HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 13th July, 2016**

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. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Minutes of the previous meeting (Pages 1 - 9)
   Minutes of meeting held on 1st June, 2016

7. Rotherham Local Digital Roadmap (Pages 10 - 87)

8. South Yorkshire and Bassetlaw Sustainable and Transformation Plan (Pages 88 - 98)

9. Date, time and venue of the next meeting
   Wednesday, 21st September, 2016, at 9.00 a.m. venue to be confirmed

Sharon Kemp.

SHARON KEMP,
Chief Executive.

HEALTH AND WELLBEING BOARD
1st June, 2016

Present:-

Members:-

Dr. Julie Kitlowski	Clinical Chair, Rotherham CCG **In the Chair**
Louise Barnett	Chief Executive, Rotherham Foundation Trust
Chris Edwards	Chief Officer, Rotherham CCG
Ian Thomas	Strategic Director, Children and Young People's Services
Terri Roche	Director of Public Health
Janet Wheatley	Chief Executive, Voluntary Action Rotherham
Councillor Yasseen	Cabinet Member, Neighbourhood Working and Cultural Services

Report Presenters:-

Anna Clack	Public Health Specialist, RMBC
Miles Crompton	Policy and Partnerships Officer, RMBC
Ruth Fletcher-Brown	Public Health Specialist, RMBC
Claire Smith	Rotherham CCG

Officers:-

Nathan Atkinson	Assistant Director of Commissioning, RMBC
Richard Bellamy	Democratic Services, RMBC
Kate Green	Policy Officer, RMBC

Observers:-

Chris Bland	Rotherham Pharmaceutical Committee
Councillor Sansome	Chair, Health Select Commission
Councillor R.A.J. Turner	

Apologies for absence were received from Sharon Kemp, Tracy Holmes, G. Parkinson, Councillor Roche and Councillor Watson.

1. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at this meeting. It was agreed that the Members' register of interests should be reviewed.

2. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public or the press in attendance.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board, held on 20th April, 2016, were considered.

Matters arising updates were provided in relation to the following items -

(i) Minute No. 69 (reference to previous minutes) – the 'Let's get Rotherham Active' event had taken place on 11th May, 2016, at which 68 people had attended. Feedback had been positive. The outcome of the event and next steps were being considered by an officer meeting on 14th June and would be shared with the Board at a later date.

(ii) Minute No. 71 (Health and Wellbeing Strategy) – there was steady progress being made with the preparation of the Strategy with the Health and Wellbeing Steering Group meeting monthly since March to support the progress. There was, however, an urgent need for a lead officer to be identified to work alongside Richard Cullen GP on aim 1 of the Strategy.

(iii) Minute No. 75(a) (Health and Wellbeing Board Self-Assessment) – the self-assessment event would be taking place on the day of this Board's next meeting, Wednesday 13th July 2016;

It was noted that the Board meeting would be an extended meeting to 12.00 Noon. The first part of the meeting, 9.00-9.30 a.m. was to conduct normal business and open to the public and observers; from 9.30 a.m. the meeting would be a closed facilitated session.

Resolved:- That the minutes of the previous meeting of the Board, held on 20th April, 2016, be approved as a correct record.

4. SOUTH YORKSHIRE AND BASSETLAW SUSTAINABILITY AND TRANSFORMATION PLAN/DRAFT INTEGRATED HEALTH AND SOCIAL CARE PLACE PLAN

Consideration was given to a report, presented by Chris Edwards, concerning the NHS Shared Planning Guidance, which asked every local health and care system in England to come together to create its own ambitious local plan for accelerating the implementation of the Five Year Forward View (5YFV). These blueprints, called Sustainability and Transformation Plans (STPs), will be place-based, multi-year plans built around the needs of local populations.

To deliver STPs, local health and care systems have come together to form 44 footprints, which collectively cover the whole of England. These geographic footprints are of a scale which should enable transformative change and the implementation of the 'Five Year Forward View' vision of better health and wellbeing; improved quality of care, and stronger NHS finance and efficiency by 2020/21.

It was noted that Rotherham sits within the South Yorkshire and Bassetlaw footprint which is led by Sir Andrew Cash (Chief Executive of Sheffield Teaching Hospitals).

A copy of the South Yorkshire and Bassetlaw Plan was included with the agenda and supporting documents for this meeting.

A comment was made as to whether there was adequate reference (within the local plan) to preventative work.

Resolved:- (1) That the report be received and its contents noted.

(2) That the Health and Wellbeing Board places on record that it feels appropriately engaged in the local plan (Sustainability and Transformation Plans) process and notes that the South Yorkshire and Bassetlaw Plan has to be submitted to NHS England by the due date of Thursday 30th June, 2016.

5. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE

Consideration was given to a report, presented by Miles Crompton (Policy and Partnerships Officer, RMBC) concerning the Joint Strategic Needs Assessment (JSNA). The report stated that the Health and Wellbeing Board has a statutory duty to evidence the needs of people in Rotherham and the JSNA assessment underpins health and social care commissioning, service development and the Health and Wellbeing Strategy.

The JSNA was refreshed as a new online resource in 2013, replacing the former fixed document format of 2011. After a period of consultation, the Health and Wellbeing Board had approved the final version of the JSNA in February 2014. The revised JSNA was used to inform the new Health and Wellbeing Strategy 2015-18.

The new JSNA format allows for updates of information so that the content is continually evolving in response to new data becoming available, or additional content being required. Contributors from a range of service areas have been asked to provide any updates required, on a quarterly basis.

The JSNA was subject to a review in 2015/16 which added a new overview of issues identified in the JSNA and made presentational changes to make it easier to find information about children and adults, and better understand the JSNA process.

The presentation and subsequent discussion about the Joint Strategic Needs Assessment highlighted the following salient issues:-

- implications of the Health and Social Care Act 2012;

- noting that the Joint Strategic Intelligence Assessment is an entirely separate process, prepared by the South Yorkshire Police and the Safer Rotherham Partnership;

- the early JSNA format had concentrated upon adult social care, although the revised document now encompasses a much wider range of issues (e.g.: domestic violence; transport, etc.);

- the JSNA includes 82 separate issues, catalogued into seven different categories;

- the emphasis upon issues affecting children and young people (eg: teenage pregnancy; smoking in pregnancy; Children in Need and living in poverty; disability and mental health);

- the specific issue of the oral health of young children (including tooth decay) – the Board noted that the statistics appeared to be in need of updating, as there was now evidence of an improving pattern being made in terms of children's oral health; it was also noted that there is no fluoridation of the water supply in the Rotherham Borough area);

- the prevalence of long-term sickness absence amongst the adult working population;

- the current life expectancy of women (81 years) and men (78 years) living in the Rotherham Borough area; the population aged over 80 years is increasing by 4% per year; the consequent demand on adult social care services;

- ethnic diversity in the Rotherham Borough area;

- the demand for food banks is increasing; some supermarkets are donating food to the food banks, in order to try and reduce the amount of food waste where the food is still fit for consumption.

It was agreed that copies of the presentation will be distributed to members of the Health and Wellbeing Board.

Resolved:- (1) That the report be received and its contents noted.

(2) That the Health and Wellbeing Board:-

(a) acknowledges that service-based contributors are being asked to provide any updates to the Joint Strategic Needs Assessment on a quarterly basis; and

(b) agrees that the Joint Strategic Needs Assessment will be subject to further review during 2016/17.

6. HEALTHY AGEING FRAMEWORK - A CO-ORDINATED WHOLE SYSTEM APPROACH TO HEALTHY AGEING FOR ROTHERHAM

Consideration was given to a report, presented by the Director of Public Health, stating that an initial draft of a Healthy Ageing Framework has been developed to raise the profile of the needs of the Rotherham Borough's ageing community and improve the coordination of the healthy ageing initiatives across Rotherham. Further stakeholder engagement will be sought to agree a vision that will drive activity forwards and improve the health and wellbeing of the Rotherham Borough's ageing population.

The report included the initial draft of the vision : "to improve the health and wellbeing of the ageing community of Rotherham. Rotherham services work together seamlessly to develop healthy, independent and resilient citizens, who live good quality lives".

The principles and desired outcomes of the Framework were also listed in the report. The next steps include a stakeholder engagement event, during July 2016, to shape the vision and framework and ensure that the Healthy Ageing Framework meets the needs and expectations of all stakeholders.

Discussion took place on the transport requirements of elderly people, many of whom will rely upon public transport (especially buses and trains). The need for a continuing dialogue with the South Yorkshire Passenger Transport Executive, about this specific issue, was acknowledged by the Board.

Resolved:- (1) That the report be received and its contents noted.

(2) That a further report about the Healthy Ageing Framework be submitted to a future meeting of the Health and Wellbeing Board, during the Autumn 2016, after completion of the stakeholder engagement event and consultation.

7. BETTER CARE FUND

Consideration was given to a report of the Head of Long Term Conditions and Urgent Care (Rotherham Clinical Commissioning Group) and the Assistant Director of Commissioning (RMBC Adult Social Care) containing an overview of the Better Care Fund Plan 2016/17 which would be submitted to NHS England.

The report stated that, in early March 2016, NHS England had issued the Better Care Fund planning requirements for 2016/17, which included the completion of a financial planning template and a narrative plan with a comprehensive set of Key Lines of Enquiry. There are eight conditions, which local areas have to meet through the planning process, in order to

access funding which is included in the Key Lines of Enquiry. These eight conditions were listed within the submitted report.

The Better Care Fund Plan had been jointly developed between the Rotherham Clinical Commissioning Group (CCG) and the Borough Council and is well aligned to the priorities within the Joint Health and Wellbeing Strategy 2015-18, the CCG Commissioning 2015-19, CCG Operating Plans 2016-17 and Provider Plans.

The Health and Wellbeing Board noted that Rotherham's Better Care Fund Plan 2016/17 had been cited as an exemplar Plan within the Yorkshire and Humberside region. The Board thanked the team of officers for their work.

Resolved:- (1) That the report be received and its contents noted.

(2) That the Better Care Fund Plan 2016/17, as now submitted, be approved and submitted to NHS England.

8. BETTER CARE FUND SECTION 75 AGREEMENT 2016-17

Consideration was given to a report submitted by the Head of Long Term Conditions and Urgent Care (Rotherham Clinical Commissioning Group) and the Assistant Director of Commissioning (RMBC Adult Social Care) containing the Framework Partnership Agreement relating to the Commissioning of Health and Social Care Services from the Better Care Fund in 2016/17 (Section 75 of the NHS Act 2006 refers). It was noted that this Agreement had been approved by the Government-appointed Commissioners to the Borough Council.

Resolved:- (1) That the report be received and its contents noted.

(2) That the 'Section 75' Framework Partnership Agreement, as now submitted, be approved and submitted to NHS England by the due date of Thursday, 30th June, 2016.

9. BETTER CARE FUND QUARTER 4 SUBMISSION

Consideration was given to a report submitted by the Chief Finance Officer (Rotherham Clinical Commissioning Group) and the Assistant Director of Commissioning (RMBC Adult Social Care) containing the fourth quarterly report to NHS England regarding the performance of Rotherham's Better Care Fund.

Resolved:- (1) That the report be received and its contents noted.

(2) That the contents of this fourth quarterly report be ratified and it be noted that the report had been submitted to NHS England by the due date of Friday, 27th May, 2016.

10. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2015-16

Consideration was given to the Director of Public Health's Annual Report 2015/16 as submitted.

The Director of Public Health has a statutory responsibility to produce an Annual Report and the Council has a statutory duty to publish it.

This report focused on an analysis of some of the key issues affecting the health and wellbeing of Rotherham's Children and Young People and explored the health inequalities that exist for children between Rotherham and the rest of England. The Report described Children and Young People's health through a life-course approach, from pregnancy and birth, through school years into young adulthood.

The Annual Report aimed to engage with professional stakeholders across the Rotherham Borough, in order to work together and deliver on a clear set of recommendations that will help improve the health and wellbeing of the Borough's Children and Young People. The recommendations are aimed at all statutory and voluntary partners across the Rotherham Borough area.

The recommendations evolved from sections in the report which highlight 'our ambitions for Rotherham'. The intention of the Public Health Annual Report is to sit alongside the Health and Wellbeing Strategy and to help inform the actions taken by the Health and Wellbeing Board. It also offers some practical interventions which will improve child health and contribute to reducing the health inequalities across the Borough. Future reports will describe progress against the recommendations and the associated action plan.

The Public Health Annual Report contained seven recommendations. The report also explained the action taken in response to the recommendations of the previous (2014) Public Health Annual Report.

The presentation and subsequent discussion highlighted the following salient issues:-

- life expectancy in the Rotherham Borough area and the impact of poverty;

- infant mortality rates; still-births and sudden infant deaths;

- accidents affecting very young children;

- physical activity and obesity amongst children and young people;

- the oral health of young children (also discussed at Minute No. 5 above);

- educating young people about positive and healthy relationships and good sexual health;

- mental health issues (including self-harm and suicide);

- the importance of the accurate recording of health data and statistics.

Resolved:- (1) That the Annual Report be received and its contents noted.

(2) That the recommendations contained within the Director of Public Health Annual Report 2015/16, as now submitted, be supported and progress on the actions taken on the recommendations be reviewed at future meetings of the Health and Wellbeing Board.

11. SUICIDE PREVENTION AND SELF-HARM ACTION PLAN UPDATE 2015-16

Consideration was given to a report, presented by Ruth Fletcher-Brown (Public Health Specialist, RMBC) providing a six months' progress report on the actions detailed in the Rotherham Suicide Prevention and Self-Harm Action Plan 2015/16. The report stated that the delivery of the Rotherham Suicide Prevention and Self-Harm Action Plan is an action within the Rotherham Health and Well Being Strategy.

Listed within the submitted report were details of the progress, as monitored by the Rotherham Suicide Prevention and Self-Harm Group, of the various actions being taken based on the six national areas for action and an additional two which are Rotherham specific.

The Board's discussion of this report highlighted the following salient issues:-

- the real-time surveillance pilot scheme in the Rotherham Borough area (with partner organisations, including the South Yorkshire Police);

- identification of any 'hot-spots' of increased rates of suicide;

- continuing partnership working with the Rotherham Youth Cabinet about mental health issues affecting children and young people;

- the value of the social marketing campaign work;

- support for bereaved families and sign-posting to appropriate services (e.g.: the Samaritans; CAMHS, etc).

Resolved:- (1) That the report be received and its contents noted.

(2) That the Health and Wellbeing Board:-

(a) accepts and endorses the report on actions taken by the Rotherham Suicide Prevention and Self Harm Group for 2015/2016;

(b) endorses the areas for future activity, including a commitment to continue Rotherham's Real Time Surveillance work and the social marketing campaign work; and

(c) receives an update report on the work of the Rotherham Suicide Prevention and Self Harm Group once per year and exception reports more frequently, as appropriate.

12. DATE, TIME AND VENUE OF THE NEXT MEETING

Resolved:- (1) That the next meeting of the Health and Wellbeing Board be held on Wednesday 13th July, 2016, at the Town Hall, Rotherham. This meeting shall be extended from 9.00 a.m.-12.00 Noon to include a developmental session for members of the Board. From 9.30 a.m. the meeting will be closed to the public and observers.

(2) That future meetings take place on: -

- extraordinary meeting in August 2016 (if deemed necessary)
- 21st September, 2016 (agenda to include a report about the Children and Young People's Services Partnership Board)
- 16th November, 2016;
- 11th January, 2017;
- 8th March, 2017.

NHS Rotherham Clinical Commissioning Governing Body

Health and Wellbeing Board – 13th July 2016

Rotherham Local Digital Roadmap

Lead Executive:	**Ian Atkinson, Deputy Chief Officer**
Lead Officer:	**Andrew Clayton, Head of Health Informatics**
Lead GP:	**Dr Richard Cullen, GP IT Lead**

Purpose:

This paper presents the draft Local Digital Roadmap (LDR) for the Rotherham Health and Care Community. The roadmap was agreed by the Rotherham Interoperability Group, the multi-agency Rotherham IT Strategy Group and Rotherham CCG Operational Executive before submission to NHS England on 30th June 2016. The Health and Wellbeing Board and are asked to endorse the Local Digital Roadmap.

Background:

The Five Year Forward View makes a commitment that, by 2020, there will be "fully interoperable electronic health records so that patient's records are paperless". This was supported by a Government commitment in Personalised Health and Care 2020 that "all patient and care records will be digital, interoperable and real-time by 2020". This has been distilled into the ambition that health and care professionals will operate 'paper-free at the point of care' by 2020.

In September 2015, a three-step process began to enable local health and care systems to produce Local Digital Roadmaps (LDRs) by 30 June 2016, setting out how they will achieve the ambition of 'paper-free at the point of care' by 2020. The first step was the organisation of local commissioners, providers and social care partners into LDR footprints. The second step was for NHS secondary care providers within LDR footprints to complete a Digital Maturity Self-assessment. Both of these steps were completed and each LDR footprint was then asked to develop and submit its own Local Digital Roadmap by the 30th June 2016.

Analysis of key issues and of risks

The attached LDR and associated appendices have been in development since the publication of the guidance and templates in late April, which has only allowed a small window of time to produce the LDR with partners across the health and care system. For the LDR submission we were required to return six documents, which are:

- Checklist for Submission
- LDR Narrative
- Capability Deployment Schedule
- Capability Trajectory
- Universal Capabilities Delivery Plan
- Information Sharing Approach diagram

The section headings that are used within the LDR narrative are prescriptive and the document sets out the local response to the requirements listed in the LDR Checklist for Submission. Development of the LDR has been led by RCCG, through the Rotherham Interoperability Group, and supported by information provided by TRFT, RDaSH, Rotherham Hospice and RMBC. Using the information from our partners along with knowledge of the local health and care agenda we have developed the LDR narrative to present a vision for the future of digitally

supported health and care services in Rotherham, and plans for delivery of these services over the next four years. Key deliverables over the period of the LDR are:

- The introduction of new core information systems at RMBC (2016) and RDaSH (2017)
- Further development and rollout of the Rotherham Clinical Portal across all health and care services (2016 – 2018)
- Development of shared infrastructure and mobile working solutions to allow practitioners to work seamlessly from all health and care settings across Rotherham and then wider across the STP footprint
- The aspiration to develop a South Yorkshire shared care record joining up the information across all providers in the SYB footprint (2020)

The Information Sharing Approach diagram shows the intention for delivery of these services in a simplified "plan on a page" and the Universal Capabilities Delivery Plan and Capability Deployment Schedule provide more detail on how and when these services will be delivered. Many of the digital services detailed in future years of the LDR are aspirational and the realisation of these will be dependent on funding, particularly funding from the national Driving Digital Maturity Investment Fund.

In the course of its development the LDR has been discussed in numerous CCG and provider forums and the LDR narrative and templates have been reviewed and agreed by the Rotherham Interoperability Group and our multi-agency IT Strategy Group and Rotherham CCG Operational Executive.

