HEALTH AND WELLBEING BOARD

Venue: **Oak House, Moorhead Way, Bramley. Rotherham. S66 1YY**

Date: **Wednesday, 8th March, 2017**

Time: **10.00 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. Communications/Updates

7. Minutes of the previous meeting (Pages 1 - 11)
   Minutes of meeting held on 11th January, 2017

For Discussion

8. Health and Wellbeing Strategy Aim 5 - Healthy, Safe and Sustainable Communities (Pages 12 - 81)
   Presentation by Rob O'Dell, South Yorkshire Police, supported by Karen Hanson, RMBC

9. The Rotherham Place Plan
   Verbal update by Chris Edwards, CCG

10. Better Care Fund (Pages 82 - 170)
    (a) Better Care Fund Draft Plan 2017/19
    (b) Better Care Fund Quarter 3 Submission
    Presented by Nathan Atkinson/Karen Smith, RMBC

11. Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND) (Pages 171 - 197)
Presented by Linda Harper, CYPS

12. Specialist Residential and Nursing Care for Adults in Rotherham (Pages 198 - 201)
Update by Nathan Atkinson, RMBC

13. Loneliness and Isolation
The Chair to present

For Information

14. Rotherham CAMHS Local Transformation Plan - Quarter 3 report 2016-17 (Pages 202 - 215)

15. Date, Time and Venue of the Future Meeting
Meetings to commence at 9.00 a.m. on:-

17th May, 2017
5th July
20th September
15th November
10th January, 2018
14th March

Venue to be confirmed

Sharon Kemp.

SHARON KEMP,
Chief Executive.

HEALTH AND WELLBEING BOARD
11th January, 2017

Present:-

Members:-

Councillor D. Roche	Cabinet Member for Adult Social Care and Health **(in the Chair)**
Jo Abbott	Public Health, RMBC (representing Terri Roche)
Karen Borthwick	Children and Young Peoples' Services (representing Ian Thomas)
Tony Clabby	Healthwatch Rotherham
Dr. Richard Cullen	Governance Lead, Rotherham CCG
Chris Edwards	Chief Officer, Rotherham CCG
Sharon Kemp	Chief Executive, RMBC
Dr. Julie Kitlowski	Clinical Chair, RCCG
Carole Lavelle	NHS England
Councillor Mallinder	
Kathryn Singh	RDaSH
Janet Wheatley	Voluntary Action Rotherham

Report Presenters:-

Sarah Farragher	Adult Care and Housing, RMBC
Ruth Fletcher Brown	Public Health, RMBC
Giles Ratcliffe	Public Health, RMBC
Sue Wilson	Performance and Planning, RMBC

Officers:-

Kate Green	Policy Officer, RMBC
Gordon Laidlaw	Communications Lead, Rotherham CCG
Dawn Mitchell	Democratic Services, RMBC

Observers:-

Councillor Sansome	Chair, Health Select Commission
Councillor Short	Vice-Chair, Health Select Commission
Janet Spurling	Scrutiny Officer, RMBC
Councillor Yasseen	

Apologies for absence were received from Louise Barnett (Rotherham Foundation Trust), Terri Roche (RMBC), Ian Thomas (RMBC) and Councillor Watson.

48. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at this meeting.

49. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

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

50. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board, held on 16th November, 2016, were considered.

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

Minute No. 36 (Health and Wellbeing Strategy), it was noted that all the five Strategic Aims' action plans would be submitted to the May meeting. A timetable would be sent to all Board sponsors and lead officers for the Aims to meet the May Board meeting deadline.
Action: Kate Green

Minute No. 36(2), it was noted that work was taking place looking at the governance framework between the Adult and Children's Safeguarding Boards and the relevant partnership boards and the system relationship. A discussion would take place with the Chairs of the 2 Safeguarding Boards and would be considered at the Rotherham Together Partnership Board. A report back would be given in March.
Action: Sharon Kemp

Arising from Minute No. 38(2) (Health and Wellbeing Strategy Aim 1 – All children get the best start in life), it was noted that the proposals regarding raising aspirations and addressing the social issues had not been submitted.

Arising from Minute No. 39(2) (Health and Wellbeing Strategy Aim 3 – All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life), it was noted that the action plan would be submitted to the May meeting as minuted above.

Arising from Minute No. 39(3), it was noted that a new working group had been established, Chaired by the Strategic Director of Adult Care and Housing, and was to hold its first meeting in January.

It was also noted that the Autism Partnership Board was to be launched at the end of the month.

Arising from Minute No. 41 (Rotherham Place Plan), it was noted that a meeting had taken place in December 2016 with Miranda Flood (Vanguard) to discuss how a bid could be structured for additional funding. No further information had been received as yet.

Arising from Minute No. 43(3) (Healthy Ageing Framework), it was noted that a piece of work was underway looking at all documents to ascertain where the gaps were. The outcome would be submitted to the Board.
Action: Terri Roche

Arising from Minute No. 43(4), it was noted that the draft Rotherham Plan (formally referred to as the Community Strategy) was to be submitted to the next meeting of the Rotherham Together Partnership Board. Consideration would then be given to which proposals contributed to an age friendly community and ascertain where the gaps were.

Minute No. 44(2) (Caring Together – The Rotherham Carers' Strategy), it was noted that the Strategy had been approved at the Cabinet/Commissioners meeting on 9th January, 2017.

Minute No. 45 (Rotherham Safeguarding Adult Board 2015-16 Annual Report), it was felt that there was need for a future discussion on care homes given the increasing pressures on the Hospital Trust and Adult Social Care Workers, Winter pressures, funding issues, viability of some homes and standards of care and quality.

Resolved:- (1) That the minutes of the meeting held on 16th November, 2016, be approved as a correct record.

(2) That Children and Young People's Services submit proposals to the next Board meeting regarding raising aspirations and addressing the social issues as agreed at the November Board meeting.
Action: Ian Thomas

(3) That the issue of care homes be included as an agenda item at the next meeting.
Action: Anne Marie Lubanski/Kate Green

51. COMMUNICATIONS/UPDATES

There were two important events taking place in Rotherham unfortunately both on the same day:-

The Rotherham Foundation Trust – NHS Integrated Locality Event
24th January, 2017 – New York Stadium

Local Government Association facilitated Workshop on Prevention
24th January, 2017 – Rotherham Town Hall

52. COMMUNICATING AND ENGAGING ON THE REGIONAL SUSTAINABILITY AND TRANSFORMATION PLAN AND ROTHERHAM PLACE PLAN

Janet Wheatley, Voluntary Action Rotherham, and Tony Clabby, Healthwatch Rotherham, reported that Healthwatch and the Voluntary and Community Sector across the STP area had been contacted by Helen Stevens to assist with the engagement and communication of the STP. The request had included holding a series of engagement events with the public. £5,000 was being offered from regional funds to undertake the engagement.

It was proposed that a series of engagement events be held targeting the north, south and central areas and some communities of interest led by Chris Edwards, Sharon Kemp and Louise Barnett. The presentation prepared by the CCG would be used with the aim of describing the STP as context but to base the majority of the conversation on the Rotherham Place Plan.

Guidance notes were to be circulated but had not been received as yet. Not to engage widely on the STP and Place Plans was not an option.

Any suggestions as to how to engage with members of the public and patients would be welcomed.

Discussion ensued with the following issues raised/clarified:-

- There was a clear distinction between the STP and Place Plan and, although interlinked, should be kept separate
- A formal route of approval of the Place Plan by Members was still required
- Important that the engagement clarified that the Place Plan and STP had totally different governance arrangements with the former owned by Rotherham and would be decided by Rotherham partners
- The engagement was an opportunity to get messages to the public about health and social care in general

It was noted that there was to be a development session on 8th February to discuss how the Rotherham Place Plan would be managed in a partner governance arrangement.

Resolved:- (1) That the outline plans submitted by approved.

(2) That officers be nominated in all bodies to take the work forward.

(3) That all stakeholders commit to support the work including actively promoting engagement.

(4) That Chris Edwards and Sharon Kemp advise Tony Clabby and Janet Wheatley on the key messages for the engagement.
Action: Chris Edwards/Sharon Kemp

53. HEALTH AND WELLBEING STRATEGY

Giles Ratcliffe, Public Health Consultant, gave the following powerpoint presentation on Aim 4 of the Health and Wellbeing Strategy

Aim 4 – “Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing”

- Reduce the number of early deaths from cardiovascular disease and cancer

- Improve support for people with long term health and disability needs to live healthier lives
- Increase the opportunities for participation in physical activity
- Reduce levels of alcohol-related harm
- Reduce levels of tobacco use

JSNA Inequalities – Why and issue?

- Inequalities in health outcomes such as life expectancy at birth and preventable years of life lost are seen as being unfair
- The weight of scientific evidence supports a socio-economic basis for inequalities. This means that a citizen's risk of ill health is determined to a varying degree by things like where they live, how much they earn, what sort of education they have had as well as their lifestyle choices and constitution
- People from more deprived backgrounds appear to bear the brunt of inequalities
- Inequalities can exist when comparing Rotherham with the England average and also within the Borough

JSNA – Local Picture

- Compared with the England average, Rotherham has lower life expectancy and higher mortality from circulatory disease and cancer
- Within Rotherham, there is a slope of inequality between the most and least deprived parts of the Borough
- The main causes of death that contribute to the gap are circulatory disease, cancer and respiratory problems. These three causes are also the main contributors to the slope of inequality that exists between the most and least deprived parts of Rotherham

Public Health Outcomes Framework (PHOF) November 2016 Data

- Gap in life expectancy at birth between each local authority and England as a whole (M 36/150; F 17/150) and worsening
- Healthy life expectancy at birth (M 58.9, 28/150 and improving; F 58.7, 21/150 and worsening; England average 63.4; Reg average 61.4)
- Slope index inequality in life expectancy at birth within England local authorities based on local deprivation deciles (M 9.5, 50/149; F 7.0, 57/149)

Workshop held 16th March, 2016 – 17 attendees

- Workplace Health and Wellbeing
- Community Assets and Health Champions
- Making Every Contact Count (MECC) or 'Healthy Conversations'
- Targeting Communities of Disadvantage e.g. Health Checks; Equity Audit
- Self-Care

Focus on MECC

- 16th December: meeting of Chief Officers/Nominated Leads
- National PHE re-launch; dedicated website; regional network; resources in development (apps, online training, videos etc.)
- Suggested Themes:
  Alcohol
  Healthy weight (physical activity +/or diet)
  Smoking?
  Mental Health (loneliness/isolation?)
- Recognition that not making the most of existing opportunities: Directory of Services; One You (not on front pages of all partner websites/points of access) Public Health television
- Services (providers and commissioners) will need to plan for increased activity
- Needs to ensure a targeted approach in terms of localities and patient/service user groups
- Organisations need to determine what methods of roll-out will work for them
- Wider than just 'professionals' e.g. community members, hairdressers, taxi drivers, local people
- Pilot area for saturation and evaluation purposes e.g. Maltby
- Requires similar messages to be delivered to next generation via schools – focus on big health issues
- Will require both online and train-the-trainer models of delivery
- Resourcing will be a challenge for all organisations especially to deliver at scale and pace – training requirements considerable
- Budget – investment vs return

Last 12 Months

- Public Health Equity Audit underway – all Public Health commissioned services
- NHS Health Checks
- Social Prescribing Service – Mental Health pilot
- Fully integrated Rotherham community model of care – continued progress
- Active for Health – first year of delivery
- Successful NHS Diabetes Prevention Programme Wave 2 bid
- Care Home Liaison Service
- £4.7M Work and Health South Yorkshire Funding – planning
- Integrated Re-ablement Village

Plans for the Future

- MECC/Healthy Conversations: training, targeting localities; Secondary Care
- Share Public Health Equity Audit findings – widen to other local authority/CCG provided/commissioned services
- NHS Diabetes Prevention Programme – focussed on areas deprivation
- Integrated Wellbeing and Behaviour Change Service

- Work and Health implementation
- Health in all Policies
- Right Care First Time – Respiratory
- STP
- Integrated IT

Discussion ensued with the following issues raised/clarified:-

- Suggested that 2 themes be focussed upon at a time i.e. Alcohol and Smoking followed by Healthy Weight and Loneliness and Isolation (Mental Health
- Favoured targeted and locality base approach
- A rolling programme approach would assist in keeping MECC at the forefront of people's minds
- Maltby, through the Area Assembly, was a model of good practice for its work on suicide and suicide prevention
- Maltby and Eastwood had been selected as proposed pilot areas
- That one of the local academic institutions should be engaged to ensure that the Rotherham model was appropriately evaluated from the beginning to demonstrate effectiveness
- That MECC should be wider than professionals and must utilise the assets in each community and involve local people in the delivery of MECC messages

Resolved:- (1) That there be a rolling programme approach of 2 themes at a time.

