HEALTH AND WELLBEING BOARD

Venue: **Town Hall, Moorgate Street, Rotherham S60 2TH**

Date: **Wednesday, 1st October, 2014**

Time: **9.00 a.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972.

2. To determine any item which the Chairman is of the opinion should be considered as a matter of urgency.

3. Questions from Members of the Press and Public

4. Minutes of Previous Meeting (Pages 1 - 9)

5. Communications
   HWB Peer Challenge
   Pharmaceutical Needs Assessment

6. Better Care Fund (Pages 10 - 90)

7. Social Care Support Grant 2014-15 (Pages 91 - 94)

8. Performance Management Framework (Pages 95 - 111)

9. Healthwatch Rotherham (Pages 112 - 116)
   Chrissy Wright to report

10. Vaccinations and Immunisations for Pregnant Women

11. Diabetic Retinopathy Screening (Pages 117 - 120)
    Jacky Mason & Fiona Jordan, NHS England to report

12. Special Educational Needs and Disability Transformation (Pages 121 - 124)
    Donald Rae to report

13. Date of Next Meeting
    Wednesday, 12th November, 2014, commencing at **1.00 p.m.**

HEALTH AND WELLBEING BOARD
27th August, 2014

Present:-

Members

Councillor John Doyle	Cabinet Member for Adult Social Care **(in the Chair)**
CI Richard Butterworth	South Yorkshire Police (representing South Yorkshire Police)
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Chris Edwards	Chief Operating Officer, Rotherham CCG
Melanie Hall	Rotherham Healthwatch (representing Naveen Judah)
Dr. Julie Kitlowski	Clinical Chair, Rotheham CCG
Councillor Paul Lakin	Deputy Leader
Carol Stubley	NHS England
Joyce Thacker	Strategic Director, Children Young People and Families Services

Also in attendance:

Tracy Clark	RDaSH (representing Chris Bain)
Miles Crompton	Policy and Partnerships
Kate Green	Policy Officer
Martin Havenhand	Rotherham Foundation Trust (representing Louise Barnett)
Michael Holmes	Policy and Partnerships
Shafiq Hussain	Voluntary Action Rotherham (representing Janet Wheatley)
Satvinder Rana	Local Government Association
Jasmine Swallow	Performance Officer
Sue Wilson	Performance and Quality Manager
Chrissy Wright	Strategic Commissioner, RMBC

Apologies for absence were received from Councillor Amy Rushforth, Chris Bain, Louise Barnett, Jason Harwin, Naveen Judah, Martin Kimber, Dr. John Radford and Janet Wheatley.

S10. QUESTIONS FROM MEMBERS OF THE PRESS AND PUBLIC

There were no questions from the press and public,

S11. MINUTES OF PREVIOUS MEETING

Resolved:- That the minutes of the meeting held on 2nd July, 2014, be approved as a correct record subject to the inclusion of the following addition:-

S5 (Better Care Fund) “Rotherham had no option but to conform to this request according to current information”.

Arising from Minute No. S3 (Dalton and Treeton Health Centres), Carol Stubley gave the following update:-

The former NHS Rotherham Board had approved, in principle, the development of new medical centres at Dalton and Treeton with tender processes to commence subject to funding being available and re-confirmation by the Board.

With regard to the Dalton Health Centre, all the legal and lease agreements had been signed on 19th August and contractors would be on site to commence the build at the end of September, 2014 with an estimated build time of 9 months.

The timescale with regard to the Treeton Health Centre was less clear at the present time. The next stage was to start work on a detailed project plan and time frame. An update would be given to a future meeting.

Arising from Minute No. S8 (Vaccinations and Immunisations), Dr. Kitlowski reported that a meeting had taken place with all the partners with regard to vaccinations and immunisations in pregnant women for influenza and whooping cough. The plan was to hopefully to implement it from 2015. An action plan would be submitted to the next Board meeting.

S12. INDEPENDENT INQUIRY INTO CHILD SEXUAL EXPLOITATION IN ROTHERHAM

The Chairman referred to the recent publication of the above Inquiry report which had yet to be considered by the Council and partners.

He felt that the Board needed to be satisfied that the systems in place were as robust as possible and fit for purpose. Accordingly he proposed that all partners consider the report and report back to the Board.

Although it was the ultimate responsibility of the Rotherham Local Safeguarding Children Board there was the governance relationship between the 2 Boards. It was noted that the Safeguarding Board was to convene a special meeting to consider the report.

Resolved:- That the Chairman of the Rotherham Local Safeguarding Children Board be invited to a future meeting of this Board.

S13. COMMUNICATIONS

Better Care Fund

The Board considered 2 letters that had been received from the Departments of Health and Communities and Local Government and the BCF Programme Director, both dated 11th July, 2014, which gave a general update with regard to the funding and the new BCF Programme Team.

A further letter had since been received which gave much more detail and included the new updated guidance and deadlines for resubmitting plans.

S14. BETTER CARE FUND

The Chairman reported that the latest letter received from NHS England dated 25th July set out the changes to the Fund.

The most important change was that in relation to the previous £1bn Payment for Performance Framework which had now been revised so that the proportion linked to performance was dependent solely upon an area's scale of ambition in setting a planned level of reduction in total emergency admissions i.e. general and acute non-elective activity.

Nationally the assumption was that this would be in the region of a 3.5% reduction against the baseline detailed in the technical guidance. If this was achieved, it would equate to a national payment for performance pool of around £300M. The remaining £700M would be available upfront in 2015/16 to be invested in NHS commissioned out-of-hospital services. The detail would be subject to local agreement.

Although Rotherham had been selected as 1 of the fasttracked 15, it had been decided not to proceed due to the unknown/unquantified burden and the changes that were being made almost on a daily basis. The present scheme was significantly changed from what had originally been proposed.

The Fund had caused tensions between the Local Authority and CCG and it was important that lessons were learnt as a result. Locally there had been groundbreaking work around integration which the Fund had diverted the partners from and it was crucial that the partnership and direction of travel was not lost.

The submission now had to be submitted by 19th September which was before the next scheduled Board meeting.

The CCG had reduced its non-elective admissions by 10% during the last 2 years; its ambition was to maintain the non-emergency admissions at the 2008/09 levels. This was part of the 5 year plan which they had widely consulted upon. NHS England would be looking for a 5.8% reduction but the CCG would strongly argue that they had already achieved the reduction and making the case of maintaining that reduction.

It was proposed that the Task Group be delegated authority to complete and submit the application by the September deadline.

Resolved:- That, subject to no significant changes being made, the Task Group be delegated the authority to complete the submission and submit to NHS England by the 17th September, 2014, deadline.

S15. HWB PEER CHALLENGE

Satvinder Rana from the Local Government Association, reported that the Peer Challenge team would be on site from 9th-12th September.

Background work had been undertaken with the questionnaires previously supplied to members analysed. Statistics had been collated and documentation reviewed by the team.

Once on site, discussions would be held with Board members/stakeholders in the health and wellbeing system to ascertain how things were going. There was a suite of core questions in addition to the direction supplied on the type of things the Board wanted the team to focus upon.

It must be remembered it was not an inspection. The team consisted of practitioners i.e. someone from health and wellbeing, a Chief Executive from a Council, Director of Public Health etc. each bringing their experiences and feeding back on what they saw.

After the 4 days the findings would be fed back. There would be a presentation on the Friday morning followed by a report in 2 weeks later. The Board would have the opportunity to comment upon the report and, once signed off, would be published.

The Chairman encouraged members to be open about their experiences within the Board. It was hoped the Peer Challenge would be a constructive and positive process and provide recommendations to continued development.

All Board members would be invited to the presentation on the 12th September and requested that responses be provided to the invitation.

Resolved:- That the report be noted.

S16. JOINT STRATEGIC NEEDS ASSESSMENT

Chrissy Wright, Strategic Commissioner, submitted a report on the progress made in updating the Joint Strategic Needs Assessment (JSNA).

The JSNA was reviewed and revised at the end of 2011, however, a further refresh was required to meet Government guidance and a new online version developed and agreed in February, 2014. The JSNA process was a co-ordinated and consistent approach to data and information that had been validated and was evidence based.

All those who had contributed to the 2013 JSNA refresh were asked to provide any changes or additions to the information previously provided. In most cases the changes so far had been minor and the key issues emerging remain as previously reported.

Revised population projections now suggested that Rotherham would have 2,500 (1%) fewer residents by 2021 than previously projected. The reduction mainly affected people of working age whilst the expected numbers of older people aged 65+ and 75+ were slightly higher than previously projected. This illustrated the value of being able to update the JSNA so that new information could quickly be made available online.

A new requirement was for an Asset Register for the Borough such as physical community resources, leisure facilities and individual community resources. Compiling the Register had been a substantial piece of work but the information could be interrogated as required by the user to identify the resource sought. It was proposed that the Asset Register be used alongside the events and organisations information database on Connect to Support. The Register was in the process of being uploaded to the JSNA website.

Discussion ensued with the following comments made:-

- The document would become increasingly important particularly for commissioners as well as the move to more community-based services and integrated working

- Similarly the Asset Register for interested parties/communities linking into case management plans and single patient records so every locality knew exactly what resources each had in their community

- It was particularly important to understand what the voluntary sector had in place so it was essential it was refreshed on a regular basis. There were champions in each organisation whose responsibility it was to feed updated information through which would then feed into the Board 6 monthly updates

- VAR had a directory of 600 organisations which spelt out which provided what services in each area

- The JSNA featured in RDaSH's 5 year strategic plan of services

- A meeting had been arranged to discuss how Healthwatch and the public could feed into the process

- RFT had found it extremely valuable when producing their 5 year strategy

Resolved:- (1) That the progress made in relation to the updating of the Joint Strategic Needs Assessment and the establishment of the Asset Register be noted.

(2) That further updates be submitted twice a year (September and March) and by exception if so required.

S17. COMMISSIONING PLANNING CYCLE

Discussion ensued on the partners' commissioning cycles and the commitment made previously to share plans as soon as possible.

However, it was noted that all of the organisation's commissioning cycles were different. The CCG was about to start consultation with their GP members shortly with a view to getting draft plans out to stakeholders in November and formally to their Board in February, 2015.

It was suggested that by January, 2015, all organisations should have a draft commissioning plan.

Resolved:- That commissioning plans be submitted to the Board in January, 2015.

S18. OPERATIONAL RESILIENCE IN 2014/15

In accordance with Minute No. S4, Chris Edwards presented a report on Operational Resilience in 2014/15.

Following direction from NHS England, Rotherham CCG had set up a System Resilience Group which would build on the successful work in 2013/14 through the Urgent Care Working Group. The membership of the former Group had been widened to include a mental health provider (RDaSH).

The role of the Group was to inform and advise NHS England how it managed allocations on NHS waiting lists and System Resilience monies for Winter. It reported to NHS England and it was proposed that the minutes of the Group be circulated to the Board.

Discussion ensued on the Group with the following issues raised:-

- It was not just a change of name but change of tenure for the Group
- Need to ensure the representatives present had the delegated authority and, if unable to attend, the appropriate deputy attended
- Due to the short timescales that were normally associated with funding i.e. Winter pressures, decisions were needed within a few days not allowing representatives to take it back through their own governance structures
- Unrealistic tight timescales for important decision to be made for Winter Resilience Monies

Resolved:- That the minutes of the Group be circulated to enable Board members to gain an understanding of what was discussed at the meeting and, if required, a meeting be convened to discuss the matter further.

S19. CUSTOMER CHARTER (EXPECTATIONS AND ASPIRATIONS WORKSTREAM)

Sue Wilson (Performance and Quality Manager) and Jasmine Swallow (Performance Officer) presented a report setting out an overview of the consultation process undertaken to develop the customer standards, suggestions for monitoring performance and future plans for launching and embedding with employees and customers.

Initial consultation to identify the top priorities had narrowed the 36 Service standards to 15 priorities which had been further consulted on at the 2013 Rotherham Show. This had identified the top 5 promises which were the most important to customers/potential customers when accessing services across the Partnership. These were:-

'Our Promises to you' Customer Charter:

- We will make it easy for you to find out what services are available
- We will aim to be flexible if you need to meet with us
- We will actively listen to you and treat you with dignity and respect
- We will be honest about what we can do to help you
- We will ensure the services we provide are timely

It had also been suggested that a strapline within individual organisations' version of the Customer Charter be included.

The concept of the design of the Charter was that the jigsaw pieces fitted together to provide a partnership commitment to promising and delivering against standards for customer service. There was a clear indication of who the Health and Wellbeing partners were which was reflected in the prominence of the logo, use of colours and each organisation's logo within one jigsaw piece.

It was proposed that monitoring performance through annual satisfaction surveys be conducted at the Rotherham Show. It was anticipated that the baseline performance would be gained at the 2014 Show as part of a 'You told us…We have…' campaign. Monitoring activity would be co-ordinated through Performance and Quality at the Expectations and Aspirations Workstream Group with results reported to the Health and Wellbeing Board and communicated to the public.

A Communications and Marketing Plan was being developed to ensure the customer standards reached a wide audience, informing customers about the standards they should expect and demand when accessing services and providing consistent standards for employees to work to assuring the best customer service possible.

It was hoped that a formal launch would be held at the New York Stadium which would see the 'jigsaw' brought to life recreating the logo as an enlarged puzzle for the photo call.

There was also a further Priority 2 action within the work plan to develop generic customer care training. This would be a further opportunity to work in partnership to provide a co-ordinated approach to embed the single set of customer standards into working practices.

Each partner gave a brief report on their involvement in the workstream:-

- VAR – involved in the development of the Charter as well as its member organisations in the development of the Standards. There was nothing contained within it they would not be able to aspire to. The VAR Board and a number of VCS networks had supported and endorsed it

- SYP – consulted/contributed as part of the process and very supportive in relation to the Standards. Unfortunately, it was a county-wide organisation of which Rotherham was an element but would initiate work with officers and staff in terms of the Standards. Feedback was already being received from Your Voice Counts but the Charter would be used as a template to get more feedback and engagement from the public on the services delivered and to what standard they were delivered to

- RFT – meeting held with Chief Executive and Communications and Marketing Manager. There had been issues with regard to the NHS Constitution but since then it had been agreed and understood that the Standards were very much complimentary and supplementary

- RDaSH – meeting held with representative of organisation and further work carried out during August. The Charter and Standards were similar to the organisation's set of values. It had not been through their governance process as yet

- CCG – some of the wording had been subtly changed to meet NHS guidance and would be used as a complimentary document

- CYPS – the Directorate had signed up to the Charter

- Healthwatch – had been part of the process and provided support at the Rotherham Show

Sue and Jasmine were thanked for their work in producing a fit for purpose and meaningful document.

Resolved:- (1) That the single set of customer Standards 'Our Promises to you' (Customer Charter) be approved and endorsed.

(2) That the partnership approach for monitoring performance, as set out in the report, be approved.

(3) That information be submitted regarding additional monitoring activities which single organisations could adopted.

S20. DATE OF NEXT MEETING

Resolved:- That a further meeting of the Health and Wellbeing Board be held on Wednesday, 1st October, 2014, commencing at 9.00 a.m. in the Rotherham Town Hall.

Rotherham Better Care Fund Plan

September 2014

Local Authority
Rotherham Metropolitan Borough Council

Clinical Commissioning Group
Rotherham Clinical Commissioning Group

Date agreed at Health and Wellbeing Board
18 September 2014

Date submitted
19 September 2014

NHS Rotherham Clinical Commissioning Group
NHS England
healthwatch Rotherham
Rotherham Metropolitan Borough Council

1) PLAN DETAILS

a) Summary of Plan

Minimum required value of BCF pooled budget	2014/15	**£20,101,000.00**
	2015/16	**£20,318,000.00**
Total agreed value of pooled budget:	2014/15	**£23,099,000.00**
	2015/16	**£23,316,000.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Rotherham Clinical Commissioning group**
By	Chris Edwards
Position	Chief Officer
Date	18 September 2014

Signed on behalf of the Council	**Rotherham MBC**
By	Martin Kimber
Position	Chief Executive
Date	18 September 2014

Signed on behalf of the Health and Wellbeing Board	**Rotherham Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	Cllr John Doyle
Date	18 September 2014

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Ref.	Document or information title	Synopsis and links
A1	**Findings from consultations**	A summary of all the consultations which have taken place as part of the BCF planning and wider health and wellbeing agenda.
A2	**Health and Wellbeing Strategy**	The joint strategy which sets out the priorities of the health and wellbeing board for 2013 – 2015.
A3	**Joint Strategic Needs Assessment**	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
A4	**Overarching information sharing protocol**	This protocol complements and supports wider national guidance, professional body guidance and local policies and procedures to improve information sharing across services in Rotherham. Signed up to by HWB September 2012.
A5	**Market Position Statement for Older People**	The Market Position Statement has been developed by Rotherham Council to inform current and potential providers of social services in the borough of the direction of social care services for older people over the next few years.
A6	**Communication Plan**	Plan for continued consultation and engagement with service users, patients and providers.
A7	**What will the BCF plan deliver for the people of Rotherham**	A public document which provides an overview of the BCF planned schemes, 'I Statements', and case studies demonstrated the what the changes will mean for local people.
A8	**BCF 'Plan on a page'**	2 page document which demonstrates how the BCF actions align with the health and wellbeing strategy and outcome measures.
A9	**Workstreams delivering savings**	Table showing the workstreams through which QIPP savings are being delivered.

A10	**Governance Framework**	Diagram demonstrating the decision making structure, as well as the framework for delivery and performance.
A11	**Healthwatch Rotherham – Better Care Consultation**	Healthwatch Rotherham report based on findings from consultation carried out December - January 2014.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

The Rotherham Health and Wellbeing Strategy sets out our overarching vision to improve health and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board has made a commitment to more integrated, person-centred working, to improve health outcomes for local people.

The Better Care Fund plan will contribute to 4 of the strategic outcomes of the local Health and Wellbeing Strategy:

- **Prevention and early intervention**: Rotherham people will get help early to stay healthy and increase their independence
- **Expectations and aspirations**: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community
- **Dependence to independence**: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances
- **Long-term conditions**: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

The Health and Wellbeing Strategy and four strategic outcomes described above have been developed based on the evidence in the local Joint Strategic Needs Assessment (JSNA). The JSNA tells us about the demographic and socio-economic changes occurring in the local area and the needs of local people as a result of this. We understand that we don't just need to focus on single health and wellbeing issues, but we need a cultural change to the way we work and deliver services which address the needs of local people in a holistic way. The focus on preventative activities alongside appropriate support and treatment will also help address the demographical challenges ahead. Our strategy was therefore created as a step-change to realise this vision for Rotherham, and the BCF plan will contribute significantly to this.

b) What difference will this make to patient and service user outcomes?

Local 'I Statements'

Our vision for integration is based on the experiences, values and needs of our service users, patients and carers. Through mapping these and understanding the journeys people take in and out of health and social care, we have identified a number of 'I statements' which demonstrate the outcomes local people want from better integrated, person-centred services. From 2015/16 our Better Care Fund plan will work towards the following:

'I am in control of my care'
People want to feel central to decision making and development of their care plans, they want all professionals and services to communicate with each other to understand their care needs and ensure they receive the most appropriate care for their circumstances, and they want to be provided with the right information to help them to manage their conditions and make informed choices about their own health and wellbeing.

'I only have to tell my story once'
Service users, patients and carers want all organisations and services to talk to each other and share access to their information, so that they only ever have to tell their story once.

'I feel part of my community, which helps me to stay healthy and independent'
People want to feel independent and part of their community and want organisations to provide better information and support to help them to do this, understanding that this reduces social isolation and avoids the need for more formal care services later on.

'I am listened to and supported at an early stage to avoid a crisis'
People want support, advice and information at an early stage to help them look after their mental health and wellbeing, avoiding the need for more intense, high-level services when they reach crisis point.

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'
People want a greater focus on preventative services and an increased capacity in community activity to prevent high intensity use of services and more formal care, and to help them better manage their conditions. They also want services to be available 7 days a week and information and advice to be more accessible. Understanding the journeys that people take into health and care services will help us to provide more appropriate information and support at times when people need it most.

'I feel safe and am able to live independently where I choose'
People want to stay independent and in their own home or community for as long as possible. They want to feel safe to do this and know that the right support is available when and where they need it.

Customer experiences will be closely monitored throughout the delivery of the BCF action plan via the 6 'I statements'. This will involve the council's Performance and Quality Team contacting relevant service users and patients, upon delivery of each of the BCF actions and obtaining their views regarding service/s they are receiving. This will help us to see the real customer journey and to learn and improve service delivery based on customer feedback.

Through surveys, telephone and face to face interviews, the team will develop a number of case studies, to identify the positive and negative impacts that the BCF plan has had on customer experiences. Rotherham Council has in place a Customer Inspection Service, with individuals who are customers and experts by experience. This group will support the assessment of the impact of the BCF plan and help us to see the implementation through the eyes of the customer. These experts by experience will also help us to identify where further improvements are needed. All feedback will be used to further enhance and improve the customer experience.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

A customer perspective

As a result of the changes we will make, we expect that all service users, patients and their carers will have confidence in the care they receive and feel supported to live independently, manage their conditions and participate in their community. They will feel well and less likely to rely on acute services, resulting in a reduction in overall pressure on the hospital and health budgets. Although, when acute care is the best option for people, they are helped to move quickly back into their community when they are ready to do so. We will see a greater shift from high cost reactive care, to lower cost, high impact preventative activity.

Integrated commissioning

To achieve this, we have agreed a number of actions that will begin this journey and result in changes short and medium term. We have a tradition of shared commitment to delivering joined up services, as demonstrated by our well-established Joint Adult Community Mental Health Services; Joint Learning Disability Service; Joint Residential and Nursing Care Service, and a joined up approach to Safeguarding of Vulnerable People; Intermediate Care Service; Stroke Recovery Services; dedicated Step- Up/Down placements; Community Occupational Therapy and Integrated Community Equipment Services, all supported either by pooled budgets and/or partnership agreements overseen by dedicated joint commissioning staff. Currently the majority of commissioning activity is undertaken separately by experienced officers in the council (including Public Health) or in the CCG (and colleagues in the Regional Commissioning Support Unit), though key partner decisions, broad commissioning intentions; and efficiency programmes are shared through our joint consultation forums: the Adult Partnership Board; Chief Executives Group; Rotherham Partnership Board; and HWB.

Our longer term, 5 year plan, will see health and social care teams working in an increasingly integrated way and our commissioning plans aligning more comprehensively to meet the priorities set by the HWB, to achieve maximum efficiencies, preserve service quality, and reach beyond critical, acute or “eligible” social care to impact on the prevention agenda. We will move to a whole-system commissioning model, which has services commissioned in line with our health and wellbeing strategy principles that are coordinated across all agencies to ensure they are person-centred and we maximise local spend. We will scope and routinely share information on commissioning activity, share respective commissioning plans and timetables, align wherever possible, and develop joint market facilitation arrangements so that market providers receive a consistent and transparent message from the Rotherham health and social care community. Our integrated approach extends to public health services; complimentary public health activity focuses on primary prevention and supporting and developing the healthy ageing agenda. The synergy between BCF and public health will help to maximise the improvements across the pathway from prevention to early diagnosis/help.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Rotherham has a strong record of joint commissioning between health and social care. We have a joint commissioning framework and governance structure which incorporates joint needs assessment, supply mapping, market analysis, pooled budgets and performance management. This has prepared the way for these new developments in integrated care which will support people with complex needs to remain independent in the community. Services that are already subject to joint commissioning and/or pooled budget arrangements include:

The Rotherham Intermediate Care Service (RICC)
RICC delivers community-based recuperation, recovery, rehabilitation and re-ablement services, supporting individuals who have a combination of nursing, therapy and mental health needs. The main aim of the service is to maximise independence and re-integrate into local communities.

The Rotherham Occupational Therapy Service
The Rotherham Occupational Therapy Service provides support on activities of daily living, ensuring that patients achieve the highest level of independence. The service helps prevent deterioration and minimises loss of function caused by illness or disability. It reduces the risk of admission to hospital by ensuring that people are living in a low risk physical environment where they can function autonomously. The service empowers patients so that they maximise their potential to engage in meaningful and productive activities/occupations

These services deliver health and social care outcomes. They perform well within a robust joint performance management framework.

Despite these successes current models of care are not designed for the health challenges of today. The ageing population, changing disease burden, and rising expectations demand fundamental change. Care outside hospitals needs to be strengthened whilst hospital care itself must be improved with 7 day working. The overriding priority must be a greater integration of services across health and social care, extended use of pooled budgets and a robust joint commissioning framework.

The Better Care Fund provides a major opportunity to drive forward integrated care. BCF offers an opportunity to deliver an evidence-based approach to investment. It has the potential to offer better value for money, a more cohesive model of care and better outcomes for people. The Better Care Fund acts as a stepping stone to the longer term transformation of services. The requirement that local plans should be part of a five-year strategy for local health and social care services from 2015 will be a helpful spur to look beyond the immediate short-term pressures and develop a shared vision of what future local services should look like.

The Better Care Fund will support the aspiration that all people with a long-term condition should have a personalised care plan which is accessible, available electronically and linked to the GP health record. Patients will be able to access self-management materials

and information so that they are empowered to manage their own condition. Effective implementation of the Better Care Fund will support the use of telehealth services to monitor conditions, deliver tele-coaching and promote self-care. The Better Care Fund will support data sharing across the local health economy. Rotherham's BCF Action Plan places a responsibility on local health communities to ensure that hospital and GP data is comprehensively connected within the next two years.

Wider prevention and public health initiatives will align to the BCF services to maximise opportunities to improve the health and wellbeing of the ageing population. The transparent links between the services and pathways will aim to keep Rotherham people healthier for longer.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Achieving our vision will mean significant change across the whole of our current health and care landscape. Commissioners and providers welcome the opportunity to adapt and change the way they do things. The actions within our plan demonstrate the commitment both the council and CCG have made to transforming services and working in a more integrated way for the benefit of Rotherham people.