LDRs will be assessed in July 2016 within the broader context of the assessment of STPs. While a signed-off STP will be a condition of accessing the Sustainability and Transformation Fund in the future, a signed off LDR will be a condition for accessing the £1.8bn Driving Digital Maturity Investment Fund. Draft guidelines for the LDR assessment indicate that those LDRs assessed as "Investment Ready" will be eligible to apply for 2017/18 funding in the autumn of 2016. LDRs which are not assessed as "Investment Ready" will be given feedback and support to revise their plans and will be expected to make a further LDR submission in November 2016.

Patient, Public and Stakeholder Involvement:

The partners to the LDR have been significantly engaged in its development. Following submission and organisation endorsement of the initial LDR we intend to engage widely with stakeholders across Rotherham on it including patients, the public and the third sector.

Equality Impact:

Programmes and projects within the LDR will have their own Equality and Privacy assessments carried out as required.

Financial Implications:

On-going programmes of work within the LDR are already funded. New developments identified in the LDR are aspirational and funding will be sought from national schemes to enable delivery.

Human Resource Implications:

As noted in the LDR there exists significant capacity and capability with the CCG and Rotherham's providers to support delivery of the LDR. The approach to Programme Management of the LDR across the community needs to be further developed and this may lead to additional resource requirements.

Procurement:
All procurement associated with the LDR will be detailed in individual business cases.
Approval history:
IT Strategy Group – 22/06/16 RCCG Operational Executive – 27/06/16 Governing Body – 06/07/16 Health and Wellbeing Board – 13/07/16 The LDR is scheduled at Provider Boards for endorsement during July and August 2016
Recommendations:
The Health and Wellbeing Board are asked to endorse the Local Digital Roadmap.

Rotherham Local Digital Roadmap

The Rotherham NHS
NHS Foundation Trust

Rotherham Hospice
always caring

NHS
Rotherham
Clinical Commissioning Group

Rotherham
Metropolitan
Borough Council

Rotherham Doncaster and South Humber NHS
NHS Foundation Trust

Contents

1. Introduction

The Rotherham Local Digital Roadmap (LDR) has been developed by the Rotherham Interoperability Group. This group has been established to support the development and delivery of the LDR and includes clinical and informatics representatives from all organisations identified in the Rotherham LDR footprint submission of October 2015. These organisations, which have all made a significant contribution to the development of the roadmap, are:

- Rotherham Clinical Commissioning Group (RCCG)
- Rotherham Hospice
- Rotherham Metropolitan Borough Council (RMBC)
- Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)
- The Rotherham NHS Foundation Trust (TRFT)

Lead individuals from all these organisations have met to understand the Digital Maturity Index and baseline position across Rotherham. A small multi-agency group has then collaboratively developed the plan for the next 5 years and shared the development of the LDR within their own organisation for comments and feedback. The LDR has been shared across the system in organisational meetings and also in system wide meetings to ensure that there is a broad understanding of the direction of travel, approval of the LDR content and ambition, and commitment at a very senior level to support the implementation of the LDR.

There are strong links between the development of the Rotherham LDR and the South Yorkshire and Bassetlaw (SY&B) Sustainability and Transformation Plan (STP). Rotherham CCG's Chief Clinical Information Officer (CCIO), who Chairs Rotherham's IT Strategy Group and is a member of the Interoperability Group, is the clinical lead for the STP Digital work stream. Other members of the Interoperability Group have participated in stakeholder engagement exercises supporting the development of the Digital Chapter. The Rotherham CCG lead for the LDR participates in the SY&B LDR leads group, which includes both of the Accountable Officer Leads for the Digital Health work stream of the STP. Through all of the above engagement there has been the opportunity for input into the STP Digital Health work stream and this has supported the alignment of the Rotherham LDR with the STP, which is reflected in the shared vision presented later in this document.

During development the LDR has been discussed in a number of forums for comment including the:

- Rotherham Health and Wellbeing Board
- Rotherham CCG Governing Body
- Rotherham CCG Operational Executive
- Rotherham IT Strategy Group
- Rotherham Interoperability Group

- South Yorkshire and Bassetlaw LDR Development Group
- TRFT Corporate Informatics Committee
- TRFT Clinical Informatics Development Group
- TRFT Trust Board
- TRFT Trust Management Committee
- RDaSH Health Informatics sub-committee
- RDaSH Finance, Performance and Informatics Committee
- RDaSH Unity (EPR) Programme Board
- Rotherham Hospice Board of Trustees
- RMBC Digital Council Board

The Rotherham Local Digital Roadmap (LDR) has been endorsed by the multi-agency IT Strategy Group and Rotherham CCG's Operational Executive. Following submission at the end of June it will be further endorsed as follows

Organisation	**Endorsed by**	**Date**
Rotherham	Rotherham Health and Wellbeing Board	13th July 2016
NHS Rotherham CCG	Governing Body	6th July 2016
Rotherham Hospice	Board of Trustees	22nd August 2016
The Rotherham NHS Foundation Trust	Trust Board	25th August 2016
Rotherham Doncaster and South Humber NHS Trust	Finance, Performance and Informatics Committee	21st July 2016
Rotherham Metropolitan Borough Council	Digital Council Board	26th July 2016

2. Our Vision

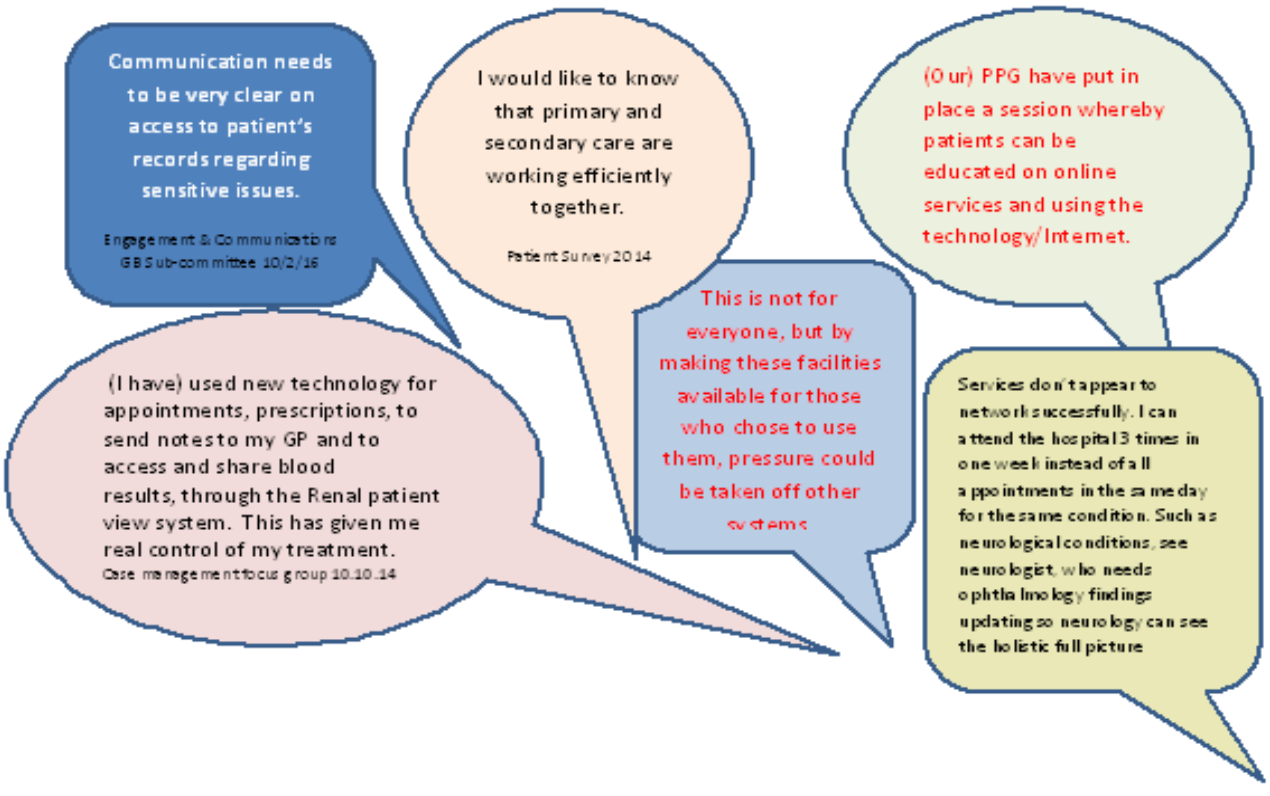
Our vision supports Rotherham's ambition to deliver care closer to home and out of hospital where possible. To enable the delivery of this ambition our roadmap will empower patients so that they can better self-manage their own health and care through digital services and support the transformation of our health and care services so that they can increasingly be delivered out in the community.

Rotherham's digital vision has been developed in the on-going context of the change in financial outlook for the NHS and the need for enabling programmes, including information technology, to drive the delivery of increased Quality, Innovation, Productivity and Prevention.

In Rotherham, we know from a range of engagement activity over the last few years that patients are frustrated when communication between services and between services and patients fail – this also leads to waste in the system and poor experiences. Simultaneously, as growing numbers people have increasingly positive experiences of digital technology in everyday life, the disparity between commercial services and the health sector is becoming more and more apparent.

We are also starting to see examples of patients choosing to be digital innovators, and where this is right, safe and beneficial for the patient it can work extremely positively. We actively acknowledge that there is some hesitancy and concern within the community, especially older people; and that patients need to be assured that their data will be safe,

In addition, we have started to discuss these issues with a variety of stakeholders and a sample of their comments is shown below:



The Vision for Rotherham Health and Care Services (Place Based Plan)

Rotherham is a fully co-terminus health and social care community with a population of 260,000, which makes a perfect test bed for new innovations. We have developed very strong, credible, robust joint working across our local Health and Care system, supported by cross stakeholder sign up to our place based plan. We are all committed to whole system partnership working and passionate about providing the best possible services and outcomes for our population and maximising the best value for of the Rotherham pound.

We have already made significant progress on delivery of the key enablers within of our place based plan. As a Health and Care Community with the additional support of transformational funding at a local place base level, we know that we can move further and faster to deliver the required transformation to support system sustainability. On our journey we are already delivering in the following areas:

- **An Accountable Care Organisation** jointly providing Acute, Community and Emergency Primary Care Services.

- **A fully integrated Multi-specialty Community Provider model (MCP)** for community based services, which maps resources to deprivation and is underpinned by comprehensive risk stratification. It encompasses the following services on a locality basis. This innovation is in its third year of development

    1. All GP practices
    2. Voluntary sector (Including the National Award Winning Rotherham Social Prescribing Service).
    3. Secondary Care Physicians
    4. Social Care
    5. Community Nursing
    6. Community Therapists
    7. Community Mental Health Services
    8. Hospice in the community
    9. Re-ablement services (including intermediate care).
    10. Fire Service
    11. Police

    A video demonstrating Rotherham's vision for the future of community-based healthcare can be accessed from the link below:

    https://www.youtube.com/watch?v=e2HlhcNI1jU

- **A new integrated Emergency Centre** due to open in spring 2017, delivering ground-breaking 'next available clinician' delivery model with innovative staffing solutions, hitting many of the requirements of the Keogh Review for Urgent Care.

- **A 24\7 Care Coordination centre and associated rapid response teams** which manages system capacity and advises on the most appropriate level of care for patients to avoid hospital admission wherever possible.

- **One Public Estate approach for Rotherham**

- **Integrated IT** across health, social care and care homes. Linking up Health and Care records is a must do and we have already made good progress. Our model of one provider for Health IT has facilitated a coordinated approach.

- **Further Development of our social prescribing service to cover mental health clients and facilitate earlier hospital discharge.** We already target the top 5% of patients at risk of hospitalisation using risk stratification and GP judgement. We have identified non-medical interventions for over 5000 patients with amazing success, saving money and improving outcomes for patients. We are further developing this approach and wish to move further and faster to develop more interventions for mental health clients and services to support early hospital discharge.

The overarching vision for our health and care services is for people to live independently in the community, with prevention and self-care at the heart of our delivery. Our Local Place Based Plan (CCG Commissioning Plan) supported by existing initiatives within our locally agreed Better Care Fund provides a real opportunity to improve the lives of the Rotherham population and some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better service and better quality of life.

We will work together to achieve the following objectives. These are aligned with the outcomes set out in Rotherham's Health and Well Being Plan.

1. An integrated health and social care delivery system which promotes joint working
2. An integrated commissioning framework with joint outcomes and service specifications
3. More care and support provided in people's homes
4. Integrated care planning that addresses physical and psychological wellbeing
5. Individuals and families taking more control of their health and care
6. Accurate identification and active case management of people at high risk of admission
7. Broader use of new technology to support care at home
8. A financially sustainable model that targets resources where there is greatest impact
9. Prevention, self-care and empowering citizens, communities and frontline staff will be at the heart of everything we do.

The Rotherham Local Digital Roadmap Vision

We have five major existing assets that can be utilized in the delivery of our digital roadmap:

- The local energy and enthusiasm of the people of Rotherham
- Established track record of working together and strong working relationships across the roadmap partners.
- There are already a large number of joint initiatives in progress.
- The availability of a wide range of health apps and device technology that already exist
- The variety of organisations that can help achieve the vision

Our objectives are that we will:

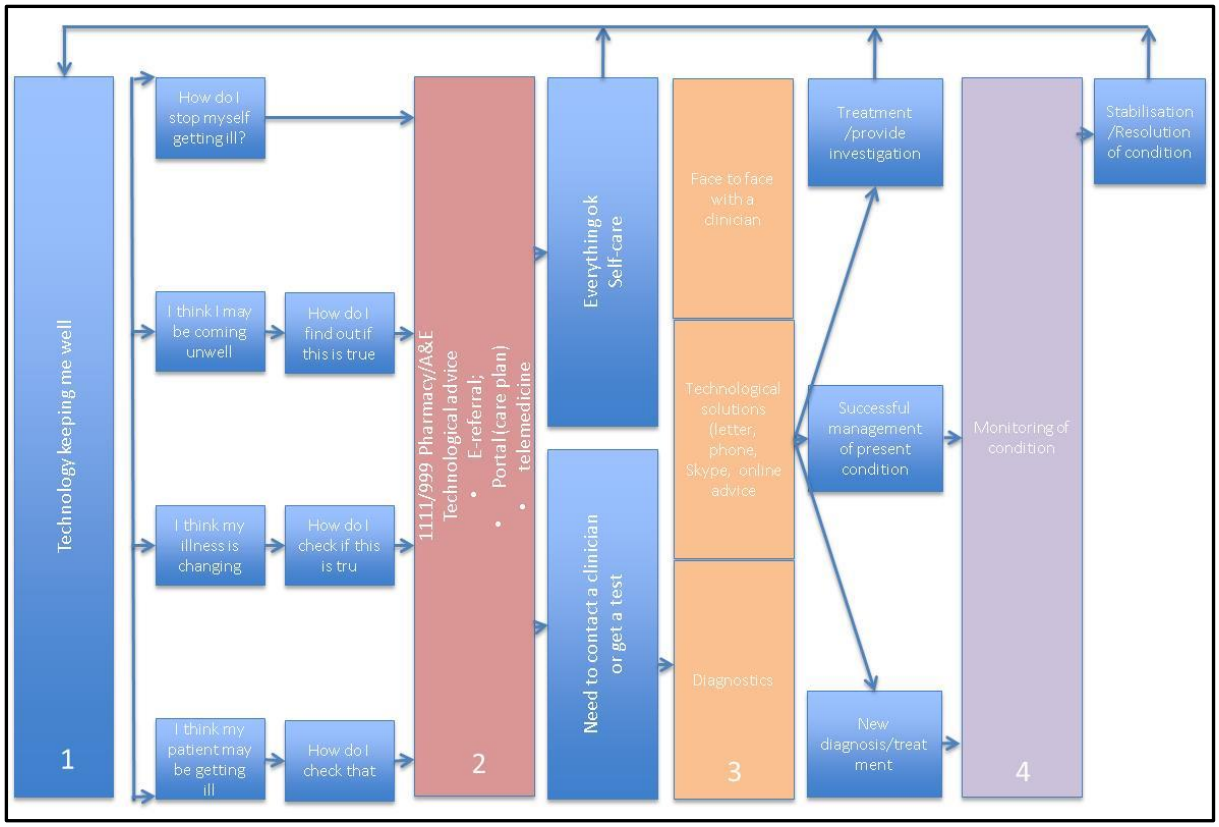
- Engage patients, staff and communities from the start, developing priorities through the eyes of those who use and pay for the NHS
- Develop services that reflect the needs of patients and improve outcomes by 2020/21 and, in doing so, help close the three gaps across the health and care system that were highlighted in the NHS 5 Year Forward View
- Mobilise local energy and enthusiasm around place-based systems of health and care, and develop the partnerships, governance and capacity to deliver
- Provide a better way of spreading and connecting successful local initiatives

Realisation of our digital roadmap vision will include:

- Access to shared records (by health professionals, carers and people themselves);
- Access to a directory of services
- Access to digital services (e.g. virtual clinics);
- Enabling digital transactions (e.g. booking of appointments);
- Access to virtual assistants
- Utilisation of personal device technology to manage wellbeing (exercise and fitness, medication compliance, managing mental illness, etc.)

In so doing we will create a community where the majority of health and wellbeing transactions are digital and these services will enable people and carers to care and be cared for in their homes.

A model of how digital care might be accessed is shown in the diagram below. It shows digital health supplementing face to face intervention and complementing the range of interventions available. In this model services will be accessed more easily and the process of making appointments in primary, secondary and community care will be facilitated and will be underpinned by access to a unified clinical record to which people can add information.



Rotherham is a leader in the delivery of social prescribing and we anticipate a range of social prescriptions being developed which will encourage the adoption of digital means of transaction, access to records and the acquisition data.

Supplementary to the above model we expect that we will increasingly utilise the developments in genetics, data analytics, population health management and personalised medicine to enable a sharper focus on more effective treatments for the citizens of Rotherham.

The key building block that underpins progress is the existence of an integrated record, between the multiple agencies involved in care and in safeguarding, a particular emphasis in Rotherham, so that all involved can be party to the transactions of others and so that patterns of abuse and exploitation can be detected and dealt with earlier in the cycle. An objective is to improve the perception of Rotherham to that of a locality that is proactively dealing with issues such as safeguarding and protection in an effective way.

Good progress has already been made towards an integrated digital care record across health, social care, care homes and citizens/patients. There has been development of the Rotherham Clinical Portal (RCP) connecting information from disparate health systems and the population of Social Care systems with NHS Numbers in preparation for further connectivity. Our portal is a central and key element in moving forward and achieving our vision.

Our plan is to further integrate systems by engaging suppliers to use national technical standards across Health and Social care and using the RCP as a secure "window" into organisational systems, and to support self-care patients will be able to view and add their own data and interact with Health and Social care professionals using modern technology. Finally, we are also planning to ensure we share and exchange information with other providers outside of Rotherham.