(2) The first 2 themes to be Healthy Weight and Mental Health (Loneliness/Isolation) followed by Alcohol and Smoking at a later date.

(3) That each organisation to be responsible for internal implementation and training (using common resources and methods).

(4) That the suggested approaches to pilot in a locality (e.g. Maltby and Eastwood), using the date to demonstrate these were areas of significance) and target service users be endorsed.

54. VOICE OF THE CHILD LIFESTYLE SURVEY 2016

Sue Wilson, Head of Service Performance and Planning, presented a report which set out the key findings from the 2016 Borough-wide Lifestyle Survey report which was open to schools throughout June and July, 2016. In total 2,806 pupils had participated in the survey.

The Lifestyle Survey results provided an insight into the experiences of children and young people living in the Borough and provided a series of measures to monitor the progress of the development of a child-centred borough and underpin the six themes of:-

- A focus on the rights and voice of the child
- Keeping children safe and healthy
- Ensuring children reach their potential
- An inclusive Borough
- Harnessing the resources of communities
- A sense of place

The positive findings of the 2016 Survey were:-

- Over 70% of young people drinking one or less high sugar drinks per day
- Reduction in the consumption of high energy drinks from 2015
- Increase % of young people who had never smoked
- Increased % of pupils who had never had an alcoholic drink
- Increased number of pupils who had received CSE training as part of the PSHE curriculum
- Decrease in the number of pupils who had not used contraception when having sexual intercourse
- Increased number of young people who had visited a youth centre/youth clinic

The report also set out the areas for attention.

Each school that participated in the Survey (12 out of 16) received their own results. Work took place with the PHSE leads in the schools targeting the particular areas of concern relating to their school. Of the 4 schools that did not take part, 3 of them undertook their own survey and used the information to develop their PHSE programme and curriculum offered to their children and young people. Access to the surveys had been requested.

Discussion ensued on the report with the following issues raised/clarified:-

- There had been an increase in the number of pupils completing the survey
- The reliability of the information was derived from looking at questions that were statistically significant
- All schools and pupils were encouraged to take part
- Disappointing result regarding the number who did not want to be in Rotherham in 10 years' time. This needed to be discussed at the Rotherham Together Partnership Board
- The need for a breakdown of those who said they had medical conditions to ascertain exactly what the conditions were
- The statistics should include numbers of pupils as well as the %
- Breakdown required of the bullying experienced and the reasons why the young people did not want to stay in Rotherham
- The information would be shared with the new School Nursing Service
- Did the increase in long term conditions include reference to mental health?

- Suggestion that the 5 Strategy Aims consider the information relevant to their Aim in the development of their action plans
- Useful to include the ages of the children

Resolved:- (1) The report be noted.

(2) That the Board sponsors and lead officers for the five Health and Wellbeing Strategy Aims ensure that the key issues raised in the report and pertinent to their particular aim were incorporated into their action plans.

(3) That further discussion take place with regard to the process and engagement.

(4) That consideration be given to submission of the report to the Rotherham Together Partnership Board.

55. CARING TOGETHER - THE ROTHERHAM CARERS STRATEGY

Sarah Farragher, Head of Service Independence and Support Planning, presented the Rotherham Carers Strategy for approval by the Board.

It was noted that at the meeting of the Cabinet/Commissioners on 9th January, 2017, the document had been endorsed for partnership approval.

The document had previously been considered by the Health and Wellbeing Board (March, 2015, March, 2016 and July, 2016).

The action plan was a “live” document. The Caring Together Delivery Group would continue to meet to implement the action plan and review as and when necessary to ensure that it worked. There would be gaps because it was an evolving document. The Foundation Trust had now been consulted; the Trust supported the Strategy and would work with partners to ensure its implementation.

Discussion ensued with the following raised/clarified:-

- Part of the outcome of the Strategy was to increase the awareness of carers
- A “hidden” carer who was admitted to hospital should be picked up upon admission but acknowledged that this was something that needed to be improved
- A member of the Trust would be part of the Caring Together Delivery Group
- There were 3 carers who were regular participants of the Group and linked with the Carers Forum.

Resolved:- (1) That the Caring Together, Rotherham Carers’ Strategy 2016-2021, be approved.

(2) That discussions take place with the Rotherham Foundation Trust regarding their procedures for identifying "hidden" carers upon admission to hospital.
Action: Sarah Farragher

(3) That an update be given in 6-12 months on the action plan.

56. ROTHERHAM PUBLIC MENTAL HEALTH AND WELLBEING STRATEGY 2017-2020

Jo Abbott, Assistant Director of Public Health, and Ruth Fletcher-Brown, Public Health Specialist, presented the Rotherham Public Mental Health and Wellbeing Strategy 2017-2020 which would look at the Mental Health promotion and prevention across a three tiered approach:-

- Universal interventions – promoting good mental health and emotional resilience for all ages (primary prevention)
- Targeted prevention and early intervention – targeted prevention of mental ill health and early intervention for people at risk of mental health problems (secondary prevention)
- Wider support for those with mental health problems – softening the impact of mental health problems (tertiary prevention).

It would draw upon the evidence of what worked for the whole population, for individuals who were more at risk of developing mental health problems and for people living with a mental health problem.

The aims of the Strategy were:-

- Have a common understanding of what it meant to improve public mental health
- Maximise the opportunities to promote mental health and prevent mental ill health within Rotherham through:-
  Taking a life course approach to promoting mental heath
  Promoting a more holistic approach to physical and mental health
  Integrating mental health into all aspects of work
  Creating environments which supported mental health and tackled the stigmas associated with mental ill health

The framework for the Rotherham Public Mental Health and Wellbeing Strategy was developed following a stakeholder event in October 2016 with partners from statutory services and the voluntary and community sector. The draft Strategy had been sent to the stakeholders for initial comments in December, 2016.

High level actions had been proposed in the Strategy but a more detailed action plan needed to be developed and submitted to a future Board meeting in 2017.

Kathryn Singh, RDaSH, reported that her organisation was fully supportive of the work that Ruth had been leading on, however, Mental Health was so much broader that the Mental Health Trust. The Prime Minister had recently announced a comprehensive package of measures to transform mental health support in schools, workplaces and communities as part of the Mental Health Service Reform. There would be a number of strands of Mental Health funding to be accessed. She agreed that the Aim 3 Working Group was not appropriate and needed to be revised so it could incorporate much more of the work.

Resolved:- (1) That the Strategy be endorsed and the high level actions as outlined in the document be endorsed by March, 2017 to allow consultation on the Strategy and sharing within individual organisations between January and March, 2017.

(2) That leads from the relevant partner organisations be identified by the end of January, 2017, to work with the Public Health lead to develop a more detailed action plan.

(3) That a detailed action plan be submitted to the Health and Wellbeing Board for approval in 2017.

(4) That a multi-agency group be established to develop and oversee the implementation of an action plan.

(5) That the terms of reference for Aim 3 be reviewed to include the Strategy within its workload.
Action:- Giles Ratcliffe/Julie Kitlowski

(6) That the Strategy be circulated widely for comment.
Action:- Ruther Fletcher-Brown

57. DATE, TIME AND VENUE OF THE FUTURE MEETING

Resolved:- (1) That the next meeting of the Health and Wellbeing Board be held on Wednesday, 8th March, 2016, venue to be confirmed.

(2) That future meetings take place on: -

- 17th May, 2017
- 5th July
- 20th September
- 15th November
- 10th January, 2018
- 14th March

All to start at 9.00 a.m., venue to be confirmed.

Health and Wellbeing Board
8th March 2017

Aim 5 : Rotherham has healthy, safe and sustainable communities and places

The Safer Rotherham PARTNERSHIP

Big hearts, big changes

Rotherham Metropolitan Borough Council

The Safer Rotherham
PARTNERSHIP

Working together to make Rotherham Safe, to keep Rotherham safe and to ensure the communities of Rotherham feel safe.

Safer Rotherham Partnership (SRP)

- Statutory partnership under the Crime and Disorder Act 1998
- 6 responsible authorities
- Statutory duty to develop an annual Joint Strategic Intelligence Assessment
- Requirement to develop and implement a partnership plan (attached)
- Safeguarding protocol linking Partnership Boards (attached)

SRP Priorities

- Reducing the threat of child sexual exploitation and harm to victims and survivors
- Building confident and cohesive communities
- Reducing the threat of domestic abuse and harm to victims and survivors
- Reducing and managing anti-social behaviour and criminal damage
- Reducing the risk of becoming a victim of domestic burglary
- Reducing violent crime and sexual offences

SRP Structure

- SRP Board
- Performance and Delivery Group
- Priority Theme Groups
- Task and Finish Groups
- Other meetings and networks:
  - Countywide meeting
  - CIMs
  - Area Assemblies

Reducing Crime and Anti-Social Behaviour

- Prevention
- Early intervention
- Development of integrated neighbourhood model
- Enforcement
- Communication

Rotherham's Local Plan

- Health is a cross cutting theme in Rotherham's Local Plan - which guides all future development in our Borough

- The Plan includes "Promoting Healthy Communities - Good Practice Guidance" which seeks to strengthen and integrate provision for health and well-being within the design of new development.

- It highlights key health impacts and requires the consideration of health and well-being in planning applications to promote healthy communities and sustainable development

Rotherham's Local Plan

- Locating shops and services in accessible areas - can promote improved walking and cycling and use of public transport.

- Providing and protecting green spaces near to home - enables greater use and enjoyment of the outdoor environment.

- The Local Plan also has policies on the Natural and Historic Environment, Air Quality and creating Safe and Sustainable Communities.

- Examples of specific polices (developed with public health partners):
  - Promoting hot food takeaways (SP25) to limit their proximity to local schools and colleges, the impact they have on local amenity and their concentration within local areas

Opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing

- Pensioners playgrounds
- New and improved children's play areas
- Allotments
- Improved changing rooms
- Tennis courts
- Footpaths
- Cycling
- Family friendly attractions
- Water sports

Opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing

- Events and activities:
  - Volunteer ramblers
  - Working with students
  - Park runs
  - Walking for Health Scheme
  - Foot golf

Questions?

Supt Sarah Poolman
South Yorkshire Police

Karen Hanson
Assistant Director, Community Safety and Street Scene

Safer Rotherham Partnership Plan 2016 – 2019

Working together to make Rotherham Safe, **to keep Rotherham safe** and to ensure the communities of Rotherham feel safe

ROTHERHAM TOGETHER PARTNERSHIP

The Safer Rotherham PARTNERSHIP

Contents

Welcome to the Safer Rotherham Partnership Plan 2016 -19.

This plan sets out how we want to work together so that people in Rotherham feel safe in their community and the borough.

It is important to start by acknowledging the failings of the Partnership which were identified in Louise Casey's Corporate Governance Inspection of February 2015, which criticised the Partnership for not ensuring a proactive role in the prevention, disruption and enforcement action against perpetrators of Child Sexual Exploitation.

Having taken over as Chair of the Safer Rotherham Partnership I would like to thank the former Chair Kath Sims for the work she started in terms of moving forward to support the fresh start all agree was needed.

Therefore we are re-focusing on the future and how the Partnership meets its obligations under the Crime and Disorder Act 1998.

