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Welcome to Rotherham CCG’s first Single Integrated Plan which sets out our three year plan for the commissioning of health services for the people of Rotherham. The plan is based on significant dialogue with local people and representative groups, and detailed discussions with our partners and local service providers. It is consistent with the priorities of the Rotherham Health and Wellbeing Board and NHS South Yorkshire and Bassetlaw.

A key driver for change is our ageing population and the numbers of people with chronic medical conditions. We need to redirect our focus from the current emphasis on acute and episodic care in hospitals towards prevention, self-care and proactive management in the community using all the resources across the health and social care community. Central to this transformation is giving local people the information and support they need to make the right choices for their own wellbeing – this is about Your Life, and Your Health.

We will focus on improvements in primary and community care, planned care, giving children the best start in life, the management of long term conditions, services for those in need of urgent care, continuing (long-term) care, the needs of those with mental health problems or learning disabilities and care at the end of life. We are introducing information systems to allow us to focus the full resources of the health and social care system upon those individuals at greatest level of need.

We know that the significant changes and improvements we are planning to deliver can only be achieved in partnership and we will continue to strengthen and develop these partnerships working across health and social care to meet the health needs of our community.

David Tooth
Chair
Rotherham CCG

John Gomersall
Vice-chair
Rotherham CCG

Chris Edwards
Chief Operating Officer
Rotherham CCG

Who are Rotherham Clinical Commissioning Group and what do they do?

Rotherham Clinical Commissioning Group (CCG) spends £338 million a year to improve the health of people in Rotherham and to provide safe, high quality health services. The CCG is responsible for commissioning community health services, hospital health services, health aspects of social and continuing care, GP prescribing and GP out of hours services that Rotherham people use.

The CCG was established in January 2011 and is led by local GPs who have day to day knowledge of the health problems that Rotherham residents face. Eight GPs lead the Strategic Clinical Executive which is responsible for producing clear and credible plans to improve health and health services and leading their delivery. A further eight GPs sit on the GP Reference Group. This is responsible for two way communication and engagement between the CCG and all 150 GPs in Rotherham. Every Rotherham General Practice is a member of the CCG. CCG decisions are made by the CCG Committee. This is currently accountable to the Department of Health through NHS South Yorkshire and Bassetlaw Board. If the current Health Bill is passed by Parliament the CCG will apply to be authorised as a statutory body before April 2013. The CCG Committee will become the CCG Board whose membership will include lay members, GPs, senior managers, a nurse, a hospital consultant and Rotherham’s Director of Public Health.

The CCG will be supported by a small team of managers who work directly for the CCG. Further support for the CCG clinicians will be provided by South Yorkshire and Bassetlaw Commissioning Support Services who will also support four other CCG’s in South Yorkshire.
Our Vision for Rotherham CCG

‘Your Life, Your Health’ - A dynamic, clinically led commissioning organisation committed to the efficient delivery of high quality care and to responding to the challenges set by the new health system. Patients and carers are at the heart of our business as we deliver safe, seamless patient-centred care, as close to patients’ homes as possible. Supported by a competent and experienced management team and working in partnership with high achieving local organisations to improve the quality and experience of health care for Rotherham people.

Our Vision for improved health and health services in Rotherham

‘Your Life, Your Health’ – Rotherham CCG will work with partners to help deliver key priorities identified by Rotherham’s Community Strategy:

- The best start in life
- Supporting the most vulnerable communities
- Supporting and sustaining the growth of the local economy

We will improve communication with the public including communicating the costs of health services and the efficiency challenges the health service faces.

We will transform the way health services are delivered, by:

- Preventing as many health problems as possible
- Helping patients to take more control over their health and the management of their health problems and supporting their carers
- Transforming the case management of 8000 people with long term conditions
- Improving the quality and efficiency of the use of diagnostic tests, medicines and referrals for specialist care
- Making sure patients with urgent needs get the right care at the right time, with better assessments and more alternatives to hospital admission. This will mean less people in hospital beds and more people being cared for in the community

Transformation is necessary if we are to continue to deliver a change for better health for the people of Rotherham now that the era of increasing NHS spending has come to an end.

CCG Values

In everything we do we believe in:

- Clinical leadership
- Putting people first, ensuring that patient and public views impact on the decisions we make
- Working in partnership
- Continuously improving quality of care whilst ensuring value for money
- Showing compassion, respect and dignity
- Listening and learning
- Taking responsibility and being accountable
Rotherham is fortunate in that overall it has good quality health services but we need to overcome significant challenges to continue to improve the quality of services.

- **NHS Efficiency requirements.** Health service funding is expected to rise in line with inflation but demands on health services rise much faster than this. Nationally the NHS has to produce £20 billion of efficiency savings over the next three years to be able to continue to afford new treatments, meet the health needs of an aging population and rising public expectations. Rotherham’s share of this efficiency challenge is £74.9 million. This is a dramatic change from the situation up to 2010 when the NHS was fortunate to receive year on year real increases in funding.

- **Impact of the economic downturn.** The NHS is not alone in having efficiency challenges. Partners such as Rotherham Metropolitan Borough Council, the voluntary sector and health service providers also have severe financial challenges and we will work closely with them so we understand the impacts we have on each other.

- **NHS reorganisation.** The CCG is one of several new NHS organisations being set up as part of the NHS Reforms at the same time as NHS management costs reduce by up to 50%. The overall aims of the health reform are to make the NHS more accountable to patients, reducing management costs to free up resources to invest in front line staff and to focus on clinical outcomes rather than management targets.

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Our four key priorities are:

- **Delivery** – making sure services are safe, improving outcomes and quality, ensuring vulnerable people have effective safeguarding and meeting our financial targets
- **Improving GP quality and efficiency** – achieving consistent improvements in primary care in partnership with NHS South Yorkshire and Bassetlaw
- **Commissioning for quality and efficiency** – leading system wide efficiency programmes
- **Transition** – achieving full accreditation by April 2013, ensuring safe transition of PCT responsibilities to successor organisations and developing strong relationships with existing and new agencies in Rotherham

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What challenges does the health service in Rotherham face?

As well as CCG funding the NHS spends an additional £130 million a year on health in Rotherham. This includes spending on public health which will become the responsibility of Rotherham Metropolitan Borough Council and on specialist services and primary health (such as GPs, dentists, pharmacist and opticians) which is the responsibility of the NHS Commissioning Board.

Overall health strategy in Rotherham is led by the Health and Wellbeing Board. This is led by Rotherham Metropolitan Borough Council and members include key agencies in Rotherham including the voluntary sector. The Health and Wellbeing Board is responsible for assessing the needs of the people of Rotherham by producing a Joint Strategic Needs Assessment and for producing Rotherham’s Health and Wellbeing Strategy.

Rotherham CCG commissions health services from a wide range of providers such as The Rotherham NHS Foundation Trust (community care and hospital care), Rotherham Doncaster and South Humber NHS Foundation Trust (mental health and learning disability services), Care UK (Walk in centre, GP Out of Hours service and diagnostics), The Rotherham Hospice (end of life care services) and a range of continuing care providers. We will work with providers to improve the quality of their individual services and to make sure that all services are co-ordinated with each other and with services from GPs and RMBC.
‘Your Life, Your Health’

General Practice
- Quality & efficiency visits
- Prescribing efficiency reviews in all GP practices
- 6 prescribing service redesign projects
- GP case management pilot (LTC)

In 2012/13 we will deliver £1.2m prescribing efficiency savings whilst maintaining high quality GP prescribing

Planned Care
- Better care pathways and GP-consultant communication reducing growth in hospital referrals and subsequent treatments
- Reducing outpatient follow-ups towards national average follow-up ratios
- More efficient blood tests (3.3% reduction)

In 2012/13 we will deliver £3.1m of efficiency savings by keeping elective growth to 1.1% from 2010/11 and reducing follow ups by 5.8%.

Unscheduled Care Efficiencies
- Enhanced GP case management of 8500 people with LTCs in practices covering 87% of the Rotherham population. Social prescribing scheme with voluntary sector giving alternatives to medical model
- Transforming unscheduled care. Efficient access and rapid assessments as alternatives to hospital admissions in 2012. NHS 111 & redesign of Walk in Centre, GP Out of hours and A&E in 2013.
- Alternative to hospital admissions. 3 enhanced community care services and intermediate care pathways
- Care pathway reviews starting with 5 adult and 3 children’s care pathways

In 2012/13 we will deliver £4.8m efficiency savings by reducing emergency admissions by 18.2% from 2010/11 levels.

Mental Health & Learning Disabilities
- Commission for outcomes through Payment by Results (PBR)
- Improved pathways including dementia and autism and pathways for psychological therapies
- Better mental health for children and young people

In 2012/13 we will increase the proportion of people with depression receiving psychological therapies from 13% to 15%

End Of Life Care
- Improve services and choice for end of life care
- New community end of life palliative care team leading to more efficient use of hospital and hospice beds and more choice for end of life patients and carers

In 2012/13 we will increase the number of people who die in their usual own home or care home from 40% to 45%.

Quality Assurance:

Effective Partnerships:
working with partners to develop and deliver Rotherham’s Health and Wellbeing Strategy and Community Strategy

Corporate Priorities

Outcomes

NHS Outcomes Framework
Domain 1: Preventing people from dying prematurely
Domain 2: Enhancing quality of life for people with long term conditions
Domain 3: Helping people to recover from episodes of ill health or following injury
Domain 4: Ensuring that people have a positive experience of care
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Social Care Outcomes Framework

Public Health Outcomes Framework
1 Introduction

1.1 Context

Rotherham Clinical Commissioning Group (CCG) has delegated responsibility from NHS South Yorkshire and Bassetlaw for commissioning health services for Rotherham’s population. The health allocation to NHS Rotherham is £469 million. Rotherham CCG has delegated authority for a budget of c. £338 million. This budget covers community and local hospital health care services, health aspects of social and continuing care and GP prescribing. NHS South Yorkshire and Bassetlaw are responsible for commissioning primary care services and specialist commissioning.

NHS Rotherham was responsible for commissioning public health services until October 2011. Subject to the NHS and Social Care Bill these responsibilities will largely pass to Rotherham Metropolitan Borough Council (RMBC) before April 2013. NHS South Yorkshire and Bassetlaw are responsible for managing this public health transition. Rotherham CCG recognises the fundamental importance of a preventative approach to tackling health and social problems. In future the effective use of the ring fenced public health budget and an emphasis on prevention throughout the CGG’s efficiency programmes will be key to the CCG delivering its outcomes. NHS South Yorkshire and Bassetlaw’s Single Integrated Plan and Rotherham’s forthcoming Health and Wellbeing Strategy will set out the details of future preventative based approaches.

This Single Integrated Plan (SIP) sets out the CCG’s vision, values and priorities. Its purpose is to allow us to see how our performance, finance, quality, efficiency, workforce and IT plans are consistent with each other and are aligned with the requirements of the NHS Operating Framework 2012/13. The document has been structured so that it integrates with the structure of NHS South Yorkshire and Bassetlaw’s SIP and with the criteria with which the Department of Health (DH) will assess the plan.

NHS Rotherham was responsible for Health Service Commissioning in Rotherham until Jan 2011. In January 2011 Rotherham’s Clinical Executive and GP Reference Group were established to work with NHS Rotherham and subsequently NHS South Yorkshire and Bassetlaw to manage the process of transferring commissioning responsibilities. In October 2011 Rotherham CCG was formally established as a sub-committee of NHS South Yorkshire and Bassetlaw. The plan reflects the thinking of the CCG 11 months into the journey towards being an autonomous statutory body in April 2013.

1.2 Vision

Rotherham CCG reviewed its vision for the CCG, for the Rotherham population and for how we expect the health and social care system to have changed by 2015 and the degree of innovation and transformation that are necessary to deliver the CCG’s vision.

The vision for Rotherham CCG is:

‘Your Life, Your Health’ - A dynamic, clinically led commissioning organisation committed to the efficient delivery of high quality care and to responding to the challenges set by the new health system. Patients and carers are at the heart of our business as we deliver safe, seamless patient-centred care, as close to patients’ homes as possible. Supported by a competent and experienced management team and working in partnership with high achieving local organisations to improve the quality and experience of health care for Rotherham people.
The vision for the health for the People of Rotherham is:

Rotherham CCG will work with partners to help deliver key priorities identified by Rotherham’s Community Strategy:

- The best start in life
- Supporting the most vulnerable communities
- Supporting and sustaining the growth of the local economy

We will improve communication with the public including communicating the costs of health services and the efficiency challenges the health service faces.

We will transform the way health services are delivered, by:

- Preventing as many health problems as possible
- Helping patients to take more control over their health and the management of their health problems and supporting their carers
- Transforming the case management of 8000 people with long term conditions
- Improving the quality and efficiency of the use of diagnostic tests, medicines and referrals for specialist care
- Making sure that patients with urgent needs get the right care at the right time, with better assessments and more alternatives to hospital admission. This will mean less people in hospital beds and more people being cared for in the community

Transformation is necessary if we are to continue to deliver a change for better health for the people of Rotherham now that the era of increasing NHS spending has come to an end.

Rotherham CCG has ambitious plans 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. To provide the fair, personal, effective and safe treatment and care we know everyone wants and to ensure these services are provided in the most cost effective way.

We need to raise everyone’s aspirations for their own health and expectations of their health service, and for people to aspire to longer, healthier lives, and to want nothing but the best from their health services. At the same time our efficiency programmes and approach to managing long term conditions encourages self care and for patients to take more control over their condition and management.

Over the past decade the NHS in Rotherham has improved dramatically, life expectancy has improved by more than two years and the number of premature deaths from heart disease and stroke has halved since 1990.

We have amongst the best access to GPs nationally, low rates of healthcare associated infections and high quality 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.

The health system in Rotherham is already performing well, and because of the careful management of local NHS finances NHS Rotherham has been able to maintain substantial progress to address the significant challenge of reducing NHS commissioning running costs. Actions taken in 2011/12 means the CCG is on track to inherit a fit for purpose organisation with effective commissioning support in April 2013.
Involving our public and patients in planning for the future is very important and during the past few years, the dialogue between the public and the NHS has grown. We know more about what they want than ever before, which means we are more able to provide services that meet their needs and aspirations.

This plan addresses the requirements of the NHS Constitution, further details can be found in section 11. Delivering improved health and wellbeing cannot be achieved in isolation. NHS Rotherham has a track record of working with partners and staff, primary care services, hospitals, RMBC and the voluntary sector to deliver seamless services that make the most effective use of the resources available. There are some far reaching agreements in place with RMBC for 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. Rotherham CCG will build on this work, underpinned by the principles of “nothing about me without me”, communication, transparency and inclusivity.

1.3 Transformation, innovation and capacity

Section 7 of this document sets out the efficiency challenges facing the health system in Rotherham and section 5 describes our quality, innovation, productivity and prevention programmes. If the local health system continues with the levels of growth seen up to 2011 and we are not successful with our efficiency plans widespread cuts will have to be made to local health services. Transformational change is required to continue to improve outcomes, safety and clinical experience whilst delivering the required efficiencies. A 16% reduction in urgent hospital admissions, controlling growth in outpatients, acute providers managing a 1.8% reduction in tariff, the local hospital changing its focus towards less beds and more efficient community services are all extremely challenging. These challenges are magnified by the fact that they are required at a time of radical transition and reduction in commissioning capacity.

There are three important reasons why we believe Rotherham CCG is extremely well placed to meet these challenges:

- There are exceptionally high levels of co-operation between the CCG and our local partners, described in detail in section 4.
- The local acute hospital, The Rotherham Foundation Trust (TRFT), has appreciated for some time the scale of transformation required to be able to continue to be viable in the new economic circumstances and has plans for reducing its bed numbers and transforming the way community services are delivered.
- The first ten months of clinically led commissioning in Rotherham has been extremely successful. Our approach to clinical leadership is set out in detail in section 4.3. We have a long track record of clinically led leadership of prescribing using both conventional and award winning, innovative methods described in section 5.1. During 2011 GP leadership has transformed our approach to clinical referrals management and we have used this model to refresh our approach to the leadership of the long term condition programmes. A diagram of our leadership structure for our Quality, Innovation, Productivity and Prevention programmes is outline in figure 5.1F (section 5).
1.4 Operating Principles

The fundamental principles upon which clinical commissioning will be carried out in Rotherham are:

- Rotherham CCG will be clinically led
- Rotherham should have one Clinical Commissioning Group (CCG) covering all patients in Rotherham
- Rotherham CCG is committed to involving public and patients, health professionals and other stakeholders in commissioning
- Rotherham primary care will have democratic representation on the Rotherham CCG board
- Rotherham primary care will appoint the best people available to manage the CCG’s work
- Rotherham GPs are committed to working towards Rotherham CCG’s objectives
- Rotherham CCG will provide an opportunity every year for all GPs to vote on the ‘direction of travel’

1.5 Priorities

The CCG’s priorities are:

Delivery

- Make sure the services we commission are safe
- Make sure that vulnerable children and adults have effective safeguarding
- Maintain and improve the quality of services
- Deliver improving outcomes
- Meet our financial targets

GP Quality and Efficiency

- Improve GP quality and efficiency in partnership with NHS South Yorkshire and Bassetlaw

Commissioning for Quality and Efficiency

- Lead system wide efficiency programmes that will deliver £28.1 million of efficiency savings out of a total of £74.9 million of efficiency saving required by the NHS in Rotherham by 2014/15 (figures from 2011/12 SIP)

Transition

- Deliver the CCG’s Organisational Development Plan to become an effective CCG with full authorisation in autumn 2012
- Work with NHS South Yorkshire and Bassetlaw to complete the transfer of responsibility for primary care contracts and specialised contracting
- Become an intelligent commissioner of commissioning support services including agreement with NHS South Yorkshire and Bassetlaw as to which support services should be provided directly and which provided by a Commissioning Support Service (CSS)
- Work with NHS South Yorkshire and Bassetlaw and RMBC to agree to maintain the public health contribution to clinical commissioning and achieve a smooth transfer of public health to RMBC
- Further develop relationships with neighbouring CCGs in NHS South Yorkshire and Bassetlaw
- Further develop relationships with the NHS Commissioning Board
1.6 Key Financial and activity assumptions

- A 2.8% growth in financial allocations in 2012/13 and increases of 2% in subsequent years.
- **First outpatients:**
  - Greater than expected reductions have been achieved in 2011/12 with further efficiency gains to be realised in this area restricting growth to 0.4%.
  - Assessment tariff: a revised pathway will see urgent assessments recorded as first outpatients resulting in an increase of 5.2% in outpatient attendances.
  
  The combined position is an increase of 5.6% from 10/11 to 14/15.
- **Follow-up outpatients:** the 2012 plan sets out a 13% reduction in follow-ups by 2015 which will progress the plan towards national average ratios.
- **Pathology blood tests:** a 10% reduction on 2010/11 levels is planned by 2015.
- **Planned admissions:** the plan has been revised to allow a slight increase of 1.3% in elective activity between 2010/11 and 2015.
- **Urgent admissions:** the planned reduction is 16% with fewer people being treated in an acute setting through the introduction of the urgent assessment pathway referenced above.
- An additional £5 million recurrent investment is available for additional community services to deliver this transformation but will only become available as the efficiency savings from reduced admissions are delivered.
- The costs of continuing care will rise by £1 million in 2012/13
2 Local Background

2.1 Population Demographics and Health Needs

Rotherham conducts an ongoing comprehensive assessment of the needs of its population, the Joint Strategic Needs Assessment (JSNA) \(^{JSNA}\). Key priorities from local needs assessments and from the national Marmot review into health inequalities (\textit{Fair Society, Healthy Lives}) have been emphasised in Rotherham’s director of public health annual report (\textit{DPH Annual Report}). The JSNA and public health report both inform Rotherham’s Health and Wellbeing Strategy which is being developed. The Single Integrated Plan (SIP) sets out how Rotherham CCG intends to best use its resources to ensure that the people of Rotherham have access to the best health care possible within the resources available and contribute to the health and wellbeing of the borough.

The health of people in Rotherham is generally worse than the England average. There is higher than average deprivation, unemployment and long term unemployment. While there have been improvements in life expectancy in Rotherham, the rate of improvement has not kept pace with elsewhere and remains below the England average, being the 53rd most deprived borough out of 326.

One of the most striking health issues in Rotherham is the degree of inequality within the borough. The gap in overall life expectancy between Rotherham and the national average is one and a half years (based on 2008-10 three years combined) but the gap in life expectancy between different parts of Rotherham is five years (2008-10: males 6.2 years, females 6.9 years, persons 5.2 years).

The gap in life expectancy between the most and least deprived as measured by the slope index of inequality has widened during the last decade. The most disadvantaged communities appear to be improving less quickly than Rotherham overall.

We will maintain the emphasis on inequalities and target our resources towards areas of need, focusing on reducing the inequities confirmed by recent Health Needs Assessment (HNAs) in Rotherham.

The population of Rotherham continues to grow and is projected to reach 267,000 by 2020. The age profile will be increasingly dominated by the elderly; the number of people aged over 65 is projected to grow by half and those aged over 85, by almost double by 2028. This is likely to be associated with an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer.