There exists in our geography resourceful and significant organisations that can contribute to this challenge - they include local colleges (for example Hallam University is one of the largest training organisations for nurse training) and educational establishments, small and medium size businesses. There are a significant number of technical start-up companies in the locality. Engaging these organisations in developing applications will enable access to an agile capacity that can respond to the market demand faster than the NHS.

All of this will still require provider organisations to digitize applications such as e-prescribing, which will clearly save lives and staff rostering systems so that resources are well managed. It will also require providers to ensure that transactions between the different care settings and agencies are digitized so that they can become part of the integrated record that is already being built and used.

It will require providers to develop virtual ward applications in which beds in people's homes are part of the virtual ward so as to extend care and clinical responsibility. There is a need to create the visibility of records and care pathways in the context of which will exist the data collected by people. There are already examples of these applications in the USA and of initiatives such as care navigators and care co-ordination that are focused on the individual not on the facility. These are initiatives are also being utilized in the NHS Vanguard sites for new care models.

The proposed change and shift of emphasis from the most expensive intervention to the most appropriate and cheaper intervention is evidenced in the new Emergency Care Centre project at Rotherham. This same shift is mirrored in the proposed changes to community care in Rotherham so that more is done in people's homes, but key to that is their engagement, involvement and sense of control over what is being done to them by whom, why and in what context.

Through implementation of our digital roadmap we expect that the delivery of new models of care in Rotherham will be significantly enhanced by the development of the digital services envisaged, so that care becomes more based upon:

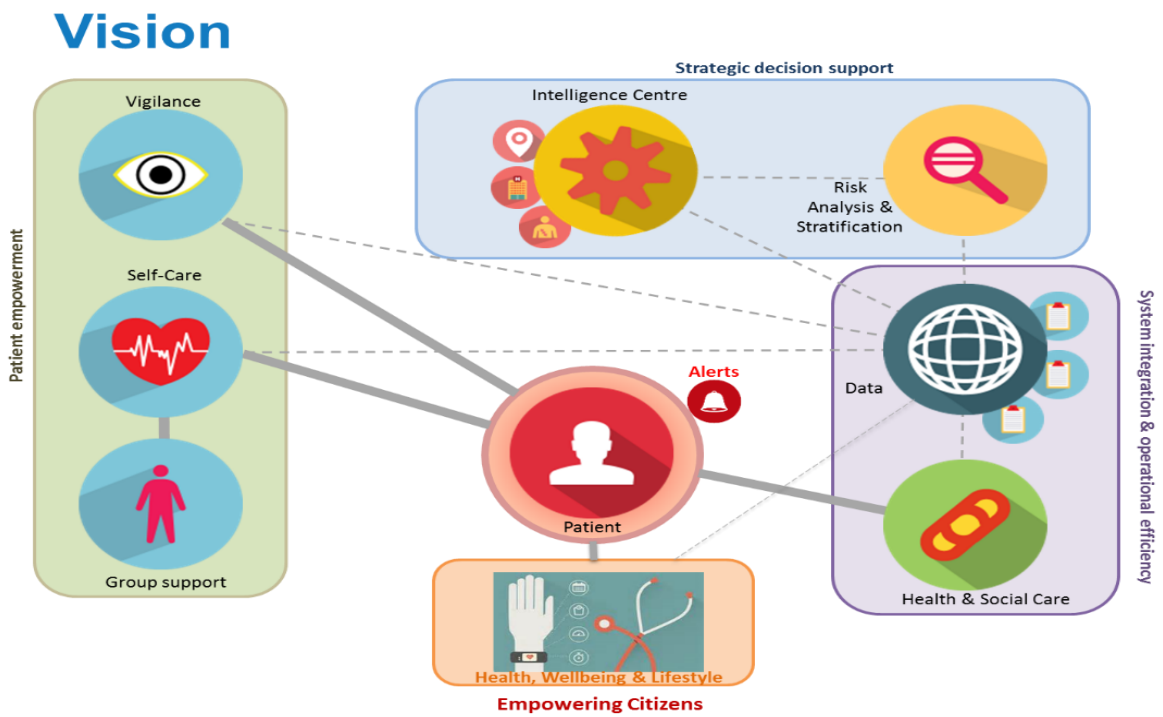
- Self-care
- Proactive care interventions
- More appropriate care interventions

The digital priorities for Rotherham fall within the wider vision set out in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan Digital Work Stream which is below.

South Yorkshire and Bassetlaw Sustainability and Transformation Plan Digital Vision

Our digital health strategy has three essential elements.

- Citizen and Patient Empowerment
- System integration and operational efficiency
- Strategic decision support



Our future technology enabled communities will therefore be characterised by:

- Enabling health and care providers' access to all patient clinical electronic data across traditional boundaries, agnostic of staff employer or organisation. Having a Shared Care Record in place, accessible to clinical staff or those who need it wherever they are, is the single most important change we need to make. As we develop our plans for clinical services across the wider SYB footprint, we will inevitably see more patients moving between organisations to receive care. Therefore it makes sense that our ambition for shared care records extends across this larger footprint. Access to Shared Care Records is particularly important for urgent and emergency care, but such a system would have significant benefits for clinical care. This ambition:

- will require up to date hardware and wireless networks so that access to data is fast and easy for our citizens, patients, carers, staff or wider health and care communities;
- will require us to develop clear rules within which we operate to ensure appropriate governance and security for patient data as well as interoperability of systems and technologies now and into the future. Consequently data, data management and systems will be subject to agreed national and local standards supporting on-going interoperability;
- will incorporate data from multiple sources (including NHS and social care as well as other public and voluntary or charitable organisations) and include citizen generated data from citizen controlled devices and innovations (e.g. Apps);
- will means citizens and patients take greater ownership for their health and wellbeing. They will be supported to do this through technology which promotes risk prediction, prevention as well as self-care and management.

- Innovation and learning will be part of our DNA, translated into rapid deployment of technology (e.g. related to access, devices, apps etc.) and signposting where helpful to achieve improved health and wellbeing outcomes. This will need us to also concentrate on improving digital literacy so that interventions help to bridge, not exacerbate, the digital health divide and health inequalities across our broad socio-economic communities. Personal health and wellbeing digital data needs to be as 'consumable' for health and care professionals as for citizens and patients in order to maximise potential.

- Robust population based analytics, supporting risk stratification and system alerts which result in rapid response and appropriate interventions tailored to the individual's needs.

Within the next five years our system will therefore deliver a new way of supporting and working in partnership with our communities to achieve improvement in health and wellbeing outcomes and address current health and care challenges.

Gap	**How we will address the Gap**
Care and quality	• Shared records offering increased access to relevant, real time, information about a patient by health and care providers as well as patient authorised viewers • Improved interoperability to enable more effective and efficient transfer of care across providers (e.g. through e-referral and discharge processes) supporting reduced waiting times and access to appropriate support

	• Promote mobile working of practitioners through Wi-Fi accessibility and roll-out of remote working solutions for practitioners • Use population data to help identify and provide evidence for best practice and quantitatively assess quality outcomes • Ensure better informed clinical decisions enabling more appropriate cost effective and safe care (e.g. avoiding drug contra-indications) as well as support for safeguarding • Improved patient experience through not having to repeatedly provide clinical details and not having to undergo unnecessarily repeat clinical tests
Health and wellbeing	• Patients will have significantly more control over their care, and experience better outcomes through improved treatment and medication adherence as well signposting to appropriate services within their community • Increased citizen, patient and carer awareness of, and involvement in, health and care support and delivery will result in better knowledge about condition management, better self-care and achievement of patient determined outcomes • Increased interoperability and strategic system intelligence will support proactive care. This will reduce the frequency of exacerbation, and support co-ordination of care to address health and care needs holistically - including mental health • Promotion of remote monitoring, new forms of consultation (e.g. video, phone) and mobile health (mHealth) will also support care based in the citizen's own home, reducing the burden of routine care on patients, their carers and families, and health professionals
Finance and sustainability	• We will develop combinatorial innovations (including technologies as well as service changes) to promote increased efficiency in the on-going care and management of patients • Greater integration of care will mean increased opportunity for admission avoidance • Increased reliance on validated risk stratification and population

	analytics will enable more efficient case finding and targeted intervention • Remote monitoring and surveillance will mean earlier intervention to avoid unnecessary use of secondary care resources and effective use of community based resources • Better tracking and scheduling of staff resources will enhance operational efficiencies • Reduced DNAs through easy access to GP booking systems, reminders, patient self-reporting/recording and active self-management • Clinicians able to use their time more effectively through the use of technology.

3. Baseline Position

In preparation for development of the Local Digital Roadmap the two secondary care providers in the Rotherham footprint carried out a Digital Maturity Assessment between in November 2015 – January 2016. A summary of the results from this initial assessment of the two providers is shown in the table below:

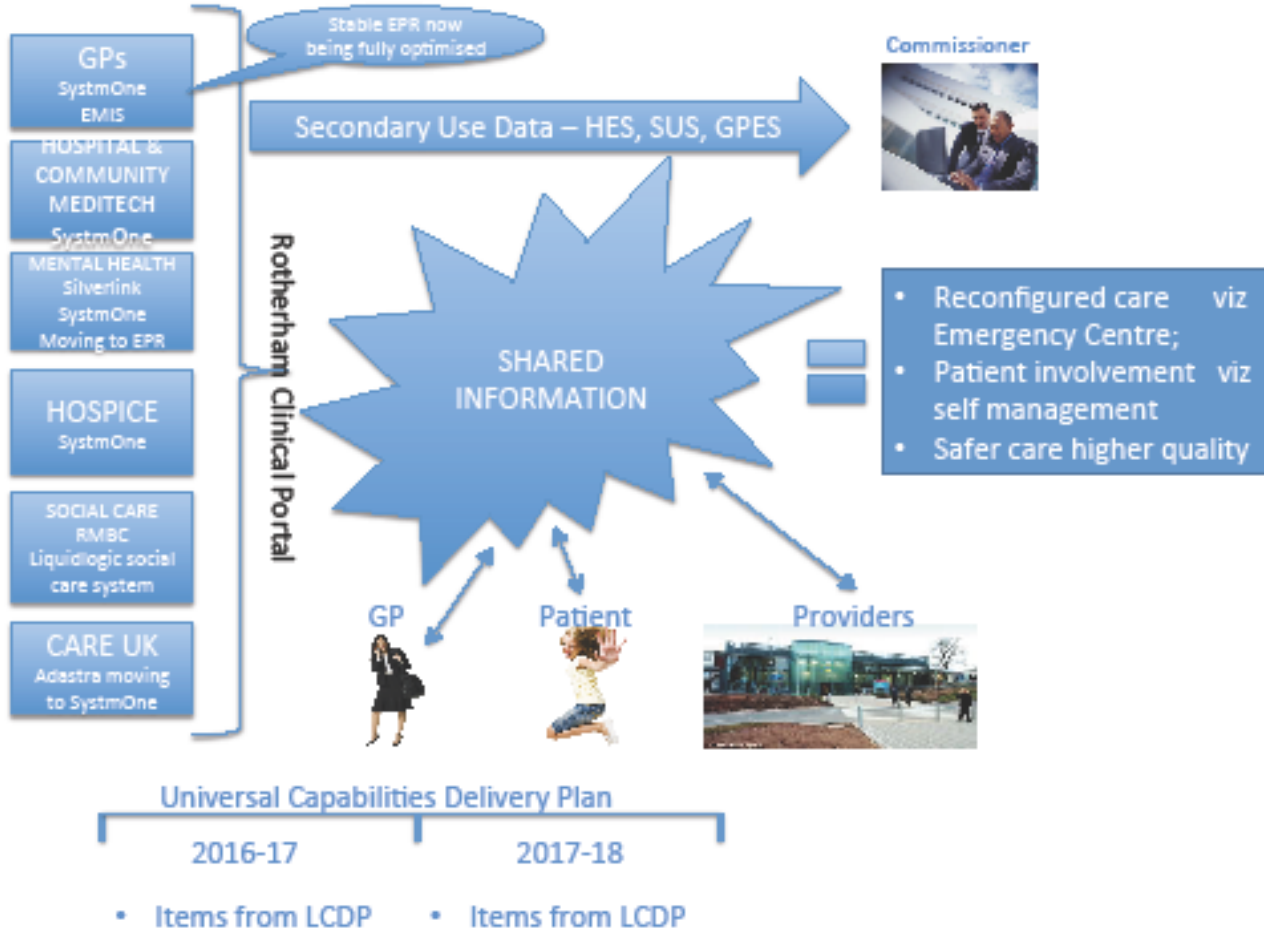
Section	Type	RDaSH	TRFT	National Average
Strategic Alignment	Readiness	85	81	76
Leadership	Readiness	95	85	77
Resourcing	Readiness	80	85	66
Governance	Readiness	70	70	74
Information Governance	Readiness	75	75	73
Records, Assessments & Plans	Capabilities	68	41	44
Transfers Of Care	Capabilities	13	58	49
Orders & Results Management	Capabilities	15	79	52
Medicines Management & Optimisation	Capabilities	11	14	29
Decision Support	Capabilities	68	48	36
Remote & Assistive Care	Capabilities	25	33	33
Asset & Resource Optimisation	Capabilities	40	10	42
Standards	Capabilities	60	50	41
Enabling Infrastructure	Enabling Infrastructure	73	57	68
Readiness Average	**Readiness**	**81**	**79**	**73**
Capabilities Average	**Capabilities**	**37**	**41**	**40**
Enabling Infrastructure Average	**Enabling Infrastructure**	**73**	**57**	**68**

As can be seen from the table above the assessment scores for the Rotherham footprint identify that our current level of development is consistent with the national position. A key insight is that organisational readiness is strong but capabilities still need to be developed. Nationally the capability areas where it has been identified that there is particular room for growth are medicines management, decision support and remote care. Our scores indicate that these with the exception of decision support are also key development areas for Rotherham along with transfers of care, orders and results management and asset and resource optimisation.

In addition to the above exercise Rotherham CCG has submitted a Digital Maturity Assessment for primary care and Rotherham Metopolitan Borough Council has

completed a Digital Maturity Assessment via the Local Government Association. Analyses of the results for these assessments will be included in future developments of the LDR.

The health and care providers in Rotherham currently have multiple record systems and multiple departmental systems. The illustration below shows the overall position.



An overview of the current digital maturity of the primary, secondary and social care providers within the Rotherham LDR footprint along with a summary of their recent achievements and current initiatives is given below:

<u>Primary Care</u>

All of the general practices in Rotherham have implemented the latest version of their chosen GP clinical system and use either TPP SystmOne (68% practice) or EMIS Web (32% practices).

Key recent achievements within primary care include:

- e-discharge has been provided to all practices from secondary care
- NHS 111 ITK has been rolled out to 70% of practices

- Mobile devices (laptops with 4G and software to support connectivity over Wi-Fi) have been deployed to all GPs and registrars and appropriate practice nursing staff.
- 100% Practices have been switched on for patient online services
- 65% Practices are ETP enabled
- SystmOne Care Home module deployed in one care home

The key initiatives currently on-going in primary care are:

- Development of an improved and extended Wide Area Network that will connect all Rotherham practices to a set of IT systems and services
- The rollout of Wi-Fi networks into all practice premises is nearing completion
- A programme of work is underway that will help practices meet quality data quality standards for recording and sharing information and improve the utilisation of GP clinical systems and utilisation of universal and local capabilities.

The Rotherham NHS Foundation Trust (TRFT)

TRFT includes both acute hospital and community services. TRFT took a decision eight years ago to procure and implement an EPR system - Meditech. There is currently an initiative to optimize the utilization of the Meditech product and to rationalise applications onto the platform. For example the A&E department is being migrated from Symphony onto a Meditech module this summer. Community records are held on SystmOne The Rotherham Clinical Portal provides an overarching capability to view record across the Trust.

Significantly the development of the Rotherham Clinical Portal (RCP) has been a precursor to any single system and has demonstrated the benefits of having an integrated view across multiple systems. The system is being extended as GP practices make their data available in the portal view and as the number of systems whose data is capable of being viewed is increased. The portal will be a key part of enabling doctors in the new Emergency Centre (which opens in 2017) to view data from Out of Hours, Walk-in, NHS111, Ambulance, hospital and community systems.

The Trust has completed a Digital Maturity Assessment which shows a high readiness, good capability but requires some improvement in the enabling infrastructure.

Key recent achievements at TRFT include:

- Integration of RCP and MT/S1 with rich clinical data
- Outpatients SNOMED compliant
- Small number of clinical specialties eNoting in Outpatients Clinics within EPR
- Small number surgical specialities documenting Operation notes within EPR

- Full Radiology Results & Reporting from within EPR
- RCP used as real-time patient flow
- MediTech & RCP Integration
- RCP and MIG Interoperability
- Heart Failure using Telehealth
- Regional Wide (7 Acute Providers) Results & Reporting integration using ICE
- Community services fully mobile

The key initiatives currently on-going at TRFT are:

Project/Initiatives	Project Status (In Progress, Approved, Planning)	Who for	What (Capability)	Capability Group
Rotherham Clinical Portal	In Progress	Hospital & Community & GPs & Social Services	Provide integrated view of clinical information across Rotherham Health and Social Care	All
South Yorkshire HIE	Planning	Hospital & Community	Share detailed clinical information across all South Yorkshire health and social care	All
RCP (SEPIA) - Rotherham Health and Social Care capacity display	Planning	Hospital & Community & GPs & Social Services	Rotherham wide view of all Healthcare & social care beds/occupancy/patient	Asset and resource optimisation
eRostering	In Progress	Hospital	digital management of hospital nursing rotas	Asset and resource optimisation
SystmOne Mobile	Planning	Community	community nursing teams to have ability to interact with community EPR whilst "offline"	All
RCP (SEPIA) Patient flow	In Progress	Hospital & Community	Clinical teams from any location on any device can manage and update patient flow across and outside of the hospital, supported by real-time patient notification	Asset and resource optimisation

NHSMail2 migration	Planning	Hospital & Community	Secure email and messaging platform	Asset and resource optimisation
Business Intelligence and Intranet	In Progress	Hospital & Community	Accurate and easily accessible hospital clinical and management information to support decision making and performance monitoring	Asset and resource optimisation
EPR Storage and Servers	In Progress	Hospital	Refresh 7+ year old EPR server and storage infrastructure	Asset and resource optimisation
Corporate Hardware Storage and Servers	Planning	Hospital & Community	Ensure servers and storage systems are fit for purpose	Asset and resource optimisation

Rotherham and South Humber NHS Foundation Trust (RDaSH)

RDaSH's current level of digital maturity for capabilities is consistent with the national average across secondary care providers. Their self-assessment indicates that growth is required in their capabilities for transfers of care, orders and results management, medicines management and optimisation and remote and assistive care.