Our overall plan includes the following key milestones:

- To develop an effective S75 agreement/pooled budget, consistent with BCF guidance.
- To include in this a risk sharing agreement and dispute resolution protocol to ensure that the key principles and outcomes of the BCF are embedded within the S75 agreement.
- Using the governance framework set out in appendix 10, all partners will monitor the BCF plan effectively. The Operational Group and Strategic Task Group reporting up to the Health and Wellbeing Board will ensure that the plans are delivered through the various workstreams put into place.
- The Health and Wellbeing Board will receive quarterly progress reports, holding partners to account, scrutinising and monitoring plans and offering challenge to the delivery of the BCF actions.

b) Please articulate the overarching governance arrangements for integrated care locally

The CCG and RMBC have co-terminus boundaries and already have a layer of governance and delivery mechanisms in place. There is clear agreement to the need to maintain a simple clear governance framework which does not add to the burden of any of the agencies or partnership mechanisms.

The delivery of the BCF will be fully integrated with the delivery of the Health and

Wellbeing Strategy and as a result, the existing mechanisms with some adaptation will be fit for purpose to ensure effective scrutiny, accountability and delivery.

The Health and Wellbeing Board will have overall accountability for the BCF plan, they will:

- Monitor performance against the BCF Metrics (National/Local) and receive exception reports on the BCF action plan
- Agree the Better Care Fund Commissioning Strategy
- Agree decisions on commissioning or decommissioning of services, in relation to the BCF

The framework shown in Appendix 10 demonstrates the decision making structure and how the BCF plan will be delivered through the various groups.

Audit and assurance process

To provide an independent review of the BCF, including the source and use of the funds, a local audit and assurance process has been agreed. The final report of which will be shared with the respective members of both organisations and the Task Group.

Scope of the Audit: that the BCF has:

- Been developed with the national planning guidance in mind
- Is fit for the purpose, in that it clearly sets out indicative budgets for the CCG and RMBC and identifies those areas for which each party will have commissioning responsibility
- Provided a clear audit trail of where funds are invested in contracted services
- Provided a clear audit trail to substantiate claims made against the risk pool;
- Provided a clear audit trail supporting the financial reporting to the CCG, RMBC and BCF Task Group
- Reflected a diligent approach by both parties to quantify and manage current and future budgets and identify future risks
- Reflected good internal control.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The management and oversight of the delivery of the BCF plan has been delegated to the BCF Strategic Task group, chaired by the HWB chair and including senior representatives from both the council and CCG.

The BCF Task group role is to:

- Monitor delivery of the Better Care Plan through quarterly meetings
- Ensure performance targets are being met
- Ensure schemes are being delivered and additional action is put in place where the plan results in any unintended consequences.
- Make strategic decisions relating to the delivery of the plan
- Report directly to the HWBB on a quarterly basis.

The Strategic Task Group is supported by the BCF Operational Officer Group, which has been meeting since April 2014. The Operational group is made up of the identified lead officers for each of the BCF actions within the plan, plus other supporting officers from the council and CCG. The Operational group meets monthly and reports directly to the Task group.

The Operational Group role is to:

- Ensure implementation of the BCF action plan
- Implement and monitor the performance management framework
- Deal with operational issues, escalating to the Task Group where needed

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	**Scheme**
1	Mental Health Service
2	Falls Prevention
3	Joint call centre incorporating telecare and telehealth
4	Integrated rapid response team
5	7 day community, social care and mental health provision to support discharge and reduce delays
6	Social Prescribing
7	Joint residential and nursing care commissioning, quality and assurance team
8	Learn from experiences to improve pathways and enable a greater focus on prevention
9	Personal health and care budgets
10	Self-care and self- management
11	Person-centred services
12	Care Bill preparation
13	Review existing jointly commissioned integrated services
14	Data sharing between health and social care
15	End of Life Care

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise?	Potential impact	Overall risk factor	Mitigating Actions
Introduction of the Care Act will result in an increase in cost of care provision from April 2015, impacting on social care services and funding	5	4 £0.850m	20	Working group established and initial impact assessment undertaken of the potential effects of the Care Bill. The Lincolnshire Model, as agreed by ADASS, is being populated and provides evidence of potential demand for additional assessments (including carers' assessments and respite) in 2015/16 of approx. £0.850m. Other models are also been populated.
Unintended consequences of achieving savings in one area of the system could result in higher costs elsewhere.	3	3 £0.750m	9	All partners have made a commitment to ensure that if evidence of these consequences is seen, cash will flow to the right place across the system that all partners will benefit from. Both partners have agreed a 'risk pool' to form part of the BCF plan, which can be used if the plan results in any unfunded consequences on any part of the system. The BCF plan is monitored on a quarterly basis by the Task group, and any consequences will be reviewed. We will consider turning this risk green in-year based on this process if both partners are comfortable with progress.

Governance is deemed by NHS England not to meet requirements to deliver the BCF change	1	1	2	Task group has agreed the most appropriate governance structure for BCF, which includes the HWBB as the accountable body and has been agreed by HWB
Failure to achieve planned savings will create financial risks for the respective parties	3	5 £1.250m	15	Performance management framework via the System Residence Group in place to monitor progress throughout 2014/15 to ensure targets are achieved.
Shifting of resources could destabilise current service providers.	2	4 £0.880m	8	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. CCG received Quality Impact Assessments from providers regarding their respective efficiency plans. Local authority will continue to engage with providers through the Shaping the Future events programme to ensure potential impact is understood and planned for.
Risks to CCG capacity and conflict of interest if the CCG takes on responsibility for primary care	2	2	4	The CCG is weighing up these risks against the opportunities and the risks of not taking on responsibility and will develop a delivery plan that mitigates against the risks and delivers the benefits

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The contingency plan and risk sharing approach is set out as follows:

(i) A risk pool of £1.5m - £2m has been included in the BCF financial plan to mitigate the risk of non-delivery of the non-elective savings requirement which is to dampen down growth and demand (rather than reduce admissions from 2013/14 outturn). The risk pool is also in place to support any unintended consequences of successful initiatives on other parts of the system eg demand created from improved case management.

(ii) A financial governance process is in place and the financial monitoring and performance information is to be provided at monthly operational group meetings and quarterly at Director and Member level. The financial framework will expose those areas of high risk in year and identify areas where slippage may be available to balance the financial pressure in year. The recurrent plans will be modified where appropriate as part of the planning cycle for both Health and Social Care in totality.

(iii) The CCG has a robust plan with regards to keeping emergency admissions within affordable levels and has been very successful since 2011. All local stakeholders are key players in delivering these plans through the System Resilience group. The CCGs contracts with providers specify that marginal tariff will apply if admissions exceed 11/12 rates, admissions above that rate will be funded at 30% of tariff, NHS England will manage through the System Resilience Group how the remaining 70% should be best invested to reduce admissions.

(iv) All local stakeholders are members of the System Resilience Group. This plan has been approved by the Task Group, comprised of Health and Wellbeing Board members and will be formally approved by the Board at its next meeting.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

These plans align with other developments within Rotherham through being consistent with and in line with the Joint Health and Wellbeing Strategy. The plans outlined in the BCF clearly build on existing good practice and evidence based services including jointly commissioned and delivered services such as the Intermediate Care Service. Personal Health Budgets are currently being delivered through the Continuing Health Care process in partnership with the Local Authority and are a sound foundation for the extension of and delivery of personal health budgets in line with the recent announcements regarding Integrated Personal Commissioning. Personal Health Budgets build on a number of existing initiatives, including those in the Better Care Fund including : person centred one page plans, social prescribing initiatives, self-care and self-management and the extension of assistive technology to include telehealth and digital assistance.

The GP Case Management Service has been designed to support many of the new initiatives in Rotherham. It uses a system of risk stratification which was used initially to identify those most at risk of admission to hospital. It has been successful through bringing all stakeholders, including customers, carers, GP's, voluntary sector and adult social care together and has been very successful in demand avoidance activity and signposting people to alternative activity in the community. It is now being extended to include people with long term conditions and people over 75. The person centred on a page plan will ensure that the views of customers as expressed in the set of 'I' statements remain at the heart of every new development.

Other than the BCF operational group and task group, there have been no new groups or processes established. The governance framework for the BCF is integrated with the delivery of Health and Wellbeing Strategy and Joint Commissioning initiatives, ensuring alignment across the health and social care economy. A specific housing strategy for older people and people with complex needs is being developed in line with the Health and Wellbeing Strategy and will incorporate assistive technology, use of Disabled Facilities Grant and specific projects that are being developed by Strategic Housing Services.

Aligning to the Health and Wellbeing Strategy also ensures our plan is in line with public health initiatives which focus on prevention and reducing need, for example the ageing well agenda, which is an important element of the whole system approach we want to achieve. Public health will provide information to relevant BCF groups to maximise improvement through partnership working.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

All schemes relying on CCG funding are included in the Rotherham 2 year operating and 5 year strategic plan. The plan has had favourable feedback externally and local clinicians have agreed that whilst challenging it is clinically deliverable.

The CCG with stakeholders is just starting the process of refreshing the 2 year plan to

include 17/18 this refresh will take the BCF as a basis for plans in relevant areas.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG is currently consulting with members and stakeholders which additional responsibilities to propose to NHS England. It is likely that the CCG will wish for some additional co-commissioning or delegated responsibilities for primary care. If this transpires this will help the delivery of the BCF plan - for example, the further development of the case management pilot will be simplified by this. Additional local responsibilities will also help mitigate some of the risks around BCF particularly with regards to hospital admissions because it would give local flexibilities over care pathways that include both primary and secondary care.

Primary care co-commissioning is being discussed at Rotherham GP Members' Committee and Governing Body in September. This paper has a full consideration of the risks of taking on delegated responsibility and also the risks of not doing so. In September /October it is being discussed with all member practices at locality meetings, attended by CO and GPMC chair.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The Better Care Fund brings together the NHS and local authority resources that are already committed to existing core activity. The Better Care Fund will be used in the first instance to protect the funding to existing services, allowing the local council to maintain its current eligibility criteria, under Fairer Access to Care Services (FACS). Current services will be reviewed and evaluated to ensure that they address the key aims of the Better Care Fund. Where they are not seen to be delivering against this, they will be re-commissioned or de-commissioned and the funding reinvested in services that support improvements in health and wellbeing, independence, and prevents admission to care services or hospital, as well as information and signposting services for people who are not eligible for services, to prevent or delay their need for such services.

The BCF will ensure we do not have to restrict access to services including assessment, care management, and commissioned support, with the potential that this investment will need to increase to maintain the offer in the light of developing 7 day services and additional responsibilities that the Care Bill will bring when enacted in 2015. If the planned investment arising from CCG efficiencies does not occur there is a risk that this will prevent adult social care from receiving the investment needed to deliver against specific commitments such as seven day working, integrated fast response services, and re-commissioning of jointly commissioned services.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

There are a number of ways in which the Rotherham BCF will protect social care services. Firstly, services such as Community Occupational Therapy, Intermediate Care and The Integrated Community Equipment Service are all fully integrated health and social care services, which are measured against the adult social care outcome framework. Placing them under the umbrella of BCF will secure these services for the future, save costs further down the care pathway, and allow for growth in social care services where transformation in other parts of the system require it.

Key to the delivery of integrated person centred services, in the context of reduced revenue and increased demand for health and social care services, is a core offer of social care services including:

- Advice, guidance and information sharing
- Preventive services such as telecare/assistive technology, re-ablement, intermediate care and Social prescribing – all designed to support independence

- Ongoing care provision including personalised services which offer choice and control to the individual to enable them to lead as independent a life as possible
- Good quality domiciliary and residential care

This approach will transform the way patients with high needs access services and will ensure more joined up working between health and social care.

It is known that cuts to social care services increase pressure on the NHS, and protecting the NHS is a key priority for central government. Without the support that is achieved through the Better Care Fund, social care reductions will negatively impact on the local NHS community. RMBC has taken the following actions to date:

- A rational approach to setting reasonable fees for provider services, including tackling high cost fees for learning disability residential placements and supporting the quality of care in older people's residential care services
- Increases in charges for care
- A greater use of re-ablement services that offer support to people to enable them to remain independent
- Implementation of personalised support, alongside effective commissioning of services

To date it is clear that these efforts have enabled the council to manage increasing demand due to demographic pressures – these approaches cannot be effective indefinitely, and in 2013/14 there are indications that demand, despite the actions taken to reduce demand through re-ablement etc, is beginning to increase significantly.

In order to prevent further cuts to services, it is essential that the BCF is used to support those care services which in turn protect the NHS. Any reduction in investment would result in potential delays for access to assessment, reduction on volume and quality of services that currently support independence such as RICC Intermediate Care Centre and other impacts that would increase pressure on NHS services and performance against

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£13m has been allocated to protect social care which includes all of the nationally prescribed funding sources.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The council has established a Care Act Steering Board which takes an inclusive planning approach – each workstream has a broad membership and will utilise the experience of customers, third sector and independent sector providers. There is a specific workstream on customer and carer engagement which will ensure that people are informed, engaged and consulted. This builds on the Making It Real initiative within the council which has had success in developing co-production approaches and ensuring that customers

remain at the heart of all we do. There have been awareness raising presentations on the Care Act 2014 to the Adult Planning Board. Learning Disability Partnership Board, Shaping the Future provider engagement events, Health and Wellbeing Board, Cabinet and Chief Executive Leadership Board. The delivery plan addresses every section of the Care Act 2014 Part 1 including: advice, guidance and information, assessment eligibility and transition, safeguarding, commissioning, workforce, carers, IT, legal and policy, customer engagement.

v) Please specify the level of resource that will be dedicated to carer-specific support

The current Carer's Grant of £500,000 delivers support that provides carers with a break. In addition, a significant number of services that are delivered to customers, i.e day services, also provide carers with a break. Carers' assessments are incorporated into the mainstream social work activity. Specific services to carers include: carers' centre, carers emergency scheme, Caring For Carers Mental Health Service.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There have been no changes to the original financial plan.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

There is a commitment in our plan to the achievement of 7 day working in all parts of the health service, parity of esteem for people living with mental health issues and better care for people requiring integrated health and social care services. This is a key element in our contract negotiations with providers.

There is also a commitment from the CCG to support GP practices in transforming the care of patients aged over 75 in line with national planning guidance. This is being developed in year to complement our strategy for vulnerable people which is also included in our plan.

Existing services, including out of hours support by social workers, access to enabling care and intermediate care, will be reviewed and strengthened where necessary in response to emerging patterns of demand.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

All Rotherham NHS correspondence uses the NHS number as primary identifier, and the council has a plan already in development to enable this to be used on social care systems. It is proposed that use of the NHS number as a unique identifier across all health and social care will create the starting point for the development of shared IT capacity locally.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Through the BCF there is a commitment to ensure that all providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual. To enable this to happen we will develop portal technology to share data in a secure way that is in the best interest of people who use care and support.

The BCF Plan has highlighted actions related to the use of technology and information that, if fully implemented, could deliver significant benefits to the health and social care economy. These benefits include improvements to quality and efficiency as well as patient experience and satisfaction.

The BCF Plan will deliver improvements in data sharing across health and social care. Accompanied with effective use of new technology it will liberate practitioners and transform the way they work. As well as delivering efficiencies, there are also tangible benefits such as the improvements in the quality of care delivered, the accuracy of data collected, improved data flow between health and social care and the increased flexibility the practitioners have in managing their time and location of work.

The BCF Plan will ensure greater efficiency in accessibility of patient information. Increased accessibility will enable faster transfer of medical history in a medical emergency or when visiting a new practitioner. Researchers and public health authorities, with the permission and consent of the patient, will be able to collect and analyse up-to-date patient data. Such access is imperative in emergency situations, and also allows public health officials to easily conduct outbreak and incident investigations. Improved accessibility will also enable health care providers to reduce costs associated with duplicate testing, appointment reminders and laboratory results.

We are committed to adopting systems that are based upon open APIs (Application Programming Interface).

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

All Rotherham NHS platforms are Information Governance Toolkit compliant and Rotherham CCG has achieved assurance on Caldicott 2 compliance in March 2014.

Underpinning the developments outlined above, the Health and Wellbeing Board has collectively signed up to an overarching information sharing protocol (appendix 5), which provides a framework for information sharing for all partner organisations.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

There is an initiative in place to improve the case management of the 5% (12,000) of patients at risk of hospitalisation which is key to our unscheduled care efficiency plan. In 2013/14 the pilot was solely for patients identified by a computer tool as being at the highest risk of admission to hospital. In 2014/15 the tool will still be used to identify the first 3% of patients eligible to be on the scheme. An additional 2% of each practices population will be eligible for the scheme, this will also include all patients in nursing and residential homes and other patients selected on the basis of clinical judgment.

Within the case management programme the accountable professional is the GP. In Rotherham the Case Management Programme places GPs at the centre of care coordination. Over the next 12 months we will transform community services to ensure that patients can access high quality, safe sustainable community services including multi-disciplinary community teams and specialist community services that target specific conditions.

We are embarking on a programme of integration across acute/community services and also across health/social care. This will ensure that packages are fully integrated and contain clear lines of accountability

In light of the planning guidance requirement to provide addition GP services for patients over the age of 75 the CCG will add an additional component to the Locally Enhanced Scheme (LES) to provide services for all 20,000 people in Rotherham over 75. The CCG will make the case management and over 75 services funding recurrent so that practices can make permanent appointments as the current shortage of locums is affecting the stability of current services.

The BCF Plan will deliver significant benefits through delivery of integrated services and joint assessment. The development of a joint assessment framework will help prevent harm and crises to individuals at risk. It will do this by promoting a shared understanding of risk amongst health and social care professionals. Case management processes, led by one person, will improve co-ordination, reduce duplication and support communication across organisational boundaries. The clear lines of accountability resulting from identifying a case manager will encourage creative approaches to assessment which are

more person-centred. The benefits of shared assessment in hospital will include improved patient information on admission and better communication between wards. It will encourage holistic working and overcome professional boundaries. There will be an improved understanding of other professional roles, increased expertise and improved decision-making through information sharing.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Rotherham uses the Healthnumerics risk stratification tool. It measures the expected health care utilisation of an individual or population and identifies patients of highest risk of chronic admission in a 12 month period. The Risk Stratification Tool takes data from multiple sources including primary and secondary care. It does not currently use social care data.

The Rotherham Case Management programme assumes that there is a high degree of correlation between the cohort of patients identified on the risk stratification tool and their level of social care need. We have joint processes in place to plan the care of these patients. The GP practice adopts the role of lead professional. Care planning is carried out by a Multi-Disciplinary Team, which incorporates specialist social workers. This ensures that health and social care plans are consistent and complementary. The social workers are funded through Re-ablement Grant and are specifically responsible for supporting the case management programme.

The risk stratification tool only uses health data to identify risk. Although this is a good proxy for social care need there are people who require a joint approach to care planning who are not flagged on the risk stratification tool. Social workers and GPs are able to make professional judgements on vulnerable adults who would benefit from a case management approach.

This joint approach to case management targets resources on the patients with the greatest need and allows for prioritisation of community based preventative care. It supports strategies to reduce emergency admissions and delivers better patient outcomes whilst driving down costs.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

GP practices in Rotherham are working towards the top 5% of those at risk having a case management plan in place. There are currently 6675 patients who have a plan (this represents approximately 2.67%).

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Our Better Care Fund vision is based on our Health and Wellbeing Strategy and on what Rotherham people have told us is most important to them. Rotherham partners have a commitment to make sure that the views and reported experience of people who use local services are heard and acted upon, and a "right first time" principle applies to the delivery of services whether they are provided directly by us or commissioned. We engage with inspirational local people in a number of forums, both formally brokered (eg the Council's Customer Inspection Team; the Rotherham Learning Disability Partnership Board; Rotherham Speak Up) and informal (eg Rotherham Older People's Forum, the Carers4Carers Mental Health Support Group; and Tassibee Womens' Group) to understand the barriers for local people in accessing the most appropriate support, staying safe; and keeping well. We have used a variety of methods to capture the views and experiences of local patients, service users and their carers to inform our local plans.

Specifically we engaged with service users and the public in the development of the April 2014 BCF submission, including:

- Healthwatch Rotherham were commissioned by the Health and Wellbeing Board to consult with the local community and engage them in the envisaged transformation of services, which took place between December 2013 - January 2014
- During January 2014 Rotherham Council consulted with a group of mystery shopper volunteers regarding the proposed vision, priorities and their views of health and social care services

Healthwatch Rotherham has supported the Rotherham Health and Wellbeing board to capture the views of the public in relation to the principles of the BCF through an initial consultation and report published on the 20 February 2014 (appendix 11). The principles of better joined up care through health and social care was used to facilitate this piece of work. The findings of the Healthwatch report have been used alongside other consultation and public intelligence to inform the BCF action plan. As a member of the Health and Wellbeing Board, Healthwatch agreed the action plan submitted initially in February 2014 and with the final plan submitted September 2014.

Responses from a range of consultation exercises and surveys previously completed have also been collated, and used to help shape our vision and priorities, including; Joint Health and Wellbeing Strategy consultation July – August 2012, ASCOF Adult Social Care User Survey 2011/2, Personal Social Services Annual Survey of Adult Carers in England 2012/13, 'Making It Real' Programme consultation in 2013, which assisted with developing Rotherham's "I" statements; Health Inequalities consultation 2011, and staff consultation regarding the hospital admission to discharge process. In addition, the council continually works to improve services through customer insight activities and learning from customer complaints, ensuring that service users are at the heart of service delivery. The council consults with and recruits customers for all major social care commissioning exercises, and undertakes rigorous customer evaluation to establish quality in the registered care sector. The annual Local Account is also used to inform

members of the public how the council is meeting the needs of service users and improving outcomes.

Rotherham CCG co-ordinates a Patient Participation Network, bringing together patient representatives from GP Practices across Rotherham. Patient Participation Groups have been meeting throughout the year, providing feedback on local health services. The Patient Participation Network meets on a quarterly basis, bringing together patients' views from across the local health economy. As part of an exercise to develop the patients' view of the CCG's five year strategy, the network identified a number of priorities that could be addressed as part of the Better Care Fund Plan.

Rotherham agencies held a Rotherham wide engagement event 'Working together' on 16 July 2014; this covered the whole health community strategy, opportunities and challenges and was attended by 150 members of the public and representatives of organisations. The event included general discussion on the health community's level of ambition and overall strategy and specific workshops on Better Care Fund Projects such as mental health, integrated working and social prescribing.

Our local NHS Provider Trusts have robust, monitored, and publicised arrangements that consult with and seek participation from people using their services, families and friends.

You Said, We Did…

Through the service user, patient and public engagement described above, we have been able to identify a number of common areas which local people have told us are important to them and areas for improvement, these include:

- Patients and service users do not always feel central to decision making, they want to be in the driving seat when it comes to their own care
- Services, local groups and organisations are not accessible due to a lack of information and advice, availability 7 days a week and long waiting times
- There needs to be better education and information available for people, particularly those with long term conditions
- People often feel unclear of expectations regarding the service they should receive and customer pathways due to a lack of advice and support and conflicting information. They are also not always signposted to appropriate services. Better staff training and education is required
- There is a lack of communication and information sharing resulting in poor joined up working between patient/service user, family and carers, health and social care services, GP, hospital, providers and partners
- Service users feel that they have to chase health and social care professionals, causing delay in the delivery of care and support
- Service users and patients would like an allocated key worker/professional; inconsistency of workers makes individuals feel unsafe
- There needs to be more of a focus on preventative, community/home-based services to reduce the number of people going into hospital and residential and nursing care. Nursing services are also critical for home-based support.
- Better after care is required. Examples provided included people felt alone, socially isolated, found it difficult to access services, no support for carers who are left behind
- Service users have a level of distrust using independent sector health and social care providers

We have used this information to inform the actions which will be delivered through the BCF plan in Rotherham and develop the set of 'I Statements' which will be used to monitor our performance of these. We want to ensure that the things that are important to local people, such as being central to decisions about their care, having access to services when they need them, feeling safe and not having to repeat themselves to numerous agencies, is at the heart of our plan for integration and we will continue to engage local people to ensure we continue to meet their needs.

Further information regarding the specific outcomes from all of the consultation activity can be found in Appendix 1.

Future engagement and consultation planned from September 2014

We have developed a consultation and engagement plan (appendix 6), which has been used from the start of this process and will ensure continued engagement and communication as we move into transition and implementation of the BCF plan.

We have produced two public-facing documents which we will use to share with local people our plans, how they align with our local priorities and what our proposed changes will mean for local people ('Plan on a page' Appendix 8 and 'What will the BCF deliver for the people of Rotherham' Appendix 7).

No further consultation and engagement has taken place specifically on BCF by Healthwatch following on from the initial report in January. However the nature of the work carried out by Healthwatch is linked to the vision of joined up health and social services and they will continue to gather views from the public and feed themes and trends into the health and wellbeing board priority areas, and to the BCF action leads. Further detail on some of the specific work to be carried out by Healthwatch to feed into the BCF actions is described in appendix 6.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

The Rotherham health and social care community has a strong track record of working together in partnership to achieve meaningful change for local people. We can evidence that we continuously work with people using services, to understand and learn from them, and to improve their experience. Their views and experiences are reflected in this plan.

Against this backdrop and using principles already established it is easy to see how our partnership around integration can be developed, strengthened and sustained.

Health providers
The Rotherham Health and Wellbeing Board has representation from the main local health providers (Rotherham Foundation Trust and Rotherham, Doncaster and South Humber Mental Health Trust (RDaSH)) and the voluntary sector (Voluntary Action

Rotherham) from the launch of the Board in 2012. They are each represented at board meetings, and their contribution has been embedded through the key theme groups, and the ongoing discussions regarding BCF. This involvement has ensured they have been engaged right through the process and are fully signed up to the principles and vision of the BCF, whilst being aware of the potential impact on services and the local community.

Healthwatch Rotherham are key partners at the board, bringing added value and independence through their direct relationship with the voluntary and community sector (VCS), and with people using services.

