduction of 4.9% over the baseline. However, the final 2007 figures, which were released in 2009 saw a return to the downward trajectory which represented a 10.5% reduction (rate of 50.7 per thousand girls aged 15-17) on the baseline and is comparable with the national rate reduction. In addition, the under 16's rate had reduced by 30%, representing one of the highest reductions nationally. In terms of teenage mothers in Education, Employment and Training (EET) the latest figures (July 2009) show a figure of 16.1% for Rotherham which is 1% less than in June 2008. However, it is positive to see only a 1% decline considering the current economic climate.

Ultimate responsibility for the Strategy and for monitoring the Teenage Pregnancy Implementation Grant resides with the Local Authority but a reduction in the conception rate is a key target for NHS Rotherham (PSA 11a). The Under 18 conception rate target is a Local Area Agreement top 35 indicator and is included in the Yorkshire and the Humber Strategic Health Authority Vital Signs performance measures for PCTs. These two measurement systems require a 27% reduction in 2008-09 and 39% in 2009-10 in order to achieve the planned 2010 target.

NHS Rotherham employs the Teenage Pregnancy Co-ordinator (TPC) and the Strategy is overseen by a multi-agency Partnership Board chaired by a senior representative of the Local Authority. NHS Rotherham commissions a number of services which all contribute to work around Teenage Pregnancy. Key services are School Nursing, Health Visiting, the Contraception and Sexual Health Service (CASH), the Youth service, GP Practices and Public Health. It also works in partnership with RMBC, Rotherham Hospital Foundation Trust and the Voluntary Sector in order to achieve the 2010 targets. Apart from use of/access to contraception, teenage pregnancy remains largely a social issue and very often is a result of deprivation and health inequalities.

Where will we be in 5 years

- To have achieved the 2010 targets, and built on them, or if not, to have established a firm downward trend in Under 18 conceptions in Rotherham (one that at least mirrors the reduction seen in England and Wales and/or our close statistical neighbours).
- To have ensured that all Rotherham Young People In Need have access to confidential advice and information and to sexual health services
- To ensure all Rotherham young people have access to good quality sex and relationships education.
- To have ensured that, both in terms of prevention and support, NHS Rotherham commissions, or supports high quality services for Young People in the Borough

Impact on health and other services

If the agreed 2010 targets are achieved, or even if levels of Teenage Pregnancy are reduced further, the impacts on health will be; a reduction in the number of terminations; a reduction in the numbers of children and young people facing social, economic and educational disadvantage; a contribution to improved performance around breastfeeding; infant mortality and smoking in pregnancy targets; a reduction in levels of children of teenage parents becoming teenage parents themselves.

All NHS Rotherham Commissioned services, will have reduced workloads around support, child protection etc. Examples of services would include: school nursing, health visiting, and midwifery. RMBC and Children and Young Peoples services would also hopefully see a reduced call on their services, e.g. social services, re-integration, Children's Centres, Connexions.

How we will make sure that the initiative will impact on the people who most need it?

By targeting services at those in need and by promoting them effectively, ensuring all services are accredited by the national "You're Welcome" young people friendly quality mark, ensuring mainstream health services address the needs of Young People particularly those most at risk of teenage pregnancy.

Finance

Of the £197k Teenage Pregnancy Support Grant that comes to the Local Authority, NHS Rotherham receives funding to help it deliver on the TP Strategy. NHS Rotherham currently spends £334,000 on termination services, £1.2m on GUM provision and around £734,000 pa on the Contraception and Sexual Health Service (CASH). NHS Rotherham also funds maternity service provision at the RFT. Health Visiting and School Nursing both contribute to prevention and support work but it is not possible to identify the percentage of time and resources spent on Teenage Pregnancy.
In the 2008-09 Operational Plan increased funding (£123k) around contraceptive work has been identified. £113k is recurrent and will overwhelmingly focus on the contraception needs of under 25s and their sexual partners as well as promoting contraceptive awareness with all young people. This will include improved availability and access to Long Acting Reversible Contraception (LARC), expansion of Condom Provision, provision of more Youth Clinics and sexual Health Needs Assessment. £30k for 2008-09 and £80k recurrently from 2009-10 has been identified for the development of an Emergency Hormonal Contraception (EHC) in Pharmacy Scheme. There is also £120k (recurrent) committed to multi-agency working to provide targeted support to young people identified as being at risk of Teenage Pregnancy.

How we will get there

The initial Rotherham Teenage Pregnancy Strategy was refreshed in 2006-07 and a Joint Commissioning Strategy for work to address Teenage Pregnancy has been established. Following the release of our 2006 conception data in early 2008 and the identified targets for the Local Area Agreement and Vital Signs, a renewed focus on areas of weakness within in the current strategy led to the identification of 3 core programme areas for development over the remaining lifetime of the existing strategy (2008-2011):

- **Targeted interventions with high risk young people**: A project piloted using NRF funding in the Maltby area was found to be effective in reducing conceptions in the most high risk girls, using early identification and referral mechanisms. This is now replicated in multi-agency prevention teams in localities with investment from NHS Rotherham and Local Authority partners.
- **Systematic approach to comprehensive contraceptive provision**: A full audit of existing sexual health services is being conducted, including consultation with stakeholders and young people. This will inform commissioning of services, which are benefiting from increased investment in targeted services for most disadvantaged groups.
- **Increasing the role of parents in improving outcomes for young people**: In partnership with the Local Authority and local media, information is being sent to parents and is developing a training programme for parents.

NHS Rotherham still needs to improve the performance of its directly commissioned and provided services regardless of any targeted improvement agreed.

How we will measure improvement

By 2010 to have reduced less than 18 conception rates by 50% from the 1998 baseline and to have increased to 60% the proportion of teenage mothers in education employment and training. It is hard to quantify the process measures as many are not directly the concern of the PCT, but are a joint responsibility with other partners. However, we will see an increased provision of sexual health services for Young People e.g. a service near to all secondary schools and colleges, improved uptake of/access to Long Acting Reversible Contraception (LARC), good quality SRE available in all Rotherham Schools, increased number of services accredited as 'You're Welcome', improved support for Teenage Parents, reduction in rate of Teenage Pregnancy, increased numbers of Teenage Mothers in EET.

Communication Plan (include patient, clinical and stakeholder input)

In 2008, a draft sexual health and teenage pregnancy communications strategy was created in partnership with key agencies contributing to the work of the teenage pregnancy and sexual Health strategies. This resulted in the creation of a resources plan to ensure that all partners receive the required resources to give accurate information and advice to young people and their parents, through the support of information leaflets, posters and other resources.

Implementation of the strategy began with the creation and launch of a strong brand for sexual health work and services in Rotherham, with the aim of increasing the attendance at services in order to increase sexual health screening and uptake of Long Acting Reversible Contraception. Consultation with professionals and young people identified that they were unsure of what services are available and who they were suitable for. In addition, there is a

distinct lack of awareness of some of the sexual health services in Rotherham and feedback from young people concluded that the use of just one memorable brand would help them to recognise sexual health services. With this, the 'S-Word, we need to talk about sex' website and campaign was launched in August 2009. As movies are a popular past time for most young people the campaign uses iconic films such as The Bourne Trilogy and P.S. I Love You, as well as imagery and a play on words to convey our key messages. The viral video has received over 3,000 hits on YouTube and the website has had 2,800 views. A data capture is being used to monitor the demographics of those viewing the site which is proving that our marketing mix is reaching our target audience. The campaign will continue to grow into the next financial year and will be evaluated in September 2010.

All services provided or commissioned directly as part of the teenage pregnancy strategy are required to conduct regular consultation and evaluation with their clients and patients in line with service specifications.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Mel Simmonds	**John Radford**	**Jane Pearson**

1.3 Healthy Childhood

This introduction sets out our overall vision for providing world class children's services in Rotherham

'We all want good health to continue during childhood. In Rotherham we are giving great priority to further improvements to children and young people's services, all aimed at helping children stay healthy, be safe, achieve their potential, enjoy economic well being and make a useful contribution.'

Introduction
We have identified four transformational initiatives relating mainly to improving healthy childhood:

TI: 8 Better mental health services and services for children with complex health needs
TI: 9 Reduce childhood obesity
TI: 10 Improve vaccination and immunisation rates
TI: 11 Integrate services with Rotherham Council

High impact priorities for children and young people
We have used all of the information from our analysis of need, results from consultation and surveys together with a visioning exercise and local intelligence to inform our priority setting, details below of how we will achieve each priority:

1. To improve the sexual health of all children and young people - achieved by:
- Increasing the awareness of common sexually transmitted infections in 11 -18 year olds, ensuring that sexually transmitted infections feature in Sex and Relationship Education lessons
- Reducing the rate of under-18 conceptions by implementing the Teenage Pregnancy Strategy.

2. To ensure that all children and young people have the opportunity to live healthy lifestyles - achieved by:
- halting the rise in obesity and improving advice on nutrition
- reducing alcohol and drug misuse and supporting children and young people wanting to stop smoking
- providing timely / accessible mental health support to children and young people, particularly in young people's settings.

3. To support children and young people with complex needs and continuing health and care needs- achieved by:
- Establishing an integrated SEN and Disability Team, bringing professionals together to provide a more co-ordinated and holistic service
- Developing co-ordinated planning through the use of Early Support and the Common Assessment Framework and providing a lead worker and a flexible 'team around the child'
- Providing support in the community with equipment, palliative care, counselling, short breaks and respite care.

Safeguarding
Improvements to the way the safeguarding children function is organised and delivered have been developed and implemented. These focus on the Local Safeguarding Children Board (the LSCB), and on operational support for staff who have safeguarding responsibilities.
For the LSCB, the LSCB manager will be responsible, in partnership with the LSCB chair, for leading and supporting all the functions of the LSCB, supported by a small team. NHS Rotherham has appointed a nurse consultant to the designated nurse function, accountable to the Director of Public Health. This post works in close partnership with the LSCB manager, and is responsible for ensuring that commissioned services meet their safeguarding responsibilities.

In relation to operational support, a safeguarding support unit has been established, accountable to the Director of Social Care, who has the lead responsibility for safeguarding. The support unit's functions will include:

- support, guidance and leadership for all front line staff
- supervision for complex cases
- administration and management of child protection conferences
- Child Protection Strategy Meetings
- Safeguarding Children Training, both single agency and multi agency.
- Multi Agency Public Protection Arrangements
- Investigation into allegations against professionals (with regard to safeguarding).
- Multi-Agency Risk Assessment Conferences
- custodian of the list of children who are subject to a Child Protection Plan (formally as the Child Protection Register)

The safeguarding support unit will comprise managers and staff who have previously worked in the social services, education and health child protection teams. For NHS Rotherham's part, this will include the senior nurse adviser for child protection, the two nurse advisers for child protection and two administrative staff. In addition two health adviser posts are being made full time in order to improve capacity for supporting front line health staff.

How will we measure our success?

Our healthy childhood goal is: By 2012 more than 9 in 10 five year olds will have full immunisation coverage.

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- All immunisation trajectories in Vital Signs (8 measures)
- Child and adolescent mental health measures in Vital Signs (4 measures)
- Percentage of children in reception year recorded as obese
- Percentage of children in year 6 recorded as obese

Transformational Initiative: Better mental health services and services for children with complex health needs (TI: 8)

Where we are now
Mental Health – NHS Rotherham and partners acknowledge that in order for C&YP to have the opportunity to achieve to the best of their ability they need to have the opportunity to be mentally healthy. Our 2008-11 Child and Adolescent Mental Health Strategy (CAMHS) focuses on developing capacity, improving access and intervening early. Office of National Statistics (ONS) research suggest that at any one time 10% of the local population will have a diagnosable mental health problem, for Rotherham we can therefore estimate that 6200 Children and Young People will have a diagnosable mental Health Disorder at any one time. In 2009 our CAMHS Single point of Access received 1541 referrals for specialist mental health assessment. **Complex health Care -** NHS Rotherham continues to prioritise Children and Young people with Complex Health Care Needs in particular within the areas of: Complex and Continuing Health Care, Palliative Care, Short Breaks / respite and Specialist Equipment. **Co-location –** Our commissioned specialist Children's service for Mental health and Complex Health Care are currently located across a range of in appropriate buildings across the borough, which NHS Rotherham would not class as fit for purpose. In 2010 it is our intention to co-locate these services with a range of complimentary Rotherham Borough Council Children's service and Voluntary sector services, this will see 16 teams being co-located within one campus.
Where we will be in 5 years
Mental Health – Our vision for CAMHS is: '*To have in place multi agency services that work together in the community to support children and young people across health, educational and social settings. Staff will work in universal*

children's services and support every child and young person with their emotional well-being and mental health through the principles of early identification and intervention. For those at risk of developing a mental health disorder or who have been identified with a mental health disorder, specialist services will provide prompt access, planned care and treatment suited to individual need(s)'

Complex health Care – Our aim is ….*'to commission services, which ensure that this identified group of Children and Young People have equitable access and receive high quality family centred, sustainable care, delivered in a setting of their choice'* We will work in partnership with other local agencies to fully identify the needs of this group, and with providers to ensure we develop and implement improvements following needs assessment and requirements from national strategies, (for example, 'Better Care: Better Lives' and 'Aiming High for Disabled Children'). This will ensure that we commission provision of the highest quality to support individuals requiring support across the following areas:

Complex and Continuing Health Care, Palliative Care, Short Break and Respite, End of life Care and Specialist Equipment

Co-location – We will co-locate our Specialist Borough wide services delivered by Health, Social Care, Education and the Voluntary Sector in order to have in place accessible joint specialist service provision, which can be delivered from fit for purpose facilities.

Impact on health and other services

Mental Health - By increasing the knowledge, skills and understanding of mental health issues across all staff working within universal services*, staff will be able to recognise early warning signs of mental health problems within all our Children and Young People, allowing for appropriate support at the earliest possible opportunity, between September 2008 and September 2009, 350 Universal staff were trained in different elements of Child Mental Health by NHSR Commissioned services. The impact of this should see a reduction in the numbers of Children and Young People needing support within specialist mental health services.

Where a child or young person does require a specific intervention from specialist CAMHS, through increasing staffing levels over the past 18 months both in Tier 2 and Tier 3 CAMHS we can ensure that services deliver provision up to the age of 18, that they become more accessible in terms of wait for a service and consequently C&YP improve their emotional health in a more timely manner. This over time should also reduce admission to inpatient mental health provision for C&YP.

*Any front line service that works with C&YP, for example, GPs, Health Visitors, School Nurses, School Staff, Youth Workers.

Complex health Care – For children and young people with life long or life limiting conditions, further developing the services described, will allow them to receive an easily accessible service, delivered in a place of their choice. This choice will empower the individual and their carers to lead as normal a life as possible while dealing with their condition, impacting positively on both their physical and mental health.

By catering for the health needs of this group of Children and Young People effectively, we will be able to ensure that wherever possible they can access mainstream services as desired, for example, education. By having in place a range of quality, flexible, proactive community services we can ensure that where Children and Young People need to be discharged from hospital, this happens in an efficient manner ensuring that beds within our local paediatric wards are not blocked.

Co-location – Through co-locating Health, Education, Social Care and Voluntary Sector services within one building, commissioned services will have opportunity for joint working to meet the needs of C&YP and their families, new facilities will also make these services more accessible and give opportunity for services to develop new ways of working making them more efficient and improve quality.

How we will make sure that the initiative will impact on the people who most need it?

Mental Health – Through recently developing the CAMHS single point of access any individual can refer for a Child or Young Person to have an initial assessment, and in depth work has taken place to promote the service. Through skilling up our universal staff workforce we should also raise the ability of individuals to identify mental health problems within Children and Young People allowing them to offer support or refer appropriately.

Complex Health Care – No Child with complex health care needs registered with a Rotherham GP that have either life limiting or long term conditions will be excluded from receiving a service. Enhancement in capacity of community nursing, now allow further choice of where to receive support.

Co-location – The co-location of services will enhance access to provision for Children, Young People and their families, enhancement of current delivery spaces will allow new types of interventions to be offered, the development of a new Short Break facility within the development will also ensure C&YP with complex health needs can access short breaks away from the home.

Finance

Mental Health - The allocated spend by NHS Rotherham's Commissioners for the core Tier 2 and Tier 3 service is £2,200,000.
NHS Rotherham also commissions a Tier 4 inpatient service at a cost of £190, 000 per year, which will expand in 2010 to meet need up to the age of 18. In 2009/10 £250,000 was identified to commission key developments for CAMHS.

Complex Health Care - The current NHS Rotherham Commissioned Service for Complex Needs has a value of £575 000. There are also packages of care for individual children totalling an additional £230 000. An additional allocation of £100 000 for specialist equipment and a further £116 000 to enhance Short Break Service is also allocated to the Complex Care Team service.

Co-location – The development to co-locate Borough wide Children's service will cost £2,967,000.00

How we will get there

Mental Health – In 2010 we will continue to work on delivering the ten key development areas highlighted with the CAMHS strategy 2008-11, in particular we will focus on:

- Continue to develop services which are accessible to local communities i.e. Children's Centres and other settings
- Develop methods of working to ensure a good interface between tiers 2 & 3, 3 & 4 and Children & Adults.
- Develop a focused needs assessment specifically covering the needs of vulnerable groups i.e. BME, Asylum Seekers & Refugees and Looked after Children
- There will be no 16-18 yr olds admitted onto adult inpatient wards into inappropriate environments.
- We will commission Tier 4 provision to ensure that needs are met up to the age of 18.
- CAMHS providers will work with Voice & Influence to develop a common user/carer consultation and involvement framework that is equitable and centrally managed
- We will ensure CAMHS services achieve 'You're Welcome' accreditation.
- We will relocate services to create a central base and develop access to services within all communities
- We will Investigate links with Children's Centres and family support workers to deliver services in the community
- We will develop robust policy and protocols for effective transition between services

Complex Health Care –
Specialist Equipment - Although substantially improved throughout 2009 we will continue to develop our processes for purchasing, storing, tracking and recycling specialist equipment to ensure we are obtaining best value for the £100,000 annual investment being made by NHS Rotherham, we will also focus on the commissioning of Wheelchair services.
Palliative Care – Having developed the capacity of our Community Children's nursing team in 2009 we will continue to work closely with them to ensure that quality palliative care is offered in the community. In 2010 we will commission Bluebell Wood children's Hospice to support with Short Breaks and respite care.
Continuing Care – Using the draft National Continuing Care Guidance criteria, NHSR and partners are currently developing a clear local continuing care approval process. NHS Rotherham is committed to meeting the needs of Children and Young People who require continuing care packages.

Co-location – In 2010, working with our partners we will refurbish a former Comprehensive school site in order to co-locate all our Borough Wide Specialist services, 16 teams will be co-located within one Children's campus.

How we will measure improvement

Mental Health
Milestones - Main developments to be achieved over the next three years 2008 – 2011
Process Measures – Monitor activity against Operational Plan development allocations, NHS Rotherham have updated all service specification for core CAMHS commissioned services, these specifications have clear monitoring and performance information requirement for providers and will be monitored quarterly.
Outcome measures - Children and Young people receive the right service in a timely manner ; Availability of specialist services are improved; Mental Health problems are identified at the earliest possibility opportunity ; Achievement of National CAMHS Indicator ; Children and Young People can receive the service in a setting that is suitable for them. ;Where necessary Young People Transit to adults in planned phased approach.

Complex Health Care -

Milestones - Develop Specialist Equipment/Wheelchairs by end of 2010, commission Hospice Service by April 2010
Process Measures - As part of the additional development allocations the Strategic Planning Department within NHS Rotherham have updated all service specification for our core commissioned services, these specifications have clear monitoring and performance information requirement for providers and will be monitored on a quarterly basis.
Outcome measures - Improved access to specialist equipment, efficient discharge from Hospital Services, access to Hospice service to meet need, choice of where to access provision from, choice of Short Break Provision on offer for children with complex needs.