RDaSH are addressing these growth areas through their 5 year strategy published in April 2016 "Information Communication and Technology Strategy – *Towards a Digitally Integrated Healthcare Environment*". This ambitious strategy which will see all Trust services transferred onto a unified EPR system has the four key strategic aims identified below:

- Improving patient experience
- Supporting agile working
- Enabling paper-free care delivery
- Reducing administrative overheads

Key recent achievements at RDaSH include:

- Procurement for the new EPR is underway using the SBS framework and is therefore due to complete end of Q2 2016
- Implementation of the EPR is scheduled for completion Sept-Dec 2017
- Large remote sites have been moved on to the Yorkshire and Humber Public Sector Network

- An upgrade of the Trust's core IT infrastructure upgrade was carried out during 2014-2016

The key initiatives currently on-going at RDaSH are:

- Procurement, configuration and implementation of a new EPR
- Development of an Agile working strategy
- A review of IT security and governance procedures
- A review of the Trust email services
- Investment in data warehouse capability

RMBC

RMBC are currently implementing a replacement social care system (Liquidlogic) across their adults and children's services. It is anticipated that the system will be fully live by the end of 2016. It is expected that that data sharing will become much easier between health and social care services when the new system is in place.

Key recent achievements at RMBC include:

- All social workers have the ability to access systems and data when mobile.
- NHS number matching processes is in place and over 90% of open cases have the NHS number recorded (children's and adults)
- New social care system procured and is being deployed, which will bring enhanced functionality.

The key initiatives currently on-going at RMBC are:

Project/Initiatives	**Project Status (In Progress, Approved, Planning)**	**Who for**	**What (Capability)**	**Capability Group**
Replacement Social Care System	In Progress	Social Care Staff	Improvements to current social care system to underpin delivery of future integration with	Records, assessment and plans

			Health	
Rotherham Clinical/Care Record Portal	Planning	All partners	A single secure website which will hold all appropriate health and social care data	All
e-Discharge	Planning	Social Care Staff	Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care	Transfers of care
Child Protection - Information Sharing	Approved	Social Care and emergency care	Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly	Decision Support
Shared HSC Wi-Fi	In Progress	Social Care Staff	Giving NHS staff the ability to work from RMBC buildings (e.g. Care Homes) and vice versa	Asset and resource optimisation
Mobile Working	In Progress	Social Care Staff	Continuing to improve (e.g.) social worker access to systems and data from (e.g.) client	Asset and resource optimisation

			homes	
NHS Number Matching and Use	In Progress	All partners	Underpins many other projects – the adoption of the NHS number as the unique ID for all clients.	All
Overarching Information Sharing	In Progress	All partners	To ensure all data exchange is legal and that clients are clear as to how their data is being used (includes the facility to opt out)	All
Fax Elimination	Planning	All partners	Digitising communication between organisations	Records, assessment and plans

Rotherham Hospice

Rotherham Hospice currently uses SystmOne as its main clinical system. For viewing of wider records it uses EMIS Web viewer, SWIFT (RMBC), The Rotherham Clinical Portal and ICE for results reporting.

Key recent achievements at Rotherham Hospice include:

- Implementation of the Rotherham Clinical Portal
- Provision of mobile devices for CNS/Community rapid response team and medics
- Implementation of the EMIS Web viewer.

The key initiatives currently on-going at Rotherham Hospice are:

- Preparation for migration of the TPP contract

- A review of IT Strategy and capabilities as a business

Out of Hours (OOH) Services

The OOH service is currently provided in Rotherham by Care UK and the system that they use is Adastra. Care UK will be moving to SystmOne during 2016/17. The data from OOH service will be integrated into the RCP as part of the development of the Emergency Centre Solution in 2017. Full integration will be sought when they have migrated to SystmOne.

Population Baseline

Our roadmap aspires to provide enhanced and increased digital services for the people of Rotherham. The information in this section provides the most recent information on the use of Internet services by the Rotherham population.

There are three main forms of access to digital services – the PC, Smartphone and Smart TV. In terms of local access to digital services, there is evidence of a local digital divide.

A recent statistical bulletin from ONS shows that the usage of the Internet in Barnsley, Doncaster and Rotherham is at one of the lowest rates in the country.

Used in the last 3 months						**Used over 3 months ago/Never used**					
2011	**2012**	**2013**	**2014**	**2015**	**2016**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
80.4	**74.4**	**79.2**	**82.2**	**81.9**	**78.3**	**19.3**	**25.5**	**20.3**	**17.8**	**17.9**	**21.7**

However statistics for phone ownership in the first quarter of 2014 and 2015 show that mobile phone ownership as a proportion of the population is high in the UK although smart phone ownership is lower.

Proportion of adults who personally own/use a mobile phone in the UK	93% (Q1 2014)	93% (Q1 2015)
Proportion of UK adults with a smartphone	61% (Q1 2014)	66% (Q1 2015)

The third means of access is smart TV and another OFCOM publication shows that over half of adults had a connected TV at the end of 2014 and evidence is that this will have increased.

Additionally access to Wi-Fi is an important enabler for smart phone access - a recent study shows that the UK had a Wi-Fi hotspot for every 11 people who were third behind the France and the US. The study predicted rapid growth in Wi-Fi hotspots between 2014 and 2018.

Access will be a key local issue that we will have to monitor so that the take up of digital services is not impeded. We will work closely with the Rotherham Digital Inclusion Network (RDIN) to encourage our citizens to get online and use digital services.

Rate Limiting Factors

There are a number of rate limiting factors in progressing paper free at point of care delivery across the Rotherham footprint. The key factors have been identified as:

- Unable to have coded data due to Clinical systems APIs not being available
- Feedback on capital funding bids delays ability to move forward with IT improvements and efficiencies
- Limited capacity to deliver in certain key areas (Project management, benefits management, Systems Architecture)
- Significant cuts in capital development
- In hospital Infrastructure near end of life
- MediTech currently does not support a "mobile interface
- Lack of single clinical system across the Trust. Resulting in reduced functionality including the ability to share data.
- Lack of interoperability within the health and social care community
- Hospice still awaiting transfer onto their own ODS number, which may delay migration and risk access to SystmOne post 7th July

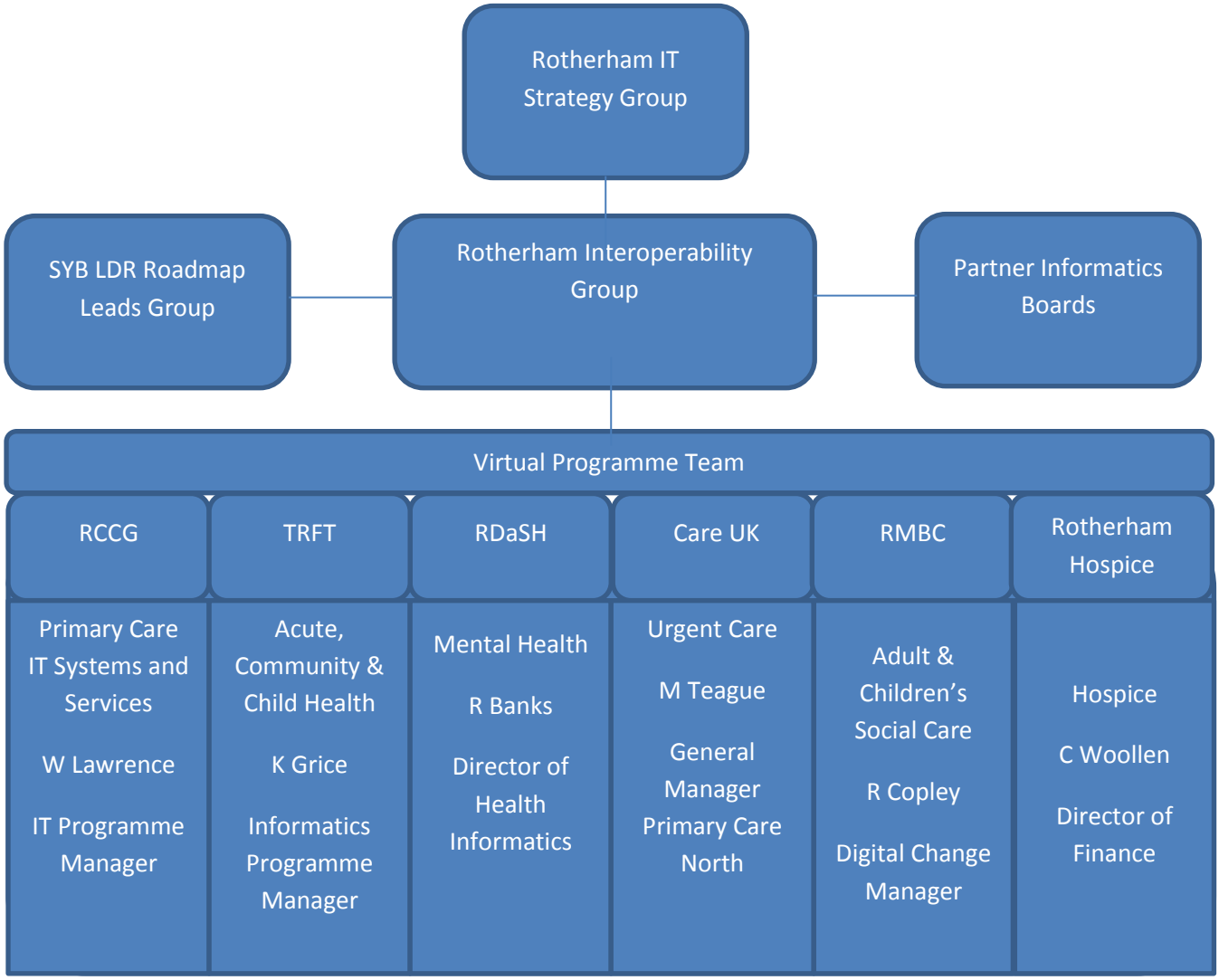
4. Readiness Assessment

As identified in section 1 we have established a new group, the Rotherham Interoperability Group, to support development and manage the delivery of our LDR. The group is chaired by the CCG Head of Health Informatics and has clinical and informatics representatives from all organisations. Clinical representation includes the CCG's and TRFT's Chief Clinical Information Officers. The seniority of the group membership helps to provide strong leadership and links back to LDR partner organisations.

The Interoperability group is accountable to the multi agency Rotherham IT Strategy Group, which is chaired by the CCG's Deputy Chair and reports to the CCG Governing Body. The Interoperability Group also reports updates and progress to partner Informatics Boards, including TRFT's Corporate Informatics Committee and RMBC's Digital Council Board. This link helps to ensure that all partner organisations are clearly sighted and supportive of the roadmap objectives.

Progress on the delivery of the LDR will be reported to Interoperability Group and to existing provider informatics groups as per existing governance arrangements.

The current governance and programme structure for the Rotherham LDR is shown in the diagram below:



As can be seen from the diagram above Rotherham doesn't currently have a shared Programme Management Office or project resources. Therefore initially delivery of the LDR will be managed using the project resources of the partner organisations, working together to ensure that changes are managed and communicated effectively. Monitoring and reporting on the LDR delivery will be carried out by Rotherham CCG as part of their responsibility for the Rotherham Interoperability Group. Over the course of the LDR programme we will review and assess the structure and resources required to support effective delivery through the Interoperability group and make changes as required. We will also continue to participate in the development of potential programme/project resources at the SYB STP level, to identify where resources supporting the LDR could be best shared across the wider area.

There already exists across the Rotherham locality a significant informatics resource and capability with experience of delivering large informatics programmes including acute and community EPRs.

We are currently exploring the potential opportunity to engage an experienced programme lead, who works for the HSCIC, to work on our LDR programme during the remainder of 2016 to help establish our formal programme approach.

Within our LDR footprint at present there isn't a common change model or benefits management approach. Discussions at the Interoperability Group have identified that currently the approach to managing technology enabled change and benefits management at an organisational level does not follow a standard methodology. Our discussion on benefits management in particular has raised awareness that partner organisations may not currently have the required skills or resources to provide a formal benefits management programme. We are clear that to achieve benefits requires addressing three elements: people, process and technology. It also requires significant documentation of the baseline position so that variances from the baseline can be observed and accounted for. We will therefore identify appropriate change and benefits management's models and implement them within our LDR community. These requirements have also been discussed at the South Yorkshire and Bassetlaw LDR Leads group and they were noted as a common requirement across several of the constituent LDR footprints. We will therefore seek to assess if these skills and resources could be provided and shared on a wider footprint.

The existing budgets for IT Capital and Revenue are already over committed throughout Rotherham. It is therefore expected that to drive digital maturity further and faster we will need access to additional funding. We have identified the following potential sources for this:

- The Driving Digital Maturity Investment Fund
- The Estates and Technology Transformation Fund
- Sustainability and Transformation Plan Funding
- Prime Minister's Access Fund

- Additional funding opportunities e.g. through Local Government and charities

Working together in partnership to deliver the LDR for Rotherham will enable and require much greater engagement, and co-working between the informatics departments across the footprint than before. It is expected that through this closer working we will be able to identify opportunities to share and rationalise systems, services, skills and resources for the benefit of the whole community.

5. Capability Deployment

Operating Paper-free at the Point of Care is about ensuring health and care professionals have access to digital information that is more comprehensive, more timely and better quality, both within and across care settings. Its scope is defined by the following seven groups of capabilities:

- Records, assessments and plans
- Transfers of care
- Orders and results management
- Medicines management and optimisation
- Decision support
- Remote care
- Asset and resource optimisation

The current level of maturity of Rotherham's secondary care providers for the above groups of capabilities, as assessed by the digital maturity assessment, is detailed below:

Group of Capabilities	The Rotherham NHS Foundation Trust	Rotherham and South Humber NHS Foundation Trust
Records assessments and plans	41	68
Transfers of care	58	13
Orders and results management	79	15
Medicines management and optimisation	14	11
Decision support	48	68
Remote Care	33	25
Asset and resource optimisation	10	40

The above identifies that the level of maturity across our two providers for these capability groups is variable with some low levels of maturity for both providers in certain groupings. The assessment indicates that there is further work to be done

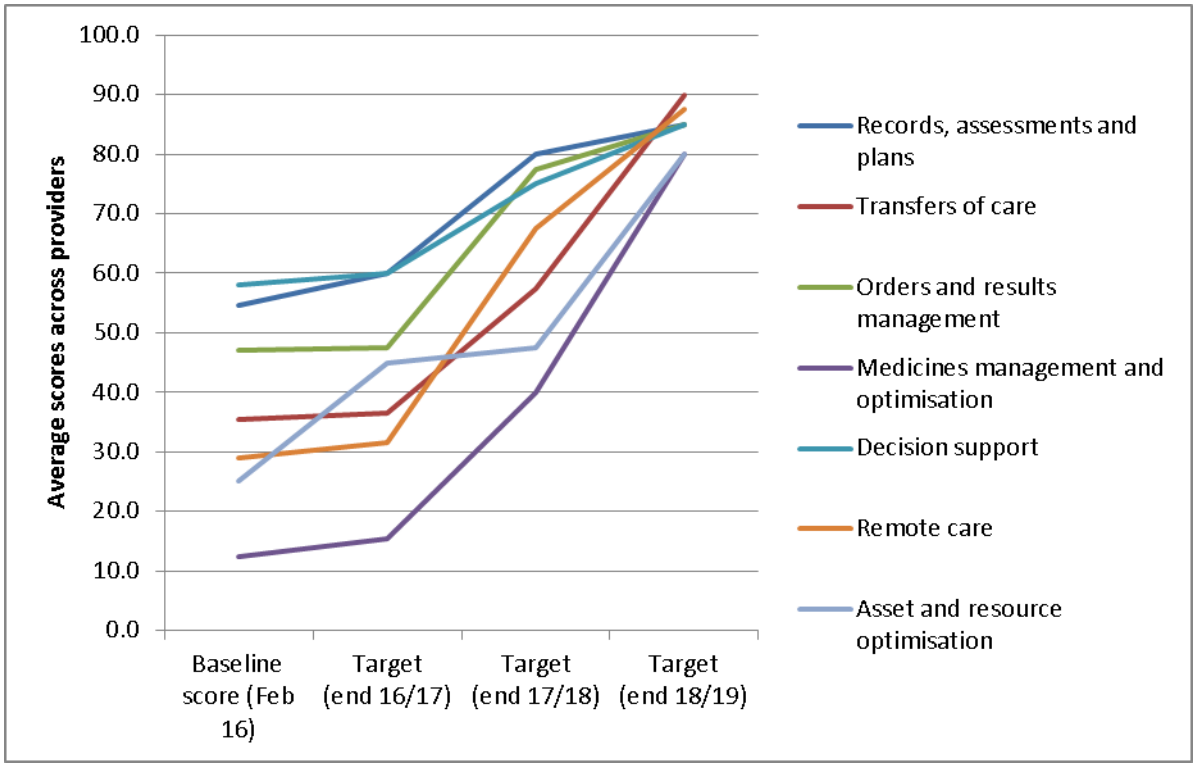
across all capability groupings to enable Rotherham to realise the ambition of operating paper free at the point of care.

As described in our vision the partners in the Rotherham LDR footprint are committed to the further delivery of digitised and shared care records across Rotherham as these will be essential to the delivery of many of our strategic ambitions. We are also committed to working with our partners across the wider South Yorkshire and Bassetlaw STP footprint to deliver shared care records across the whole STP footprint.

To address the growth areas above we have identified a range of projects across the Rotherham LDR footprint that will support development of the necessary capability. The outputs from these projects have been captured in the Capability Deployment Schedule shown in Appendix 1. The deliverables for 2016/17 are based on in-flight projects that will delivered this year. Deliverables for future years are aspirational and will be dependent on approved business cases and funding. To deliver on our roadmap we will require finance and support and will make bids against the available technology funds for this.