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

Rotherham has a relatively small black and minority ethnic (BME) community but one that is growing and becoming increasingly diverse. The single largest minority ethnic group is Pakistani (Kashmiri) and the second is White Other which includes EU migrants.

Staying healthy remains a significant challenge for many people in Rotherham. The following issues are likely to compound the effects of the ageing population and are likely to amplify the increase in the prevalence of long term conditions:

- 10.5% of children at Reception and 20.2% of children at Year 6 were classified as obese in Rotherham in 2009/10. Adult obesity prevalence is estimated to be 27.6%. All are significantly worse than the England average
- Smoking prevalence is estimated to be 24.5% in Rotherham which is significantly worse than the England average
Physical activity levels and prevalence of healthy eating in adults are estimated to be significantly worse than the England average.

Levels of substance misuse and alcohol related harm is significantly worse than the England average.

Maternal, infant and childhood health give quite considerable cause for concern, with smoking in pregnancy, low birth weight, breast feeding initiation and teenage pregnancy being significantly worse than the national average. This remains a significant barrier to Rotherham achieving the best start in life for its citizens.

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

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

While life-expectancy has improved, healthy life expectancy has improved more slowly. In response to the growth in long term conditions and care needs, the number of informal carers has increased and is currently estimated at 35,000. The age profile of carers is following the same pattern as the general population and is believed to reflect the increasing number of spouse carers. The increase in the number of younger carers is more modest and this is likely to result in a widening of the “care gap” which could lead to greater demands on formal care services including acute care.

In summary, health needs in Rotherham are significantly greater than the average for England and are associated with a striking level of inequalities; while there have been improvements in life expectancy, the key causes of early death remain largely preventable and related to lifestyle. Healthcare priorities remain promotion of the best start in life, prevention, early detection and effective management of long term conditions.

2.2 Health Services in Rotherham

The 38 general practices in Rotherham are of relatively high quality as measured by case finding and clinical outcomes. There have been particular striking improvements in cardiovascular outcomes over the last decade, premature cardiovascular mortality has halved over the last ten years. Access to primary care has significantly improved but there remains a significant variation between practices on expenditure per patients. The CCG has published a wide range of comparative data on Rotherham general practices (GP Comparative Data) and carries out an annual quality and efficiency review on all practices.

The CCG has a framework of 6 providers of domiciliary continuing care in addition continuing health care beds are commissioned from nursing homes in Rotherham and from external specialist providers. All continuing care patients are reviewed as a minimum at three months and six months by the continuing care team.

The majority of community services in Rotherham are managed by The Rotherham NHS Foundation Trust (TRFT). The CCG is working closely with TRFT to ensure the quality and efficiency benefits from the integration of community and hospital services are realised. The CCG also has contracts with Rotherham Hospice to provide end of life care and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) to provide community mental health care.
RDaSH deliver the majority of mental health and learning disabilities health services in Rotherham. The CCG is working closely with RDaSH and RMBC to ensure quality, efficiency benefits and service improvement through initiatives, such as the Mental Health Adult Service Model, dementia pathway work and a new programme of quality visits introduced in 2011/12. The CCG, RDaSH and RMBC have worked closely together to invest £20m on providing a new state of the art inpatient facility for Older People’s Mental Health Services and to fully update the Swallownest Court unit for Adult Mental Health Inpatient Services, which includes the provision of a brand new and modern, Psychiatric Intensive Care Unit.

Currently, mental health services are commissioned on a block contract arrangement. In 2012/13 the CCG and RDaSH will commence the move to a Payment by Results arrangement, which will be supported by a Memorandum of Understanding to manage the financial risks. 2012/13 will be a year of learning for both organisations as cluster based prices and care pathways and packages are developed.

Around 70% of secondary care activity for Rotherham residents is carried out by TRFT. Our other major secondary care providers are Sheffield Teaching Hospitals NHS Foundation Trust and Doncaster and Bassetlaw Hospitals NHS Foundation Trust. All these providers are high performing foundation trusts but there are still substantial challenges to ensure that clinical quality is central to the commissioning process and that we obtain maximum efficiency. All local providers are under substantial financial pressure because they are subject to substantial efficiencies on their tariff and block contracts in addition to being affected by commissioner led work to curb the increasing volume of activity. The tariff adjustment in the 2012/13 contract is a 1.8% decrease, this means that it is especially important to ensure that required efficiency savings do not impact on patient outcomes, experience and safety.

The Rotherham health system is characterised by an over-reliance on hospital admission as a solution to a wide range of problems and consequently a large proportion of health resources go to fund urgent admissions. Our unscheduled care efficiency programme will provide better alternatives to hospital admission and so shift funding from acute hospital care to community care. The CCG ensures the quality of the services we commission through contract quality meetings and a regular programme of clinically led visits. More details of the approach to quality assurance is given in section 3.8.

Figure 2.2A shows the breakdown of contract values of the £338 million for which the CCG is accountable. It should be noted that the £2.2 million for GP Locally Enhanced Scheme (LES), including the Local Incentive Scheme (LIS), has been included in this figure however, it is still unclear whether these will be under the remit of the CCG or NHS CB.
2.3 Any Qualified Provider

In line with Department of Health Guidance issued in July 2011 the Clinical Commissioning group is working with NHS South Yorkshire and Bassetlaw to open up an Any Qualified Provider (AQP) approach for three services in 2012. Current thoughts are that the following areas will be considered:

- Carpel tunnel management and treatment
- Endoscopy
- 24 hour ECG and cardio-memo

Detailed specifications will be advertised on the Supply2Health website and the three services will be available to patients by 1 September 2012. NHS South Yorkshire and Bassetlaw will evaluate the impact of AQP on these service areas prior to making decisions on whether to expand AQP to other services in 2013/14.

The DH have announced a further six AQP areas and may introduce a national list of services that commissioners will be expected to offer choice of AQP. The CCG will seek to use AQP to improve access for patients but will also be mindful of the potential risks that AQP could create for the CCG’s efficiency programmes.
3 Strategic and Transformational Priorities

3.1 Strategic Aims

In January 2011 NHS Rotherham refreshed its strategy ‘Better Health, Better Lives, Adding Quality and Value’. The strategy was developed by integrating joint strategic needs assessments, analysing service provision, performance and financial positions and most importantly the insights of public and patients, who played a key role in determining the priority areas of work. Key parts of the refresh were:

- protecting and sustaining the major improvements made 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 the right configuration of services and providers

A key focus of the last 18 months has been the development of efficiency programmes particularly in prescribing, planned care and unscheduled care. These programmes have been further developed during 2011 by the CCG Strategic Clinical Executive, GP Reference Group and key partners and form an important part of the strategy because if the efficiency programmes are not delivered there will have to be unplanned cuts to services.

This 2012 refresh of the CCG’s plans refreshes the strategic aims that need to be achieved to get best outcomes for the £338 million the CCG has delegated responsibility for, establishes a new vision, sets out the corporate priorities and explains the new outcomes frameworks that will begin to apply in 2012.

3.2 General Medical Practice

Primary care contracting will become the responsibility of the NHS Commissioning Board (NHSCB) however high quality and efficient general practice is essential to the CCG in order to deliver its delegated responsibilities. The CCG will work closely with NHS Yorkshire and Bassetlaw as NHS Rotherham transfers its contracting responsibilities and will play a continuing role in several key areas:

- **Programme of annual quality and efficiency visits.** The CCG produces and makes publically available an annual report of GP comparative data. This information is used together with soft intelligence to prioritise an annual programme of visits and follow up actions to obtain assurance on and improve the quality and efficiency of general practice in Rotherham. All practices are visited every year and a selection of practices are chosen for a more in depth visit with all practices receiving follow up actions. The programme is led by the clinical executive GP quality lead and NHS Rotherham’s medical director. Support to this process is by staff whose future alignment is to both CCG commissioning and to the NHSCB. The CCG will ensure that a comparable or better process is maintained during and after the transition as this is essential to local delivery of high quality and efficient clinical care across the system.

- **Local input to NHS performers list.** The NHSCB will remove the risk of conflicts of interest between the CCG and its GP members in cases where performance investigations are required. It will provide the opportunity for a more standardised approach to the most difficult decisions regarding practitioners on performers list but effective improvement and assurance of local clinicians practice is critically dependant on local intelligence and support at an early stage and the CCG will continue to play a key role in this.
• **Local primary care contracting where this is essential for CCG efficiency programmes.** Current examples where local contracts with primary care providers are essential to delivering the CCG’s efficiency programmes include, the Commissioning Local Incentive Scheme (which includes prescribing incentives), Locally Enhanced Service (LES) contracts with optometrists for cataract and intraocular hypertension, and the anti-coagulation LES with GPs. The CCG is likely to propose a LES for GP follow up of patients previously followed up in hospital in 2012.

• **Long term conditions case management pilot.** This is described in section 5.2.3.

• **Programme of protected learning time events.** NHS Rotherham delivers a well attended and well regarded programme of protected learning time events for primary and community care staff. This is important in assisting local GPs and their employees to meet parts of their continuing professional development needs and is increasingly important as a forum for peer discussion and discussions with hospital colleagues about the efficiency challenges facing the Rotherham Health System. The CCG will continue to develop this programme.

• **Primary care medicines management.** This is described in section 5.1.

Prior to transfer of contracting responsibilities NHS Rotherham will undertake a stocktake of all its primary care contracts.

The Operating Framework requires that all general practice lists are reviewed and any anomalies corrected by March 2013. The South Yorkshire Primary Care Agency manages the registration process on behalf of NHS Rotherham. Data quality policies are in place and aim to minimise inaccuracies on an ongoing basis. The latest figures published on list inflation showed all South Yorkshire PCT’s at 4/5% against, for example, a 30%+ rate in London. However, list reconciliation is dependant on the quality of data provided, and it is anticipated that further national guidance will be published.

### 3.3 Planned Care

Planned care is one of the main areas of focus in our efficiency plans, further details of this programme can be found in section 5.3.

### 3.4 Unscheduled Care

Unscheduled care (long term conditions and urgent care) is one of the main areas of focus in our efficiency plans, further details of this programme can be found in section 5.2.

### 3.5 Continuing Health Care

In recent years, the cost of Continuing Health Care (CHC) has risen significantly whilst the costs of NHS-Funded Nursing Care (FNC) clients has declined. Across Yorkshire and the Humber, NHS Rotherham’s benchmarking position is 11th out of 15 PCT’s for CHC Activity, 9th out of 15 for year to date CHC expenditure and 7th out of 15 for average weekly costs of care packages (15 = lowest, 1 + highest for all these positions).

Following a steep rise in 2010/11 the growth rate has now reduced. The CCG has allowed for a £1 million increase on a £13.3 million budget in 2012/13.
Rotherham CCG has reviewed the rising costs and concluded that:

- The National Framework for Continuing Healthcare and NHS-Funded Nursing care was introduced in 2007 resulting in an increase in expenditure;
- Adherence to the process described by the National Framework for Continuing Healthcare and NHS-Funded Nursing care is imperative to ensure access to care packages which are commensurate with need. This encompasses application of the criteria for access to CHC and FNC and timely reviews of existing clients to ensure that care packages change in line with need.
- Rotherham CCG needed to seek opportunities to enter contractual arrangements with providers to establish consistent pricing mechanisms
- Rotherham CCG needed to work in partnership with Rotherham Council (RMBC) and providers to explore what measures can be put in place to mitigate against the risk of rising costs and to ensure the appropriate care and funding arrangements are in place.

A multi-stakeholder meeting was held on 15 July 2011 which included representatives from NHS Rotherham, TRFT, RMBC, RDaSH and representatives from domiciliary providers of care in Rotherham. 60 colleagues worked together to formulate an action plan to improve processes, ensure high quality service provision and control rising costs.

Our programmes of work to contain the growth in continuing health care are as follows:

- **Contractual arrangements for CHC packages will be established to control costs of packages**
  There are 31 care homes in Rotherham, 3 of which charge higher rates but do not provide noticeably higher quality care. The NHS Standard Contract for care homes has recently been published and Rotherham CCG is working to implement it across its care homes. Rotherham CCG is working closely with commissioners across South Yorkshire to share learning in addition to looking to establish a consistent tariff across all providers through the Any Qualified Provider Process. Rotherham CCG will also explore opportunities to enter into contractual arrangements across South Yorkshire and Bassetlaw where there is potential to reduce the costs of spot purchases for high cost packages such as learning disability clients. We will work collaboratively with RMBC to ensure that we realise all opportunities.

- **Patients need to be assessed in their optimum environment**
  The National Framework for Continuing Healthcare encourages the assessment of patients in their optimum environment. Assessment in a hospital environment or immediately following the sub-acute phase of an illness can distort the outcome and increase the costs of continuing health care provision. Funding was set aside through the reablement and discharge support monies to provide nursing support for patients to reach their optimum state prior to CHC assessment. Rotherham CCG is working with TRFT to look at whether intermediate care, the hospice and care homes could be used to stabilise patients prior to CHC assessment.

- **Ensuring appropriate access to the fast track pathway**
  The fast track pathway is appropriate for patients who are in the terminal or rapidly deteriorating phase of life. Rotherham has a longer than average length of stay on fast track continuing healthcare packages which could be due to differences in the accuracy of assessment for end of life care packages. Rotherham CCG is working with providers to improve understanding of CHC processes and implementing assessment tools to support accurate assessment for fast tracks, potentially through the Commissioning for Quality and Innovation (CQUIN) scheme.

- **Understanding and awareness of Adult CHC processes across the health economy**
  There needs to be a common understanding of CHC and discharge processes across health care organisations and health care professionals so that all parties are aware of their roles and
responsibilities. Continuing healthcare training is scheduled to take place in 2012/13 to continue to promote awareness of and understanding of the CHC processes.

- **Understanding and awareness of Children’s CHC processes across the health economy**
  We will work with partners to better manage children’s continuing care needs. This will include a reduction in the number of children receiving out of area services and better provision of service to children within Rotherham.

Rotherham CCG is committed to collaborating closely with NHS South Yorkshire and Bassetlaw PCT commissioners of continuing care and RMBC to ensure best practice in this area.

### 3.6 Mental Health and Learning Disabilities

#### 3.6.1 Mental health

In 2010/11 mental health services across Rotherham saw the introduction of the new adult service model and the opening of new wards for both adults and older people services on the Swallownest and TRFT sites. During this period the health service provision element of the Joint Learning Disability Service, transferred to RDaSH as part of the NHS Rotherham ‘Transforming Community Services’ initiative. New to the contract process in 2011/12 was the introduction of commissioner quality review visits. Further work will be undertaken to develop these programmes to undertake both planned and unplanned quality review to RDaSH services. Rotherham CCG will continue to work with providers of services for learning disability to ensure that all out of area placements provide safety and quality in line with the SHA Commissioner Assurance process.

In 2012/13 the introduction of Mental Health: Payments by Results will mean a move away from block arrangements to cost and volume contracts for mental health. Rotherham CCG will work with providers to mitigate the financial risks to all parties while ensuring that robust tariffs and reconciliation processes are built into 2012/13 contract for mental health services. As part of this process the CCG will work with RDaSH to develop new pathways of care in line with the 21 clusters identified in the mental health clustering tool. Other key pathway work will include the development of autism pathway in partnership with the RMBC, service users, carers, voluntary sector and other key stakeholders.

The Department of Health’s 2012/13 Operating Framework highlighted a range of new requirements. In particular for mental health services the improvement of dementia and care of older people, carers support and military /veteran’s health. Over the coming year the CCG will work with both RDaSH and TRFT to improve and develop dementia services for older people, their carers in both mental health and learning disability services. Work will also be undertaken to develop a range of outcome measures in line with the NHS Outcomes Framework and to improve waiting times across agreed pathways of care.

In 2011 the Department of Health published the document ‘Talking Therapies a Four Year Plan of Action’. This plan outlines the government’s commitment to expand access to psychological therapies over the next four year period. Rotherham currently has an excellent Improving Access to Psychological Therapies (IAPT) service based in all GP practices across the district. During 2012/13 the CCG will continue to work with RDaSH to expand this service to provide IAPT services to older people, people living with long-term conditions, children and adolescents.

#### 3.6.2 Learning disabilities

In partnership with RMBC work continues to ensure that services commissioned for people with learning disabilities are person-centred and deliver high quality care. In light of the Winterbourne View events, Commissioners from both organisations have undertaken a review of their quality assurance mechanisms to ensure robust processes are in place with all Providers.
During 2012/13, in partnership with the Rotherham local Learning Disability, we have continued to work with GPs to ensure the delivery of Annual Health Checks for people with learning disability. The local Learning Disability Awareness Training programme for GPs has proved popular and during 2012/13 this programme will focus on increasing awareness of autism in primary care. Over the following year we will continue to take action to support the improved uptake of the Annual Health Check.

3.7 End of Life Care (EOLC)

3.7.1 Developments in 2011/12

In April 2011 specialist palliative care services were commissioned from Rotherham Hospice. This included the transfer of staff previously employed by Rotherham Community Health Services to the Hospice so that specialist EOLC staff are managed by one provider and the Hospice playing an increasing role in co-ordinated EOLC across Rotherham. At the same time we saw the opening of an impressive building extension that increased hospice capacity from six to fourteen beds. These beds have been fully utilised and are delivering high quality end of life care to the people of Rotherham.

In 2011/12 a comprehensive training programme was delivered to all care homes and GP practices in Rotherham to equip staff with the skills and tools to continue delivering high quality end of life care. As a result we have seen an increase in the number of people supported to die in their preferred choice. Rotherham CCG and Rotherham Metropolitan Borough Council are working together to develop a framework for care homes that will support the ongoing training and development of staff. To complement the framework the CCG has commissioned advanced communication training, crucial conversation training and facilitation for e-learning.

The third annual End of life Care Strategy (DH 2011) highlights progress made to date in end of life care. The strategy together with the NICE End of Life Care Quality Standards (2011) has influenced the CCG’s commissioning intentions for 2012/13. The intentions will ensure that people at the end of life:

- Have a positive experience of care and support
- Have equality of access to care with reduced inequalities
- Have care delivered by health care providers who work collaboratively to ensure that the best quality of care is provided
- Have enhanced quality of life including choice and control of care
- Are protected from avoidable harm
- Have the opportunity to document their preferences and options for their end of life care

During 2012/13 the CCG will be working closely with providers to continue developing innovative services for end of life care. For example, Rotherham Hospice will expand its services to develop their Short Stay Palliation Unit where patients will receive enhanced care of:

- blood transfusions
- blood tests
- ultra sound scans
- relaxation therapy
- complementary therapies

3.7.2 Transformational investment in Hospice Community Team

The CCG is making a non recurrent investment £860K for each of the next 2 years in a hospice community team pilot. The objectives are to provide high quality specialist EOLC in the community and result in an
increase from 40% to 45% of the percentage of people in Rotherham who are able to die in their usual home. The pilot will also deliver a 24/7 advice service from the hospice, allow more efficient use of hospice beds and allow hospice admissions at weekend and out of hours. The pilot will include 2 nurse practitioners, 3 staff nurses and 7 health care assistants. The pilot is being delivered on an ‘invest to save’ basis. It will result in 366 fewer hospital admissions a year. Rotherham benchmarks high for the length of time people receive EOLC continuing care and the pilot is also estimated to produce £200K savings by reducing the length of time people will require continuing care packages.

The pilot will be evaluated and the CCG will consider re-commissioning in this area in 2014 if the pilot meets its objectives and savings in hospital admissions and continuing care costs are delivered.

3.8 Quality Assurance

Rotherham CCG/NHS Rotherham currently has robust arrangements for assuring patient safety, experience and outcomes and working with providers to improve quality and efficiency. The CCG will ensure that these arrangements are maintained and developed during the transition. This section covers quality assurance and need to be read together with section 10 which details performance management and assurance on outcomes.

3.8.1 Reporting Arrangements

Urgent concerns and immediate notification of incidents are escalated to CCG senior managers (Chief Operating Officer and Deputy Chief Operating Officer) and NHS Yorkshire and Bassetlaw executives (chief executive, chief nurse and medical director). These are reviewed at the weekly CCG Operational Executive meeting.

Monthly quality reports are produced for the CCG Audit and Quality Assurance Group and NHS South Yorkshire & Bassetlaw Quality Committee with escalation to CCG Committee and Cluster Board as required. This report consists of a ‘dashboard’ detailing information including Methicillin-resistant staphylococcus aureus (MRSA) and Clostridium Difficile (CDiff) rates, numbers of new serious incidents and safeguarding concerns. This is supported by a narrative document describing, by exception, the detail behind the numbers in the ‘dashboard’, together with relevant actions and any public and patient engagement information.

The CCG operational executive and Audit and Quality Assurance (AQuA) Group keep a regular review of statutory officer functions to ensure these remain clear at all times throughout the transitions.