In addition to this, the BCF has been embraced by The Adults Partnership Board (APB), which acts as a commissioner/provider interface on jointly commissioned services. The board is coordinated jointly by the council and Rotherham CCG and includes representation from The Rotherham Foundation Trust (TRFT), RDaSH (Rotherham, Doncaster and South Humber Mental Health Trust) and the voluntary/community sector. The Adult Partnership Board agrees commissioning plans which address outcomes identified in the local Health and Wellbeing Strategy, examines national policy and directive and conducts impact assessments for Rotherham, making recommendations about commissioning priorities to the Health and Wellbeing Board. The APB has a key role in overseeing performance on jointly commissioned services including: registered residential and nursing care homes; community therapy: equipment; and enabling services; intermediate care; and services for older people with mental health problems. The Rotherham System Resilience Group (formally the Urgent Care Group) has cross system membership, and the BCF outline plans have been considered carefully at this forum. These discussions will continue as the action plans are shaped and revised, and developed into detailed implementation.

Local health providers understand that Rotherham CCG has identified a range of services which will be transferred into the BCF, and that the commissioning arrangements, including future specifications and targets for these services are likely to to change significantly. Locally the BCF will affect services delivered by Rotherham Foundation Trust (RFT) and key voluntary sector partners. All provider organisations have expressed a willingness to work under the new commissioning framework, recognising the potential opportunities to improve outcomes for Rotherham people. RFT is committed to delivering integrated health and social care pathways and regard the BCF as a vehicle through which these can be achieved.

Key local healthcare providers have been engaged through monthly clinically led QIPP (Quality, Innovation, Productivity and Prevention) groups where pathway redesign, innovation and efficiency are key deliverables. Therefore the clinical areas where savings are planned from acute care have been generated over the last twelve months from a multi-disciplinary group of clinicians and officers of the CCG, local authority and appropriate provider. Appendix 9 shows the workstreams through which the QIPP savings are being delivered.

This revised template was shared with Rotherham's main acute and mental health providers on Tuesday 26 August (TRFT and RDaSH).

ii) Primary care providers

The plans requiring health funding were fully consulted on with local primary care providers as part of developing the 14/15 Rotherham commissioning plan. This BCF plan is an integral part of the CCGs plans for 15/16 and will be consulted on with all member practices in September/October through the GP Members Committee and through the Chief Officer and GP Members Committee chair visiting all locality meetings.

iii) Social care and providers from the voluntary and community sector

Voluntary sector providers

Rotherham commissioners have a long established relationship with the local voluntary and community sector (VCS), both as partners in working to improve social capital locally, and directly as provider organisations. Commissioners engage formally through the Council Contracting for Care and Provider Forums, partnership and consultation meetings; and through the Adult Social Care Consortium and Health Networks. The VCS has a strong local voice with elected members and trust boards, and are seen as true partners where opportunities for not-for-profit organisations and charities to unlock funding streams not accessible to public services present themselves. We understand the remit and the influence of the VCS extends far beyond that of our public services and interfaces with people in our communities who do not use statutory services and who arrange their own care.

Voluntary sector partners have engaged with us variously in delivering a wide range of services, some of which are included in our BCF plan and form part of integrated care pathways in stroke, dementia care, carer support, and crisis services for people with mental health problems, We see the BCF as a catalyst and enabler to embed voluntary sector services into other condition specific care pathways, and maybe more importantly, as a key partner in prevention and early detection - signposting and offering advice and support to people who may be at risk of needing acute interventions, and offering more sustainable and meaningful activity to offset or delay entry into health and social care pathways. The BCF plan supports this specifically through the social prescribing project (Action Plan reference: BCF06).

Social care providers

Rotherham Council formally commissions social care services from over 100 independent providers delivering registered care (care homes and domiciliary care services) and smaller scale specialised services, and operates a robust framework of contract management and quality assurance (including gathering intelligence from and working closely with CQC and other commissioners) to make sure that services are safe, good quality, relevant, and value for money. In addition, growing numbers of customers purchase their own support services directly using Direct Payments, and these service providers are regulated through formal review arrangements with appropriate and proportionate scrutiny. The council operates a risk register and applies appropriate incentive to contracts with providers to encourage innovation, added value, and high standards, and has a good record of positive engagement with the sector.

Local social care providers – the full range of independent sector organisations - have been engaged specifically on the implications of the BCF and to better understand some of the issues and good practices already taking place. This was undertaken using an

online survey circulated to a wide database of local providers, consisting of those who are already engaged in work with commissioners, and those who are registered on the Rotherham E-Marketplace (Connect to Support), and holding a round-table discussion for a smaller group. The round-table provided an opportunity to use their experiences to explore potential solutions and enabled providers with a local focus to engage with the priorities for the BCF plan. A number of common themes have been identified which have informed the plan.

The council has a well-developed process for engagement with adult social care providers and has an ongoing programme for the year, called Shaping the Future, which includes engagement to explore the implications of BCF and the Care Act. A presentation to adult social care providers took place on the 7 May 2014, which brought together both pieces of work and resulted in a co-produced action plan for the year. The Market Position Statement for Older People's services (Appendix 5) has been published and provides clear direction for existing and new providers, this will be updated and evaluated periodically, and an additional position statement will be available later in the year that will scope activity and intentions across all adult care sectors and with close collaboration with health commissioners.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

NHS Rotherham CCG's share of the national efficiency challenge is around £80 million over five years and is referred to as QIPP (Quality, Innovation, Productivity and Prevention). QIPP has two components:

1. Provider QIPP: Efficiencies passed onto health service providers. For the last three years and for the foreseeable future, providers have been expected to provide the same services with less funding. For example in 2014/15 providers will be given 2.1% uplift for inflation but are then expected to make 4% efficiencies. The efficiency requirement is **£8.8m** in 2014/15 and the 5 year plans are as follows

QIPP Plans 2013/14	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
4% Efficiency	(8,750)	(8,993)	(8,993)	(8,993)	(8,993)

2. System Wide QIPP: NHS financial allocations are expected to rise by around 1-2% each year over the next 5 years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth will continue at around 6% a year because of the ageing population, rising expectations and new medical technologies.

In addition to the £8.8m above, there are two key areas for acute savings:

Unscheduled Care – reducing avoidable admissions - £1.3m
Historically, Rotherham health community has been an outlier for emergency admissions to hospital. This is not fully explained by the higher than average levels of morbidity and there is evidence that individual clinicians involved in hospital admissions such as GPs, ambulance staff, and accident and emergency doctors have different thresholds for admission. Whilst hospital admission may seem like the safest and easiest way of dealing with an emergency, for many people high quality care at home or in a community setting could be a better, safer option. The CCGs strategy provides more alternatives to hospital admission, treats people with the same needs more consistently and deals with more problems by offering care at home or close to home. There are important links between this area and plans to improve community services such as further developing the care coordination centre and providing alternative levels of care.

Clinical Referrals - £3.4m
The CCG will continue its approach based on clinical leadership and peer influence. Work with GPs and referring clinicians and providers will ensure referrals and elective and non-elective procedures are kept within affordable limits. If the current consensual, educationally based approach continues to be successful it will mean that Rotherham can maintain short waiting times and avoid unnecessary restrictions on the numbers of types of procedures that are available to patients.
Key to the work is effective communication with all clinicians in Rotherham, by face to face meetings, working with GP localities and hospital specialists through the Hospital Management Team and Medical Staff Committee, educational events, monthly newsletters, top tips for important pathways and by providing benchmarking information.
Patient experience will be enhanced by improving the quality of referral information to consultants, high quality discharge letters back to GPs with advice and management plans.

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

Details of how savings are to be invested is covered under section 3.1

Quality Impact Assessments (QIAs)
QIAs are an integral part of the annual planning cycle and are completed by the healthcare provider, proposed by the Chief Nurse and Medical Director and adopted by the Trust's Board. The Commissioner reviews the QIAs in advance and views are taken on board prior to the final submission. The CCG must also report through to NHS England the assurance level it has of provider efficiency savings and the extent to which quality and safety is optimised. This process will be completed in April 2014.

ANNEX 1 – Detailed Scheme Description

Scheme ref no. BCF01

Scheme name: Mental Health Service

Overview of scheme

A jointly agreed plan which results in a reduction in formal, high intensity use of services (including acute services and police intervention) and a greater investment in community-based and primary care preventative activity which addresses mental health issues much earlier on. This new service will be addition to existing services and will transform how patients with Mental Health issues are treated in the Rotherham urgent care system. This will also improve patient experience and health outcomes.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

The mental health liaison service will be provided through a multidisciplinary team working to support people with mental health problems including dementia who attend the acute hospital for treatment and/or in a crisis. The team will also work in partnership with care homes, the Police, other health and social care providers, and general wards in the hospital. Its minimum function will be to reduce admissions into acute hospital wards by supporting people effectively in the community, and also to support timely discharges from hospital.

We have identified the following key objectives for developing the service.

- Improve the provision of mental health liaison across CAMHS, Adults and Older People services
- Reduce avoidable emergency admissions and re-admission to The Rotherham NHS Foundation Trust (TRFT).
- Reduce the number of admissions and length of stay for people with mental health problems including older people and people with dementia.
- Improve outcomes and patient experience for people with mental health illness accessing TRFT.
- Raise the profile and increase awareness of mental health and dementia within TRFT as an aspect of holistic health.
- Improved compliance of TRFT with the legal requirements of the Mental Health Act (2007) and Mental Capacity Act (2005).
- Improve access to mental health services through 7 day working.
- Improve parity of esteem.
- Ensure people with mental health problem receive the right treatment in the right location at the right time

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

- Commission a 7-day a week with extended hours (9.00am – 8.00pm) for mental health liaison service for adults with mental health problems and older people with dementia.
- Raise the profile and awareness of mental health within TRFT as an aspect of holistic

health. This will be achieved through the increase prominence of mental health services at TRFT and the delivery of training programme to TRFT staff.
- Ensure there is effective liaison and improved pathway of care with other parts of the health / social care system, including Rotherham GPs, Crisis and inpatient teams (TRFT, Woodlands, Swallownest etc.), specialist mental health teams (adult and older people), social services, emergency service and non-statutory agencies, Alcohol Liaison service, Substance misuse services.
- Provide expert advice on capacity to consent for treatment in complex cases, including advice regarding the use of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS).

Who will benefit?
Customers will benefit from being provided with more skilled and appropriate support when they do need to experience a hospital admission, and will also benefit from having care provided to them where they live. The coordinated assessment and care plan should result in more person centred care and better outcomes for people using services. Those who will benefit include:
- People with dementia and their carers
- Adults with mental health problems and their carers
- Children and young people with mental health problems and their carers
- Staff in TRFT, RDaSH, social care and working in the Emergency Care Centre
- NHS England interface with Rotherham services, such as RDaSH, social care and TRFT

Measures
- Admissions to residential and care homes
- Avoidable emergency admissions
- Patient/service user/ carer experience
- Emergency readmissions
- Use of compulsory powers in MHA

Finance
£1.1m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

- By April 2015 the mental health liaison service will be recruited to and fully established and retrospective analysis been carried out to establish historical and post intervention trajectories for the 4 outcomes measures for the cohort of people with mental health problems

- April 16 – first full years outcomes – trajectory will be dependent on analysis work referred to above
- April 2019 – scheme will have been revised according to evaluation; if successful there will be a switch in emphasis of funding from acute mental health liaison to investment in more upstream prevention services.

Scheme ref no. BCF02

Scheme name: Falls Prevention

Overview of scheme

Older people are aware of the risks of falls and have opportunities to remain active and healthy in their community. Where a person is more at risk of a fall, they are provided with the right advice and guidance to help prevent them.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

Rotherham will set out a systematic approach to falls and fracture prevention. We have identified four key objectives for developing the service

1. Improve patient outcomes after hip fractures through compliance with core standards
2. Respond to a first fracture, through falls and fracture services in acute and primary care settings
3. Early intervention to restore independence, through falls and fracture care pathways
4. Prevent frailty, promote bone health and reduce accidents through encouraging physical activity and healthy lifestyle, and reducing unnecessary environmental hazards

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

Engaging all key partners to comprehensively scope and apportion lead responsibility for the actions needed, and establish an intelligence network to collect evidence to be presented at a bi-yearly clinic around falls prevention, pro-actively engaging care sector providers through the Shaping the Future Forum. To link this work to the Dependence to Independence Workstream and the partnership approach around risk management.

- Identifying patients presenting with fragility fracture and assess them to determine their need for bone active therapy to prevent future osteoporotic fracture
- Ensuring that people at high risk of falls and fracture are given comprehensive assessment and evidence based intervention
- Introducing a care management pathway with clear lines of referral for an integrated approach to bone health, fracture liaison and falls prevention
- Reducing year on year increase in falls that result in hospital admission and serious injury and to reduce the numbers of people who sustain fractured neck of femur following a fall.

Who will benefit?
There will be separate care pathways for each of these cohorts;

- People at risk of an injurious fall - Primary and community care
- People who have had a recent fragility fracture - A&E and Fracture Clinic
- People with an injurious fall who have complex needs - Case management

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance
£0.9m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

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Expected Impact

April 16	Integrated Falls and Bone Health Service is established
April 17	Reduction in fragility fractures for people >55years against trajectory
April 19	Reduction in fractured neck of femur against trajectory
April 2021	Falls and Bone Health Service extends its role to support people <55 years

Scheme ref no. BCF03

Scheme name: Joint call centre incorporating telecare and tele-health

Overview of scheme

A coordinated response is provided to individuals' needs and an increased use of assistive technologies to support independence and reduce hospital admissions.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

This workstream provides a joint vision for the development of telehealth and telecare services in Rotherham. It sets out the principles for care pathway development, maps current telecare provision and puts forward proposals for joint commissioning activity.

The overall objective of developing a joint telecare/telehealth strategy is to optimise the care of patients with long term conditions. Rotherham MBC and Rotherham CCG recognise that technology is an enabler for optimisation but not the whole solution. Pathways should be developed in conjunction with national guidelines and strategies for the management of long term conditions. All pathways should be systematically reviewed with clinicians in order to draw on their local expertise.

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

Rotherham CCG and Rotherham MBC will work to together to develop telecare prescriptions for GP Practices participating in the case management programme. We will introduce integrated telecare and telehealth packages which can be offered as part of a self-management programme for patients with a long term condition. We will scope the potential for development of a joint telecare/telehealth hub. Specifically we examine the potential for combining the Rothercare Service with the Care Coordination Centre.

Who will benefit?

The main benefit of this initiative is its potential to deliver improvement in outcomes for people who have a high dependency on health and social care services. A combined approach to care coordination, telehealth and telecare allows local practitioners to maintain contact with vulnerable patients. It can help improve the reach of health and social care, supporting those who are often 'invisible' from main acute services.

This initiative is more likely to ensure that intervention is early and appropriate. It makes more efficient and effective use of available clinical teams by reducing unnecessary home visits. It involves people far more in the management of their own healthcare and could lead to significant reductions in A&E usage and unplanned admissions

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance

This will require scoping of the existing service and a transfer of funds

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care

Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.	
Expected Impact	
April 2016	Care Coordination Centre and Rothercare are co-located and working together through joint protocols
April 2017	Reduction in number of falls related A&E attendances against trajectory
April 2019	CCC and Rothercare are fully integrated with single management structure
April 2021	40% increase in the number of people who have Rothercare across Rotherham with substantial proportion having an integrated telehealth/telecare package

Scheme ref no. BCF04

Scheme name: Integrated rapid response team

Overview of scheme

A coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

Rotherham will extend the current Fast Response Service so that it is capable of meeting the holistic needs of adults with long term conditions who experience an exacerbation. The new service will incorporate community nursing, social work support, enablement and commissioned domiciliary care. The main aims of the service will be to;

- Prevent avoidable admission to hospital for people with long term conditions
- Support discharge from hospital for those who are medically stable
- Ensure that patients receive the most appropriate level of care that can meet their needs
- Ensure that patients receive seamless care that is patient focused and clinically safe
- Provide a service from 7am until 2am, 7 days a week including bank holidays

Ensure safe and effective handover of care to mainstream primary and community services

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

We will enhance the current Fast Response Service so that it incorporates social workers, re-ablement workers and it will work in a streamlined way with commissioned domiciliary care providers. The new Integrated Rapid Response Service will assess patients who are medically stable but need additional support to remain at home. The service will meet all the health and social care needs of eligible patients for up to 72 hours at which point there will be a hand-off to mainstream services.

Under this enhanced service model the GP will retain overall medical responsibility for patients. The team will have access to the Fast Response beds located at Lord Hardy Court. If it is not possible to meet the needs of the patient at home, the Integrated Rapid Response Service will be able to arrange transfer to one of the Fast Response beds for recovery and recuperation.

Who will benefit?

In order to qualify for support from the Integrated Rapid Response Service the patients has to be 18 years or over. They have to have a Rotherham GP and they must be medically stable at the time of referral.

The patient may require rehabilitation. They may be a falls risk or have poor mobility. Patients who require IV Therapy would be eligible for the service as would those

experiencing an exacerbation of a medical or long term condition.

Measures

- Admissions to respite care in residential care homes
- Effectiveness of re-ablement
- Delayed transfer of care
- Avoidable emergency admissions
- Patient/service user experience
- Emergency hospital re-admissions

Finance
£1.2m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

2016 Effectiveness of re-ablement increased to 90%. Hospital length of stay down 1%
2017 Effectiveness of re-ablement increased to 91%. Hospital length of stay down 2%
2019 Effectiveness of re-ablement increased to 92%. Hospital length of stay down 3%
2021 Effectiveness of re-ablement increased to 93%. Hospital length of stay down 5%

Scheme ref no. BCF05

Scheme name: 7-day community, social care and mental health provision to support discharge and reduce delays

Overview of scheme

Appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

Rotherham will extend current provision so that appropriate services are available 7 days/week. This will enable timely discharge from hospital and avoid unnecessary admissions to hospital or residential care.

Emergency care should not be used when patients would benefit from care in other settings. We will ensure that community health and social care services deliver a high quality, responsive service both in and out of hours. We will focus on improving

diagnostics and urgent care. Through good partnership working, we will ensure that community services deliver a high quality, responsive service both out of hours. We will ensure that when someone has an urgent care need out of hours the quality of health provision is maintained and that patient outcomes are good.

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

Rotherham will review and evaluate existing arrangements against potential increase in demand arising from 7-day working across community, social care and mental health. We will increase social work capacity and, through jointly agreed specifications, we will commission future domiciliary care capacity, to support discharge at weekends. We will enhance and integrate out of hours services, and review commissioning arrangements, so that they are more responsive.

Who will benefit?

7 day services have the potential to drive up clinical outcomes and improve patient experience through, reducing the risk of morbidity and excess mortality following weekend admission in a range of specialties. Case studies reveal the potential for:

- improved quality, efficiency and innovation through
- Admission prevention;
- Speed of assessment, diagnosis and treatment;
- Safety and timing of supported discharge;
- Reduced risk of emergency readmission;
- Better use of expensive plant and equipment;
- Avoidance of waste and repetition
- Service rationalisation to enable safe consultant staffing levels.

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Delayed transfer of care
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance

£4.8m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care

Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.
Expected Impact
2016 Community nursing, Care Coordination Service and ALOC operating 7 days/week 2017 Significant reduction in OOH hospital admissions for people with LTCs 2019 Fully integrated Health and Social care Services OOH services 7 days/week 2021 Fully integrated community and primary care OOH services 7 days/week

Scheme ref no. BCF06
Scheme name: Social Prescribing
Overview of scheme
The need for more formal care services is reduced, creating an opportunity to shift investment into community activity that fosters independence and encourages local people to participate in their community. This service won a National Award from NHS England for best practice and will transform services from being reactive to a pro-active multi agency approach for Rotherham patients with high needs.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
The social prescribing project has had a successful start and has been recognised nationally as good practice. The plans included in the Better Care Plan will extend availability. The project acts as a portal for health professionals to access voluntary and community support services, to enable existing third sector providers and groups to complement the formal support that people with long term conditions receive. They are able to provide flexible, appropriate services that help people to self-manage.
The key success factors including an outline of processes, end points and timeframes for delivery
How will we do this? Through funding community navigators, employed by VAR, the local community and voluntary service, people with long terms conditions are able to access through their GP the following services: • Condition management programmes: education, managing pain and fatigue, healthy eating, exercise, emotional support, support to self-care, understanding care pathways, self-help groups. • Health and wellbeing: craft groups, music sessions for people with dementia, community garden projects, peer support groups, healthy cooking clubs, walking groups, specialist yoga and assistive technology support. • Employment, education or wider community participation: one to one support, group work, social activities, training, apprenticeship s, support to access community facilities, travel support, community transport. The service employs dedicated workers whose role includes liaison with providers and

support to enable referred patients to access the prescribed service. This may include a short period of one to one support to access available services, taking someone to a self-help group or organised activity.

Who will benefit?

GPS will benefit from being able to support patients to follow through on self-help activities. Customers will benefit from being able to access a wider range of support that enables them to regain or gain independence, and the community benefits from having a wider range of people actively engaged. The third sector is fully engaged into patient care pathways. It contributes to a reduction in formal social care packages and reduces admission to hospital.

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Delayed transfers of care
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Initial headlines from evaluation:

Patients and Carers

- 1,607 local people referred to the Social Prescribing Pilot
- 1,118 onward referrals to community based services
- 83 per cent made progress towards self-management
- 38 per cent had fewer A&E attendances
- 40 per cent had fewer in-patient stays
- 47 per cent had fewer outpatient appointments
- £350,000 in additional welfare benefits claimed
- General improvements in wellbeing, mental & physical health, isolation and independence

Public Sector

- 20 per cent reduction in A&E attendances
- 21 per cent reduction in in-patient stays
- 21 per cent reduction in outpatient appointments
- Potential well-being value of £742,000 in the first year post-referral
- Improvements in patient satisfaction
- Potential wider savings for primary and social care
- Up to £148,000 contribution by volunteers

Voluntary Sector

- £1m investment in VCS service provision
- £30,000 in additional funding accessed (figure tbc)
- Opportunity to innovate and deliver health outcomes for the first time
- Highlights the potential for micro-commissioning with local infrastructure as the accountable body
- Improved sustainability of small organisations
- Improved collaboration and partnership working
- Stimulates social action through the creation of new groups and activities

- National spotlight on their work

Finance
£0.6m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

Results from the first evaluation indicate that the benefits for the cohort who receive social prescribing will be:
April 2016 - Potential cost reductions of £415,000 in first year post referral

- 20 per cent reduction in A&E attendances
- 21 per cent reduction in in-patient stays
- 21 per cent reduction in outpatient appointments

April 2021 - Potential cost reductions of £1.9 million, post referral

Scheme ref no. BCF07

Scheme name: Integrated residential and nursing care quality assurance team

Overview of scheme

Reduction in the cost of contract compliance increased monitoring of nursing standards, reduced admissions to hospital and improved hospital discharges.
Reduced cost of significant service failure and safeguarding though a more proactive/ preventive/ coordinated approach.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

What are we trying to achieve?

Approximately 1,700 people Rotherham people live in care homes in Rotherham, under a diverse set of funding arrangements. Rotherham currently has more available placements than demand requires, and this suggests a degree of fragility for the sector. The intention of this workstream is to develop a joint approach towards quality assurance of residential and nursing care homes. Rotherham CCG and Rotherham MBC will work closely to develop an integrated quality assurance service that fulfils the following functions;

- Integrated care home quality assurance arrangements in place

- Increased monitoring of nursing care standards
- Earlier response to health related safeguarding alerts and contracting concerns
- Improved standards in care homes, resulting in fewer CQC compliance actions and warning notices
- Reduction in the number of contracting and safeguarding concerns
- Safeguarding through a more pro-active, preventative and co-ordinated approach
- Reduced admissions to hospital
- Improved hospital discharges
- Reduced cost of significant service failure
- Reduce A&E referrals, ambulance journeys and hospital admissions from residential care
- Address health training needs of care home staff
- Ensure appropriate access to falls prevention services
- Promote healthy living initiatives
- Review health aspects within care homes and ensure they are contract compliant
- Improve communication and align local routes for delivering improvements in care home standards and quality.

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

Rotherham will carry out a review of existing services to examine where joint working arrangements can best apply. We will explore the potential for developing an integrated quality assurance service, incorporating the current functions of the team with responsibilities for contract compliance. Health and social care staff will work closely together to improve quality and monitor performance. Where the team identifies issues with care quality or where a training need is identified for staff, the service will directly intervene. Interventions can include; the development of remedial improvement plans, co-ordinating tailored training programmes and case management support for complex residents.

Who will benefit?

The development of integrated quality assurance service will ensure that care home contracts are monitored effectively and that health related concerns are properly picked up within the local authority contracts. Residents will benefit because quality and performance issues will be identified early, enabling Homes to take remedial action before concerns regarding safeguarding start to arise. Care Home Providers will benefit from a unified approach to contract monitoring and a consistent message from commissioners. They will understand better the local intentions, which will assist them to make positive and informed business continuity decisions in a local market that is under the development of this type of integrated support provision will support good practice and protect residents.

Measures

- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions
- Reduction in the number of contracting and safeguarding concerns
- Reduction in CQC compliance actions and warning notices

Finance

This will require a review of existing services and creation of a jointly commissioned/ managed team supported by but not necessarily funded by the BCF

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

2016 A&E attendances from care homes reduced by 1% against trajectory
2017 A&E attendances from care homes reduced by 2% against trajectory
2019 A&E attendances from care homes reduced by 3% against trajectory
2021 A&E attendances from care homes reduced by 5% against trajectory

Scheme ref no. BCF08

Scheme name: Learn from experiences to improve pathways and enable a greater focus on prevention

Overview of scheme

A shift in investment from high-cost, high-intensity users of health and social care, to low cost high impact community initiatives which focus on prevention.

A co-produced (between health, public health and social care) risk stratification tool to identify high intensity users.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

We want a clearer understanding of the journey through health and social care services for people with long term conditions. We want to answer the following questions about our local services:

- Is our care proactive, holistic, preventive and patient-centred
- Are people playing an active role in their care? Are they engaged, informed and empowered?