Over the course of the next three years, as we deliver on the ambitions set out in this roadmap, our capabilities for the delivery of paper free care will be significantly increased. The estimated trajectories for the overall increase in the capabilities of our secondary care providers in shown in the Capability Trajectory score and diagram below (and in appendix 2):

	Average scores across providers			
Capability group	**Baseline score (Feb 16)**	**Target (end 16/17)**	**Target (end 17/18)**	**Target (end 18/19)**
Records, assessments and plans	54.5	60.0	80.0	85.0
Transfers of care	35.5	36.5	57.5	90.0
Orders and results management	47.0	47.5	77.5	85.0
Medicines management and optimisation	12.5	15.5	40.0	80.0
Decision support	58.0	60.0	75.0	85.0
Remote care	29.0	31.5	67.5	87.5
Asset and resource optimisation	25.0	45.0	47.5	80.0


Average scores across providers
100.0
90.0
80.0
70.0
60.0
50.0
40.0
30.0
20.0
10.0
0.0
Baseline score (Feb 16)
Target (end 16/17)
Target (end 17/18)
Target (end 18/19)
Records, assessments and plans
Transfers of care
Orders and results management
Medicines management and optimisation
Decision support
Remote care
Asset and resource optimisation

6. Universal Capabilities Delivery Plan

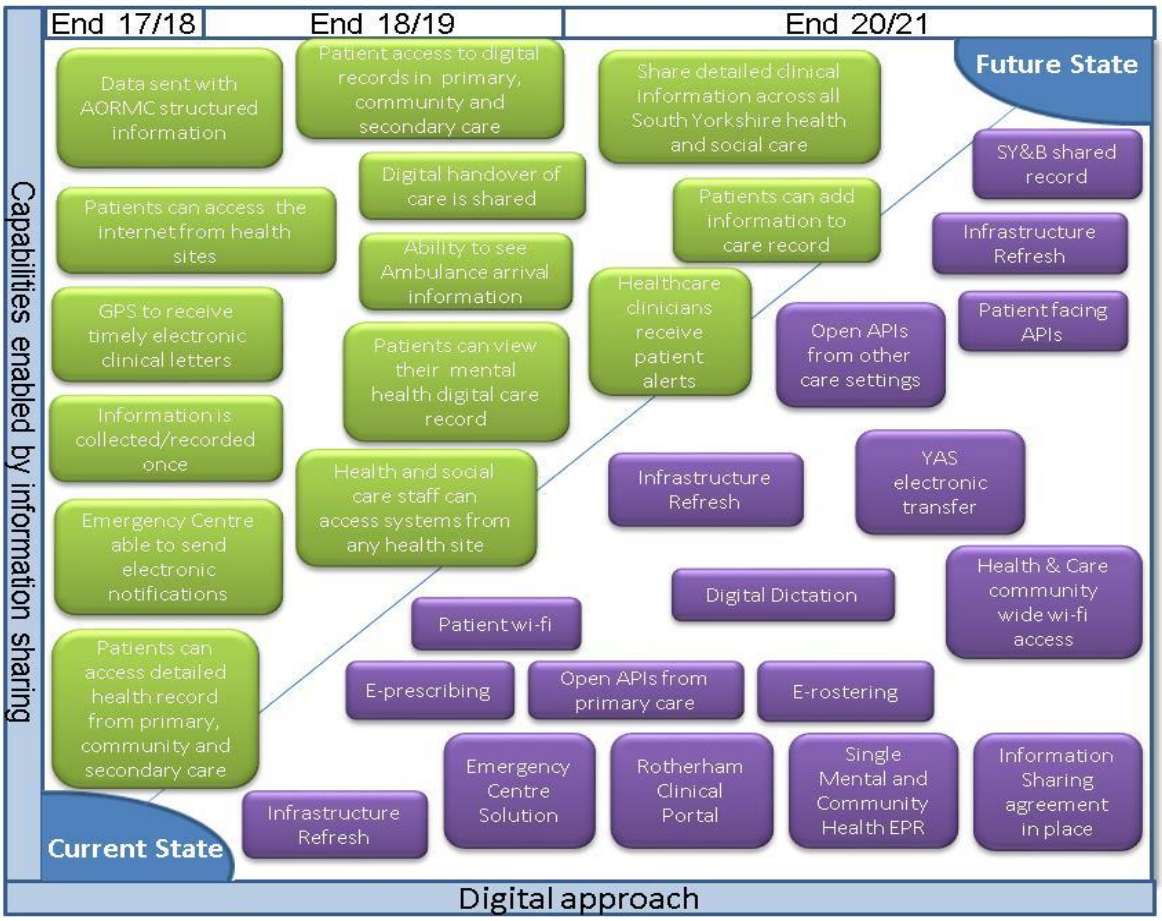
The Rotherham health and care system will make progress on the 10 universal capabilities, listed below,

- Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
- Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)
- Patients can access their GP record
- GPs can refer electronically to secondary care
- GPs receive timely electronic discharge summaries from secondary care
- Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care
- Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
- Professionals across care settings made aware of end-of-life preference information
- GPs and community pharmacists can utilise electronic prescriptions
- Patients can book appointments and order repeat prescriptions from their GP practice

Our approach for addressing each of these capabilities is detailed in the Universal Capability Delivery Plan in appendix 3. The delivery plan details the baseline, ambition, key activities and approach to evidencing progress for each of the capabilities.

7. Information Sharing

A diagram showing how new information sharing capabilities will be deployed in Rotherham over the next 5 years and the corresponding solutions that will enable this information sharing are shown below (and in appendix 4):



The diagram above shows how we will optimize information from the variety of existing source systems via use of the Rotherham Clinical Portal to enable patients, GPs, providers and carers to get an integrated view of a patient record across multiple systems. The RCP is important in also enabling the capture and dissemination of end of life preferences and indeed will be linked up to the Rotherham Hospice early in the plan. The actions detailed in the Capability Deployment Plan (appendix 3) in 2016/7 and 2017/8 will underpin progress to achieving this vision.

Health and Care organisations in Rotherham are in the process of signing up to an existing Inter-Agency Information Sharing Protocol which has over 60 signatories from a variety of organisations across the Yorkshire and Humber region, including NHS Foundation Trusts, Clinical Commissioning Groups, Mental Health Trusts, Local Authorities, Ambulance Service, Voluntary Sector Organisations, Police and Fire Services. The protocol covers the sharing of person-identifiable confidential data where a legal basis exists to allow information sharing (where this is not the explicit

consent of the individual, another legal or statutory basis for the sharing must be identified).

In Rotherham, Information Sharing Agreements have been developed to enable the sharing of records using the Rotherham Clinical Portal. The RCP allows health and care organisations who are providing direct care to individuals a view of the clinical records of patients held across a number of care settings, where the patient has explicitly consented to this view at the point of care. It is anticipated that sharing agreements will be in place between The Rotherham NHS Foundation Trust, Rotherham, Doncaster and South Humber NHS Foundation Trust, GP Practices under Rotherham CCG, Rotherham Hospice, Yorkshire Ambulance Service and Rotherham Metropolitan Borough Council.

This will be supported by communications to the public across Rotherham, co-ordinated by Rotherham CCG, to ensure that patients are made aware of the RCP, how information will be shared and used and will allow patients the opportunity to object to their record being made available to view within the RCP. The viewing of the records within the Portal will be on explicit consent of the patient only. Access to the Portal will only be available to Health and Social Care Professionals who have a direct care relationship with the patient. In future the portal will also be made available to patients and their carers.

Information Governance Leads from health and care organisations across Rotherham (Acute, CCG, Mental Health and Local Authority) meet on a monthly basis as an Information Governance Group to facilitate partnership working. This group reports to the Rotherham Interoperability Group This approach ensures consistency with regards to information sharing between the organisations and allows for any concerns regarding the lawful basis for proposed information sharing to be discussed and satisfied before sharing takes place.

The Information Governance Group will consider proposals for new projects which require the sharing of information between the member organisations and will advise on the appropriate requirements including the completion of privacy impact assessments to ensure that information sharing is lawful and that due consideration is taken regarding appropriate safeguards that should be in place to protect patient information.

As part of our work within the wider SYB footprint we recognise the need to have a shared approach to information sharing (through both an information governance framework and technical solutions). Our intention is to engage in a wider joint approach across all SYB (or wider) health and care organisations and we will be seeking to take this work forward within the SYB STP governance arrangements. We also recognise that we will need to develop an approach to appropriate information sharing with other organisations including emergency services and the voluntary sector.

The current level of adoption of the NHS Number across health and care providers in Rotherham is shown in the table below:

Provider	% records in key systems with NHS number	Action Plan
TRFT	Meditech (Acute EPR) - 99.8% SystmOne (Community) EPR – 99.9% Symphony (A&E) – 86.6%	The A&E department will migrate from the Symphony system to Meditech during 2016/17. This will facilitate improved NHS Number completion in A&E
RDaSH	99.9%	None required
Rotherham Hospice	A spine compliant system is used for Hospice records. Therefore very high NHS number completion is reported.	None required
RMBC	96.0% for open cases	RMBC has established a relationship with colleagues in TRFT Informatics and the CCG Business Intelligence Teams. RMBC now have an agreement with the Informatics Team whereby they will match records and assign NHS numbers. NHS Informatics uses their own routines to analyse the data and send back matched records. RMBC also receive analysis as to why any unmatched records have failed to achieve a match. Business as usual NHS number assignment will become considerably easier after the new social care system goes live later in 2016. The new system includes the facility to integrate with the NHS 'Patient Demographic Service' (PDS) – which will deliver the ability to quickly look up NHS numbers on the NHS spine. Whilst RMBC are waiting for that facility to go live they will add new NHS numbers manually and also continue to use the local Informatics' team

		matching bureau for batch processing.

In order to extract the most value from the sharing of information, the SNOMED-CT and Dictionary of Medicines and Devices (dm+d) information coding standards will have to be rolled out across the local health and care system. Our plans and milestones for the adoption of these standards are summarised in the table below:

Provider	Action Plan
Primary Care	SNOMED is already implemented in EMIS Web. The CCG will seek confirmation from the GPSoC programme of when it will be available in SystmOne. dm+d is already available in EMIS Web and SystmOne.
TRFT	SNOMED is within the acute EPR system. TRFT will continue to review when this functionality will be available for community SystmOne. dm+d is available within the EPR system
RDaSH	The implementation of SNOMED will be facilitated by the introduction of the new EPR system.
Rotherham Hospice	The hospice will continue to review when this will be available for SystmOne Hospice. dm+d is already available in SystmOne.

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8. Infrastructure

The development of network connectivity between sites and mobile infrastructure has been progressed significantly in Rotherham over recent years. We have been working to rationalise and deploy network connections from the Yorkshire and Humber Public Sector Network (PSN) across primary care, secondary care and local authority sites for several years. These network connections are now fully deployed in RDaSH and RMBC and continue to be rolled out into TRFT and primary care, giving us increased capability to share information and services across providers. Rotherham has supported the development of the NHS Roam Wi-Fi solution, developed under the Working Together Partnership, and this has been implemented in sites at TRFT and RDaSH allowing staff to move and work across sites. In the future we aim to further develop this capability to allow seamless mobile working for health and care practitioners across all health and care sites in Rotherham.

A summary of the current mobile working capability in Rotherham and plans to develop this further is shown below:

Primary Care	All GPs and Registrars within Rotherham practices have been allocated a laptop with mobile provision. The mobile connection is delivered by a solution that provides access over 4G and Wi-Fi networks helping to maintain a secure and reliable connection to system. To support mobile connectivity in GP practices we have invested in a GP practice Wi-Fi solution for all sites and this was deployed during 2015/16. Wi-Fi connectivity is also available for GP connection at some care/nursing homes and this will be further rolled out to more sites over 2016/17.
TRFT	The majority of community teams have mobile devices. In the hospital site laptops on wheels are used. Wi-Fi is available across all key buildings and locations. The RCP is already accessible from any mobile device. TRFT will deploy SystmOne mobile in 2016/17 to relevant teams and explore the suitability of alternative devices. In hospital, TRFT are exploring with their EPR supplier the ability to use handheld devices to interact with the patient record and add clinical data. The "Opening" of back office systems is also planned to enable access from any mobile device.
RDaSH	Infrastructure to facilitate mobile working (3G/4G plus VPN) is available. Staff have the ability to access this infrastructure depending on need. Wi-Fi is deployed to areas across the Trust.

	A Mobile/Agile programme is now in place to support the Trust wide Transformation Programme. This will include extending Wi-Fi coverage across the whole Trust.
Rotherham Hospice	All community nurses and medics have ability for mobile working. Rotherham Hospice is planning to develop their in-house IT service capability and capacity.
RMBC	All RMBC staff has access to their systems and information from any location where an internet connection can be established. It is planned that more care home Wi-Fi will be enabled and Social workers are to be issued with tablet devices.

As detailed above the providers in Rotherham have implemented connectivity to a common wide area network infrastructure (PSN) and have discussed how this could be used to support collaboration and shared infrastructure in the future. There are currently discussions underway in the footprint regarding a shared data centre between TRFT and RMBC, an initiative to join-up active directories and the potential for BI tools and dashboards to be cloud hosted. We haven't yet considered the implementation of tools to support collaboration across the Rotherham footprint but adoption of the NHSmail2 service is currently under consideration for primary care, TRFT, RDaSH and the CCG and we are keen to see how this development could support a future collaboration platform.

In Rotherham we have some areas of shared infrastructure in place across our organisations. TRFT provide an IT service that covers themselves, all General Practices and the CCG. This service has significant areas of shared infrastructure and this continues to develop as the IT services grow and are rationalised across our organisations.

As our LDR programme develops and the partner organisations develop their digital maturity we will use the opportunities provided by working in partnership to identify where infrastructure, systems and IT services could be shared across the Rotherham footprint or possibly wider across the STP or Working Together areas.

9. Minimising Risks Arising from Technology

All partners within the Rotherham LDR footprint have their own well established Information Governance functions and will remain responsible for minimising risks associated with data security, clinical safety, data quality, data protection, privacy, business continuity and disaster recovery.

The routine reporting of risks and issues has been established at the Rotherham Interoperability Group and we will use this process to ensure that key risks to LDR delivery and operation are communicated across the footprint and mitigated as appropriate. Within the Rotherham locality over the next three years there will be changes to core systems of several providers and we will monitor and review issues and risks associated with these developments through the Interoperability Group.

In addition we have established a footprint wide Information Governance operating as sub-group to the Interoperability Group. We have also recognised that there is the opportunity for working more collaboratively on the wider STP footprint to support this agenda and we will continue to engage with partners across this wider area.

TRFT and RDASH are both developing plans for the GS1 standards. All TRFT systems procurements include reference to GS1 standard and they have completed a review of key patient ID systems and confirmed that they are GS1 compliant (track and trace, Patient ID).

Glossary

A&E (Accident and Emergency)	A medical treatment facility specialising in acute care of patients who present without prior appointment.
CCG (Clinical Commissioning Group)	Clinical commissioning groups will cover the whole of England and will be responsible for commissioning the majority of healthcare for their local population. They will work with partners including NHS England and local authorities, who have responsibility for commissioning areas such as specialised services, primary care and public health, to commission integrated care for patients.
DMA (Digital Maturity Assessment)	The Digital Maturity Assessment measures the extent to which healthcare services in England are supported by the effective use of digital technology. It will help identify key strengths and gaps in healthcare providers' provision of digital services at the point of care and offer an initial view of the current 'baseline' position across the country.
EPS (Electronic Prescription Services)	The Electronic Prescription Service is an NHS service that allows a GP to send prescriptions directly to a patient's chosen pharmacy. This means that patients can choose to have a paper-free prescription.
GP (General Practice)	General practice (GP) General practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.
GPSoC (GP Systems of Choice)	GP Systems of Choice is a programme through which the NHS funds the provision of GP clinical IT systems in England.
Local Digital Roadmap (LDR)	Local health economies are required to produce Local Digital Roadmaps detailing the actions they will take to deliver the ambition of being paper-free at the point of care by 2020. Local Digital Roadmaps will generate momentum and drive transformation across local health economies, inform local investment priorities and support local benefit realisation strategies.
NHS Digital (HSCIC)	The national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care. NHS Digital (HSCIC) is an executive non-departmental public body, sponsored by the Department of Health.
NHS e-RS (NHS	NHS e-Referral Service replaced Choose and Book in 2015. This

e-Referral Service)	service is used to manage all appointments referred to secondary care from primary care
PF@POC (Paper Free at the Point of Care)	Paper free at the point of care means that all authorised care givers can access a patient's relevant digital records when and where they need them.
PSN (Public Services Network)	The Public Services Network (PSN) is the UK government's high-performance network, which helps public sector organisations work together, reduce duplication and share resources.
SCR (Summary Care Record)	The Summary Care Record is an electronic record used to support patient care. The SCR is a copy of key information from a patient's GP record, such as medication, allergies and adverse reactions. It provides authorised healthcare staff with faster, more secure access to essential patient information
Social Care	Social care in England is defined as the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.
SNOWMED	SNOMED CT (Systematized Nomenclature of Medicine -- Clinical Terms) is a standardized, multilingual vocabulary of clinical terminology that is used by physicians and other health care providers for the electronic exchange of clinical health information.
Sustainability and Transformation Plan (STP)	Local health and care blueprints for accelerating implementation of the Forward View.
Working Together Programme (WTP)	Working Together is a partnership involving seven hospital Trusts in South Yorkshire, Mid Yorkshire and North Derbyshire. Collaborating on a number of common issues will allow the Trusts to deliver benefits that they would not achieve by working on their own.

Footprint:	Rotherham

Capability				Locally defined attributes ->			
Who	**What**	**Year**	**Capability group**				
Community and secondary care clinicians	Ability to view rendered view of GP data	16/17	Records, assessments and plans				
GPs	Receive Academy of Medical Colleges coded e-discharge messages	16/17	Records, assessments and plans				
GPs	Ability to access information from secondary care to deliver safe, high quality care.	16/17	Records, assessments and plans				
Care / Nursing home staff	Ability from some care / nursing home staff to send electronic communication/queries to GP practices	16/17	Records, assessments and plans				
H&SC	Have an agreed consent model to support data sharing across H&SC	16/17	Records, assessments and plans				
Patients	Can access detailed health record from primary care	16/17	Records, assessments and plans				
Patients	Can book appointments and order repeat prescriptions from GP practice	16/17	Records, assessments and plans				
Secondary and Community care	Review requirements for Hospital Electronic Patient Record system post March 2019 contract end	16/17	Records, assessments and plans				
Social care staff	Ability to send automated notification when a CPP or LAC child presents in an unscheduled setting.	16/17	Records, assessments and plans				
Social Service Staff	Ability to identify patients/clients using NHS numbers	16/17	Records, assessments and plans				
Social care staff	NHS number used as the client identifier	16/17	Records, assessments and plans				
GPs	Receive timely electronic clinical letters	16/17	Transfers of care				
GPs	Receive coded NHS 111 ITK Messages	16/17	Transfers of care				
GPs	Receive timely electronic discharge summaries	16/17	Transfers of care				
Unscheduled care teams	Ability to see ambulance arrival information	16/17	Transfers of care				
Care / Nursing home staff	Ability for some care / nursing home staff to request patients repeat medication electronically	16/17	Medicines Management and Optimisation				
Community Pharmacists	Can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions	16/17	Medicines Management and Optimisation				
Secondary and Community care clinicians	Access to relevant detailed primary care information.	16/17	Decision Support				
Patients	Ability to self-monitor and submit results electronically	16/17	Remote care				
GPs	Ensure data quality standards for recording and sharing information are met	16/17	Asset and resource optimisation				
GPs	Improve utilisation of GP clinical systems and utlisation of universal and local capabilities	16/17	Asset and resource optimisation				
GPs, Community Nursing, Health Visitors, Midwives, Social Services staff	Can access wi-fi across Rotherham Health sites	16/17	Asset and resource optimisation				
H&SC	Ability to view Rotherham wide Healthcare & social care beds/occupancy/patient	16/17	Asset and resource optimisation				
Hospital Nurses	digital management of hospital nursing rostas	16/17	Asset and resource optimisation				
Patients	Ability to access the internet from the hospital and community sites	16/17	Asset and resource optimisation				
Primary Care, Secondary Care, Community Care	Shared digital data network across local health economy	16/17	Asset and resource optimisation				