Co-location –
Milestones – Complete refurbishment of Building by November 2010
Process Measures – Have in place a clear Business and project plan for delivery of the refurbishment and also workforce development linked to the refurbishment
Outcome measures – Improved access to services, opportunities for joined up service delivery to Children, Young People and their families.

Communication Plan (include patient, clinical and stakeholder input)

Mental Health – Input of stakeholders through CAMHS Strategy and Partnership Groups and CAMHS development groups. All Service specifications have the requirement for Services to consult with those using their services. Clinicians hold key position on partnership groups.

Complex Health Care – Input of stakeholders through Partnership Groups and development groups. All Service specifications have the requirement for Services to consult with those using their services. Clinicians hold key position on partnership groups.

Co-location – All stakeholders have been consulted through a three phase approach (sharing plans, visiting the site, approving design), Clinicians have been given opportunity to feed views into clinical spaces, C*YP have been consulted on their requirement and will be given further input into the build design.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Ian Atkinson	**Kath Atkinson**	**Steve Burns/Judy Dalton**

Transformational Initiative: Reduce Childhood Obesity (TI: 9)

Where we are now

60% of the local adult population is currently classified as overweight (Body Mass Index >25) or obese (BMI>30). The most up to date figures for childhood obesity are those collated as part of the National Child Measurement Programme during 2008/09. Levels of childhood obesity in Rotherham are higher than the national average. Nationally, of those children measured, 13.2% of 4-5 years olds are overweight with 9.6% obese. Of 10-11 year olds 14.3% are overweight, and 18.3% obese. In Rotherham at 4-5 years 24.4% are overweight and obese and by 10-11 this figure has risen to over a third at 33.3%. This was a very slight, but not statistically significant decrease compared to 2007/08 figures for Rotherham.

Where we will be in 5 years

In Rotherham, childhood obesity in Year 6 (NI 56) is a Local Area Agreement (LAA) target for 2008-11, whilst still performance managing and measuring both the Year 6 and Reception year obesity targets as part of the NHS Operating Framework **(Vital Signs)** through the National Child Measurement Programme (NCMP).
Good performance is defined as a minimum of 85% of eligible pupils being measured and a reduction in the proportion of obese children over time, initially showing a reduction in the rate of increase in the proportion of obese children.

Impact on health and other services

It is likely that within a few years, being overweight or obese will overtake smoking as the major cause of preventable ill health. Obesity is an important risk factor for many chronic diseases, including heart disease, stroke and some cancers. It is a major cause of Type 2 diabetes and the psychological and social burden of obesity can be significant. Social stigma, low self-esteem and a generally poorer quality of life are common experiences for many overweight and obese people. Rotherham PCT recognises being a healthy weight, eating healthily and being physically activity are important to prevent overweight and obesity in the short and longer term. The PCT have chosen to invest in a range of obesity services including Carnegie Clubs, a multi-disciplinary team of health professionals and Carnegie Residential Camp to support children, young people and families over the next 3 years to have a healthier lifestyle and healthier future. Evidence from these planned interventions show that if this is successful, this investment will pay for itself by preventing overweight and obesity and the ill health associated with it. We are investing now to save in the future.

If we do nothing the costs and activity for a wide range of activities in both primary and secondary care will continue to rise. Tackling obesity will reduce the prevalence and improve outcomes for a range of other long term conditions such as diabetes and cardiovascular disease. We will increase the appropriate prevention and treatment of obesity in primary care, but we acknowledge that because of the overall increasing prevalence there will continue to be substantial numbers of obese children and young people that will require management by secondary care specialists and due to current unmet need it is unlikely that we will see significant overall reductions in direct secondary care activity for obesity.

How we will make sure that the initiative will impact on the people who most need it?

Obesity is not equally experienced across all sections of the population. Some communities have a higher risk of becoming obese. These include:

- People in lower socio-economic groups, especially women.
- Some ethnic groups.
- Children and young people who have at least one obese parent.
- People with physical or learning difficulties.

The greater prevalence of obesity among poorer social groups implies that efforts to counter health inequalities must take account of obesity; conversely, action on obesity must take account of socio-economic factors. Obesity is not exclusively a matter of social class and inequality, but a society wide epidemic. However, efforts to combat obesity in lower-income groups will have positive consequences for both health and inequality.

Finance

We have no information which quantifies the total current spend on childhood obesity. The costings for Tiers 2 to 4 childhood obesity services are detailed blow:

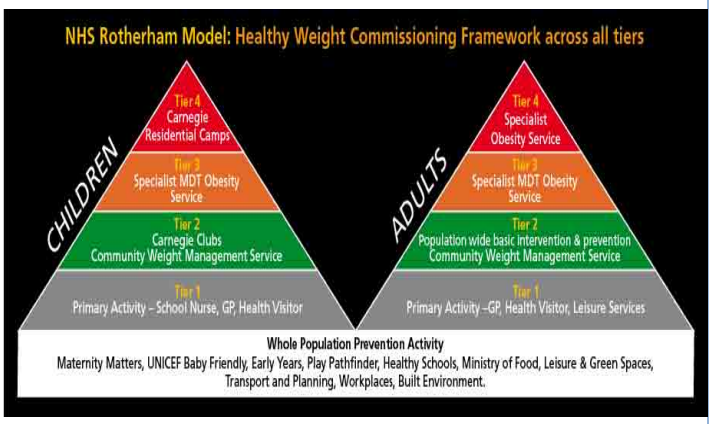
Table 1. NHS Rotherham Commissioned Child Obesity Services

Tier		**3 year numbers**	**Total 3 year cost**
Tier 2 PCT Commissioned	Carnegie Clubs	879 successful clients	£510,000 (£170,000 pa)
Tier 3 PCT Commissioned	Specialist MDT (Rotherham Institute for Obesity – RIO)	600 successful clients	£1,545,000 *(£515,000* pa)
Tier 4 PCT Commissioned	Residential Camps (Carnegie International Camps)	62 successful clients* *31 per year for 2 year contract	£300,000 (£100*,000 pa)*

How we will get there

The response to increasing numbers of overweight and obese people in Rotherham has the following elements:

- **Treatment:** developing treatment services to help obese people to reduce their weight.
- **Prevention**: assisting those of healthy weight to maintain this; preventing the overweight from becoming obese.
- **Environment:** Developing a leptogenic environment, i.e. one promoting healthy lifestyle choices.
- **Adaptation:** Ensuring that existing services can respond to the needs of the increasingly obese population.



In all of these areas a partnership approach is vital. NHS Rotherham has established multi-agency groups to develop strategic action plans for childhood and adult obesity, currently in draft. This will be finalised in the coming months and full consultation has been undertaken before pursuing sign off through relevant processes.

The Rotherham Healthy Weight Action Plan focuses on activity in line with national Healthy Weight, Healthy Lives and NICE Guidance. The action plan focuses on the preventative activity needed in Rotherham to increase the proportion of the population who are classed as having a healthy weight BMI. The 6 main areas of focus are:

1. Promoting child health
2. Promoting healthy food

3. Building physical activity into our lives
4. Supporting health at work and providing incentives more widely to promote health
5. Personalised advice and support
6. Strategic development

How we will measure improvement

Tiers 2 to 4 of the Child Obesity Services above have now been procured through a tendering process. Services commenced in April 2009, with a formal launch of the services at NHS Rotherham's Protected Learning Time events in September 2009.
Work also commenced in April 2009 with NHS colleagues and partner agencies to map preventative activity against NICE guidance and Healthy Weight Healthy Lives Guidance. The Rotherham Healthy Weight Action Plan, currently in draft, focuses on preventing obesity. Each accountable lead within this document will be responsible for reporting on progress against the actions for which they are responsible for.

Process Measure – Performance management systems have been established to monitor outputs of each newly commissioned service on a quarterly basis. Service managers are also required to attend monthly Performance Update Meetings with NHS Rotherham to ensure that each service continues to perform against the service specification. The Obesity Strategy Group (meets 6 monthly) of which performance management is a standing agenda item, a Weight Management Services Group currently meets quarterly, and an Obesity Prevention Group will meet every quarter once the Healthy Weight Action Plan has been approved and endorsed. Various sub groups feed into these groups, namely – RMBC Officers Group, National Child Measurement Programme (NCMP) Group etc.

Outcome measure – Targets have been set for each service which are broken down into annual and quarterly targets where applicable. The overall targets for each service are as follows.

Carnegie Club - 1465 individuals attending Carnegie Clubs with 879 achieving at least weight maintenance (by the end of the course) and 75% attendance by 2011/2012.

Specialist Child MDT - 600 individuals attending the service at least of achieving weight maintenance by 2011/12

Residential Camp - 31 individuals per annum attending a Residential Camp with all achieving at least weight management (by the end of the camp, as defined by appropriate measures including BMI, weight, waist circumference and centile. In addition to these measures services are required to provide evidence of outcomes on request in line with service specifications which demonstrate effectiveness, quality and service user experience.

Communication Plan (include patient, clinical and stakeholder input)

A Weight Management Strategy Communications Group is chaired by NHS Rotherham's Head of Communications and meets as required to produce coherent and coordinated messages across the commissioned services and strategy partners. A considerable amount of positive media attention has been paid to the Child Obesity Services including national coverage on the Carnegie Camp and Carnegie Club on programmes such as GMTV and The One Show. The formal opening of Rotherham's Institute of Obesity attracted considerable media attention and was coincided with National Obesity Week in November 2009. All of the above interviews / new pieces included service user input and views.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Gillian Harrison	**John Radford**	**Judy Dalton**

Transformational Initiative: Improve vaccination and immunisation rates (TI: 10)

Where we are now

NHS Rotherham's immunisation programme performance is monitored annually. The immunisation is part of 'VITAL SIGNS' and challenging yearly uptake rate targets have been set, rising year-on-year. A challenge has been presented with the Vital Sign Target increasing by 5% in April 2010. The vaccine coverage targets to be achieved by 2010-2011 are: 95% for primary immunisations, and 90% for pre-school boosters. Rotherham's immunisation rates have vastly improved since Quarter 1 of the last period. The latest data shows Rotherham on track to succeeding the target in two thirds of the vaccination areas. With current figures a third of these areas are set to exceed the targets. Despite the improvement there is still some way to go with 23% of practices below the 90% target for childhood immunisations and 46% of practices below the 90% target for pre-school boosters.

A review of the immunisation programme which identifies issues and gaps has been undertaken. Some progress has been made for example:

- Short-fall in staff to undertake mandatory V&I training has been addressed in conjunction with the local Health Protection Unit.
- The HPV programme planning is progressing well and a V&I team has been appointed to address shortfall in capacity to deliver this programme.

However there is still work to be done. Performance Clinics will be held to address problems, and regular meetings will be held to ensure issues are addressed as quickly as possible.

Where we will be in 5 years

Within 5 years we will:

- be reaching and/or exceeding targets for all childhood immunisations and have the flexibility and capacity to respond to new or catch up additional campaigns.
- have a coordinated approach to V&I with systems in place to review and update policies and procedures on a regular basis to ensure safe evidence based practice.
- have a well trained workforce, able to advise the public on V&I in order to ensure informed decision making and to improve uptake.
- provide high quality public information in a variety of metrics to support staff working with the public.
- have a co-ordinated and well trained workforce who will take a joined up and flexible approach to childhood V&I. This will be supported through robust protocols and procedures.
- have in place a systematic client centred approach to follow-up of defaulters. We will keep QOF exceptions to a minimum and clearly record if families decline to have their children vaccinated based on informed consent.
- improve IT and data systems in order to support more efficient call and recall systems and provide quality information.
- record equality information as routine and this information will help identify any inequalities in uptake.
- limit the number of exemptions and will clearly record if families decline to have their children vaccinated based on informed consent.

Impact on health and other services

Immunisation is a key intervention for health improvement, protection and reducing health inequalities. In order for the population to be adequately protected against preventable infectious diseases, coverage of around 90% is required. In the light of outbreaks of vaccine-preventable infections such as measles and mumps in the region, poor immunisation rates are a health hazard that needs to be urgently addressed.

Comparing ourselves to other areas in South Yorkshire, we have higher incidences for Measles, Mumps and Rubella according to the notification information presented to the HPA January – June 2008. Outbreaks of vaccine-preventable illnesses can and have occurred amongst children and young adults who are not protected. The subsequent ill-health leads to time off school and/or work for the patients, parents and carers. In addition, complications of these illnesses may be long-term such as hearing loss and developmental delay.

How we will make sure that the initiative will impact on the people who most need it?

Deprivation and population mobility affect vaccine uptake in certain communities. Evidence shows those at risk of low uptake of immunisation experience barriers to access. Social inequalities significantly affect immunisation rates: uptake tends to be poorer amongst children of young single mothers, mothers who have lower educational attainment and income, and children of large families. Uptake is also poor for children of travellers and children in care. By achieving a 90% coverage rate we will increase overall protection. We will need to improve our equality data recording to enable us to review uptake for specific population groups as well as geographical update.

Finance

Payment to GPs is currently under review as part of the V&I performance review. Currently we are unable to identify payment for V&I as it is part of the global sum. We are unable to identify specific spending on V&I from within NHS Rotherham Community Health Services. We currently invest £87,000 a year to support additional staff to deliver the HPV vaccination programme.

How we will get there

- By developing a more joined up systematic approach to Childhood V&I.
- A V&I co-ordinator has been appointed within Public Health to oversee and performance manage the programme in order to achieve the target uptake rates.
- Performance clinics involving all stakeholders will be arranged to identify further action required.
- A Rotherham V&I Steering Group will be reinstated in the Spring; membership will include all key stakeholders (including HPA representation). This will link strongly to the South Yorkshire and Yorkshire & Humber V&I Group.
- The Child Health Systems moved to SystmOne in September 2009. Allowing for an embedding period, this will aid the improvement of data collection and information.

- Work to rectify the call / recall and data systems is ongoing.
- Primary care providers and other professionals involved with immunisations will continue to proactively promote immunisations to families.
- We will revisit the role of Health Visitors with an element of V&I training to support GP practices in following up on defaulters.

How we will measure improvement

Process measures will be identified though the performance clinic action plan which will be monitored initially monthly then quarterly via the Infection Control Committee.

Immunisation Rates in Vital Signs (8)* as follows:

Immunisation	***2009-10***	***2010-11***
Age 1 DTaP/IPV/Hib	***92%***	***95%***
Age 2 (PCV)	***80%***	***85%***
Age 2 (Hib/MenC)	***85%***	***90%***
Age 2 (MMR)	***88%***	***95%***
Over 5's		
Age 5 DTaP/IPV	***85%***	***90%***
Age 5 (MMR 2)	***85%***	***90%***

Communication Plan (include patient, clinical and stakeholder input)

It is essential that all stakeholders are communicated with clearly and the roles of the Commissioner, RCHS, Child Health and GPs are communicated.

LEAD MANAGER	**LEAD DIRECTOR**	**LEAD CLINICIAN**
Kathy Wakefield/Kelly Clayton	**John Radford**	**Russell Brynes**

Transformational initiative: Integrate services with Rotherham Council (TI: 11)

Where we are now

The government requires the establishment of **children's trust arrangements**, where we are expected to work as if we are one organisation, focusing on five core priorities:

- A shared vision and integrated strategy
- Inter-agency governance
- Joint commissioning
- Integrated processes for information sharing and assessment
- Integrated front-line services.

The proposed model for the integration of Children and Young Peoples' Services in Rotherham has been carefully considered. Its' aim is to ensure that our front-line teams work seamlessly together under one unified management structure and are easily and locally accessible to children, young people and their families.

We have successfully co-located all community staff across the 7 geographical areas in Rotherham.

Where we will be in 5 years

Our aim is to improve outcomes for children, young people and their families by bringing together services from health, social care and education into seamless, locally accessible services. By doing this we will:

- deliver world-class, locally accessible services to improve outcomes for all children and young people
- shift the balance of service delivery towards prevention and early intervention wherever possible
- create multi-disciplinary teams at every level within the structure including primary care
- deploy existing staff in a creative and productive way, using existing resources differently to have the best impact.
- Improve paediatric expertise in primary care to ensure better access to staff trained in the needs of children
- Improve access via the existing free-phone number, text and e-mail service hosted by the local authority family information service.

How do we get there?

This TI will be included within our commissioning intentions around 'Transforming Community Services' and will be subject to detailed discussions with RMBC, RCHS and other Health organisations. There will be significant 'staff employment' issues to be thoroughly discussed.

How we will make sure that the initiative will impact on the people who most need it?

We believe that by working together more closely we can deliver a brighter, better future for every child and young

person in Rotherham. The Children Act 2004 requires us to establish structures and processes that enable multi-agency governance, commissioning and delivery of services for children, young people and their families. At the heart of this is a drive to genuinely improve outcomes for every child and particularly for those who are most vulnerable and at risk. The aim is for every child, whatever their background or their circumstances, to have the support they need to meet our aims.

Finance

This TI will be delivered within existing resources. The detail will be a critical part of discussions with RMBC, RCHS and other Health Organisations.

How we will measure improvement

NHS Rotherham will ensure that specific statutory duties are being met through a detailed agreement with RMBC about the health services to be provided by the new integrated service. These include a comprehensive service specification and introducing new performance management and accountability arrangements; these will ensure that the terms of this agreement are fully met to the satisfaction of NHS Rotherham's Board. In addition, RMBC and NHS Rotherham will agree detailed arrangements around both clinical and information governance, thereby building on the robust systems and processes already operated by NHS Rotherham.

Communication Plan (include patient, clinical and stakeholder input)

There has been a full Consultation with all Stakeholders in 2008. This included NHSR, RMBC, RCHS, the Voluntary Sector, SY Police, Primary Care and Children & Young People. All Stakeholders will participate in any future discussions

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Sarah Whittle	**Kath Atkinson**	**Russell Brynes**

1.4 Staying Healthy

"Staying healthy as we become adults, and throughout adulthood is crucial to our quality of life and our life expectancy. There is overwhelming evidence that our lifestyles i.e., smoking, low levels of physical activity, alcohol, poor nutrition, can cause serious illnesses such as diabetes, heart disease and cancer."

Introduction
We continue to take forward the five transformational initiatives which are central to improving peoples' life expectancy and quality of life:

TI: 12 Reduce numbers of smokers
TI: 13 Improve primary care services for alcohol misuers
TI: 14 Improve access to sexual health services
TI: 15 Reduce adult obesity
TI: 16 Follow up people identified at risk through the NHS Health Check

Our continued commitment to these initiatives will support the trend in increased life expectancy, and will also ensure that peoples' additional years are lived as actively as possible and are free from illness and infirmity. The section also covers our approach to health inequalities, enabling public health actions and other public health priorities not included as transformational initiatives.

Key national documents that have informed our plans are; '*Choosing Health'; 'Our Health, Our Care, Our Say'; 'Health Inequalities: Progress and next steps', 'High Quality Care for everyone'* and '*Healthy Ambitions*'. This strategy will be supported by the continued implementation of the following local strategies: *'Rotherham Public Health Strategy, (2006), 'Rotherham Community Strategy and Local Area Agreement' (2005-2011), 'Rotherham Health Inequalities Action Plan' 2007-2010,* and *'Rotherham Neighbourhood Renewal Strategy' 2004-2010.*
Improving the health of the people of Rotherham is a priority, not only for NHS Rotherham but also the wider community in the Borough. Public health features strongly in Rotherham's Local Area Agreement, the 'Alive' theme of the Local Strategic Partnership and in the plans of key partners such as RMBC, RNHSFT and RDASH. Many of the initiatives described in other priority areas in this document are also key to staying healthy for example, promoting mental health, reducing infant mortality, promoting healthy childhood and promoting health through primary care services.