- Do health and social care professionals adopt a partnership approach with their customers
- Are clinicians competent in supporting shared decision-making and goal setting
- Can we reduce duplication of input between health and social care
- Is the risk stratifications tool identifying high intensity users of health and social care services
- Is there a link between care planning for individuals and commissioning for local populations
- Do we have a diverse range of quality providers to call on that allow sufficient choice and flexibility to meet the specialist needs and preferences of people in our communities

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

We will gain this understanding by:

1. Undertaking a deep dive exercise which maps the care pathway of a specified number of high intensity uses of health and social care services, using customer journey tools to enable a better understanding of the customer experience of services.
2. Carrying out a full evaluation of the risk stratification tool and developing a mechanism for identifying high intensity users of health and social care services
3. Involving customers and carers in refreshing the JSNA so that demand is better understood and partners have as much intelligence as possible on which to base their commissioning activity.
4. Health and Social Care Market Facilitation Programme

Who will benefit?

This piece of work will ensure that we are targeting resources at the correct cohort of people. It will inform plans to reduce duplication within care pathways and it will support a partnership approach to care delivery. It will promote partnership working between the patient and health & social care professional. It will also support partnership working on a case and individual level between health and social care services.

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Delayed transfers of care
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance

£0.03m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

2016 Development of an integrated health and social care risk stratification tool
2017 Introduction of an integrated health and social care plans for community
2019 Integrated health and social care plans in place for high risk patients
2021 Introduction of integrated health and social care teams

Scheme ref no. BCF09

Scheme name: Personal health and care budgets

Overview of scheme

Individuals are provided with the right information and feel empowered to make informed decisions about their care.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

The council has a positive record in delivering personalised services, including personal budgets and direct payments. Collaborative work between the Council, CCG, and CSU has resulted in the early delivery of personal health budgets for people in receipt of fully funded health care, so the health and social care economy is on track to deliver personal health budgets by 1st April 2015. Through the Better Care Fund, it is our aspiration to continue to deliver on these agendas and to extend our current plans to a wider group of individuals, ensuring that they have choice and control.

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

As the personalisation agenda is rolled out, the CCG will review its the payment mechanisms for community services to ensure that where patients choose alternative services over commissioned services, the CCG does not pay twice. Where commissioned services are no longer required we will seek to decommission services without destabilising existing providers. There is potential for a much wider range of providers which require the appropriate oversight to ensure quality requirements are being achieved, and RMBC and the CCG will work together to present a consistent approach to the care market, and develop streamlined and flexible contract management arrangements.

Over the next year we will roll out training to offer personal health budgets (PHB) to all

patients in receipt of a domiciliary Continuing Healthcare package, including notional budgets. We will monitor the impact of PHB roll out on expenditure. We will hold stakeholder development sessions to build strong partnerships between RMBC, Rotherham CCG and Commissioning Support Unit colleagues. Finally we will develop a service level agreement with RMBC, subject to agreement of final costs.

Who will benefit?
Customers and their families will benefit from being able to choose the way in which their services are delivered, offering increased choice and control. Service providers will benefit from positive engagement with customers and the ability to work in a more person centred way.

Measures
- Admissions to residential and care homes
- Effectiveness of re-ablement
- Patient/service user experience

Finance
£1.6m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

Roll out of personalisation service – all domiciliary Continuing Healthcare patients will have a right to have a PHB from 1 October 2014.

Roll out of personalisation service to all SEN children.

NHS mandate sets an ambitious objective that people living with long term conditions who could benefit should have the option for a personal health budget, including a direct payment, from April 2015. Further NHS England guidance expected in due course.

Scheme ref no. BCF10

Scheme name: Self-care and self-management

Overview of scheme

Individuals are provided with the right information and support to help them self-manage their condition/s.

Professionals are equipped with the right skills to enable self-care / self-management and promote independence.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

The purpose of this workstream is to ensure that self-management is embedded in all aspects of health and social care. A good system of self-management will support the development of knowledge, skills and confidence in self-care support. Health and social care services should support people with long term conditions to actively participate in care planning. Care plans should include actions for the person receiving support aimed at improving or maintaining their condition. High-risk patients with long term conditions should have a person held record, which includes their care plan. Case managers should ensure planned follow up on goals. Scheduled appointments should be in place to plan care, treatment or support.

Some specialist teams such as the Home Care Enabling Service, Intermediate Care , Falls Service, Breathing Space and the Community Stroke / Neurological Conditions Teams and community matrons are built on an ethos of self-management. These services have the clinical systems in place to support self-care. However many mainstream health services still focus on direct support rather than support with self-management.

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

Rotherham will evaluate the current patient skills programme and reconfigure. We will bring all self- management programmes under a single banner “Rotherham Patient Skills Programme”. We will extend the current patient skills programme so that it supports patients on the GP case Management Programme. We will develop specialised psychological support services for people with long term conditions, so that they are better able to self-manage**.**

Rotherham will set up a local self-management network, responsible for promoting self-management and acting as an interface between the statutory, voluntary and independent sectors. We will develop a multi-agency practitioner development programme, equipping works with the skills to assist in self-management. Finally Rotherham will introduce a person held record for people with a long term condition, enabling them to monitor their condition and track the progress of their care plan.

Who will benefit?

Every person in Rotherham with a long-term condition should have an opportunity to participate in a collaborative care planning process with effective self-management support. People who recognise that they have a role in self-managing their condition, and have the skills and confidence to do so, experience better health outcomes. With

effective support and education, evidence shows that these skills can be developed and strengthen, even among those who are initially less confident, less motivated or have low levels of health literacy. Professionals gain new knowledge and skills, leading to greater job satisfaction.

Measures

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance
£0.05m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

April 2016 Integrated patient skills programme in place for people with long-term conditions and being utilised fully by primary care, social care and community health services

April 2017 Workforce development programmes have created an organisational ethos which focuses on self-management

April 2019 35% of people on chronic disease registers have attended patient skills programme

April 2021 50% of people on chronic disease registers have attended patient skills programme

Scheme ref no. BCF11

Scheme name: Person-centred one page plan

Overview of scheme

Each individual has a single, holistic, co-produced one page plan , meaning they only need to tell their story once and key details are available (in home and on shared portal initially, building to shared IT capacity) which enables integrated, person-centred service delivery. This approach will transform the way patients with high needs access services

and will ensure more joined up working between health and social care.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

Each individual in contact with services will have a person-held one page plan that informs them, their family and professionals involved with their care of their story, their plan and what they can do to keep themselves healthy, safe and living in the community. It will outline about what is important to that individual. The GP case management project funds additional clinical time in primary care to case manage patients at highest risk of hospital admission (as identified by the risk stratification tool), all patients in nursing and residential homes and links to work to provide additional GP support for all patients over 75. Community nursing and social workers are refocused to provide input into patient reviews. This builds on the success of the case management pilot, which has seen every person in the pilot being provided with a care plan that is held in the home, the document will be agreed with the customer and will be developed in line with current best practice

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

We work with customers and patients to develop an agreed format. This will then be tested with a small group of customers and once the result is effective and meets customers' needs, will be rolled out through the case management process, through social work assessments and other routes.

Who will benefit?

Customers will only have to tell their story once, and will be able to work with their GP or other professional on developing a plan that reflects their needs, and also includes their self-care or self-management plan, plus a plan that informs, when needed, other professionals to ensure that they receive the care they need where they need it. This plan will ensure that people's needs are met. The case management pilot has resulted in a number of people having person held plans in their homes, and this has been welcomed by the ambulance service who have found them useful and have been able to use them to support decision making – the person centred one page plan will build on this.

Measures

- Patient/service user experience

Finance

£2.5m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made

through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

- April 2016 – the person centred one page plans will be available to people on the GP case management process
- April 2015 - case management of 12,000 patients in Rotherham at highest risk of admission to hospital
- April 2017- person centred one page plans will be embedded in practice and available to anyone who wants one
- April 2019 (three years after 2015/16)
- April 2021 (five years after 2015/16)

Scheme ref no. BCF12

Scheme name: Care Act 2014 preparation

Overview of scheme

Rotherham adult social care is able to meet the increased demand and maintain / protect the existing level of service.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

The Care Act 2014 presents significant challenges to the Local Authority and partners in relation to a duty to provide effective advice, information and guidance services, extended rights for carers, statutory responsibilities for safeguarding adults, deferred payments and care accounts including new responsibilities in relation to people who fund their own care and an increased focus on personalisation. The council will identify the cost and activity pressures resulting from this new legislation.

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

There is a Care Act Steering Board in place which has five workstreams each focussing on key elements of the Act, The Steering Board will work with customers, providers, and partners to determine the actions needed, and will then guide the action plans to deliver effective change by 1 April 2015.

Who will benefit?

The Care Act will ensure that there is a consistent approach nationally in relation to the eligibility for adult social care, portability of assessment, and the delivery of more personalised services., It will ensure that carers are supported. The action plan will

ensure that staff needs for training, development and information are met at a time of significant legislative change.

Measures

- The Care Bill will impact on all BCF outcome measures

Finance

£0.3m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

- by April 2016 the Care Act 2014 will be fully implemented including the Care Funding Reforms , the new services and approaches in place will be supporting the strategic Health and Wellbeing outcomes of prevention and early intervention and a reduction in dependence , increase in independence for people
- By April 2017 the new legislation will be fully embedded and social care services will be sustainable and able to support the Health and Wellbeing Strategy and BCF ambitions
- April 2019 (three years after 2015/16) safe services will be delivered
- April 2021 (five years after 2015/16) safe services will be delivered

Scheme ref no. BCF13

Scheme name: Review existing jointly commissioned integrated services

Overview of scheme

All jointly commissioned services provide value for money and are aligned with the BCF vision and principles. Where services are not efficient and effective, a plan is developed to de-commission/re-commission as appropriate.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

All jointly commissioned services will be reviewed to establish if they provide value for money and are aligned with the BCF vision and principles. Where services are not efficient and effective, services will be reconfigured or decommissioned. There is a recognition that the shift from care in hospital to the community will impact on social care services. Where this impact is apparent the Better Care Fund will provide additional

support to social care services through the service review process.

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

Rotherham will develop a 3 year review programme for all services funded through the Better Care Fund. We will also develop a robust review process which enables commissioners to form a clear picture of the strategic relevance and performance of existing services. We will set out joint governance arrangements for making decisions on review recommendations. Finally we will put in place a proper performance framework for BCF services which demonstrates the effectiveness of services against BCF criteria

Who will benefit?

Reviewing the current portfolio of BCF services will ensure that there is proper alignment between health and social care locally. Commissioners from the local authority will have a direct influence over the configuration of services that were historically commissioned by health. Local Authority commissioners already have a good dialogue and contract management arrangements with the care market and involve health partner commissioners in its engagement/ market facilitation programme, to present a united approach to commissioning and procurement of services wherever possible. The BCF presents an opportunity to understand more thoroughly the models and drivers for commissioners from each organisation and to improve future collaborative commissioning for the health and social care community.

All commissioned services can be realigned to deliver a combination of health and social care outcomes rather than being totally focused on the targets of a single organisation. This inevitably benefits the patient as it moves both CCG and Council commissioners towards a position where they are commissioning fully integrated health and social care services.

Measures

- All integrated services impact on BCF outcome measure/s

Finance

£7.9m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact
April 2016 All services currently funded under S256 and S75 reviewed and reconfigured
April 2017 All services included in the Better Care Fund have been reviewed and new services re-commissioned. Those services that are no longer strategically relevant or performing poorly have been decommissioned
April 2019 Services commissioned under BCF are fully integrated across health and social care
April 2021 BCF is expanded to incorporate new service from health and social care. Existing BCF services deliver fully integrated health and social care packages

Scheme ref no. BCF14
Scheme name: Data sharing between health and social care
Overview of scheme
All providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual.
Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)
All Rotherham NHS correspondence uses the NHS number as primary identifier, and the council has a plan already in development to enable this to be used on social care systems. It is proposed that use of the NHS number as a unique identifier across all health and social care will create the starting point for the development of shared IT capacity locally. We aim to provide information sharing capacity between and across health and social care that is effectively governed and safe.
The key success factors including an outline of processes, end points and timeframes for delivery
How will we do this? Through the BCF there is a commitment to ensure that all providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual. To enable this to happen we will develop portal technology to share data in a secure way that is in the best interest of people who use care and support. Accompanied with effective use of new technology it will liberate practitioners and transform the way they work. **Who will benefit?** The BCF Plan has highlighted actions related to the use of technology and information that, if fully implemented, could deliver significant benefits to the health and social care economy. These benefits include improvements to quality and efficiency as well as patient experience and satisfaction. As well as delivering efficiencies, there are also tangible benefits such as the improvements in the quality of care delivered, the accuracy of data collected, improved

data flow between health and social care and the increased flexibility the practitioners have in managing their time and location of work.

The BCF Plan will ensure greater efficiency in accessibility of patient information. Increased accessibility will enable faster transfer of medical history in a medical emergency or when visiting a new practitioner. Researchers and public health authorities, with the permission and consent of the patient, will be able to collect and analyse up-to-date patient data. Such access is imperative in emergency situations, and also allows public health officials to easily conduct outbreak and incident investigations. Improved accessibility will also enable health care providers to reduce costs associated with duplicate testing, appointment reminders and laboratory results.

Measures

- Delayed transfer of care
- Avoidable emergency admissions
- Patient/service user experience
- Emergency readmissions

Finance
£0.3m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

April 2016 – NHS Number available in social care systems for all people on GP Case Management Process
April 2017 – NHS Number recorded in social care system for 12,000 patients in Rotherham at highest risk of admission to hospital
April 2019 (three years after 2015/16) - Ability to view information securely across networks
April 2021 (five years after 2015/16) – Ability to update information across networks

Scheme ref no. BCF15

Scheme name: Community End of Life Care pilot

Overview of scheme

Investment in enhanced community end of life care services by Rotherham Hospice to augment the current day hospice /Inpatient Patient Unit services with hospice at home

provision.

Description of the proposed schemes and impact on outcomes, including a summary of the evidence base and assumptions underpinning planned changes (including references)

The scheme is similar to successful schemes operating in numerous other districts. Rotherham has invested non-recurrently in this area for the last 18 months and outcomes to date are being evaluated at system wide event on 22 October 2015.

The key success factors including an outline of processes, end points and timeframes for delivery

How will we do this?

Rotherham hospice will provide a community end of life care team that will provide care and support to patients and their carers. This includes a 7/7 service and 24/7 advice line working in partnership with other providers such as GPs and district nurses.

Who will benefit?

Service provided to an average of 34 patients at any one time totalling more than 400 patients per year.

Measures

- Avoidable emergency admissions

Reduction of hospital admissions for EOLC patients by 330/year

- Patient/service user experience

Percentage of patients in the scheme receiving care in their preferred place over 80%
Overall percentage of people dying not in an acute hospital to be more than 50%

- Emergency readmissions

No more than 20% of the EOLC Hospice at Home register patients to have a hospital admission. This will have a substantial impact on re-admissions for this cohort.

Finance

£0.8m

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

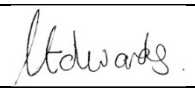
We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. The Community End of Life pilot is an important part of the Rotherham 2014-2016 Commissioning plan where there is an explicit commitment to evaluate its impact in October 2015, this will be an event with RMBC and the CCG together with all other health providers in Rotherham. The alignment between the BCF and the Care Bill has been recognised; there is cross-membership between the Better Care Fund Operational Group and the Care Act Board and the two plans will cross reference to ensure consistent delivery of the changes needed.

Expected Impact

April 2016: We has some confidence in predicting that the outcomes detailed above 9360 avoided admissions, more than 50% of all Rotherham residents people dying not in an acute hospital) will be maintained if the level of investment is maintained. Future annual evaluations will show if there is scope for improving outcomes for the same level of investment or if there is a compelling case for increasing the level of funding. In this case the expected outcomes in future years will be amended.

April 2017: expected outcomes as in 2016 unless evaluation suggests increased outcomes or increased investment is prioritised.

[ANNEX 2 – Provider commentary]

Name of CCG	NHS Rotherham Clinical Commissioning Group
Name of CCG Accountable Officer	Chris Edwards
Signature (electronic or typed)	
Name of Provider organisation	The NHS Rotherham Foundation Trust
Name of Provider CEO	Louise Barnett
Signature (electronic or typed)	

For CCG to populate:

Total number of non-elective FFCEs in general & acute **[see E.C.4 of planning guidance]**	**2013/14 Outturn**	23,200
	2014/15 Plan	23,200
	2015/16 Plan	23,200
	14/15 Change compared to 13/14 outturn	0
	15/16 Change compared to planned 14/15 outturn	0
	How many non-elective admissions for the CCG is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions for the CCG is the BCF planned to prevent in 15-16?	0

For Provider to populate:

	Question	Response
1.	**Do you recognise the planned non-elective (general and acute) admissions data for 14/15 and 15/16 submitted by the CCG?**	YES
2.	**Do you agree with the data submitted for the impact of the BCF in terms of planned in non-elective (general and acute) admissions 15/16 compared to 13/14 outturn and planned 14/15 outturn?**	YES
3.	**If you answered 'no' to Q.2 above, please explain why you do not agree?**	N/A
4.	**Can you confirm that you have considered the resultant implications on your organisation?**	YES

[ANNEX 2 – Provider commentary]

Name of CCG	NHS Rotherham Clinical Commissioning Group
Name of CCG Accountable Officer	Chris Edwards
Signature (electronic or typed)	Edwards
Name of Provider organisations	Rotherham, Doncaster and South Humber Mental Health Trust
Name of Provider CEO	Christine Bain
Signature (electronic or typed)	Approved via email

For CCG to populate:

Total number of non-elective FFCEs in general & acute **[see E.C.4 of planning guidance]**	**2013/14 Outturn**	N/A
	2014/15 Plan	N/A
	2015/16 Plan	N/A
	14/15 Change compared to 13/14 outturn	N/A
	15/16 Change compared to planned 14/15 outturn	N/A
	How many non-elective admissions for the CCG is the BCF planned to prevent in 14-15?	N/A
	How many non-elective admissions for the CCG is the BCF planned to prevent in 15-16?	N/A

For Provider to populate:

	Question	Response
1.	**Do you recognise the planned non-elective (general and acute) admissions data for 14/15 and 15/16 submitted by the CCG?**	N/A – RDaSH does not provide these services.
2.	**Do you agree with the data submitted for the impact of the BCF in terms of planned in non-elective (general and acute) admissions 15/16 compared to 13/14 outturn and planned 14/15 outturn?**	RDaSH notes and agrees the 'Expected Impact' on the Mental Health Scheme along with on page 28 future specifications and targets for this service which are likely to change significantly.
3.	**If you answered 'no' to Q.2 above, please explain why you do not agree?**	NA
4.	**Can you confirm that you have considered the resultant implications on your organisation?**	When considering the Mental Health Service Scheme, and the need to, as a minimum function, reduce admissions into the acute Trust, through the 'Key

		Objectives' and 'Expected Impact' for the Scheme, RDaSH would also seek to understand the inter-operable connection for patients with dementia associated in the *'Joint assessment and accountable lead professional for high risk populations'*, in the following areas: • Patients at risk of hospitalisation. • Case management programme. • Use of risk stratification tool • In order to build on existing arrangements for joint patient management. RDaSH notes the following schemes and in particular the 'Expected Impact' and look forward to the future integrated system: • Falls prevention • Integrated rapid response team • 7-day working Social prescribing

Health and Wellbeing Board Details

ROCR approval applied for
Version 2

Please select Health and Wellbeing Board:

Rotherham

Please provide:

Keely Firth
keely.firth@rotherhamccg.nhs.uk

Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Rotherham

1. Reduction in non elective activity

Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	29,770
Change in Non Elective Activity	0
% Change in Non Elective Activity	0.0%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds

Figures in £

Financial Value of Non Elective Saving/ Performance Fund	0
Combined total of Performance and Ringfenced Funds	5,303,468
Ringfenced Fund	5,303,468
Value of NHS Commissioned Services	8,366,930
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	7,447	15,017	22,383	29,770
Cumulative Change in Non Elective Activity	0	0	0	0
Cumulative % Change in Non Elective Activity	0.0%	0.0%	0.0%	0.0%
Financial Value of Non Elective Saving/ Performance Fund (£)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Health and Wellbeing Funding Sources

Rotherham

Please complete white cells

	Gross Contribution (£000)	
	2014/15	**2015/16**
Local Authority Social Services		
Rotherham	3,453	3,670
Rotherham	6,166	-
<Please select Local Authority>		
<Please select Local Authority>		
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<Please select Local Authority>		
Total Local Authority Contribution	**9,619**	**3,670**
CCG Minimum Contribution		
NHS Rotherham CCG	12,217	18,350
-		-
-		-
-		-
-		-
-		-
-		-
Total Minimum CCG Contribution	**12,217**	**18,350**
Additional CCG Contribution		
NHS Rotherham CCG	**1,263**	**1,296**
<Please Select CCG>		
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<Please Select CCG>		
Total Additional CCG Contribution	**1,263**	**1,296**
Total Contribution	**23,099**	**23,316**

Summary of Health and Wellbeing Board Schemes

Rotherham

Please complete white cells

Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	275	275			
Mental Health	445	445			
Community Health	4,160	4,160			
Continuing Care	616	616			
Primary Care	2,200	2,200			
Social Care	13,465	13,682	13,465	13,682	
Other	1,938	1,938			
Total	**23,099**	**23,316**		**13,682**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure	
		2015/16
Mental Health		-
Community Health		3,111
Continuing Care		-
Primary Care		-
Social Care		5,026
Other		230
Total		**8,367**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	154	22	
Increased effectiveness of reablement	-	-	
Reduction in delayed transfers of care	-	-	
Reduction in non-elective (general + acute only)	66	66	-
Other	294	294	
Total	**513**	**382**	**-**

Health and Wellbeing Board Expenditure Plan

Rotherham

Please complete white cells (for as many rows as required):

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
BCF01 - Mental Health Service	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	100	100
BCF01 - Mental Health Service	Social Care		Local Authority			Private Sector	CCG Minimum Contribution	309	309
BCF01 - Mental Health Service	Social Care		CCG			Local Authority	Additional CCG Contribution	274	274
BCF01 - Mental Health Service	Mental Health		CCG			NHS Mental Health	Additional CCG Contribution	445	445
BCF02 - Falls prevention	Other	Voluntary Sector	Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	20	20
BCF02 - Falls prevention	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	608	619
BCF02 - Falls prevention	Acute		CCG			NHS Acute Provider	Additional CCG Contribution	275	275
BCF04 - Integrated rapid response team	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	280	280
BCF04 - Integrated rapid response team	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	60	60
BCF04 - Integrated rapid response team	Continuing Care	Private Sector	CCG			Private Sector	Additional CCG Contribution	616	616
BCF04 - Integrated rapid response team	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	270	270
BCF05- 7 day community social care and mental health provision to support discharge and reduce delays	Social Care		CCG			Local Authority	CCG Minimum Contribution	480	480
BCF05- 7 day community social care and mental health provision to support discharge and reduce delays	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	778	778
BCF05- 7 day community social care and mental health provision to support discharge and reduce delays	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	756	756
BCF05- 7 day community social care and mental health provision to support discharge and reduce delays	Social Care		CCG			Local Authority	Additional CCG Contribution	566	566
BCF05- 7 day community social care and mental health provision to support discharge and reduce delays	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	2,064	2,064
BCF05- 7 day community social care and mental health provision to support discharge and reduce delays	Other	Voluntary Sector	CCG			Charity/Voluntary Sector	Additional CCG Contribution	158	158
BCF06 - Social Prescribing	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	100	100
BCF06 - Social Prescribing	Other	Voluntary Sector	CCG			Charity/Voluntary Sector	Additional CCG Contribution	505	505
BCF08 - Learn from experiences to improve pathways and enable a greater focus on prevention	Social Care		CCG			Local Authority	CCG Minimum Contribution	27	27
BCF09 - Personal health and care budgets	Social Care		Local Authority			Private Sector	CCG Minimum Contribution	1,643	1,643
BCF10 - Self-care and self management	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	50	50
BCF11 - Person-centred services	Primary Care	Private Sector	CCG			Private Sector	Additional CCG Contribution	2,200	2,200
BCF11 - Person-centred services	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	264	264
BCF12 - Care Bill preparation	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	200	200
BCF12 - Care Bill preparation	Social Care		CCG			Local Authority	Additional CCG Contribution	75	75
BCF013 - Review existing jointly commissioned integrated services	Social Care		CCG			Local Authority	CCG Minimum Contribution	482	482
BCF013 - Review existing jointly commissioned integrated services	Social Care		CCG			Private Sector	CCG Minimum Contribution	1,740	1,740
BCF013 - Review existing jointly commissioned integrated services	Other	Private Sector	CCG			CCG	CCG Minimum Contribution	30	30
BCF013 - Review existing jointly commissioned integrated services	Other	Voluntary Sector	CCG			Charity/Voluntary Sector	CCG Minimum Contribution	200	200
BCF013 - Review existing jointly commissioned integrated services	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	490	490
BCF013 - Review existing jointly commissioned integrated services	Community Health		Joint	68%	32%	NHS Community Provider	CCG Minimum Contribution	1,452	1,452
BCF013 - Review existing jointly commissioned integrated services	Social Care		Joint	57%	43%	Local Authority	CCG Minimum Contribution	2,901	2,901
BCF013 - Review existing jointly commissioned integrated services	Social Care		CCG			Local Authority	CCG Minimum Contribution	643	643
BCF14 - Data sharing bewteen health and social care	Other	Private Sector	CCG			Private Sector	Additional CCG Contribution	250	250
BCF15 - END OF LIFE CARE	Other	Voluntary Sector	CCG			Charity/Voluntary Sector	Additional CCG Contribution	775	775
Disabled Facilities Grant	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	1,013	1,219
Total								**23,099**	**23,316**