We have reviewed the governance and structure of the partnership and agreed to address six big issues facing Rotherham:

- Reducing the Threat of Child Sexual Exploitation and the Harm to Victims and Survivors
- Building Confident and Cohesive Communities
- Reducing the Threat of Domestic Abuse and reducing the harm to victims and survivors
- Reducing and Managing Anti-social Behaviour and Criminal Damage
- Reducing the Risk of Becoming a Victim of Domestic Burglary
- Reducing Violent Crime and Sexual Offences

There are no easy answers to these challenges and in order to deliver it is paramount that ownership of the plan is retained within the Partnership and all the partners involved are committed to working together without barriers to deliver positive outcomes for people.

I look forward to working with members of the board,

Councillor
Emma Hoddinott
Chair of the Safer Rotherham Partnership

Our vision is to work together to make Rotherham Safe, to keep Rotherham safe and to ensure the communities of Rotherham feel safe.

In her 'Report of Inspection of Rotherham Metropolitan Borough Council' February 2015, Louise Casey levelled considerable criticism at the Police, Council and the Safer Rotherham Partnership on how they failed to address the widespread child sexual exploitation that had been taking place in the borough for a considerable number of years.

The report rightly highlighted that the Safer Rotherham Partnership (SRP), the Police and the Council should have taken a much more proactive role in the prevention, disruption and enforcement action against perpetrators.

'The Safer Rotherham Partnership is the Community Safety Partnership for Rotherham. It is a statutory body required under the Crime and Disorder Act 1998. Its mission is: 'to make Rotherham safe, keep Rotherham safe and to ensure communities of Rotherham feel safe.' For many children and young people it has not succeeded in this mission'

Report of Inspection of Rotherham Metropolitan Borough Council 2015, Page 123 – Louise Casey CB

Since the report the SRP has completed a thorough review of its Governance and Structure arrangements and how it delivers its statutory obligations under the Crime and Disorder Act 1998, much of which has been put into place during 2015.

The SRP has a statutory duty to develop and implement a Partnership Plan which describes how responsible authorities will work together to tackle crime and disorder. The plan is refreshed at the beginning of each financial year and as part of that refresh, the SRP will demonstrate its progress over the previous year. It is the SRP's plan for tackling crime and disorder and responding to those priorities outlined within the SRP's Joint Strategic Intelligence Assessment.

Despite significant challenges in recent years, the strength of the local community and people's willingness to become involved in community life are recognised in this plan. The formal and informal partnerships that are in place are testament to the value of joint working.

The Plan provides a clear picture of how the SRP will continue to work towards creating a safe and more socially cohesive borough and contribute to a better Rotherham.

The purpose of the SRP Plan is to build on previous achievements and deliver improved, more joined up services, especially in the safeguarding of our most vulnerable people and communities. It will continue to demonstrate new and innovative approaches as we respond to an ever changing and more challenging landscape. In this way, we will provide ourselves with the best opportunity to maintain strong performance and deliver the outcomes needed to achieve our vision.

The SRP Plan demonstrates how strong strategic leadership, planning, performance management and problem solving will result in action plans which aim to deliver positive, long term sustainable solutions and improved outcomes for the people of Rotherham.

The Plan also identifies how the partnership will respond to the impact of national policy changes and new and emerging risks, such as the impact of welfare reforms, austerity measures and radicalisation.

An annual refresh of the Plan will take place to ensure that any new and emerging policies, risks and consultation feedback are identified and responded to. This will also provide the opportunity to keep the people of Rotherham up to date with our progress.

The Safer Rotherham Partnership is the borough's Community Safety Partnership with statutory responsibilities established under the Crime and Disorder Act 1998. The partnership has a legal responsibility to tackle crime, anti-social behaviour, drug and alcohol misuse, and to enhance feelings of safety.

There are currently six responsible authorities on the SRP, who have a legal duty to work in partnership to tackle crime, disorder, substance misuse, anti-social behaviour and other behaviour adversely affecting the environment and to reduce re-offending.

The six responsible authorities are:

- Rotherham Metropolitan Borough Council
- South Yorkshire Police
- South Yorkshire Fire & Rescue Service
- National Probation Service
- South Yorkshire Community Rehabilitation Company
- Rotherham Clinical Commissioning Group

The SRP also brings together a range of interested parties from the public, private, community and voluntary sectors to help deliver the outcomes in the SRP Partnership Plan through our strategic and operational structures, as well as representation from the Office of the Police and Crime Commissioner.

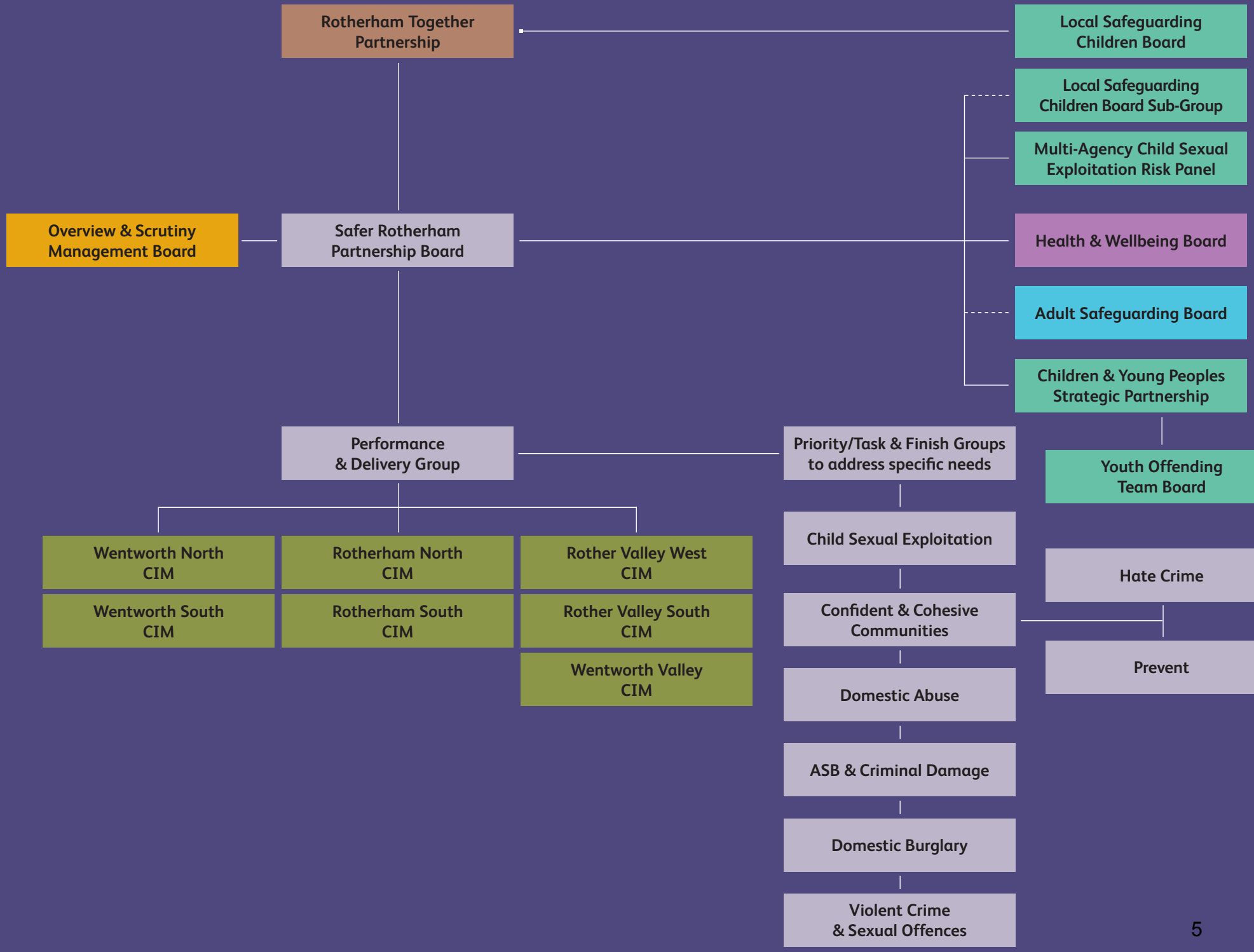
The SRP has a statutory duty to develop an annual Joint Strategic Intelligence Assessment of the risks and threats that crime and disorder poses to the communities of Rotherham. The purpose of the assessment is to:

- Identify the partnerships priorities for the forthcoming year.
- Highlight performance, progress and achievements against the commitments made in the 2014/16 Partnership Plan.
- Identify key crime and disorder risks and threats to the community.

In May 2015 South Yorkshire Police began rolling out a new Local Policing Unit model (LPU) that replaced the Safer Neighbourhood Teams. It aims to provide greater consistency and accountability and put 'Neighbourhoods at the Heart of Policing'. The new model combines Response Teams and Safer Neighbourhood Teams to create multi-skilled Local Policing Teams (LPT) that are supported by Police and Community Support Officers (PCSO).

The previous seven Safer Neighbourhood Team meetings have now been replaced by Case Identification Meetings (CIM). A local support hub that specialises in proactive investigations supports the LPU, The new policing model started in Rotherham in October 2015.

Safer Rotherham Partnership – **Governance Structure 2016**



The Safer Rotherham Partnership Board agrees and manages the strategic direction of the Community Safety Partnership and has oversight of its priority action plans. It agrees and oversees the funding plans of the partnership and monitors performance against set targets. The Board is accountable to the Rotherham Together Strategic Partnership.

The Performance and Delivery Group ensures two way feed-back between the strategic and operational arms of the partnership. It has strategic focus and its role is to ensure that the partnerships financial plan meets the priorities of the partnership. Its operational role is to make tactical resourcing decisions regarding community safety in line with the partnerships priorities. It highlights and tasks action plans in line with crime and disorder issues and priorities through a tactical assessment of crime and disorder in the Borough and emerging trends and related issues.

Priority/Task & Finish Groups are dynamic groups that deliver thematic outcomes. The groups operate by sharing knowledge, expertise and information in order to understand and tackle problems and drive the activity of the area based Case Identification Meetings.

Case Identification Meetings are geographically located multi-agency groups across the Borough whose role is to make a significant difference to the levels of crime and community safety through effective on the ground partnership working. They produce an action plan to address place based crime and anti-social behaviour, share information and intelligence to promote the effectiveness of planned interventions, identify new and emerging hotspots, task individual services with specific actions and monitor and review progress against previous agreed actions.

1
Reducing the Threat of Child Sexual Exploitation and the Harm to Victims and Survivors

2
Building Confident and Cohesive Communities

3
Reducing the threat of Domestic Abuse and Reducing the Harm to Victims and survivors

4
Reducing and managing Anti-Social Behaviour & Criminal Damage

5
Reducing the risk of becoming a victim of Domestic Burglary

6
Reducing Violent Crime & Sexual Offences

Cross Cutting Themes Alcohol & Substance Misuse

Priority 1: Reducing the Threat of Child Sexual Exploitation (CSE) and the Harm to Victims and Survivors

Why this is a priority

Preventing and tackling CSE in all its forms is the key priority for RMBC and SYP. CSE has a lifelong impact on its victims, and therefore, children, young people and their families must have confidence in Rotherham's multi-agency approach to prevention, support and bringing perpetrators to justice. The coming period will continue to see an increase in investigations and prosecutions, and ongoing activity by SYP and the National Crime Agency (NCA) may trigger further historic reporting which will require a full partnership response. Our success in tackling CSE has a profound link to the reputation of the Council and SYP and the public's confidence in the services we provide as a Safer Rotherham Partnership.

What are we going to do?

- The Local Safeguarding Children Board (LSCB) is the leading body for the work undertaken to both investigate perpetrators and support for victims and survivors. The SRP will ensure all agencies support that work and deliver the actions set by the LSCB.
- Our shared aims and Priorities will be achieved through:
- Increased staff awareness;
- Effective information sharing;
- Targeted preventative measures; and
- Disruption opportunities in intelligence led 'hot spot' locations.

Priority 2: Building Confident and Cohesive Communities

Why this is a priority

Community Cohesion is vital to achieving a safer and more harmonious Rotherham. The multiple demonstrations and protests in the town since the publication of the Jay report has heightened community tensions and increased incidents of hate crime. Not all these incidents are being reported.

Ongoing individual criminal trials concerning CSE offences and those involved in disturbances/public order may also give rise to further tensions.

Community cohesion involves:

- Creating a common vision and sense of belonging.
- Valuing and appreciating people from different backgrounds and circumstances.