Footprint:	Rotherham

Secondary and community care	Accurate and easily accessible hospital clinical and management information to support decision making and performance monitoring	16/17	Asset and resource optimisation				
Secondary and community care	50% replacement of UPS enabling infrastructure is protected against environmental failure	16/17	Asset and resource optimisation				
Secondary care	Improved EPR server and storage facilities	16/17	Asset and resource optimisation				
All Community and MH Clinicians	Information is collected/recorded once; healthcare professionals do not have to copy or re-enter it from one system to another	17/18	Records, assessments and plans				
GPs	Receive Academy of Medical Colleges coded for all local clinical correspondence	17/18	Records, assessments and plans				
H&SC	Provide integrated view of clinical information across Rotherham Health and Social Care	17/18	Records, assessments and plans				
Patients	Can access detailed health care record for primary and secondary care	17/18	Records, assessments and plans				
Secondary and Community care	Commence procurement of hospital EPR system	17/18	Records, assessments and plans				
All Community and MH Clinicians	Healthcare professionals use digital systems to record relevant patient information at the point of collection	17/18	Records, assessments and plans				
A&E clinicians OOH clinicians GPs Social Services hospital specialists community staff	Able to access one single patient record with integrated workflows to and from ambulance, social services, hospital specialists, community and primary care	17/18	Transfers of care				
GPs Community and Secondary care staff	Ability to receive electronic tasks and messages from social services	17/18	Transfers of care				
Secondary Care	Electronic entry of outpatient clinical narrative	17/18	Transfers of care				
Social care staff	Receive timely electronic discharge summaries	17/18	Transfers of care				
GPs Community and Secondary care staff	Emergency Centre able to send electronic notifications	17/18	Transfers of care				
All Community and MH Clinicians	Healthcare professionals can track the status of requests at all times, including receipt, authorisation, scheduling and completion.	17/18	Orders and results management				
All Community and MH Clinicians	Ability to view test results within clinical system.	17/18	Orders and results management				
Community and MH prescribing staff	Medicines and infusions are automatically scheduled for administration and the outcome is digitally recorded, including reasons for non-administration.	17/18	Medicines management and optimisation				
Community and MH prescribing staff	Dgitally monitoring of prescribed medications administered early, late or not administered at all, and reviews the reasons recorded.	17/18	Medicines Management and Optimisation				
H&SC	Ability to provide better management information	17/18	Decision Support				
Secondary and Community care clinicians	Access to summary care record information.	17/18	Decision Support				
Mental Health Clinicians	Ability to identify patients and medicines prior to administration through automatic identification and data capture using barcode technology	17/18	Decision Support				
GPs and Patients	Ability to have remote consultations	17/18	Remote care				
Patients	Empower patients to triage and check symptons to make a better decision to the right place of care	17/18	Remote care				

Footprint:	Rotherham

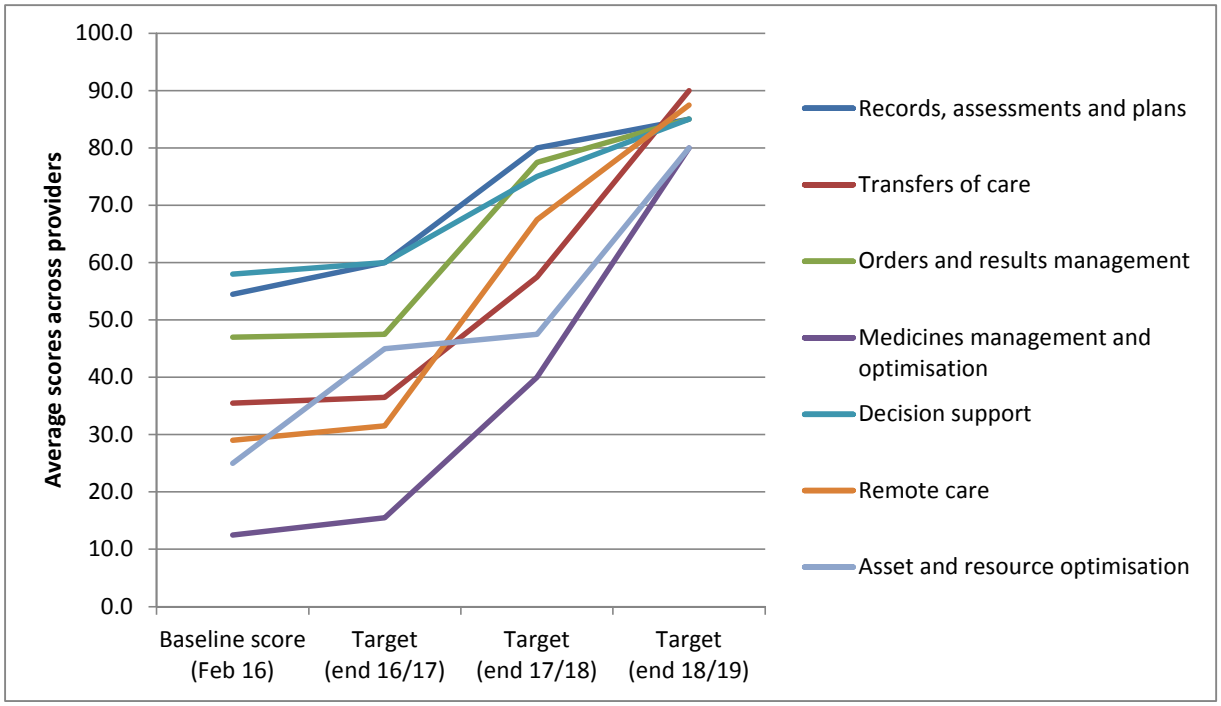
GPs	Ability to view and input data from the GP system across a federation when providing services across practice boundaries	17/18	Asset and resource optimisation				
GPs Secondary care clinicians	ability to electronically communicate with clinicians across care settings, with the ability to add attachments and other supporting information to support advice and virtual clinics	17/18	Asset and resource optimisation				
GPs, Community Nursing, Health Visitors, Midwives, Social Services staff	Can access wi-fi across Rotherham NHS and Social Care premises to enable access to patient/client data systems remotely.	17/18	Asset and resource optimisation				
GPs, Nurses, health visitors, midwives, hospice clinicians and mental health clinicians	Ability to send electronic tasks and messages between clinical systems	17/18	Asset and resource optimisation				
Patients	Ability to access the internet whilst at NHS and social care premises	17/18	Asset and resource optimisation				
Primary Care, Secondary Care and Community Care	Secure email and messaging platform	17/18	Asset and resource optimisation				
Secondary and community care	50% replacement of UPS enabling infrastructure is protected against environmental failure	17/18	Asset and resource optimisation				
Social Care	Partly shared digital data network across local Health and Social Care	17/18	Asset and resource optimisation				
Social Service Staff	Ability to access client information remotely	17/18	Asset and resource optimisation				
All Community and MH Clinicians	Healthcare professionals use digital systems to manage inpatient beds throughout the organisation	17/18	Asset and resource optimisation				
Social Care Staff	Ability for social workers to access systems from client homes	17/18	Asset and resource optimisation				
Social Care Staff	Ability to complete case conferences between partners electronically	17/18	Asset and resource optimisation				
Hospital Nurses	Resource and specialism to support digital agenda within nursing teams	17/18	Leadership				
Secondary and Community Care	Commence migration to EPR system	18/19	Records, assessments and plans				
Secondary and community clinicians	Ability to access digitized medical records	18/19	Records, assessments and plans				
Secondary care clinicians	Ability to record structured digital clinical information within outpatients	18/19	Records, assessments and plans				
GPs and secondary care	Ability to electronically exchange information from referrals directly into EPR	18/19	Transfers of care				
Secondary and Community care clinicians	Ability to electroncially order/task clinical services from within EPR	18/19	Transfers of care				
Secondary Care	Electronically manage patient pre-assesment workflow, utlimatley allowing patients to "pre-asses" from home	18/19	Transfers of care				
Secondary Care and Social Services	Refer to hospital social services teams from with the EPR	18/19	Transfers of care				
Secondary care clinicians and community care	Safely and consistently handover patients between clinical teams, whilst maintaining an accurate clinical record	18/19	Transfers of care				
Unscheduled care teams	Ability to see ambulance demand and electronic transfer ambulance information into EPR / RCP	18/19	Transfers of care				

Footprint:	Rotherham

All Community and MH Clinicians	Increase the proportion of patient information relating to handovers of care within the organisation that is shared by Healthcare professionals digitally	18/19	Transfers of care				
Secondary care clinicians and community care	Ability to view up-to-date clinical record when completing handover of patients	18/19	Decision Support				
Secondary and Community care Patients	Inter-organisational / cross-organisation and patient communications from any device and any location.	18/19	Remote care				
Community Nursing	Ability to interact with community EPR offline	18/19	Asset and resource optimisation				
H&SC	Support ANY clinician to use ANY device to access clinical systems, irrespective of the "owner" of that device	18/19	Asset and resource optimisation				
Primary Care, Secondary Care, Community Care and Social Care	Shared digital data network across Health and Social Care	18/19	Asset and resource optimisation				
Secondary and community care	Hospital data and wifi networks can support modern devices and are supported 24x7, with medium and long terms refresh programmes	18/19	Asset and resource optimisation				
Secondary and Community Care	Clinical teams from any location on any device can manage and update patient flow across and outside of the hospital, supported by real-time patient notification	18/19	Asset and resource optimisation				
H&SC	Share detailed clinical information across all South Yorkshire health and social care	19/20	Records, assessments and plans				
Secondary and Community Care	Migrate identified services to new EPR system	19/20	Records, assessments and plans				
All Community and MH Clinicians	All information is available at the point of care; paper records are used by exception.	19/20	Records, assessments and plans				
All Community and MH Clinicians	Remote/virtual clinical consultations and clinical advice are available to patients using tools such as online meetings, videoconferencing, skype, email or instant messaging,	19/20	Records, assessments and plans				
Secondary Care	Electronic entry of inpatient clinical narrative	19/20	Transfers of care				
Secondary and community clinicians	Integrated bed to pharmacy prescribing with decision support	19/20	Medicines Management and Optimisation				
Secondary Care clinicians	Ability to electronically capture patient vital signs, and auto-alert to responsible clinical teams	19/20	Decision Support				
Primary Care, Secondary Care, Community Care and Social Care	Transfer onto HSCN data network across Health and Social Care	19/20	Asset and resource optimisation				
Secondary and Community Care	All services migrated to new EPR system	20/21	Records, assessments and plans				
Secondary and community clinicians	Ability to access clinical systems from any location	20/21	Remote care				
All	Ability to use patient acquired data	20/21	Records, assessments and plans				
All	Shared detailed clinical information across South Yorkshire Health and Social Care	20/21	Records, assessments and plans				

Footprint:	Rotherham

Capability group	Average scores across providers			
	Baseline score (Feb 16)	Target (end 16/17)	Target (end 17/18)	Target (end 18/19)
Records, assessments and plans	54.5	60.0	80.0	85.0
Transfers of care	35.5	36.5	57.5	90.0
Orders and results management	47.0	47.5	77.5	85.0
Medicines management and optimisation	12.5	15.5	40.0	80.0
Decision support	58.0	60.0	75.0	85.0
Remote care	29.0	31.5	67.5	87.5
Asset and resource optimisation	25.0	45.0	47.5	80.0



Appendix 3

Universal Capabilities Delivery Plan

Footprint:	Rotherham

Instructions for Completion

- Please indicate your Local Digital Roadmap Footprint above
- Complete questions A to E in the subsequent pages – the same structure is used for each of the 10 universal capabilities
- For further guidance, refer to:
    - Sections 6.24 to 6.30 of the Developing Local Digital Roadmaps Guidance
    - The Universal Capabilities Information and Resources document
- This template and the documents referenced above can be downloaded from the LDR page on the NHS England website

Universal Capabilities Delivery Plan

Universal Capability:	A. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
Capability Group:	Records, assessments and plans
Defined Aims:	• Information accessed for every patient presenting in an A&E, ambulance or 111 setting where this information may inform clinical decisions (including for out-of-area patients) • Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

The Summary Care Record has been uploaded by 100% practices. Plans are in place to also implement the MIG to provide further detailed information to unplanned and emergency care services. The acute Trust and Hospice also have EMIS Web viewers.

400 SCRs viewed across Rotherham per week

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Implement MIG views across secondary care. Consenus and protocols agreed for coherent GP record sharing Development plan agreed with HSCIC to integrate SCR into Rotherham Clinical Portal As part of Emergency Care project, doctors and ANP issued with smartcard to access SCR and CP-IS Community teams dependant on GP sharing of the primary care data through SystmOne.

17/18	Integrate SCR information into local Mental Health and Community system to improve accessibility of SCR by clinical staff and remove requirement to log on to SCR separately. SCR integrated into Rotherham Clinical Portal accessible from within EPR

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Local workshops are being arranged by Midlands and Lancashire CSU for all South Yorkshire and Bassetlaw pharmacies, this has been arranged by HSCIC. • Meeting scheduled with HSCIC to plan SCR integration • Plan for all Junior Doctors to be issued with smartcards
16/17 Q2	• Review Information Governance processes for viewing of primary care information via the MIG • SCR integration confirmed with HSCIC • Integration plan confirmed with supplier community • Confirmed Emergency Centre SCR and smartcard plans
16/17 Q3	• Patient engagement and implementation of the MIG across secondary care. • SCR Integration work commenced • Emergency Care live and using SCR
16/17 Q4	• Review MIG implementations and potential to expand to further services. • Test SCR integrated into Rotherham Clinical Portal for all patients • approach agreed as to how to "pull" SCR information into TRFT EPR • Rotherham wide consent model agreed and confirmed
17/18 Q1	• Live SCR integration into Rotherham Clinical Portal • Specification and plan confirmed for SCR data exchange
17/18 Q2	• Implementation commenced for SCR interoperability into EPR • Testing of SCR interoperability into acute EPR
17/18 Q3	• Live SCR Interoperability into acute EPR
17/18 Q4	• Integrate SCR with Mental Health and Community EPR system.

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

In conjunction with the SCR, implementing access to the Medical Interoperability Gateway (MIG) to provide more detailed information straight from the primary care clinical systems.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

HSCIC SCR access reports % reported to the Rotherham Interoperability Group. MIG deployment Progress/Highlight reports to the Rotherham Interoperability Group. SCR integration highlight report to Rotherham Interoperability Group.

Universal Capabilities Delivery Plan

Universal Capability:	B. Clinicians in U&EC settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)
Capability Group:	Records, assessments and plans
Defined Aims:	• Information available for all patients identified by GPs as most likely to present, subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisations • Information accessed for every applicable patient presenting in an A&E, ambulance or 111 setting (including for out-of-area patients)

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

The Summary Care Record has been uploaded by 100% practices. Plans are in place to also implement the MIG to provide further detailed information to unplanned and emergency care services.

400 SCRs viewed across Rotherham per week

Currently no additional information is recorded on the Summary Care Record.

The Medical Interoperability Gateway (MIG) has been implemented across Eight (24%) practices to enable primary care information to be sent via the MIG.

EMIS Web viewer and TPP CRV deployed across the hospital, although usage is low.

SCR deployed across the hospital – uptake is slow due to the system being separate and impeded by internal capacity to provide smartcards

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Provide access to detailed primary care data to OOH and emergency care settings across Rotherham via the MIG. Improved use of MIG to enhance sharing to stop paper trail and ability to inform advance care management plans. SCR information is integrated within EPR system for all MH Clincians, removing the requirements for separate sign on
17/18	Integrate SCR with Mental Health and Community EPR system. SCR integrated into Rotherham Clinical Portal and accessible from within acute EPR

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Provide SCR enhanced workshops at practice managers meetings and clinical system users groups. • Include SCR enrichment in the paperlight and system optimisation practice work plan • Increase number of practices signed up to send information to the MIG • Acute sector meeting with HSCIC to plan SCR integration • Junior Doctors issued with smartcards
16/17 Q2	• Review Information Governance processes for viewing of primary care information via the MIG • SCR integration confirmed with HSCIC • Integration plan confirmed with supplier community • Confirmed Emergency Centre SCR and smartcard plans
16/17 Q3	• Patient engagement and implementation of the MIG across secondary care. • SCR Integration work commenced • Emergency Care live and using SCR

16/17 Q4	• Review MIG implementations and potential to expand to further services. • Test SCR integrated into Rotherham Clinical Portal for all patients • approach agreed as to how to "pull" SCR information into TRFT EPR • Rotherham wide consent model agreed and confirmed
17/18 Q1	• Live SCR integration into Rotherham Clinical Portal • Specification and plan confirmed for SCR data exchange
17/18 Q2	• Implementation commenced for SCR interoperability into acute EPR
17/18 Q3	• Testing of SCR interoperability into acute EPR
17/18 Q4	• Integrate SCR with Mental Health and Community EPR system. • Live SCR Interoperability into acute EPR

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

In conjunction with SCR, implementing access to the Medical Interoperability Gateway (MIG) to provide more detailed information straight from the primary care clinical systems.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

HSCIC SCR access reports % reported to the Rotherham Interoperability Group. MIG deployment Progress/Highlight reports to the Rotherham Interoperability Group. SCR integration highlight report to Rotherham Interoperability Group.

Universal Capabilities Delivery Plan

Universal Capability:	C. Patients can access their GP record
Capability Group:	Records, assessments and plans
Defined Aims:	• Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition • Patients who request it are given access to their detailed coded GP record

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Patient online is deployed at 100% of practices 13% of patients currently have patient online access across Rotherham

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Increase no. of patients having access to their detailed coded record.
17/18	Increase no. of patients having access to their detailed coded record.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Promote patient online with practices via system optimisation programme
16/17 Q2	• Promote patient online with practices via system optimisation programme; identifying patients who might benefit from access to their detailed record. • Set-up local report to review patient online access against 2016/17 target, provide practices with monthly report.
16/17 Q3	• Provide monthly report against 2016/17 target to practices.
16/17 Q4	• Provide monthly report against 2016/17 target to practices.
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Provide patient online statistics per practice to the Rotherham Interoperability Group.

Universal Capabilities Delivery Plan

Universal Capability:	D. GPs can refer electronically to secondary care
Capability Group:	Transfers of care
Defined Aims:	• Every referral created and transferred electronically • Every patient presented with information to support their choice of provider • Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability) • [By Sep 17 – 80% of elective referrals made electronically]

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

An estimated 63.5% of referrals are sent via NHS e-referrals currently across Rotherham.