Health and Wellbeing Board Financial Benefits Plan

Rotherham

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

			2014/15					
Benefit achieved from	**If other please specify**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in permanent residential admissions		Combination of schemes	Local Authority	7	21,935	153,545	Unit price is weighted average cost of residential/nursing care in a full yeart but does not take into account any additional costs of alternative social care provision	Regular monthly monitoring in line with normal practice
Reduction in non-elective (general + acute only)		Combination of schemes	NHS Commissioner	44	1,800	65,560	Growth avoided @ 4% multiplied by the percentage attributable to the BCF investment eg 5.5% of the whole plan multiplied by the price.	Through System Resilience Group and Performance Report at public Governing Body each month.
Other	Reduction in emergency readmissions	Combination of schemes	NHS Provider	141	2,080	294,264	Savings requirement for the acute trust via tariff (4%) multiplied by the number of readmissions that will not be paid for through tariff rules multiplied the percentage attributable to the BCF investment eg 5.5% of the whole plan multiplied by the price.	Through performance report at public Governing body and monthly contrract meetings with the acute FT.
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Total			-	**192**	**25,815**	**513,369**	-	-

2015/16

			2015/16					
Benefit achieved from		**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in permanent residential admissions		Combination of schemes	Local Authority	1	22,264	22,264	Unit price is weighted average cost of residential/nursing care in a full yeart but does not take into account any additional costs of alternative social care provision	Regular monthly monitoring in line with normal practice
Reduction in non-elective (general + acute only)		Combination of schemes	NHS Commissioner	44	1,800	65,560	Growth avoided @ 4% multiplied by the percentage attributable to the BCF investment eg 5.5% of the whole plan multiplied by the price.	Through System Resilience Group and Performance Report at public Governing Body each month.
Other	Reduction in emergency readmissions	Combination of schemes	NHS Provider	141	2,080	294,264	Savings requirement for the acute trust via tariff (4%) multiplied by the number of readmissions that will not be paid for through tariff rules multiplied the percentage attributable to the BCF investment eg 5.5% of the whole plan multiplied by the price.	Through performance report at public Governing body and monthly contrract meetings with the acute FT.
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Total			-	**186**	**26,144**	**382,088**	-	-

Rotherham

Red triangles indicate comments

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**2,865**	**2,913**	**2,834**	**2,842**	**2,856**	**2,903**	**2,825**	**2,833**	**2,845**
	Numerator	7,447	7,570	7,366	7,387	7,447	7,570	7,366	7,387	7,447
	Denominator	259,889	259,889	259,889	259,889	260,782	260,782	260,782	260,782	261,739

P4P annual change in admissions *0*
P4P annual change in admissions (%) *0.0%*
P4P annual saving *£0*

Rationale for red/amber ratings: The 2014/16 Rotherham operational plan has ambitious trajectories to keep overall admissions flat, this is ambitious because there has already been a 20% reduction in non elective admissions over the previous 3 years. The do nothing scenario assumes a 5-6% annu

£1,490 National average cost of non-elective admission[1]

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Rotherham	% Rotherham resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Barnsley CCG	8,087	8,220	7,590	7,940	3.4%	3.2%	278	283	261	273
NHS Bassetlaw CCG	2,880	2,791	2,605	2,627	0.9%	0.4%	27	26	24	24
NHS Doncaster CCG	9,728	9,638	9,423	9,537	1.1%	1.3%	109	108	106	107
NHS Rotherham CCG	7,080	7,202	7,032	7,032	97.9%	93.6%	6,928	7,048	6,882	6,882
NHS Sheffield CCG	15,409	15,588	13,852	14,970	0.7%	1.4%	104	105	93	101
Total						**100%**	**7,447**	**7,570**	**7,366**	**7,387**

References

1. Based on 12-13 Reference Costs: average cost of a non-elective inpatient short and long stay combined excluding excess bed days. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/261154/nhs_reference_costs_2012-13_acc.pdf

Rotherham

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)

Planned improvement on baseline

Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Residential admissions

Metric		Baseline (2013/14)	Planned □14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**694.6**	**649.0**	**633.7**
	Numerator	325	317	316
	Denominator	46,645	48,842	49,864
	Annual change		*-8*	*-1*
	Annual change (%)		*-2.5%*	*-0.3%*

Rationale for red rating

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**87.7**	**88.5**	**90.0**
	Numerator	115	115	117
	Denominator	130	130	130
	Annual change		*0*	*2*
	Annual change (%)		*0.0%*	*1.7%*

Rationale for red rating

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**405.3**	**332.2**	**389.0**	**537.6**	**537.6**	**537.6**	**537.6**	**535.2**	**535.2**	**535.2**	**535.2**	**533.0**
	Numerator	821	673	788	1,096	1,096	1,096	1,096	1,096	1,096	1,096	1,096	1,096
	Denominator	202,588	202,588	202,588	203,867	203,867	203,867	203,867	204,794	204,794	204,794	204,794	205,610
						Annual change			*1006*			*Annual change*	*0*
						Annual change (%)			*29.8%*			*Annual change (%)*	*0.0%*

Rationale for red ratings

Patient / Service User Experience Metric

Metric		Baseline 2013	Planned 14/15 (if available)	Planned 15/16
Inpatient Experience: The proportion of people reporting a poor patient experience of inpatient care. (Average number of negative responses per 100 patients)	*Metric Value*	124.2	123.08	121.96
	Numerator			
	Denominator			
Improvement indicated by:	Decrease			

Local Metric

Metric		Baseline April-Dec 2013 (9 months)	Planned 14/15 (if available)	Planned 15/16
Emergency readmissions < 30 days of hospital discharge (all ages) PHOF4.11NHSOF3b - NB. local variation to national measure, using patients registered with a Rotherham GP, not LA population.	*Metric Value*	12.2	12.2	12.2
	Numerator	2,328	2,328	2,328
	Denominator	19,136	19,136	19,136
Improvement indicated by:	Decrease			

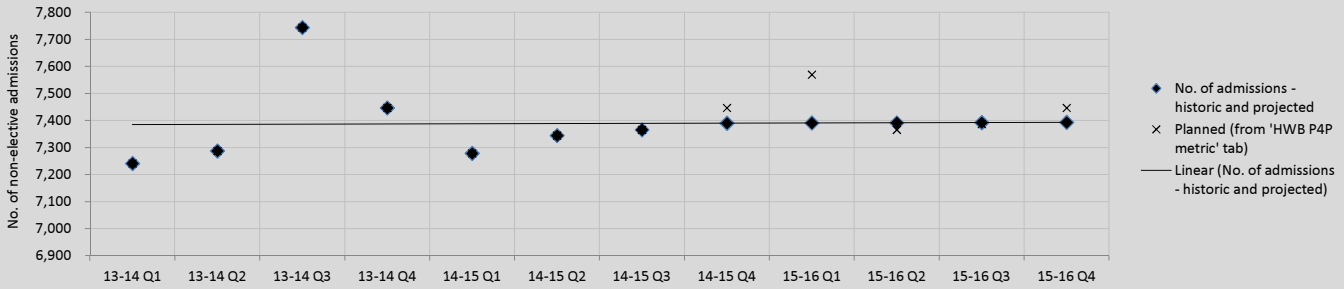
Rotherham

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	7,241	7,288	7,744	7,447	7,279	7,345	7,366	7,390	7,391	7,392	7,393	7,393

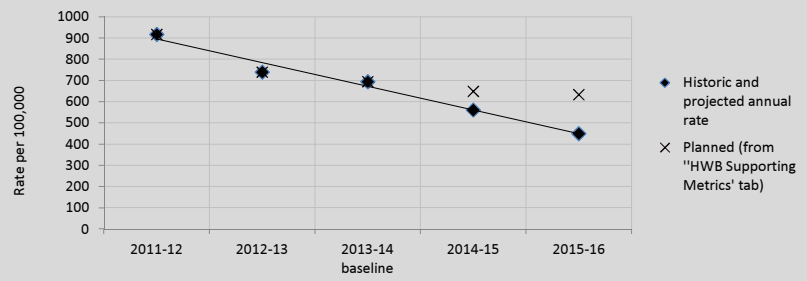


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*2,843.6*	*2,834.2*	*2,834.5*	*2,834.8*	*2,824.7*
	Numerator	*7,390*	*7,391*	*7,392*	*7,393*	*7,393*
	Denominator	*259,889*	*260,782*	*260,782*	*260,782*	*261,739*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

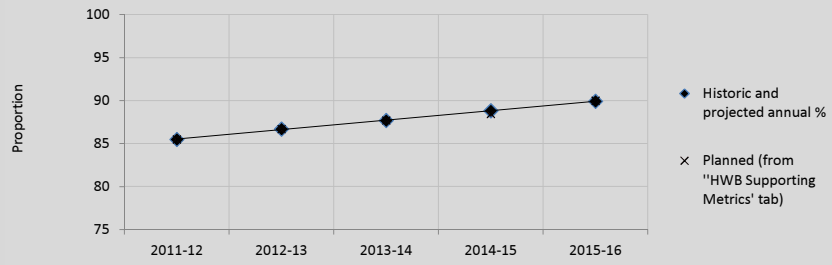
Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	917	740	695	*561*	*450*
	Numerator	415	345	325	*274*	*224*
	Denominator	45,130	46,645	46,645	*48,842*	*49,864*



This is based on a simple projection of the metric proportion.

Reablement

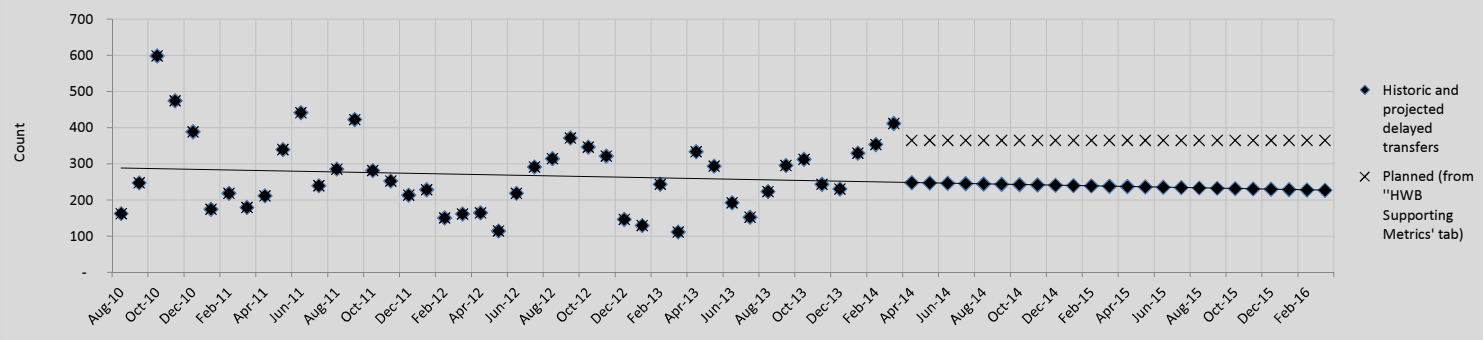
Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	85.5	86.7	87.7	*88.8*	*89.9*
	Numerator	120	110	115	*115*	*117*
	Denominator	140	130	130	*130*	*130*



This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic											
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	163	248	599	475	389	175	219	180	212	340	442	240



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*364.3*	*360.3*	*356.3*	*350.6*	*346.6*	*342.6*	*338.6*	*333.2*
	Numerator	*743*	*735*	*726*	*718*	*710*	*702*	*693*	*685*
	Denominator	*203,867*	*203,867*	*203,867*	*204,794*	*204,794*	*204,794*	*204,794*	*205,610*

* The projected rates are based on annual population projections and therefore will not change linearly

HWB Financial Plan

Date	Sheet	Cells	Description
28/07/14	Payment for Performance	B23	formula modified to *=IF(B21-B19<0,0,B21-B19)*
28/07/14	1. HWB Funding Sources	C27	formula modified to *=SUM(C20:C26)*
28/07/14	HWB ID	J2	Changed to Version 2
28/07/14	a	Various	Data mapped correctly for Bournemouth & Poole
29/07/14	a	AP1:AP348	Allocation updated for changes
28/07/14	All sheets	Columns	Allowed to modify column width if required
30/07/14	8. Non elective admissions - CCG		Updated CCG plans for Wolverhampton, Ashford and Canterbury CCGs
30/07/14	6. HWB supporting metrics	D18	Updated conditional formatting to not show green if baseline is 0
30/07/14	6. HWB supporting metrics	D19	Comment added
30/07/14	7. Metric trends	K11:O11, G43:H43,G66:H66	Updated forecast formulas
30/07/14	Data	Various	Changed a couple of 'dashes' to zeros
30/07/14	5. HWB P4P metric	H14	Removed rounding
31/07/14	1. HWB Funding Sources	A48:C54	Unprotect cells and allow entry
01/08/14	5. HWB P4P metric	G10:K10	Updated conditional formatting
01/08/14	5. HWB P4P metric	H13	formula modified to *=IF(OR(G10<0,H10<0,I10<0,J10<0),"",IF(OR(ISTEXT(G10),ISTEXT(H10),ISTEXT(I10),ISTEXT(J10)),"",IF(SUM(G10:J10)=0,"",(SUM(G10:J10)/SUM(C10:F10))-1)))*
01/08/14	5. HWB P4P metric	H13	Apply conditional formatting
01/08/14	5. HWB P4P metric	H14	formula modified to *=if(H13="","",-H12*J14)*
01/08/14	4. HWB Benefits Plan	J69:J118	Remove formula
01/08/14	4. HWB Benefits Plan	B11:B60, B69:B118	Texted modified

Appendix 6 - Better Care Fund Consultation and Communication Plan

Objective	Communication method used	Delivered by	Delivered to	Timescales	Feedback Mechanism	Progress
Consultation pre development of the plan						
Initial consultation to obtain individuals views regarding integrated support and care	Survey using the healthwatch database and survey monkey Semi structured interviews Report key findings from comments which relate to people who have used more than one service (Collected from July 13 – December 13)	Rotherham Healthwatch	Healthwatch members and individuals who have accessed the advocacy service and had experiences of poor care	Concluded on 24th January 2014	Reported to Task Group on 31st January 2014	**COMPLETE** – evaluation report submitted to RMBC and findings used to inform the development of the BCF action plan
Gather existing information available regarding provider, patient and service user experiences via previous: • Consultation exercises • Surveys • Case studies	RMBC - Annual ASCOF – Adult Social Care User Survey RMBC – Social Services Survey of Adult Carers Health and Wellbeing consultation RMBC Learning from customers - Complaints, compliments and lessons learnt	Tanya Palmowski and Claire Green (Performance and Quality Team) and Dominic Blaydon (CCG)	Providers, Services users, patients, carers, VCS,	Concluded 24th January 2014	Reported to task Group on 31st January 2014	**COMPLETE** – existing information available has been gathered and summarised and the findings have been included within the Better Care Fund consultation document. The findings have also been used to inform the development of BCF action plan

Appendix 6 - Better Care Fund Consultation and Communication Plan

	RMBC Local Account					
	Public Health - Health Inequalities consultation					
	RMBC - Staff consultation previously conducted with RMBC and Health staff to identify improvements to the hospital admission to discharge process					
	CCG – Patient Participation Network					
	Consultation on the CCG Commissioning Plan					
To consult with providers on a range of issues around better joined up working with Health.	Survey via survey monkey to be distributed via email	RMBC Commissioning Team	305 Health and adult social care providers	Concluded 28th January 2014	Reported to task Group on findings on 31st January 2014	**COMPLETE** – 40 providers responded
	Provider Focus Group –	RMBC Commissioning Team and Kate Green (Policy Officer)	Health and adult social care providers	Concluded 28th January 2014		**COMPLETE** – 9 providers attended
	Evaluation of findings	RMBC Commissioning and Kate Green (Policy Officer)		Concluded 29th January 2014		**COMPLETE** – the findings have been summarised and included within the BCF consultation document. The findings have also been used to inform the development of the BCF action plan

Appendix 6 - Better Care Fund Consultation and Communication Plan

Consultation with RMBC customer inspectors on the vision, priorities and experiences of health and social care	Surveys completed over the telephone	RMBC Tanya Palmowski and Claire Green (Performance and Quality Team)	RMBC Customer inspectors representatives	Took place between 20th–24th January. Analysis concluded 28th January 2014	Reported to task Group on findings on 31st January 2014	**COMPLETE** – The RMBC customer inspectors were asked various questions focussed around the proposed vision and obtain their views on what needs to change to improve services. The findings have been summarised and included with the BCF consultation documents and used to inform the development of the BCF action plan.
Rotherham Working Together event Rotherham wide consultation event led by the CCG. The aim of the day was to inform people about the work that is currently happening, and to consider the challenges that we will face in the future.	Community-wide engagement event	Health & Wellbeing Board Partner Agencies	150 members of the public and representatives of Rotherham agencies	16 July 2014	Widely disseminated	**COMPLETE -** Conclusions and responses to questions available on CCG website http://www.rotherhamccg.nhs.uk/engagement-events.htm.
Future Communication and engagement post development of the BCF Plan						
Communication and engagement with elected members on the BCF proposed actions, targets, I statements and case studies	This will be done via one of the following methods: • Elected member briefings • Member seminars	Tanya Palmowski and Claire Green (Performance and Quality) Dominic Blaydon (CCG)	Elected members	Following sign-off of the BCF plan post-September 2014	Comments received fed back to Operational Group and Task Group	

Appendix 6 - Better Care Fund Consultation and Communication Plan

Communication and engagement with staff on the BCF proposed actions, targets, I statements and case studies	This will be done via one of the following methods: • Intranet • Staff and Manager briefings • Manager briefing sessions	Tanya Palmowski and Claire Green (Performance and Quality) Dominic Blaydon (CCG)	RMBC and CCG staff and managers	Following sign-off of the BCF plan post-September 2014	Comments received fed back to Operational Group and Task Group	
Communication and engagement with members of the public, patients and service users on the BCF proposed actions, targets, I statements and case studies (using public 'case study' document produced	Website, electronic mail out, workshops, Patient Participation Groups, newsletters, service area user groups, Healthwatch, Area Assemblies, attendance at events	Tanya Palmowski and Claire Green (Performance and Quality) Dominic Blaydon (CCG)	Service users and patients Healthwatch members and individuals who were involved in previous BCF consultation and/or have accessed the advocacy service and had experiences of poor care	Following sign-off of the BCF plan post-September 2014	Comments received fed back to Operational group and Task Group	
Communication and consultation with health and social care providers on the implications of the BCF, Care Act and implementation of the co-produced action plan.	RMBC Shaping the Future of Care events	RMBC Commissioning	Social Care providers	Dates tbc	Outcomes reported to Operational Group and action leads	Initial meeting took place on 7 May 2014 which resulted in the co-produced action plan for the year.
Consultation with health providers on the implications of the BCF	Provider Focus Group	Dominic Blaydon	Health and Social Care providers	Dates tbc	Evaluation of findings to Task Group	

Appendix 6 - Better Care Fund Consultation and Communication Plan

Future Communication and engagement on specific Better Care Fund actions (Includes all planned activity from September 2014, this will continue to be added to as the plan progresses)						
BCF 06 – Social Prescribing Event to share initial findings of the pilot conducted	Event	CCG	TBC	26th September 2014	TBC	
BCF 01 – Mental Health	Recruitment of an Older Peoples Service user group as part of the process of ensuring that all anticipated benefits are being realised	CCG	TBC	TBC	TBC	
	Undertake an investigation into the experiences and expectations of people who use or may use a mental health liaison service This will build on the report completed on the statutory Child and Adolescent Mental Health Service.	Healthwatch	Mental Health Service Users	October – December 2014	TBC	
BCF15 – End of Life Care CCG revaluation event which will use a range of quantitative measures and patient and carer feedback to refine the project	Event	CCG	TBC	October 2014	TBC	

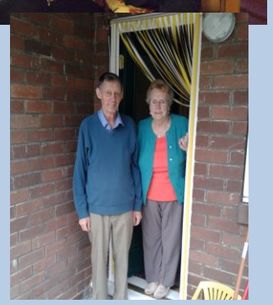
Appendix 6 - Better Care Fund Consultation and Communication Plan

BCF12 – Care Act	Attendance at regional Care Act conference feeding in comments from Rotherham Residents	Healthwatch	TBC	TBC	TBC	
	Feedback on the Care Act DoH regulations and guidance using Rotherham residents comments	Healthwatch	Safeguarding Carers and Adults	TBC	TBC	

WHAT WILL THE BETTER CARE FUND PLAN DELIVER FOR THE PEOPLE OF ROTHERHAM

Better Care Fund Targets:

- *More people will have been supported to live independently in the community and the number of people admitted into residential and nursing care will have reduced*
- *We will have increased the number of people who are still at home 91 days after hospital discharg*
- *The number of people who are unnecessarily delayed from being transferred from hospital back into the community will have reduced*
- *Avoidable admissions to hospital will continue to be reduced*
- *Emergency re-admissions within 30 days of discharge will have reduced*



Better Care Fund Actions:

- ***BCF01*** *- Increased community based preventative support for people with mental health needs*
- ***BCF02*** *- A preventative community based Falls Service which targets those most vulnerable and those most at risk*
- ***BCF03*** *- Increased access to and use of assistive technology to support people to live independently in the community*
- ***BCF04*** *- A joint health and social care Rapid Response Team, including out of hours, providing a direct route to community based services and reducing the need for hospital admissions*
- ***BCF05*** *- A 7-day a week joint community, social care and mental health service which is there to promptly support people back into the community who need to be discharged from hospital*
- **BCF06** *- Increased use of voluntary and community based services by GP's, reducing the need for individuals to access formal care services and supporting independence*
- ***BCF07*** *- Improved standards in residential and nursing care through the development of a joint quality assurance team*
- ***BCF08*** *- Improved customer pathways as a result of listening to their experiences, providing better preventative services to support more people in the community*
- ***BCF09*** *- Increased the use of personal health and care budgets to help more customers have choice and control about the support they receive*
- ***BCF10*** *- Provided Information and support to help people-self-manage their conditions and stay independent*
- ***BCF11*** *- Each person has a single, health and social care plan which means they need to only tell their story once*
- ***BCF12*** *- Social Care Services meet the new requirements and demands of the Care Bill to ensure that people of Rotherham are supported when they need it most*
- ***BCF13*** *- Joint health and social care services deliver the best outcomes for the people of Rotherham*
- ***BCF14*** *- Customers see that health and social care information about themselves is shared and supports them to receive a better joined up service*
- ***BCF15 –*** *Investment in enhanced community end of life care services by Rotherham Hospice*

WHAT WILL THE BETTER CARE FUND PLAN DELIVER FOR THE PEOPLE OF ROTHERHAM

Brian is a 65 year old man and lives alone in a rented property. Brian has recently retired under ill-health. He has suffered with bi-polar disorder for a number of years which affects his mood; sometimes he can feel very depressed whilst other times he is overactive. Brian's sister recognises that he is increasingly showing signs of depression so she takes him to see the GP.

Brian was referred to the Mental Health Liaison Team promptly by his GP to ensure he is supported early to prevent his health and wellbeing deteriorating and reaching crisis point. The service encourages Brian to be actively involved in his support plan which keeps him in control enabling him to manage his condition more effectively. Brian has a person held record which sets out his goals. Brian has a schedule of appointments with his support worker which encourages him to live independently and safely in the community. He is also supported to access a Personal Health Budget to meet his long term needs, giving him control over the care and support he receives. This prevents Brian from reaching crisis and ensures that his condition is managed in a way that promotes better quality of life.

Without intervention Brian would be prone to neglecting himself when feeling depressed. This would impact on his general health and wellbeing and quality of life. He would also become increasingly dependent on other crisis intervention services including the Police and A&E.

Brian said 'I am listened to and supported at an early stage to avoid *crisis.'*

Dorothy is 73 years of age and lives with her husband in their own property. Dorothy has recently suffered a number of falls due to dizziness. This has had a significant impact on the couple's quality of life and independence. At 11pm one evening Dorothy fell. Her husband knew to ring the out-of-hours number due to previously contacting Assessment Direct for information and advice.

The Rapid Response Team visits immediately to listen to both Dorothy and her husband's concerns. Dorothy's social care needs are assessed and it is recommended that she would benefit from some equipment to help her to move safely around the house. A number of referrals are made to specialist services to make sure Dorothy's health and wellbeing needs are met. This includes the GP for further tests to be undertaken to diagnose the cause of Dorothy's dizziness. A referral was also made to a team specialising in falls prevention - the community based Falls and Fracture Service due to her being at risk of future falls.

The specialist assessments resulted in Dorothy being provided medication to prevent her dizziness, a falls belt and several grab rails being installed around the house to help Dorothy to move safely and independently. Dorothy was also provided with Rothercare Alarm System to provide her and her husband with peace of mind and reassurance that support is just a call away. Dorothy received a 12 week exercise programme and information and guidance to prevent future falls and following this she attended a community exercise programme to help maintain her functional ability, strength and balance. Each intervention has prevented Dorothy from falling again and potentially being admitted to hospital.

Dorothy said 'I feel safe and am able to live independently where I choose.'

Emma is 42 years old and lives with her daughter who is her main carer. Emma has Multiple Sclerosis, which is a long term health condition. She was recently involved in a car accident. Emma was admitted to hospital to treat a broken leg and head injury. Emma is due to be discharged from the hospital back home.

The Social Care and Mental Health Community Team work 7 days a week to ensure Emma care and support needs will be met upon discharge from hospital. As Emma wishes to return home, the team recommends the Home Enabling Service. Emma is also referred to a specialist brain injury service.

Back home Emma receives support from the Home Enabling Service. The team helps Emma on a short term basis to mobilise safely and regain her confidence and independence. The Home Enabling Team and brain injury service recognise that Emma has ongoing care needs due to her brain injury and refer her for a social care assessment. Longer term social care support is provided to Emma through a jointly agreed support plan. This helps her maintain her independence and enable her to live at home, as she chooses. The brain injury service provides information and advice to Emma's carer to enable her to encourage Emma's recovery and provide practical day to day support at home. Without this intervention, Emma would have experienced a longer stay in hospital and as a result her long term health and quality of life could have been affected.