Reducing health inequalities
We have reviewed our life expectancy/health inequalities action plan and fully integrated the revised initiatives within this strategy. There is overlap with the long term conditions, intermediate care and emergency care programme and a number of smaller scale initiatives will be developed during 2010/11. We have also identified some areas for focused social marketing activity in the coming year. We will also review our programme of equity audits to support the monitoring and evaluation of these initiatives.

Enabling public health actions
We will continue to improve the use of **intelligence** for commissioners and the public and will use a wide range of resources to help us understand our population better. We will extend our use of Social Marketing methodologies to ensure that the information that we provide for the public and patients is targeted and appropriate to their needs.

As part of further analysis of Index of Multiple Deprivation data we will identify actions targeted at the most deprived areas in Rotherham. Although specific programmes and initiatives are important our main resource in supporting people to remain healthy are the existing staff of all agencies involved with public health in Rotherham. We will ensure that capacity is built within service provision (including our partner organizations) and communities to support healthy choices. This will be supported by public and patient information being available to raise awareness and signpost people to appropriate support. We want to

continue to see all staff applying an ***'every contact counts'*** approach when working with vulnerable patients – for example, staff knowing how to signpost people to weight management, smoking cessation programmes, debt advice or Affordable Warmth interventions. This will be delivered through training and a commitment from front line staff to a "one stop shop" approach.

Screening

Good uptake of evidenced based screening is an important part of staying healthy.
We will concentrate on the following areas:

- *Maximising the health promoting opportunities of over 40 cardiovascular risk assessment (NHS Health Check)*

A Locally Enhanced Service has been put in place to deliver NHS Health Check, and we are determined to make the most of the general health promotion opportunities that will arise as a consequence of this programme.

- *Maximising the uptake of existing screening programmes*

Rates of cervical screening are falling in Rotherham. We are addressing both by working directly with women in the screening population and also by highlighting this in the primary care annual reviews for practices with particularly low rates. We will ensure that Rotherham has a high uptake of colorectal screening and will be introducing a new programme to screen for Abdominal Aortic Aneurysm this year.

Reducing harm from Substance Misuse

The HNA shows that Rotherham has a significant problem with regards substance abuse but also a strong well performing Drugs Action Team. We are currently working to a plan to target the maximum number of problem drug users. We will continue to invest in prevention, harm reduction and treatment for substance abuse problems. Rotherham has a significant alcohol problem which contributes to a number of our health and social issues. The transformational initiatives will ensure adequate treatment capacity, and we will work with partners on delivering the local strategy.

Physical activity

Promoting increased levels of physical activity is key to several sections within the strategy (e.g. CVD risk reduction, diabetes, obesity, children's and young people's health) and we will continue to work with our partners to provide and promote the use of high quality, affordable activities for Rotherham residents.

Improving Workplace Health

Rotherham has high levels of worklessness due to ill health and we will continue to promote workplace wellbeing and provide support to individuals and employers to keep people in work healthy and productive. There are a number of initiatives that support workplace wellbeing including Rotherham Occupational Health Advisory Service (ROHAS) and the Condition Management Programme which seek to reduce sickness absence and encourage employers to make adaptations to support people back into work following a period of sickness.

How will we measure our success?

Our staying healthy goals are:

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- We will report key health outcomes for Rotherham NRS target areas so we can show improvements in the most deprived 25% of Rotherham
- We will develop a metric that reliably triangulates available data on smoking prevalence
- *Obesity status of GP registered population aged 16 and over (HA Metric)*
- Sexual health targets for Chlamydia, gonorrhoea and access to GUM
- Number of GP practices delivering alcohol related treatment

- *Rate of hospital admissions for alcohol related harm (HA Metric)*
- CVD mortality rate
- Cervical and breast cancer screening coverage rates
- Cancer mortality rate

Transformational Initiative: Reduce number of smokers (TI:12)

Where we are now
Smoking is a national and local priority. It is a major contributor to ill health and health inequalities in the Borough and results in 500 tobacco related premature deaths each year. We have 3 ways of estimating smoking prevalence, attribution from national data, using GP recorded data and data from the 3 yearly Rotherham lifestyle survey. GP data and attributed data suggest that prevalence is above national average at around 26%, in the most recent Rotherham lifestyle survey 24% of respondents smoked. Smoking rates in the the most deprived parts of the Borough are higher and in some areas almost 50%. Of particular concern is the number of under 16s who smoke (9% in2009) and the 33% of pregnant women who present to ante-natal services as smokers. Rotherham's Specialist Stop Smoking Service has continued to grow and develop and we continue to set them challenging targets. Our Vital Signs target is 1,468 quitters in 2009/10, but for World Class Commissioning we have set a stretch target of 2,550quitters. The implementation of smokefree legislation in workplaces and public places and action on under-age sales has been a success with high levels of compliance locally and the most recent Rotherham lifestyle survey data described in the Strategic Intelligence Review section shows an encouraging drop in prevalence since we went smokefree. However evidence elsewhere shows that if the people of Rotherham are to experience the same level of health as other parts of the country, smokefree legislation has to be backed up by a comprehensive tobacco control programme.
Where we will be in 5 years
By 2012 smoking prevalence will be at least as low as the national average. This will involve further substantial reductions in smoking across the Borough with a particular focus on routine and manual workers, pregnant women and children.
Impact on health and other services
Continuing to reduce smoking rates is essential if the we are to achieve our life expectancy target. In addition less smoking will result in fewer adult hospital admissions, better outcomes from pregnancy, better health in children and reductions in health inequalities. In addition to the impact on health and health services, fewer smokers will result in economic benefits to families and individuals and substantial savings to the local economy from reduced time off work and premature deaths from smoking.
How we will make sure that the initiative will impact on the people who most need it?
There are wide ranges in smoking rates between different parts of the borough and different population groups. We have commissioned specific development of the Stop Smoking Support Service to address the needs of low-income groups, pregnant women and young people. We are investing in Social Marketing activity to ensure that our services are marketed effectively to those sections of our community who have the greatest need. We will continue to produce annual equity audits attributing quit rates to practices, pharmacists and clinical services who initiated referrals and to practice populations.
Finance
Much smoking advice is given by generic health service staff such as primary care staff, midwives and health visitors and so is not specifically costed. We will review existing expenditure on stop smoking initiatives to ensure they deliver value for money. Specific investments include: a tobacco control public health specialist, a commissioned stop smoking support service and a primary care locally enhanced service. These cost £600K per year. In the 2008/9 we allocated an addition £50K for a smokefree homes project and additional smoking cessation services in pregnancy. We have also invested non-recurrent funds in a social marketing project.

How we will get there

We will implement a broad strategy through refreshed partnership structures to address tobacco control in line with new national guidance (due to be published early in 2010 and the targets identified in '*Smoking Kills'*.

Making it harder to start smoking

- Further work to reduce the number of children and young people who start to smoke, particularly targeting schools High level partnership action to tackle counterfeit, smuggled and under aged sale of tobacco
- Extension of the Smokefree Homes programme

Making it easier to stop smoking

- Ensure our Stop Smoking Service is accessible to all smokers Industrialise brief interventions across all partners and major employers
- Active referral of all smokers from all occupational health services
- Increase the number of smokers that quit prior to hospital admissions for surgery through 'stop before your op'
- Implement Smoking Cessation in Practice (SCIP) toolkit across independent contractors
- Deliver state of the art smoking in pregnancy service, ensuring that all women who smoke are referred to a specialist Stop Smoking Midwife at their first visit to antenatal services
  Open

High level of Communication and Marketing

- Focus marketing and communication on targeted groups
- Promote the local stop smoking service, dovetail with national campaigns

How we will measure improvement

The stretch target is 2550***smoking quitters**** p.a. reported in the monthly Board reports.

The most important outcome is a reduced smoking prevalence; we will continue to use a number of sources such as GP data and Lifestyle Surveys to measure our progress

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Alison Iliff	**John Radford**	**Jayne Pearson, Mike Foster**

Transformational Initiative: Improve primary care services for alcohol misusers (TI: 13)

Where we are now

The HNA sections showed that alcohol misuse is responsible for around 10% of all health problems. In addition there are major impacts on the economy and wider social issues such as social cohesion. Yorkshire and Humber has the highest levels of binge drinking and the highest percentage of alcohol dependence of any region (5%; national average 3.6%). In the 2005 Rotherham lifestyle survey 23% of respondents said they had drunk more than the recommended units of alcohol in the previous week, 14% felt ashamed or guilty about their drinking and 15% felt they should cut down.

In addition Rotherham has been identified within the region as having one of the highest rates of alcohol related hospital admissions (NI39).

As part of its role with the Safer Rotherham Partnership, NHS Rotherham are involved in the delivery of the cross agency Alcohol Harm Reduction Strategy.

Where we will be in 5 years

- All GPs will be screening patients for alcohol consumption and identifying those at risk of harm from drinking.
- The majority of practices will be offering a range of service in-house to deal with these issues ranging from brief interventions, which are an evidence based practice to reduce the harm from drinking without the need for referral to a specialist.
- Some GPs will be offering a full range of services under the local enhanced service level agreement to eliminate any need for referral to secondary care services apart from in the most extreme circumstances.
- Waits for specialist secondary care interventions will be maintained at no longer than 11 weeks (also RDASH target).
- There will be an effective range of screening methods in place in the Accident and Emergency Services to identify intensive users of the service and ensuring that onward and appropriate referrals are made.
- There will be effective and widespread screening of in-patients in our local hospital to identify those where alcohol is contributing to their poor health coupled with the provision of appropriate interventions.
- There will be stabilisation of the alcohol related hospital admission rate (NI39) to bring it in line with the average for the region.
- Successful realisation of the Strategy also requires widespread identification and delivery of simple structured advice

across a range of services in order to address the culture of excessive drinking and aid the early identification of problems.

Impact on health and other services

A reduction in alcohol consumption across the borough would be seen immediately in the arena of crime and disorder and health trauma, but there will also be important longer term health impacts including cardiovascular, cancer, infant health and perinatal mortality. There will be wider benefits for sexual health, teenage pregnancy and injuries related to domestic violence

How we will make sure that the initiative will impact on the people who most need it?

The introduction of screening through primary care will over time capture a very high percentage of the population but may also need to be supplemented by initiatives directed at vulnerable groups eg, those who are already known to be drinking excessively, high volume users of health and criminal justice services and groups such as problem drug users of whom every year 1500 enter services requesting help for illegal drug use, the vast majority of which are also using alcohol excessively. Mental health services users who are using alcohol to self medicate are also identified as being an at risk group.

Finance

Initial investment has been made in the alcohol and primary care service (£150,000 per annum) by NHS Rotherham but will require additional funding in order to fully implement the scheme across all practices including the screening tools which have proved more popular more quickly than first anticipated.

How we will get there

In January 2010 23 practices are delivering the LES although many of these are not yet fully implementing the screening tools and recording this correctly. Additional work needs to be undertaken to pull information together from the screening in the practices.

Over the next 12 months a minimum of a further five practices will join the scheme giving a total of 28. Plans to bring the remaining 13 practices into the scheme will also be formulated over the year with consideration given where practices will be unable to deliver the LES in the long term to alternative access arrangements for those patients.

How we will measure improvement

- We will develop an understanding, by GP practice of the levels of alcohol consumption for the patient groups across the borough and use this as a population baseline
- We will continue to work to understand why the NI39 rate is high in Rotherham (this indicator is developed from a number of compound indicators which are worked out by proxy and therefore may be unreliable).
- We will commission additional activity from the Foundation Trust or explore ways of delivering within the existing contract
- We will work with secondary care services to continue to transfer possible patients back into primary care and ensure adequate capacity to keep waiting times as short as possible.

Communication Plan (include patient, clinical and stakeholder input)

The Alcohol Harm Reduction Strategy for Rotherham includes a substantial programme of awareness raising and education programmes aimed specifically at older people, under 25s, those who drink at home and parents. Specific targeted messages have been developed in consultation with population groups aimed at key messages in relation to alcohol related harm. Other initiatives such as the E-learning package aimed at both the general public and specific plans for work place activity will complement schemes which have been developed to tackle problems with the night time economy and alcohol related accidents. The majority of this work is funded via the Safer Rotherham Partnership.

The Drug and Alcohol Service User Forum (SURF) are actively involved in the development of both the primary care scheme and secondary care services.

GP stakeholders are engaged with the development of the LES via the Shared Care Monitoring Group and Dr Russell Brynes is engaged as a sessional specialist to advise on the development of clinical guidelines for the primary care scheme. Key partner agencies via the Safer Rotherham Partnership are involved in the ongoing monitoring and delivery of the overall Harm Reduction Strategy for the borough.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Anne Charlesworth	**Kath Atkinson**	**Russell Brynes/Wendy Edmondson**

Transformational Initiative: Improve access to sexual health services (TI: 14)

Where we are now

Sexual Health is National and a Local priority re-iterated in '*High Quality Care For All'.* As such it is an important part of existing Rotherham multi-agency strategies such as the Local Area Agreement and the Children and Young Peoples Plan. NHS Rotherham has approved a Sexual Health Strategy outlining how over the next 5 years we will commission sexual health services more coherently to meet the sexual health needs of the local population.

The key issues the strategy sets out are:

- Rotherham like other communities has increasing rates of sexually transmitted infections (STIs). This means that achieving PSA targets on sexual health and access to services will be challenging.
- The challenges of reducing teenage pregnancy are covered in a separate transformational initiative
- Rotherham has a number of sexual health services many of which though offering services of a high quality are not joined up as effectively as they could be.
- To date Health Needs Assessments have not effectively informed the development of existing services and the piecemeal nature of those that have taken place means that there has been no coherent body of evidence on which to base commissioning decisions for the future.
- There are current performance issues relating to the delivery of chlamydia screening

The following table sets out the extent of the challenge of the PSA targets

Sexual health PSA Targets "The PSA is to reduce the under 18 conception rate by 50% by 2010 (from the 1998 baseline) **as part of a broader strategy to improve sexual health"**			
NHS Local Delivery Plan lines	Targets	Present position	For the future
PSA 11a and NI112: Under 18 conception rates (Vital Signs target)	To reduce by 50% the under 18 conception rate by 2010 from the 1998 baseline	2007 final year rate of 50.7 (per 1000 girls 15-17yrs) 10.5% reduction over 1998 baseline *2007 ONS statistics	Target reductions 2007/8 37.9% (target trajectory renegotiated) 2008/9 = 27% 2009/10 = 39% 2010/11 = 50%
PSA 11b: Access to GUM clinics within 48 hours	100% offered an appointment within 48 hours 80% seen within 48 hours	2008/09 Q4 100% offered80.1% seen	Continue to monitor and maintain targets
PSA 11c: Decrease in rates of new diagnoses of gonorrhoea	Trajectory: Not to exceed 60 cases in a year	2009/10 Q2 21 cases against a trajectory of 15	Increases in screening may result in an increase in the number of cases found
PSA 11d & NI113: Percentage of young people aged 15-24accepting chlamydia screening (Vital Signs target)	200/08 = 15% 2008/09 = 17% 2009/10 = 25%	2008/09 target met (final figure 19.7%) 2009/10 Q2 = 10.28% (0.78% above planned)	2009/10 = 35%

Where we will be in 5 years

Sexually Transmitted Infections (STIs) in Rotherham have continued to increase at a similar rate to the regional and national trend. This could be as a result of more cases being diagnosed due to the emphasis put on improving sexual health services, including increased levels of screening activity, sexual health awareness campaigns and more people being proactive about their sexual health.

Using local hospital episode data for births and terminations, it is now possible to estimate more up to date progress towards the Under 18 conception rate target. Recent analysis indicates that the final year figure for 2008 is likely to increase, however the 2009 statistics are likely to see a steep decline. Local data is also being used to identify trends and hotspot areas to plan and target service delivery.

Impact on health and other services

Sexual health is key to people's sense of well-being. Prevention and early treatment of STIs is highly cost effective. The

consequences of not having an up-stream approach to sexual health include complications for the individual and increased population levels of STIs including conditions with major health and health service implications such as HIV.

How we will make sure that the initiative will impact on the people who most need it?

Sexual Health is closely related to all forms of deprivation with populations experiencing deprivation very often showing evidence of poor sexual health.

Barriers exist for the general population but certain groups and individuals experience greater barriers and therefore health inequalities. These groups include (but are not restricted to) Lesbian, Gay, Bisexual & Transgender (LGBT) People, People with disabilities (including Learning Disabilities), People with HIV, Minority Ethnic Communities, Sex Workers, Older people, Children & Young People, particularly those from marginalised groups such as Looked After Young People, those excluded from school.

Our commissioning strategy will ensure that services are designed to meet the needs of the most vulnerable groups and we will monitor this by equity audit.

Sexual health services are increasing their accessibility for key vulnerable groups by providing more outreach and community based services.

There have been a number of successes in the roll out of the strategy. The Maltby Linx Young Women's project was awarded the regional Health & Social Care Award for Success in Partnership Working and was shortlisted for the national award. The launch of the new branding for Rotherham's young people's sexual health services 'The S Word: We need to talk about sex' was very well received by both professional and young people. The website has received almost 67,000 hits since August 2009. Enhancement of the roles of specialist nurses for sexual health services has resulted in increased awareness of services, more referrals from professionals working with young people and a reduction in conception and termination rates in young women.

Finance

Following increases in investment from regional and local funds, NHS Rotherham now invests £2.7m in termination, contraceptive and STI services, which includes Genito-Urinary Medicine.

We will continue to expand and develop services such as Long Acting Reversible Contraception (LARC), emergency hormone contraception (EHC), free condom provision and increased outreach.

How we will get there

The focus of the Sexual Health Strategy is on assessing local needs, reducing inequalities in sexual health and commissioning services in line with national standards and best practice.

Milestones include:

- Gap analysis of existing sexual health needs assessments and commissioning of research to address unmet need: March 2009
- Audit of Sexual Health Commissioning Strategy and action plan agreed: March 2009
- Teenage pregnancy action plan refreshed March 2010
- Managed network of integrated sexual health services performing effectively March 2011

How we will measure improvement

-Achievement of PSA and Vital signs targets (see table above)
-Patient and Public Involvement
-Reduction in numbers of cases of STIs, particularly HIV
-Uptake of LARC

Communication Plan (include patient, clinical and stakeholder input)

Partners and young people were consulted and involved in every element of the planning and implementation of The S Word campaign and will be involved with future developments.