The e-Referral processes are fully embedded within the hospital. The acute Trust has engaged with HSCIC to explore the e-referral system integrating with the local EPR and to also include transfer of a minimum dataset into EPR.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	80% elective referrals are sent via the NHS e-referral service. Mental Health referral process mapping and redesign in conjunction with primary care
17/18	100% elective referrals are sent via e-referral service. Data from NHS e-referrals will be auto-populating secondary care EPR

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Meetings arranged to discuss Rotherham position with HSCIC and primary care teams. • Meetings arranged with secondary care to discuss Rotherham hospital appointment availability. • Quality framework put in place for NHS e-referrals. • Training and support provided to practices via IT Project and data quality team where identified.
16/17 Q2	• Promote e-referrals with practices via system optimisation programme. • Training and support provided to practices via IT Project and data quality team where identified. • Develop delivery plan with HSCIC and EPR supplier
16/17 Q3	• Promote e-referrals with practices via system optimisation programme. • Training and support provided to practices via IT Project and data quality team where identified. • Develop delivery plan with HSCIC and EPR supplier. Commence build of local business case
16/17 Q4	• Mental Health and community services referral process mapping and redesign in conjunction with primary care • Acute Business case approved
17/18 Q1	• Commence implementation of integration
17/18 Q2	• Acute Integration implementation ongoing
17/18 Q3	• Acute Integration implementation ongoing • Implement new referral pathways in line with mental health and community EPR go live and September 17 target of 80% of elective referrals made electronically
17/18 Q4	• Acute Integration complete

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

% of GP referrals via NHS e-referral service reported to Rotherham Interoperability Group.

Universal Capabilities Delivery Plan

Universal Capability:	E. GPs receive timely electronic discharge summaries from secondary care
Capability Group:	Transfers of care
Defined Aims:	• All discharge summaries sent electronically from all acute providers to the GP within 24 hours • All discharge summaries shared in the form of structured electronic documents • All discharge documentation aligned with Academy of Medical Royal Colleges headings

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

MediTech (EPR) discharge letter functionality fully deployed, and once letter completed is electronically delivered to GPs
MediTech (EPR) is ITK/CDA ready and waiting on GP suppliers for deployment
Assessing changes required to be compliant with Academy of Medical Royal Colleges headings
Performance managing clinical teams to monitor compliance of 24 hour target

The mental health trust has funded Silverlink to develop the current system to enable a 'system to system' transfer which has been delayed in its delivery due to an accreditation process with the HSCIC. The Information Team are currently working with Silverlink to ensure the necessary technical set up that is required across GP practices and will then be able to test the new functionality in house.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	All practices receive electronic discharge notifications with AoRMC headings by December 2016 Performance systems embedded within the organisation to ensure compliance Commenced a pilot for clinic letter deployment
17/18	All discharge summaries to be sent within 24 hours, using structured electronic document Implement new referral pathways in line with EPR go live and September 17 target of 80% of elective referrals made electronically

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Agreeing roll-out plan for e-discharge notifications with acute and mental health trusts • Messaging services moved to MESH from DTS. • Build performance reporting systems • test Clinical Letter CDA • plan discharge letter changes to structured format • MH Wards Technical set-up/configuration – Silverlink
16/17 Q2	• Business change and training for services • Technical changes to systems to set-up electronic discharge notifications • Pilot e-discharge messaging with identified primary care pilots. • Performance reporting deployed • Plan in place for full clinical letter rollout • Plan in place for changes to discharge letters structures • MH Wards, Training for staff. Testing for 'dummy patient;. Test for live-discharges with limited GP practices. • Go-live and monitoring
16/17 Q3	• Finalise business change processes with staff. • Provide training and training material for staff. • Action plan in place to meet 24 hour target • MH Wards - monitoring, completed December 2016

16/17 Q4	• Clinic letters to be deployed • Changes made to discharge letters
17/18 Q1	• Discharge and clinic letters being sent electronically for inpatient and outpatient
17/18 Q2	•
17/18 Q3	• Mental health and community services transfer and update e-discharge functionality and processes with replacement EPR solution.
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress/Highlight Reports provided to Doncaster Interoperability Group.

Universal Capabilities Delivery Plan

Universal Capability:	F. Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care
Capability Group:	Transfers of care
Defined Aims:	• All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care within the timescales specified in the Act

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

There is currently no e-Referrals system in place. Plans are to use MediTech and integrate directly with Social Services to deploy an automated referral notification process/system so that social care staff receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Migrate away from unconnected Social Services referral system
17/18	Interoperability between TRFT and Social Services systems

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Complete plan to migrate away from disconnected systems
16/17 Q2	•
16/17 Q3	• Hospital Social Services teams using EPR for Section 2 and Section 5.
16/17 Q4	• Commence planning for Hospital to Social Serivces integration and interoperability
17/18 Q1	• Plan agreed by all parties and supplies and deployment started
17/18 Q2	• Proof of Concept integration
17/18 Q3	• Commence deployment and process change
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress/Highlight report sent to Rotherham Interoperability Group.

Universal Capabilities Delivery Plan

Universal Capability:	G. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
Capability Group:	Decision support
Defined Aims:	• Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk (including for out-of-area children) • Indication of child protection plan, looked after child or unborn child protection plan (where they exist) flagged to clinician, along with social care contact details • The social worker of a child on a child protection plan, looked after or on an unborn child protection plan receives a notification when that child presents at an unscheduled care setting and the clinician accesses the child protection alert in their record

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

No information currently provided for CPIS from RMBC.

CP-IS fully deployed in unscheduled care settings - awaiting RMBC CP-IS integration

Safeguarding flags recorded within SystmOne and MediTech, and locally looking to visualise flags and raise alerts within the Rotherham Clinical Portal

Mental Health crisis team have access to SystmOne EPR and SCR where the CP-IS information is recorded. There are also some manual processes in place across the mental health trust.

RMBC is committed to supplying and consuming data to/from the CP-IS system. Currently migrating to a new social care system, but plans are in place to go live with CP-IS in early 2017.

In addition RMBC will be participating in the roll-out of the Rotherham Care Record Portal. We will be supplying and data to the portal for NHS use and our social workers will use the facility to view NHS data.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	To have safeguarding information available via the Rotherham Clinical Portal
17/18	Able to view RMBC social services information within CP-IS. Childrens Social Services information included in Rotherham Clinical Portal SCR information is integrated within EPR system for all MH Staff providing access to CPIS information held within SCR

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Plan community safeguarding information to be available within Rotherham Clinical Portal
16/17 Q2	• Start development of portal to include safeguarding information
16/17 Q3	• Complete development of portal.
16/17 Q4	• Commence planning for Hospital to Social Serivces integration and interoperability
17/18 Q1	• Plan agreed by all parties and supplies and deployment started
17/18 Q2	• Proof of Concept integration
17/18 Q3	• Commence deployment and process change
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Using Rotherham Clinical Portal to view safeguarding information and developed to include CP-IS information.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress/Highlight reports sent to the Rotherham Interoperability Group.

Universal Capabilities Delivery Plan

Universal Capability:	H. Professionals across care settings made aware of end-of-life preference information
Capability Group:	Decision support
Defined Aims:	• All patients at end-of-life able to express (and change) their preferences to their GP and know that this will be available to those involved in their care • All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

No additional information currently added to enhanced SCR.

Local GP clinical templates created to support capture of end of life care preferences.

EMIS Web viewers have been deployed within the hospice and acute trust to view more detailed primary care.

SystmOne patients records are shared across Community, hospice and primary care with the patients consent.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	All relevant clinicians recording end of life patients information using local templates. Linking all end of life information via the Rotherham portal to ensure all clinicians are able to view patients

	preferences and be able to see who is involved in their care.
17/18	

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Introducing primary care quality contract to include end of life care. This will increase the number of GP practices to use the local end of life template.
16/17 Q2	• Working with clinicians involved in end of life care to determine requirements for Rotherham portal across primary, community, secondary and hospice services. • Review SCR enriched record benefits for end of life care.
16/17 Q3	• Develop Rotherham portal in line with requirements. Linking local and national systems to portal to support sharing relevant information to clinicians providing direct care. • Develop links with open APIs from SystmOne and EMIS to the Rotherham clinical portal
16/17 Q4	• Clinicians able to view end of life care information via the Rotherham portal
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Local templates are being used to capture end of life information across primary and community care settings. Rotherham Clinical Portal being developed to support ePaCCS, the local clinical portal will contain richer information to the summary care record with the ability to develop the portal further to meet requirements of the

multi-disciplinary teams.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress / Highlight reports are sent to the EPACCS Task and Finish Group and Rotherham Interoperability Group.

Universal Capabilities Delivery Plan

Universal Capability:	I. GPs and community pharmacists can utilise electronic prescriptions
Capability Group:	Medicines management and optimisation
Defined Aims:	• All permitted prescriptions electronic • All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic • Repeat dispensing done electronically for all appropriate patients • [By end 16/17 – 80% of repeat prescriptions to be transmitted electronically]

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

20 (65%) practices live with EPS Release 2.
100% pharmacies live with EPS

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	All permitted prescriptions are sent electronically by practices. Rollout EPS R2 to six practices. By end 16/17 – 80% of repeat prescriptions to be transmitted electronically.
17/18	All permitted prescriptions are sent electronically by practices. Rollout EPS to the remaining five practices.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Rollout EPS to 1 practices. • Work with medicines management team and practices to increase utilisation.
16/17 Q2	• Rollout EPS to 1 practices. • Working with medicines management team and practices to increase utilisation.
16/17 Q3	• Rollout EPS to 2 practices. • Working with medicines management team and practices to increase utilisation.
16/17 Q4	• Rollout EPS to 2 practices. • Working with medicines management team and practices to increase utilisation.
17/18 Q1	• Rollout EPS to 1 practice. • Work with medicines management team and practices to increase utilisation.
17/18 Q2	• Rollout EPS to 2 practices. • Working with medicines management team and practices to increase utilisation.
17/18 Q3	• Rollout EPS to 2 practices. • Working with medicines management team and practices to increase utilisation.
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress/Highlight reports to Rotherham Interoperability Group and SY&B NHS England primary care team

Universal Capabilities Delivery Plan

Universal Capability:	J. Patients can book appointments and order repeat prescriptions from their GP practice
Capability Group:	Remote care
Defined Aims:	• [By end 16/17 – 10% of patients registered for one or more online services (repeat prescriptions, appointment booking or access to record)] • All patients registered for these online services use them above alternative channels

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

All practices enabled to provide ordering of repeat prescriptions appointment booking and access to patients record.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Provide all patients with the opportunity to access to book appointments, order repeat prescriptions and view their detailed care record
17/18	Optimise online appointments to increase number available.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Promote patient online with practices via system optimisation programme
16/17 Q2	• Promote patient online with practices via system optimisation programme
16/17 Q3	• Promote patient online with practices via system optimisation programme
16/17 Q4	• Promote patient online with practices via system optimisation programme
17/18 Q1	• Promote patient online with practices via system optimisation programme
17/18 Q2	• Promote patient online with practices via system optimisation programme
17/18 Q3	• Promote patient online with practices via system optimisation programme
17/18 Q4	• Promote patient online with practices via system optimisation programme

D. National Services / Infrastructure / Standards

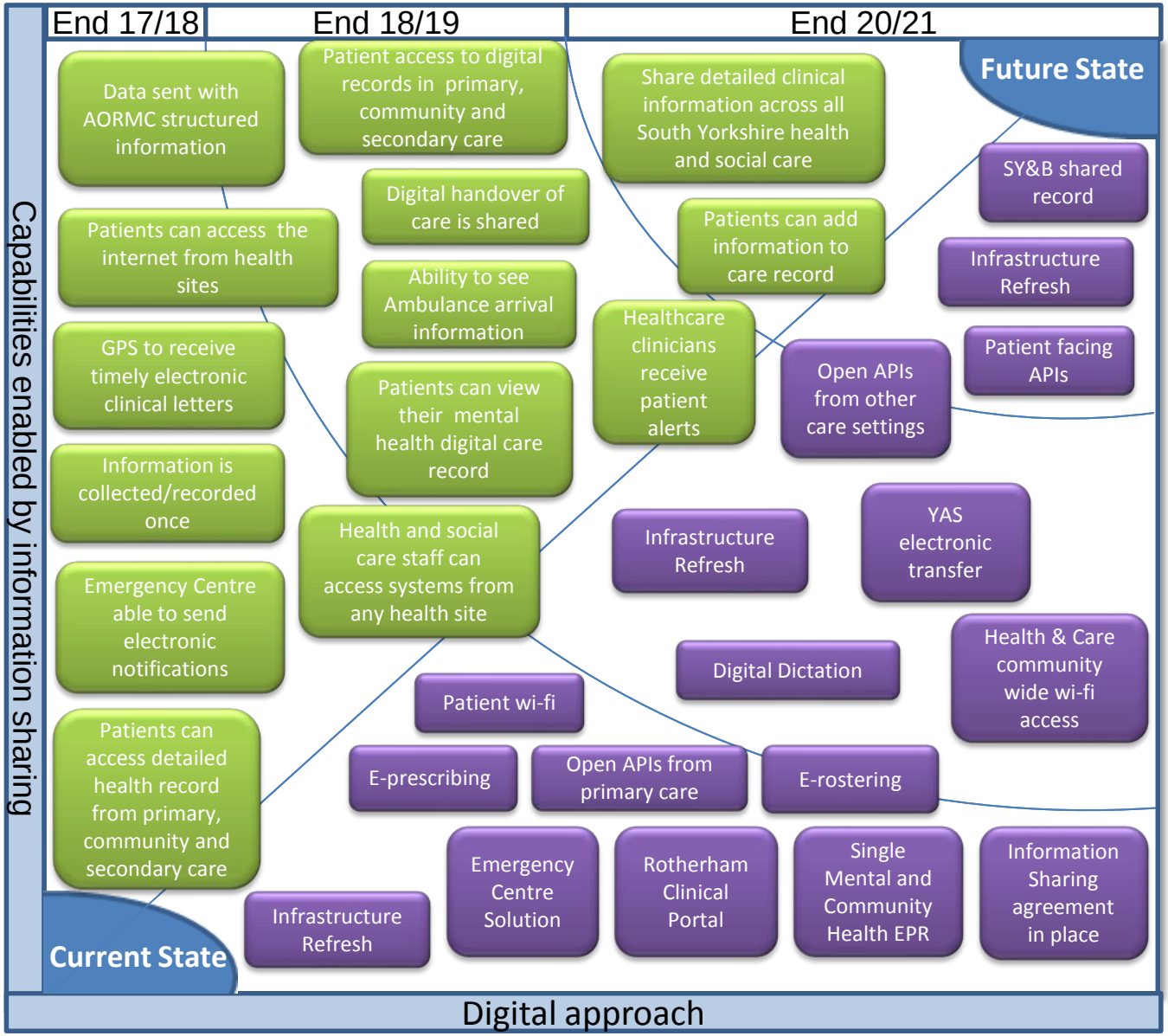
In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

% patients using online functionality reported to Rotherham Interoperability Group.

Information sharing approach – Rotherham



NHS Rotherham Clinical Commissioning Group

Health & Wellbeing Board – Weds 13 July 2016

South Yorkshire & Bassetlaw Sustainable & Transformation Plan (STP)

Lead Executive:	**Chris Edwards**
Lead Officer:	
Lead GP:	**Julie Kitlowski**

Purpose:

To update the Health and Wellbeing Board on the South Yorkshire and Bassetlaw STP process.

Background:

The NHS Shared Planning Guidance asked every local health and care system in England to come together to create its own ambitious local plan for accelerating implementation of the Five Year Forward View (5YFV). These blueprints, called Sustainability and Transformation Plans (STPs), will be place-based, multi-year plans built around the needs of local populations.

To deliver STPs, local health and care systems have come together to form 44 footprints, which collectively cover the whole of England. These geographic footprints are of a scale which should enable transformative change and the implementation of the Five Year Forward View vision of better health and wellbeing; improved quality of care, and stronger NHS finance and efficiency by 2020/21.

Rotherham sits within the South Yorkshire and Bassetlaw footprint which is led by Sir Andrew Cash (Chief Executive of Sheffield Teaching Hospitals).

The Rotherham place based plan is a draft document which is currently being developed and summarises local ambitions for the STP and is jointly produced by the Rotherham Clinical Commissioning Group (RCCG), Rotherham Metropolitan Borough Council (RMBC), The Rotherham NHS Foundation Trust, (TRFT), Rotherham, Doncaster & South Humber NHS Foundation Trust, (RDASH) and Voluntary Action Rotherham (VAR).

Financial Implications:

NHSE has indicated that transformation funding will be made available plans which meet their criteria.

Recommendations:

- The Health and Well Being Board are asked to note progress and delegate responsibility to individual organisations to sign off the September submission.
- Note that it is proposed to bring the September submission to a future meeting.

Rotherham's Integrated Health and Social Care Place Plan

Rotherham is a fully co-terminus Health and Social Care Community with a population of 260,000, which makes a perfect test bed for new innovations. We have developed very strong, credible, robust joint working across our local Health and Care system, supported by cross stakeholder sign up to our strategy described within our 'local place plan'. We are all committed to whole system partnership working and passionate about providing the best possible services and outcomes for our population and maximising the best value for the Rotherham pound.

We have already made significant progress on delivery of the key enablers within our place base plan. As a Health and Care Community with the additional support of transformational funding at a local place level, we know that we can move further and faster to deliver the required transformation to support system sustainability. We believe our strong track record of patient level evaluation would also allow the wider system to learn from our innovations.

Our ambition would be to establish these initiatives on a Rotherham footprint to prove the concept and then 'industrialise' on a South Yorkshire and Bassetlaw footprint.

On our journey we are already delivering in the following areas:

What is Rotherham's ambition for doing more on prevention?

- **Further Development of our social prescribing service to cover mental health clients and facilitate earlier hospital discharge.** We already target the top 5% of patients at risk of hospitalisation using admission risk stratification and GP judgement. We have identified non-medical interventions for over 5000 patients with significant success, saving money and improving outcomes for patients. We are further developing this approach and wish to move further and faster to develop more interventions for mental health clients and services to support early hospital discharge. We intend to target the top 10% at risk patients as our patient level evaluation has shown this cohort of patients will benefit from the service.

- **Prevention and Self Care.** More systematic primary prevention is critical in order to reduce the overall burden of disease in the population and maintain the financial sustainability of the NHS. While prevention in childhood provides the greatest benefits, it is valuable at any point in life. It is estimated that 80 per cent of cases of heart disease, stroke and type 2 diabetes, and 40 per cent of cases of cancer could be avoided if common lifestyle risk factors were eliminated (World Health Organization (2005). Preventing Chronic Diseases: A vital investment. Geneva: World Health Organization. Available at: www.who.int/chp/chronic_disease_report/full_report.pdf)

- Further develop a self-care approach for patients using emerging technology such as approved health apps on smart phones and embracing the benefits of the 'Internet of Things' concepts for Health and Social Care. Patients would be encouraged and supported by professionals, the voluntary sector and peers to maximise the use technology as part of their approach to self-care.

- **Attainment of self-determined goals** to be captured in smart phone apps, e.g. to walk 5,000 steps per day or to take a daily blood pressure reading would be reinforced through a strengths based approach from community health champions and social prescribing services. Patients would be encouraged to record their progress and to electronically feed information into a single contact point. The access point would collate real time data and this would assist in more detailed risk stratification exercises and in determining where to target future interventions.

- '**Internet of Things'.** The approach would be applied to support people within their home environment to promote positive behaviours to alleviate harm e.g. through the use of talking fridges to ensure people eat regularly, pill dispensers to prompt medication and door sensors to alert if people are leaving the property at unusual times. The internet link would enable predetermined automated scenario based access to professionals, family members or friends should the alerts not trigger the necessary behaviours, thereby preventing escalation and ultimately A&E admission.