Emma said 'I am able to access information, advice and support

Harry is a full time Carer for his wife who suffers with dementia and has been feeling depressed and isolated. Harry is also worried about the couple's finances. This has meant that Harry has been making regular visits to the GP surgery as a coping mechanism.

Upon visiting the GP it was identified that Harry was at risk of a breakdown and the GP made arrangements for a Multi-disciplinary Team meeting (which includes various representatives including; GP, Voluntary Action Rotherham, Social Worker). The meeting resulted in Harry being provided with various information and advice about local support groups for those suffering with dementia and their careers and being signposted to financial support services.

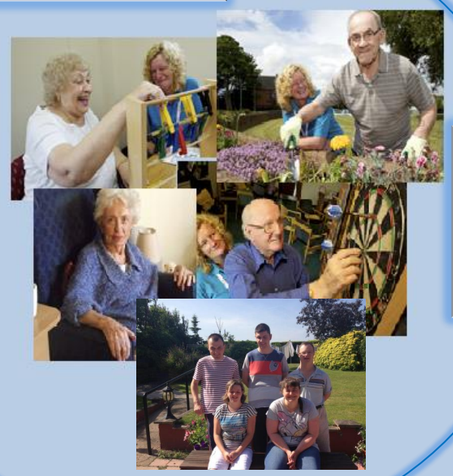
Harry and his wife now attend a regular dementia café and support sessions which have prevented them from feeling isolated and accessing formal care services. Harry also receives 3 hours respite a week, to allow him to socialise within the community and he no longer has concerns about their finances. Through the support received and self-help Harry and his wife have been able to stay independent and improve their health and wellbeing.

Harry stated 'I feel part of my community, which helps me to stay healthy and independent.'

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing' (BCF05, 08, & 12)

'I feel part of my community, which helps me to stay health and independent' (BCF06 & 10)

I am listened to and supported at an early stage to avoid a crisis' (BCF01 & 12)



'I am in control of my care' (BCF09, 10 & 11)

'I feel safe and am able to live independently where I choose' (BCF02, 04, 07 & 03)

'I only have to tell my story once' (BCF11, 13 &14)

Jackie is 35 and suffers from rheumatoid arthritis. Due to a long term condition Jackie spends a lot of time in hospital, which can last for several weeks. Jackie is at breaking point and wants to spend more time at home, managing her condition, so she contacts her GP for help.

Jackie's GP arranges for her to receive a joint health and social care assessment of her needs. During the assessment it is agreed that a personal health and care budget would provide Jackie with choice and control over the support she receives.

Jackie is involved in developing her support plan and provided with information regarding various local groups that could support her, to manage her condition. Discussions also take place regarding things that Jackie could do for herself, to reduce the support she requires, for example staying healthy.

Using the personal health and care budget, Jackie decided to appoint a personal assistant to support her with daily tasks and purchased a gym pass to improve her health and wellbeing. Jackie also attends a number of activities in her local community. Through involvement in self-managing her condition Jackie's health is significantly improved.

Jackie stated 'Through my personal health care budget I am in control of my care.'

George is 72 years of age and lives alone. George has diabetes and his health recently deteriorated, resulting in him being admitted to hospital. George is discharged from hospital and various support services are put in place.

Upon returning home George takes to his bed and is at risk of developing bed sores. The district nurse visits George and although she has never met him before, she has full access to his health and social care records and is able to make informed decisions regarding the treatments he requires.

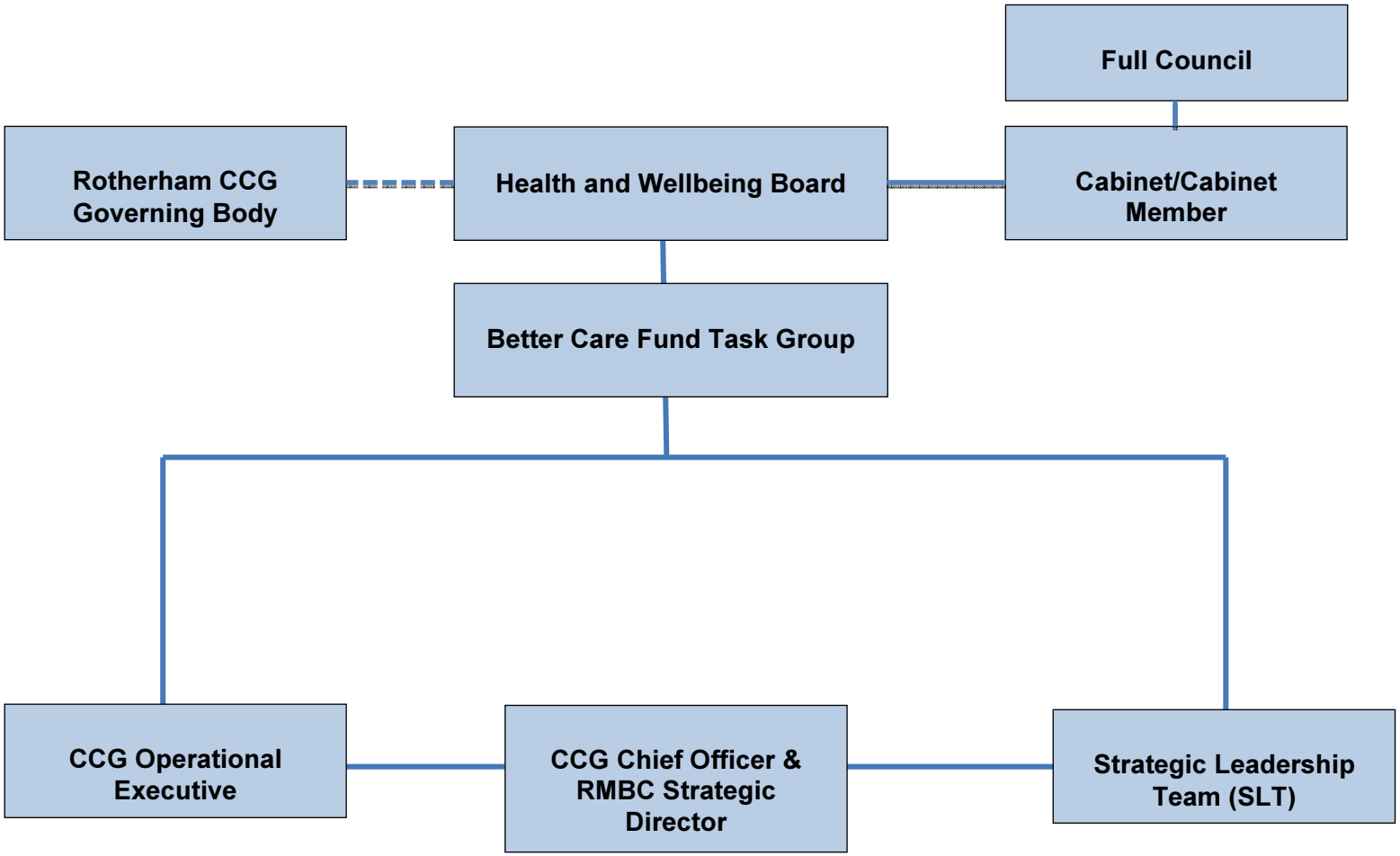
6 weeks after discharge, a Social Worker visits George to review his care and support. During the review George says that he would like more support to help him within the community and it is agreed that a direct payment would give him the flexibility required, giving him more choice and control. The Social Worker has access to all George's records and works with him to develop a support plan, to meet all his longer term health and social care needs. The Social Worker develops a person centred plan which includes self-care/management to help George manage his condition.

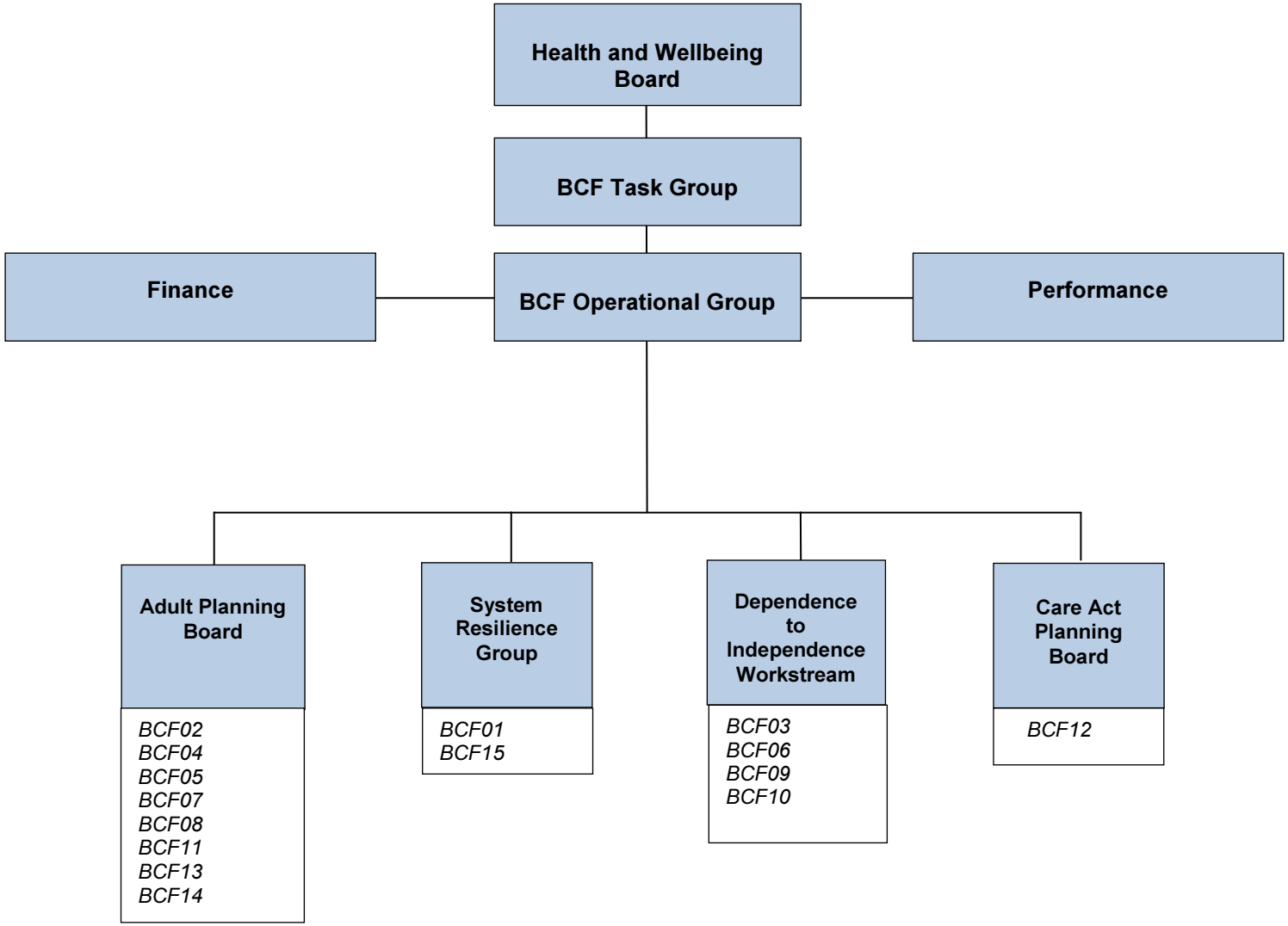
George now has a managed direct payment which is paid directly to a provider and receives both home care and community support to help him with shopping and visiting the local café. Through improved joint working and data sharing George's customer/patient experience is significantly improved. Health and Social Care staff were also able to deal with Georges needs in a more timely manner.

George stated 'I only had to tell my story once.'

BCF Appendix 10

Better Care Fund Governance Framework




Health and Wellbeing Board
BCF Task Group
Finance
BCF Operational Group
Performance
Adult Planning Board
BCF02
BCF04
BCF05
BCF07
BCF08
BCF11
BCF13
BCF14
System Resilience Group
BCF01
BCF15
Dependence to Independence Workstream
BCF03
BCF06
BCF09
BCF10
Care Act Planning Board
BCF12

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1	**Meeting:**	**Health and Wellbeing Board**
2	**Date:**	**1st October 2014**
3	**Title:**	**Social Care Support Grant 2014/15**
4	**Directorate:**	**Neighbourhoods and Adult Services**

5. Summary

This report provides information on the transfer to Rotherham MBC of the Social Care Support Grant. It provides details of the local allocation and sets out recommendations on how the allocation will be spent for the 2014/15 financial year. NHS England will transfer £6.166 million to Rotherham MBC. This includes an increase of £1.351m from 2013/14.

Payment of the Social Care Support Grant is to be made via an agreement under Section 256 of the 2006 NHS Act. The agreement will be administered by the NHS England Area Team (not the Rotherham Clinical Commissioning Group). Funding from NHS England will only pass over to local authorities once the Section 256 agreement has been signed by both parties.

Social Care Support Grant must be used to support adult social care services that deliver a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.

Guidance relating to the Social Care Support Grant requires NHS England to ensure that the local authority agrees with its local health partners on how the funding is best used. Health and Wellbeing Boards will be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent.
In line with their responsibilities under the Health and Social Care Act, NHS England will make it a condition of the transfer that RMBC and RCCG have regard to the Joint Strategic Needs Assessment for their local population. NHS England will also make it a condition of the transfer that RMBC demonstrate show the funding transfer will make a positive difference to service users.

From 2015/16 this grant and all services commissioned with it will be incorporated into the Better Care Fund. This fund will be overseen by a robust joint governance framework which supports achievement of the following metrics

- Reduction in emergency admissions
- Reduction in delayed transfers of care from hospital
- Proportion of older people still at home 91 days after hospital discharge into rehabilitation
- Number of readmissions to hospital within 30 days of discharge

6. Recommendations

That the Health and Wellbeing Board:

- **Agree to the programme of expenditure set out in Section 8**
- **Agree to the development of a light-touch performance framework for the grant**

7. Proposals and details

It is proposed that the Social care Support Grant be used to support existing services and transformation programmes, where such services or programmes are of benefit to the wider health and care system. The funding will support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

NHS England will ensure that the CCGs and local authority take a joint report to the Health and Wellbeing Board to agree what the funding will be used for, any measurable outcomes and the agreed monitoring arrangements in each local authority area.

As part of the S256 agreement, NHS England will ensure that it has access to timely information (via Health & Wellbeing Boards) on how the funding is being used locally against the overall programme of adult social care expenditure, in order to assure itself that the conditions for each funding transfer are being met.

It is proposed that funding focuses on the following key areas.

- Additional short term residential care places, or respite and intermediate care.
- Increased capacity for home care support, investment in equipment, adaptations and telecare.
- Investment in crisis response teams and preventative services to avoid hospital admission.
- Further investment in reablement services, to help people regain their independence

8. Finance

Appendix 1 sets out the proposed spending programme for 2014/15.

9 Risks and Uncertainties

The key risks associated with the Social care Support Grant funding are;

- That the funding is subject to annual review so could reduce in future years
- Difficulties in measuring health outcomes

10. Policy and Performance Agenda Implications

There is no requirement to develop a performance framework for this funding. However national guidance does stipulate that investment should focus on health outcomes. It is proposed that the Health and Well Being Board endorse the development of a light-touch performance management framework for this grant, overseen by the Adult Partnership Board

11 Contacts

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Title: Head of Long Term Conditions and Urgent Care
Organisation Rotherham CCG
Tel: 01709 302 131

Appendix 1: Proposed Spending Programme – Social Care Support Grant

Social Care Grant 2014-15	£000s
Interim Care beds	100
Community based support - home care/re enablement	500
Therapy staff x 2	100
Social workers in A & E	180
Expand fast response service	220
2 SSO reviewing officers to fast track assessments during re enablement	98
Fast response Nursing team	60
Home improvement agency (HIA)	60
Provision of residential short term or respite care for older people to avoid hospital admission or speed up discharge.	115
Learning Disabilities independent sector residential care	582
EMI Day Care	100
Social Workers in GP Practices	100
Mental Health - To promote early discharge from hospital into specialist rehabilitative care to enable access to community based services.	150
PDSI -Community support including Direct Payments/ Personal Budgets	220
To provide additional home care/supported living through Direct payments/Self Directed Support.	734
Older People - Pressures on Domiciliary Care Budgets	380
Learning Disabilities - increase in demand for Direct Payments	314
Mental Health - Increased Drug and Alcohol Community based rehabilitation	59
Development of specialist supported living scheme for people with a learning disability	46
Develop community based dementia care service	100
Investment into specialist community based support for people with a learning disability	37
Further Investment into Intermediate Care	560
Transitional placements from Childrens to Adults	400
Additional demand for Direct Payments	375
Additional provision of Domiciliary/Enabling Care	376
Care Bill Preparation	200
Total Social Care Grant	6,166

Health and Wellbeing Strategy Reporting Framework

Priority 1 - Smoking

High level aspiration - Rotherham: a smoke free town

Goal 1 - Preventing initiation of tobacco use amongst children and young people

	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
Key Measure	Percentage smoking at delivery 20.1% (12/13 Qtr 2) to below the national average by 2015	20.8%	19.2%	19.1%	A	19.9%	17.9%	R	Q4 13/14	19.3%	17.9%	R	16.7%	Alison Iliff
	Percentage of young people (Year 7 & 10) smoking (CYPS lifestyle survey) (regular smokers)	2%/14%	2%/14%	No target		1%/9%	1.9%/13.5%	G	2013	1%/9%	See notes		1.8%/13%	Alison Iliff

	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
Quarterly Proxy Measure	Participation in Responsible Retailer Scheme in CAP areas	New Measure for 2013-14				50%	50%	G	01-04-14 to 31-07-14	50%	50%	G	75%	Alan Pogorzelec
	Number of enforcement interventions taken in relation to the sale of tobacco to children	New Measure for 2013-14				5	5	G	01-04-14 to 31-07-14	0	0	G	5	Alan Pogorzelec
	Schools with anti-tobacco policies approved by Head	New Measure for 2013-14				55%	50%	G	Q4 13/14	55%	50%	G	100%	Alison Iliff

Goal 2 - Reducing Harm to Adults from tobacco consumption

	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
Key Measure	Percentage of adults 18 and over smoking (integrated household survey)	23.3%	22.7%	N/A	N/A		22%		2012	22.7%	23%	G	22%	Alison Iliff

	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts						75%						100%	
	Participation in Responsible Retailer Scheme in CAP areas	New Measure for 2013-14				50%	50%	G	01-04-14 to 31-07-14	50%	50%	G	75%	Alan Pogorzelec
	Number of enforcement interventions taken in relation to illicit and / or counterfeit tobacco	New Measure for 2013-14				8	5	G	01-04-14 to 31-07-14	6	4	G	5	Alan Pogorzelec

Priority 1 - Smoking

General A new tobacco control programme has been commissioned to begin in April 2014 comprising a new Doncaster and Rotherham Smokefree Service, smoking in pregnancy support further embedded within midwifery, enhanced enforcement of illicit tobacco and age of sale legislation, youth prevention activity and social marketing for tobacco control across Rotherham, Doncaster and Sheffield. Performance of the new services will be monitored against service specifications and nationally collected data.

Goal 1 **KM 1 (smoking at delivery)**

Baseline data may be affected by high percentage where mother's smoking status not known (quarters Q1 and Q2 2011/12)
Targets adjusted to match national ambition decrease of 21.7% between 2009/10 and 2014/15 (to be achieved between Q3 2010/11 and 2014/15) (31/05/13)(AI)
Quarterly position shows high variation, so suggest notice is predominently taken of outturn figure.
Smoking at delivery rates have risen slightly during 2013/14, when we would have anticipated a continued fall. There are number of factors which could have influenced this including: transition of service from the stop smoking service to midwifery, specialist midwife sickness during Q4 affecting capacity, inaccurate recording of smoking at delivery status and uncertainty of midwifery staff about how to record smoking status of women who switch to electronic cigarettes during pregnancy.
New systems have been put in place since the team has moved to midwifery, including electronic booking of stop smoking appointments by community midwives, clinic lists and text appointment reminders. An audit of smoking at booking and smoking at delivery recording is planned as this is has been shown to be inaccurate in other areas in Yorkshire and Humber, with appropriate follow-up dependent upon results.

KM 2 (young people smoking)

Data shown as Y7/Y10. Baseline represents 2011 Survey data, 2012-13 represents 2012, and 2013-14 and Current Position represents 2013. Survey is conducted and reported annually.
When information issued about data collection mechanism for PHOF indicator "Smoking at age 15", this KM will be amended.

QPM 3 (anti-tobacco policies)

New measure for 2013-14. Whole school review audit used to establish baseline of schools with policies. As at quarter 4 2013-14 this was 55%.
Denominator = 120 schools (24/06/13). Denominator figure = 120 schools (Primary – 95 LA and 3 Academies, Special 6 LA, Secondary 11 LA and 5 Academies). (AI)
Work is continuing to contact schools without up to date whole school reviews, to ask if they have a smoke free policy. If the answer is no, we are sending the Rotherham Healthy Schools model smoke free policy for their information and asking if they would adapt it for their own use.

Goal 2 **KM 1 (adults smoking)**

2011-12 represents 12 months April 11-Mar 12. 2012-13 and Current Position represent Jan-Dec 2012.

QPM 1 (making every contact count)

Under development.

Goal 1 - QPM 3	**13/14**			**14/15**						
Trajectory for schools with no-smoking policies:	Q2	Q3	Q4	Q1				Q2	Q3	Q4
	40%	45%	50%	65%				72%	90%	100%

Priority 2 - Alcohol

High level aspiration - Rotherham: a place where people drink responsibly

Goal 1 - Preventing harm to children and young people from alcohol consumption

	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
Key Measure	Percentage of Year 10s reporting that they drink alcohol (CYPS Lifestyle Survey) (regular drinkers)	30%	12%				0%		2013	11%			0%	Kay Denton

	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts													
	Community Alcohol Partnerships across the Borough	New Measure for 2013-14						No target	Q3 13/14	2	No target	A	11	Mel Howard
	Participation of retailers in Responsible Retailer scheme in CAP areas	New Measure for 2013-14				50%	50%	G	01-04-14 to 31-07-14	50%	50%	G	75%	Alan Pogorzelec

Goal 2 - Reducing Harm to Adults from alcohol consumption

	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
Key Measure	Reduce hospital admissions due to alcohol related illness		1,069	No target		1,162	1,069	R	Q1 14/15	345	214	R	20% less	Anne Charlesworth

	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts													
	Community Alcohol Partnerships across the Borough	New Measure for 2013-14					No target		Q3 13/14	2	No target	A	11	Mel Howard
	Participation of retailers in Responsible Retailer scheme in CAP areas	New Measure for 2013-14				50%	50%	G	01-04-14 to 31-07-14	50%	50%	G	75%	Alan Pogorzelec
	Number of FPN waivers which result in attendance at binge drinking course		86	No target		55			Q1 14/15	10	No target	R		
	Number of brief interventions in general practice		8,749	No target		29,424	12,000	G	Q1 14/15	5,720	4,000	G	16,000	Anne Charlesworth
	Number of brief interventions in community settings (Lifeline plus Health Trainer statistics)	2,673	3,192	No target		5,111	4,000	G	Q1 14/15	1,826	2,000	A	8,000	Anne Charlesworth
	Number of brief interventions in hospital settings													Anne Charlesworth

Priority 2 - Alcohol

Goal 1 **KM 1 (Year 10s reporting drinking)**

Represents those reporting drinking regularly. Baseline represents 2011 Survey data and 2012-13 represents 2012 Survey data. Survey is conducted and reported annually.
The 2011 baseline figure of 30% was set before the category of 'social/infrequent' was added to the question on frequency of drinking in 2012;
'regular' was classed as 'at least once per week' to be able to compare with national survey data (In 2012 Rotherham was 12% compared to 11% for England)
In the 2014 Rotherham Lifestyle survey it has been suggested that the alcohol question mirrors the national categories to compare them more accurately.
As it is **not** against the law to drink alcohol if you're age 5 or over , the target of 0% could be considered a little unrealistic/ambitious and one set to fail;

perhaps we should aim to try to reduce the % of young people drinking to be equal or lower than the national average, which may be still be challenging.

QPM 2 (community alcohol partnerships)

A full analysis of the 2 pilot CAPs will be undertaken in the summer. As an alternative to further CAP's an alcohol toolkit is in its draft format to be shared across the borough.

Goal 2 **KM 1 (hospital admissions due to drinking)**

Data represents number of admissions to Rotherham Foundation Trust by Rotherham CCG patients.

The team to deliver this piece of work has now been selected, work was scheduled to begin in October/November but this was delayed until quarter 4.

Due to the late start to the work the 2013-14 target was adjusted to maintain 2012-13 level with the 20% reduction set as the 2014-15 target.

Although the metrics for the project are not demonstrating reductions in admissions overall, reductions for the cohort of 3+ admitters are now in evidence, and length of stay is significantly reduced. The CCG will be reviewing this scheme in October.

QPM2 (community alcohol partnerships)

(see Goal 1 QPM2)

QPM 4 (Fixed Penalty Notice waivers)

(At Q2) This figure has dropped significantly. SYP are aware and agreed to take steps to improve awareness across borough. From December SYP will also use conditions on cautions to ensure those with alcohol related offending engage in the education workshop.

(At Q3) Although there is an increase on previous quarter SYP are continuing to promote this action within all settings.

QPM 5 (brief interventions in general practice)

This is a significant increase, the contract specifications changed from 1/4/2013 to 'any' patient aged 18 or over (from specified diagnosis group).

Q1 + Q2 = Year Target exceeded. Please also note due to late submissions quarter 1 figure now stands at 7,263.

QPM 6 (brief interventions in community settings)

Community brief interventions includes Lifeline and Health Trainer provision - in 2012-13 this was 1952 and 1240 respectively.

Its anticipated that this will hit target within quarter 4 - the new service specification came into place in November 2013.

QPM 7 (brief interventions in hospital settings)

The team to deliver this piece of work has now been selected, work will begin in October/November.