- Providing similar life opportunities for people from different backgrounds.
- Developing strong, positive relationships between people from different backgrounds in the workplace, in schools and within neighbourhoods.
- Brokering good relations between groups and communities.

There is no doubt that community division and segregation affects many aspects of our lives and this can prevent the best use being made of existing housing and land. People who need housing in the social and affordable sectors must have greater choice. It is our duty to make sure that housing is provided on the basis of need. If we are to meet housing need in all its forms we must work to make progress. Because of this, the promotion of good relations is one of our key objectives.

What are we going to do?

- Ensure joint community engagement and tension monitoring plans are in place
- Review the tactical approach to policing protests, to ensure a robust method which complies with legislation, but limits impact on the community and town centre businesses
- Work with the Home Office on increased scope to avoid events leading to public disorder
- Knowing that hate crimes are under reported, we will build increased confidence in reporting these crimes through ongoing engagement, support and the bringing to justice of perpetrators.
- Effective and positive media engagement which publicises when perpetrators of hate crime and large scale public order are prosecuted
- As a partnership we will ensure that we are adhering to our respective codes of ethics, professional practice and service standards.
- We will ensure that we are having efficient, representative engagement with communities and actively seeking to implement public feedback in delivering our services
- We will prioritise the delivery of services to those most in need of them, ensuring a visible presence in the areas where this will have the most impact.
- We will robustly tackle crime and Anti-Social Behaviour and work to prevent people becoming victims or being vulnerable to becoming a victim

Priority 3: Reducing the Threat of Domestic Abuse and reducing the harm to victims and survivors

Why this is a priority

The impact of Domestic Abuse on the victim and children is severe and can be long lasting. In Rotherham domestic-related crimes increased by 28% (386 recorded incidents) in 2015/16 compared to 2014/15, which is comparable to other similar areas. This rising level of incidents impacts on all services and can only begin to be tackled by a multi-agency response. Whilst the Partnership has a range of measures and services in place, endemic under-reporting means there is scope to review and focus our resources to greater effect. Honour Based Abuse and Forced Marriage are also areas where we need to improve confidence in reporting, only then can we understand the true picture and apply resources most effectively.

What are we going to do?

- Listen and learn from the victims and survivors of domestic abuse
- The Partnership will focus on reviewing the current effectiveness of our services to gain a better understanding and definition of the outcomes that need to be achieved
- Increase support for victims to reduce the number of incidents occurring before initial reporting
- Focus on offender management to reduce repeat offences, including changing behaviour as well as securing better outcomes in prosecutions
- Engage with communities affected by Honour Based Abuse and Forced Marriage to improve intelligence gathering in these areas and increase confidence in reporting

Priority 4: Reducing and Managing Anti-social Behaviour (ASB) and Criminal Damage

Why this is a priority

Anti-social Behaviour is a key issue of public concern both locally and nationally and impacts on the public's overall wellbeing and feelings of safety in their neighbourhoods. Proactive collaborative working enabled a reduction in ASB in the last year, however In order to build on this, it is crucial that we continue to make best use of the resources available to us as a Partnership. Following an increase last year, greater focus is required on reducing Criminal Damage and Arson; along with ASB there is particular concern for the impact that these crimes have on business confidence and footfall in the town centre.

What are we going to do?

- We will identify geographical high demand locations and focus on joint enforcement, clean ups and disruption of anti-social activity as well as ensuring a positive diversionary offer for those involved, or at risk of being involved in ASB
- We will have a specific focus on multi-agency working within the town centre in partnership with local businesses to provide a safe, clean and vibrant public space for people to both shop and work
- Through increased joined up working between agencies we will robustly tackle ASB using all of the tools and powers now available to us as a Partnership
- We will ensure Rotherham's newly introduced Community Justice Panels work effectively in bringing perpetrators and victims together to help resolve the conflict and harm caused by ASB and crime
- Fully utilise the benefits of the Selective Licensing Scheme to reduce levels of ASB in defined areas

Priority 5: Reducing the Risk of Becoming a Victim of Domestic Burglary

Why this is a priority

Domestic Burglary has seen an increase, with rates towards the end of 2015 recording above those of peer Community Safety Partnership (CSPs). Because of its intrusive nature, it can leave families feeling distressed, vulnerable, and unable to feel safe within their own homes. Rotherham's position in relation to other similar areas may also impact on people's decision to purchase property and future investment in Rotherham.

What are we going to do?

The Partnership will focus on the following activities:

- We will robustly pursue and bring to justice those who commit crime.
- We will reduce both adult and youth re-offending rates.
- Employ effective integrated offender management to prevent the cycle of offending behaviour by deterring and rehabilitating habitual perpetrators
- We will raise crime prevention awareness across the borough through first responders, partners and effective media awareness
- We will expand our community engagement approaches to drive prevention in localities of concern

- We will ensure that designing out crime opportunities are maximised through a coherent partnership approach with planning departments
- We will formulate a strategy to engage with and monitor second hand goods markets
- We will continue to work with 'Crime Stoppers' to develop a campaign to identify offenders and handlers of stolen property
- We will continue to launch seasonal crime initiatives to address the varying risks encountered throughout the year
- We will ensure that Police & partners actively target and disrupt known prolific offenders
- We will ensure that we engage with partners and communities to gather intelligence and tackle locally based problems.

Priority 6: Reducing Violent Crime and Sexual Offences

Why this is a priority

Violence against the person and sexual offences are two key crime areas that have seen increases in the past 12 months. The increases in Violent Crime are thought to reflect changes in recording practices as it is a rise seen nationally and our rate of offences remains low in comparison with similar CSP areas. An increase of 71% in sexual offences is believed to reflect increased confidence in reporting historic offences and is not representative of the actual number of Sexual Offences that have occurred in 2015. This is a new priority area for the partnership so that focus can be given to understanding the issues further and, where possible, tackling the associated increases.

What are we going to do?

The Partnership will focus on a review of the prevalence of these crimes and the way agencies deal with them in order to identify scope for multi-agency action to tackle criminality and support victims. On conclusion of this review further actions will be developed in respect of this priority.

Performance against priorities will be measured by a local 'outcome' based accountability performance management framework. This performance framework is intended to monitor and assess the crime and community safety work of the partnership by asking and addressing the following:

- How much did we do? (Quantity) – What we have/are doing to tackle the priority.
- How well did we do? (Quality) – Achievement against the identified priority.
- Is anyone better off? – e.g., has crime/antisocial behaviour reduced, do the people of Rotherham feel safer as a result.

The partnership will use scorecards detailing the key initiatives under each strategic priority including measures of success, time scales, lead partner or officer, resources required and progress to date.

The lead partner or officer for each action will co-ordinate partnership activity, review progress and report back to the partnerships Performance & Delivery Group.

The Performance & Delivery Group will be responsible for maintaining an overview of activity in respect of all agreed priorities and to address potential barriers to successful outcomes. It will also be responsible for providing regular intelligence updates in relation to agreed crime and disorder priorities, including any emerging trends that may threaten performance and outcomes.

The partnerships accountable body, the Safer Rotherham Partnership Board will be responsible for undertaking a strategic review, on a quarterly basis, of progress against priorities and determine any support measures needed to ensure successful outcomes. The Safer Rotherham Partnership is accountable to the 'Rotherham Together' Local Strategic Partnership and scrutiny by Rotherham Councils Overview & Scrutiny Management Board.

Aspects of the National Intelligence Model (NIM), which is an intelligence led business process, will be used as a framework for partnership working. The use of NIM will ensure that activity to reduce crime and disorder is delivered in a targeted manner through the collection and analysis of information and provides direction based on priorities, risk and available resources.

The partnership will make available on a quarterly basis the latest position on performance against agreed priorities, partnership issues, risks, emerging issues and action plans. This report will be made available to the councils Overview & Scrutiny Management Board for comment and review.

How will we measure and monitor whether our actions are achieving our priorities?

Performance Indicators 2016/17

Child Sexual Exploitation

1. Increased 'positive' outcomes for victims and survivors of CSE
2. Number of enforcement/disruption activities of people and premises
3. Feedback from survivors of CSE
4. Increased awareness of CSE and improved information sharing pathways
5. Increase the number of CSE referrals

Confident & Cohesive Communities

6. Increased reporting of hate crime
7. Increased 'positive' outcomes for victims and witnesses of hate crime offences
8. Increase customer satisfaction levels
9. Increased awareness of the impacts of the work of the Safer Rotherham Partnership
10. Number of Hate Crime and Community Cohesion activities delivered

Domestic Abuse

11. Increased reporting of domestic abuse
12. Increase 'positive' outcomes for victims and survivors of domestic abuse
13. Reduced number of repeat cases of domestic abuse heard at the Multi-Agency Risk Assessment Conference (MARAC).
14. Increase in referrals of victims of domestic violence to the appropriate agencies
15. Increase the number of 'victims' supported by the Independent Domestic Advocacy Service
16. Number of domestic abuse awareness raising initiatives

Anti-Social Behaviour & Criminal Damage

17. Reduction in the number of anti-social behaviour incidents reported to the Police
18. Reduction in the number of anti-social behaviour incidents reported to the Council and Registered Social Landlords.
19. Reduction in the number of recorded criminal damage offences
20. Reduction in the number of repeat victims of anti-social behaviour.
21. Increase 'positive' outcomes for victims of anti-social behaviour and criminal damage.

22. Reduction in the number of people who think that anti-social behaviour is a problem in their area.
23. Number of diversionary activities to engage young people and direct them away from anti-social behaviour
24. Monitor and evaluate the effectiveness of the Rotherham Community Justice Panels.
25. Use of available enforcement powers to tackle anti-social behaviour and criminal damage.
26. Reduction in the number of offences of arson.
27. An increase in successful, community-based resolutions of Anti-Social Behaviour

Burglary Dwelling

28. Reduced burglary dwelling offences
29. Reduced number of repeat victims
30. Increase 'positive' outcomes for victims of burglary dwelling offences.
31. Fewer people who think that crime is a problem in their area.
32. Number of enforcement/prevention initiatives to tackle burglary dwelling offences

Violent Crime & Sexual Offences

33. Increased reporting of sexual abuse
34. Reduction in offences of violence with injury
35. Increase 'positive' outcomes for victims of violent crime and sexual offences
36. Increase in referrals of victims of sexual violence to the appropriate agencies
37. Number of sexual offences awareness raising initiatives
38. Reduced re-offending rates

For 2016/17 the South Yorkshire Police & Crime Commissioner has allocated a Community Safety Fund of £224,550.00 to the Safer Rotherham Partnership as a contribution towards tackling both the Partnerships and Commissioners priorities.

It is the role of the Safer Rotherham Partnership to oversee the delivery of this plan, including how financial and other resources are utilised. At each of its bi-monthly meetings the Safer Rotherham Partnership Board will receive a report on our performance against our Priorities, to ensure that we are able to address any areas of concern and task any action to be taken.

The Safer Rotherham Partnership will work closely with the Office of the Police Crime Commissioner to ensure Rotherham's priorities are represented in the South Yorkshire Police and Crime Plan.

Value for public money

Why is important?

The Vision for the Safer Rotherham Partnership is to work together to make Rotherham Safe, to keep Rotherham safe and to ensure the communities of Rotherham feel safe. Achieving this vision, against an increasingly difficult financial and economic backdrop, means that even greater emphasis is being placed on changing the way we work to deliver better services and improve value for money.

This means redesigning services to make better use of resources. Value for money is therefore about making the best possible use of resources to achieve our intended outcomes. In essence it means spending less, spending well and spending wisely.

Demand for community safety services still continues to be high, however available resources are limited due to cuts in government funding across all sectors.

What we are going to do?

- Invest in prevention activity
- Adopt a neighbourhood working approach
- Adopt and share good practice
- Look to improve outcomes by working more closely with the community and local partners

How are we going to do this?