3.8.2 Clinical Governance Arrangements

The following areas are kept under regular review by the CCG AQuA Group and are escalated to CCG Committee and NHS South Yorkshire and Bassetlaw Quality and Patient Safety Committee and Board as required:

- Serious incident reporting and performance management - NHS Rotherham is responsible for performance managing, on behalf of the SHA, SIs reported by TRFT
- Complaints and compliments
- Incidents mainly those reported by independent contractors
- Patient safety agenda, ensuring continual improvement
- Safeguarding – arrangements are described in more detail in section 4.5
- Patient experience including Patient Reported Experience Measures (PREMS). Patient Reported Outcome Measures (PROMS)
3.8.3 Monitoring of individual providers

- **Independent contractors**: the medical director is responsible for the local management and escalation of individual general practitioner performance issues. A Strategic Clinical Executive GP leads the process of GP annual quality and efficiency reviews. The CCG’s approach is described in more detail in section 3.2. Medical revalidation is being led by the NHS Rotherham medical director who is also co-ordinating its introduction across NHS South Yorkshire and Bassetlaw and the region with other PCT medical directors.

- **TRFT**: Rotherham CCG/NHS Rotherham are the lead commissioner for TRFT. A consultant in Public Health acts as clinical guardian for assurance on quality with TRFT working closely with NHS Rotherham’s nurse quality lead, the Strategic Clinical Executive GP lead for TRFT and NHS Rotherham’ s head of commissioning. Serious incidents, outcome measures (including CQINS and hospital standardised mortality data), patient experience and soft intelligence are discussed with TRFT at regular quality meetings. NHS Rotherham carries out an annual programme of clinically led visits which can be modified to include areas of potential concern and these add greatly to intelligence and assurance.

- **Other acute foundation trusts**: NHS Rotherham maintains close links with commissioning quality leads for other local foundation trusts and ensures a two way flow of intelligence and assurance (Yorkshire Ambulance Service/ Sheffield Teaching Hospitals/Sheffield Children’s and Doncaster and Bassetlaw Hospital)

- **RDaSH**: NHS Rotherham has similar quality assurance mechanisms for RDaSH with close collaboration between GP Strategic Clinical Executive mental health lead, nurse clinical guardian and senior commissioning manager.

- **Care Homes**: Monthly meetings are held between health, social care and the CQC. The agenda covers information sharing about concerns including safeguarding, compliance actions, action plans and progress. The Continuing health care team has an annual programme of joint visits with the Local Authority to care homes across the Rotherham borough. NHS Rotherham head of CHC and FNC is working with other leads across NHS South Yorkshire and Bassetlaw to ensure a consistent approach in this area.

3.9 Effective Partnerships

Partnership working is covered in section 4.
4 Engagement/Partnerships

4.1 Empowering Patients

The CCG is committed to enabling patients to have more choice and control over their condition and health services. There are three important means of delivering this, Choose and Book and personal health budgets as outlined below, and the LTC Case Management Pilot, which will be important means of supporting patients and carers. It aims to offer everyone with a long term condition a personalised care plan tailored to their individual needs, this is further described in section 5.3.2.

4.1.1 Choose and Book

Choose and Book has been in operation since 2004 and is now well-established as both a technological solution and a collection of business processes that, together, are able to deliver benefits covered by all four elements of the QIPP (Quality, Innovation, Productivity and Prevention) initiative. The system nationally has had over 29 million referrals booked through it to date.

When a referring clinician and their patient agree that a referral to a specialist is required Choose and Book is able to generate a list of appropriate services for the patient to choose from in both secondary and primary care and give guidance to the GP about any additional requirements the patient would need prior to attending.

Benefits to patients include:

- Patients can choose any consultant led service commissioned by the NHS and many non consultant services
- Patients can also choose their preferred date and time from the available appointments offered by the hospital provider
- Patients experience greater convenience and certainty
- The transfer of clinical information is more secure as it is transferred electronically
- Patients can check the status of their referral and change or cancel appointments easily over the phone or on the internet

Locally, over 80% of services available on Choose and Book have a least one named clinician available, on average 72% of referrals by Rotherham GPs are made using Choose and Book.

A Single Point of Access (SPA) is being developed for Mental Health services to be available on Choose and Book and improvements are being made for accessing local maternity services on the system. Providers are monitored on their appointment availability for patients on Choose and Book.

4.1.2 Personal Health Budgets

Personal health budgets allow people to have more choice, flexibility and control over the health services and care they receive. At the heart of a personal health budget is a care plan, the agreement between the commissioner and the individual that sets out the person’s health needs, the amount of money available to meet those needs and how this money will be spent.
It is argued that the current efficiency targets within the NHS could be met if personalisation was fully embraced. Several key areas where personalisation could bring about rapid improvements include:

- End of life care
- Mental health
- Out of area placements
- NHS continuing care
- Frequent users of healthcare
- Jointly funded care

The CCG will review and evaluate the current pilots across Yorkshire and Humber which are due to be completed in October 2012 and consider implementing the good practice.

4.2 Public and Patient Engagement

NHS Rotherham and RMBC currently have well developed methods of engaging with patients and the public and with a wide range of community and voluntary groups. During 2012/13 Rotherham CCG will review these and produce its own plan for ensuring that we tap into the wealth of information that is already known by primary care staff so that there are better information flows from the consultation room to the board room and that patient opinion can be shown to have had a demonstrable impact on decisions made by the CCG. We will seek to get maximum impact from Quality Outcome Framework (QOF) incentives for practice involvement groups.

Involvement and engagement will be key to planning services so that stakeholders and the public can shape the way services are delivered and understand the rationale for the allocation of finite resources. Their input will be vital to identifying areas of waste and best placed to identify solutions to this important problem. The NHS in Rotherham will undoubtedly face some difficult decisions and it will be vital to achieve public support for the impact that this may have on families and communities.

It is recognised that an investment of time, capacity and money is needed to make meaningful engagement work. So it is essential that we build on existing models of engagement and also work in partnership with other agencies to share resources. In order to do this, we have undertaken a comprehensive mapping exercise of partners, stakeholders, and voluntary and community groups to understand the range of existing and potential engagement mechanisms and sources of intelligence available so that they can inform commissioning (PPE Plan). As well as existing practice based patient participation groups, Rotherham CCG has the opportunity to make use of community based organisations working to improve health and social care services. Local improvement networks, the local Health and Wellbeing Board, Healthwatch bodies and third sector organisations will all be key. The foundation trust memberships may also provide a route to engagement but there is a need to consider members’ affiliation to their foundation trust.

In addition the local authority has existing engagement mechanisms which may be used to inform strategy. The Health and Wellbeing Board which has statutory responsibilities will also play a role. Diagram 4.2A is a simple visual representation of the mechanisms.
The work of Rotherham CCG will be underpinned by the following principles in regard to engagement;

“Nothing about me without me” will be an active driver.

- Patients will be encouraged and supported to be actively involved in their own health care and informed decision making, through the *Choice* agenda, and through effective commissioning
- Communities (both geographical and communities of interest) will be encouraged and supported to be part of health planning and development

**Communication and Transparency.**

- Meaningful communications and engagement is underpinned with open and honest dialogue, and clear and accessible information through a variety of media
- A fundamental part of meaningful engagement is two-way communication; we will listen, act and report back.

**Inclusivity - the services commissioned should be accessible, appropriate and of a high quality for each and every member of our population.**

- Underpinned by our Equality Delivery System, the engagement of all Rotherham’s diverse communities will support the commissioning of services needed and valued by all.
- Communications and engagement with communities experiencing the greatest health inequalities and barriers in accessing services will contribute to reducing health inequalities and barriers to accessing services.
Key engagement objectives include

- To establish a small working group to lead and champion engagement in the emerging structures;
- To develop implementation plans which reflect the SIP priorities (our ‘plan on a page’ for engagement);
- To map and understand our local community, including third sector networks, organisations and structures, and maintaining relationships with these;
- To have a variety of mechanisms in place to allow the Rotherham CCG to communicate and engage with individuals, communities, stakeholders and the Rotherham public as a whole;
- To form lasting and constructive relationships to facilitate joined up working and strong partnerships with key stakeholders and structures (including with new and emergent structures);
- To analyse and use the information from engagement activity and patient experience data consistently and effectively, thereby ensuring that GPs are able to feed individual patient experience into the commissioning decision making processes; better informing decision making;
- aiding us in ensuring the services commissioned are safe and effective

4.3 Clinical Leadership

Rotherham has had strong clinical involvement in commissioning for several years. The CCG will take this to a new level through GP leadership and close engagement with other professional groups and doctors in other organisations.

GP leadership of clinical commissioning is through the clinical executive of eight GPs who joined NHS Rotherham’s medical director in January 2011. These eight GPs were selected on the basis of their existing competence by a formal process which was facilitated by the LMC. Each of the eight GPs lead on a specific area of commissioning and have been ‘learning on the job’ alongside the relevant NHS Rotherham teams for most of this year. The high level meeting structure including the links to NHS South Yorkshire and Bassetlaw, RMBC and other key partners has been mapped to illustrate the key strategic meetings and key interactions across Rotherham (Meetings structure).

Working closely with the strategic clinical executive is the GP Reference Group who provide a way for all GPs to be represented in the commissioning process so that the views of all GPs in Rotherham and all Rotherham GP practices can:

- ensure that the views of Rotherham GPs and Rotherham GP practices are represented on the CCG Committee
- ensure that all GPs are involved in the process of developing new guidelines and pathways of care
- provide two way communications between Rotherham CCG Committee and individual practices
- encourage all practices and all GPs to understand and influence the processes and decisions of the Committee
- ensure that any changes that happen are properly disseminated

Practice Based Commissioning in Rotherham built a strong locality structure providing the essential link between the patients in the consulting room reporting their experiences, and the commissioning team. The CCG has built on this structure to form the GP Reference Group which facilitates strong engagement from the wider GP community, ensures the Clinical Executive is accountable to all GPs and ensures that programmes and guidance are effectively disseminated.
Rotherham has well established communication links with its practices through a structured programme of regular communications activity. The Strategic Clinical Executive have all undertaken media training and are gradually gaining confidence in engaging with the media under the guidance of the communications team.

The CCG holds well attended twice yearly commissioning events for all GPs and there is a well established programme of protected learning time events for primary care and community staff which includes sessions by Strategic Clinical Executive GPs and involvement of secondary care colleagues.

There are close clinical relationships with our main secondary care providers such as TRFT and RDaSH. The Strategic Clinical Executive holds GP to consultant meetings as well as executive to executive meetings.

Clinical leadership of efficiency programmes is through three multi agency groups each with a Strategic Clinical Executive GP lead. In 2012 we will build on this approach with three groups that will each meet fortnightly (Medicines Management Committee, Clinical Referrals Management Committee and Unscheduled Care Management Committee). We have established a senior level multi-agency QIPP Board to oversee the whole QIPP/transformation programmes.

Clinical input from a nurse and a hospital doctor will add to the quality of our CCG Committee and we intend to engage all other health professionals whenever it is possible.

4.4 Rotherham Metropolitan Borough Council (RMBC)

CCG lead GPs and officers have an extremely strong relationship with RMBC, two key areas of work include Joint Commissioning of Adult and Children Services. Both the Adults and Children & Young Peoples Boards will be accountable to the Health and Wellbeing Board.

4.4.1 The Adults Board

The adult board is responsible for both Health and Social Care priorities which are set in line with key frameworks issued by the respective Government Departments. These frameworks are built around key outcomes as follows:

- Improving health and well-being
- Improving quality of Life
- Personalisation, choice and control and positive contribution
- Freedom from discrimination and feeling safe
- Dignity and respect
- Economic well-being

Currently the Board are working on the following integrated areas:

- Management of long term conditions
- Intermediate care services
- Older people’s mental health
- Integrated community equipment service
- Community occupational therapy service
- Third sector commissioned services
4.4.2 The Children’s Board

The children’s board has four main priority areas agreed by the board, these are:

- Children get the best start in life which includes implementing the early prevention agenda and reducing health inequalities including tackling obesity.
- Reducing substance misuse by young people, specifically in relation to alcohol.
- Children and young people affected by domestic abuse are supported and protected.
- To ensure all Rotherham schools are performing well, especially in relation to Key Stage 2.

Other areas of focus that fall outside these priorities are looked after children, understanding and responding to the needs of migrant communities, 14-19 and post-16 opportunities for young people with learning difficulties and disabilities.

4.4.3 Economic Development

Rotherham CCG/NHS Rotherham also works collaboratively with the ‘Economic Development Services’ in developing joint service centres across Rotherham these include Maltby, Aston, Kimberworth and Rawmarsh (due to open March 2012).

4.4.4 Public health

Ensuring a smooth transition of public health services to RMBC is a priority. The CCG is committed to maintaining current public health programmes until their future commissioner has the chance to understand the services and the public health budget is clear. The CCG has identified a lead GP to champion the public health agenda. The effective use of the ring fenced public health budget will be of critical importance to the CCG in order to deliver health outcomes and to minimise the numbers of people who will require health treatments. The CCG will ensure that all its efficiency programmes, for example, the care pathway work (section 5.3) maximise opportunities for prevention. The CCG recognises that the public health budget will not on its own be sufficient to deliver a comprehensive prevention based approach to health and social problems in Rotherham. The CCG is working with partners to develop Rotherham’s Health and Wellbeing strategy and this will be key to ensuring that prevention is central to the plans of all Rotherham Health and Wellbeing Board members.

4.5 Health & Wellbeing Board and the Local Strategic Partnership (LSP)

The Local Authority, with the CCG and our major providers, has formed a Rotherham Health and Wellbeing Board which will be the cornerstone of our collaborative working with key partners in Rotherham.

Rotherham Health and Wellbeing Board will be a statutory board with a wide ranging focus looking at health, social, environmental and economic issues which impact on the health and well being of the people in Rotherham and includes the new local government responsibility for public health. It will act as a system leader through work on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. The Board is currently operating in shadow form and will be statutorily operational from April 2013.

Rotherham Health and Wellbeing Board is chaired by the Cabinet Member for Health and Wellbeing and has members including two other Cabinet Members, RMBC executives, HealthWatch and the Voluntary Sector. There will be three Rotherham CCG Committee representatives (2 GPs and COO) as well as other health representatives from the directorate of public health, NHS South Yorkshire and Bassetlaw, The Rotherham NHS Foundation Trust (TRFT) and Rotherham, Doncaster and South Humber Foundation Trust (RDaSH).

The Chair of Rotherham Health and Wellbeing Board attends Rotherham CCG Committee.
Current activity includes the development of the Health and Wellbeing Strategy which will be based on the National Outcome Frameworks for Health and Social Care and Public Health.

The Local Strategic Partnership (LSP) is currently updating its Community Strategy. The key priorities that have been identified are:

- The best start in life
- Supporting the most vulnerable in our communities and
- Supporting and sustaining the growth of the local economy

The partnership is developing a prevention and early intervention strategy and action plan focusing on families across Rotherham.

In addition to focusing on these three high level priorities there will also be a focus on the eleven Rotherham neighbourhoods that fall within the 5% most deprived neighbourhoods in England. These neighbourhoods are East Herringthorpe, East Dene, Eastwood, Canklow, Town Centre, Dalton and Thrybergh, Ferham and Masbrough, Rawmarsh East, Dinnington Central, Maltby South East and Aston North.

To support this approach partner agencies are currently identifying what they currently provide in each of the eleven neighbourhoods.

Partners have signed up to the key principles outlined below.

- Resources are deployed to narrow the inequalities gap
- Working collaboratively and through consensus to address our priorities
- Only focus on areas where we can make a difference to local people
- Focus on prevention and early intervention
- Agree to a common information/data sharing framework
- Work to a common referral framework
- Look to co-locate teams/services where it is beneficial to communities
- Make sure we have community buy in

The LSP will be signing off the Community Strategy 2012/15 at its March 2012 Rotherham Partnership Board meeting Community Strategy.

4.6 Safeguarding Vulnerable Groups

Prevention and effective responses to harm, neglect and abuse is a basic requirement of modern health care services. This section sets out the current robust arrangements for safeguarding. The CCG has lead GPs for children’s and adult safeguarding. Specific officer support for safeguarding roles is by staff who may transfer to the CCG or RMBC public health or to commissioning support. There is active representation by NHS Rotherham on the Rotherham Local Safeguarding Children and Rotherham Safeguarding Boards and this will continue. NHS Rotherham adheres to the South Yorkshire Safeguarding Adults Multi-agency procedures and also ensures that it and the services that it commissions comply with national frameworks for investigating patient safety incidents. The CCG will ensure that responsibility and accountability for safeguarding vulnerable adults and children are safely managed and maintained at all times during and following this transition.
Safeguarding is integral to:

- **Patient Care** – achieving high quality care for patients, safeguarding is relevant to domains four and five of the NHS Outcomes Framework
- **Regulation** – safeguarding is a fundamental requirement for compliance with the CQC essential standards for quality and safety
- **Legislation** – the commissioners duty to comply with legislation including the Human Rights Act and Mental Capacity Act
- **Cost Effectiveness** – harm, neglect and abuse have a cost to the NHS in avoidable admissions and care

NHS Rotherham is responsible for improving the health and wellbeing of their local population. This responsibility includes vulnerable groups such as children, young people, those with disabilities and older people. To achieve this PCT’s comply with their legal duty to work with the local authority and partner organisations to assess and deliver health services that the local population need. NHS Rotherham have in place a S256 agreement that supports the arrangements that are currently in place to support the development and delivery of the Safeguarding Adults Board, the delivery of the Bronze to Platinum Safeguarding Adults Training Programme, the delivery of safe and effective arrangements under the Mental Capacity and Deprivation of Liberty orders. NHS Rotherham ensures that all staff are appropriately trained in safeguarding children and young people adhering to the expectations of Working Together 2010.

Rotherham, like many areas across the United Kingdom, has a significant number of residents living in deprived areas; 14.2% of all Rotherham children live in areas which are within the 10% most deprived nationally (using the Index of Deprivation Affecting Children (IDAC) 2007) with 31% of families living in low income households. NHS Rotherham acknowledges that effective universal health services can significantly reduce the escalation of problems if needs are identified and tackled at an early stage. They therefore play an active partnership role in early intervention and prevention work across the health and social care economy.

NHS Rotherham ensures that all NHS organisations comply with the following standards:

- Senior management commitment to the importance of safeguarding and promoting welfare
- There are clear lines of accountability within the organisation for work on safeguarding and promoting welfare and adherence to local multi-agency safeguarding procedures
- Service developments take account of the need to safeguarding procedures, Mental Capacity and Deprivation of Liberty orders and promoting welfare of all vulnerable residents.
- Staff are appropriately trained in safeguarding and promoting the welfare
- Safe recruitment procedures are in place
- Effective inter-agency working to safeguard and promote the welfare of children
- Effective information sharing
- Integration of safeguarding in to governance frameworks to enable services to understand and be accountable for their safeguarding activity

NHS Rotherham is clear that everyone has a right to protection from abuse and neglect. When raising concerns about the safety or well-being of a client all health staff will take into account their holistic needs. This includes taking into account their maturity, capacity and understanding, their ethnicity, culture, gender, sexual orientation, religion or belief, and any known disability.
We will adhere to the six fundamental actions for safeguarding:

1. We will use safeguarding principles to shape strategic and operational safeguarding arrangements
2. We will set the safeguarding of vulnerable children and adults within our strategic objectives
3. We will use integrated governance systems and processes to prevent abuse occurring and respond effectively where harm does occur
4. We will work with the local Safeguarding Adults Board, and Safeguarding Children’s Board, patients and community partners to create safeguards for patients
5. We will provide leadership to safeguard adults and children
6. We will ensure accountability and use learning from lessons to bring about improvement

4.7 The Wider NHS

Through the Specialised Commissioning Group (SCG) and NORCOM, NHS Rotherham maintained an active role in the development of the specialist commissioning agenda. Although this role will transfer ultimately to the NHS Commissioning Board it has been important for Rotherham CCG to build up an understanding of the role of the SCG. The CCG is forming the opinion that there should be greater GP involvement in specialist commissioning decisions.

We have already started networking with other aspirant CCGs within the NHS South Yorkshire and Bassetlaw cluster of PCTs and we intend to develop these relationships further over the coming months.
5  Quality, Innovation, Productivity and Prevention/ Efficiency Programmes

5.1  The QIPP challenge

5.1.1  Overview of efficiency programmes

NHS funding is expected to continue to increase each year however the increased funding will not keep up with the growth in the aging population, rising patient expectations and the costs of medical technologies. In 2011 the Chief Executive of the NHS set out a four year, £20 billion, efficiency challenge. This represents the gap between historical rates of cost growth that occurred up to 2011/12 and anticipated funding increases until 2014/15. For Rotherham the efficiency challenge is to make £74.9 million recurrent savings per year by 2014/15. We are on track to achieve the 2011/12 savings but the challenge will become harder each year.

All providers are under extreme pressure to deliver their contribution to the £20 billion challenge, chart 5.1A divides savings into provider efficiencies (savings that are passed on through tariff) and ‘commissioner savings’. ‘Commissioner savings’ are savings made by reducing future growth. It is important to recognise that these savings also have major impacts on providers as they reduce their future funding. It is also the case that our plans are based on DH assumptions and any pressure over and above will be borne by providers. So with the small exceptions of commissioner management costs and GP prescribing costs all efficiencies are passed on to providers and the figure of £74.9 million in some scenarios will underestimate the full scale efficiencies required, see breakdown in chart 5.1C.