Brief Interventions carried out by the Alcohol Liaison Service will be available from Q4 onwards.

After consideration, it was decided that Best Bar None would not be progressed as responsible retailer should do the same job without the cost that is incurred.

Priority 3 - Obesity

High level aspiration - Rotherham: a place where being a healthy weight is the norm

Goal 1 - Preventing obesity in children and young people

	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
Key Measure	Percentage of overweight and obese children in Reception	16.1%	22.2%			2013-14 due Dec 2014			2012/13	22.2%		R	12%	Joanna Saunders
Key Measure	Percentage of overweight and obese children in Year 6	33.0%	35.2%			2013-14 due Dec 2014			2012/13	35.2%		R	25%	Joanna Saunders
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts													
Quarterly Proxy Measure	Referrals of children to Healthy Weight Framework interventions	313	286	No target		N/A			Q3 13/14	99	No target	G		Joanna Saunders
Quarterly Proxy Measure	Completed Healthy Weight Framework interventions by children	144	119	No target		N/A			Q3 13/14	54	No target	G		Joanna Saunders
Quarterly Proxy Measure	Percentage of applications for fast food outlets approved that are within close proximity to a school or in a deprived area (in accordance with policy)													Helen Sleigh

Goal 2 - Reducing harm to adults from obesity

	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
Key Measure	Healthy eating prevalence (Integrated Household Survey/ Active People Survey)	21.3%	No further data. Indicator replaced by 'Excess weight in Adults' in Local Authority Health Profiles						2011-12	21.3%	28.7%	R		Joanna Saunders
Key Measure	Increased prevalence of diagnosed diabetes	6.20%	6.35%			2013-14 due Oct14			2012-13	6.35%	No target	G		Dominic Blaydon
Quarterly Proxy Measure	Percentage of key public sector staff undertaking Making Every Contact Counts													
Quarterly Proxy Measure	Referrals of adults to Healthy Weight Framework interventions	2884	2253	No target		N/A			Q3 13/14	389	No target	A		Joanna Saunders
Quarterly Proxy Measure	Completed Healthy Weight Framework interventions by adults	1414	1067	No target		N/A			Q3 13/14	172	No target	A		Joanna Saunders
Quarterly Proxy Measure	Increased greenspace utilisation and access	13.7%	10.1%			Due late 2014	15%		2012-13	10.1%		A	16%	Chris Siddall

Priority 3 - Obesity

Goal 1 **KM1 &2 (overweight and obese children)**

Data published annually in December.

QPM 2/QPM 3 (Healthy Weight Framework interventions)

Activity figures presented are enrolments and completions. The latter is a subset of the former and the duration of the treatment may go beyond the reporting cut-off.

Quarter 4 2013/14 figures are incomplete.

QPM 4 (fast food outlets)

Planning policy relating to this is currently out for consultation.

Goal 2 **KM 1 (healthy eating)**

Baseline represents modelled data for 2006-2008 based on Health Survey for England data.

'Diet' Indicators being developed nationally for Public Health Outcomes Framework on which target can be set.

One indicator planned to be similar to 'healthy eating prevalence'. Data to be collected via the Active People Survey from late 2014 and hoped to be published Feb or May 2015.

KM 2 (diagnosed diabetes)

Prevalence data published annually. This is ranked green from the view that practices are identifying people with diabetes.

QPM 2/QPM 3 (Healthy Weight Framework interventions)

Activity figures presented are enrolments and completions. The latter is a subset of the former and the duration of the treatment may go beyond the reporting cut-off.

Quarter 3 numbers are traditionally low for adults. Quarter 4 2013/14 figures are incomplete.

QPM 4 (greenspace utilisation)

Baseline represents survey period March 2009 - February 2012. Indicator is based on annual survey data

2012-13 represents period March 2012 - February 2013.

Priority 4 - NEET

High level aspirations outcome - Our commitment is that by 2016 all Rotherham's young people will participate in education or training up to the age of 18.

Goal 1 - Reduce percentage of Academic Age 16 - 18 Young People who are Not in Employment, Education or Training (NEET)

Key Measure	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
	Percentage of Academic Age 16 - 18 Young People who are NEET	7.6%	7.4%	7.1%	A	6.4%	7.1%	G	July 2014	6.6%	7.0%	G	7.0%	Collette Bailey

Goal 2 – Reduce percentage of Academic Age 16 - 18 Young People whose current situation is Not Known

Key Measure	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
	Percentage of Academic Age 16 - 18 Young People whose current situation is Not Known	4.8%	3.9%	5.0%	G	5.6%	5.0%	A	July 2014	4.6%	5.0%	G	5.0%	Collette Bailey

Goal 3 – Increase percentage of Young People Participating (reporting to commence April 2013)

Key Measure	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
	Percentage of Academic Year 12 participating	89.0%	N/A	N/A	N/A	95.4%	92.0%	G	July 2014	93.7%	90.0%	G	95.0%	Collette Bailey
	Percentage of Academic Year 13 participating	80.0%	N/A	N/A	N/A	86.5%	82.0%	G	July 2014	85.5%	83.0%	G	85.0%	Collette Bailey

Goal 4 – Reduce percentage of RMBC Corporate Responsibility LAC/CL Young People (Academic Year 12 -14) who are Not in Employment, Education or Training (NEET)

Key Measure	Indicator	2011-12 Baseline	2012-13			2013-14			Current Position				2014-15 Target	Accountable Lead
			Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG		
	Percentage of RMBC Corporate Responsibility LAC/CL Young People (Academic Year 12 -14) who are NEET	28.0%	25.3%	N/A	N/A	26.9%	24.0%	A	July 2014	27.9%	24.0%	R	20.0%	Collette Bailey

Priority 4 - NEET

Goal 1/2 **KM1 (NEET/ Young people whose situation is not known)**

2011-12 Baseline is the 2011/12 reported data and Outturn 2012-13 is the 2012 reported data (Nov-Jan averages)(from DfE)

Goal 2 The tracking of young people is posing a problem nationally for all authorities as it is such a resource intensive exercise.

Goal 3 **KM 1&2 (academic year 12/13 participating)**

Baseline taken from the Annual Activity Survey for 2012.

Targets are profiled on a monthly basis to take into consideration the seasonal trends associated with academic years etc.

The annual targets are taken as an average over November, December and January as per DoE expectations that this is when destination data nationally is at it's most robust.

Towards the end of academic years ((ie, June, July, August) participation reduces as 1 year courses come to an end in colleges etc and this has a knock on effect on NEET and and Not Known as we work with young people to clarify their progression routes.

Goal 4 **KM 1 (RMBC corporate responsibility NEET)**

This cohort comprises 29 individual young people, of whom 22 (76%) are aged 18 and 19. This age group are able to claim benefit in their own right, and live independently, therefore are an extremely hard group to engage in any form of learning. We, as a service, are endeavouring to work more closely with Job Centre Plus to provide a more coherent approach to this group.

A further 1 (3%) is of Y13 academic year, and has recently left an EET training programme.The service is currently trying to reengage and support the young person. The remaining 6 (21%) have all recently left compulsory education and have a range of complex needs. One young person in this group is resident outside the Rotherham area but are still being supported by the service, one is a Teenage parent, one is Not yet ready for work or learning, one has never engaged despite persistent attempts, whilst the other 2 are currently engaging with the service and moving towards a learning outcome.

(see also Goal 3 re Targets)

NB - DoE changed the count for NEET as at April 2013 - currency will no longer apply and therefore the adjustment set to NEET % has been amended.

This is projected to inflate the NEET % by approximately 1%.

Participation is defined as

- full-time education, such as school, college or home education
- an apprenticeship
- part-time education or training if they are employed, self-employed or volunteering full-time (which is defined as 20 hours or more a week).

Priority 5 - Fuel Poverty														
High level aspiration - Everyone in Rotherham can afford to keep warm and keep well														
Goal 1 - Reducing the effects of Fuel Poverty														
			2012-13			2013-14			Current Position					
	Indicator	2010 Baseline	Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG	2014-15 Target	Accountable Lead
Key Measure	Percentage of the population needing to spend more than 10% of household income to achieve adequate levels of warmth in the home and meet their other energy needs.	18.2%	Data Released in 2014						01/01/2011-31/12/2011	16.7%	17.2%	G		Catherine Homer
			2012-13			2013-14			Current Position					
	Indicator	2011-12 Baseline	Outturn	Target	RAG	Outturn	Target	RAG	Period	Outturn	Target	RAG	2014-15 Target	Accountable Lead
Quarterly Proxy Measure	The number of properties receiving energy efficiency measures through Community Energy Saving Programme (CESP)		1,049	1,285	R	1,162	1,285	R	Superceded by GD/ECO					
	The number of properties receiving energy efficiency measures through Carbon Emissions Reduction Target (CERT)		1%	1%	G	CERT schemes have come to an end (31st March 2013) and have been superseded by Green Deal / ECO								
	The number of properties receiving energy efficiency measures through Dept of Energy & Climate Change (DECC)	To be delivered July 2013 onwards				68	65	G	01/04/2014-31/07/2014	27	25	G	252	
	The number of properties receiving energy efficiency measures through Green Deal / Energy Company Obligation (ECO)	1st year of collection anticipated in 4th quarter 2013-14				5,140			2013/14	5,140				

Priority 5 - Fuel Poverty

Goal 1 **KM 1 (spending more than 10% of household income to keep home warm)**

Current Position represents 2011 calendar year. Baseline represents 2010 calendar year.

QPM 1 (energy efficient measures through CESP)

Funding available to Utility Providers, ear-marked for 2012-13, was rolled over into 2013-14. The anticipated target of 1,285 will not be met as CESP has come to an end.

The reason for not meeting the target was because Utility Providers had made the required carbon savings on other earlier national schemes.

QPM 3 (Properties receiving DECC funded works)

It was anticipated that by the end of 2014/15 320 properties would benefit from works. The outturn for 2013/14 was 68 properties receiving measures, leaving a 2014/15 target of 252 properties with 27 delivered upto 31/07/2014. The remaining 225 properties are anticipated to be completed by 31st March 2015.

Currently there are 276 properties which have been identified as being suitable to receive measures and depending on take-up, an additional 556 (in two additional mail shots) will be targeted to meet any shortfall, budget depending.

QPM 4 (energy efficient measures through Green Deal/ECO)

Public Health Outcomes Framework Scorecard – August 2014 update

Overarching indicators

Public Health Outcomes

Update published: 05-August-2014

Position Key: (compared to England) — Better; Average; Worse; Not compared; Lower; Higher

Trend Key: Improving; Stable; Worsening; Increasing; Decreasing

Indicator	Period	Value	Lower CI	Upper CI	Count	Denom	Sex	Age	Position	Trend	Note
0.1i - Healthy life expectancy at birth	2010 - 12	58.5	56.8	60.1		379,282	Male	All ages			Updated
0.1i - Healthy life expectancy at birth	2010 - 12	60.3	58.6	62.0		393,679	Female	All ages			Updated
0.1ii - Life Expectancy at birth	2010 - 12	78.0	77.6	78.4		379,282	Male	All ages			
0.1ii - Life Expectancy at birth	2010 - 12	81.6	81.3	82.0		393,679	Female	All ages			
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area	2010 - 12	8.9	6.8	10.9		379,282	Male	All ages			
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area	2010 - 12	6.4	4.1	8.6		393,679	Female	All ages			
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	2010 - 12	-1.2	-1.6	-0.8			Male	All ages			
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	2010 - 12	-1.4	-1.7	-1.0			Female	All ages			

Improving the wider determinants of health

Indicator	Period	Value	Lower CI	Upper CI	Count	Denom	Sex	Age	Position	Trend	Note
1.01i - Children in poverty (all dependent children under 20)	2011	22.6	22.3	23.0	13,205	58,360	Persons	0-19 yrs			
1.01ii - Children in poverty (under 16s)	2011	23.2	22.9	23.6	11,525	49,610	Persons	<16 yrs			
1.02i - School Readiness: The percentage of children achieving a good level of development at the end of reception	2012/13	55.7	54.0	57.4	1,843	3,308	Persons	5 yrs			(1)
1.02i - School Readiness: The percentage of children with free school meal status achieving a good level of development at the end of reception	2012/13	39.9	36.3	43.7	272	681	Persons	5 yrs			(1)
1.02ii - School Readiness: The percentage of Year 1 pupils achieving the expected level in the phonics screening check	2012/13	62.5	60.7	64.1	1,966	3,148	Persons	6 yrs			(1)
1.02ii - School Readiness: The percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	2012/13	47.8	44.1	51.5	330	691	Persons	6 yrs			(1)
1.03 - Pupil absence	2012/13	5.9	5.7	6.2	763,158	12,879,236	Persons	5-15 yrs			Updated
1.04 - First time entrants to the youth justice system	2013	535	447	632	134	25,019	Persons	10-17 yrs			Updated
1.05 - 16-18 year olds not in education employment or training	2013	6.4	5.9	6.9	620	9,714	Persons	16-18 yrs			Updated
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2012/13	76.2			555	730	Persons	18-64 yrs			
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2012/13	77.0			335	435	Male	18-64 yrs			
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	2012/13	75.0			220	295	Female	18-64 yrs			
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation	2012/13	78.5			845	1,075	Persons	18-69 yrs			
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation	2011/12	63.6			410	640	Male	18-69 yrs			
1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation	2011/12	66.1			305	460	Female	18-69 yrs			
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	2012	6.0					Persons	16-64 yrs			
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	2011/12	61.3					Persons	18-64 yrs			
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	2012/13	60.8					Persons	18-69 yrs			
1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week	2009 - 11	2.9	2.1	4.0		1,367	Persons	16+ yrs			(1)
1.09ii - Sickness absence - The percent of working days lost due to sickness absence	2009 - 11	2.3	1.7	3.2		5,612	Persons	16+ yrs			(1)
1.10 - Killed and seriously injured casualties on England's roads	2010 - 12	29.7	26.0	33.9	230	773,148	Persons	All ages			
1.11 - Domestic Abuse	2012/13	27.1	26.7	27.4			Persons	18+ yrs			
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	2010/11 - 12/13	75.2	69.1	81.5	583	772,961	Persons	All ages			
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	2012/13	7.6	7.2	7.9	1,950	257,700	Persons	All ages			
1.12iii- Violent crime (including sexual violence) - Rate of sexual offences per 1,000 population	2012/13	.54	.46	.64	140	257,700	Persons	All ages			

Improving the wider determinants of health (continued)

Indicator	Period	Value	Lower CI	Upper CI	Count	Denom	Sex	Age	Position	Trend	Note
1.13i - Re-offending levels - percentage of offenders who re-offend	2011	26.3	24.6	28.0	672	2,557	Persons	All ages			
1.13ii - Re-offending levels - average number of re-offences per offender	2011	.67	.64	.71	1,723	2,557	Persons	All ages			
1.14i - The percentage of the population affected by noise - Number of complaints about noise	2011/12	8.7	8.4	9.1	2,245	257,716	Persons	All ages			
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	2011	3.9			10,070	257,280	Persons	All ages			Updated
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	2011	7.5			19,330	257,280	Persons	All ages			Updated
1.15i - Statutory homelessness - homelessness acceptances	2012/13	1.2	1.0	1.4	132	109,000	n/a	n/a			
1.15ii - Statutory homelessness - households in temporary accommodation	2012/13	.21	.13	.32	23	109,000	Persons	All ages			
1.16 - Utilisation of outdoor space for exercise/health reasons	Mar 2012 - Feb 2013	10.1	5.8	14.3		241	Persons	16+ yrs			
1.17 - Fuel Poverty	2012	9.8	9.7	10.0	10,895	110,778	Persons	All ages			Updated
1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	2012/13	39.5	34.9	44.1		385	Persons	18+ yrs			
1.18ii - Loneliness and Isolation in adult carers	2012/13	53.2	48.3	58.1		330	Persons	All ages			(1)

Health improvement

Indicator	Period	Value	Lower CI	Upper CI	Count	Denom	Sex	Age	Position	Trend	Note
2.01 - Low birth weight of term babies	2011	3.5	2.9	4.3	98	2,794	Persons	>=37 weeks gestational age at birth			
2.02i - Breastfeeding - Breastfeeding initiation	2012/13	58.5	56.7	60.3	1,713	2,928	Female	All ages			
2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth	2012/13	29.7	28.1	31.3	914	3,079	Persons	6-8 weeks			
2.03 - Smoking status at time of delivery	2012/13	19.2	17.8	20.7	563	2,928	Female	All ages			
2.04 - Under 18 conceptions	2012	30.0	25.3	35.3	144	4,797	Female	<18 yrs			
2.04 - Under 18 conceptions: conceptions in those aged under 16	2012	6.8	4.6	9.6	32	4,730	Female	<16 yrs			
2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds	2012/13	22.2	20.8	23.6	709	3,199	Persons	4-5 yrs			
2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds	2012/13	35.2	33.5	37.0	989	2,807	Persons	10-11 yrs			
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	2012/13	102.3	93.3	111.9	473	46,247	Persons	<15 yrs			
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	2012/13	126.0	109.3	144.7	202	16,026	Persons	0-4 yrs			
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24)	2012/13	117.9	106.2	130.6	370	31,376	Persons	15-24 yrs			
2.08 - Emotional well-being of looked after children	2012/13	15.2				180	Persons	5-16 yrs			
2.12 - Excess Weight in Adults	2012	65.3	60.5	70.1	422	647	Persons	16+ yrs			(1)
2.13i - Percentage of physically active and inactive adults - active adults	2013	48.9	44.6	53.3	247	504	Persons	16+ yrs			Updated
2.13ii - Percentage of active and inactive adults - inactive adults	2013	34.4	30.3	38.6	178	504	Persons	16+ yrs			Updated
2.14 - Smoking Prevalence	2012	22.7	20.5	24.8		1,450	Persons	18+ yrs			
2.14 - Smoking prevalence - routine & manual	2012	30.5	26.0	35.1		392	Persons	18+ yrs			
2.15i - Successful completion of drug treatment - opiate users	2012	5.5	4.3	7.0	63	1,148	Persons	18-75 yrs			
2.15ii - Successful completion of drug treatment - non-opiate users	2012	42.6	35.7	49.9	78	183	Persons	18-75 yrs			
2.17 - Recorded diabetes	2012/13	6.4	6.3	6.5	13,139	206,476	Persons	17+ yrs			(2)
2.18 - Alcohol related admissions to hospital	2012/13	704	671	738	1,758	258,352	Persons	All ages			
2.19 - Cancer diagnosed at early stage (Experimental Statistics)	2012	34.4	31.5	37.3	358	1,042	Persons	All ages			
2.20i - Cancer screening coverage - breast cancer	2013	79.9	79.5	80.4	22,915	28,666	Female	53-70 yrs			
2.20ii - Cancer screening coverage - cervical cancer	2013	76.0	75.7	76.3	48,813	64,240	Female	25-64 yrs			
2.21vii - Access to non-cancer screening programmes - diabetic retinopathy	2011/12	66.7	65.7	67.6	6,660	9,992	Persons	12+ yrs			
2.22iii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check	2013/14	6.6	6.5	6.8	5,286	79,838	Persons	40-74 yrs			New (6)
2.22iv - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received one	2013/14	100.0	99.9	100.0	5,286	5,286	Persons	40-74 yrs			New (6)
2.22v - Cumulative % of the eligible population aged 40-74 who received an NHS Health Check	2013/14	6.6	6.5	6.8	5,286	79,838	Persons	40-74 yrs			New (6)
2.23i - Self-reported well-being - people with a low satisfaction score	2012/13	6.6	4.7	8.5		893	Persons	16+ yrs			
2.23ii - Self-reported well-being - people with a low worthwhile score	2012/13	5.5	3.8	7.2		886	Persons	16+ yrs			
2.23iii - Self-reported well-being - people with a low happiness score	2012/13	11.2	8.8	13.7		896	Persons	16+ yrs			
2.23iv - Self-reported well-being - people with a high anxiety score	2012/13	22.2	19.3	25.1		892	Persons	16+ yrs			

Health improvement (continued)

Indicator	Period	Value	Lower CI	Upper CI	Count	Denom	Sex	Age	Position	Trend	Note
2.24i - Injuries due to falls in people aged 65 and over (Persons)	2012/13	1,570	1,450	1,697	720	46,645	Persons	65+ yrs			
2.24i - Injuries due to falls in people aged 65 and over (males/females)	2012/13	1,338	1,159	1,536	226	20,827	Male	65+ yrs			
2.24i - Injuries due to falls in people aged 65 and over (males/females)	2012/13	1,803	1,646	1,970	494	25,818	Female	65+ yrs			
2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79	2012/13	749	659	848	253	34,931	Persons	65-79 yrs			
2.24iii - Injuries due to falls in people aged 65 and over - aged 80+	2012/13	3,953	3,568	4,366	467	11,714	Persons	80+ yrs			

Health protection

Indicator	Period	Value	Lower CI	Upper CI	Count	Denom	Sex	Age	Position	Trend	Note
3.01 - Fraction of mortality attributable to particulate air pollution	2012	5.2					Persons	30+ yrs			Updated
3.02i - Chlamydia diagnoses (15-24 year olds) - Old NCSP data	2011	2,555	2,383	2,736	819	32,055	Persons	15-24 yrs			
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD	2013	2,653	2,406	2,919	422	15,904	Male	15-24 yrs			Updated
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD	2013	3,956	3,648	4,282	612	15,472	Female	15-24 yrs			Updated
3.02ii - Chlamydia diagnoses (15-24 year olds) - CTAD	2013	3,311	3,113	3,519	1,039	31,376	Persons	15-24 yrs			Updated
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	2012/13						Persons	1 yr			(3)
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	2012/13						Persons	2 yrs			(3)
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	2012/13	96.4	95.6	97.0	2,984	3,097	Persons	1 yr			(4)
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	2012/13	97.0	96.4	97.6	3,048	3,141	Persons	2 yrs			(4)
3.03iv - Population vaccination coverage - MenC	2012/13	95.8	95.1	96.5	2,968	3,097	Persons	1 yr			(4)
3.03v - Population vaccination coverage - PCV	2012/13	96.0	95.2	96.6	2,973	3,097	Persons	1 yr			(4)
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	2012/13	95.0	94.1	95.7	2,983	3,141	Persons	2 yrs			(4)
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years)	2012/13	95.0	94.2	95.7	3,036	3,195	Persons	5 yrs			(4)
3.03vii - Population vaccination coverage - PCV booster	2012/13	93.9	93.0	94.6	2,948	3,141	Persons	2 yrs			(4)
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	2012/13	93.2	92.3	94.0	2,928	3,141	Persons	2 yrs			(4)
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	2012/13	94.5	93.6	95.2	3,019	3,195	Persons	5 yrs			(4)
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	2012/13	91.2	90.2	92.2	2,915	3,195	Persons	5 yrs			(4)
3.03xii - Population vaccination coverage - HPV	2012/13	91.5	90.1	92.7	1,537	1,680	Female	12-13 yrs			(4)
3.03xiii - Population vaccination coverage - PPV	2012/13	73.4	73.0	73.8	33,374	45,492	Persons	65+ yrs			(4)
3.03xiv - Population vaccination coverage - Flu (aged 65+)	2012/13	75.7	75.3	76.1	34,747	45,915	Persons	65+ yrs			(4)
3.03xv - Population vaccination coverage - Flu (at risk individuals)	2012/13	55.0	54.4	55.6	16,029	29,140	Persons	6 months - 64 yrs			(4)
3.04 - People presenting with HIV at a late stage of infection	2010 - 12	58.1	39.1	75.5	18	31	Persons	15+ yrs			
3.05i - Treatment completion for TB	2012	68.4	46.0	84.6			Persons	All ages			
3.05ii - Incidence of TB	2010 - 12	8.6	5.4	12.9	22		Persons	All ages			
3.06 - NHS organisations with a board approved sustainable development management plan	2012/13	100.0			5	5	n/a	n/a			