Clinicians and the public have been consulted as part of the LARC social marketing campaign and further consultation is due to take place in 2010. Professionals and partners are involved in the development of the sexual health communications strategy and planning meetings

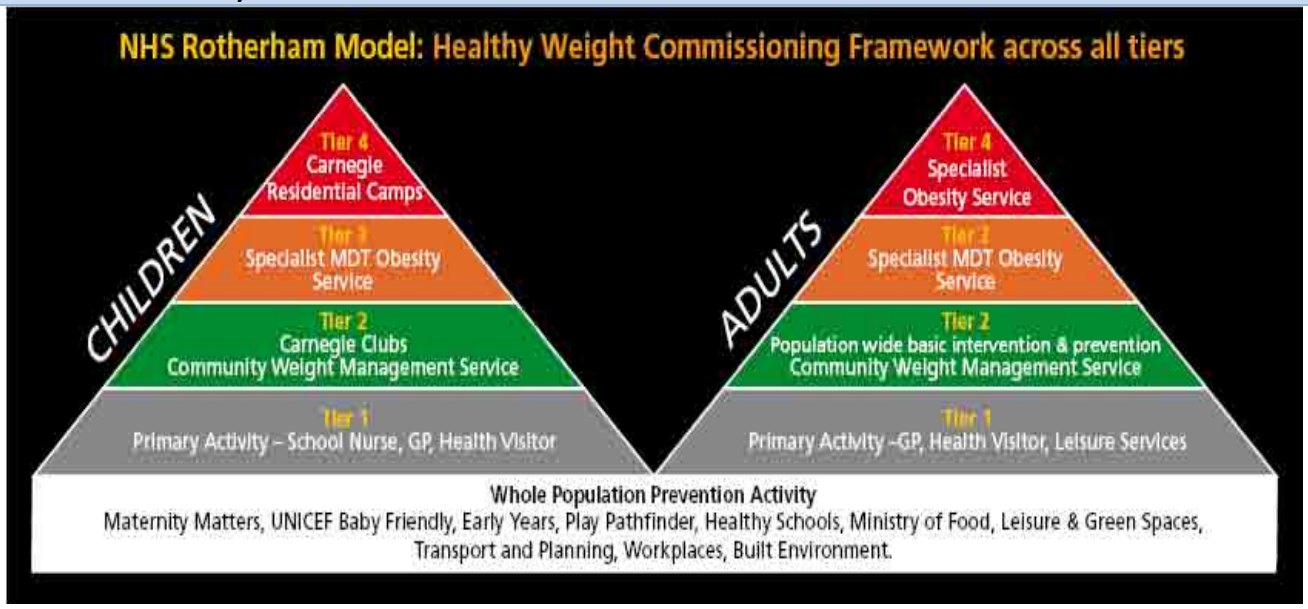
LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Melanie Simmonds	**John Radford**	**Julie Kitlowski**

Transformational Initiative: Reduce adult Obesity (TI: 15)

Where we are now

Levels of obesity in Rotherham continue to rise. GP data suggest that at least 23% of Rotherham population are obese (BMI>30) with a further 32% overweight (BMI 25-29). Over 600 people are morbidly obese with BMI of greater than 50. If current trends continue, projections are that 50% of the adult population of Rotherham will be obese by 2050. A Healthy Weight Framework was commissioned in 2008/9 and new tiered services were introduced. Contracts for these services are now in place with robust monitoring, performance review and evaluation. Awareness of services and referrals are increasing and following success in the national Health & Social Care Awards for Excellence in Commissioning, the model developed in Rotherham has been adopted by many other commissioners in England.

Where we will be in 5 years



The services described above have been commissioned for a period of 3 years. Our target continues to be "to halt the rise in adult obesity, but the services have more specific targets over their 3 year programmes (outlined below in the measurement section).

All the weight management services for adults are now operational. The Community Weight Management Programme, Reshape Rotherham, has had 150 adults who have completed their 12 week programme with a 35% success rate. The Specialist Adult MDT – Rotherham Institute for Obesity or RIO – have had 148 adults through their service with a success rate of 52%. A 'Healthy Weight Action Plan' will be finalised in the coming months. The action plan focuses on the preventive activity needed in Rotherham to increase the proportion of the population who are classed as having a healthy weight and BMI.

Impact on health and other services

A) Health Impact – Being overweight or obese will eventually overtake smoking as the major cause of preventable ill health. Obesity is an important risk factor for many chronic diseases, including cardiovascular disease, diabetes, some cancers and has substantial implications on self esteem. Both healthy eating and physical activity are important to prevent overweight and obesity in the short and longer term. The PCT is investing in a range of obesity services including community weight management programmes, a Multi Disciplinary Team of health professionals and Bariatric surgery to support 2000 adults over 3 years. Evidence from published papers shows that community weight management programmes (Tier 1) can reduce the population incidence of diabetes. Local Yorkshire and Humber programmes which follow the same model report an average of 5% body weight loss in those completing the programme. Rotherham's programme will also address other lifestyle issues such as: alcohol; smoking, and social support.

B) Impact on other services: If we do not tackle obesity costs of hospital activity for a wide range of activities such as diabetes and cardiovascular disease will increase steeply. We will increase the appropriate prevention and treatment of obesity in primary care, but we acknowledge that because of the current unmet need there will continue to be substantial numbers who will require specialist management, so we will not see significant overall reductions in secondary care activity.

How we will make sure that the initiative will impact on the people who most need it?

Obesity is not equally experienced across all sections of the population. Some communities have a higher risk of becoming obese. These include:

- People in lower socio-economic groups, especially women.

- Some ethnic groups.
- People with physical or learning difficulties.
- People who have recently stopped smoking.

The greater prevalence of obesity among poorer social groups implies that efforts to counter health inequalities must take account of obesity; conversely, action on obesity must take account of socio economic factors. Obesity is not exclusively a matter of social class and inequality. The suggestion that it is primarily a feature of lower-income groups would disguise the society-wide character of the epidemic. However, efforts to combat obesity in lower-income groups will have positive consequences for both health and inequality.

We have included some specific "quality" measures into the data collection from our services so that we can track how our services are meeting the needs of communities of greatest need. We are also asking our services to specifically target communities/individuals in greatest need (eg targeting the delivery of services in areas of deprivation to promote access and take up).

Finance

Prior to the procurement of newly funded services, we had no information on the spend on obesity

Our investment is £370,000 annually, broken down as follows:

- Adult tier 2 (Reshape Rotherham, delivered by RFT) - £110K
- Adult MDT tier 3 (RIO, delivered by Clifton Medical Centre) - £260

The funding for bariatric surgery is managed through the Specialised Commissioning Group. The approximate cost of 55 obesity surgery procedures, assuming an 80/20 split between banding/bypass is approx. £470K.

How we will get there

NHS Rotherham's strategy has four elements:

- **Treatment:** developing treatment services to help obese people to reduce their weight.
- **Prevention**: Developing preventive services assist those of healthy weight to maintain their weight, and to prevent those who are overweight from becoming obese.
- **Environment:** Developing a leptogenic environment, i.e. one that promotes enjoyment and healthy lifestyle choices.
- **Adaptation:** Ensuring that existing services are able to respond to the needs of the increasingly obese population.

In all of these areas a partnership approach is vital. NHSR has established multiagency groups to develop and implement our strategies for both childhood and adult obesity and these are supported by our multiagency partners.
The overall strategy is overseen by the Obesity Strategy Group. Sub groups have been established to oversee Performance Management, Provider-Commissioner Operational Issues and Obesity Prevention.

How we will measure improvement

Performance management systems have been established to monitor outputs of each commissioned service on a quarterly basis. Service managers are also required to attend monthly performance update meetings to ensure that each service continues to perform against the service specification. The Obesity Strategy Group meets 6 monthly, has performance management as a standing agenda item and there is a Weight Management Service Provider Group which meets quarterly.

Targets have been set for each of the services as follows:

Specialist Adult MDT (RIO) – 1,800 individual achieving a minimum 3% body weight loss, aiming for 5% body weight loss by the end of the three year period
Community Weight Management (Reshape Rotherham) – 2,000 individual achieving a minimum of 3% body weight loss by the end of the three year period.

Communication Plan (include patient, clinical and stakeholder input)

There is now a Weight Management Strategy Communications Group (chaired by NHSR's Head of Communications & External Relations). The group includes clinical and stakeholder input and meets to ensure a coordinated response to communications in relation to the commissioned services and the weight management programme in general. It is intended that user representation will be recruited to the group in the near future.

There is considerable feedback from service usesrs and their views are represented in all our communications.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Gill Harrison	**John Radford**	**Judy Dalton**

Transformational Initiative: Follow up people identified at risk through the NHS Health Check (TI: 16)

Where we are now

Improving CVD outcomes at a rate faster than the national average has been a major success story for Rotherham over the last decade, achieved through the implementation of the NSF for Coronary Heart Disease.

Cardiovascular Disease risk screening, or NHS Healthcheck, has been introduced for everyone aged 40-74 in Rotherham and is being delivered by local general practitioners through a Locally Enhanced Service. To date, 10% of the estimated 89,000 people in this age group have been screened. The screening programme is identifying new diabetes patients, patients with hypertension and kidney disease. People found to be at 20% or more risk will be treated with medications or referred to lifestyle interventions which will reduce their risk of going on to develop cardiovascular disease in the future.

Appropriate cardiovascular risk interventions (particularly stop smoking advice) are highly cost effective and are one of the areas where we can most easily model the health outcomes of health initiatives.

A range of lifestyle support services are in place to address smoking cessation, weight management and increasing levels of physical activity. Lifestyle change support will be enhanced by the Health Trainer Service and clear targets for all lifestyle intervention services are in place. We have commissioned some additional capacity in the new adult community weight management service (Reshape Rotherham) and have established a pathway for referral to free physical activity programmes with our local Leisure Services Provider, DC Leisure.

Where we will be in 5 years

Our target population will all have been screened and we will have agreed a framework for the screening of newly eligible people and rescreen in accordance with national guidance.

We will see reductions in overweight/obesity and smoking levels in the population and evidence of increased use of physical activity opportunities.

We will see earlier diagnosis and better management of Type 2 diabetes, which should reduce complication rates and improve the health outcomes of people with T2 diabetes.

Impact on health and other services

A) Health

Modelling work suggests this initiative will deliver substantial benefits. For people at medium risk, smoking cessation advice, weight management and exercise programmes are highly cost effective. At higher levels of risk, medication such as statins, aspirin and antihypertensives along with intensive lifestyle management for impaired glucose regulation, are also cost effective. Extrapolating national predictions to Rotherham's population it is anticipated that:

- 50 heart attacks and strokes a year will be prevented
- 20 people a year will be prevented from developing Diabetes
- 120 people a year will be detected earlier with diabetes or kidney disease

B) Impact on other services

The initial screening and assessment of this population will increase GP work load because it will identify a high-risk cohort of patients who require medication and referral on to lifestyle interventions.

If the initiative is successful in promoting a broader (rather than a purely medicalised) approach to cardiovascular risk the initiative will increase demand for services such as smoking cessation and obesity services. Demands on diabetic services will also be increased.

The Health Trainer Service has increased its capacity and skills to support clients within lifestyle change programmes and to provide particular support to those that are difficult to engage or require tailored, one to one support

In the longer term the initiatives will result in hospital admissions for acute cardiovascular events falling quicker than they would otherwise. It will also increase the rate of fall in demand for interventional cardiac procedures such CABG and PCTA.

How we will make sure that the initiative will impact on the people who most need it?

Dedicated project management for the programme will ensure that progress is monitored and practices will be audited for compliance with the service specification. IT templates and support systems have been put in place to enable audit of performance, including uptake of screening in the most deprived practice populations.

We will continue to carry out CVD equity audits.

Finance

The programme budget for cardiovascular disease is around £12m.

Although age specific rates are falling cardiovascular disease is still a major contributor to the PCTs overall primary care, prescribing, and secondary costs. An early milestone will be to establish current spend on cardiovascular disease so this can be used as one of the outcome measures of the initiative.

In 2008/9 the PCT has allocated an additional £400k recurrent to fund the additional prescribing spend on Aspirin and Statins for people on disease registers that are at risk of developing CVD.

Implementing cardiovascular risk assessment for all people over 40 will require substantial funds that have not yet been fully worked out or reflected in the PCTs 5 year financial plan. National funding that might become available in 2009 has not been announced. The full costs of the initiative will involve:

– The cost of procuring the screening assessments
– The additional costs of providing additional non medical interventions (smoking cessation, obesity services, exercise referral if available)
– The recurrent costs of drugs for those people with 20% 10 year CVD risk

How we will get there

A CVD Risk assessment group will be established to scope the project and agree milestones and costs. It is likely that the procurement strategy will involve a range of providers but an essential part of the specification will be good information to avoid duplication and allow Rotherham-wide and by practice reporting on CVD risk coverage.

- To develop a model addressing CVD Risk across Rotherham and go out to tender by 1 April 2009
- To develop a phased implementation staring with the most deprived areas in Rotherham and to achieve coverage of a high proportion of the 100,000 Rotherham residents over 40 as soon as funding and capacity allow.
- To develop the capacity to manage the additional non-medical and medical interventions that the programme will generate.

How we will measure improvement

- Numbers of people aged 40-74 who have had cardiovascular risk assessments
- Number of people who have received additional interventions, such as ***smoking quits**** weight management, exercise programmes and appropriate medication.
- To rates of fall in age standardised cardiovascular admission rates.
- Increased rate of fall in cardiovascular mortality rates in Rotherham contributing to life expectancy.

Communication Plan (include patient, clinical and stakeholder input)

A media and communication strategy is being developed. To date, this has included production of a locally relevant booklet for people who have been screened, to signpost them to lifestyle intervention programmes and motivational support from the Health Trainer Service. Rother FM is running promotional information broadcasts during January and February 2010. Further social marketing and media campaigns will be developed in year.

We will continue to use the "Every Contact Counts" opportunities to promote lifestyle change, through PLT and other stakeholder engagement activity.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Jo Abbott	**John Radford**	**Russell Brynes**

1.5 First Class Services – Planned Care

Introduction
We have identified four transformational initiatives relating mainly to improving hospital services:

TI: 17 Implement a referral management/advisory programme
TI: 18 Secure efficiency from Specialised Services (via SCG)
TI: 19 Increase clinical efficiency
TI: 20 Manage and reduce health care acquired infections

This introduction sets out our overall vision for commissioning world class planned care services. This will involve designing care pathways so that patients can obtain the right care at the right time in the right place and commissioning for quality improvements.

Commissioning for quality improvements
In addition to having the right care pathways we will ensure that our ability to monitor and improve clinical quality across care pathways is improved. We will work with providers to define local quality metrics, including patient reported outcomes measures and patient reported experience measures (PROMS and PREMs) to augment the outcome frameworks that are being developed regionally, via the proposed Quality Council, and nationallly by the Commisioning for Quality and Innovation Scheme (CQUINS).

Planned Care
NHS Rotherham has met the national targets for waiting times and has comparatively low waiting times for access to most services. However, we also have higher than average usage of both elective and outpatient care, which is continuing to rise at an unsustainable rate. There is an urgent need to develop a system of limiting demand to first outpatient appointments those which are absolutely necessary. Work is ongoing with Practice Based Commissioners to design and apply a number of techniques to achieve this.

Healthcare Associated Infections have not been a significant recent issue in Rotherham, however, with additional staffing and pro cesses having been re enforced to ensure that progress continues, we are confident that we will significantly reduce these further. This will impact on patients' safety, length of stay and satisfaction rates.

Specialized services have continued to add financial pressures and due to rising expectations, national guidelines, clinical, technological and pharmaceutical developments, will, if unchecked prove impossible to maintain. Working within a commissioning framework, we will be challenging the quality, efficiency and effectiveness of services and new developments. We will ensure that we ensure appropriate quality and productivity of the wider system which will in some instances necessitate rationalization of providers.

Improving planned care will reduce the demand on urgent care and so allow improvements in response time and quality of care. Improvements in care pathways for planned care include:

- Maintaining and where appropriate, to improve waiting times and delivering choice to patients.
- Improved access to diagnostics. In the last 2 years, waits for diagnostic tests have decreased significantly. In 2000/10 we are commissioning additional diagnostics at Rotherham Community Health Care Centre. This service will offer a quality service for direct GP referrals with quick turnaround avoiding unnecessary hospital outpatient referrals.
- Providing more care nearer patients home. GPs are already providing additional services in dermatology and orthopaedics. We recognize that further work needs to be done to increase the number of out of hospital treatment options.
- Reducing any unnecessary steps in pathways eg. pre- operative assessments and stays, excess bed days, follow – up outpatient appointments

Delivery of Same Sex Accommodation

- NHS Rotherham accords a high priority to ensuring that all patients who access health care are treated with dignity and respect. A key element of this is ensuring that they are cared for in buildings which are compliant with the guidance on Delivering Same Sex Accommodation. All our providers are proposing to declare compliance in March 2010.
- Robust plans are in place to ensure continued delivery against the requirements on estates, systems and processes, staff culture and patient experience.

Patient Experience

- Rotherham NHS FT has in place a PET tracker which is commissioned by NHS Rotherham and actively seeks the experiences and views of patients and service users. Questions around DSSA are included on the survey and a report is sent to the RFT Board on a quarterly basis. The information gained from this survey is incorporated into all future plans for the hospital. Included in this report is information gathered from complaints. Governors will be actively involved with the PET tracker in the future. Each ward has a ward sister to whom they can report issues around DSSA. NHS Rotherham also use patient opinion and feedback all information to relevant people. The In-patient survey will also show information around DSSA. All the above information will be collated by NHS Rotherham and a report will be sent to Board.

Estates

- Rotherham NHS FT have a Capital Investment Plan in place where major alterations will take place in the future. Patient experience has played a huge part in the development plans with DSSA being a major influence. Major works will commence to the admissions ward in June 2010 and further work will be carried out with the agreement of plans to hopefully include 4 bedded bays with en-suites.

Systems and Processes

- Discussions are in place with contracting to monitor DSSA through patient experience feedback processes. Out comes from the PET tracker will continue to go to NHS Rotherham FT Board on a regular basis and to NHS Rotherham Board along with patient complaints and patient opinion feedback.

Staff Culture

- It has always been and will continue to be high on the agenda of all staff in provider services to ensure that patient's privacy and dignity are always maintained. Providers have designated staff to ensure that the privacy and dignity agenda is taken forward. The Deputy Chief Nurse and the Chief of Quality and Standards are committed to delivering SSA. Policies are in place at the NHS Rotherham FT for training of all new staff around privacy and dignity and staff training occurs when staff are assigned to a new ward.

Transformational Initiative: Implement a referral management/advisory programme (TI: 17)

Where we are now
Waiting times, for most services, benchmark very well and are amongst the lowest in the country for many services. However, we also know that our usage of outpatient and elective care is comparably high and continuing to increase. This will, if unchecked, lead to an unsustainable financial burden.
Where we will be in 5 years
We aim to continue to meet or exceed all national targets for access to planned care within an affordable framework. We will closely monitor the outpatient and elective work undertaken at Practice level. We will have reduced demand for planned care to an activity level nearer to that nationally expected and benchmarked. Clinicians will have a leading role in referral management control. The efficacy of interventions will be scrutinized and access to interventions of limited clinical value will be further restricted.
How do we get there?

In order to ensure that we appropriately control this increasing demand, we need to ensure the appropriateness of referral and efficacy of interventions. This process will require significant input from clinicians. A number of options are identified:

- Thoroughly analyse source and type of referrals
- Set referral targets for GPs
- Provide education / advice in referral management to clinicians
- Revise care pathways restricting access to what care is appropriate and necessary
- Provide primary care triage schemes
- Set treatment thresholds
- Set Outpatient follow up thresholds

We are working with PBC lead commissioners to develop a scheme which will encompass a combination of these initiatives. A task group of clinicians from primary and secondary care has been established to ensure this work can be implemented across the community in 2010. A key element of this work will also include a review of very low referral rates. It is not expected that this is a closed list and we would as a matter of course continue to identify and implement evidence based best practice.

How we will make sure that the initiative will impact on the people who most need it?

We have good knowledge of the needs and demographics at ward and Practice level and we are better able to predict demand. Monitoring of this activity will be closely monitored at GP level. Public and Patient Engagement activities will continue to identify and support targeted investment.

Finance

The key outcome from this transformational Initiative is ensuring that necessary treatment will continue to be provided within an affordable financial envelope. Savings should result from reduced outpatient referrals and follow- ups.

Some of this released saving will be required to develop alternative community models of care to ensure that patients get a better understanding of their conditions so that they are better able to self manage.

How we will measure improvement

Services will be subject to a robust performance management approach which will identify and address contractual shortcomings. Trends in referral and conversion rates will be reviewed on an ongoing basis, the MIDAS information system allows GPs and PBC real time access to information.