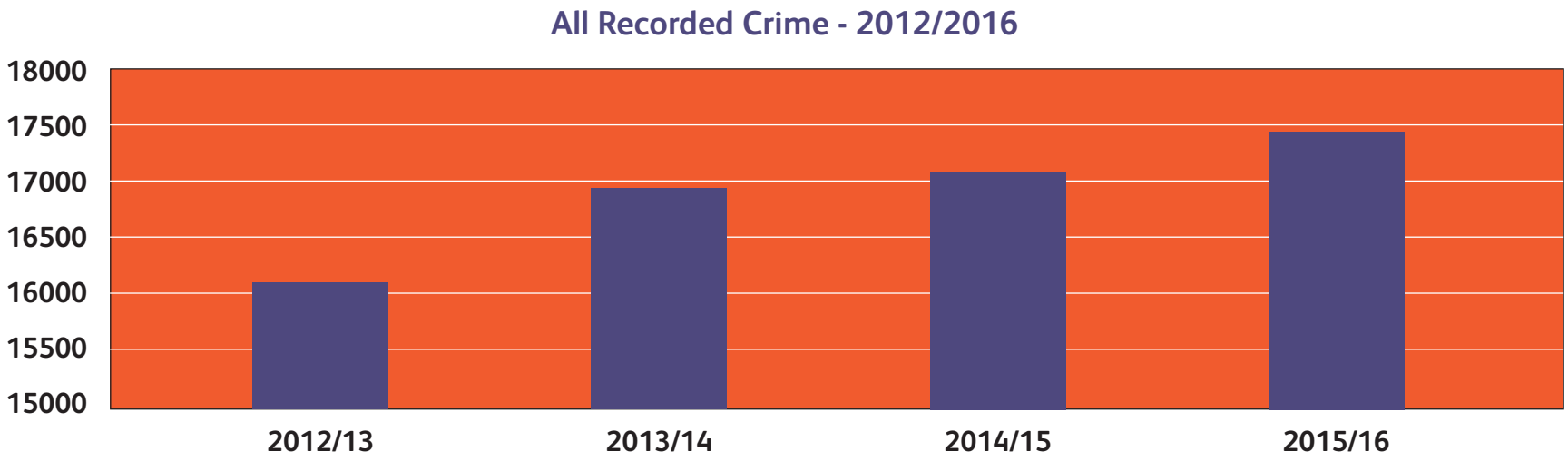
- Explore the possibility of joining up resources and sharing facilities – to achieve more for less
- We will focus our resources on prevention activity to reduce the longer term cost.
- We will strengthen our neighbourhood working by adapting services according to the needs of the local communities rather than having a one size fits all approach.

- The partnership will adopt and share good practice with other Community Safety Partnerships and local authorities to save resources and to achieve desired outcomes.
- At an early stage engage with the voluntary, community and faith sectors in developing community led responses to crime and disorder issues, be that through community development or through a commissioning process.

Levels of Recorded Crime

Recorded crime in Rotherham fell by 12.1% between 2009/10 and 2012/13 with reductions in criminal damage and violent crime. However rising burglary, shoplifting and vehicle crime caused a 6.4% increase in recorded crime between 2012/13 and 2013/14. Between April 2014 and March 2015 recorded crime increased by a further 1% compared to the previous year, predominantly due to continued increases in offences of violence and the reporting of historical sexual offences in the wake of the Alexis Jay Report into Sexual Exploitation in Rotherham. Despite the increase, violent crime in Rotherham remains lower than the national average.

The period did see significant reductions in burglary offences, vehicle crime and shoplifting. However the period April 2015 to February 2016 showed an increase of 2% (412 offences) compared to the previous year. This is in context with a rise locally and nationally and the impact of historical offences and changes to the Police recording procedures.

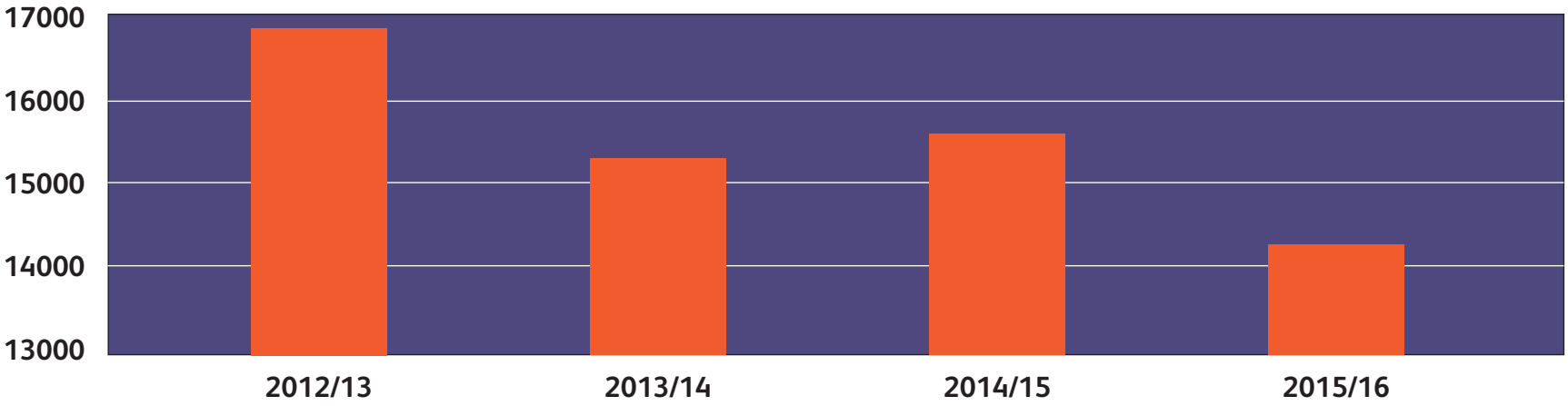


Fewer complaints of anti-social behaviour

Recorded anti-social behaviour (ASB) incidents have shown a downward trend, falling by 36.4% between 2009/10 and 2013/14.

Between April 2014 and March 2015 there were 15,553 ASB incidents recorded to the police, which is an increase of 2% when compared to the same period of the previous year. From April 2015 to March 2016, there were 14,343 incidents of ASB recorded, a reduction of 7.8% compared to the same period in the previous year.

Total Ant-Social Behaviour 2012/2016



Tackling Child Sexual Exploitation (CSE)

Between April 2015 and January 2016, South Yorkshire Police received 288 referrals resulting in 38 people being charged or summoned to Court for CSE related offences, including prolific offenders.

In March 2015 a package of support was introduced for victims and survivors of CSE delivered by a range of quality third sector organisations. (Around 500 victims and survivors supported at the end of February 2016)

In January 2016 the Council launched a new Early Help Service to ensure that problems are identified and addressed quickly and that our children are kept safe.

In February 2016, four men and two women were convicted at Sheffield Crown Court of the "systematic" sexual abuse of teenage girls in Rotherham over a number of years. Five of the six defendants were jailed for a combined total of 102 years. Investigations into historical and current cases continue.

'EVOLVE' – Rotherham Child Sexual Exploitation Multi-Agency Team

In July 2015 a multi-agency CSE Team (Evolve) was established with South Yorkshire Police on the prevention, disruption, protection and prosecution of CSE.

The Safer Rotherham Partnership is fully committed to ensure that lessons learnt from inspections and reviews into Child Sexual Exploitation in Rotherham are translated into robust, effective and accessible services that are delivered where and when they are needed the most. It is very clear from our understanding of the experiences of abused and exploited children and young people that we need to adapt and change previous methods of engagement and approach in order to be able to respond their rights and needs for both for protection and justice.

Services have been reviewed along with approaches to supporting and protecting children and young people who are at risk or suffering from child sexual exploitation. The Multi-Agency Child Sexual Exploitation Project, Evolve was developed based on good practice principles, standards and, most importantly, the voices and experiences of young people, children and their families.

The Evolve team is located in Riverside House.

Hackney Carriage and Private Hire Licensing Policy

The council's revised Hackney Carriage and Private Hire Licensing Policy was agreed on 6th July 2015. The policy introduced a number of significant changes to the standards that are expected of licence holders, and the way that the councils assesses the suitability of drivers, operators and vehicles has been reviewed.

In order to allow the changes to be introduced as effectively as possible, the council has developed an implementation scheme that details the timescales over which the most significant changes will be introduced (primarily in relation to existing licence holders). This scheme was agreed on 24th August 2015 and saw the introduction of most of the new requirements by the end of March 2016, with the remainder coming into effect before July 2016.

The council is confident that the requirements of the new policy will address many of the concerns and issues identified within Professor Alexis Jay's and Louise Casey's reports of 2014/15, and will ensure that the standard of drivers, vehicles and operators working in Rotherham will be amongst the highest in the country.

Multi-Agency Service Hub (MASH)

The Multi-Agency Safeguarding Hub (MASH) was established in April 2015 and acts as the central resource for the whole of Rotherham receiving all safeguarding and child protection enquiries.

The MASH is staffed by professionals from a range of partner agencies including Social Care, Police, and the Rotherham Foundation Trust (TRFT). These professionals share information to ensure earlier identification of vulnerable children, and take a whole family approach to safeguarding children.

The MASH adopts a 'single view of the child approach' by gathering information from partner agencies and uses this to decide the most appropriate intervention to respond to the child's and family's identified needs.

The MASH provides a 'single front door' that can draw on multi-agency experience, create swifter checks ensuring that services for children work more effectively together at the point of referral and decision making. It simplifies processes and communication between professionals and with families.

The MASH method enables more preventative actions to be taken, addressing cases before they escalate. It facilitates faster and more co-ordinated responses to safeguarding concerns and helps to detect long standing patterns of abuse and neglect. It provides an improved journey for the child and parent/carer with a strong emphasis on early intervention.

Between April 2015 and February 2016, the MASH had received 8,727 contacts with 96% of referral decisions made within 48 hours.

Vulnerable Persons Unit

The partnership's Vulnerable Persons Unit (VPU) is co-located with the council's Community Safety and Anti-Social Behaviour Unit at Riverside House. Its role is to develop sustainable cross-agency interventions to improve outcomes for vulnerable adults, reduce risks and reduce avoidable demands on emergency

and crisis services. The Unit is staffed by a Police Sergeant, four Police Constables and a council Community Safety Officer. On a daily basis, the staff review incidents to identify and manage vulnerability and the risks associated with each individual case. They ensure that hate crimes/incidents have been identified and dealt with appropriately and raise any community tension issues that have not already been identified and addressed by the appropriate agencies.

The Unit receives referrals from the police and other agencies such as Social Services, Mental Health, Housing and Care Workers. It co-ordinates the implementation of the Rotherham Vulnerable Adults Risk Management (VARM) framework, bringing together specialist workers from multiple disciplines to identify risk, seek solutions, challenge blockages and reduce the risk to an acceptable level, with consideration given to the Care Act 2014, the Mental Health Act, the Mental Capacity Act and other relevant legislation.

The unit provides early identification of vulnerable victims so that appropriate interventions can be put in place to reduce the risk of harm to those individuals.

Families for Change Programme

In April 2012 the government launched the Troubled Families Programme, known in Rotherham as Families for Change, to incentivise local authorities and their partners to turn around the lives of over 120,000 families. The SRP works jointly on this agenda with other agencies.

Phase One of the programme aimed to work with families where children are not attending school, young people are committing crime, families are involved in anti-social behaviour and adults are out or work.

Our Families for Change Programme met the target at the end of phase one (March 31st 2015) to turn around its targeted number of 730 families.

In June 2014 the government announced plans to expand the Troubled Families Programme for a further five years from 2015/16 and to reach an additional 400,000 families across England. For Rotherham this means an additional 2470 families will be targeted. In Rotherham we began to deliver the expanded programme in April 2015.

Phase Two brings an explicit expectation that the Troubled Families work will be a driver for organisational change. In Rotherham, the Improvement Plan, 'A Fresh Start', sets out how we intend to achieve four key outcomes, including 'Rotherham being a Child-Centred borough, where young people are supported by their families and their community, and are protected from harm'. Families for Change will support change, particularly in the way that services are organised to meet the needs of families who are experiencing problems.

Community Justice Panels

Community Justice Panels, also known as Neighbourhood Justice Panels, bring victims and perpetrators together to resolve conflict and the harm caused by anti-social behaviour and crime.

The Panels are not designed to punish individuals, rather encourage perpetrators to acknowledge the impact of what they have done and make amends to the victim and the wider community by apologising and engaging in reparative work.