Healthcare public health and preventing premature mortality

Indicator	Period	Value	Lower CI	Upper CI	Count	Denom	Sex	Age	Position	Trend	Note
4.01 - Infant mortality	2010 - 12	4.8	3.5	6.4	46	9,551	Persons	< 1 yr			
4.02 - Tooth decay in children aged 5	2011/12	1.44	1.15	1.73		259	Persons	5 yrs			(1)
4.03 - Mortality rate from causes considered preventable	2010 - 12	202.7	192.6	213.3	1,498	772,961	Persons	All ages			
4.03 - Mortality rate from causes considered preventable	2010 - 12	248.9	232.5	266.1	886	379,282	Male	All ages			
4.03 - Mortality rate from causes considered preventable	2010 - 12	160.0	147.6	173.3	612	393,679	Female	All ages			
4.04i - Under 75 mortality rate from all cardiovascular diseases	2010 - 12	92.1	85.0	99.7	616	712,461	Persons	<75 yrs			
4.04i - Under 75 mortality rate from all cardiovascular diseases	2010 - 12	122.8	111.0	135.5	402	355,111	Male	<75 yrs			
4.04i - Under 75 mortality rate from all cardiovascular diseases	2010 - 12	62.8	54.6	71.8	215	357,350	Female	<75 yrs			
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2010 - 12	63.3	57.4	69.6	423	712,461	Persons	<75 yrs			
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2010 - 12	90.1	80.0	101.0	294	355,111	Male	<75 yrs			
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	2010 - 12	37.7	31.4	44.8	129	357,350	Female	<75 yrs			
4.05i - Under 75 mortality rate from cancer	2010 - 12	168.7	159.0	178.8	1,140	712,461	Persons	<75 yrs			
4.05i - Under 75 mortality rate from cancer	2010 - 12	185.9	171.4	201.3	612	355,111	Male	<75 yrs			
4.05i - Under 75 mortality rate from cancer	2010 - 12	152.9	140.1	166.5	528	357,350	Female	<75 yrs			
4.05ii - Under 75 mortality rate from cancer considered preventable	2010 - 12	96.8	89.5	104.5	656	712,461	Persons	<75 yrs			
4.05ii - Under 75 mortality rate from cancer considered preventable	2010 - 12	103.0	92.3	114.6	340	355,111	Male	<75 yrs			
4.05ii - Under 75 mortality rate from cancer considered preventable	2010 - 12	91.2	81.4	101.8	316	357,350	Female	<75 yrs			
4.06i - Under 75 mortality rate from liver disease	2010 - 12	18.3	15.3	21.8	127	712,461	Persons	<75 yrs			
4.06i - Under 75 mortality rate from liver disease	2010 - 12	23.8	18.9	29.6	81	355,111	Male	<75 yrs			
4.06i - Under 75 mortality rate from liver disease	2010 - 12	13.0	9.6	17.4	46	357,350	Female	<75 yrs			
4.06ii - Under 75 mortality rate from liver disease considered preventable	2010 - 12	15.5	12.7	18.7	108	712,461	Persons	<75 yrs			
4.06ii - Under 75 mortality rate from liver disease considered preventable	2010 - 12	20.5	15.9	25.9	70	355,111	Male	<75 yrs			
4.06ii - Under 75 mortality rate from liver disease considered preventable	2010 - 12	10.7	7.5	14.6	38	357,350	Female	<75 yrs			
4.07i - Under 75 mortality rate from respiratory disease	2010 - 12	45.3	40.3	50.8	301	712,461	Persons	<75 yrs			
4.07i - Under 75 mortality rate from respiratory disease	2010 - 12	53.1	45.4	61.7	172	355,111	Male	<75 yrs			
4.07i - Under 75 mortality rate from respiratory disease	2010 - 12	38.0	31.8	45.2	130	357,350	Female	<75 yrs			
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2010 - 12	20.1	16.8	23.8	134	712,461	Persons	<75 yrs			
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2010 - 12	21.4	16.6	27.1	69	355,111	Male	<75 yrs			
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	2010 - 12	19.0	14.6	24.2	65	357,350	Female	<75 yrs			
4.08 - Mortality from communicable diseases	2010 - 12	91.0	83.8	98.6	605	772,961	Persons	All ages			
4.08 - Mortality from communicable diseases	2010 - 12	112.6	98.8	127.8	277	379,282	Male	All ages			
4.08 - Mortality from communicable diseases	2010 - 12	77.3	69.1	86.2	328	393,679	Female	All ages			

Healthcare public health and preventing premature mortality (continued)

Indicator	Period	Value	Lower CI	Upper CI	Count	Denom	Sex	Age	Position	Trend	Note
4.09 - Excess under 75 mortality rate in adults with serious mental illness	2011/12	376.3	314.8	446.2			Persons	18-74 yrs			New
4.10 - Suicide rate	2010 - 12	6.1	4.4	8.1	46	772,961	Persons	All ages			
4.10 - Suicide rate	2010 - 12	9.2	6.4	12.9	34	379,282	Male	All ages			
4.10 - Suicide rate	2010 - 12				12	393,679	Female	All ages			(5)
4.11 - Emergency readmissions within 30 days of discharge from hospital	2011/12	13.4	13.1	13.8	4,741	33,861	Persons	All ages			
4.11 - Emergency readmissions within 30 days of discharge from hospital	2011/12	13.7	13.2	14.3	2,215	15,656	Male	All ages			
4.11 - Emergency readmissions within 30 days of discharge from hospital	2011/12	13.2	12.6	13.7	2,526	18,205	Female	All ages			
4.12i - Preventable sight loss - age related macular degeneration (AMD)	2012/13	128.6	98.2	165.6	60	46,645	Persons	65+ yrs			Updated
4.12ii - Preventable sight loss - glaucoma	2012/13	19.9	13.1	29.0	27	135,375	Persons	40+ yrs			Updated
4.12iii - Preventable sight loss - diabetic eye disease	2012/13	3.6	1.6	7.1	8	221,475	Persons	12+ yrs			Updated
4.12iv - Preventable sight loss - sight loss certifications	2012/13	52.3	43.8	61.8	135	258,352	Persons	All ages			Updated
4.14i - Hip fractures in people aged 65 and over	2012/13	577	506	655	272	46,645	Persons	65+ yrs			
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	2012/13	277.5	224.0	339.9	94	34,931	Persons	65-79 yrs			
4.14iii - Hip fractures in people aged 65 and over - aged 80+	2012/13	1,445	1,220	1,697	178	11,714	Persons	80+ yrs			
4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2011 - Jul 2012	8.1	-0.3	17.3	67	825	Persons	All ages			
4.15ii - Excess Winter Deaths Index (single year, ages 85+)	Aug 2011 - Jul 2012	26.7	10.9	44.7	75	281	Persons	85+ yrs			
4.15iii - Excess Winter Deaths Index (3 years, all ages)	Aug 2009 - Jul 2012	11.5	6.4	16.9	281	2,432	Persons	All ages			
4.15iv - Excess Winter Deaths Index (3 years, ages 85+)	Aug 2009 - Jul 2012	20.4	11.3	30.4	167	815	Persons	85+ yrs			

Based on data from August 2014 quarterly update of the Public Health Outcomes Framework (PHOF) (published 05/08/14).
Source - Public Health England.

Notes

1. Trend data not available.
2. Value estimated.
3. Value missing in source data.
4. Value estimated from former primary care organisations covered by the local authority.
5. Value cannot be calculated as number of cases is too small.
6. Replace 2.22i, 2.22ii (Take up of NHS Health Check - Offered, Take up)

n/a - not applicable

ROTHERHAM BOROUGH COUNCIL – REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**1st October 2014**
3.	**Title:**	**Healthwatch Rotherham Update**
4.	**Directorate:**	**Neighbourhood and Adults Services**

5. Summary:

Healthwatch Rotherham is commissioned for and on behalf of the Rotherham Health and Wellbeing Board as the consumer champion for health and social care services in Rotherham. The contract commenced following an open tender with Parkwood Healthcare Ltd., on the 1st April, 2013 for a period of 2 years.

As set out in the contract and agreed by the Health and Wellbeing Board in March 2014 the contract was to novate from Parkwood to a social enterprise – Rotherham Healthwatch Ltd.

The contract for Healthwatch Rotherham with Parkwood Healthcare Ltd was terminated on 31st August 2014 and the contract commenced with the social enterprise Rotherham Healthwatch Ltd on 1st September 2014. These were both within the timeline set by the Health and Wellbeing Board.

Rotherham Healthwatch will continue to deliver the service under the same terms and conditions as the previous provider using the original specification for the service and the existing staffing arrangements.

This report also sets out, as the required scheduled update, the staff, performance and activities of Healthwatch Rotherham.

6. Recommendations

That the Health and Wellbeing Board:

6.1 Acknowledges the setting up of the social enterprise Rotherham Healthwatch Ltd

6.2 Notes the termination of the contract with Parkwood Healthcare Ltd and the transfer of the rights and obligations of the Healthwatch Rotherham service to Rotherham Healthwatch Ltd

6.3 Notes the progress achieved by Healthwatch Rotherham

6.4 Receives further reports as scheduled updates

7. Background

7.1 Service Delivery

Healthwatch Rotherham (HWR) was commissioned by Rotherham Borough Council on behalf of the Health and Wellbeing Board as the consumer champion for health and social care services in Rotherham. The contract commenced following an open tender with Parkwood Healthcare Ltd., on the 1st April, 2013 for a period of 2 years with an option to extend for a further 1 year dependent on central government funding being made available.

The contract for HWR with Parkwood Healthcare Ltd was terminated on 31st August 2014 and the contract commenced with the social enterprise Rotherham Healthwatch Ltd on 1st September 2014. These were both within the timeline set by the Health and Wellbeing Board.

The Outcomes Framework for HWR was approved at the HWBB in October 2013 and is used to measure performance at the monthly contract review meetings. A suite of key performance indicators are in place to measure performance against the outcomes framework and record the engagement activity undertaken. The PMF and annual work plan is agreed at HWBB and is subject to rigorous monitoring.

7.2 Rotherham Healthwatch Ltd – Social Enterprise

The contract with Parkwood Healthcare Ltd. included a clause to novate the contract and following agreement by the HWBB on 26th March 2014 a letter formally advised Parkwood of the intention to novate by 1st September to a social enterprise – Rotherham Healthwatch Ltd. Negotiations commenced with Parkwood regarding the novation and were conducted in an open, transparent way in line with the positive and professional relationships built with the provider.

Novation of contract was formally challenged by Parkwood Healthcare Ltd on 8th August 2014. Following advice from RMBC Legal team the Council entered into a deed of termination agreement with Parkwood Healthcare to end any rights and obligations under the existing contract with Parkwood Healthcare Ltd (confidentiality and National Audit requirements not withstanding) and to ensure that delivery of the service could commence by Rotherham Healthwatch Ltd (social enterprise) on 1st September 2014 as agreed. The termination process was successfully completed by 31st August 2014 and a new contract was established with Rotherham Healthwatch Ltd on 1st September 2014 until 31st Match 2015, this was within the timeline set by the Health and Wellbeing Board on 26th March 2014.

The Chair, Board of Directors and management staff of HWR were supported to set up a social enterprise to deliver the services as set out in the original specification and contract and existing staff have been TUPE'd into the social enterprise. The social enterprise was incorporated as a company limited by guarantee on 8th April 2013 by the Board of Healthwatch Rotherham. The company was incorporated to transfer the rights and obligations of the HWR contract by means of novation and is known as Rotherham Healthwatch Ltd.

7.3 Rotherham Healthwatch Ltd Staff and Directors

All existing HWR staff at 31st August 2014 were transferred to Rotherham Healthwatch Ltd under TUPE regulations:-

- Healthwatch Rotherham Manager – now Chief Executive of Rotherham Healthwatch Ltd
- Research & Information Officer
- Advocacy Worker
- Engagement Officer
- Engagement officer

There are outstanding vacancies across the Board of Directors with two directors of Rotherham Healthwatch Ltd registered with Companies House. These are:
- Chair
- Director for Prevention and Early Intervention

The aim is to recruit a number of directors aligned to the priorities of the Health and Well Being Strategy, whilst also ensuring individuals have the skills needed to ensure the new social enterprise is sustainable. As well as the positions above, directors will cover:
- Expectations and aspirations
- Healthy lifestyles
- Long term conditions
- Poverty
- Dependence to Independence
- Children and Young People work abroad

It is planned that the Director responsible for Poverty will return following a short illness.

7.4 HWR Performance

HWR have spent the majority of the first half of the year continuing to establish the service and raise awareness of Healthwatch and its purpose to local organisations and members of the public in Rotherham. Activity undertaken in line with its purpose is recorded and reported on a monthly basis. Such activity for the period includes:

KPI	June	July	YTD
Number of contacts made	71	63	195
Number of views and opinions collected	43	117	419
Number of engagement activities	11	20	70
Number of meetings attended	14	14	48
Number of volunteer hours	50	16	71
Number of volunteers used	6	4	6
Number of members	28	21	62

Number of Advocacy cases for NHS complaints	8	9	34
Number of advocacy cases closed	0	3	9

Number of Healthwatch Rotherham complaints received	1*	0	0
Healthwatch Rotherham Complaints percentage	1.41%	0	0%

*HWR received a verbal complaint regarding a member of staff being late to a meeting with a client. The complaint was resolved with the client immediately.

Performance is monitored against an outcomes framework at monthly contract review meetings. The work plan for HWR details the specific pieces of work to be undertaken, or contributed to, in line with their role. Contingency has been built into the work plan to ensure that any urgent or critical work can be delivered within the overall capacity.

HWR continues to pass on concerns raised by members of the public to commissioners and where appropriate the CQC, Ofsted, South Yorkshire and Bassetlaw Quality Surveillance Group (QSG), Scrutiny, RCCG, NHS England, TRFT and Healthwatch England. HWR ensure providers inform them of actions taken to improve, or recognise good practice. This process is detailed in the HWR Escalation Policy and Process. Some of the changes that HWR have influenced include:

- SEND – HWR highlighted that children (and their families) who were statemented at school were not aware of this. They valued the skills of reading and writing; some felt let down by education as they did not have these skills; bullying is an issue. This report was provided to the SEND commissioning board in July.
- Advocacy is still very high demand and we require extra resources.

Impacts from the external review of CAMHS are:-

- RDaSH have recruited 6 extra staff and a new clinical lead and have introduced mandatory customer service training. They are also setting up governance arrangements which include service users and parents.

- HWR & RDASH have agreed HWR will be meeting service users and parents in early 2015 to see if the actions have reduced dissatisfaction highlighted in the HWR report.

7.5 Activities of HWR

The community engagement and project work planned over the next 6 months includes:

- HWR will continue to hold community engagement events across the borough, mainly at community buildings such as the customer service centres, to both raise the awareness of HWR but also to gather the views around health and social care services.
- Drop in sessions will continue to be delivered in Maltby, Dinnington, Thurcroft, Swinton.
- Further work to be completed on the looked after children research project around the barriers for health care for looked after children commenced in January undertaken by a public health student from Sheffield University with support from HWR.

Projects completed:

- Engagement and consultation with parents/carers and young people around changes required for the development of an integrated health, social care and education service for children with disabilities and/or special educational needs (outcomes and measures are yet to be agreed). Completed reading and writing valuable skills, bully issue. Completed 19/07/2014.

8. Finance

The value of the HWR contract is £215,000 per annum. The contract with Rotherham Healthwatch ltd is £125,417 (7 months) to 31st March 2015 with an option to extend for

a further year (if the funding is available). The budget continues to be monitored by the RMBC commissioning team.

9. Risks and Uncertainties

That the newly established social enterprise is not sustainable beyond 2015 due to lack of funding from central government.

10. Policy and Performance Agenda Implications

Rotherham Healthwatch Ltd contributes to the achievement of objectives set out in the Corporate Plan:

CP1 Stimulating the local economy and helping local people into work

CP2 Protecting our most vulnerable people and families, enabling them to maximise their independence

CP4 Helping people to improve their health and wellbeing and reducing inequalities within the borough, and,

The way we do business

11. Background Papers and Consultation

Consultation with HWR and Parkwood Healthcare regarding the contents of this report.

Health and Wellbeing Board minutes 26th March 2014.

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Health and Wellbeing Board

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1 October 2014

Diabetic Eye Screening Programme Rotherham

Introduction

This report from the South Yorkshire and Bassetlaw Screening and Immunisation Team and is in response to request from the Rotherham Health and Wellbeing Board.

Background to the Diabetic Eye Screening Programme

The NHS Diabetic Eye Screening Programme was introduced to reduce the risk of vision loss in people with Diabetes. Everyone with Diabetes who is 12 years of age or over should have their eyes screened once per year to check for signs of Diabetic Retinopathy.

There are 3 types of Diabetic Retinopathy:

Background retinopathy:
Small blood vessels in the back of the eye become blocked or may bulge or leak blood or fluid. This does not affect the eyesight but it needs to be carefully monitored, so that any early changes are detected early and treatment can be offered to stop it becoming more serious.

Maculopathy:
The macula provides central vision and is essential for clear detailed vision. If the background retinopathy described above is in/around the macula the fluid leakage causes swelling which can lead to loss of vision. This is more common in people who have Type 2 Diabetes (those who need Insulin) and if left untreated can cause blindness.
Proliferative retinopathy:
As background retinopathy develops, large areas of the retina are deprived of a proper blood supply because of the blocked or damaged blood vessels. This stimulates the growth of new blood vessels to replace the blocked ones. The new vessels are very weak so bleed easily. The bleeding causes scar tissue that then shrinks and pulls on the retina leading to it becoming detached and causing blindness. This is more common in people who have Type 1 Diabetes (those who do not need Insulin)

Screening

Newly diagnosed diabetic patients are referred to the local programme by their GP and booked onto a new patient clinic list as they require a longer appointment.

For subsequent annual screens the patients are sent an invitation letter, which asks them to phone to book an appointment for screening at a time to suit their convenience.

When a patient arrives for screening he/she is given eye drops to enlarge the pupils and then photographs are taken of the retina. Results from screening are:

- No retinopathy
- Background retinopathy
- Degrees of referable retinopathy

Treatment is dependent on the outcome of the screening.

Barnsley and Rotherham Diabetic Eye Screening Programme

The joint Barnsley and Rotherham programme was commissioned in 2007, to service the population of Barnsley and Rotherham The programme provider is Barnsley Hospital Foundation Trust.
In line with the national trend the diabetic population in Barnsley and Rotherham is increasing year on year. The programme currently has 27,707 patients registered, 25,906 are eligible for screening. Those not eligible for screening are managed in line with the national programme guidance relating to exclusions and suspensions. This list of patients are reviewed and validated every 3 months by the failsafe team within the programme, to ensure they still meet the criteria for exclusion/suspension.

The programme is currently commissioned on behalf of Public Health England via NHS England South Yorkshire and Bassetlaw (SYB) Area Team, to the national service specification for Diabetic Eye Screening.

There are a number of screening sites/venues in Rotherham including:

- Rotherham Hospital Diabetes Centre
- Anston, Swallownest, Clifton Medical Centre, Greasborough, Kilnhurst, Kimberworth Park, Kiveton Park, Maltby Service Centre, Parkgate, Rawmarsh, Swinton, Treeton, Wath Upon Dearne.

Performance

Programme performance is reported nationally on a quarterly basis and also into the quarterly SYB Programme Board. The quarterly programme board is chaired by a member of the SYB Screening and Immunisation Team and membership includes representation from Commissioners, Programme Providers across SYB, SYB Area Team, the national Quality Assurance Team and the IT software provider.

Any performance issues are escalated as required to the SYB Screening and Immunisation Advisory Group (SIAG) NHS England Public Health

Commissioning Local Delivery Group and South Yorkshire Commissioners group.

Directors of Public Health are represented at SIAG and this provides their assurance/information on the performance of each of their Screening/Vaccination and Immunisation programmes in their area.

The Diabetic Eye Screening programme in Rotherham is currently underperforming in some areas. These are being monitored via an action plan, with a monthly update report submitted to the SYB Screening and Immunisation Team.

Invitations:

100% of the eligible population should be offered an invitation to participate in screening on an annual basis (every 12 months)
Historically invitations for screening were managed through a closed model of invitations. The providers sent out the invitations and appointments based on their available clinic capacity/staffing/camera availability at that time. Which in addition to reducing the number of appointments they could offer also resulted in a backlog meaning patients were being seen within 14 months instead of the required 12 months.
Action taken by the provider to address this issue includes changing the invitation model to an open model, increasing clinic capacity, operating an accelerated service and recruiting staff. It is expected that improvements in this standard will be reflected in the data from September 2014 onwards.

Uptake:

The combined programme uptake currently is above the Public Health Outcomes Framework standard of 70% but below the stretch achievable target of 80%. Each individual programme uptake shows a similar picture. The programme provider has recognised that there are a number of patients who repeatedly do not attend for screening (DNA). In attempting to address this they have surveyed the patients who DNA and have acted upon some of their findings including offering clinics at evenings and weekends, phoning the patients the day before the screening appointment to act as a reminder, engaging with/visiting GP Practices who have high numbers of DNAs from their practice, asking them to reinforce the importance of screening with individual patients and, in addition, offering practices health promotion materials to advertise the programme and visiting Practice Manager meetings to promote the programme. Data cleansing of practice lists of registered patients is undertaken on a regular basis to ensure that the diabetic patient list held by practices reflects the list held by the programme and vice versa. The programme will also participate in the newly formed SYB Health Promotion meeting facilitated by the SYB Screening and Immunisation Team. This meeting brings together a number of providers across from both the cancer and non-cancer screening programmes and other stakeholders following a ‘Do once and share model’ in an attempt to work collaboratively towards

improving coverage/uptake and access to all screening programmes in SYB, especially for those groups with known health inequalities

Slit Lamp Biomicroscopy (SLB):

SLB is a procedure that allows an examination to see the front of the eye (including the retina) in order to detect any problems with the eye.
SLB should be offered within 14 weeks of screening. Compliance with this standard has varied over the last few months. 12 patients outstanding (Dec 2013) being the highest and 3 patients outstanding in the August report (Planned appointment 15 weeks after screening) This is monitored by the Screening and Immunisation Team on a monthly basis and is improving

Quality Assurance Review

All cancer and non-cancer screening programmes are subject to an external quality assurance review. A new national framework has been developed to support the quality assurance review process. The Barnsley and Rotherham Diabetic Eye Screening programme review (planned for October 2nd 2014) will be the first programme in SYB to be quality assured in this way.
The one day review will consider the overall quality of the programme provision and where applicable the reviewers will make recommendations where they feel the quality of that provision can be improved. The provider will then be expected to address the recommendations from the visit via an action plan that will then be monitored by the QA team and the SYBSIT. A copy of the report will also be provided to the Director of Public Health by the Quality Assurance Team

Recommendations

Rotherham Health and Wellbeing Board are asked to note the content of this report.

South Yorkshire and Bassetlaw Screening and Immunisation Team October 2014

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**October 1st 2014**
3.	**Title:**	**Special Educational Needs and Disability Transformation**
4.	**Programme Area:**	**Children and Families**

5. Summary

This report provides an update on the implementation of the reforms to support children and young people with special educational needs and a disability. New duties for local authorities and clinical commissioning groups commenced on September 1st 2014.

6. Recommendations

- **Committee members are asked to comment on the report and note the progress made.**

7. Proposals and Details

7.1 The Children And Families Act (2014) introduced the first major reform of the ways we support children and young people with special educational needs for over 30 years. The Committee received a report on June 4th 2014 which provided the background to the reforms. In July, Rotherham's Children, Young People and Families Partnership agreed to add the following priority to the Children and Young People's Plan:

"With parents and young people, we will transform how education, care and health partners ensure that children and young people with special educational needs or a disability are identified early and supported to achieve the best possible outcomes in adult life. We will focus on making the transition between different services as seamless as possible."

7.2 In preparation for the start of the new special needs system in September, the 'In It Together' event was held on July 4th. Organised by the Parents' Forum, Clinical Commissioning Group and Council staff, 'In It Together' attracted over 500 parents and young people who were able to gather information from education, health and care providers and attend workshops to discuss how best to introduce a more personalised approach or how the new assessment model was developing. The event was remarkably successful and drew praise locally and nationally, including from Brian Lamb, chair of the DfE Inquiry in Parental Confidence and SEN, which started the process of reform. It is expected that the "in It Together' event will take place each summer, not least to ascertain the views of children, young people ad parents about Rotherham's SEND Local Offer website.

7.3 Whilst there are a wide range of actions required to transform the ways in which children and young people with special educational needs and disability are supported, there were two key tasks which had to be ready for September 1st. The first of these was to have established a single place where information and advice about all aspects of special educational needs and disability could be found. Rotherham's SEND Local Offer Website started at noon on September 1st and continues to develop. Information from schools, colleges, local authority services, voluntary organisations, health and care providers has been brought together at www.rotherhamsendlocaloffer.org. Following discussion with parents and young people, Rotherham's local offer site aims to provide as much information as possible within the site and not to simply link to other sites – a virtual equivalent of parents being passed from pillar to post. For example, unlike some other local authorities, information about special needs support in schools and colleges has been specifically collected and included. The site continues to improve and a steering group to test out developments with parents and young people has been set up.

The second key task to be ready for September was to have introduced a new assessment system for those with special educational needs and disability, bringing together separate systems for early years, schools and colleges. SEN statements and Learning Difficulty Assessments have been replaced by Education Health and Care plans and a timetable has been published

showing how those with statements will transfer to the new EHC Plan. Details of the new assessment system are available on the local offer website. Training sessions about the new arrangements with schools, colleges, care and health providers have started.

7.2 In addition to getting ready for September 1st, a range of actions has been agreed by the Special Educational Needs and Disability Transformation Commissioning Group, which consists of representatives from parents and education, health and care sectors. Whilst some of the tasks will be delivered quickly others are more long term, reflecting that the transformation of services will take up to three years. The key tasks – and progress on achieving them- are :

- Local Offer Website established : complete
- SEND Assessment Pathway established : complete
- How the voice of parents, children and young people is heard, including consideration of support for the parents' forum and parent partnership : Partially complete
- Establish a group between education, health and care to consider how best to commissioning SEND services, including understanding demographic pressure : Set up and underway
- Develop personal budgets for children and young people with SEN : underway
- Commission an external body to provide mediation and dispute resolution services : Existing provider contracted to offer the new services for one year, whilst new commissioning arrangements are undertaken.
- Build on the success of the Rotherham Charter : Discussions underway
- Develop an accountability policy which describes how the local authority and CCG will monitor the outcomes for children and young people with SEND and make that information available : Underway.
- Consider the impact of the changes in providing SEN support for young people in custody (which start in April 2015) : Underway
- Ensure maximum transparency and understanding of how national funding is provided to schools and colleges to support SEN : Discussion with the Schools' Forum is underway.

8. Finance

The new SEND System is being introduced against a backdrop of reducing budgets and increased demographic pressures. Whilst various grants have been provided by central government to assist local authorities in setting up the new system, for example for the local offer website, it is not clear whether this funding will continue beyond March 2016. Gathering better demographic information about, for example, the number of babies and young children with complex needs, will help the authority and CCG plan more effectively to meet the needs of these children as they progress into adulthood.

9. Risks and Uncertainties

Meeting the rising expectations of parents and young people is a welcome challenge and effort must be focussed on how parents and young people are placed at the heart of the new system. Rotherham, like many other LAs, is experiencing a rise in the number of young children with complex needs. It is not clear whether this is a short or long term trend. The Department for Education has commissioned an external body to review how national funding is provided to local councils to support those with high levels of need.

10. Policy and Performance Agenda Implications

One of the ambitions of the new system is to enhance the independence of young people with special educational needs and disability when they reach adulthood. This is not only better for the person involved, but could also reduce costs in the long term. Monitoring the outcomes of young people and the performance of education health and care providers to encourage independence is a key task in the medium to long term.

11. Background Papers and Consultation

Report to the Health and Wellbeing Board, June 4 2014.

DfE guidance, including to local authorities, is available at : https://www.gov.uk/government/publications/special-educational-needs-and-disabilities-send-reform-letters

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