Communication Plan (include patient, clinical and stakeholder input)

Significant change will be subject to stakeholder engagement activity. Where there are proposed changes to clinical pathways at specialty or sub specialty level, patients will be engaged in the process to ensure that the new process are safe and equitable.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Keith Boughen	**John Radford**	**David Tooth**

Transformational Initiative: Securing efficiency from Specialised Services (TI: 18)

Where we are now

NHS Rotherham is one of fourteen members of the Y+H Specialised Commissioning Group, (SCG). It is a well established and highly reputable consortium with a track record of ensuring appropriate funding levels for specialised services. This is an ever changing scenario with new technologies, drug treatments and recommended best practice guidelines changing on a frequent basis. This, alongside public perceptions of acceptability does and will increasingly pose a significant financial pressure on commissioners.

SCG, whilst commissioning for specialised services, also serves to allow a collective commissioning approach to some less specialist services where there are perceived benefits to commissioners of not working alone.

Where we will be in 5 years

Commissioning for a wider range of services in collaborative manner, we will be better able to influence the major service providers in respect of productivity and service models. We will have identified priorities to achieve the most health gain and productivity and value for money.

The quality of provision in many cases is variable and providers will be challenged to meet best practice or fail to meet designation standards.

How do we get there?

We will work closely with other commissioning bodies and in partnership where appropriate to gain maximum benefit from investment and disinvestment opportunities.
We will challenge existing practice in respect of Quality, Finance and Performance. The SCG will provide a collective

approach to difficult decision making and, because of it's history of engagement and governance it should remain a sustainable model for targeted investment. Risk sharing protocols may be challenged because of legacy of local provision and financial constraint .

The provider landscape will be closely monitored and increasingly, services and providers will be designated to ensure consistent models of provision and appropriateness of capacity. Commissioners will utilise a wider range of health and financial indicators which continue to develop to support economic decision making.

How we will make sure that the initiative will impact on the people who most need it?

The SCG will engage with all members in ensuring that investment addresses inequalities. There is also a Patient and Public Engagement Group coordinated specifically for specialised services. Outcomes and trends will continue to be monitored and the focus readdressed as appropriate to address changes identified.

Finance

The current spend through SCG is over £32m and this has increased year on year. This area has, historically, been a significant area of cost pressure. It is not anticipated that this will change and it will become increasingly challenging. However, in the current financial climate, many difficult decisions will need to be taken and some previously prioritised investments may require reappraisal when compared with emergent opportunities. In all investments there is a need to balance quality, risk and financial viability.

Financial risk sharing will continue across SCG members. It is important that this risk share arrangement remains transparent and is proportionate to local financial and legacy issues and not leading to any inappropriate subsidy.

How we will measure improvement

Services will be subject to a robust performance management approach which will identify and address contractual shortcomings. Benefits of scale will be realised in terms of VFM by securing quality and productivity at proportionate levels for specialist services. This will be realised in terms of reductions in health burden and targeted capital investment and disinvestment. Potential investment will be subject to rigorous QIPP challenge.

Communication Plan (include patient, clinical and stakeholder input)

Significant change will be subject to stakeholder engagement activity. Where there are proposed changes to clinical pathways at specialty or sub specialty level, patients will be engaged in the process to ensure that new processes are safe and equitable.

Clinical engagement is widespread at a regional level and this will continue with significant input from key providers in option formulation and decision making.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Keith Boughen	**Kath Atkinson**	**John Radford**

Transformational Initiative: Increase clinical efficiency (TI: 19)

Where we are now

We have successfully invested in new services and improving access over the last 5 years. This has been carried out in a favourable financial environment when improving health outcomes and access has been a higher priority than detailed attention to allocative efficiency.

We have identified scope for efficiency savings in services that are duplicated across the GP, community, hospital interface. We bench mark high on the five less effective surgical procedures identified by the CMO.

We do not routinely use clinical thresholds in deciding which patients should have priority for common procedures. Through specialised commissioning we have been able to rapidly implement NICE approved treatments including those that are marginally effective such as third line cancer drugs and multiple cycle IVF.

We have a well respected prescribing advisers that have worked successfully over the last 5 years to deliver increasing clinically effective prescribing with much lower than average cost growth. We do not yet have an equivalent process to influence the unsustainable growth in elective referrals and procedures.

Where we will be in 5 years

We will have generated efficiency savings through decommissioning ineffective services across the primary, community, hospital interface (including re-negotiating GP PMS and Locally Enhanced Services and efficiency savings through mergers of some community and hospital services).
We ill have kept referrals for secondary and specialised services in Rotherham within agreed and affordable limits.

Working through specialised commissioning we will ensure that overall spend on specialised commissioning is kept within agreed and affordable limits.

Impact on health and other services

Increased attention on allocative efficiency across the system will ensure that we will be able to maintain the improvement in health outcomes that we have seen over the last 5 years during a period when there will be much reduced financial growth.

How we will make sure that the initiative will impact on the people who most need it?

Giving greater attention to ineffective services, duplication of services, and ensuring procedures are effective and delivered to the right patients will enable funds to remain available for more effective treatments.

We have a robust procedures process for individual treatment requests that ensures that we consider exceptionality in individual cases and where there are multiple requests for non funded procedures we ensure we develop general policies based on NHS Rotherham's prioritisation criteria.

Finance

This is a cross cutting initiative that will ensure that we keep to financial allocations for primary care, elective referrals and specialised commissioning. The current spend in these three areas is over £165m.

How we will get there?

We will review GP PMS and LES as set out in the first class primary care transformation initiatives.
We will use the reshaping of community services to streamline services that are currently duplicated between primary, community and secondary care.

We will undertake a wide range of work coordinated though the new Clinical Referral Committee. This is a high level group including NHS Rotherham and RNHSFT Directors and experienced consultants and GP PE chair and PBC chair. It will co-ordinate work using a 'right care, right setting, right time' approach based on clinical and cost effectiveness to keep referrals within agreed and affordable limits. The approach will include working on clinical behaviours and incentives as well as thresholds and care pathway redesign. The work will involve enhancing the work currently being undertaken through PBC on benchmarking and peer discussion of referrals with an increased emphasis on GP - hospital consultant dialogue providing clinical feedback on individual cases, generalised management guidance and clinical leadership of overall care pathway design.

How we will measure improvement

Benchmarking on numbers of CMO less effective surgical procedures carried (and additional procedures and thresholds as they are identified locally and nationally).
Reduction in the rate of increase in elective referrals generally and for key specialities such as orthopaedic, ophthalmology and gynaecology. Reduction in variation of GP £ per patient metric at annual assessment reviews

Communication Plan (include patient, clinical and stakeholder input)

Different initiatives will use different patient engagement. High profile changes such as Transforming Community services or potential changes to thresholds for cancer treatments of IVF will be subject to public consultation. Individual care pathways re-design will use the expertise of specific patients.

As part of the dissemination of Adding Quality and Value we will be engaging with a expanded range of clinicians across all health providers in Rotherham as it is individual clinical decisions that deliver the quality of health services in Rotherham and are responsible for its costs. As part of Shaping the Future we are restating the roles of the high level clinical groups in Rotherham that provide clinical leadership and engagement (NHS Rotherham Professional Executive, Rotherham Practice Based Commissioning Committee, Rotherham Clinical Quality Board and Rotherham Clinical Referral Committee.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Keith Boughen	**John Radford**	**Charles Collinson**

Transformational Initiative: Manage and reduce healthcare acquired infections (TI: 20)

Where we are now

Rates of healthcare associated infection (HCAIs) in RNHSFT and Sheffield Teaching Hospitals Trust are low compared to other secondary and specialist hospitals within York and Humber. For MRSA bacteraemia and C *Difficille* RNHSFT is one of the best performing Trusts in Yorkshire and Humber. However it is still the case that the public put eliminating risk from HCAIs in Rotherham at the top of their list of concerns.

Rates of MRSA have been low in Rotherham for several years. In 2006/7 rates of C. D*ifficille* at RNHSFT were higher than at some neighbouring acute trusts so robust performance targets were set and a 40% reduction in C. *Difficille* infections between 2006/7 and 20089 was achieved. Targets have been set nationally and locally to continue this reduction over the

next 5 years.

An integrated infection and prevention control team works collaboratively across health providers to ensure infection prevention supports the Rotherham health community and supports all patient pathways. This includes primary care, community health services, mental health, learning disability services and the acute sector. It is recognised that historically the focus of much of this work has been secondary care based.

Until 2008/9 performance monitoring was carried out on an acute trust basis. The new vital signs metric on overall commissioner performance allows us to monitor community wide MRSA and C. D*ifficille* rates, it also brings the challenge of ensuring robust infection prevention and control in Trusts where NHS Rotherham is not the main commissioner. This process will be facilitated by the recent appointment of a strategic lead for infection prevention and control within the commissioning organisation. This will particularly serve to strengthen our position within primary care.

Where we will be in 5 years

- We will continue to improve patient safety and so increase public confidence in the delivery of healthcare services
- By 2012 rates for MRSA bacteraemia and C *Difficille* will be in the lowest 10% nationally. MRSA bacteraemia will be rare and C. *Difficille* rates will have been reduced in Rotherham faster than the national average. This will apply both for RNHSFT as our main provider and for all health and social care providers NHS Rotherham commissions with
- We will also be in a position where any new and emerging healthcare associated infections are identified early and effective systems of prevention and control are in place.eg ESBL's
- All patients will be screened for MRSA prior to or on admission to hospital.
- We will ensure an ongoing system of surveillance to monitor trends and facilitate effective allocation of resources
- We will have developed a culture of 'zero tolerance', knowing the cause and outcome of all relevant HCAIs, with a strong focus on those which are deemed preventable.
- We will have a system for monitoring and reducing the incidence of surgical site infections
- We will ensure the most appropriate use of antibiotics and other anti microbial agents

Impact on health and other services

Maintaining our current rate of progress will impact on a number of areas:

- Restore and improve public confidence in local services and those we commission outside of Rotherham (in relation to public concerns around 'super bugs' and 'dirty' hospitals, as reported in the media).
- A reduction in deaths, which may be linked to healthcare associated infections
- Support an improvement in rates of recovery following surgery, hospital admission and other healthcare interventions. This will impact upon length of stay, readmission rates etc.
- Help in reducing hospital admissions due to healthcare associated infections
- A re-investment of any monies saved into priority areas.
- Most appropriate allocation of resource

How we will make sure that the initiative will impact on the people who most need it?

Infection prevention and control, with regards to healthcare associated infections, impacts across the whole of our population.

- In working with our partners we will ensure that infection prevention and control is inherent in services delivered to those who are vulnerable, regardless of where that service or care is delivered (e.g. care homes, patient's own home)
- We will report C. *Difficille* rates at GP practice population level so that variation in local rates are transparent and to help GPs make the link between primary care antibiotic prescribing rates and HCAIs
- Our commissioning process will ensure that those who require healthcare interventions (in acute, community or primary care settings) can expect safe care, which is delivered in a clean environment.
- Working with commissioners in other PCTs and in areas of specialist commissioning, we will ensure those requiring specialist care or care outside Rotherham can expect the same standard of infection prevention and control practices as care delivered locally
- In working with our public we will ensure that information is available which offers them advice, reassurance, guidance and information on local infection issues. This will address all age groups, e.g. working with other local services such as schools we will embed good practice, develop public knowledge and awareness at an early age. This will also offer a public health approach for those who are not in receipt of care delivery, but may be at risk through underlying illness or treatment. This approach also supports those who are carers.
- Recognise that healthcare is diverse and delivered in a wide variety of care environments
- All outbreaks will be investigated, managed and reported appropriately.

Finance

The investment required has already been committed. Delivery will result in both commissioner and provider savings due to reduced admission rates for MRSA and C. *Difficille* and reduced length of stay and complications. Complaints may

impact on reputation and lead to litigation.

How we will get there

Our approach will be:

- Challenge - setting high expectations and challenging targets
- Collaboration – working with healthcare commissioners in other PCTs to ensure safe services for our population, with the Local Authority to ensure a whole system approach across health and social care (incorporating the care home sector, environmental health etc), and with our providers to ensure the entire patient care pathway is addressed and infection prevention and control is not seen just as an issue for the acute hospitals.
- Performance – ensuring we monitor and address performance issues. Not only the targets as in reported cases of infection, complaints and clinical incidents, but seeking assurance that our providers comply with Care Quality Commisssion standards, Health and Social Care Act 2008 and other relevant legislation and/or standards.
- Key milestones will include;
  1. 2008/2010 – achieve rates already set for C *Difficille* (local acute trust and by commissioner)
  2. Annual reduction in reported MRSA bacteraemia cases
  3. By 2012 – rates for MRSA bacteraemia and C *Difficille to be* in the lowest 10% nationally
  4. Annual compliance with Hygiene Code and Care Quality Commission for all providers in relation to infection prevention and control standards
  5. Annual reduction in complaints and serous untoward incidents related to infection issues.
  6. Annual improvement in staff survey re infection control (all providers)
  7. Ensure that all practices/services are evidence based

How we will measure improvement

- MRSA bacteraemia rates (actual against plan) for Acute and Primary care (monthly, quarterly and annually)
- Evidence of Root Cause Analysis (RCA) in MRSA cases
- Evidence of RCA in C *Difficille* cases resulting in a serous untoward incident
- C *Difficille* rates, actual against plan, for both local acute provider and registered GP population (monthly, quarterly and annually)
- Monitoring of other healthcare associated infections and related issues (as contained within the Hygiene Code) and via the relevant Local Infection Prevention and Control Committee
- Evidence of compliance in relation to the Hygiene Code (via our contracts with providers)
- Evidence of clinical interventions which support patient pathways (e.g. adherence to health community wide antibiotic prescribing policies)

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Kathy Wakefield	**John Radford**	**Charles Collinson**

1.6 Long Term Conditions, Intermediate Care and Urgent Care

'Despite much improved prevention and excellent primary care and hospital services, many people will still get long term conditions such as heart disease and diabetes, and we need to make sure that we provide excellent services for people with these conditions'

Introduction
We have identified three transformational initiatives relating mainly to improving services for people with long term conditions:

TI: 21 System wide redesign of care pathways for long term conditions
TI: 22 Commission alternative levels of care closer to home
TI: 23 Reconfigure intermediate care

This introduction sets out our overall vision for providing world class services for people with long term conditions and those who require urgent care. The majority of patients requiring urgent intervention have an established long term condition, by linking these two areas together we believe that improving support and proactive care will reduce the need for urgent intervention. In addition to the transformational initiatives identified above we will continue to develop services in the following ways.

NHS Rotherham currently commissions a range of services which help meet the needs of people with long term conditions. The Community Matron Service is responsible for the case management and clinical nursing care of people with long term conditions who have complex needs. Specialist Case Managers carry out a similar role but focus on people with a single long term condition where needs are less complex. Both these services build on the established district nursing team which provide episodic treatment and some case management for people in the community.

Rotherham's Expert Patient Programme has been recommissioned with a new independent sector service provider now delivering the service in Rotherham. The Expert Patient Programme is a series of six week courses for people with chronic or long-term conditions. Courses are delivered by trained and accredited tutors who are also living with a long term health condition. The programme aims to give people the confidence to self-manage their condition, while encouraging them to work collaboratively with health and social care professionals. EPP focuses on issues such as healthy eating, pain management, relaxation techniques and maintaining mental health.

NHS Rotherham has recently developed a Care Home Liaison Service, aimed at supporting people in residential care who have long term conditions. Headed by a community matron and senior occupational therapist, the service identifies people at high risk of hospital admission and provides them with enhanced support. The team also provides support to care homes on maintaining physical function, improving mental health, medicine management and falls prevention. This year we have enhanced the advanced nurse practitioner service to care homes. The service now runs from 8am to 8pm during the week and from 8am to 3.30pm at weekends. This extended service should have an impact on the quality of health care to people in care homes and the number of unplanned hospital admissions.

NHS Rotherham has recently commissioned a pilot Long Term Conditions Team located at Maltby. This multidisciplinary team consisting of district nurses, community matrons and therapy staff is responsible for the case management of people with multiple long term conditions. The team also carries out duties performed by district nursing services, which are traditionally delivered for GPs. One of the key outcomes expected from this pilot is a reduction in the number of unplanned hospital admissions for patients with long term conditions.

NHS Rotherham already has a track record in developing services for people with long term conditions. During the next 5 years, as well as the transformational initiatives we will be focusing on the development of nursing and rehabilitation services in the community.
We will work closely with the local authority to develop an appropriate system for identification of people with long term conditions who are High Intensity Users (HIUs) of services. We will stratify this cohort of individuals and develop a tiered and integrated service model which can respond to different levels of need, adopting an integrated case management approach for those with most complex needs.

We will carry out a strategic review of the community nursing service. The review will consider the strategic relevance and performance of community matrons, district nurses and specialist case managers. We will reconfigure community nursing services within the life of this strategy. The Community Nursing review will focus on;

- Delivering safe, high quality patient care in the community
- Deliver high levels of patient satisfaction
- Are effective in preventing avoidable hospital admission
- Provide the appropriate support to GP practices
- Are fully integrated with each other and with relevant health and social care services
- Developing case management and a common assessment framework for people with long term conditions
- Promoting self care and self management

In addition to the Long Term Conditions Team at Maltby NHS Rotherham will pilot an integrated nursing service at Dinnington and Kiveton. It is envisaged that this will deliver some of the objectives set out in the community nursing review but more importantly it is intended to provide a seamless community nursing service within that area. We will be comparing the outcomes of pilots and using this information to inform the strategic review of community nursing

We will commission an integrated stroke care pathway which incorporates acute care, early supported discharge, a secondary prevention service and community rehabilitation. The service will reduce the recurrence of stroke and reduce incidence of secondary conditions. It will provide support to stroke victims and families on discharge from hospital. Finally the new service will ensure that stroke victims attain full physical and cognitive potential after having had a stroke.

We will carry out a strategic review of rehabilitation services. Rotherham has a range of rehabilitation facilities targeting different user groups and run by separate providers. The Review of Rehabilitation Services will focus on the following services;

• Breathing Space	Respiratory conditions
• The Rotherham Intermediate Care Service	Frail elderly
• Park Rehabilitation Centre	Orthopaedics / Neurological
• OCRM	Neurological
• Community occupational and physiotherapy services	Generic

Each of these services is individually commissioned and run autonomously from other parts of the rehabilitation care pathway. Breathing Space, Intermediate care and Park Rehabilitation are all locate on the same site; there is an opportunity to develop this site as a Rehabilitation Hub for Rotherham, delivering time-limited rehabilitation packages to patients with a range of needs.

We will explore the potential for the development of a single point of access into community health services. Feedback from GPs and community health workers shows that there is a mixed awareness of the types of health services that are available in the community. Also there is significant frustration and confusion over how to gain access to services. A single point of access would provide information and advice on what services are available and provide a single referral pathway into services.

At present for many patients the route into acute care is through A&E; for emergencies this is a vital service that NHS Rotherham is committed to maintaining. However, in many instances attendance at A&E is not appropriate and patients present with health problems that can easily be treated by other services in the community. 95% (covering 98.1% of population) of GPs now have core opening hours and 72% (covering 85% of population) offer extended hours . In June 2009 we extended the Walk-in Centre to open 7 days a week from 8am – 9pm, this is based in the new Rotherham Community Health Centre in the town centre. This is proving very successful and approximately 700 patients a week are seen at present. Along this there is a new GP practice that offers longer opening hours and a pharmacy on site which adds to an all-round convenient service. We plan to make further improvements to the Walk-in Centre that includes:

Access to medical records

To maximise the treatment of patients who attend the Walk-in Centre gaining access to their medical history and records is important. We plan to introduce a new electronic clinical system that will enable records to be integrated with the GP record where they are compatible. This means that health professionals will have up-to-date medical information about patients enabling them to give the most appropriate treatment safely and effectively.