The Panels deal with categories of low-level crime and anti-social behaviour, including neighbour disputes, criminal damage, thefts and assaults, taking referrals from the Police, Council and other partners where appropriate.

Successful panels have been established in Sheffield and Barnsley for some time and Doncaster has recently introduced a panel.

In 2015, supported by the Office of the South Yorkshire Police and Crime Commissioner, Rotherham Council employed a full time Co-ordinator to establish panels in Rotherham, including the recruitment of an appropriate number of trained volunteers to facilitate the panel meetings. The Rotherham Panel started taking referrals in April 2016.

Together Rotherham Pathways Project

The Rotherham Pathways project is based in Riverside House and is one of six that form part of a three-year (Ending December 2016) national 'Transition to Adulthood Pathway' programme to deliver interventions to young adults involved with the criminal justice system. Together runs the project in partnership with South Yorkshire Police, Rotherham Metropolitan Borough Council and Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust (RDaSH).

The project offers support to vulnerable young adults aged 17-24-years-old, in contact with police and emergency services in Rotherham. They work with individuals who are at risk of offending or are at a pre-conviction stage to respond to their needs at the earliest possible stage of contact.

Based on a holistic assessment, individuals are given practical support to manage their mental wellbeing and to access community resources, from employment and training, to housing, mental health and substance misuse services. Workers also support young adults to identify, understand and alter any behaviour that is perpetuating their mental distress. They work with individuals to develop tools that enable them to sustain these changes, for example, emotional awareness, assertiveness, negotiation and problem-solving skills. A key focus is on strengthening their informal support networks and relationships.

Young adults are supported for approximately six months, for up to six hours per week (dependent on individual need) with the aim being that on leaving the service, they will have developed a personal set of resources that will reduce their mental distress, risk of offending and dependency on emergency services.

Private Landlord Selective Licensing Scheme

Rotherham Council introduced a mandatory licensing of private sector lets in four areas of the borough in 2015 which lasts until 2020. These Selective Licensing areas are Eastwood, Masbrough, Maltby South East and Dinnington.

The Selective Licensing scheme is intended to drive up the quality of private rented housing in those areas where it applies. It is designed to improve the lives of tenants and their local communities. Since its introduction, more than 1000 properties have been registered with the scheme, which accounts for more than 80% of the estimated licensable houses in these areas. The licences require landlords to abide by certain conditions relating to the management of their property, and licensed properties will be regularly inspected to ensure this happens.

Failing to license a house or breaching the conditions of licences can also result in a range of penalties Court. These can be financial penalties through the courts, revocation of licences, rent repayment orders or, ultimately, a management order.

The Safer Rotherham Partnership

Community Safety & Anti-Social Behaviour Unit

Community Safety & Street Scene

Environment & Development Services

Rotherham MBC

Riverside House

Main Street

Rotherham S60 1AE

Tel: 01709 334562

Community.safety@rotherham.gov.uk

Visit the Safer Rotherham Partnership Website at:
www.rotherham.gov.uk/srp

Appendix 1

National Policy & Key Policy Drivers

Appendix 2

Priorities and links to other plans and strategies

Appendix 3

Commissioning Framework 2016/17

National Policy & Key Policy Drivers

Since 2010 the SRP has operated in a time of significant change in the public sector. Key statutory partners who make up the SRP have faced reductions in expenditure and resources. Home Office grants to the SRP have also reduced significantly.

In 2011 some legislation and performance requirements relating to the SRP were repealed, however, many statutory requirements placed on the responsible authorities remain. The SRP no longer operates in the context of a National Community Safety Strategy but there are key thematic policy drivers which influence our strategic direction.

Key Policy Drivers

Anti-Social Behaviour, Crime & Policing Act 2014

The Act introduced new powers to tackle anti-social behaviour (ASB) that provide better protection for victims and communities. The new Community Trigger and Community Remedy will empower victims and communities, giving them a greater say in how agencies respond to complaints of ASB and in out of court sanctions for offenders. The SRP has worked with the Police and Crime Commissioner (PCC) to implement the new measures contained within the Act which commenced in October 2014.

Transforming Rehabilitation: A Strategy for Reform

The Transforming Rehabilitation Programme implemented Government plans to transform the way in which offenders are managed in the community, in order to bring down re-offending rates.

The key aspects of the reforms are:

- The creation of a new public sector National Probation Service to manage high risk offenders (June 2014)
- The creation of twenty one regional private sector Community Rehabilitation Companies (CRCs) managing all other offenders (February 2015)
- Every offender released from custody will receive statutory supervision and rehabilitation in the community.
- A nationwide 'Through the Prison Gate Resettlement Service' put in place, meaning most offenders are given continuous support by one provider from custody into the community. Offenders are held in a prison designated to their area for at least three months before release.
- New payments by results incentives for CRCs to focus on reforming offenders

Police and Crime Commissioners (PCC)

In November 2012 the first PCC for South Yorkshire was elected, replacing Police Authorities who were a responsible authority on the SRP. A range of funding streams was transferred from the SRP the PCC in April 2013.

In November 2014, Dr Alan Billings was elected the South Yorkshire PCC following the resignation of the previous Commissioner and was re-elected in May 2016. A renewed South Yorkshire Police & Crime Plan was published in March 2016 which places emphasis on restoring trust in the police service and 'enabling people to feel safe and be safe'. The SRP and PCC work collaboratively on shared strategic Priorities within the parameters of this plan.

New Domestic Abuse Measures

In March 2014 the Domestic Violence Disclosures Scheme (Known as Clare's Law) was extended to Police Forces across England and Wales. It followed a successful 14 month pilot in four police force areas, which provided more than 100 people with potentially life-saving information. It is a scheme allowing the police to disclose to individuals details of their partners abusive past.

Further protection has been provided through the introduction of Domestic Violence Protection Orders (DVPOs); a new power introduced by the Crime and Security Act 2010. It enables the police to put in place protection for the victim in the immediate aftermath of a domestic violence incident. Under DVPOs, the perpetrator can be prevented from returning to a residence and from having contact with the victim for up to 28 days, allowing the victim a level of respite to consider their, with the help of a support agency. This provides the victim with immediate protection.

Ending Violence against Women and Girls Strategy 2016 – 2020

Through this refreshed strategy in March 2016, the Government have set out its vision to tackle violence against women and girls in all its forms over the next four years. It is intended to drive a transformation in the delivery of Violence against Women and Girls (VAWG) services, make prevention and early intervention the foundation of its approach, and embed VAWG as 'everyone's business' across agencies, services and the wider public

Working Together to Safeguard Children 2015

In March 2015, the Department for Education brought out new guidance for people working with children in England, Working Together to Safeguard Children (2015).

This guidance updates the previous version, Working Together to Safeguard Children (2013). Although not a major review, the 2015 guidance includes changes around:

- How to refer allegations of abuse against those who work with children;
- Clarification of requirements on local authorities to notify serious incidents; and
- The definition of serious harm for the purposes of serious case reviews.

The 2015 guidance also incorporates legislation and statutory guidance published since 2013.

Counter Terrorism and Security Act 2015

The threat to the United Kingdom (UK) from the terrorist organisation Islamic State has resulted in the threat level to the UK being raised to severe. This means an attack is highly likely.

The government responded to this threat by introducing the Counter Terrorism and Security Act 2015.

The Act puts Channel on a statutory footing. Channel is a multi-agency approach to provide support to individuals at risk of being drawn into terrorist related activity. It forms a key part of the governments Prevent Strategy which aims to stop people becoming terrorists or supporting any form of terrorism. Channel seeks to:

- Safeguard individuals who might be vulnerable to being radicalized, so that they are not at risk of being drawn into terrorist related activity.
- Ensure that individuals and communities have the ability to resist all forms of terrorism and violent extremist activity likely to lead to terrorism.

The Channel process identifies those most at risk from radicalisation and refers them, via the police, for assessment by a multi-agency panel. The panel then considers how best to safeguard them by ensuring they have access to support from mainstream services, such as health and education, through to specialist mentoring or faith guidance and wider diversionary activities. Each support package is monitored and reviewed regularly by the multi-agency panel.

Under the new Act, specified authorities (local authorities, police, education, probation, prisons and health) have a duty, while exercising its functions, to have due regard to the need to prevent people from being drawn into terrorism.

Organised Crime

In October 2013 the government published its Serious and Organised Crime Strategy to deal with the challenges faced from serious and organised crime. It was published to coincide with the launch of the National Crime Agency (NCA) and reflects changes to the threats we face and lessons learned from previous work.

Organised crime includes drug trafficking, human trafficking and organised illegal immigration, high value fraud and other

financial crimes, counterfeiting, organised acquisitive crime and cyber-crime. The strategy also deals with serious crime which demands a national coordinated response, notably other fraud and Child Sexual Exploitation (CSE).

Organised crime is a threat to national security. It cost the UK at least £24 billion each year, leads to loss of life and can deprive people of their security and prosperity.

The aim of the strategy is to substantially reduce the level of serious and organised crime affecting the UK and its interests. It uses the framework developed for counter-terrorist work and has four components: prosecuting and disrupting people engaged in serious and organised crime (Pursue); preventing people from engaging in this activity (Prevent); increasing protection against serious and organised crime (Protect); and reducing the impact of this criminality where it takes place (Prepare).

Gang Violence and Exploitation

In January 2016 the government published the document Ending Gang Violence and Exploitation which sets out a refreshed approach to tackling gang related violence and exploitation, and its priorities for the future. It is aimed at local partners, especially in the 52 local areas that have already worked on the Home Office funded 'Ending Gang and Youth Violence programme. Although Sheffield is currently the only area in South Yorkshire involved with the programme, its proximity to Rotherham and the potential for cross-border activity cannot be underestimated.

The government has identified the following six priorities to support this refreshed approach with the expectation that partners continue to work closely together and have a good understanding of current and emerging local problems and how they can be addressed more effectively:

- Tackle county lines – the exploitation of vulnerable people by a hard core of gang members to sell drugs.
- Protect vulnerable locations – places where vulnerable young people can be targeted, including pupil referral units and residential children's care homes.
- Reduce violence and knife crime – including improving the way national and local partners use tools and powers.
- Safeguard gang-associated women and girls – including strengthening local practices.
- Promote early intervention – using evidence from the Early Intervention Foundation to identify and support vulnerable children and young people (including identifying mental health problems).
- Promote meaningful alternatives to gangs such as education, training and employment.

Cyber-Crime

In November 2013 the government published a progress update on its National Cyber Security Strategy. The first year saw activity across a wide range of areas and with many partners, generating increasing momentum across the National Cyber Security Programme. Key enabling structures and capabilities were introduced or enhanced and groundwork laid. Since that time the government has built on this groundwork to deliver real progress. This year is about continuing to cement that progress and filling gaps where work to date has shown there is more to do.

The government's forward plan focusses on the core Priorities of:

- Further deepening our national sovereign capability to detect and defeat high end threats.
- Ensuring law enforcement has the skills and capabilities needed to tackle cyber- crime and maintain the confidence needed to do business over the internet.
- Ensuring critical UK systems and networks are robust and resilient.
- Improving cyber awareness and risk management amongst UK business.
- Ensuring members of the public know what they can do to protect themselves and are demanding good cyber security in the products and services they consume.
- Bolstering cyber security research and education so we have the skilled people and know how we need to keep pace with this fast moving issue into the medium term.
- Working with international partners to bear down on havens of cyber-crime and build capacity and to help shape international dialogue to promote an open, secure and vibrant cyberspace.

Code of Practice for Victims of Crime

In October 2015 the Ministry of Justice published a Code of Practice for Victims of Crime. This Code forms a key part of the wider Government strategy to transform the criminal justice system by putting victims first, making the system more responsive and easier to navigate. Victims of crime should be treated in a respectful, sensitive, tailored and professional manner without discrimination of any kind. They should receive appropriate support to help them, as far as possible, to cope and recover and be protected from re-victimisation. It is important that victims of crime know what information and support is available to them from reporting a crime onwards and who to request help from if they are not getting it.

The Code sets out the services that must be provided to victims of crime by organisations in England and Wales and sets minimum standards for those services.