What is Rotherham's ambition for doing more on integration and sustainability?

- **An Accountable Care Organisation** jointly providing Acute, Community and Emergency Primary Care Services.

- **A fully integrated Rotherham community model of care** based on a Multi-specialty Community Provider model (MCP) for community based services, which also incorporates principles from the Primary and Acute Care Systems (PACS) model. The Rotherham model maps resources to deprivation and is underpinned by comprehensive risk stratification. It encompasses the following services on a locality basis.

    1. All GP Practices
    2. Voluntary Sector
    3. National Award Winning Rotherham Social Prescribing Service
    4. Secondary Care Physicians
    5. Social Care
    6. Community Nursing
    7. Community Therapists
    8. Community Mental Health Services
    9. Hospice in the Community
    10. Re-ablement Services (including intermediate care)
    11. Fire Service
    12. Police

This innovation is in its third year of development, the table sets out key developments in years one and two:

Community Developments made in **2014/15** include:	Community Developments continued in **2015/16** include:
• Restructured community nursing service and GP practices into 7 localities • An integrated falls and bones pathway • Implementation of a Care Coordination Centre as a single access point • Risk stratification of patients and Case Management approach for top 5%	• Integrated Rapid Response services • Creation of a new IT portal providing visibility of community case load patients in the hospital • Introduced Care Home Liaison Service • Enhanced Care Coordination Centre provided on a 24/7 basis

The Rotherham model is comprehensive and covers a range of service areas. Further evidence is required to demonstrate detailed cost benefit analysis. However, an indication of the level of potential benefits realisation comes from an example at North Manchester General Hospital with the Common Assessment Support Service (CASS). This intermediate care pilot is based around timely assessment and effective use of re-ablement services to avoid hospital admissions and short term residential care needs. The CASS model demonstrates a likely cost benefit ratio over a five year period of £2.24 to £1 invested. This could be scaled up when factoring in the wider scale of the Rotherham MCP.

Evidence from the Salford Integrated Care Team approach demonstrates potential benefits of £5.29 for every £1 invested in a service hub.

We also intend to further develop new funding and risk sharing models across Health and Social Care.

- **A new integrated Urgent and Emergency Care Centre** due to open in spring 2017, delivering a ground-breaking 'next available clinician' delivery model with innovative staffing solutions, hitting many of the requirements of the Keogh Review for Urgent Care.

- **A 24/7 Care Coordination Centre and associated rapid response teams** which manages system capacity and advises on the most appropriate level of care for patients to avoid hospital admission wherever possible.

- **One public estate approach for Rotherham** which ensures that the most efficient use is made of the public estate and that surplus sites are released to support growth, housing and Capital receipts. There are emerging opportunities arising from closer linkages with the Sheffield City Region, including the Joint Assets Board which is leading on the One Public Estate approach on behalf of public sector partners locally. This alignment could include access to revenue funding to support the realisation of ambitious plans and focus on a transformational asset based approach. Rotherham is conducting a review of estate across health and social care, and RMBC is also leading a wider review across the Sheffield City Region.

- **We will make best use of existing assets**, dispose of those not fit for purpose and further increase our use of joint service centres

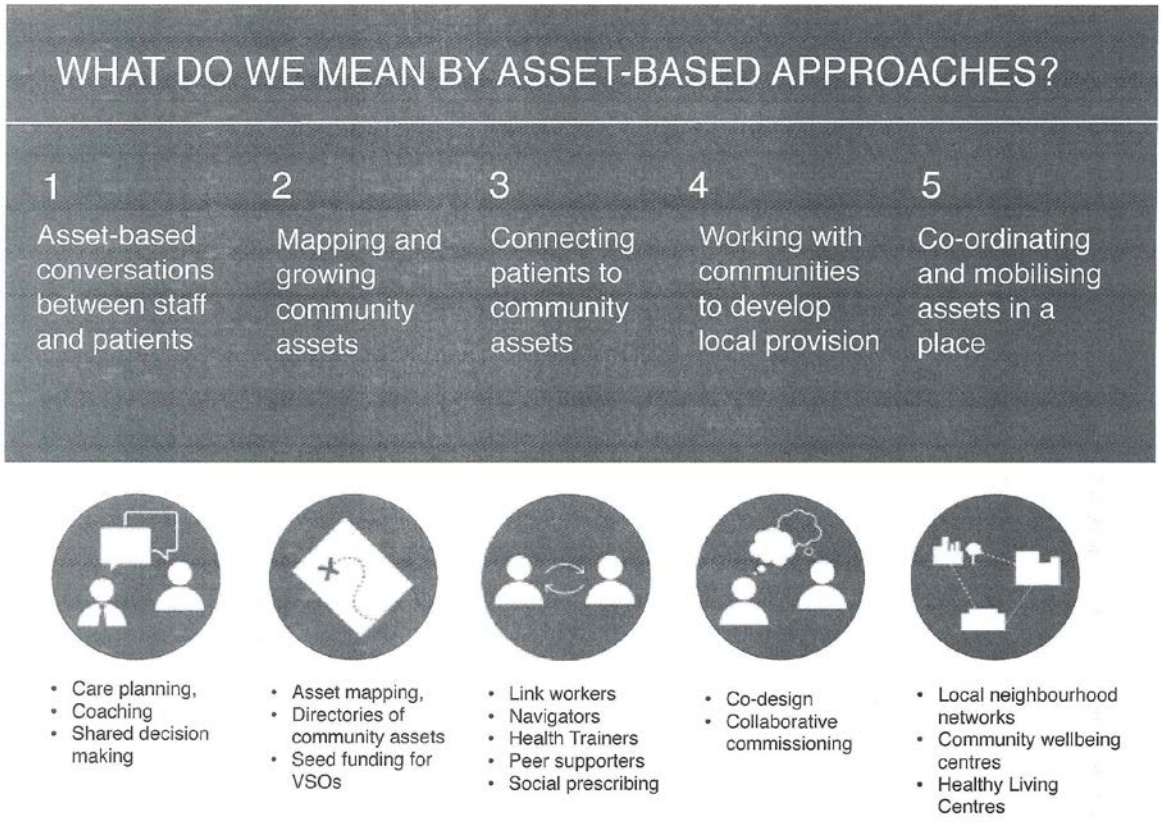
- **Integrated IT** across Health, Social Care and Care Homes. Linking up Health and Care records is a must do and we have already made good progress. Our model of one provider for Health IT has facilitated a coordinated approach.

- **Further development of an Integrated Re-ablement Village.** We have co-located all re-ablement services and all partners are fully committed to further develop the integration of all services to offer the best possible recovery pathway.

The overarching vision for our Health and Care services is for people to live independently in the community, with prevention and self-care at the heart of our delivery. Our Local Place Plan supported by existing initiatives within our locally agreed Better Care Fund provides a real opportunity to improve the lives of the Rotherham population and some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better service and better quality of life.

We plan to achieve this through a multi-agency strategy of early intervention and prevention. We will integrate services to improve the health and well-being of people in Rotherham. We will focus on information, prevention, enablement, rather than providing on-going support which increases dependence and reliance on health and social care services. We will build resilience by empowering individuals, families and communities and provide better support for carers so that they can continue in their caring role.

We already have effective joint commissioning arrangements which drive the integration of services, but we can do more. We will promote multi-disciplinary working between primary care, social care, mental health, community health services and the voluntary sector. We will expand community based services, reducing reliance on the acute sector.



Produced by the Greater Manchester Public Health Network / Innovation Unit

We will work with communities to have a different conversation to understand what matters to them, with a focus on their strengths and values. These conversations will inform commissioners about requirements outside of traditional service models. People can be linked to mapped assets readily available in their local community or the wider borough. Where there are gaps in provision e.g. for people with learning disabilities, we will support, and where necessary, seed fund organisations to develop local services. This approach embeds an owned culture of wellbeing and prevention across communities as well as within statutory services in addition to demand shift with clear fiscal benefits.

An evidence base to inform a more detailed investable proposition for Rotherham linked to wider asset based approaches will need to be developed. However, the *Wigan Deal* Programme demonstrates that for every £1 invested in community assets generates benefits of £1.95 per person over a five year period.

We will streamline and simplify care pathways, providing better information, advice and signposting to preventative service and the third sector for on-going support. We will ensure that better information sharing between Health and Social Care services.

Service integration will be used as a vehicle to deliver “parity of esteem”. Integrated locality teams will incorporate mental health staff, working alongside health professionals whose focus is on physical health. Care planning and support will address the psychological and physical needs of the individual, recognising the huge overlap between mental and physical well-being.

Rotherham CCG and Rotherham MBC and provider partners will work together to achieve the following objectives. These are aligned with the outcomes set out in Rotherham’s Health and Well Being and Rotherham CCG’s Commissioning Plan.

1. An integrated health and social care delivery system which promotes joint working
2. An integrated commissioning framework with joint outcomes and service specifications
3. More care and support provided in people's homes
4. Integrated care planning that addresses physical and psychological wellbeing
5. Individuals and families taking more control of their health and care
6. Accurate identification and active case management of people at high risk of admission
7. Broader use of new technology to support care at home
8. A financially sustainable model that targets resources where there is greatest impact
9. Prevention, self-care and empowering citizens, communities and frontline staff will be at the heart of everything we do.

Evaluation

We have a strong record of evaluation of our innovative projects and our partnership with Sheffield Hallam University delivers patient level evaluation on our key projects to gather evidence and inform our investment decisions. We will use evidence cost benefit analysis from other areas where we do not have local evidence.

What STP transformation funding do we need for prevention at scale?

Our key enablers for transformation at a local place base level would be enhanced with non-recurrent funding identified through the national STP fund in the following ways:

- **Further Development of our social prescribing service to cover mental health clients and facilitate earlier hospital discharge.** Our national award winning Social Prescribing service was highlighted in the Five year forward View as exceptional practice and we have aspirations to expand the service to support hospital discharge and mental health service. We expect to increase referrals to 2000 per year we expect the cost to be an additional **£1.1m per annum**. Our evaluation shows we should expect further system benefits of £1.98 for each £1 in savings as well as significantly improved outcomes.

- **Further develop the prevention offer to better meet the needs of local people by targeting communities and individuals that can gain most benefit.** The development of a comprehensive health improvement model presents new opportunities to increase capacity across the health and social care system, supporting individuals to make positive, sustained lifestyle changes by adopting a person-centred and a whole community approach to improving health and well-being.

  Initial funding would be to industrialise the approach, building on the evidence from the national NHS diabetes and CVD prevention programme, and moving forward using the Making Every Contact Count (MECC) model. We would use transformation funding to fast-track these schemes in partnership with the other communities in South Yorkshire and Bassetlaw. It is expected funding of £1.8m per year would be required .

- **Self-Care Proposal**

  Working in partnership with the strong voluntary sector in Rotherham to deliver innovative solutions to benefit the health and wellbeing of residents is a core element of the STP submission. In many instances impartial voluntary sector organisations can have more

positive impact on encouraging and delivering behaviour change messages to support residents to self-care than statutory partners. Further, this often offers better value for money.

Voluntary Action Rotherham (VAR) have developed a public on line 'platform' for voluntary, community groups (VCS) and social enterprises in Rotherham. Rotherham GISMO (Group Information Services Maintained Online) is unique, in that it is the single, most comprehensive and largest directory of VCS groups and organisations publically available and easily accessible. 700 groups are members of GISMO.

VAR aims to develop the directory of groups on the Rotherham Gismo website. The aim is to make it more detailed, interactive and more widely used by groups, the general public and support staff in partner agencies. The particularly focus will be on promoting self-care and prevention, linked to the wider community assets and social prescribing agendas. This will require an investment of £0.045m In addition to expanding the website offer, VAR would like to run a small grants process to pump prime the sector with a total pot of £0.025m.

VAR also run a Community Health Champions scheme supported by volunteer health ambassadors who have talked to numerous people and groups about 'Right Care Right Time message, use of Pharmacy First and Prescription Waste Management. This approach has effectively targeted communities where there has been a high incidence of attendance at A&E. The pilot in Eastwood, Rotherham has proved to be successful in reducing attendance and a further roll out to other deprived communities in Rotherham would demonstrate fiscal benefits beyond the requested £0.025m.

What STP transformation funding do we need for integration at scale?

- **A fully integrated Rotherham community model of care** based on a Multi-specialty Community Provider model (MCP) for community based services, which also incorporates principles from the Primary and Acute Care Systems (PACS) model.

  Additional one off funding of **£1.5m** would support the borough wide roll out the Rotherham integrated model facilitating relevant one off initial infrastructure / set up costs within our system. We would also like to invest **£1.25m per annum** to trial new staffing models in primary care and to fund transformational support to ensure patients receive services in the right place, first time. This development should reduce non elective bed days by 10,000 and allow the Trust to reduce the bed stock by 31 beds recurrently saving £1.5m per annum. This will also support our strategy for sustainable primary care services.

- **A 24/7 Rotherham wide Care Coordination Centre (CCC)** which manages system capacity and advises on the most appropriate level of care for patients to avoid hospital admission wherever possible. Our aspiration is to enhance our CCC beyond Acute Hospital provision and co-ordinate care across Social Care, Acute and Mental Health services, improving access for patients through a comprehensive directory of services, driving efficiency and cutting down waste. The solution will also support the sharing of information among all health and social care professionals to quickly identify individuals at risk and where a needs assessment can be made and to identify the most appropriate pathway and correct deployment of resources. The CCC will also act as a single point of access for patients by giving them access to health and social care professionals on a 24/7 basis through which initial assessments can be undertaken and teams deployed to provide

support and avoid potential hospital presentation or admission. The non-recurrent infrastructure cost for this work is estimated at **£0.46m per annum** and is our formal evaluation suggests this will deliver at least £0.86m additional system wide efficiencies and also improve the efficiency, and further integrate health and social care services.

- **One Public Estate approach for Rotherham**

  The Strategic Transformation Plan – Carter group / Proposed Estates Plan states that Rotherham will actively explore opportunities to align activity with the Sheffield City Region Alignment could include access to **£0.5m** revenue funding to support the realisation of ambitious plans and focus on a transformational asset based approach:

  - To divest of poor quality, poorly performing and surplus assets
  - Identification and release of major site opportunities, including joint bidding opportunities, skills and expertise sharing etc.; Pipeline developed by **Nov 16**
  - Development of agile working approaches allowing staff the flexibility to benefit from touch down facilities in partner buildings by **March 17**
  - Establishment and joint commitment to the development of a “Pain share/Gain share” approach which seeks to address issues relating to unintended consequences of individual organisational property decisions by **October 16**
  - Agreement of overarching principles focused upon seeing the estate in aggregate, with decision making informed by impact on the whole public sector community – rather than individual organisations by **September 16**
  - Establishment of joint metrics aligned to Carter Review enabling consistent measurement of utilisation, benchmarking, good practice sharing etc by **July 16**
  - Collective review of emerging property requirements to enable the best system-wide solutions to be established. On-going based on emerging service and clinical requirements

- **Integrated digital care records** across health, social care, care homes and citizens/patients. Excellent progress has already been made with over 5000 records being integrated through our Better Care Fund Plan, with the Rotherham Clinical Portal connecting disparate health systems and the population of Social Care systems with NHS Numbers in preparation for further connectivity. We plan to further integrate systems by engaging suppliers to use national technical standards across Health and Social care and using the Rotherham Clinical Portal as a secure “window” into organisational systems, and to support our self-care agenda, citizens/patients will be able to view and add their own data and interact with Health and Social care professionals using modern technology. Finally, we are also planning to ensure we share and exchange information with other providers outside of Rotherham.

  Integrated digital care records across Health, Social Care and Care Home requires significant multi-year investment to move organisational processes from traditional paper based systems to electronic systems with a robust shared infrastructure platform. Non-recurrent cost estimates suggest approx. **£15m over 5 years** to meet full regional digital STP aspirations with a further **£0.4m** in the next two years to further integrate the Rotherham Clinical portal between Health and Social care. Potential cash and non-cash benefits would be circa £0.96m.

Further work will be undertaken to fully understand the transformation requirements to inform the 30 June submission.

- **Urgent and Emergency Care Centre Development with innovative 'next available clinician staffing model'** which integrates GPs, A&E consultants, highly trained nurses and is not reliant on middle grade medical staff and significantly reduces waiting times. The centre will offer alternative services to 120,000 patients a year. The project requires a new capital build and transformation investment of **£0.45m** would enable to us to go further, faster in developing the model and would help us to realise system savings of £30m over 10 years. 2017 will see increased provision at the hospital site with the opening of the new integrated centre. The Walk in Centre will no longer be commissioned.

- **Development of a Reablement Village**

  As part of our Community Transformation Programme, Rotherham will develop a Reablement Village, commencing in 2016/17. This single site development will consolidate existing provision and provide fully integrated community rehabilitation, residential intermediate care provision (step up and step down) and discharge to assess beds.

  The Village will incorporate an environment that supports integrated working, a combination of health and social care professionals working as part of a multi-disciplinary team. This model will enable Rotherham people to access a range of services whilst remaining in their community throughout their life course.

  The Reablement Village will deliver quality and drive efficiencies through economies of scale, a single point of access, shorter travel times, reduced duplication and lower running costs. We estimate that **£3m** per year STP funding will:

  - Allow the transition to new staffing and skill mix models of care
  - Enhance the clinical and caring environment to ensure that people receive reablement services in a world class caring environment
  - Allow the transition of long-stay residents from existing provision into new care home provision.

  To enhance our current provision we will work in partnership with an independent provider to deliver the capital solution, considering the most advantageous geographical location to meet local need, whilst offering opportunities for joint provision across the wider STP footprint.

- **Transformation of the care home sector**

  Partnership with the care home sector is an integral part of the management of frail older people. Whilst some people may be able to be assessed on a frail elderly unit and discharged home with appropriate support and others transferred to an intermediate care setting as part of the Reablement Village, there are a third and important group of people who are in hospital for legitimate medical reasons and then require an alternative level of care prior to decisions about their final destination. Not all these patients require intermediate care and so timely relocation to a care home facility in conjunction with hospital and community support is a preferable option to remaining an in-patient whilst ongoing care issues are decided. In addition we are aware that care home staff remain uncomfortable in managing a care home resident who is frail and deteriorating due to infection or dehydration. Whilst advance care plans can help inform decision-making there

is an important need to upskill staff in this sector with the assessment and practical skills to manage residents with higher acuity medical problems. We would like to develop a syllabus and upskill staff in some of our care homes to develop a subspecialty interest in higher acuity patients in order to reduce unnecessary transfers to different levels of care and also to facilitate earlier discharge from hospital. In the short term, this could be provided by the provision of 50 nursing home beds whilst the facilities and skill profile is addressed, and has potential fiscal benefits of up to £1200 per patient per week. We estimate that £0.6m funding would provide appropriate training and equipment to revitalise the nursing home sector to manage high acuity patients in a more appropriate setting.