Develop Care Pathways

We will work with the ambulance service to make sure that patient's are transported to the Walk-in Centre where it is right to do so. At present most patients are taken directly to A&E when an ambulance has been called for, in some cases patients could be seen and treated more quickly at the Walk-in Centre.

If a patient still needs hospital attention after attending the Walk-in Centre, for example if a broken bone is suspected and an x-ray is required, we will make sure they are seen directly and do not have to go to the back of the queue.

Another unplanned route into acute care is directly by GPs, both in and out of hours. Detailed analysis shows that just under half (45%) of these admissions stay less than 24hrs and that many of these admissions are avoidable.

There are many reasons why people end up attending hospital and being admitted that could have been avoided:

- Lack of alternative levels care
- Fast and easy access to certain tests is not available outside of hospital
- Existing care pathways are confusing and not easily accessed
- Lack of clinician to clinician support across primary and secondary care
- Patients do not always understand what services are available and how to access them

We are working with GPs to develop initiatives that aim to support them in managing these patients more effectively. One particular initiative is the development of a GP referral support unit; this means that any GPs wanting to admit a patient can access support to explore different options of managing the patient first, for example a patient may require some simple tests that need doing that day, or may need a dose of intravenous medication to rapidly kick start a treatment for a particular infection, these can be organised avoiding the need for a hospital admission.

For patients who experience an unplanned health problem, both community and hospital services must be able to respond to that need. To enable the health system to cope with this demand there are many different services set up to direct and support patients to access the right care and treatment; however, patients and professionals sometimes find this confusing. Our aim is simplify this and make sure the system is joined up in its approach, to this end we have participated in an external review of all of our urgent care services. We will set up an emergency care network that includes all our urgent care services; we will work through and implement recommendations making sure that we streamline systems and processes across services.

We commission a Fast Response Nursing Service that initiates care within 2 hours of referral for a period of up to 72 hours. The aim of this service is to prevent avoidable hospital admission and facilitate early discharge where possible; the service is a crucial in supporting the management of patients within the urgent care pathway. We will review this service to ensure that resources are targeted appropriately and performance is optimised.

The Yorkshire Ambulance Service (YAS) provides services to Rotherham people as a result of a 999 call. There are national targets that have been set that measure their response time from a call being received to an ambulance arriving on scene. YAS are struggling to achieve these targets in Rotherham; we will continue work with YAS to adopt new ways of working and through contracts to ensure that ambulance response times are achieved.

Diabetes

Background

There are 39 GP practices in Rotherham, caring for over 11,000 people with diabetes of which over 2500 are on insulin (QUEST Qtr 2 2009). There are 10 people diagnosed with type II diabetes for every person diagnosed with type I.

Compared to the YHPHO PBS prevalence model, the actual prevalence of diabetes (as measured by QOF) is about 10% less than predicted which means that there may be approximately 1100 people with undiagnosed diabetes across the district.

The prevalence of diabetes is forecast to grow at a rate of about 2.5% per year which means that by 2020, there may be 16,500 people with diabetes (both diagnosed and undiagnosed) in Rotherham.

Levels of controlled diabetes, blood pressure <= 145/85 mmHg and total cholesterol <= 5mmol/l are the same as or slightly better than that achieved by PCTs most like ourselves (YHPHO diabetes community health profile). However, there is considerable variation between practices within Rotherham which provides scope for improvement in diabetic and risk factor management.

Current issues

Discussions have been held with the various providers of diabetes care within the district including, GPs, DSNs, consultants and PCT staff and the following issues have been raised:

- There is no intermediate level of care between care provided by the GP and Specialist care provided in hospital.
- There is variation in outcomes and prescribing costs per person with diabetes with particular concern about insulin prescribing
- Shortage of structured education for people with diabetes and in particular top-up education for people with type II diabetes.
- Fragmentation of the specialist diabetes care team
- Lack of incentives for GPs to take on more advanced management of diabetes in primary care such as insulin initiation and review

Aims of redesign

- Improve effectiveness of diabetes care as measured by practices achieving higher levels of HbA1C <7.5
- Ensure that all risks are appropriately managed in people diagnosed with diabetes (non-hypergycaemic, CVD, neuropathy, hypertension, thrombosis, renal, foot complications, eye complications) in order to prevent avoidable complications
- Reduced referrals to secondary care diabetology service (particularly for insulin initiation)
- Increased utilisation of Diabetes Specialist Nurse Service based in community locations
- Facilitate change to in-reach working for DSNS and Consultant Diabetology Service
- Reduced overall prescribing cost per person with diabetes
- Free up resources to increase structured education capacity and facilitate GPs to take on more advanced management of diabetes in primary care

How will we measure our success?
Our long term condition goals are:

- *By 2012 we will have maintained our above average performance on cardiovascular mortality so that deaths will be well below the national average.*

- *By 2012 cardiovascular mortality in the Rotherham Neighbourhood Renewal Strategy Target area will have increased faster than the Rotherham average.*

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- Patients of diabetes registered with HBA1c reading 7.5 or less
- Diabetic retinopathy screening
- Patient reported outcome measures (PROMs) and quality adjusted life years gained (QALYs) for COPD patients
- Hospital admissions for COPD related conditions
- Thrombolysis call to needle time
- Stroke deaths within 30 days
- Proportion of TIA's scanned and treated within 24 hours
- Proportion who spend at least 90% of their time on a stroke unit
- Delayed transfers of care

Our Urgent Care goals are:

- *By 2012 hospital admissions for ambulatory care sensitive conditions will have decreased by 10%*

We will continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- Ambulance response times
- Emergency bed days
- A&E waiting times

Transformational Initiative: System wide redesign of care pathways for long term conditions (TI: 21)

Where we are now
Our intelligence review shows that there are major potential efficiencies to be obtained by radically improving the management of long term conditions, supported by much improved intermediate levels of care, and hence reduced utilisation of unplanned or emergency care. Services for people with long term conditions are provided by GPs, Rotherham Community Health Services, Rotherham Foundation Trust, and Rotherham, Doncaster and South Humber Foundation Trust, as well as by Rotherham Metropolitan Borough Council adult services and independent sector care services. All parts of the system must work efficiently and effectively in themselves to ensure that services for people with long term conditions provide optimal benefits. Under this configuration no one service 'holds the ring', clinicians are not incentivised to achieve optimal service utilisation or patient outcomes, there are many hand offs between the different services, the interface with social services is not always effective, incentives are not aligned to the outcomes we wish to secure, capacity is concentrated in consultant led hospital services, there is relatively little sub acute bed based capacity, and information systems are not aligned. This does not create the conditions from which transformational change can be achieved.
Where we will be in 5 years
We aim to achieve long term conditions care pathways and service models, and a supporting organisational infrastructure, which: • Place the needs of people with long term conditions and frail older people at the heart of service delivery • Provide personalised services tailored to individual patients and carers needs

- Achieve much better outcomes for less investment
- Provide seamless care pathways for the major long term conditions – cardio vascular disease, diabetes, respiratory disease – and for frail older people
- Are inclusive of patients with dementia, with a highly effective interface to the services for older people we commission from RDASH
- Include a highly effective interface with social services
- Provide high quality support for carers
- Have an effective interface with specialist palliative and end of life care services
- Create whole system leadership and engagement – clinical, professional and managerial - which transcends traditional organisational and care-domain boundaries
- Provide care closer to home, with a radical reduction in emergency hospital activity without a compensating rise in planned hospital activity
- Are based on a high standard of evidence
- Make excellent use of innovative technologies and care processes, including self care and tele care
- Deliver 10 – 20% efficiency gain over four years from the total investment made in long term conditions, intermediate care and emergency care services
- Have an efficient and reasonable distribution of risk which will ensure the viability of commissioners and providers, acting together in the best interests of patients and the population, hence making best possible use of the NHS Rotherham resources
- Have long term sustainability

How do we get there?

We will develop a comprehensive statement of the standards, outputs, outcomes and efficiencies we wish to secure from reformed care pathways and service models. This will provide the basis upon which to appraise the various options for securing improvement. We have excluded "do nothing" as we are certain that change is needed – doing nothing will simply sustain sub-optimal outcomes and inefficiency.

We have therefore identified five options:

- Retain current service configuration (with the existing or a new community service provider) and seek to align pathways and incentives to secure improved outcomes and efficiency
- Commission GPs to assume greater responsibility for managing long term conditions, including the management of exacerbations and risk
- Commission vertical integration with hospital services, resulting in a single provider managing whole pathways
- Commission horizontal integration with social services, resulting in a single provider of home and community based health and social care
- A combination of two or all three of the latter three options

All these options would require significant changes to contracts, including changes to the tariff and other payment systems, leading to effective incentives and distribution of risk. For some of the options these changes would need to be fundamental, and would see us stepping away from national frameworks for contracts and PBR.

We will need to consider the options with great care (including potentially with external advice); we will need to engage effectively with all partners, including staff; we will need to proceed decisively and with pace.

How we will make sure that the initiative will impact on the people who most need it?

Over the last two years we have improved in our ability to monitor the impact on people who most need. We will ensure that all services have a clear specification. Their roles will be mapped out accurately. The impact of services will be measured against key performance indicators which are specific, measurable, achievable, realistic and time limited. Services will be effectively performance managed by commissioners with regular reviews, continuous dialogue with providers and a regular assessment of strategic relevance.

Finance

One of the key outcomes from this transformational initiative is to generate efficiency savings. This can be achieved by streamlining care pathways and integrating services. The intention is to maintain and/or enhance frontline service but reduce support costs through service integration, flatter management systems and the availability of alternative levels of care.

Impact on health and other services

Despite the current economic situation it is our intention to ensure continued improvements in the delivery of community health care services. The development of a range of alternative levels of care delivered within integrated care pathways will ensure that people receive support earlier, reducing the need for acute care and making savings further down the care pathway.

How we will measure improvement

Improvement will be measured by:

- A reduction in the number of unplanned admissions of people with long term conditions
- A reduction in the number of emergency bed days of people with long term conditions
- Increased patient satisfaction

Communication Plan (include patient, clinical and stakeholder input)

We have embarked on a five stage process with this part of our strategy:

1. Initial informal dialogue with patient and carer representatives, GPs and practice based commissioners, RMBC, RFT, RCHS and RDASH, and with staff
2. Formal option appraisal, leading to the selection of a preferred option, supported by a strategic business case
3. Formal consultation with the public, patients, staff and partners, leading to the confirmation of an agreed option
4. Contract negotiations with the preferred provider(s)
5. Implementation

We recognise that the engagement of stakeholders – in particular clinicians and other staff – will be critical to this programme succeeding. We will agree and implement a dedicated communications and engagement programme to achieve this.

We will pay due regard to the requirements of the NHS Yorkshire and the Humber Strategic Change Assurance Process, and the national rules for cooperation and competition.

We will also take very careful account of the impact this programme may have on other parts of the local health economy. Our goal is to achieve change during 2010/11.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Jackie Brown/Dominic Blaydon	**Kath Atkinson**	

Transformational Initiative: Commission alternative levels of care closer to home (TI: 22)

Where we are now

Better Health Better Lives identified that many people who are admitted and stay in hospital do not need that intensity of care. Inpatient acute care is essential for patients who need 24 hour nursing care and medical intervention. Unnecessary stays in hospital expose patients to other risks associated with hospitalisation, such as infections, low satisfaction levels and de-compensation of existing conditions.

Last year a transformational initiative of implementing a robust admission and discharge (InterQual®) was agreed. InterQual® is an evidence-based, clinical decision tool that supports clinicians in determining the appropriate level of care needed to maximise patient's recovery. NHS Rotherham sponsored a steering group to set key milestones and develop this initiative. The first stage was to implement InterQual® at admission and discharge from hospital in selected wards and areas of the hospital; this is now complete. The information gathered from this has been analysed and identifies that many of the patient's that are in an acute hospital bed do not need that level of care; what they do need is either therapy led rehabilitation, skilled nursing care or a combination of these. This type of care can be provided in different ways for example: - as inpatient rehabilitation/nursing facility, day care rehabilitation from home, as outreach into people's own home.

Where we will be in 5 years

- Rotherham residents requiring care and treatment will be admitted to the most appropriate facility to meet their needs and transferred at the right time in their pathway to a less intensive setting.
- A range of care environments to be available which are able to meet those needs at the most appropriate level
- The emphasis will be on provision of care closer to home, with individual care packages, delivered in the patient's home where it is reasonable to do so.
- High quality hospital and specialist services will be available to meet needs that cannot be met in other settings.

How do we get there?

The key to delivering this transformational change is to identify the current gaps in service provision, reconfigure intermediate care services (TI: 23) and reconfigure acute inpatient provision. We will work with existing providers to deliver the following changes:

- Develop a range of sub acute facilities that are therapy and skilled nurse led that can be accessed from primary and secondary care.
- Adopt a case management approach using InterQual® to move patients though care pathways
- Reduce the number of acute inpatient beds
- Continue to embed InterQual® across the healthcare system
- Commission care pathways that avoid duplication and information systems interface with each other
- Reduction in the number of clinical 'hand-offs' as patients move through the pathways

How we will make sure that the initiative will impact on the people who most need it?

The health community is clear that if this system is to have maximum impact it will need to be employed routinely to

manage patients as they move through the care pathways. All patients who require a level of healthcare but do not meet the acute admission criteria and where care cannot reasonably be provided at home will receive care in a facility appropriate to their level of need.

We will determine eligibility criteria in line with InterQual® along with a single point of access to ensure the service is available to those who most need it.

Finance

The reconfiguration of acute beds will release a proportion of funding that can be used to provide care in less intensive more appropriate settings. The cost of this care will be less expensive as routine medical intervention is not required; utilising beds more cost effectively will release further efficiency savings.

Having alternative levels of care available provides a 'real' option for clinicians and patients rather than the default position of a hospital admission. Non recurrent pump priming in 2010/11 will facilitate delivery of this initiative.

Impact on health and other services

Utilising inpatient beds more effectively will present a challenge for the Rotherham NHS Foundation Trust. NHS Rotherham will work closely with them over the next 12 months to manage this change clinically and contractually.

As the emphasis shifts towards a more focused rehabilitation and skilled nursing model from that of a traditional medical one this will require a change in the skill mix. It is intended that changes will be stepped and managed through integration of services.

How we will measure improvement

Improvement will be measured by:

- Reduction in hospital admission rates for ambulatory care sensitive conditions
- A reduction in the number of unplanned admissions of people
- A reduction in the number of emergency bed days
- Increased patient satisfaction
- Reduction in the length of stay, particularly people with long term conditions
- Uptake in referrals to ALOC facility
- Greater use intermediate care as a vehicle for preventing hospital admission

Communication Plan (include patient, clinical and stakeholder input)

We will embark on a communications strategy which will seek views from patients, clinicians, RMBC, RFT, RCHS and RDASH using a variety of different forms.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Jackie Brown/Dominic Blaydon	**Kath Atkinson**	**Julie Kitlowski**

Transformational Initiative: Reconfigure intermediate care (TI: 23)

Where we are now

Better Health Better Lives identified the development of effective intermediate care services as a transformational initiative in 2008. Since the service was reviewed in 2006 NHS Rotherham and Rotherham MBC have worked closely to deliver better strategic fit and improved performance. We now have robust joint commissioning arrangements underpinned by a pooled budget and partnership agreement. There has been a significant improvement in the performance of the service over the last two years.

In the residential service bed occupancy has increased from 56% to 72% with admission rates increasing by 38%. 82 % of patients are still at home 3 months after discharge from hospital (NI125) which places Rotherham in the top quartile for this national indicator. Admission rates to the community rehabilitation service have increased by 26%. The Community Rehabilitation Team now delivers over £500k of savings to the home care budget in Rotherham. This indicates that the service is successful at maximising independence and improving physical function. Finally the Millennium Day service has demonstrated some success at improving health and independence levels. 70% of patients reported that their health/condition had improved as result of their intervention. 80% reported increased confidence. All elements of the intermediate care service showed very high rates of patient satisfaction.

NHS Rotherham recently conducted a strategic review of intermediate care services which highlighted the following issues. Bed occupancy in the residential service is still lower than in comparator authorities. Average length of stay increased last year from 35 days to 39 days. More importantly the intermediate care service is not being utilised effectively as a vehicle for preventing hospital admission. Last year only 4% of admission into the residential service were

though community pathways.

Where we will be in 5 years

There are a number of key outcomes which we intend to achieve in the next 5 years. We will provide a service option for people with long term conditions who experience an acute exacerbation, which does not need to be managed in hospital. We will rehabilitate people on discharge from hospital so that they can re-adjust to life back in the community. We will also provide a short-term solution for people ready to be discharged from hospital in order for their long-term care options to be assessed and arranged

The new service will provide alternative care pathways out of hospital, reducing hospital length of stay and delivering a stepping stone back to full independence. We will develop step-up provision to provide GPs and community based health professionals with an alternative to hospital care, reducing admissions to hospital. Commissioners and providers will work together to co-locate of health and social care staff. The new service will improve performance, increase capacity and broaden the range of patients who can benefit from the service.
Finally we will ensure that the new intermediate care service produces a measurable impact on the costs of secondary care reducing the burden on the health economy.

How do we get there?

The Strategic Review of Intermediate Care set out the following recommendations for service reconfiguration which are now adopted by NHS Rotherham's Strategic Plan. NHS Rotherham will work with Rotherham MBC to deliver the following service changes

- KPIs for bed occupancy and length of stay in the residential service will be revised to 80% and 28 days respectively
- Introduce new KPIs on reductions in unscheduled hospital admissions for people with ambulatory sensitive disorders
- Development of a bed management service for the intermediate care residential beds
- Incorporates the community rehabilitation service, residential therapists and the social work service into a single team
- Adopt a case management approach, co-ordinating rehabilitation packages through the whole intermediate care pathway
- Develop a single line management structure led by a senior therapist working exclusively in-service
- Develop an intermediate care hub at the Millennium Centre, co-locating the Intermediate Care Team
- Develop a single point of access for the intermediate care service, incorporating an out-of-hours access point
- Commission additional care enabling hours in the residential service to meet higher level of need
- Decommission Ackroyd Fast Response beds
- Integrate Millennium rehabilitation and maintenance teams into the Intermediate Care Team
- Reconfigure the maintenance service so that it provides a 6 week rehabilitation and community integration programme
- Enhance the intermediate care team include nurse practitioners and health support workers
- Introduce dedicated social services officers to the intermediate care team
- Introduce a common assessment framework and single patient record to the service
- Incorporate the Falls Prevention Service into Intermediate Care

How we will make sure that the initiative will impact on the people who most need it?

In order to ensure that the service is available to those who most need it we will develop a single point of access which applies common criteria for eligibility. We will monitor utilisation of the service by GP practice, ensuring that those GPs located in areas of deprivation have proportionate access. Commissioners will work with RCHS and RFT to ensure that there is appropriate access for people with dementia and patients who have suffered a stroke. We will also remove all age barriers to access, particularly for people who require support in their own homes.

Finance

There are some additional costs required to meet the outcomes set out in this initiative. The strategic review also includes the development of a nursing service within intermediate care to support the rehabilitation units and divert people from A&E. These costs will be offset by savings made in secondary care, particularly in reductions of unplanned admissions for patients with ambulatory care sensitive disorders.

Impact on health and other services

The current intermediate care service has proved successful at facilitating hospital discharge, freeing up acute beds and improving levels of independence for those leaving hospital. Over the next 5 years the service will develop so that patients who have an exacerbation can be cared for away from hospital in an environment which is more appropriate to their needs. We envisage that the impact on people with long term conditions will be significant with improved levels of physical function, better self management and greater independence.