Chart 5.1A shows the Quality Innovation Productivity and Prevention (QIPP) savings that the NHS in Rotherham is required to make. A large part of the savings are passed automatically to providers who are required to make efficiency savings through tariff or block contracts, for example, tariff has been reduced by -1.8% in 2012/13. This reflects 4% efficiency on each patient seen (2.2% funding uplift minus 4% efficiency gives -1.8%). These provider efficiencies will contribute £47 million savings by 2014/15.

Chart 5.1A: Rotherham QIPP savings
Table 5.1B shows how the £28.1 million commissioner savings will be achieved. Three programmes are particularly important to the CCG: prescribing, unscheduled care (long term conditions and urgent care) and planned care and these are described in detail later in this section.

**Table 5.1B: Commissioner Efficiencies**

<table>
<thead>
<tr>
<th>QIPP Programme</th>
<th>QIPP Project</th>
<th>2011/12 (£000's)</th>
<th>2012/13 (£000's)</th>
<th>2013/14 (£000's)</th>
<th>2014/15 (£000's)</th>
<th>Total for 2012/13 to 2014/15 (£000's)</th>
<th>Total for 2011/12 to 2014/15 (£000's)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing</td>
<td>Overarching programme</td>
<td>1,132</td>
<td>1,180</td>
<td>1,190</td>
<td>3,502</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transformational prescribing projects</td>
<td>100</td>
<td>180</td>
<td>200</td>
<td>480</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Sub total: Prescribing</strong></td>
<td><strong>1,209</strong></td>
<td><strong>1,232</strong></td>
<td><strong>1,360</strong></td>
<td><strong>3,982</strong></td>
<td><strong>5,191</strong></td>
<td></td>
</tr>
<tr>
<td>Unscheduled Care</td>
<td>Access to urgent care</td>
<td>1,804</td>
<td>327</td>
<td>554</td>
<td>2,685</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alternative levels of care</td>
<td>649</td>
<td>118</td>
<td>200</td>
<td>967</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Case management pilot</td>
<td>361</td>
<td>65</td>
<td>111</td>
<td>537</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>End of life care</td>
<td>787</td>
<td>655</td>
<td></td>
<td>1,442</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursing home pilot</td>
<td>72</td>
<td>13</td>
<td>22</td>
<td>107</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care pathways</td>
<td>721</td>
<td>131</td>
<td>222</td>
<td>1,074</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ward attendant activity</td>
<td>168</td>
<td>-</td>
<td>-</td>
<td>168</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obstetric admissions (not related to delivery event)</td>
<td>267</td>
<td>-</td>
<td>-</td>
<td>267</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Sub total: Unscheduled Care</strong></td>
<td><strong>1,329</strong></td>
<td><strong>4,829</strong></td>
<td><strong>1,309</strong></td>
<td><strong>1,109</strong></td>
<td><strong>7,247</strong></td>
<td><strong>8,576</strong></td>
</tr>
<tr>
<td>Planned Care</td>
<td>Demand management first outpatient</td>
<td>404</td>
<td>213</td>
<td>175</td>
<td>792</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follow-up appointments</td>
<td>1,264</td>
<td>1,042</td>
<td>1,042</td>
<td>3,348</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demand management pathway redesign</td>
<td>1,371</td>
<td>762</td>
<td>818</td>
<td>2,951</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnostics</td>
<td>64</td>
<td>64</td>
<td>64</td>
<td>192</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Sub total: Planned Care</strong></td>
<td><strong>4,110</strong></td>
<td><strong>3,103</strong></td>
<td><strong>2,081</strong></td>
<td><strong>2,099</strong></td>
<td><strong>7,283</strong></td>
<td><strong>11,393</strong></td>
</tr>
<tr>
<td>Specialised Services</td>
<td>Sub-total: Specialised Services</td>
<td>176</td>
<td>211</td>
<td>78</td>
<td>-</td>
<td>289</td>
<td>465</td>
</tr>
<tr>
<td>Management cost savings</td>
<td>Sub-total: Management Costs</td>
<td>2,157</td>
<td>353</td>
<td>-</td>
<td>-</td>
<td>353</td>
<td>2,510</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>8,981</strong></td>
<td><strong>9,728</strong></td>
<td><strong>4,828</strong></td>
<td><strong>4,598</strong></td>
<td><strong>19,154</strong></td>
<td><strong>28,135</strong></td>
</tr>
</tbody>
</table>

Chart 5.1C shows contributions to the commissioner efficiency savings, it identifies direct and indirect commissioner savings and presents a fuller understanding of how these savings are dependent upon provider savings.

**Chart 5.1C: Breakdown of commissioner efficiency savings**
The CCG ensures that all contracts and all providers provide value for money and keep to affordable limits. The QIPP programmes are specific programmes, with specific milestones to achieve savings compared to a ‘do nothing’ scenario based on historical growth.

The CCG is committed to sustaining local services for Rotherham residents however all health service providers are under unprecedented pressure to increase efficiency. For services to remain affordable there has to be a transformation in the way services are delivered with more community care and less reliance on hospital admissions. The CCG is fortunate that its main provider, TRFT, has been working toward this objective for some time. The transfer of the majority of community service to TRFT in April 2011 was an important enabler in terms of being able to deliver more efficient care to the right person in the right place. The CCG’s contract with TRFT will set out the joint commitment to delivering on the QIPP agenda including the transformation required to ensure the sustainability of local services.

A key challenge in the QIPP agenda is ensuring that quality is not impacted upon by the efficiency requirements and transformation. Clinical Quality Incentives (CQUIN) are an important mechanism to incentivise the quality of services and the CCG will use CQUIN to incentivise quality including the quality component of the efficiency programmes.

The activity trajectories that are required to be delivered for QIPP (section 7) are extremely challenging particularly the absolute reduction in urgent admissions by 2014/15 which will take our non-elective expenditure to 2008/09 levels. This requires a transformation to a system that is less reliant on hospital admission as a solution to most problems. There are two sets of investments that will enable this transformation. The first of these is shown in Table 5.1D that sets out the £1.6 million that has been allocated for reablement and discharge support in 2012/13.

**Table 5.1D: 12/13 Investment in reablement and discharge support initiatives required**

<table>
<thead>
<tr>
<th>Reablement and discharge support investments</th>
<th>2012/13 £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home enabling service</td>
<td>300</td>
</tr>
<tr>
<td>Continuation funding for posts from last year</td>
<td>16</td>
</tr>
<tr>
<td>Increase residential capacity by 8 beds</td>
<td>228</td>
</tr>
<tr>
<td>Therapy and nursing cover for new beds</td>
<td>100</td>
</tr>
<tr>
<td>Social work support for the fast response service</td>
<td>54</td>
</tr>
<tr>
<td>Enhanced GP support for intermediate care</td>
<td>30</td>
</tr>
<tr>
<td>Fast response twilight service</td>
<td>60</td>
</tr>
<tr>
<td>Continuation funding for posts from last year</td>
<td>140</td>
</tr>
<tr>
<td>Continuation of the stroke association service</td>
<td>100</td>
</tr>
<tr>
<td>Social work support for care pathway</td>
<td>27</td>
</tr>
<tr>
<td>Psychological support for stroke care pathway</td>
<td>25</td>
</tr>
<tr>
<td>Enhanced dementia reablement service - crossroads</td>
<td>70</td>
</tr>
<tr>
<td>Establishment of a social work GP pilot</td>
<td>200</td>
</tr>
<tr>
<td>Integrated community neurological conditions service</td>
<td>152</td>
</tr>
<tr>
<td>REWS Urgent Response service</td>
<td>35</td>
</tr>
<tr>
<td>Development of a Care Enhanced Call Centre</td>
<td>43</td>
</tr>
<tr>
<td>Voluntary sector - Otago exercise programme</td>
<td>20</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td><strong>1,600</strong></td>
</tr>
</tbody>
</table>
The CCG is also making other substantial non-recurrent investments to facilitate the transformation in delivery of unscheduled care and improve management of long term conditions. Providing that non elective activity is kept to affordable limits an additional £5 million of recurrent funding will become available to fund the community care of people with long term conditions. Table 5.1E below summarises non recurrent investments. Each of these investments will be evaluated and the projects will potentially be re-commissioned recurrently depending on the degree to which they are successful in keeping non-elective admissions to affordable limits.

**Table 5.1E: Investment in alternatives to drive the transformations of services required**

<table>
<thead>
<tr>
<th>Initiative/Project</th>
<th>2012/13 £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case management pilot</td>
<td>1,300</td>
</tr>
<tr>
<td>Social prescribing</td>
<td>500</td>
</tr>
<tr>
<td>Nursing homes pilot</td>
<td>90</td>
</tr>
<tr>
<td>End of life care project</td>
<td>750</td>
</tr>
<tr>
<td>Increased intermediate care community beds (nurse led)</td>
<td>1000</td>
</tr>
<tr>
<td>Increased capacity in fast response</td>
<td>220</td>
</tr>
<tr>
<td>Single point of contact - care enhanced call centre</td>
<td>310</td>
</tr>
<tr>
<td>Enhanced Community Care Services - additional medical and non-medical staff</td>
<td>570</td>
</tr>
<tr>
<td>Paediatrics OOH care</td>
<td>80</td>
</tr>
<tr>
<td>Access to urgent care</td>
<td>175</td>
</tr>
<tr>
<td>Falls care pathway</td>
<td>500</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td><strong>5,495</strong></td>
</tr>
</tbody>
</table>

### 5.1.1 QIPP Governance

Figure 5.1F shows how the QIPP programmes will be delivered. The overarching QIPP board will be chaired by the CCG chair and three GP led committees that will meet every two weeks to deliver the three key QIPP programmes; the Medicines Management Committee, Clinical Referrals Management Committee and Unscheduled Care Management Committee.
Figure 5.1F – Rotherham wide QIPP management structure

QIPP Board
Meets every 2 months

Chair of CCG
CCG chief operating officer
CCG lead GPs and executive leads for each programme
Senior executives from RMBC, TRFT and RDaSH
Programme management and support

Clinical Referrals Management Committee
Programme 1
Meets every 2 weeks
CCG lead GP
CCG executive lead
CCG project leads
Senior representatives from key partners
Programme management and support

Medicines Management Committee
Programme 2
Meets every 2 weeks
CCG lead GP
CCG executive lead
CCG project leads
Senior representatives from key partners
Programme management and support

Unscheduled Care Management Committee
Programme 3
Meets every 2 weeks
CCG lead GP
CCG executive lead
CCG project leads
Senior representatives from key partners
Programme management and support

Projects covered by committee

<table>
<thead>
<tr>
<th>Project</th>
<th>CCG GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue 2011/12 workstreams</td>
<td>Julie Kitlowski</td>
</tr>
<tr>
<td>Follow-ups</td>
<td>Julie Kitlowski</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>Julie Kitlowski</td>
</tr>
<tr>
<td>Continuation of haematology</td>
<td>Julie Kitlowski</td>
</tr>
<tr>
<td>Adult Care Pathways (on behalf of UCMC)</td>
<td></td>
</tr>
<tr>
<td>• COPD</td>
<td>Julie Kitlowski</td>
</tr>
<tr>
<td>• Dementia</td>
<td>Russell Brynes</td>
</tr>
<tr>
<td>• CVD</td>
<td>Phil Birks</td>
</tr>
<tr>
<td>• Falls</td>
<td>Ian Turner</td>
</tr>
<tr>
<td>• Diabetes</td>
<td>Jason Page</td>
</tr>
</tbody>
</table>

Projects covered by committee

<table>
<thead>
<tr>
<th>Project</th>
<th>CCG GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing efficiency review</td>
<td>Jason Page</td>
</tr>
<tr>
<td>Stoma care</td>
<td>Jason Page</td>
</tr>
<tr>
<td>Wound care</td>
<td>Jason Page</td>
</tr>
<tr>
<td>Gluten free prescribing</td>
<td>Jason Page</td>
</tr>
<tr>
<td>Nutrition service</td>
<td>Jason Page</td>
</tr>
<tr>
<td>Incontinence service</td>
<td>Jason Page</td>
</tr>
</tbody>
</table>

Projects covered by committee

<table>
<thead>
<tr>
<th>Project</th>
<th>CCG GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self care</td>
<td>David Tooth</td>
</tr>
<tr>
<td>Closer working</td>
<td>Ian Turner</td>
</tr>
<tr>
<td>Risk stratification /Dashboard</td>
<td>David Tooth</td>
</tr>
<tr>
<td>GP Case Management</td>
<td>David Tooth</td>
</tr>
<tr>
<td>Social prescribing</td>
<td>David Tooth</td>
</tr>
<tr>
<td>End of life care</td>
<td>Russell Brynes</td>
</tr>
<tr>
<td>Nursing home pilot</td>
<td>David Tooth</td>
</tr>
<tr>
<td>Access to urgent care</td>
<td>Richard Cullen</td>
</tr>
<tr>
<td>Alternative levels of care</td>
<td>David Tooth</td>
</tr>
<tr>
<td>Adult care pathways</td>
<td>Julie Kitlowski</td>
</tr>
<tr>
<td>Children’s care pathways</td>
<td>David Polkinghorn</td>
</tr>
</tbody>
</table>
5.2 Prescribing

5.2.1 Description

This programme is based around work with all 38 general practices in Rotherham to deliver practice specific prescribing plans. Historically, performance in improving prescribing quality and efficiency has been very strong and we are confident that we will continue to make efficiency savings although as many of the easy wins have already been delivered this becomes increasingly challenging.

Prescribing savings consist of an overarching programme and six transformation projects. In 2012/13 there will be efficiency savings of £1.2 million (£4 million over the three year period 2012/13 to 2014/15).

The overarching programme has regular reviews and the monitoring of Rotherham wide and practice specific prescribing efficiency plans uses the local QIPP/cost efficiency programme and prescribing quality and efficiency quilt table. There are a number of prescribing cost efficiency schemes running over the year as well as one specific scheme each month. Practices and medicines management staff are performance managed against predetermined targets in delivery of this programme.

GPs in Rotherham have extremely well developed relationships with their local medicines management team and the level of savings achieved in Rotherham over the last five years compares very favourably with the rest of the country, with Rotherham achieving a lower prescribing cost growth than the SHA and England average in four of the last six years.

There are six specific projects which incorporate prescribing and an element of service redesign:

- Stoma care
- Wound care
- Gluten free prescribing
- Nutrition services
- Incontinence service
- Oxygen service

All the above are innovative programmes taking areas where GPs do not have detailed expertise and giving overall control of the budget to dedicated specialists who do. The nutrition and continence projects are established and continue to deliver impressive savings against national cost growths and improvements in quality of care. The redesigned continence service has won two national awards since its establishment.

The medicines management team, working with procurement are about to award a contract for the provision of continence equipment for patients managed in the community. This has been challenged by the urology trade association. However once awarded this nationally unique contract will deliver both improvements in patient care and cost efficiencies. Oxygen costs have decreased this year against a trend of increasing costs in the previous five years. An oxygen assessment pathway has been developed and is to be launched shortly this again should improve patient care and produced cost efficiencies. The prescribing of gluten free food stuffs was transferred to the dieticians in 2010; this has delivered impressive savings compared to national cost growth. A pathway for the diagnosis of coeliac disease has also been developed; all patients receiving gluten free products will be assessed against this pathway, and in future only patients with a definitive diagnosis of coeliac disease will receive gluten free products in Rotherham on the NHS.

The work undertaken by the Medicines Management Team received a ‘highly commended’ in the finals of the Health Service Journal efficiency awards.
Financial performance of established products

<table>
<thead>
<tr>
<th>Project</th>
<th>Established</th>
<th>Cost growth since established</th>
<th>Actual exp</th>
<th>Predicted exp if cost growth had matched national cost growth</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Rotherham</td>
<td>England</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>April 2006</td>
<td>-18.9%</td>
<td>79.9%</td>
<td>£513,092</td>
<td>£1,165,194</td>
</tr>
<tr>
<td>Continence</td>
<td>April 2009</td>
<td>-6.4%</td>
<td>20.3%</td>
<td>£577,344</td>
<td>£741,847</td>
</tr>
<tr>
<td>Gluten Free</td>
<td>September 2010</td>
<td>-35.2%</td>
<td>10.4%</td>
<td>£178,053</td>
<td>£305,917</td>
</tr>
</tbody>
</table>

Some of the savings have been re-invested into the respective services to improve the quality of service provision.

5.2.2 Governance

The programme is monitored and delivered by the Medicines Management Committee whose members include one Clinical Executive GP and the medical director. There is long established and effective multi-agency governance through Rotherham Area Prescribing Committee which includes TRFT and RDaSH clinicians. From January 2012 the Medicines Management Committee will report to the QIPP Board on progress with the efficiency programme.

5.2.3 Risks

Cost pressures from changes in national pricing (especially category M drugs). Recent large cost increases with SSRI antidepressants and antibiotics, not being available at drug tariff price, have had an adverse impact on Rotherham’s prescribing costs.

Changes in national guidance such as the new antiplatelet drug Ticagrelor and the introduction of new diabetes drugs, both of which have received very favourable NICE appraisals, also add financial pressures which require planning and managing. There are a number of new drugs on the horizon whose introduction will also require careful management.

Continuing to deliver the efficiency savings year on year requires constant focus by GPs and the medicines management team on the few remaining areas of inefficiency. Future challenges will be the volume of prescribing and the amount of waste especially with increased pharmacy ordering on the patient’s behalf and the roll-out of electronic prescribing.

5.3 Unscheduled Care (long term conditions and urgent care)

5.3.1 Introduction

Rotherham health community is an outlier for emergency admissions to hospital. This is partly due to high morbidity but also because of a lack of integration of services, a lack of availability of alternative levels of care and variability in the quality of primary care for these patients. A high proportion of our patients are discharged following attendance at A&E requiring no further treatment or requiring follow up by their GP. Our strategy aims to address these issues working in collaboration with partners across the health community.

Over 80% of Rotherham’s acute services are provided by TRFT. On 1 April 2011, the majority of Rotherham’s community services integrated with TRFT. This presented a key opportunity to redesign services to deliver the transformational change demanded by our efficiency requirements. To ensure that all partners are engaged with our plans Rotherham CCG held a long term conditions/urgent care summit with key stakeholders to shape our transformational initiatives in June 2011.
We will transform the way patients with long term conditions are managed which will result in a 16% absolute decrease in the number of people who require admission to hospital. An additional £5 million of recurrent investment for community services is included in our plan to deliver this transition but it will only become available recurrently as the efficiency savings from reduced admissions are delivered.

The key aim of our unscheduled care efficiency programme is to reduce admissions to hospital by:

- Ensuring patients receive the right care at the right time in the right place.
- Taking a proactive approach to improving the care of patients with long term conditions
- Ensuring the optimum pathways are in place to enable patients to receive high quality care which represents the best value for money
- Maximising the benefits of partnership working to ensure services are efficient and effective.

The table below lists our projects and the workstreams they fit into. The three enabling projects are necessary to enable the other projects to be delivered but will not produce quantifiable savings. The remaining nine projects are divided into four workstreams; better case management of people with long term conditions, transforming unscheduled care, providing alternative levels of care to acute hospital admission and transforming care pathways. The individual projects are described in detail in Sections 5.3.2.

In 2012/13, there will be £4.8 million savings (£7.2 million over the three year period 2012/13 to 2014/15). The table in the previous section (5.1) shows the efficiency contributions of the individual projects. The case management pilot will increase the savings from all the programmes for patients in those general practices who are part of the pilot, the savings have been calculated as 7% of the total savings for unscheduled care this is to avoid any double counting.

Table 5.3A: Summary of unscheduled care projects

<table>
<thead>
<tr>
<th>Overall work stream</th>
<th>Project Number</th>
<th>Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling</td>
<td>1</td>
<td>Self Care (including reablement)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Closer Working</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Risk Stratification/ Urgent Care Dashboard/other IT</td>
</tr>
<tr>
<td>Case Management</td>
<td>4</td>
<td>GP Case management pilot</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Social prescribing</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>End of life community care pilot</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Nursing home pilot</td>
</tr>
<tr>
<td>Transforming unscheduled care</td>
<td>8</td>
<td>Review of unscheduled care including redesign of walk in centre, GP out of hours, assessment pathway and A&amp;E</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Efficient access to unscheduled care (single point of contact leading to NHS 111)</td>
</tr>
<tr>
<td>Alternative levels of Care</td>
<td>10</td>
<td>Alternative levels of care including Enhanced Community Care Services, and intermediate care pathways</td>
</tr>
<tr>
<td>Care Pathway Review</td>
<td>11</td>
<td>Adult care pathways (COPD, Dementia, CVD, Falls, Diabetes)</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Children’s care pathways</td>
</tr>
</tbody>
</table>
5.3.2 Individual projects

Our approach to working together with our key partners across the Rotherham health and social care community is to focus services around the patients who are most in need of services, this is illustrated in diagram 5.3B below.

Diagram 5.3B: Patient centred care

[Diagram showing patient centred care with connections to GP, Social Worker, Community Nursing, Hospice in the community, Voluntary Sector, Case Management Plan co-ordinator, and Patient.]  

Workstream 1: Enabling projects

Project 1: Self Care

Working in partnership with RMBC and TRFT we will support patients to take more control over their condition and management. The GP case management pilot (project 4 below) will offer enhanced care to patients most at risk of hospitalisation, supporting self care and the setting of goals by patients are critical components of the scheme. We are also looking to pilot innovative assisted living services/technologies (DALLAS).