Priorities and Links to other Plans and Strategies

The SRP works collaboratively on a range of shared Priorities to make Rotherham a safer place to live work and visit. These shared Priorities and how they are delivered are detailed in the following table.

Safer Rotherham Partnership Priority	Other Plans & Priorities
1. Reduce the threat and harm of becoming a victim of Child Sexual Exploitation	**Rotherham Together Partnership Plan 2016/17 - Themes** • **1. Bringing People Together** • Key Action: Let's Get Rotherham Talking • **2. Opportunity & Equality** • Key Action: Let's Get Rotherham Working • **3. Welcoming Places** • Key Action: Let's Get Rotherham Cleaning **Rotherham Children & Young Peoples Plan - Priorities:** • We will ensure children have the best start in life • We will engage with parents and families • We will reduce the harm to children and young people who are exposed to domestic abuse, alcohol and substance misuse and neglect • We will work with partners to eradicate child sexual exploitation from the borough
2. Building Confident & Cohesive Communities	
3. Reduce the threat and harm to victims of domestic abuse, stalking, harassment, honour based abuse, forced marriage and reducing the harm to victims	
4. Reducing and managing anti-social behaviour and criminal damage	
5. Reducing the risk of becoming a victim of Domestic Burglary	
6. Reducing Violent Crime & Sexual Offences	

Safer Rotherham Partnership Priority	Other Plans & Priorities
	• We will focus on all children and young people making good progress in their learning and development • We will target support to families in greatest need to help access learning/employment opportunities **South Yorkshire Police & Crime Plan 2013/17 (Refreshed March 2016) Strategic Priorities** **1. Protecting Vulnerable People.** • Effective action tackling child sexual exploitation, rape and serious sexual offences. Effective response to threats to the most vulnerable people. Appropriate response by police and justice services to those suffering mental health issues. **2. Tackling Crime & Anti-Social Behaviour.** • Effective action tackling crime, anti-social behaviour and re-offending. • Targeted response to those who cause most harm in the community and intervention with others before they enter the criminal justice system. • Prioritising the crime and behaviours that cause the most harm within the community.

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Safer Rotherham Partnership Priority	Other Plans & Priorities
	3. Enabling Fair Treatment. • Planned engagement that seeks public feedback to inform the delivery of policing and crime services • Deploying resources to areas of highest demand based on threat, harm and risk • Finding ways to understand and address appropriately feelings of safety • Services that inspire trust in the general public • Recognise staff confidence and morale and adherence to codes of ethics and professional practice as central to delivering an efficient and effective police service **Rotherham Local Safeguarding Children Board Business Plan 2014/15** • Child Sexual Exploitation • Child Neglect • Domestic Abuse • Providing Early Help

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Safer Rotherham Partnership Priority	Other Plans & Priorities
	Rotherham Local Safeguarding Children Board Business Plan 2014/15 • Child Sexual Exploitation • Child Neglect • Domestic Abuse • Providing Early Help **Child Sexual Exploitation Delivery Plan 2015/18** • Prevent children and young people from becoming sexually exploited through effective leadership, governance and a wider culture embedded within organisations that recognise the root causes of CSE, the signs and risk indicators and do all they can to tackle them • Protecting children and young people who are at risk of sexual exploitation as well as those already victims and survivors • Pursue relentlessly perpetrators of CSE, leading to prosecutions of those responsible • Provision of support for survivors of CSE, ensuring their needs are met • Ensure the participation of all children, young people and families, ensuring that their voices are heard and listened to at all times

Safer Rotherham Partnership Priority	Other Plans & Priorities
	Adult Safeguarding Strategy Priorities • Review and update the Board's organisation to give it the capacity to deliver its strategic Priorities and promote a constructive and challenging culture. • Review and update the Board's constitution to maximise partnerships and establish its identity. • Involve the public in planning, quality assurance, service provision and communication. • Promote a culture change within all the organisations to embed a person-centred approach. • Establish a user-friendly reporting framework which measures and assures the Board's work and its impact on safeguarding. **Rotherham Joint Health & Wellbeing Strategy Priorities** • Rotherham people will get help to stay healthy and increase their wellbeing • All Rotherham people will have high aspirations for their health & wellbeing and expect good quality services in their community, tailored to their personal circumstances

Safer Rotherham Partnership Priority	Other Plans & Priorities
	• Rotherham people will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances • People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles • Rotherham people will be able to manage long term conditions so that they are able to enjoy the best quality of life • Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skill and employment

Our Vision

Working together to make Rotherham Safe, to keep Rotherham safe and to ensure the communities of Rotherham feel safe.

Our Priorities 2016/17

1. Reducing the threat of child sexual exploitation and the harm to victims (Gary Ridgway – Evolve Project)
2. Building confident and cohesive communities (Zafar Saleem* – RMBC)
3. Reducing the threat of domestic abuse and reducing the harm to victims (RMBC Domestic Abuse Co-ordinator)
4. Reducing and managing anti-social behaviour and criminal damage (Chief Insp Richard Butterworth/Steve Parry-RMBC)
5. Reducing the risk of becoming a victim of Domestic Burglary (Det Chief Insp Sarah Poolman)
6. Reducing violent crime and sexual offences (Det Chief Insp Sarah Poolman)

Funding

For 2016/17 the South Yorkshire Police & Crime Commissioner has allocated a Community Safety Fund of £224,550.00 to the Safer Rotherham Partnership as a contribution towards tackling both the Partnerships and Commissioners priorities.

It is the role of the Safer Rotherham Partnership to oversee the delivery of the Partnership Plan, including how financial and other resources are utilised. At each of its bi-monthly meetings the Safer Rotherham Partnership Board will receive a report on our performance against our Priorities, to ensure that we are able to address any areas of concern and task any action to be taken.

The Safer Rotherham Partnership Board has delegated the responsibility on how this funding is utilised to its Performance & Delivery Group, with a fresh emphasis towards a commissioning process as opposed to previous bidding processes. As part of this process, the Board will prioritise projects and activity that directly address the following priorities:

- Improving Community Cohesion in Rotherham
- Tackling Hate Crime
- Addressing issues around domestic abuse, violent crime and the night time economy

All services and activity commissioned will:

- Target the partnerships 2016/17 priorities through the agreed approach (below)
- Demonstrate value for money
- Fully comply with the Funding Allocation conditions of the Police & Crime Commissioners Office
- Have the support of the respective Partnership Priority Group/ Theme Lead
- Be agreed by the Performance & Delivery Group (Both Joint Chairs if necessary and between meetings)

As part of its overall function, the Partnership Priority Group/ Theme Lead is accountable to the Performance & Delivery Group for performance against their respective priority. A key part of this process is the identification and commissioning of services and activity.

Value for public money

Achieving the partnerships vision, against an increasingly difficult financial and economic backdrop, means that even greater emphasis is being placed on changing the way we commission and deliver better services and improve value for money.

The Safer Rotherham Partnership aims to provide an environment where those residing, visiting and working within the borough do not fear crime and ASB and show confidence in our response to tackling it. Activity to deliver this and the overall vision will be focussed on the following principles which will be reflected in the commissioning of services as part of the funding process.

Our 'over-arching' approach to financial resource allocation is to:

- Invest in prevention activity
- Adopt a neighbourhood working approach
- Adopt and share good practice
- Look to improve outcomes by working more closely with the community and local partners
- Increase public confidence

How are we going to do this?

- Explore the possibility of joining up resources and sharing facilities – to achieve more for less
- We will focus our resources on prevention activity to reduce the longer term cost.
- We will strengthen our neighbourhood working by adapting services according to the needs of the local communities rather than having a one size fits all approach.
- The partnership will adopt and share good practice with other Community Safety Partnerships and local authorities to save resources and to achieve desired outcomes.
- At an early stage engage with the voluntary, community and faith sectors in developing community led responses to crime and disorder issues, be that through community development or through a commissioning process.

Partnership Approach

Prevention and Early Intervention

Ensure an holistic approach to tackling crime and ASB which emphasises prevention and changing behaviour.

Targeted prevention and early intervention plays an essential role in the reduction of crime and ASB. Where possible, prevention is always preferable to a cure and therefore it is important that the services are capable of working in partnership, to deliver preventative strategies, and thereby minimise the risk of becoming a victim.

Enforcement

To deal quickly, sensitively and appropriately with all incidents of crime and ASB in accordance with published procedures and legal remedies.

Partners are equipped with a range of legal tools and powers for use against persistent offenders. Whilst support and early intervention is recognised as playing a huge role in reducing crime and ASB, we must not shy away from using enforcement where issues persist.

Support and Reassurance

Develop sensitive and tailored support protocols for crime and ASB victims and witnesses, particularly repeat victims, along with broader reassurance for the wider community.

Support plays a large part in the resolution of crime and ASB both in terms of reducing offending and its impact on the victim. Support should be more frequently utilised as a means to seek a resolution as the benefits often impact a large range of agencies and hold greater potential to provide a resolution long term. It is important that services remain focussed on the needs of the victims and are equipped to recognise where issues may exist and access the relevant help and support on behalf of the individuals we are working with.

Reassurance to the wider community of actions and availability of services to tackle crime and ASB is paramount. Communities need to feel confident in the joint services offered and the strength of the partnership.

Partnership Working

To have effective partnerships at a local level with statutory and other agencies on the sharing of information and tackling crime and ASB.

No one agency alone holds the key to resolving all problems. Support is widely accepted as being more effective, when successful, in reducing crime and ASB long term; particularly where issues relate to mental health, substance misuse and complex family history/problems.

For further information contact:

The Safer Rotherham Partnership

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S60 1AE

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Community.safety@rotherham.gov.uk

February 2017 **(Draft V2)**

Rotherham Safeguarding Partnership Protocol

Purpose of this protocol

To describe the roles, functions and interrelationship between the various strategic partnerships across the borough in relation to safeguarding and promoting the welfare of children, young people, adults and their families.

To ensure that the complementary but distinctive roles of the partnership boards are understood and carried out so that the needs of children, adults and their families in the borough are identified, planned for and addressed.

To ensure a shared focus on positive outcomes for children, young people, adults and their families; and that appropriate arrangements are in place between strategic leaders, elected members and chairs to ensure strategic priorities in relation to safeguarding are translated effectively into action plans.

Partnership board signatories

The strategic partnerships which are stakeholders to this protocol include:

1. **Rotherham Health and Well Being Board (RHWBB)**
2. **Rotherham Children and Young People's Partnership Board (RCYPPB)**
3. **Safer Rotherham Partnership (SRP)**
4. **Rotherham Local Safeguarding Children Board (RLSCB)**
5. **Rotherham Safeguarding Adults Board (RSAB).**

Principles

This protocol does not seek to dilute the discreet responsibilities of each board. Its focus is to ensure that the following principles underpin how the five boards will operate:

- **Safeguarding people is the business of all the boards listed above**
- **Boards will understand each other's business**
- **A culture of challenge will exist across the boards**
- **The boards will work collaboratively to avoid duplication and ensure consistency.**

Context

Rotherham Council believes that every child, young person and adult, regardless of their background, age, culture, sexual orientation, gender identity, disability, ethnicity or religious belief, should be able to participate in a safe society without any fear, violence, abuse, bullying, discrimination or exploitation (Corporate Safeguarding Policy Statement).

A Child-Centred Borough: One of the priorities in the Improvement Plan for the Council and its partners is for Rotherham to become a 'child-centred borough'.

The aim of a child-centred borough is for communities of children, young people and adults, including elected members as locally democratically elected representatives, to combine their resources to support every child to be the best they can. The strength of resources within families can be better utilised in realising the potential of children and young people and therefore the child centred borough plan will focus on how better links can be made, both within the council and with partners, to ensure that families are supported to thrive.
Aspirations for Rotherham to be a child-centred borough include the following six principles:

- A focus on the rights and voice of the child
- Keeping children safe and healthy
- Harnessing the resources of communities
- An inclusive borough
- Ensuring children reach their potential
- A sense of place.

Whilst becoming a child centred borough is a key priority for the Council, it will also be important to ensure this is achieved in harmony with the Council's responsibility to keep all its residents safe, including adults and older people, and the boards included in this protocol reflects that.