How we will measure improvement

Improvement will be measured by:

- A reduction in the number of unplanned admissions of people with long term conditions

- A reduction in the number of emergency bed days of people with long term conditions
- Increased patient satisfaction
- Improved performance on bed occupancy and length of stay within the residential service
- Greater use intermediate care as a vehicle for preventing hospital admission

Communication Plan (include patient, clinical and stakeholder input)

The Joint Commissioning Team will lead on developing an effective communication strategy. This will include;

- Better engagement with GPs on remodelling of the service
- Use of Citizens Juries
- Continuations of the Intermediate Care Priority, which acts as an interface between commissioners, providers, patients, and carers

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Dominic Blaydon	**Kath Atkinson**	**Paul Chapman**

1.7 Better Mental Health Services

'At some point in our lives, many of us will have a mental health problem, which for some people can be very serious. As people live longer, more elderly people are at risk of depression or dementia'

Introduction

In 2010/11 the mental health programme has identified the following two Transformational Initiatives as its key priorities:

TI: 24 Improve mental health promotion
TI: 25 Commission new wards and day patient services

Building on the work undertaken in the in 2009/10 the Better Mental Health programme over the coming year will continue to strive to improve the delivery of both mental health promotion and secondary care provision across Rotherham.
During 2009 /10 the programme successfully implemented 2 of it Transformational initiatives (TI). The first was TI 26 (Accessible high quality psychological therapies). This service was developed in line with the National IAPT Programme and has achieved over the past year:

- The recruitment of the workforce to deliver the service.
- Working with the SHA and local Universities to ensure that the local service is engaged in the national training programme and is able to fulfill the appropriate requirements for high and low intensity worker in line with National Programme requirements.
- Establishing the SHA reporting mechanism and that data is collected across the pathway in accordance with Department of Health guidelines.
- Work is underway to agree referral thresholds across the whole system to ensure that an integrated pathway between primary and secondary care services is achieved.

The second Transformational Initiative in which the programme has also made some significant achievements is TI: 28 (Improving mental health services for older people). Over the past year the following has been achieved:

- The Older Peoples Mental Health service has moved to a new location and established a revised community based service. The development of this new service model has undertaken a process of rationalization of the inpatient and residential services.
- In April 2009 a pilot of the specialist domiciliary enabling and support services was commissioned from Crossroads.
- Referrals to the Memory Service have also exceeded all expectations with 507 referrals against the expected target of 350 referrals. A performance appraisal of the service has also shown good performance and carer satisfaction.
- The introduction of the Mental Health Liaison Team has also been successful, with the service receiving 340 referrals in the first 4 months.

The Rotherham MH programme team is currently participating in a pilot regional 'peer review' process to assess our local progress against the regional 'Healthy Ambitions' MH pathway. This process will help us to identify where other programmes of work will be needed to bring Rotherham services in line with the aspirations in Healthy Ambitions.
The publication by the DH of 'New Horizons: Towards a shared vision for mental health' document in 2009 builds on the reforms implemented with the Mental Health National Service Framework (DOH 1999) and identifies the following eight key themes which will drive forward the development of the mental health agenda:

- **Prevention and public mental health** – this highlights the need to prevent as well as treat mental health problems by promoting mental health and well-being, although there are already many

examples of good practice in public mental health across Rotherham, such as the Mental Health First Aid Training, Community Development Workers for BME communities, 'Mind your own Business' project and Healthy Schools mental health promotion activity. In the light of the publication of New Horizons the Rotherham Mental Health Team is planning a refresh of the 'Promoting the Mental Well-Being of Rotherham People' strategy.

- **Stigma** – this theme will strengthen the focus on social inclusion and tackling stigma and discrimination wherever they occur. This is an area of work in which activity is already being undertaken through the work of the Rotherham Community Development Workers and the wider NHS Rotherham mental health programme team. It is an area that is becoming increasingly seen in National initiatives, such as 'Time to Change' and is an area in which further work needs to be undertaken locally as highlighted in TI: 25.

- **Early intervention** – this challenges health communities to expand the principle of early intervention in order to improve long-term outcomes and is an area that is starting to emerge at a local level in our care pathways work into eating disorders and maternal mental health problems. Both initiatives have started to highlight the benefits in both patient experience and improved resource allocation that can be gained with the introduction of early intervention approaches in pathways.
- **Personalised care** – this theme is focused on ensuring that care is based on individuals' needs and wishes, leading to recovery. It is this theme that potentially has one of the greatest impacts on the way mental health services are commissioned over the next 10 years. NHS Rotherham is starting to work with RMBC to look at this agenda and build on their current good practice. Local examples of good practice in health include the Islamic therapy perspective group and Staying In Control pilot during 2009 (*not been any outcomes from this… do we even want to mention it? Or say that we need to mainstream it?).*

- **Multi-agency commissioning/ collaboration** – This theme challenges local authorities, the NHS and others to work together. We already have examples of where NHS Rotherham has worked with employers though the 'Mind your Own Business' project and with Area Assemblies, for example, to deliver the recent stress control courses. This work will need to go further to deliver on the local and national vision. We need to work with leisure, housing and the wider Local Strategic Partnership (LSP) to contribute to improving social inclusion and outcomes for people with Mental health problems in Rotherham. Locally we are also starting to see examples of this happening across health commissioning organizations. Indeed, NHS Rotherham is currently working with NHS Doncaster to commission a pilot IMHA (Independent MH Advocacy) service. It is envisaged that over the next couple of years this area of work will become increasingly important. Early indications from the care pathway work are starting to highlight further opportunities for NHS and LA Commissioning organizations to work together to jointly commission.

- **Innovation** – High Quality Care for All (HQCfA), (2008) placed significant emphasis on the role of innovation as an enabler for delivering the national and regional visions through the Next Stage Review (NSR) process. The importance of innovation is also emphasized within the 'New Horizon's' document. Over the coming years in Rotherham we need to work with partners and providers to improve quality, value for money and people's experiences of health and healthcare through the commissioning of innovative, efficient and responsive services.

- **Strengthening transition** – this highlights the need to improve the often difficult transition from child and adolescent mental health services to adult services, and from adult to older people's services for those with continuing needs. This theme highlights the importance of matrix working across organizations and the need to ensure successful cross working between the Mental Health, Children and Young People and Long-term conditions programmes within NHS R. A major target is to ensure that no-one under 18 is admitted to an adult ward from April 2010, unless this is demonstrably 'age appropriate' (*is this right*). NHSR commissioners from the MH and from the Children's programme areas

are working with RDASH and other providers to ensure that we have services in place by the national deadline.

- **Value for money** – This theme challenges NHS organizations to deliver cost-effective and innovative services in a period of recession. Locally, the mental health programme will develop an investment / disinvestment strategy to support this. Initial suggestions for potential disinvestment opportunities include:

    - Redirect resource allocations into prevention and early intervention activities. To develop an Invest to save approach; ensuring better services and outcomes for less costs.
    - Benchmark secondary care prescribing, service mapping and finance.
    - Undertake a number of service reviews

The current economic climate will also provide a particular challenge to the mental health programme over the coming year. As research over the years has clearly demonstrated links between poverty, social deprivation and mental health problems. It is also know that some of our most vulnerable groups, such as those with fewer qualifications, lower incomes, those living in areas of higher socio-economic deprivation and BME communities are more likely to have mental health problems. Indeed, it is these same groups that are also more likely to experience problems in the economic downturn with higher unemployment and rising debt (Department of Health 2009).

The link between mental health and physical health problems is one which cannot be ignored. It is known that people with severe mental health problems die younger and indeed some studies have shown that on average it is 25 years earlier (DoH 2009). This group of people is also known to find it harder to access the screening services and other primary care services they require to improve their life expectancy rates. Therefore, it is important that during the current economic climate, mental health programmes do not merely focus on dealing with the potential increased prevalence of MH problems within its health community population. It also has an important role to play in working with the other programmes to address the access and inequality issues faced by this group of patients which result in their increased risk of premature death from conditions, such as strokes and coronary heart disease.

It is these Key factors that will influence the programme over the coming year and will be focused on through the delivery of the programmes 2 Transformational Initiatives (TI: 23 & 24).

Dementia

The changes in population profile present a significant challenge to older people's services and particularly to services targeting people with dementia. Failing to respond to the rising demand for dementia care would lead to service deterioration, greater vulnerability for older people, increased burden on carers and acceleration into institutionalised care. NHS Rotherham has made significant investment into specialist community services to reduce the burden on hospital and residential care. New community services have been developed which promote independence, prevent illness and therefore reduce reliance on some of the high-cost health and social care services.

The new service model addresses the priorities set out in the NICE guidance for dementia. Most relevant policies and guidelines recommend a focus on promoting independence and preventing deterioration. Alongside RDASH we have commissioned a new-build inpatient unit, which will provide a modern and safe environment for older people with mental health issues. In 2008 we commissioned the Rotherham Memory Service, which provides early assessment for people with memory problems. It delivers pre-diagnosis counselling and comprehensive memory assessments. We have also established a *Mental Health Liaison Service,* which provides support to people in care homes, general hospital and mental health wards. Finally, we have developed a *Dementia Enabling and Support Service.* This provides respite breaks to carers of people with dementia. All the services identified supports people with dementia to be more independent in

the community. They enhance the quality of life of people with dementia and their carers, reduce avoidable admissions to hospital and premature admission to long-term residential care.

Learning Disability

Another key part of the work of the MH programme team is commissioning and supporting the development of excellent health services for people with a learning disability in Rotherham. The Y&H SHA is working on the development of a new 'Healthy Ambitions' pathway for people with a learning disability. The Region has also just launched the third year of it's regional health assessment process, which is now being rolled out nationally. In Rotherham all GPs have signed up to deliver annual health checks for people with a learning disability (who are known to social services) and we have appointed a strategic health facilitator for 18 months to work with practices and with the acute hospital and with MH services to improve access to services for people with learning disabilities. 'Valuing People Now' published by the DH in January 2009 contained the government's response to a series of critical national reports and an enquiry into people's experience of accessing health services. Our local work on the assessment framework, and with our provider trusts is to ensure that we act on these recommendations in Rotherham.

The other important area, in the regional healthy ambitions pathway, is about ensuring that people with learning disabilities have local access to the specialized services that they need to support them. This is particularly the case for people with more complex needs, including behaviours which challenge services, or people with complex autism, or people who offend. NHS Rotherham has invested in the past to ensure that our local services are good. We will be working with our local joint provider of learning disability services to agree service specifications and a contract to ensure that services continue to be as effective as then can be, and that they provide quality and a good experience for people and value for money for commissioners.

How will we measure our success?

Our better mental health goal is: what?

During 2009/10 we successfully:
Commissioned and delivered improved access to psychological therapies:
High intensity treatments:
Low intensity:

Commissioned and delivered improved MH services for people with dementia:
No of people attending memory clinic: 507 referrals (against target of 350)

By 2011 the programme will have

- *Developed and implemented a new community MH service model.*
- Commissioned new wards and day patient services at the Rotherham DGH site and at Swallownest Court.
- Delivered 19 Mental Health First Aid courses. *Jess need to update*
- Engaged at least 100 small /medium employers and 6 large employers in the 'Mind your business' project. *Jess needs to update*
- Updated the MH promotion strategy in line with New Horizons
- Developed a new commissioning model for MH services
- Ensured that everyone with a learning disability (known to social services) will be offered a check of their general health needs by their GP
- Ensured that 75% of people with a learning disability, who want one, have a Health Action Plan which is updated by their GP

- Developed protocols for admission and discharge of people with a learning disability with the general hospital and with Mental Health services.
- As part of transforming Community services we will revisit the current arrangements for specialist community support to people with a learning disability to ensure it is in-line with the Valuing People guidance.

We will also continue to refine measures of quality in this area and improve ways of making them available to the public, patients and clinicians. Other key metrics will include:

- Suicide rate
- Access to psychological therapies
- Patient experience of mental health services
- Patient experience of Learning Disability services
- Access to services by BME communities
- Number of people receiving dementia assessments (local target)

Transformational Initiative: Improve mental health promotion (TI: 24)

Where we are now

Mental health (MH) continues to be an important health nationally and locally. Local areas are required to have Mental Health Promotion Strategies based on local need, which should be implemented and evaluated. Based on national estimates we can calculate that in Rotherham: -

- 27,100 people in Rotherham aged 16-65 will have a common mental health problem anxiety and or depression. (1 in 6 people aged 16-65 will have a common mental health problem at any one time).
- 800 people will have a psychotic disorder. (1 in 200 people aged 16 to 65)
- 1,850 people over the age of 65 will have dementia. (5% aged over 65 will have dementia)
- 3,700 of 5-15 year olds will have a diagnosable mental health disorder. (10% of people aged 5-15 years)

We know that there are around 20-25 suicides per year in Rotherham; MH problems are the leading cause of Disability Adjusted Life Years (DALYS); there is little evidence to suggest that this disease burden is decreasing.

The Rotherham Mental Health Promotion strategy covers a **whole population approach**, the settings of **schools**, **primary care** and **workplaces** and refers to work taking place on social inclusion for people with MH problems.

Where we will be in 5 years

Through implementation of the Rotherham Mental Health Promotion Strategy, we aim to see: -

- Improvements in MH literacy amongst frontline workers, (esp. BME), through initiatives like MH First Aid.
- Earlier detection of MH problems, with support and signposting, targeting employers, carers and frontline staff.
- People with MH problems having improved access to healthy lifestyle information and support
- Improved mental well-being through targeted work with employers to promoting mental health in the workplace
- People having a better understanding of how to look after their mental health, with examples of good practice
- Reduction of stigma and discrimination towards people with mental health problems

Impact on health and other services

Mental health problems account for 5 of the 10 leading causes of disability worldwide (WHO). MH promotion can reduce risk of some people developing a mental health problem, strengthen protective factors and decrease psychiatric symptoms and disability. (WHO 2004) Potentially mental health promotion could account for a saving by preventing mental health problems occurring in the first place and by a reduction in prescribing.

Good mental health is a protective factor for physical health. It also improves health outcomes and recovery rates (coronary heart disease, diabetes and stroke). Poor MH is associated with slow recovery rates for physical health problems, poor self-management of health conditions and health damaging behaviours. Even small improvements to MH contribute to improved physical health, productivity and quality of life. Improving MH could make a positive contribution towards other Choosing Health priorities. If we implement a programme of MH promotion for all ages then the impact on other services will include;

- A significant contribution to all Choosing Health target areas.
- MH promoting workplaces leading to increased job satisfaction, and a reduction in MH related sickness absence,

lower staff turnover, and a higher return to work rate of people absent with a MH problem.
- Individuals feeling able and motivated to exercise choice, including the adoption of healthy lifestyles.
- Improvements in quality of life for individuals, families and communities.
- reduced prescribing
- Potential improved outcomes in education, employment, crime, relationships and parenting.

How we will make sure that the initiative will impact on the people who most need it?

In relation to income deprivation, Rotherham is worse than the national average. (DH 2007, Community Health Profiles) It is an acknowledged fact that MH problems are more common in areas of deprivation. (Wanless 2004, Choosing Health 2005). We have identified vulnerable groups who need additional attention in relation to MH promotion (BME communities, carers, and people living within the most deprived areas of Rotherham). These groups have also been identified as priority groups in areas other than mental health. We know that action to address the broader determinants of health (improving housing, reducing crime, increasing access to facilities and services, access to green open spaces) all contribute to promoting the mental health of these vulnerable groups.

In addition we have used equity audits to determine where MH services need to be prioritized. We have Community Development Workers (CDWs) working with BME communities to raise the communities understanding of mental ill health and to work with services to make them more accessible to BME communities.

The workplace project will measure the contact it has with employers in the NRS areas.
MHFA has been run with communities of interest and in the Neighbourhood Renewal Strategy areas. Future rollout will look at targeting carers and BME workers in particular.

Finance

Many workers employed by NHS Rotherham do deliver MH promotion initiatives in their day-to-day work. In addition partner agencies are also delivering work, which has a mental health promotion component. The resource we have also identified a Public Health Specialist with a lead responsibility for MH promotion, and delivered 19 Mental Health First Aid courses.

How we will get there

We will implement the Rotherham Mental Health Promotion Strategy based on local need.

- By promoting the mental well being of the population of Rotherham through a settings approach, paying particular attention to vulnerable and at risk groups.
- By raising public understanding of MH and ways people can protect their own MH and that of others.
- By involving organisations and communities in taking positive steps to promote and protect mental well-being.
- By combating discrimination against individuals with mental health problems and promote their social inclusion.

We will focus on the whole population and settings of schools, primary care and workplaces. Actions will include: -

Whole population
- Roll out of Mental Health First Aid (MHFA), focusing on frontline workers, carers and BME workers
- Marketing promotion messages to enable people in accessing appropriate information highlighting the positive steps they can take to look after their mental health.

Schools
- Encourage all Rotherham schools to attain Healthy Schools Status.
- Encourage schools to assess their bullying policies in line with national and local criteria and best practice.

Workplaces
- Continue to implement the 5-year local lottery Mental Health Promotion in the Workplace Project, which looks at a 3 Tier approach to mental health promotion within the workplace.
- Provide information, workshops and training for employers, including MHFA and stress Management.
- Promote local mental health provision to employers and encourage referral to these services as appropriate. (Rotherham Primary Care Mental Health Service- Stresspac, CCBT and Books on prescription)

Primary Care
- A rolling programme of Stresspac educational workshop across all 7 Area Assemblies.
- Health trainers supporting people on the Severe Mental Illness Register who want to make lifestyle changes.
- MHFA Training for non clinical and non expert staff.

Progress made:
- 16 Mental Health First Aid training courses delivered to 171 people (7 GP practice staff, 128 frontline staff, 20 BME workers and 15 others)
- Mental health awareness e.g. bus station plasma screen

- NHS Rotherham has worked with 19 SMEs and 21 large employers to improve their working practices in relation to mental health. 340 direct beneficiaries in receipt of training or support.
- 70 employers are in contact with the 'Mind Your Own Business' project and have received information about local Mental Health services e.g. stress control, books on prescription. There is anecdotal evidence that employers publicise these services to employees and there are cases of employees that have been signposted to NHS services by their employer. Books on prescription loans have increased to over 400 loans per month borough-wide.
- 2 stress Control groups have run this year 1 in the town centre and 1 in Dinnington. There were 50-60 attendees at each.
- Health Trainer pilot established at Woodstock Bower

How we will measure improvement

Milestones/timelines –

- Implementation of the MH Promotion Strategy in line with best practice in the Department of Health's documents 'Making it possible framework'.
- Refresh of the MH Promotion Strategy in 2010 to ensure it is aligned with the Department of Health's document 'New Horizons'.
- MH promotion in the workplace-min. work- 100 Small Medium Employers, 6 large employers and 1650 employees.
- MHFA- minimum of 19 courses to be delivered 2008- 2010

Process measures –

- Quarterly Big lottery returns for MH Promotion in the Workplace project; evidence of output and outcomes achieved.
- Quarterly review of the performance of the MH Promotion Strategy to the Mental Health Planning Team

Outcome measures - Reduced prescribing and reduced uptake of mental health services due to prevention.
Reduced duration of contact with MH services due to early detection and patient choice of provision (e.g. Stress Pac)
Reduced sickness absence due to mental health problems; Improved physical health of people with MH problems
Self-reporting on the Rotherham Lifestyle surveys.