Self care will also be supported by the social prescribing scheme (project 5 below) which will allow patients to access a wider range of services across health and social care which will help them to avoid hospitalisation.

This approach will be further supported by our partners, RMBC, as social workers will be refocused to work closely with GP Practices to facilitate multi disciplinary assessments of the patients most at risk of being admitted to hospital.
Project 2: ‘Closers working’ of general practice, community health services and social service teams

This underpins the other long term condition workstreams. Following the integration of community and hospital services, community nursing services are being reconfigured to be better aligned with general practices in three localities and 11 neighbourhoods and work is continuing to better align these services with social care.

Project 3: Risk stratification, urgent care dashboard and IT support

Accurate identification of people at increased risk of hospital admission is vital to our long term conditions strategy (for example the enhanced community care services and case management pilots). Currently different services have different methods for risk stratification and tools are not used in general practice at all. As part of the case management pilot we will rapidly appraise the currently available tools and use the preferred choice systematically across the system.

Rotherham CCG is currently leading a health system wide project to develop high quality risk stratification tools. By April 2012 we expect to have implemented a risk stratification tool which is considered ‘best practice’ nationally. We will use this tool to assess the risk of patients being admitted to hospital. Through our case management pilot we will use this tool to identify over 8,000 patients at high risk of hospitalisation and direct our primary care resources towards these patients. We expect this approach will allow care to be tailored to the individuals needs and help many of them to avoid hospital admission.

We will make available to GPs a real time urgent care dashboard. GPs currently receive accurate information on the urgent care utilisation of their patients via our MIDAS information system. As this relies on data from the national secondary care user system it is more than a month post the event. This new dashboard will allow GPs to manage patients with long term conditions more effectively.

Several aspects of the IT strategy (set out in Section 9) are important enablers of the unscheduled care condition efficiency programmes. These include assistive technology and multi agency access to care planning information.

Workstream 2: Case management of people with long term conditions

Project 4: GP Case management pilot

This programme funds additional clinical time in primary care to case manage up to 5% of each practice’s population based on patients at highest risk of hospital admission. Each patient will be reviewed and given a case management plan. The GP will have continued responsibility as ‘conductor’ of the various professional and informal services involved in supporting the patient.

The scheme covers practices serving 215,000 patients (out of 250,000 patients in Rotherham) and using a best practice risk assessment tool 8000 patients with the highest risk of hospital admission will be targeted.

GPs will have dedicated time to review patients. Community nursing services will be re-focussed to allow nursing input into the patient reviews, and social workers will be re-focussed to input into the reviews.

The social prescribing pilot (project 5 below) will also link directly to this pilot to allow these patients to access a wider range of services which are aimed to help them avoid hospitalisation.

It will be evaluated in terms of overall impact on all admissions for all practices in the pilot.

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‘Your Life, Your Health’ Rotherham CCG Single Integrated Plan 19 03 12
Project 5: Social Prescribing

As part of the case management approach we are also taking a proactive approach to involving the community and voluntary sectors in patient case management. We will contribute to the voluntary sector to use care coordinators to engage with the GP case management project to refer people with non-clinical support needs to voluntary and community sector providers.

The care coordinator will engage voluntary sector providers to allow these high risk patients to access services which should allow them to manage their own conditions better and avoid hospital admission and A&E attendances. The care co-ordinator will also monitor performance as part of the case management approach.

Services which patients will be able to access that will help them to manage their own conditions include:

- **Condition management programmes** e.g. education, managing pain and fatigue, healthy eating, exercise, emotional support, support to self-care, understanding care pathways, self-help groups
- **Health and well-being programmes** e.g. support groups, craft group, interactive music sessions for people with dementia, community gardening project, men’s groups, cooking club, walking group, specialist yoga, chair-based exercise, assistive technology support
- **Support to access or maintain employment, education or wider community participation**: 1:1 support, group work, social activities, training, apprenticeships, support to access community facilities, travel support, community transport
- **Emotional and practical support**: e.g. peer mentoring, stroke communication group, welfare rights/benefits advice, signposting, befriending, dementia cafes, gym buddies, support with aids and adaptations, handyperson service
- **Volunteering opportunities** e.g. peer mentors, befrienders, community car drivers

Project 6: End of Life Care (EOLC) Community Care Pilot

This two year non recurrent pilot is described in section 3.7.2. The pilot is an investment in community palliative care nurse practitioners, nurses and health care assistants. The scheme will increase the proportion of people who die in their usual home from 40% to 45%. The pilot is expected to reduce the number of hospital admissions by 366 a year and also to save £200K per year on EOLC continuing care packages.

Project 7: Extension of nursing home pilot

Rotherham has a successful single GP pilot scheme that has reduced admissions from patients in nursing homes. The scheme will be extended to up to six more practices covering patients in the six nursing homes that account for the most hospital admissions in Rotherham.

Workstream 3: Transforming unscheduled care

Unscheduled care is care that is not booked in advance and includes attendance at the walk in centre, unscheduled and out of hours GP activity and accident and emergency attendances.

Project 8: Review of unscheduled care (including re-design of Walk In Centre, GP out of hours, A&E)

There are a whole series of problems that patients or their GPs feel need to be urgently addressed that are currently resolved by acute hospital admission. In April 2012 we will introduce a revised pathway supported by an assessment tariff to fund clinical situations that need urgent assessment, often including a diagnostic procedure, but do not require hospital admission.
Improving urgent assessment pathways will be followed by a fundamental review and redesign of how patients access unscheduled care across Rotherham. We will review how urgent and unscheduled care is currently provided by GPs, the GP out of hours service, the Walk In Centre and A&E. The review will be informed by the intelligence gathered from our current GP in A&E pilot. We will continue to work closely with TRFT to redesign services to ensure access to urgent assessment. This will help avoid the need for hospital admission. The review will be completed by September 2012 so that solutions in identified quick win areas can be in place for the 2012/13 winter. Full implementation of plans to reform access to Walk In Centre, GP out of hours service and access to A&E will be in place by 2013/14.

**Project 9: Efficient access to unscheduled care (moving to 111 services)**

Rotherham introduced a winter single point of contact in October 2011. The aim of the service is to ensure that people who have an urgent health need are directed to the right services, in the right place, at the right time. We will continue to evaluate and develop this service and ensure it aligns with regional and national developments around 111 services. The national 111 number will be rolled out in April 2013. We will also explore the potential for a care enhanced call centre to support people with long term conditions.

**Workstream 4: Alternative levels of care**

**Project 10: Alternative levels of care to admission**

Rotherham currently has one enhanced community care service consisting of a community physician, care home liaison team and community matrons with a defined case load of patients. A second enhanced community care service will become operational June 2012 and, depending on evaluation, a third in March 2013.

Working with TRFT we have successfully diverted patients from A&E and the Medical Assessment Unit into alternative levels of care. We have extended the rapid response team to work across the non elective pathway, preventing admission to hospital and diverting patients to the most appropriate care setting. We have increased utilisation of existing step-up provision in intermediate care and Breathing Space. Working with TRFT we have reconfigured both these services so that they can react to and meet the needs of patients who have an exacerbation of their condition in the community. We have also reconfigured the neuro-rehabilitation care pathway to deliver step up provision at Breathing Space.

A key part of the 2012/13 QIPP programme is to successfully integrate the additional alternative levels of care into the way patients access care so that the new capacity is successful in reducing admissions.

**Workstream 5: Care Pathways**

**Project 11: Optimising long term condition care pathways**

We are re-designing five care pathways (dementia, CHD, falls, COPD and diabetes). The aim is to rapidly scope the opportunities for significant improvements in quality and efficiency, then make any required changes to care pathways or disseminate education and guidance to clinicians using a model similar to that which has worked successfully for elective referrals. We will initially focus on pathways that account for the highest proportion of admissions and then work through the remaining specialties prioritised by the number of emergency admissions and opportunities for impact. Whilst all these care pathways are important, it is the dementia pathway that carries the most risk and was flagged up by the JSNA and by all partners as the long term condition where prevalence is increasing most rapidly.
Project 12: Children’s QIPP programmes

The CCG GP children’s lead is leading on key care pathways for children. Currently three pathways are being reviewed, diabetes, asthma and the feverish child. The first two of these pathways will be delivered in the same way as those described in the section above. The feverish ill child is an important consideration in the review of urgent care described earlier.

5.3.3 Governance

The clinical leader of the unscheduled care conditions efficiency plans is the GP Chair of the CCG. The executive lead is the CCG Chief Operating Officer. In 2011 the programme was overseen by a high level multi agency steering group with individual workstreams co-ordinated by a multi agency group led by a Strategic Clinical Executive GP. We have strengthened these arrangements in 2012 by having an overall QIPP Board (that also oversees the planned care and prescribing efficiency programmes) and a multi agency unscheduled care management committee that meets fortnightly and co-ordinate the individual workstreams.

Each of the five clinical pathways is led by a multi agency group and this overall programme will be co-ordinated by the current Strategic Clinical Executive GP referrals lead who will work very closely with the medical director and clinicians at TRFT and use the methods used successfully by the existing clinical referrals group to disseminate messages to community and hospital clinicians.

Partnership working

All of our projects that require multi agency involvement have been jointly agreed by Rotherham CCG, NHS Rotherham, TRFT and RMBC, the governance group ensures that all partners are actively engaged and ‘signed up’ to all the key workstreams.

5.3.4 Risks

The unscheduled care workstreams are key to the success and sustainability of the Rotherham health care system, any underperformance will have consequences for patients, the CCG and providers. It requires full engagement of all partners, clinical leadership, cultural change and system transformation.

As commissioners we recognise that the pace of change and these transitional arrangements will be challenging for providers and we will endeavour to support them through this transitional process.

The risk is mitigated by the commitment of all partners and project management and risk management which we have recently enhanced (see governance section).
5.4 Planned Care

5.4.1 Description

Our planned care efficiency programme is focussed on four key areas:

1. Demand management initiatives – focussing on reducing the number of referrals and subsequent treatments
2. Reducing follow up appointments
3. Pathway redesign - eliminating waste and shifting care into more appropriate settings, reducing planned procedures not carried out
4. Reducing waste from diagnostics

This section describes the work in 2011/12 which will impact on activity in 2012/13 and new initiatives that will be delivered in 2012/13. Section 7 shows planned and actual activity trajectories for referrals, first outpatients, follow ups and elective admissions. Reductions in first outpatients in 2011/12 have been greater than planned but to date there has been less impact than expected on elective admissions.

As part of the discussions of this refreshed strategy we will review what has worked well in 2011 and what has been less successful. We will conduct the review on three levels; internal discussion within Rotherham, discussions with other South Yorkshire CCG’s about the strengths and weaknesses of their approaches to referral management and by a literature review led by a public health consultant to identify and learn from other areas that have particularly successful programmes.

In 2012/13 there will be efficiency savings of £3.1 million (£7.3 million over the three year period 2012/13 to 2014/15). The table in section 5.1 shows the proportion of the savings anticipated from each of the four projects outlined in section 5.4.3.

5.4.2 2011/12 initiatives

The overall approach is based an educational approach and clinical leadership including:

- Production of localised guidance and ‘top tips’ to emphasise key efficiency opportunities
- Care pathway re-design: diabetes, orthopaedics, ophthalmology, gynaecology, dermatology
- Introduction of advisory thresholds for cataracts and for hip and knee interventions
- Extensive dialogue between clinical leaders and all GPs about referral activity; joint GP consultant discussions at regular GP protected learning time events, through discussions at the GP Reference Group and locality meetings, ad hoc educational events such as joint injection training and optometrist training , GP attendance at TRFT’s clinical directors meetings and regular ‘survey monkey’ dialogue with all GPs on key issues
- Active dissemination of audit, benchmarking and other referral information through; the monthly bite sized referrals newsletter, the process of Annual Quality and Efficiency Reviews with all Rotherham GP practices, by referral audits being incentivised in the 2011/12 Commissioning Incentive Scheme and videos of consultants’ advice on what to refer/ what not to refer
- Attention to the quality of referrals; through audit, promotion of an electronic referrals template, modification and discussion of DNA procedures and an audit of consultant to consultant referrals.
- Piloting of virtual clinics in haematology and rheumatology by telephone rather than face to face consultations
- Consideration of guidelines for procedures of limited clinical value.
Five specialities were initially prioritised; diabetes, gynaecology, orthopaedics, dermatology and ophthalmology. Work has now started on other specialities; haematology, rheumatology, urology, general surgery and ENT.

Two projects have been particularly successful; dermatology where an educational/audit approach has reduced referrals by 10% and the haematology virtual clinic with a 30% reduction in face to face consultations.

5.4.3 2012/13 initiatives

Continuing the 2011/12 workstreams. Work is still underway particularly in gynaecology, ENT, urology, pre-operative assessment, consultant to consultant and ‘other’ referrals. It is also unclear how long the impact of educational initiatives will last so continued monitoring, benchmarking and re-enforcing of existing messages will be required.

Follow-ups. Rotherham has higher than average follow-up ratios for most specialities. We aim to move to national averages. We will start with specialities furthest from the average and identify:

- Which follow-ups are unnecessary
- Which follow-ups could be delivered by another means such as telephone consultation
- Which follow-ups could be carried out in primary care

It is likely that we will need to commission a GP LES for follow ups in areas such as cancer where the work could take place in primary care but would require additional quality and assurance systems.

Diagnostics. There are efficiency opportunities from eliminating unnecessary and duplicated tests. The literature suggests that between 25 to 40% of tests are unnecessary. We will start by a clinical review of blood tests and then consider other imaging tests. The IT strategy includes work to ensure GPs have electronic access to radiology results which will increase efficiency and reduce duplication.

Continuation of haematology virtual clinics. The pilot has shown that the service is popular with patients and clinicians and that a substantial proportion of patients do not require face to face consultation. We will aim to mainstream this service in the context of the overall funding envelope for haematology first outpatients and follow-ups.

5.4.4 Governance

Planned care efficiencies are delivered through the Clinical Referrals Management Committee (CRMC). A Strategic Clinical Executive GP provides the overall leadership of the referrals management work, TRFT medical directors are members of the CRMC and Clinical Directors and consultants lead work in their specialities. There are three other GP members of the CRMC and high level management support including NHS Rotherham’s deputy COO and TRFT’s chief of Rotherham Hospital. The educational and benchmarking approaches used to successfully reduce clinical referrals will also be used in 2012 for educational events and guidance on key care pathways for urgent admissions, the Strategic Clinical Executive GP referrals lead will also co-ordinate these workstreams.

5.4.5 Risks

Clinical leadership and partnership. The success of this work to date is based on clinical leadership and effective partnership work between primary and secondary care clinicians. Continued progress requires a continued recognition of this area as a priority by the CCG and TRFT.

Project management support. Like all commissioner led initiatives there is a risk to sustainability from the need to make continued running cost savings.
Lack of effective IT support. Several of the initiatives particularly diagnostic efficiencies require the successful implementation and utilisation by clinicians of IT solutions so that community and hospital clinicians have access to all recent tests carried out in order to eliminate duplication. Most general practices now have access to blood test information but their use of this information is patchy. Community access to imaging results is an IT priority but has not yet delivered.

Failure to maintain progress on first outpatient referrals. There are still some untouched areas where there may be scope for further impacts from guidance and pathway re-design but we have to acknowledge that there is considerable uncertainty about the sustainability of the impacts seen from the educational initiatives in 2011/12 so referral trends in all specialities will have to be continually monitored.

Failure to meet trajectories for elective admission. This is a considerable challenge. First outpatients have reduced in 2011 but electives have gone up. This increase in conversion rates shows the system is working more efficiently but highlights the challenge of reducing electives. Threshold initiatives such as those for cataracts, hips and knees will have more impact in 2012/13 but the long term impact of these initiatives is uncertain as in some cases they are delaying rather than preventing procedures.

External impacts. Local guidance and care pathways are not the only factors that influence whether patients and clinicians make referrals. National guidance, publicity campaigns and screening programmes are also important. An example is the national bowel cancer awareness campaign that will be rolled out in Rotherham in 2012. Experience in the rest of the country shows that this will increase referrals and elective procedures.

5.5 Specialised Commissioning

The commissioning responsibility for delivering efficiency savings from specialised commissioning lies with NHS South Yorkshire and Bassetlaw. Efficiency savings are included in NHS Rotherham’s QIPP reports see section 6.2. Rotherham CCG GPs expect to be fully involved in relevant specialist commissioning discussions and already make a contribution for example the CCG vice chair is sub-regional GP cancer lead.

5.6 Running Costs

Rotherham CCG will deliver required running cost savings in collaboration with NHS South Yorkshire and Bassetlaw. The financial impact of this is covered in section 6.2. The workforce implications are in section 8.
6 Finance

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

6.1 Financial Planning Assumptions

The financial assumptions are:

1. A 2.8% growth in financial allocations in 2012/13 and increases of 2% in subsequent years.

2. First outpatients:
   - Greater than expected reductions have been achieved in 2011/12 with further efficiency gains to be realised in this area restricting growth to 0.4%.
   - Assessment tariff: a revised pathway will see urgent assessments recorded as first outpatients resulting in an increase of 5.2% in outpatient attendances.

The combined position is an increase of 5.6% from 10/11 to 14/15.

3. Follow-up outpatients: the 2012 plan sets out a 13% reduction in follow-ups by 2015 which will progress the plan towards national average ratios.

4. Pathology blood tests: a 10% reduction on 2010/11 levels is planned by 2015.

5. Planned admissions: the plan has been revised to allow a slight increase of 1.3% in elective activity between 2010/11 and 2015.

6. Urgent admissions: the planned reduction is 16% with fewer people being treated in an acute setting through the introduction of the urgent assessment pathway referenced above.

7. An additional £5 million recurrent investment is available for additional community services to deliver this transformation but will only become available as the efficiency savings from reduced admissions are delivered.

8. The costs of continuing care will rise by £1 million in 2012/13.

9. The plan assumes that there is no uplift to GP baseline contracts. National guidance has increased the Quality and Outcomes Framework payment by 2.49%. This equates to an overall increase of 0.5% across GP practice funding.

10. The plan assumes that running cost reductions throughout 2012/13 will achieve a £0.35 million reduction with planned recurrent reduction of £1.5 million by 2013/14.

11. The plan assumes that the 2% recurrent headroom will remain in the baseline beyond 2012/13.

12. A contingency of £2.2m (0.5%) is built into the baseline.

13. Prescribing growth is 5.5% before efficiency gains of 3%.


The 4 year I&E is set out below:-
## Income and expenditure

<table>
<thead>
<tr>
<th></th>
<th>2012/13 £000</th>
<th>2013/14 £000</th>
<th>2014/15 £000</th>
<th>2015/16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>469,391</td>
<td>482,511</td>
<td>491,654</td>
<td>498,880</td>
</tr>
<tr>
<td>Expenditure</td>
<td>467,191</td>
<td>480,311</td>
<td>489,454</td>
<td>496,680</td>
</tr>
<tr>
<td>Surplus</td>
<td>2,200</td>
<td>2,200</td>
<td>2,200</td>
<td>2,200</td>
</tr>
</tbody>
</table>

### 6.2 Efficiency Assumptions (QIPP)

<table>
<thead>
<tr>
<th>Savings assumed in Financial Plan</th>
<th>2012/13 £000</th>
<th>2013/14 £000</th>
<th>2014/15 £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Achievement of system efficiencies</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>(1,232)</td>
<td>(1,360)</td>
<td>(1,390)</td>
<td>(3,982)</td>
</tr>
<tr>
<td>Unscheduled care</td>
<td>(4,829)</td>
<td>(1,309)</td>
<td>(1,109)</td>
<td>(7,247)</td>
</tr>
<tr>
<td>Planned care</td>
<td>(3,103)</td>
<td>(2,081)</td>
<td>(2,099)</td>
<td>(7,283)</td>
</tr>
<tr>
<td>Specialised services</td>
<td>(211)</td>
<td>(78)</td>
<td>0</td>
<td>(289)</td>
</tr>
<tr>
<td>Corporate efficiency</td>
<td>(353)</td>
<td>0</td>
<td>0</td>
<td>(353)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(9,728)</td>
<td>(4,828)</td>
<td>(4,598)</td>
<td>(19,154)</td>
</tr>
</tbody>
</table>

In addition the 4% price reduction through national tariffs is not included in this table however it is included in the national QIPP submission.

### 6.3 Risks to Recurrent Balance

1. The drive to reduce clinical referrals growth and unplanned admissions to hospital is reliant upon transformational change across the health community driven by clinical leaders and service providers. If clinical referrals are not managed within planned levels then cuts across a range of services will be inevitable.

2. Prescribing risks:
   - Shortages in the pharmaceutical supply chain can occur at any time forcing category M prices to suddenly increase.
   - The increasing tendency for community pharmacists to order on behalf of patients is challenging to control and has been identified as increasing medicines waste.
   - NICE guidance can at any time have an adverse effect on cost growth forecasts.

3. Changes to the structure of the tariff could generate (unplanned) financial pressures and the plan is predicated upon zero inflationary uplifts in national prices. This saving is a direct efficiency which providers must deliver and is managed through the annual contract.