Difficult to state because mental health promotion has never really had tools to measure good mental health. Identifying indicators has been a national challenge. Suggestions have included: - general health questionnaires, quality of life indicators, social capital indicators**.**

Communication Plan (include patient, clinical and stakeholder input)

- Through the delivery of the Mental Health First Aid courses the programme has created a network of champions to promote mental health awareness in the communities across the district.
- The programme is also working with the Communication and Graphic teams to produce a range of publicity activities. These include a QTV advert, Plasma screen advert being displayed in the Rotherham bus station etc.
- The team is also working with the Health Advice and Library teams to not only raise awareness of mental health but also promote an anti-stigma message through the delivery of the Time to Change campaign messages.
- The 'Mind Your Own Business' project has an engagement and communication plan in place.
- The programme is working to refresh the Mental Health Promotion Strategy. For this, a communication and consultation process is in place.
- There is a process in place to promote and recruit people to the Stress Pac programme across the district.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Ruth Fletcher-Brown	**Kath Atkinson**	**Steve Burns**

Transformational Initiative: Commission new wards and day patient services (TI: 25)

Where we are now

Inpatient mental health beds in Rotherham are provided on five wards on the Rotherham District General Hospital (RFT) site, with additional interim care beds for older people and rehabilitation beds for adults of working age at Swallownest Court. The accommodation for mental health patients on the RFT site was originally a maternity unit. It is not designed to cater for the specific needs of people with acute mental health problems and the environment does not promote modern therapeutic care. In addition the beds for each age group are spread over two sites. Finally there is an over reliance on beds in Rotherham, and for older people, in particular, poorly developed community services.

Where we will be in 5 years

We will have the following:

- Ward environments that meet the best standards of design and which promote modern therapeutic care and facilitate recovery.
- A care pathway which is not over reliant on inpatient beds, but which has a range of community services to support social inclusion and promote independence.
- An excellent inpatient services which provide a clearly defined intervention and treatment, for as short a time as possible, to enable people to return to their homes or back to the community to continue their recovery.
- Staff with the highest possible skills to deliver evidence based inpatient care to the most seriously ill and distressed people.

Impact on health and other services

The Darzi next stage review emphasises the importance of quality, dignity, the patient experience and personal control over services for all that use them. Emerging policy in mental health services has been focusing over the past 4 to 5 years on the importance of mental health services promoting social inclusion, in addition to the important therapeutic interventions necessary to help people to recover from acute episodes of ill health. (NSF Five Years On 2004, SEU Report 2004, Vision for Better MH 2008 and others).

The impact of improvements in the MH ward environment and, importantly in the care pathway, should be significant:

a) improved experience for service users and carers – fewer compulsory detentions, better engagement with care; shorter lengths of stay;
b) a less institutional response to care for older people – maintaining people in their own homes or in community settings for as long as possible; better maintained links with community for adults of working age resulting in better social inclusion (or less social exclusion) and better recovery as defined by the service user.

How we will make sure that the initiative will impact on the people who most need it?

We will

- Ensure that people from BME communities have a fair and equal access to services, the development of the new services will have strong CDW involvement.
- Older People are among the most socially excluded, and Older People Mental Health (OPMH) services are often currently inadequate; the new services will ensure that older people have access to quality, appropriate services.
- An equality impact assessment (EIA) will be completed for all services.
- The new build / refurbishment, will be fit for purpose, will have ground floor access, and better need a variety of needs both in terms of access and privacy / dignity

Finance

£000s (invested in RDASH services only)	AWA	OPMH
Acute beds	£2,684	£1,989
PICU	£694	
Rehab	£1,661	£1,170

(ref national finance mapping 08/09) could inc 09/10 figs once validated

Additional spend:

The move to purpose built state of the art facilities and the refurbishment of existing accommodation will require an ongoing investment of over £2m per year. A further investment of over £400,000 will be made to ensure the increased level of community services are up and running and fully tested prior to the reduction in bed numbers

How we will get there

The proposal is to develop the wards on two separate sites - Swallownest Court for adults of working age and a new build at Rotherham Foundation Trust for Older Adults

Progress made:

- RPCT Board signed up in principle to re-providing the MH inpatient wards in late 2007.
- RDASH identified as preferred provider (recent excellent HCC commission rating)
- In Conjunction with its partners, NHS Rotherham has undertaken a number of consultation events over the last 12 months to ensure that the development of the project has received contributions from a wide range of stakeholders.
- Public Open Evening held at Swallownest Court July 2009.
- Planning permission was granted August 2009.
- Quarterly Public Forums established September 2009.
- Rotherham FT, RDASH and NHS Rotherham sign-off lease for Older Peoples building October 2009.
- Building commenced October 2009.

Further action required:

- Completion of the building 2010
- The reduction in the number of beds and a new community service model to be developed.
- Implementation of the new community service model expected late 2010
- Project completion 2010

How we will measure improvement

Milestones/timelines –

- Formal consultation process Sept – Dec 08 -
- Strategic Outline Case – Aug 08
- Outline Business Case – Oct 08
- Feedback from the consultation to the Boards – Dec/Jan 08/09
- Full Business Case – March 09
- Building work completed – May 10

Process measures –

Achievement of the above timelines with submissions of the above Cases and consultation finding to the NHS Rotherham Board.

The completion of the building work is the only one of the above milestones that is outstanding, all other milestones have been achieved.

Outcome measures –

- Establishment of a new service models for Adults of Working Age and Older Adults. As part of this process outcome measures for the new service will be agreed with the Provider.
- Implementation of the new service models for Adults of Working Age and Older Adults
- Value for money

New and refurbished facilities

Communication Plan (include patient, clinical and stakeholder input)

- RDASH has established a Communication and Marketing group
- NHS Rotherham and RDASH are currently developing a joint communication and engagement plan.
- Consultation feedback has taken place through the publication of the 'In Touch' publication and various other stakeholder forums.
- RDASH have established a resident's forum to provide regular feedback to people living near the Swallownest court site
- The internal NHS Rotherham infrastructure is to be used to provide a mechanism to update staff with the projects development.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Kate Tufnell	**Kath Atkinson**	**Steve Burns**

1.8 End Of Life Care

Introduction

"How people die remains in the memory of those who live on"
Dame Cicely Saunders
Founder of the Modern Hospice Movement

TI: 26 Improve services and choice for end of life care
TI: 27 Review and extend the Rotherham Hospice Service
TI: 28 Re-commission an enhanced hospice at home service
TI: 29 Implement the Gold Standard Framework across Rotherham

End of life care will impact on every Rotherham resident at some point and we have a responsibility to get it right first time as there are no second chances. Consequently NHS Rotherham has actively listened to the voice of service users either through direct clinical contact, user forums or personal experience. This has enabled the development of our vision for a world class end of life care (EOLC).

Rotherham currently has a wide range of high quality multi-agency services for people at the end of life however to be truly world class we need to develop a consistent, holistic approach that ensures services are coordinated around the patient. Our highly specialised hospital services mainly focus on treatment and cure however some people choose to end their life in hospital consequently the Rotherham Foundation Trust have a range of highly skilled staff who provide EOLC.

NHS Rotherham commissions a wide range of core and specialised community services which includes;

- GPs and their team, who play a vital role in the delivery of end of life care. This is part of their core business and is important to the effective provision of all other end of life care. Patients and carers value the clinical expertise from their trusted family doctor and in Rotherham 100% of GP practices have adopted level one of the Gold Standard Framework for EOLC.
- A Lymphoedema service that provides care and support to people with complex lymphoedema enabling them to manage the condition.
- Specialist Palliative Care Services which includes hospital and community clinicians, Specialist Heart Failure Nurse, Macmillan nurses, Hospice at Home staff, Specialist Physiotherapists and Occupational therapists. The service provides coordinated care across all settings in the patient pathway, from the hospital, to community and patients own home. This service is essential in supporting not only patients but their family and carers throughout the end of life journey including after death care.
- In Rotherham we are fortunate to have an excellent adult hospice service, which has recently been awarded the Rotherham Community Achievement Award 2009. The Rotherham Hospice provides day hospice and inpatient facilities that offer high quality specialist care for people with life limiting illness.
- For Children and Young People (C&YP) we currently commission a range of services for individuals who have life limiting conditions or require end of life care. Our local community Children's Nursing team has been recognised nationally as an excellent service and will provide 24/7 nursing care in the home for those C&YP reaching the end of life. In 2008 Bluebell Wood Children's Hospice was opened within the Rotherham area, and is one of only 40 children's hospices in the country, from October 2009 NHS Rotherham has actively commissioned services directly from the hospice to support C&YP and their families both in the hospice and within the community setting. Having these services in place reduces the need for inappropriate hospital admissions and gives Children, Young People and their families a choice of where to access services at this important point in their lives.
- Community Matrons and the District Nursing services provide essential care and support for people at the end of life who choose to stay at home. This vital service ensures that care packages are tailored to individual patients needs.

- Breathing Space is a unique service developed to provide disease management and rehabilitation for people with Chronic Pulmonary Disease. This highly specialised service is the only one of its kind in England and has now extended its scope of services to provide in-patient care for people at the end of life with pulmonary disease.
- A specialist Macmillan nurse who is dedicated to work with care homes to provide EOLC education, training, advice and support, to staff, residents and carers.
- A range of bereavement services to provide counseling and support.

Our world class commissioning outcome measure is to decrease the numbers of people who die in acute hospitals. By 2010 we will have reduced the number of people who die in hospital by 100 deaths per year

Transformational Initiative: Improve services and choice for end of life care (EOLC) (TI: 26)

Where we are now

Currently most Rotherham residents die in acute hospitals; this is 5% more than the national average and much higher than peoples stated preference of place of death.

In 2007 we carried out a Palliative Care population health needs assessment, developed a Palliative Care Strategy and appointed an EOLC Planning & Development Lead within the Strategic Commissioning team. The Darzi NHS Review and the National EOLC Strategy; (*End of Life Care Strategy: Promoting high quality care for all adults at the end of life, DOH, July 2008)* has further informed the milestones of this transformational initiative.

Currently we do not have sufficient capacity to provide world-class EOLC services for everyone who needs them. Services are compartmentalised by disease groups such as Cancer Care, Palliative Care Services, & Cardiac Care. A whole system approach is required to provide consistent high standards and avoid duplication. This will involve working with charitable organisations, Rotherham Council, Hospice services, Community organisations and the Foundation Trust. The whole system approach will be based upon a care pathway structure both for commissioning services and for delivery of integrated care for individuals. The care pathway involves the following six steps:

Step 1 -Consultation around EOLC approaches
Step 2 -Assessment, care planning and review
Step 3 -Coordination of care for individual patients
Step 4 -Delivery of high quality services in different settings
Step 5 -Care in the last days of life
Step 6 - Care after death.

More attention needs to be given providing support, information and spiritual care for patients and carers.

Where we will be in 5 years

We will have a single point access, rapid response, district wide 24/7 EOLC service that meets the needs of the local population, is based upon quality benchmarks, outcomes measured and offers a choice of place of death.
This will reduce the percentage of people who die in hospital to the national average or below by 2014.

Impact on health and other services

The EOLC transactional initiatives will deliver improved choice and quality of care at the end of life for patients, their family and carers including the opportunity for patient's wishes around EOLC to be expressed and met.

The EOLC initiatives will result in fewer admissions to RNHSFT for people at the end of their life. It will still be the case that for some people an acute hospital will be their choice of place of death. More people dying outside hospital will have implications not just for specialist palliative care services but for primary care, social services, nursing and residential homes and the voluntary sector.

How we will make sure that the initiative will impact on the people who most need it?

Equality Impact Assessments will be undertaken. There is also a need to define EOLC as it should not be associated with Cancer Care and/or confused with Palliative Care. Recent advances in treatment have resulted in people living for longer with long term conditions that are palliative. EOLC can be defined as:

"Helps all those with advanced, progressive incurable conditions to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement.. EOLC does not normally begin earlier than one year before death and for most individuals it may come much later than that (The National Council for Palliative Care, 2007).

How we will get there

An EOLC Commissioning Group has been established with the Local Authority and Practice Based Commissioners to affect a whole system review and approach. The EOLC Commissioning plan will address five key areas:

- Workforce Development
- Advanced Care Planning
- Coordination of Care
- Rapid Access
- Quality Initiatives

How we will measure improvement

Milestones/timeline

2010/11

Hospice Medical cover review will be undertaken in order to plan for Hospice extension of inpatient capacity.
Establishment of an Advanced Nurse Practitioner role at Rotherham Hospice.
Investigate the establishing of a district EOLC register, possibly a pilot
To have rolled out the Integrated Pathway of Care for the Dying to 60% of Community services.
To establish a self assessment system for peer review quality standards
To successful meet the national peer review quality standards for Palliative Care Services across the district.
To review continuing Health Care service
Ambulance services will be reviewed, with enhanced ambulance transport services for people near the end of life.
There will be a review of Bereavement Care Services in order to establish further enhanced services
Surveys of bereaved relatives and carers will be introduced
A training package for communication skill such as Breaking Bad News and general EOLC be made available for all health and social care staff

2011/12

Health and social care professionals will be trained in assessing the needs of patients and carers
All people approaching the end of life will have their needs assessed, their wishes and preferences discussed and an agreed set of actions reflecting the choices they make about their care recorded in a care plan.
Carer's to have their own needs assessed and reviewed and to have a Carer's care plan.

2012/13

A local EOLC centre will be established to coordinate care across organisational boundaries
Access to comparable medical provision out of hours that compliments community services
A district EOLC register will be in place to ensure that every organisation which will be involved in care is aware of a patient's wishes.
To ensure that medical, nursing and personal care and Carers' support services are made available in the community 24/7, including care homes, and can be accessed without delay. This will include access to a 24/7 telephone EOLC helpline and rapid access homecare services.

2013/14

To have reduced deaths in the acute hospital aged 65+ to bring figures in line with the national average or below, through a whole system approach, shifting the balance of care
Look at sustainability of providing (through the commissioning structure) enhancements for improving on quality benchmarks and targets
Re-evaluation of EOLC services

Process measures

Establish a performance management framework for all elements of End of Life Care.
Quarterly review of performance information at EOLC Commissioning Group and reported to NHS Rotherham board.

Outcome measures

Enhanced Palliative Care Services
Achievement of national Peer Review Quality Measures for Palliative Care Services
Reduced hospital admissions for patients at the End of Life
Achievement of Quality Benchmarks
Evidence-based services

Communication Plan (include patient, clinical and stakeholder input)

The EOLC advisory group will disseminate information across the Rotherham community
Press release where appropriate
Formal consultation process where appropriate

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
Gail Palmer	**Kath Atkinson**	**Gail South**

Transformational Initiative: Review and extend the Rotherham Hospice Service (TI: 27)

Where we are now
A review of the Rotherham Hospice has been completed and options proposed for the future model of service provision. The increase in bed capacity is well underway with an ambitious building extension planned for completion in the autumn of 2010 This will increase in-patient beds from 8 to 14.
Where we will be in 5 years
Rotherham Hospice will be a centre of excellence for adult palliative and end of life care
Impact on health and other services
The additional Hospice capacity will provide increased choice for people at the end of life. This will reduce the number of people ending their of life in hospital as alterative care options will be available for those choosing a hospice environment. Also the increased beds will increase the opportunity for a respite service to be developed.
How we will make sure that the initiative will impact on the people who most need it?
A simple marketing campaign will inform all key stakeholders of the increased in patient bed capacity of the hospice. A range of (PROMS) Patient Recorded Outcome Measures and, (PREMS) Patient Recorded Experience Measures will be used as quality measures to evaluate the impact and uptake of the service.
Finance
Non recurrent funding of £1m will be provided to support Hospice modernisation in 2010/11.
How we will get there
The EOLC Commissioning Group and the Palliative Care Advisory group have been established to agree and drive forward systems and processes that will support coordinated pathways of care.
How we will measure improvement
• Increase inpatient bed capacity from 8 to 14 beds by 2010 • Increase in the number of patients at the end of life entered onto the integrated pathway of care (IPOC) • Opportunity for patients to be admitted 24/7 • Opportunity for patients to access respite care • Patient and carer experience surveys • Seamless care pathway between community, secondary, voluntary and primary care providers • A decrease of people with life limiting illness ending their life in hospital
Communication Plan (include patient, clinical and stakeholder input)
All providers will be informed of the bed availability once the extension is completed Caner forum to disseminate information to service users Press release to the general public

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
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Transformational Initiative: Re-commission an enhanced hospice at home service (TI:28)

Where we are now
We have an established hospice at home service that provides active, holistic care for patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. However currently only a limited number of people can access the service. Despite only a restricted number of people being able to access the service due to limited capacity the service has achieved national acclaim in the Department of Health "Making a Difference" document plus they currently have an article submission to in the National Journal of Primary Care and in 2009 they won the Outstanding Chairman's Award.
Where we will be in 5 years
Rotherham will have a service that is provided 365 days per year 24 hours per day 7 days per week. It will offer one to one palliative care provided in the patient's normal place of residence that includes a single point of contact system for clinician's service users and their carers. The single point of contact system will provide EOLC coordination and triage service. We will evaluate usage by practice and ward.
Impact on health and other services
This is a planned care service that operates all year round therefore impact on a range of alternative services will be reduced. The service will support community services when planning case loads. It will reduce the inappropriate use of hospital services as care will be planned and managed according to individual patients needs. This will impact on out of hour's services because medicines management and care will be anticipated, planned and optimised.
How we will make sure that the initiative will impact on the people who most need it?
A range of on-line and paper information for patients, carers and health professionals will be available.

The service will be included in the EOLC pathway. A range of (PROMS) Patient Recorded Outcome Measures and, (PREMS) Patient Recorded Experience Measures will be used as quality measures to evaluate the impact and uptake of the service.
How we will get there
A Hospice at Home group has been established to drive the initiative forward. NHS Rotherham will work with charitable and other associations to develop this service.
How we will measure improvement
• More patients achieving their preferred place of care at the end of their lives • A reduction in unnecessary emergency hospital admissions • Patient and carers experience survey • An increase in the number of people supported to die at home if that is their wish
Communication Plan (include patient, clinical and stakeholder input)
The hospice at home coordinator will inform all providers of the service and how to access it Cancer forum to disseminate information to service users and carers. Breathing Space and the Rotherham Hospice to advertise the service.

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
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Transformational Initiative: Implement the Gold Standard Framework across Rotherham (TI: 29)

Where we are now
100% of GP practices in Rotherham operate at level one of the Gold Standard Framework (GSF)
Where we will be in 5 years
100% of GP practices in Rotherham have adopted the 'Going for Gold' GSF 90 % of adult care homes that provide services to people approaching the end of life have adopted the GSF.
Impact on health and other services
• Reduction in the use of unplanned secondary care services for EOLC • Reduction of avoidable hospital admissions • Advance care planning ensures that care is tailored to individual patients needs so other services are aware of what is needed and when. • Reduction in the use of unplanned out of hour's services. • Improved staff confidence, skill and team working will result in a reduction of unplanned and urgent care.
How we will make sure that the initiative will impact on the people who most need it?
Care homes and GP practices will adopt the GSF methodology therefore ensuing that patients and carers experience the benefits of a structured EOLC approach. A range of (PROMS) Patient Recorded Outcome Measures and, (PREMS) Patient Recorded Experience Measures will be used as quality measures to evaluate the impact and uptake of the service.
How we will get there
NHS Rotherham has employed two GSF facilitators to work with GP practices and Care Homes Protected learning time for GP practices and Care Homes Accredited training programme offered to all GP practices and Care homes
How we will measure improvement
GSF After Death Analysis audit and improvement tool • More patients achieving their preferred place of care at the end of their lives • A reduction in unnecessary emergency hospital admissions • Improved patient and carers experience evaluated using survey, questionnaires • An increase in the number of people supported to die at home if that is their wish • Number of care homes adopting GSF • Number of GP practices adopting GSF to level 4
Communication Plan (include patient, clinical and stakeholder input)
• GSF facilitators to liaise with all relevant stakeholders • GSF forum • Relatives/carers meetings in care homes • Multi-disciplinary meetings in GP practices • Web based online information and chat rooms is available

LEAD MANAGER	LEAD DIRECTOR	LEAD CLINICIAN
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