4. Continuing care is a high risk area as the impact of the change in criteria is difficult to assess. The growth assumption of £1m per annum may be compromised in the current climate i.e. with the link to RMBC elements of these areas.

5. High cost patients are a risk to the plan, both Mental Health and Learning Disability patients can be high cost, and individual funding requests could increase in risk if NICE guidance changes.
6. The challenge to reduce running costs in 2012/13 by a further £0.35 million may compromise the overall ability to deliver the core business.

7. The plan is predicated upon the prioritisation of a range of services funded non recurrently, examples include childhood obesity and teenage pregnancy.

8. The ongoing commitment of our main providers to our efficiency programmes is essential to our achievement of many of our efficiency programmes.

9. We are assuming that that the 2% recurrent headroom will remain in our baseline in all years of the plan.

10. There is a risk that future policy changes may create financial obligations from our existing baseline.

6.4 Further Actions Required

1. Sustained clinical leadership is required of the three efficiency programmes set out in section 5 (prescribing, planned care and unscheduled care). Chief amongst these is unscheduled care to realise the potential of GP leadership to lead a system which is less dependent upon hospital admissions (Rotherham wide QIPP leadership structures are shown on page 11).

2. The current allocation to Rotherham PCT will be distributed to the component parts of the new system e.g. NHS Commissioning Board, Public Health England and the Clinical Commissioning Group. There is a risk that the allocations may not be sufficient for the planned cost base in the new system.

3. Monitoring of other financial risks not including the current efficiency programmes which could impact upon financial balance.

4. The investments to be made non recurrently require clear project management by a named executive to lead the process of evaluating the outcomes of the investment and identify the scope for delivering the recurrent efficiency requirements.

6.5 Other Issues

- We have provided for an increase of six Health Visitors in 2012/13.

- We have provided for treatment to military veterans in our financial plans. This has resulted in an increased forecast in our continuing care expenditure.

6.6 Capital

The planning assumption for capital spend is that £1 million will be required to support essential developments, service reconfiguration, replacement equipment and IT.

6.7 Cash

Cash limits will be achieved and there are no major operational risks to this.
7 Activity

7.1 Introduction

This section sets out affordable activity trajectories for the period until 2014/15 together with performance to date.

The data used are Monthly Activity Returns data (MAR), the data stipulated by the DH for the 2010/11 planning round. Technical definitions in MAR differ from the alternative Secondary Uses Service data (SUS) that are used for contract monitoring and payment. For example maternity activity and non consultant activity is treated substantially differently. This affects how trends are reported, for example, there is an anticipated 4.4% reduction in first outpatients in Rotherham in 2011/12 based on MAR data but a lower 3.2% reduction based on SUS data. We very much hope in the future that the SIP can be submitted using SUS data, as it will simplify local discussions on performance. Moving to SUS data will change the numbers in this section but not change the percentage changes described.

For both electives and non electives TRFT is the main provider of services to Rotherham CCG patients. Percentages of CCG activity by main providers are as follows: non electives; TRFT 84%, DBH 6% STHT 6%: for electives, TRFT 74%, STHT 14% DBH 6%.

7.2 Changes to trajectories in the 2012 SIP

The table below shows trajectories set out in the 2011 SIP, forecast out turn for 2011/12, and revised trajectories in the 2012 SIP.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Electives</td>
<td>-1.3%</td>
<td>-1.9%</td>
<td>1.3%</td>
<td>1.1%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Non Electives</td>
<td>-2.5%</td>
<td>-13.3%</td>
<td>0.9%</td>
<td>-18.2%</td>
<td>-18.2%</td>
</tr>
<tr>
<td>All First Outpatients</td>
<td>-1.2%</td>
<td>5.0%</td>
<td>-4.4%</td>
<td>4.9%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Follow Up Outpatients</td>
<td></td>
<td></td>
<td></td>
<td>-5.8%</td>
<td>-13.2%</td>
</tr>
<tr>
<td>Pathology blood tests</td>
<td></td>
<td></td>
<td></td>
<td>-3.3%</td>
<td>-10.0%</td>
</tr>
</tbody>
</table>

The 2012 SIP has the following key changes to trajectories from the 2011 plan:

- **First outpatients:** Greater than expected reductions have been achieved in 2011/12. There are still some efficiency gains to be realised in this area and work will continue to address these. The trajectory shows an increase in activity in 2012/13. This reflects project 8 of the transforming unscheduled care workstream (Section 3.2), introducing a revised pathway supported by an assessment tariff. These urgent assessments will need to be recorded as outpatients to ensure they flow through national systems, such as SUS, effectively. A resulting increase in outpatient attendances will therefore be seen.

- **Follow up outpatients:** The 2011 efficiency plan did not include any efficiency savings in follow ups. The Clinical Referrals Management Committee has looked at this area. In the majority of specialities Rotherham has higher than average follow up ratios. The 2012 plan sets out a 13.2% reduction in follow ups by 2015 which will go a considerable way towards national average ratios.
• **Pathology blood tests**: The Clinical Referrals Management Committee has identified this as additional area for efficiency saving in 2012. There is a considerable amount of duplication and unnecessary tests carried out. Although there are also some anticipated cost pressures, such as additional testing for Vitamin D, clinicians feel a 10% reduction on 2010/11 levels is deliverable by 2015.

• **Planned admissions**: It has proved to be harder to reduce elective admissions than first outpatients. The fact that conversion ratios have increased is an indication that the health system is performing more efficiently. Some actions taken in 2011 such as the implementation of cataract scoring thresholds through the ophthalmology Local Enhanced Scheme will have an impact on electives in 2012 but the plan has been revised to allow a slight increase of 1.0% in elective activity between 2010/11 and 2015.

• **Urgent admissions**: The CCG’s plans for non electives remain transformational, substantially less people will be treated in acute hospital settings despite an ageing population with increasing expectations. The implementation of project 8 of the transforming unscheduled care workstream (Section 3.2) will result in a reduction in activity levels. The anticipated reduction is 18.2%. An additional £5 million recurrent investment is available (see section 5, table 5.1E) for additional community services to deliver this transformation but will only become available as the efficiency savings from reduced admissions are delivered.

The following charts set out historical activity for the first 3 years and planned activity from 2011/12.

**7.3 Rotherham CCG Affordable Trajectories**

![Graph showing historical activity and planned activity for electives, non-electives, GP referrals, other referrals, and all first outpatients from 2008/2009 to 2014/2015.](image-url)
### All First Outpatients

![Bar chart showing the number of all first outpatients from 2008/2009 to 2014/2015.](image)

### Electives

![Bar chart showing the number of electives from 2008/2009 to 2014/2015.](image)

### Non Electives

![Bar chart showing the number of non electives from 2008/2009 to 2014/2015.](image)
7.4 The Rotherham Foundation Trust Trajectories

We have worked with our main provider TRFT to align our activity planning. TRFT will also use the information from Rotherham CCG and other CCGs to refresh its capacity plan. In the 2011 SIP, TRFT had planned a modest reduction of six beds in 2011/12. This assumption may change as the capacity plan is refreshed.

7.5 Triangulation of Activity Assumptions

The planning processes associated with the SIP and contract negotiations require a wide range of data to be gathered and analysed. We have worked across the CCG and with our main provider TRFT to triangulate our planning assumptions across activity, finance, workforce, QIPP and contracts.
8 Workforce

8.1 Workforce Assurance

NHS Rotherham in conjunction with the rest of the South Yorkshire and Bassetlaw, will continue to regularly review workforce metrics for ourselves and our main providers against national comparators to inform the contract and monitoring arrangements, utilise in procurement activity and provide assurance to the NHS South Yorkshire and Bassetlaw Board. This will be provided through the Workforce Information Template for the Rotherham Health Community 2012/13 which has been submitted as part of this annual planning process.

The workforce plans/projections for 2012/13 are realistic and are aligned with finance and activity plans. DH/SHA assumptions about affordable annual paybill growth, aggregate pay pressures and natural wastage are embedded and align with NHS Rotherham’s financial projections. The details are as follows:

NHS Rotherham

All management/running cost requirements in 2011/12 have been met through the utilisation of two VR/VER schemes and a recruitment freeze. A subsequent reorganisation of NHS Rotherham ensured that it maintained sufficient expertise and capacity to deliver commissioning requirements in 2011/2012 and support the development of the Rotherham CCG. NHS South Yorkshire and Bassetlaw are assessing the requirement for further workforce reconfiguration to meet efficiency targets for 2012/13 and to support the emerging CCG to meet running cost requirements of £25 per head in order to gain authorisation by the Department of Health. This will include maintaining restrictions on pay affecting changes and recruitment, a further VR/VER scheme and organisational change through the development of a structure for the CCG and arrangements for the CSS. This period will also see the transfer of staff in Public Health and associated functions to RMBC and Public Health England, subject to the passage of the Health and Social Care Bill. These changes will be managed sensitively in order to protect the interests of staff and ensure that we retain the right skills and capacity in the right place to continue to deliver on this strategy.

The Rotherham Foundation Trust

TRFT are currently developing a £14.5 million cost improvement plan necessary to address anticipated funding shortfalls over the next three years in which workforce plans would play a significant part. Plans currently include the introduction of the electronic patient record, e-rostering and restructuring of services including the shift of activity from acute hospital services to the community now facilitated by the successful transfer of community services to the management of TRFT. There are currently significant numbers of staff employed on fixed term contracts which are linked to the implementation of efficiency programmes. Other workforce reduction strategies are expected to include voluntary and compulsory redundancy and mutually agreed resignation (MAR) schemes which have contributed to significant reductions over the last year.

The intention to increase health visitor numbers in Rotherham by 2015 by 24 is reflected in the previous workforce projections with the requirement for consequent training places. This is supported by a recruitment and retention plan which is in place in TRFT.

TRFT are mindful of the extreme care that will be needed to manage the workforce reductions whilst ensuring that patient’s outcomes, safety and experience continue to improve. The CCG’s approach to quality assurance is set out in section 3.8.
Rotherham Doncaster and South Humber NHS Foundation Trust

Workforce projections show an average 2.5% decrease in staff numbers in the first three years from 2011/12 to 2014/15 which are in line with NHS Rotherham’s commissioning, financial and activity expectations. The decreases occur in the qualified nursing, manager and support staff (clinical and non-clinical) categories.

We will also maintain and review the Rotherham Health Community consolidated workforce risk assessment incorporating NHS Rotherham, The Rotherham Foundation Trust (TRFT) and Rotherham Doncaster and South Humberside Foundation Trust (RDASH). This is cross referenced to clinical pathways, with local providers to assess the quality, sustainability and deliverability of the summation of provider workforce plans across the local health economy and provide the assurance that service plans are achievable with the necessary action being taken for high level risks. Workforce plans and the Risk Assessment will be reviewed at the NHS South Yorkshire and Bassetlaw workforce assurance meeting with providers and the North of England SHA (NoESHA). A copy of the latest iteration of the health community workforce risk assessment has been provided.

8.2 Transition

In common with all other primary care trusts, 2012/13 will be a year of transition as NHS Rotherham moves towards abolition in April 2013. Working within the principles outlined in the HR Transition Framework, the Public Health HR Concordat and the more detailed guidance in associated People Transition Policies, for example for the NHS Commissioning Board, NHS Rotherham as part of NHS South Yorkshire and Bassetlaw will develop workforce transition plans for the associated transfer of functions to the new organisations. This will involve the analysis of functions for associated new receiver organisations, initial alignment/assignment and the eventual appointment and/or transfer of staff. Arrangements will be in place to support staff through this process including any people who are displaced and placed at risk and/or made redundant as a result. Other aspects of the transition are discussed in section 11.

8.3 Staff Engagement

The changes required under Liberating the NHS and further running cost reductions call for consistent and ongoing staff engagement and communication to support staff through these changes. This is being achieved in a number of ways and will continue into 2012/13:

- Regular all staff and management meetings where current information and its impact are shared openly with staff with opportunities for questions and discussion.
- A cluster wide Social Partnership Forum (SPF) which meets regularly to consult on the staffing issues associated with transition.
- The SPF supplemented within each of the constituent PCTs by the continuation of local joint consultative meetings to address local issues.
- Regular 1:1 meetings between staff and their managers/directors to provide latest updates, assess the needs and wishes of individual staff and provide indication of likely receiver organisations for the functions staff work in.
- Participation in national transition policies and exercises dealing with alignment and assignment.
- Joint staff and management meeting with receiver organisations, e.g. local authority to prepare the way for transition, involving both HR and staff representatives.
- Ongoing participation in the staff survey to check staff perception of the effectiveness of staff engagement strategies and develop action plans to address any perceived shortcomings.
- The launch of a new digital internal communications strategy.
NHS Rotherham also monitors the staff survey outcomes for our main providers and in relation to staff pledge 4 of the NHS Constitution, staff engagement, the latest indicators are as follows:

- **NHS Rotherham - highest (best) 20%** in both staff engagement indicators in 2011 survey.
- **TRFT** – score **above average** on two of the three staff engagement indicators on the 2010 Staff Survey Outcomes including % of staff able to contribute towards improvements at work (an 8% increase from 2009), and staff recommendation of the Trust as a place to work.
- **RDaSH** - Improved scores on two out of three staff engagement indicators.

These are all good scores in a period of unprecedented organisational change and downsizing.

A new internal communications strategy has been launched with a move to e-communications for all staff. The strategy incorporates a four pronged approach and aims to promote the essence of teamwork and staff involvement.

8.4 **Leadership, Transition and Support to CCG**

CCG Committee, Strategic Clinical Executive and GP Reference Group members will be supported throughout the transition period to authorisation, reflected in an agreed organisational plan.

This includes:

- Shadow management and governance arrangements with NHS Rotherham executive and commissioning lead officers
- Collaborative working with NHS Rotherham lead managers
- Dedicated support via named NHS Rotherham staff
- Identification of individual and collective development needs
- Access to external (national/ regional / cluster-wide) leadership and change management programmes and activities
- Access to internal support and leadership development programmes and interventions via NHS Rotherham specialists
- Financial resources to provide appropriate support and development
This SIP is supported by the Rotherham CCG IT Strategy 2012/13 (IM&T Strategy). The strategy sets out a one year work plan for better information systems and information sharing across the health community. Stakeholders engaged in the development of the strategy were:

- General Practitioners
- Rotherham CCG
- TRFT
- RDaSH
- The Rotherham Hospice
- RMBC (social services)

The IT strategy for the next year is largely based on local priorities identified by the multi agency IT strategy group. The exceptions to this are the Summary Care Record and Electronic Prescription Service workstreams which we will continue to implement. The strategy has the following priorities:

- Electronic access to hospital information for GPs (discharge summaries, clinical letters and radiology)
- Access to relevant parts of GP patient records for clinicians across the system
- Interoperability between hospital and GP systems
- GP clinical system migrations; this involves migrating Rotherham practices currently using EMIS to a centrally hosted system. Under GP System of choice most of the practices will choose EMIS web so by April 2013 Rotherham will have just two centrally hosted GP IT systems EMIS web and System 1.
- GP to GP transfers
- Clinical outcomes monitoring
- SCR (Summary Care Record)
- EPS (Electronic Prescription Service)
- Clinical dashboards and risk stratification
- Access to clinical guidelines, which will incorporate work to enhance the public facing health information database to include information to support GPs in the consulting room. The e-clinical information toolkit will provide a one stop shop for GPs to access a bundle of information to support decision making and to improve the patient experience.
- SLAM upgrade
- Telehealth

In addition to delivery of the IT Strategy we will also address the other priorities identified in the Operating Framework for 2012/13 as detailed below:

**Patient access to on-line records:** We will continue to work with our practices to provide patients with the facility for online access to view and request their medication. We will work with our GP system suppliers as they develop the functionality for greater access to the full medical record and prepare plans with practices to deploy this as it becomes available.

**NHS Number compliance/usage:** The NHS Number is key within contract reconciliation and contract monitoring data flows. We will work with Trusts to ensure as high a level of NHS number completion as is possible, utilising contract sanctions where appropriate.

**Information to support patient choice:** Work will continue with data flows beyond SUS, which are key to commissioning, particularly including outcomes data and patient experience data. We will await the detailed guidance on the provision of information for patients to support choice and then work with our providers to deliver this.
It is anticipated that further informatics planning guidance will be issued during 2012/13 in the forthcoming Information Strategy for Health and Social Care. Publication of the national strategy may require that a review and revision of our strategy and plans be carried out in year.

**Governance**

Delivery of IT strategy will be monitored through the Rotherham health community IT Strategy group and Rotherham CCG IT Steering Group which contains senior clinicians and representatives from all key agencies. Implementation of the IT strategy will be taken forward by the CCG IT service and the TRFT IT Service through the existing service level agreement for IT services.

We will continue to manage a local Information Governance (IG) programme that reports into the annual IG Toolkit assessment undertaken by NHS South Yorkshire and Bassetlaw. The IG programme will ensure that appropriate policies, guidance and workstreams are in place to support the organisation through transition.

**Risks**

Full benefits from IT across the system require the successful implementation of TRFT’s Electronic Patient Record (EPR) system. This is planned to go live during 2012/13 but previous go live dates have been missed in order to make sure the system is fit for purpose on day one. Until EPR is operational, projects such as electronic discharge letters will be delivered as individual projects.

IT staff working for the CCG and those working for the TRFT who support commissioning are subject to running cost targets and so there may have to be further staff reductions during 2012/13 which may impede the implementation of projects.

IT projects such as GP migration are dependent on the capacity of third party suppliers.
10  Performance Outcomes and Accountability

10.1 Accountability and Performance Frameworks

For 2012/13, PCT Clusters and SHA Clusters are the organisations accountable for the NHS Operating Framework implementation. Rotherham CCG will ensure that all 2012/13 outcomes relating to its areas of delegated authority are delivered and will also make plans in anticipation of the three new Outcome frameworks that are being developed during 2012/13.

A total of four outcome frameworks are relevant to the CCG and its partners:

- The Performance Framework in the 2012/13 Operating Framework
- The NHS Outcomes Framework 2012/13
- The Outcomes Framework for Adult Social Services
- The Public Health Outcomes Framework

The 2012/13 Operating framework is structured around five domains that are also used by the NHS Outcomes Framework (13 key measures). In addition there are two public health measures (smoking quitters and NHS Health checks), 11 measures relating to resources and 10 measures relating to reform. A full list of the metrics has been produced together with a risk assessment of the likelihood of underperformance in 2012/3.

Annex A of the Operating Framework for 2012/13 shows the full set of national performance measures.

<table>
<thead>
<tr>
<th>Quality</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Preventing people from dying prematurely</td>
<td></td>
</tr>
<tr>
<td>- Ambulance quality (Category A response times)</td>
<td></td>
</tr>
<tr>
<td>- Cancer 31 day, 62 day waits</td>
<td></td>
</tr>
<tr>
<td>2 Enhancing quality of life for people with long term conditions</td>
<td></td>
</tr>
<tr>
<td>- Mental health measures (Early intervention, Crisis resolution, CPA follow up, IAPT)</td>
<td></td>
</tr>
<tr>
<td>- Long term condition measure (Proportion of people feeling supported to manage their condition, Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults), Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s)</td>
<td></td>
</tr>
<tr>
<td>3 Helping people to recover from episodes of ill health or following injury</td>
<td></td>
</tr>
<tr>
<td>- Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td></td>
</tr>
<tr>
<td>4 Ensuring that people have a positive experience of care</td>
<td></td>
</tr>
<tr>
<td>- Patient experience of hospital care</td>
<td></td>
</tr>
<tr>
<td>- Referral to Treatment and diagnostic waits (incl incomplete pathways)</td>
<td></td>
</tr>
<tr>
<td>- A&amp;E total time</td>
<td></td>
</tr>
<tr>
<td>- Cancer 2 week waits</td>
<td></td>
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<tr>
<td>- Mixed-sex accommodation breaches</td>
<td></td>
</tr>
<tr>
<td>5 Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td></td>
</tr>
<tr>
<td>- Incidence of MRSA</td>
<td></td>
</tr>
<tr>
<td>- Incidence of C. difficle</td>
<td></td>
</tr>
<tr>
<td>- Risk assessment of hospital-related venous thromboembolism (VTE)</td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td></td>
</tr>
<tr>
<td>- Smoking quitters</td>
<td></td>
</tr>
<tr>
<td>- Health checks</td>
<td></td>
</tr>
<tr>
<td>Reform</td>
<td></td>
</tr>
<tr>
<td>- Commissioning Development</td>
<td></td>
</tr>
<tr>
<td>- % delegated budgets</td>
<td></td>
</tr>
<tr>
<td>- Measure of £ per head of devolved running costs</td>
<td></td>
</tr>
<tr>
<td>- % authorisation of clinical commissioning groups</td>
<td></td>
</tr>
<tr>
<td>- % of General Practice list reviewed and “cleaned”</td>
<td></td>
</tr>
<tr>
<td>- Public Health</td>
<td></td>
</tr>
<tr>
<td>- Completed transfers of public health functions to local authorities</td>
<td></td>
</tr>
<tr>
<td>- FT pipeline</td>
<td></td>
</tr>
<tr>
<td>- Progress against TFA milestones</td>
<td></td>
</tr>
<tr>
<td>Choice</td>
<td></td>
</tr>
<tr>
<td>- Bookings to services where named consultant led team was available (even if not selected)</td>
<td></td>
</tr>
<tr>
<td>- Proportion of GP referrals to first outpatient appointments booked using Choose and Book</td>
<td></td>
</tr>
<tr>
<td>- Trend in volume of patients being treated at non-NHS hospitals</td>
<td></td>
</tr>
<tr>
<td>Information to Patients</td>
<td></td>
</tr>
<tr>
<td>- % of patients with electronic access to their medical records</td>
<td></td>
</tr>
</tbody>
</table>
The **NHS Outcomes framework 2012/13** uses the same domains as the operating framework:

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing quality of life for people with long term conditions
- Domain 3: Helping people to recover from episodes of ill health or following injury
- Domain 4: Ensuring that people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Some of the suggested metrics are still under development and the framework will share some metrics with the partner outcomes frameworks for public health and adult social services. This framework is designed to hold the NHS Commissioning Board (NHSCB) to account. During 2012/13 a Commissioning Outcomes Framework will be developed by the NHSCB to hold commissioning groups to account for effective commissioning and to promote improvements in quality and efficiency.

The **Public health Outcomes Framework 2012/13** was published in January 2012.

The **Social Care Outcomes Framework**

The current Adult Social Care Outcomes Framework 2011/12 contains a number of outcome measures which overlap with the NHS Operating Framework or which the NHS will play a part in achieving. The Framework is built around the following 4 domains:

- Domain 1: Enhancing quality of life for people care and support needs
- Domain 2: Delaying and reducing the need for care and support
- Domain 3: Ensuring that people have a positive experience of care and support
- Domain 4: Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm.

Rotherham CCG, through the Health and Wellbeing Board, will play its role together with partners in delivering the three outcomes frameworks which will form key elements of the Health and Wellbeing Strategy.

### 10.2 Performance Reporting and Performance Management

**CCG and Cluster Performance reports**

The CCG performance team has collaborated with colleagues in the four other CCG’s and NHS South Yorkshire and Bassetlaw during 2011. Currently separate performance reports are produced for cluster Board and CCG Committee. Both reports will need to be updated to take into account the new national outcomes frameworks and we will take this opportunity to use the same report for both purposes.

**Quality reports**

The CCG produces a report and narrative of exceptions for each NHS South Yorkshire and Bassetlaw Quality Committee and this is also reviewed by CCG Audit and Quality Assurance Group.
**Health and Wellbeing Board**

We will work closely with the Local Authority to support the development of a performance management framework with the Health and Wellbeing Board.

**Performance management framework**

Rotherham CCG/NHS Rotherham has an effective performance management framework that sets out its vision, methods of reporting and reviewing performance, data quality, partnership arrangements, accountabilities and escalation policies. This policy will be reviewed in light of the changed national frameworks and the possible transition to commissioning support arrangements for performance management.

**10.3 Trajectories**

In accordance with the recently published ‘Technical Guidance for 2012/13 Operating Framework’, the following indicators are required to submit planning trajectories:

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Measure</th>
<th>Requirements</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ10</td>
<td>Mental Health: Early Intervention in Psychosis</td>
<td>Yes, for non-FT MH Trusts</td>
<td>Quarterly (2012/13)</td>
</tr>
<tr>
<td>PHQ27</td>
<td>HCAI measure (MRSA)</td>
<td>Yes, provider and commissioner</td>
<td>Monthly (2012/13)</td>
</tr>
<tr>
<td>PHQ28</td>
<td>HCAI measure (C.Diff)</td>
<td>Yes, provider and commissioner</td>
<td>Monthly (2012/13)</td>
</tr>
<tr>
<td>PHQ20</td>
<td>Smoking Quitters</td>
<td>Yes, commissioner plans</td>
<td>Quarterly (2012/13)</td>
</tr>
<tr>
<td>PHQ31</td>
<td>Coverage of NHS Health Checks</td>
<td>Yes, for commissioners</td>
<td>Quarterly (2012/13)</td>
</tr>
<tr>
<td>PHS01</td>
<td>Financial forecast outturn &amp; performance against plan</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>PHS03</td>
<td>Delivery of running costs targets</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>PHS04</td>
<td>Progress on delivery of QIPP savings</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>PHS06</td>
<td>Non-elective FFCEs</td>
<td>Yes – provider forecast with SHA assurance of PCT sign off; and commissioner forecast</td>
<td>Monthly (2012/13); and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS07</td>
<td>GP Written Referrals to Hospital</td>
<td>Yes – provider forecast with SHA assurance of PCT sign off; and commissioner forecast</td>
<td>Monthly (2012/13); and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS08</td>
<td>Other Referrals for a First Outpatient Appointment</td>
<td>Yes – provider forecast with SHA assurance of PCT sign off; and commissioner forecast</td>
<td>Monthly (2012/13); and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS09</td>
<td>First Outpatient Attendances following GP Referral</td>
<td>Yes – provider forecast with SHA assurance of PCT sign off; and commissioner forecast</td>
<td>Monthly (2012/13); and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS10</td>
<td>All First Outpatient Attendances</td>
<td>Yes – provider forecast with SHA assurance of PCT sign off; and commissioner forecast</td>
<td>Monthly (2012/13); and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS11</td>
<td>Elective FFCEs</td>
<td>Yes – provider forecast with SHA assurance of PCT sign off; and commissioner forecast</td>
<td>Monthly (2012/13); and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS12</td>
<td>A&amp;E Attendances</td>
<td>Yes - provider forecast with SHA assurance of PCT sign off</td>
<td>Quarterly (2012/13) and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS13</td>
<td>Ambulance Urgent and Emergency Journeys</td>
<td>Yes, provider (ambulance trust) forecast with SHA assurance of PCT sign off</td>
<td>Quarterly (2012/13) and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS14</td>
<td>Diagnostic Activity – Endoscopy based tests</td>
<td>Yes, commissioner forecasts</td>
<td>Monthly (2012/13) and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS15</td>
<td>Diagnostic Activity – Non-Endoscopy based tests</td>
<td>Yes, commissioner forecasts</td>
<td>Monthly (2012/13) and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS16</td>
<td>Numbers waiting on an Incomplete Referral to Treatment Pathway</td>
<td>Yes, commissioner forecasts</td>
<td>Monthly (2012/13) and outline annual forecasts for 2013/14 and 2014/15</td>
</tr>
<tr>
<td>PHS17</td>
<td>Health Visitor Numbers</td>
<td>Yes, provider</td>
<td>Monthly</td>
</tr>
<tr>
<td>PHS19</td>
<td>Total Pay Costs</td>
<td>Yes, forecasts are required from SHA and PCT clusters</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
Rotherham CCG/NHS Rotherham will agree and submit these trajectories which will ensure that national standards and outcomes are being met in Rotherham and that continued improvement in healthcare is maintained. The trajectories are also likely to incorporate key patient activity targets which will help to measure the impact of QIPP programmes.

10.4 Performance Risks

The following have been identified as posing the most significant performance risks for Rotherham CCG in the coming year.

NHS Operating Framework

PHQ17 – Emergency admissions for acute conditions that should not usually require hospital admission. Rotherham has historically high emergency admissions to hospital, and this forms a key element of the QIPP programme for unscheduled care 2011/12 to 2014/15.

PHQ23 – Total time in A&E - Whilst performance measured against the 4 hour target is above target it has fluctuated during 2011/12, and at times fallen below standard. Significant non-recurrent investment in additional A&E doctors has been made during 2011/12 to maintain the performance above the required target, however it will remain a significant risk in 2012/13. The review of urgent care (section 5.3.3) is key to providing our long term solution to this problem.

PHQ27 and PHQ28 – MRSA and CDiff. Targets were challenging in 2011/12 and are expected to be more so in 2012/13. Rotherham has a good record of low healthcare associated infections, however district wide Infection control arrangements need to continue to keep careful scrutiny of this issue.

10.5 Operating Framework Key Commitments

The following areas are identified in the Operating Framework as requiring particular attention during 2012/13. The table below lists the areas and signposts to where further information can be found.

<table>
<thead>
<tr>
<th>Area</th>
<th>Signpost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia and care of older people</td>
<td>See section 3</td>
</tr>
<tr>
<td>Mental health services – including offender health</td>
<td>See section 3</td>
</tr>
<tr>
<td>Increasing access to psychological therapies</td>
<td>See section 3</td>
</tr>
<tr>
<td>Children and young peoples mental health</td>
<td>See section 3</td>
</tr>
<tr>
<td>Safeguarding children</td>
<td>See section 4</td>
</tr>
<tr>
<td>Stroke</td>
<td>See section 5</td>
</tr>
<tr>
<td>Diabetes</td>
<td>See section 5</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>See section 5</td>
</tr>
<tr>
<td>NHS 111</td>
<td>See section 5</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>See section 3</td>
</tr>
<tr>
<td>Healthcare acquired infections</td>
<td>See section 11</td>
</tr>
<tr>
<td>Health visitors</td>
<td>See below</td>
</tr>
<tr>
<td>Family Nurse Partnerships</td>
<td>See below</td>
</tr>
<tr>
<td>Military and veterans health</td>
<td>See below</td>
</tr>
<tr>
<td>Support for carers</td>
<td>See below</td>
</tr>
<tr>
<td>Eliminating mixed sex accommodation</td>
<td>See below</td>
</tr>
<tr>
<td>Cancer</td>
<td>See below</td>
</tr>
<tr>
<td>Abdominal aortic aneurysm</td>
<td>See below</td>
</tr>
<tr>
<td>Venous thromboembolism (VTE)</td>
<td>See below</td>
</tr>
</tbody>
</table>
Health Visitors

In line with the government’s commitment to strengthen the health visiting workforce by 4,200 in 2015, the CCG has developed and agreed an implementation plan to deliver an additional 24.00 FTE Health Visitors (HV) by 2015 from a baseline position of 35.66 FTE at May 2010.

Below is a projection of the expected increase in the FTE HV workforce as reported to SHA Yorkshire and Humber. This may vary as HV’s become available which will require funds to be allocated flexibly. 20.00 FTE posts will be funded by Rotherham CCG/NHS Rotherham and 4.00 FTE from existing resources within the service.

<table>
<thead>
<tr>
<th>Financial year</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase</td>
<td>4 plus 3 FNPs</td>
<td>6</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Total HV’s to be achieved in Service (Baseline 36.00 FTE)</td>
<td>43.00</td>
<td>49.00</td>
<td>54.00</td>
<td>60.00</td>
</tr>
</tbody>
</table>

We are mindful that HV’s will continue to leave, therefore active recruitment will continue alongside training students. Relocation packages will be offered by TRFT for hard to recruit posts. Staff Nurses will continue to be recruited, developed and enabled to access the HV Degree Course using a ‘grow your own’ method of converting Staff Nurses to Health Visitors. Three of the qualifying students in September 2011 were previous Staff Nurses in the service.

We will be attracting qualified HV’s back into service with a ‘Return to Practice’ Programme which is now being provided in collaboration with the University.

Staff wishing to retire will be encouraged to take ‘flexi-retirement’ so they are not lost completely from the service and HV’s displaced from other posts e.g. Public Health, Specialist Roles are offered redeployment back into Health Visiting.

Family Nurse Partnerships

A Family Nurse Partnership (FNP) is in the process of being established in Rotherham. The FNP is a preventive programme for young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses (Family Nurses), from early pregnancy until the child is two. The programme will achieve the following outcomes:

- improved early language development, school readiness and academic achievement
- improvements in antenatal health
- reductions in children’s injuries, neglect and abuse
- improved parenting practices and behaviour
- fewer subsequent pregnancies and greater intervals between births
- increased maternal employment and reduced welfare use
- increases in fathers’ involvement
- reduced arrests and criminal behaviour for both children and mothers

Military and Veterans Health

Rotherham CCG/NHS Rotherham signed the Armed forces covenant on 21 January 2012. Dr Nagpal Hoysal (Public Health Consultant) is responsible for leading on this important work. The CCG will encourage member practices to sign the covenant and make it visible as part of the campaign to raise awareness amongst Rotherham residents.
Support for Carers

Rotherham CCG has a strong record of close partnership working with carer organisations. The GP case management pilot and in particular the social prescribing element will dramatically improve the co-ordination and support of people with long term conditions and their carers (see section 5.3.2 projects 4 & 5). Working with partners we will refresh the Rotherham Carers strategy by September 2012 and make this available on our website. We provide funding to a range of voluntary organisations which support carers, including Headway and Age UK. Two examples of carers support services directly commissioned by Rotherham CCG are set out below.

1. **Carer Support Service for People with Dementia: Crossroads**

We commission a specialist carer support service for people diagnosed with dementia. The aims of the service are to:

- Provide emotional support and respite breaks to carers of people with dementia
- Support people with dementia be more independent at home and in the community
- Enhance the quality of life of people with dementia and their carers

According to the National Dementia Strategy evidence suggests that this type of support delivered as a partnership between statutory and voluntary services can decrease institutionalisation by 22%. Carer support and counselling at diagnosis stage can reduce care home placements by 28%. Short-term breaks delivered by this service are vital to support families in their caring role in the community.

2. **Family and Carer Support Service for Stroke Survivors: Stroke Association**

Rotherham CCG also commissions a Family & Carer Support service for stroke survivors from The Stroke Association. This is a visiting service that gives practical information and emotional support to the families and carers of people who have had a stroke. It helps families prepare for the changes that happen because of a stroke and makes sure they are able to cope, both physically and emotionally. The main objectives of the service are to provide stroke survivors and their families with timely and appropriate information and advice. It supports carers through the process of discharge planning and transfer of care. The Family and Carer Support Service offers practical and emotional support to assist with living with aspects of stroke. It also provides advice on stroke prevention and support to facilitate health lifestyle changes among all family members, including carers.

**Eliminating Mixed Sex Accommodation**

Local hospitals have made consistent improvements in performance and have reported zero breaches since May after implementing the new quality assurance process. Stringent, regular performance management arrangements are now in place.

**Cancer**

Improving Outcomes a strategy for cancer (2011) sets out a simple aim: to deliver health outcomes that are among the best in the world. Rotherham CCG has representation at the North Trent Cancer Network where the strategy is addressed collectively by the PCT’s across the sub-region.
In 2012/13 the focus will be to reduce the incidence of cancers which are preventable, by lifestyle changes; as screening is an important way of detecting cancer early. We will:

- Participate in the Department of Health early breast cancer awareness campaign for the over seventies. The aim being to increase survival by early diagnosis
- Participate in a national cancer awareness campaign that commenced in January 2012. The aim is to increase awareness of symptoms to encourage people to seek medical advice early
- Participate in phase 2 of a social marketing campaign to target predominantly young women aged 25 years to 35 years who do not participate in cervical screening

Rotherham CCG is also working closely with the Macmillan to develop survivorship services to support people living with and beyond cancer.

**Abdominal Aortic Aneurysm**

In 2012/13 the intent for the Abdominal Aortic Aneurysm Screening service is for commissioners to complete a procurement process and have a provider in place to start providing the service in late January 2013.

**Venous Thromboembolism (VTE)**

VTE is part of the national CQUIN Scheme and achievement of the 90% target realises a monthly payment. Whilst early in the year TRFT fell slightly short of the threshold, since June they have consistently achieved over 90%. Rotherham compares well with the England average and regular performance management arrangements are in place.
11 Managing Transition

11.1 Clinical Commissioning Group Development

In September NHS South Yorkshire and Bassetlaw Board members held a ‘confirm and challenge’ meeting with Rotherham CCG. The outcome was confirmation that Rotherham CCG be formally established as a committee of the NHS South Yorkshire and Bassetlaw Board with delegated commissioning responsibility.

Rotherham CCG aims to achieve full authorisation by the Department of Health by October 2012 prior to assuming autonomous commissioning of those healthcare services that are to be commissioned by CCG’s from April 2013. Our approach is to harmonise the expertise and the organisational memory of the current commissioning workforce with the clinical expertise and vision of our nominated GP representatives and officers in the collaborative development of Rotherham CCG. In doing so, Rotherham CCG will be an organisation that comprises of:

- robust governance structures
- clear and workable strategies
- a skilled, capable and professional workforce
- a culture that values quality, innovation and fairness
- commissioning practices that deliver beneficial results for the people of Rotherham

An organisational development plan towards a Clinical Commissioning Group has been developed and provides a summary of Rotherham CCG’s strategic OD priorities. It is supplemented by a dynamic plan, represented in a ‘timeline’ and a number of dedicated project plans for key actions. It will be reviewed frequently in response to emerging landscape within the NHS, both nationally and locally (OD Plan and timeline).

11.1.1 Key Strategic Organisational Priorities and Outcomes

The key strategic OD priorities towards an authorised CCG for Rotherham are:

- Obtain a mandate to operate as a CCG in Rotherham in consultation with and the engagement of all local GPs & GP Practices
- Establish and develop organisational governance structures and roles that enable us to function as a CCG for Rotherham from October 2011 and become authorised from October 2012
- Develop the capacity and capability of Rotherham CCG executives, GP representatives and officers to commission healthcare services on behalf of and for the people of Rotherham
- Support and develop the NHS Rotherham workforce towards Rotherham CCG and other ‘future-form’ organisations to meet new arrangements and the cost efficiency programme

These strategic priorities will inform and be informed by the organisational development plans, priorities and activities of NHS South Yorkshire and Bassetlaw.

11.1.2 CCG Constitution

Rotherham CCG members have drafted a Constitution which proposes the principles by which the Rotherham CCG will operate. It reflects the CCG position following formal authorisation in April 2013, taking into account the transitional arrangements up to that point. The Constitution is subject to ongoing review and alignment with emerging national guidance CCG Constitution.

The Constitution sets out the operating principles, key work with all clinical groups, arrangements for involving constituent practices and covers the membership and chairing of all groups including the CCG Committee and sub-committee and covers external relationships.
11.1.3 NHS Constitution

The Constitution sets out various rights of and pledges to the people of England (including NHS staff) and sets out various principles and responsibilities for NHS organisations (and staff as individuals).

Rotherham CCG has prioritised efforts to meet the requirements. Indeed, some have been exceeded: for example, a local referral-to-treatment target agreed with our main acute care provider means that on average, patients do not wait longer than 10 weeks for treatment, but the Constitution focuses on 18 weeks. Also, Rotherham CCG has introduced the 5-yearly health checks that have been pledged to all 40-74 year olds. Funding will continue into the first part of 2012/3 - pending clarity on an anticipated change in funding responsibilities between NHS Rotherham and the Rotherham Metropolitan Borough Council.

Local surveys also tell us that a very high 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.

The PCT is the local leader of the NHS and is the local guardian of the Constitution. Subject to legislation, in April 2013 the PCT will cease to operate and this leadership role passes to the Health and Wellbeing Board. During 2012/3 we will advise the shadow Health and Wellbeing Board on the (assumed) guardianship role it will inherit.

11.1.4 GP Mandate

In September 2011, GPs were asked to give their mandate to the existing Strategic Clinical Executive and GP Reference Group to form a Clinical Commissioning Group for Rotherham. 112 voted out of the 150 eligible to vote. 103 (92%) agreed with this recommendation, providing a clear mandate for the proposal.

During 2011/12 Rotherham CCG Committee will consult and then make proposals for the reselection, responsibilities, numbers and length of tenure of GP members of Rotherham CCG Committee, Strategic Clinical Executive and representative bodies, how best to arrange annual confirmation that the CCG still has a mandate from local GPs and how to ensure that new GPs are enabled to become involved in clinical leadership. To ensure that the mandate remains stable, thresholds will be defined on the level of support needed, and a trigger point identified at which a review process would be initiated.

11.1.5 Governance

Rotherham CCG has taken great lengths to ensure that strong governance arrangements are in place to take the organisation through the transition period and beyond. Building on the strong NHS Rotherham local governance arrangements, one of the Strategic Clinical Executive GPs has been working closely with managers since January 2011. In addition we have worked closely with NHS Yorkshire and Bassetlaw colleagues to make sense of the emerging central guidance. Details can be found in the CCG’s constitution and the meetings structure CCG Constitution Meeting structure.

To ensure strong governance is maintained four of the previous NHS Rotherham non-executive directors have become independent lay members on the Rotherham CCG Committee, with our experienced Audit Committee Chair taking the role of vice chair of the CCG Committee. The GPs that make up Rotherham CCG acknowledge there is an inherent conflict of interest for GP commissioners but their knowledge of providing and commissioning services gives them a unique insight into how the system works. It is expected that by having GPs in a narrow minority on Rotherham CCG Committee this will maintain an independent focus at all times. The CCG has an agreed conflict of interest policy.
11.1.6 Required milestones for CCG authorisation

National planning guidance published on 19 December (Gateway reference number 17042) sets out milestones that have to be met by CCGs in order to achieve authorisation by April 2013. Rotherham CCG has included all these milestones in its OD plan - ‘Working Timeline in the Development of a CCG in Rotherham’.

11.1.7 Clinical Senates

The role and function of Clinical Senates are still being defined, however there are likely to be 15 nationally. Rotherham CCG expects to be involved in discussions about which clinicians should be represented on the senates.

11.2 NHS South Yorkshire and Bassetlaw / Commissioning Support Services Development

The functions of the NHS South Yorkshire and Bassetlaw will be to operate during the transition period and be responsible for:

- Supporting the development of CCGs towards full authorisation
- Managing performance during the transition
- Supporting and performance managing Quality Innovation Prevention and Productivity arrangements
- Leading the formation of NHS-run commissioning support services
- Establish effective transition arrangements to the NHS Commissioning Board of the services which the NHS Commissioning Board will be directly accountable for, and
- Prepare for formal transfer of staff to the new commissioning architecture

Rotherham CCG is currently working with NHS South Yorkshire and Bassetlaw to reach agreement on the future commissioning support arrangements for Rotherham.

During the transition period Rotherham CCG Committee will operate as a committee of the NHS South Yorkshire and Bassetlaw Board.

Currently all NHS Rotherham staff are involved in supporting CCG priorities. The CCG has an understanding of the running costs of NHS Rotherham staff and will seek to ensure that resources are equitably divided between successor organisations once agreement on future commissioning support arrangements are concluded.

11.3 NHS Commissioning Board

The NHS Commissioning Board has been established as a special health authority to allow it to prepare for taking on its full statutory duties from April 2013. Its broad responsibilities will be to provide leadership and hold CCGs to account for delivering their statutory responsibilities, and to commission services such as primary care, specialised services, prison/ offender health and military health. The CCG will support NHS Rotherham as it transfers the staff responsible for NHS Commissioning Board responsibilities to NHS South Yorkshire and Bassetlaw during 2012.

Good progress is being made with plans for revalidation for GPs in Rotherham. This work is led by the NHS Rotherham medical director who is working closely with the medical director at NHS South Yorkshire and Bassetlaw to develop a consistent cluster wide approach.
11.4 Public Health Commissioning

Formal responsibility for managing the transition of public health responsibilities to local authorities and Public Health England lies with NHS South Yorkshire and Bassetlaw. The CCG will continue to work closely with public health colleagues and RMBC during this transition and to ensure that key programmes such as screening, immunisation, smoking cessation and NHS Healthchecks are maintained and outcomes monitored.

Public health staff presently employed by NHS Rotherham currently carry out important roles in clinical commissioning, clinical governance and safeguarding and the CCG will work with RMBC to agree a memorandum of understanding to ensure continued public health input into clinical commissioning.

The transition of public health services to RMBC is currently a priority focus ensuring that the transfer goes smoothly. A lead GP has been identified to oversee this transition from a GP perspective.

11.5 Emergency Planning and Resilience

Rotherham has robust emergency planning arrangements that have been tested by recent incidents and planning exercises. Local NHS specialist expertise is provided by NHS Rotherham public health staff. NHS South Yorkshire and Bassetlaw have taken over the lead PCT role previously provided by NHS Sheffield. There are well established links with wider emergency planning through RMBC and through the South Yorkshire Health Emergency Planning Forum. The CCG will ensure that it is clear on its responsibilities and accountability for emergency planning throughout the transition.
12 Risks and Mitigation

This risk assessment sets out the risks of the CCG not delivering the ambitious programmes described in the Single Integrated Plan and identifies executive and GP Strategic Clinical Executive leads for each risk. It should be read in combination with the risk register which is an up to date, comprehensive register of all current risks. The risk register identifies the likely future owners of all the risks, in many cases this is anticipated to be the CCG either on its own or in combination with another successor body such as the NHS Commissioning Board, RMBC or Public Health England.

The identified risks are the risks of not delivering our SIP priorities and the potential impact the SIP may have on existing CCG risks. Risks in this section are ordered by the organisational priorities set out in Section 1.5.

Priority 1: Delivery

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
<th>GP lead</th>
<th>Exec Lead</th>
<th>RAG Rating</th>
</tr>
</thead>
</table>
| 1.1a) Failure to ensure the services we commission are safe  
  • Commissioners do not maintain an effective grip on patient safety during transition | Mechanisms in Rotherham are currently robust and assured by the CCG Audit and Quality assurance Group.  
  Procedures are being reviewed and strengthened in partnership with NHS SY&B officers and assured by NHS SY&B Quality Ctte  
  Clear accountability of commissioners’ responsibilities will be maintained through the transition | RCu | RCa | A |
| 1.1b) Failure to ensure services we commission are safe  
  • Providers efficiency programmes compromise patient safety | Providers will continue to be held to account throughout the transition including by quality contract meetings, monitoring safety metrics, incident reports and programme of clinically led visits | PB (RFT)  
  RB (RDASH)  
  IT (GP) | RCa | A |
| 1.2) Failure to ensure that vulnerable children and adults have effective safeguarding  
  • Commissioners do not maintain effective grip on safeguarding procedures during the transition | Mechanisms for both children and adult safeguarding in Rotherham are currently robust but NHS Rotherham's risk register identifies that this will always be an area with considerable residual risks.  
  CCG assurance is through the Audit and Quality Assurance Group  
  Clear lines of accountability will be maintained during the transition with particular emphasis on accountability for roles that are currently provided by public health aligned staff | RB (Adults)  
  DP (Children) | CE | G |
| 1.3a) Failure to maintain and improve the quality of services  
  • Commissioners efficiency and transition programmes compromise safety and efficiency | During the transition we will continue to monitor quality through the same mechanisms described in 1.1a | RCu | RCa | A |
| 1.3b) Failure to maintain and improve the quality of services  
  • Providers efficiency programmes compromise quality | The CCG leads the CRMC and long term conditions groups which oversee the efficiency programmes. These groups are responsible for delivering the efficiencies without compromising quality of services | DT (ltc/uc)  
  JK (planned care) | CE  
  RCa | A |
| 1.4) Failure to deliver improving outcomes  
  • New outcomes frameworks, organisational changes and changes of performance management arrangements will compromise our ability to continue to improve outcomes | The CCG will ensure that patient outcomes and metrics required for national outcomes frameworks are monitored and necessary actions taken to address issues as they arise. This includes risk assessment on the new outcomes framework metrics and monthly performance reporting on outcomes to the CCG committee. | DT | RCa | G |
### Priority 2: GP quality and Efficiency

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
<th>GP lead</th>
<th>Exec Lead</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) Failure to Improve GP quality and efficiency in partnership with NHS South Yorkshire and Bassetlaw</td>
<td>Currently there are effective mechanisms of peer influence, annual quality and efficiency visits, monitoring contractual compliance, outcomes, compliments, complaints and incidents and raising and addressing performance list issues and potential GMC referrals in Rotherham. The CCG will ensure that clarity is maintained during the transition. NHS Rotherham’s medical director attends Strategic Clinical Executive meetings and so acts as a link between the CCG and NHS SY&amp;B</td>
<td>IT RC</td>
<td>G</td>
<td></td>
</tr>
</tbody>
</table>

### Priority 3: Commissioning for quality and efficiency

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
<th>GP lead</th>
<th>Exec Lead</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to deliver system wide efficiency programmes that will deliver £28.1m of efficiency savings out of a total of £74.9m of efficiency savings required by the NHS in Rotherham by 2014/15 (figures as per 2012/13 SIP)</td>
<td>See 2.1, 2.2 &amp;2.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1) Failure to deliver savings from the prescribing efficiency programme</td>
<td>The CCG has a well respected medicines management team which maintains effective relationships with prescribers and manages the quality and efficiency programmes through the medicines management ctte. The GP lead and prescribing team have regular face to face contact with prescribers and run an efficient prescribing incentive scheme. All these aspects will be maintained by the CCG.</td>
<td>JP RC</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Risk</td>
<td>Mitigation</td>
<td>GP lead</td>
<td>Exec Lead</td>
<td>RAG Rating</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>------------</td>
</tr>
</tbody>
</table>
| 2.2) Failure to deliver LTC Efficiency programme  
- Failure to deliver the necessary culture shift for patients, carers and clinicians  
- Failure of partners to work together  
- Lack of commitment of GPs as providers to the efficiency programme | The multi-agency LTC group is responsible for delivering, monitoring and evolving plans in this area. Plans are reflected in all discussions with patients and with voluntary sector, and reflected in joint commissioning plans and will be central to 2012/13 contract agreements with providers. GP time commitment is funded by the case management pilot. | DT      | CE        | A          |
| 2.3) Failure to deliver planned care Programme  
- Failure to deliver the necessary culture shift for patients and clinicians  
- Failure of the CCG and health service providers to work together  
- Lack of commitment of GPs as providers to the efficiency programme | The CRMC is responsible for delivering, monitoring and evolving plans in this area. RFT will be incentivised to work with commissioners through the 2012/13 contract. GPs have responded very positively to the 2011 programme. Additional impacts on them such as the safe follow up of patients previously followed up in hospital will be funded by a follow-up LES. | JK      | RC        | A          |

**Priority 4: Transition**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
<th>GP lead</th>
<th>Exec Lead</th>
<th>RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to become an effective CCG with full authorisation in autumn 2012</td>
<td>The CCG maintains an updated OD plan which contains all required actions and milestones (see section 11.1)</td>
<td>RCu</td>
<td>CE</td>
<td>G</td>
</tr>
<tr>
<td>Underperformance due to lack of clarity during the transfer of responsibility for primary care contracts and specialised contracting to NHS South Yorkshire and Bassetlaw</td>
<td>NHS SY&amp;B is already responsible for specialised contracting. Line management of primary care contracting will be transferred by 1 April 2012. NHS Rotherham’s medical director attends Strategic Clinical Executive meetings and so acts as a link between the CCG and NHS SY &amp; B with regards to aspects of GP contracting.</td>
<td>RCu</td>
<td>RC</td>
<td>G</td>
</tr>
<tr>
<td>Become an intelligent commissioner of commissioning support services including agreement with NHS South Yorkshire and Bassetlaw as to which support services should be provided directly and which provided by a Commissioning Support Service (CSS)</td>
<td>The CCG will continue to work in partnership with NHS SY&amp;B and the 4 other CCGs in SY to agree which services should be in a CSS and develop the SLA to ensure the CSS delivers the CCGs requirements.</td>
<td>RCu</td>
<td>CE</td>
<td>G</td>
</tr>
<tr>
<td>Work with NHS South Yorkshire and Bassetlaw and RMBC to agree to maintain the public health contribution to clinical commissioning</td>
<td>The CCG will ensure that elements of commissioning that are currently provided by public health are reflected in a memorandum of understanding with RMBC.</td>
<td>DPo</td>
<td>CE</td>
<td>G</td>
</tr>
<tr>
<td>Further develop relationships with neighbouring CCGs in NHS South Yorkshire and Bassetlaw</td>
<td>The CCG will maintain and expand its current links both by direct contacts and at events facilitated by NHS SY&amp;B</td>
<td>DT</td>
<td>CE</td>
<td>G</td>
</tr>
<tr>
<td>Further develop relationships with the NHS Commissioning Board</td>
<td>The CCG will work with NHS SY&amp;B to develop strong relationships with the NHS Commissioning Board.</td>
<td>DT</td>
<td>CE</td>
<td>G</td>
</tr>
</tbody>
</table>
13 Equality and Diversity

Rotherham CCG/NHS Rotherham has retained an equality and diversity function and expertise within its workforce, and are active participants in the Equality Delivery System (EDS) clusters within the region to facilitate shared learning primarily around EDS.

Our commissioning intentions will reflect the EDS objectives and outcomes, including the analysis of outcomes for each protected group reflecting comprehensive engagement and using reliable evidence.

Following the transfer of services under Transforming Community Services there were no patient safety, quality or wider performance problems. The contract and performance management of the services following their transfer to new providers has and will remain a high priority. All service specifications have gone through the equality impact assessment process to assess the impact of the transition on the diverse population served.

13.1 Equality Delivery System

The five constituent PCT’s in South Yorkshire and Bassetlaw have agreed to work in partnership to support each other in achieving compliance with the general and specific public sector duties and in using the Equality Delivery System. A cluster equality leads Group has been meeting monthly since May 2011 to take forward this agenda in partnership. NHS Sheffield will continue to engage in partnership, but are focussing more than the other communities on their internal systems and processes whilst NHS Barnsley, NHS Bassetlaw, NHS Doncaster and NHS Rotherham are working particularly closely through this group on joint compliance.

A mapping of equality activity across the five constituent PCT’s identified areas for joint working as shown below such as a joint approach to the development of a cluster level equality strategy and mandatory training. As a result, for example, mandatory equality and diversity training has been rolled out across the entire cluster via the core learning unit equality e-learning package.

<table>
<thead>
<tr>
<th>EQUALITY STRATEGY</th>
<th>Development of a joint equality strategy across the cluster including a vision statement and communications plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EQUALITY OBJECTIVES</td>
<td>Development of a limited number of joint cluster objectives as required under the draft specific public sector duties and the Equality Delivery System, which will be supplemented by local objectives agreed in local health communities.</td>
</tr>
<tr>
<td>PUBLISHING EQUALITY DATA</td>
<td>Development of a core data set for publication of data across the Cluster as required under the draft specific public sector duties. A core data set will be developed for both workforce data (based on ESR) and population data (comprising as a minimum from each constituent PCT the Joint Strategic Needs Assessment, the director of public health annual report and the equality &amp; diversity annual report).</td>
</tr>
<tr>
<td>EQUALITY DELIVERY SYSTEM</td>
<td>A joint approach to assessment based on combining individual assessments into a single cluster assessment, supplemented by local work within local health communities. Effective use of local PPI Leads to engage with local communities. Embedding into 2012/13 contracts the requirement for providers to undertake the EDS.</td>
</tr>
<tr>
<td>EQUALITY TRAINING</td>
<td>Cluster requirement for e-learning on the core learning unit website by 31 October 2011 for all staff across the cluster. Consistency of approach for other areas of equality training, including a need for consistency of training/message around the Equality Delivery System.</td>
</tr>
<tr>
<td>EQUALITY IMPACT ASSESSMENTS</td>
<td>Local arrangements to continue, but any cluster EIA’s should be included on all constituent PCT websites e.g. assignment, Clustering.</td>
</tr>
<tr>
<td>TRANSLATION &amp; INTERPRETATION</td>
<td>All constituent PCTs have their own systems for translation &amp; interpretation and there would be benefit in a longer term project to align systems and achieve economies of scale moving forwards in the long term in 2012/13.</td>
</tr>
<tr>
<td>ENGAGEMENT</td>
<td>Joint engagement activity at a cluster level with regional rather than local groups, starting with engagement around the Equality Delivery System.</td>
</tr>
</tbody>
</table>
To support compliance with the specific public sector duty to publish equality data relating to both the workforce and the population, a joint compliance template has been developed and organisations have published this on their websites.

To support compliance with using the Equality Delivery System in assuring progress against the general public sector duties, the group has also developed an Equality Delivery System Project Charter and a project action plan with a clear timeline of activity to publication of equality objectives on 1 April 2012.

Individual PCT localities are also working locally in partnerships across their health economies with their local foundation trusts to develop partnership objectives. In addition to these, it is intended that shared equality objectives across the cluster area will also be developed.

The cluster objectives from the self-assessments and engagement work undertaken across the NHS South Yorkshire and Bassetlaw have been agreed as:

- Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within provider contracts
- Ensure appropriate and accessible targeted communication with local communities to empower patients
- Develop consistency of equality approach across the clustered PCT’s in respect of leadership, staff empowerment and access to development opportunities
- Demonstrate leadership in advancing the equality agenda internally and with partners and providers to ensure inequalities are addressed within a partnership approach to ensure equity of access experience and outcomes for patients.

The next steps for the NHS South Yorkshire and Bassetlaw constituent PCTs in Equality Act compliance are detailed below:

<table>
<thead>
<tr>
<th>Task</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete local PCT self-assessments.</td>
<td>End of December 2011</td>
</tr>
<tr>
<td>Complete ‘local interests’ assurance on self-assessments.</td>
<td>End of January 2012</td>
</tr>
<tr>
<td>Publish equality data on websites x5.</td>
<td>31 January 2012</td>
</tr>
<tr>
<td>Embed Equality Act and Equality Delivery System requirements into provider contracts and potentially via a CQUIN.</td>
<td>February 2012</td>
</tr>
<tr>
<td>Equality Report containing equality objectives to Clinical Commissioning Groups Committees / Interim Commissioning Committees x5.</td>
<td>February 2012</td>
</tr>
<tr>
<td>Equality Strategy containing equality objectives to cluster Board for approval.</td>
<td>15 March 2012</td>
</tr>
<tr>
<td>Publish equality strategy containing equality objectives on PCT websites.</td>
<td>1 April 2012</td>
</tr>
<tr>
<td>Embed equality objectives into mainstream business planning and performance monitoring processes.</td>
<td></td>
</tr>
</tbody>
</table>
13.2 Equality Impact Assessments

Arrangements for assessing and consulting on the likely impact of proposed policies on the promotion of equality take the form of Equality Impact Assessments (EIAs). Rotherham CCG/NHS Rotherham is continuing to implement a programme to fully embed the use of equality impact assessments throughout all key functions.

All new and reviewed policies, strategic proposals and significant pieces of work now routinely are subject to a full equality impact assessment.

An equality impact assessment toolkit has been produced appropriate for workplace policies and commissioning. This will enable those staff involved in policy, strategy development, or review and service specification to carry out a comprehensive assessment on the proposed policy, strategy and service specifications. Equality Impact Assessment can be found on our website.

Equality Impact Assessments are the way we check how an existing or new service, policy or procedure and the services being commissioned affects groups of people. It allows staff to look at evidence or consult as to whether the service or policy is discriminating against particular groups of people. We can then make the necessary changes if there are adverse effects on some groups, or indeed highlight it as good practice if it is having a beneficial effect.

This process is overseen by the Equality, Diversity and Human Rights Steering Group. Rotherham CCG/NHS Rotherham is committed to assessing policies and functions for impact on disabled people, race, gender and age, as a minimum. Our equality and diversity webpage can be found at:
http://www.rotherham.nhs.uk/about/equality
## 14 Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AQP</td>
<td>Any Qualified Provider</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic (groups)</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CHC</td>
<td>Continuing Health Care</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DPH</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>EDS</td>
<td>Equality Delivery System</td>
</tr>
<tr>
<td>FNC</td>
<td>Funded Nursing Care</td>
</tr>
<tr>
<td>GPRG</td>
<td>GP Reference Group</td>
</tr>
<tr>
<td>H&amp;WB</td>
<td>Health and Wellbeing Board</td>
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<tr>
<td>IDAC</td>
<td>Index Affecting Children</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
</tr>
<tr>
<td>LMC</td>
<td>Local Medical Committee</td>
</tr>
<tr>
<td>LES</td>
<td>Local Enhanced Service</td>
</tr>
<tr>
<td>LIS</td>
<td>Local Incentive Scheme</td>
</tr>
<tr>
<td>LSP</td>
<td>Local Strategic Partnership</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Conditions</td>
</tr>
<tr>
<td>NHS SY&amp;B</td>
<td>NHS South Yorkshire and Bassetlaw</td>
</tr>
<tr>
<td>OE</td>
<td>Operational Executive</td>
</tr>
<tr>
<td>PBC</td>
<td>Practice Based Commissioning</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity and Prevention</td>
</tr>
<tr>
<td>RCHS</td>
<td>Rotherham Community Health Services</td>
</tr>
<tr>
<td>RDaSH</td>
<td>Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust</td>
</tr>
<tr>
<td>RMBC</td>
<td>Rotherham Metropolitan Borough Council</td>
</tr>
<tr>
<td>SAAP</td>
<td>Single Assessment and Assurance Process</td>
</tr>
<tr>
<td>SCE</td>
<td>Strategic Clinical Executive</td>
</tr>
<tr>
<td>SCG</td>
<td>Specialised Commissioning Group</td>
</tr>
<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
</tr>
<tr>
<td>SPA</td>
<td>Single Point of Access</td>
</tr>
<tr>
<td>TRFT</td>
<td>The Rotherham NHS Foundation Trust</td>
</tr>
<tr>
<td>VR</td>
<td>Voluntary Redundancy</td>
</tr>
<tr>
<td>VER</td>
<td>Voluntary Early Retirement</td>
</tr>
</tbody>
</table>
## 15 List of linked documents

The following is a list of the embedded documents within the SIP, if you require any assistance please contact Lydia George at: [lydia.george@rotherham.nhs.uk](mailto:lydia.george@rotherham.nhs.uk)

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<tr>
<th>Title</th>
<th>Page number</th>
</tr>
</thead>
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</tr>
<tr>
<td>2 Director of Public Health Annual Report</td>
<td>13</td>
</tr>
<tr>
<td>3 GP comparative data</td>
<td>14</td>
</tr>
<tr>
<td>4 Meaningful engagement with patients, carers and the community</td>
<td>25</td>
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<tr>
<td>5 Meetings structure as at 31 December 2011</td>
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<tr>
<td>6 Rotherham Community Strategy 2012 to 2015</td>
<td>30</td>
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<tr>
<td>7 IM&amp;T strategy</td>
<td>59</td>
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<tr>
<td>8 OD Plan and timeline</td>
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</tr>
<tr>
<td>9 CCG Constitution</td>
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</tr>
<tr>
<td>10 Equality and Diversity webpage</td>
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</tbody>
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