Functions and responsibilities of the five strategic partnerships

Rotherham Health and Well Being Board

Overview functions: setting strategic vision, objectives and outcomes / influence and oversight of relevant commissioning plans.

The Health and Wellbeing Board (HWbB) is a statutory sub-committee of the council, established under the Health and Social Care Act 2012. The HWbB responsibilities include:

- Assessing the needs of the population and producing the local joint strategic needs assessment (JSNA)
- Using the data and knowledge in the JSNA to publish a local health and wellbeing strategy, setting local priorities for joint action
- Using the strategy and its priorities to influence and inform commissioning decisions for the health and wellbeing of Rotherham people
- Enabling, advising and supporting organisations that arrange for the provision of health or social care services to work in an integrated way
- Hold relevant partners to account for the quality and effectiveness of their commissioning plans
- Ensure that public health functions are discharged in a way that helps partner agencies fully contribute to reducing health inequalities.

Rotherham Children and Young People's Partnership Board

Overview functions: setting strategic vision, objectives and outcomes / influence and oversight of relevant commissioning plans.

Rotherham's Children and Young People's Partnership Board (CYPP Board) brings together representative partners from a wide range of children and young people's services. The partnership is the driving force in ensuring improved services and outcomes for children, young people and families in Rotherham. The CYPP Board promotes collaborative working and creative thinking, their responsibilities include:

- Working with children and their families to provide strategic direction for children's services, improve joint working between agencies, and shape the children and young people's plan for Rotherham
- Create an environment where staff from all organisations, communities and families can work well together to deliver on local priorities, including those identified by the HWbB
- Consulting with children, young people and families and respond to their needs
- Monitoring progress against shared priorities and targets in the children and young people's plan and being accountable for outcomes
- constructively challenging areas of under-performance and deploy resources to ensure improvement
- Championing Rotherham as a child-centred borough, ensuring that the voice of children and young people and their families is at the heart of the CYPPBs work
- Aligning and/or pooling budgets to enable joint commissioning of services and the most effective use of resources
- Working with the HWbB to deliver the aims of the health and wellbeing strategy in relation to children and young people, and reporting to the HWbB on progress
- Providing direction and specific actions to task and finish groups and reporting outcomes, achievements and issues to the Children's Improvement Board.

Safer Rotherham Partnership

Overview functions: setting strategic vision, objectives and outcomes / influence and oversight of relevant commissioning plans.

The Safer Rotherham Partnership (SRP) is the borough's community safety partnership with statutory responsibilities established under the Crime and Disorder Act 1998. The partnership has legal responsibilities to:

- Produce a local assessment of crime and disorder: joint strategic intelligence assessment (JSIA)
- Tackle crime, anti-social behaviour and drug and alcohol misuse
- To enhance feelings of safety delivered through Safer Neighbourhood Teams
- To undertake Domestic Homicide Reviews and advise on lessons to be learned.

Rotherham Local Safeguarding Children Board

Overview functions: providing challenge and oversight of practice in relation to safeguarding children outcomes

The Rotherham Local Safeguarding Children Board (LSCB) is a statutory body. It is neither a commissioning body nor a provider of services. The core objectives of the LSCB, as set out in Section 14 of the Children Act 2004 are:

- To coordinate what is done by each person or body represented on the LSCB for the purposes of safeguarding and promoting the welfare of children in the area, and ensure the effectiveness of what is done by each such person or body for those purposes
- To develop policies and procedures for safeguarding and promoting the welfare of children in the area of the authority
- To communicate to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so
- To monitor and evaluate the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advise them on ways to improve
- To participate in the planning of services for children in the area; and undertake reviews of serious cases and advise the authority and their partners on lessons to be learned.

Rotherham Safeguarding Adults Board

Overview functions: providing challenge and oversight of practice in relation to safeguarding adults outcomes

Rotherham Safeguarding Adults Board (SAB) is established in line with duties set out in the Care Act 2014 as the statutory mechanism for agreeing how partner agencies within Rotherham cooperate to protect adults at risk, prevent neglect and abuse and promote the wellbeing of adults in its area. The SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. The Care Act 2014 requires that statutory safeguarding responsibilities arise where there is reasonable cause to suspect that an adult:

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The responsibilities of the SAB include:

- Assuring itself that safeguarding practice is person-centred and outcome-focused
- Working collaboratively to prevent abuse and neglect where possible
- Ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
- Assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area
- Concerning itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- the safety of people who use services in local health settings, including mental health
- effective interventions with adults who self-neglect, for whatever reason
- the quality of local care and support services
- the effectiveness of prisons in safeguarding offenders
- making connections between adult safeguarding and domestic abuse

Opportunities and expectations for effective coordination

Share Priorities; share strategic risks; share learning; consultation; promote joint communication and engagement.

All key strategic plans overseen by the bodies referenced in this protocol, whether they are formulated by individual agencies or by partnership forums, should address safeguarding issues. This will help to ensure that existing strategies and service delivery, as well as emerging plans for change and improvement, include effective safeguarding arrangements that ensure that all people in Rotherham are safe and their wellbeing is protected and promoted.

It is critical that in drawing up, delivering and evaluating all plans and strategies there is effective interchange between the LSCB, SAB, HWbB, CYPPB and the SRP.

Specifically there needs to be formal interfaces with the safeguarding boards on key issues including:

- Ensuring that safeguarding is everyone's responsibility
- Ensuring that the LSCB and SAB's needs evaluations are fed into the JSNA and JSIA, and that the outcomes of these assessments are used to inform priorities and fed back into safeguarding boards' planning
- Ensuring each board is updated on progress made in the implementation of the HWB Strategy, the SRP Plan, the CYP Plan in a context of mutual challenge
- Sharing annual plans and relevant evaluations of the safeguarding boards to ensure effective coordination, share learning and enable all boards to feed any improvement and development needs into the planning process for future years' strategies and plans.
- To provide mutual support, guidance, advice and challenge to ensure that all partners discharge their safeguarding responsibilities effectively and that relevant strategic plans include complementary objectives and actions to promote the safeguarding of children, young people and vulnerable adults
- Aligning the work of the LSCB and SAB business plans with the HWB Strategy, SRP Plan and CYPP Plan where relevant
- Identifying a coordinated approach to communication, learning and improvement, performance management, change and commissioning.

Arrangements between the 5 strategic partnership boards The following details the activity that will take place between the strategic boards.	
Bi-Annually	The chairs of the all boards will meet to ensure the coordination of leadership, the coherence of respective plans and to consider the strategic risks facing children, young people, families, adults and communities. The supporting officers for the boards will also meet, at the Partnership Steering Group, to follow up key decision and planning actions.
Annually	Update reports on relevant plans/strategies – i.e. Health and Wellbeing Strategy, Safer Rotherham Partnership Plan and Children and Young People's Plan, to be shared with the safeguarding boards to enable appropriate challenge, in relation to commissioning decisions and outcomes, and ensure that the respective safeguarding business plans appropriately reflect relevant priorities set by the HWBB, SRP and CYPP.
Between September and November	The independent chairs of the two safeguarding boards will present to the HWbB and the SRP Board their Annual Reports outlining performance against their business plan objectives in the previous financial year. The LSCB will also present its Annual Report to the CYPPB. This will be supplemented by a position statement on the boards' performance in the current financial year. This will provide the opportunity for the HWbB, CYPPB and the SRP Board to challenge the effectiveness of safeguarding arrangements across the borough, to draw across evidence and data to be included in the JSNA and JSIA and to reflect on key issues that may need to be incorporated in the refresh of the Health and Wellbeing Strategy, CYP Plan and the SRP Strategy.
On-going	The strategic boards will share their refreshed plans when they are published to ensure co-ordination and coherence. (this may be different for each board and is up to the chair and responsible officer to ensure this reporting is factored into their forward plans). In addition to the scheduled interface across all 5 boards, it is expected that relevant learning arising from reviews is shared; and opportunities for coordinating consultations, communications and engagement are fully utilised.
Relationship between the Safeguarding Boards	There should be equally effective co-ordination and coherence between the two safeguarding boards. This will be achieved in part by the arrangements set out above but it is critical that there are processes in place to ensure effective cross-working and challenge. This will be achieved in two ways: • Sharing annual plans during the formulation stages to enable co-ordination and coherence where there are overlaps in business. • Ensuring that there is cross-Board representation to secure on-going communication.

SIGNATORIES

Name	Designation / Organisation	Signature

The Eastwood Deal

A partnership plan for Eastwood Village

Ward Councillors: Wendy Cooksey, Deborah Fenwick-Green, Tajamal Khan

Lead Officer: Karen Hanson, Assistant Director Community Safety and Street Scene, Rotherham Metropolitan Borough Council

Date: July 2016

Version 1.0

The Safer Rotherham PARTNERSHIP

A Partnership Plan for Eastwood Village

Our priority is to: 'To improve residents' quality of life by improving the local environment and reducing crime and anti-social behaviour in Eastwood'

We will do this by:

- Targeted enforcement – use combined powers of Council and partners to change inappropriate behaviour and reduce demand for Council services
- Working with the Police to effectively reduce levels of crime and anti-social behaviour in the area
- Provision of effective environmental services - use Council resources as effectively as possible with appropriate equipment and well trained staff
- Enhancing the feeling of pride in Eastwood and encourage volunteers to work in partnership with the Council. Develop the 'Eastwood Deal' and encourage residents to get involved
- Encourage and nurture effective community engagement – working with new and established community groups to jointly create and deliver sustainable solutions
- Celebrating achievement and positive outcomes with Eastwood's communities
- Ensure plans are aligned to the Rotherham Health and Wellbeing strategy

Eastwood housing stock includes a mix of private rented, owner occupied and social rented housing.

Across the area as a whole, 24% of households are private rented, 37% social rented (19% council) and 35% owner occupied. 6.5% of homes are empty, rising to 9% in Eastwood Village.

It is the most ethnically diverse area in Rotherham with over 5000 residents, over 27% are under the age of 15 and fewer than 10% are over 65.
An impact on engagements in the Eastwood Village area particularly is the high turnover of residents running at around 27% per year.

The Eastwood deal is designed to build upon existing partnership activity, to provide sustainable improved outcomes for the residents and communities.

IMPROVE THE QUALITY OF THE LOCAL ENVIRONMENT AND IMPROVE RESIDENTS PERCEPTIONS OF THE ENVIRONMENT
Targeted enforcement - use combined powers of Council and partners to change inappropriate behaviour and reduce demand for Council services
Action
Create and deliver an Enforcement Plan covering: • garden clearance • fly tipping • side waste • bins left on pavements • Anti-social behaviour • Selective Licensing
Ensure that enforcement is overt, visible, communicated and targeted for sustained impact - share outcomes widely with residents and Ward Councillors

IMPROVE THE QUALITY OF THE LOCAL ENVIRONMENT AND IMPROVE RESIDENTS PERCEPTIONS OF THE ENVIRONMENT
Effective environmental services - use Council resources as effectively as possible with the best equipment and well trained staff
Action
Organise a programme of quarterly multi-agency super-blitzes including with sustainable improved outcomes including: • Easily accessible bulky waste collections for landlords and tenants (chargeable service) • High quality street cleansing operations as part of community clean-ups, provision of brooms and litter picks • Selective Licensing enforcement
Review street cleaning operations / schedules to ensure targeting areas of greatest need
Co-ordinate a response to SYP crime prevention survey which covered • improving / installing lighting • removing / cutting back vegetation • installing CCTV
Develop a bulky / trade waste offer for private landlords that is easily and quickly accessible at an appropriate price
Develop a process for identifying infestation of cockroaches, rats and bedbugs, covering awareness raising and reporting

IMPROVE THE QUALITY OF THE LOCAL ENVIRONMENT AND IMPROVE RESIDENTS PERCEPTIONS OF THE ENVIRONMENT
Enhance the feeling of pride in Eastwood and encourage volunteers to work in partnership with the Council
Action
Develop a work programme for the new Love My Streets Co-ordinator
Produce a Love my Streets Plan with a section dedicated to Eastwood. Develop a brand, campaign and delivery plan
Work with community groups / individuals through a campaign approach to increase number of Love my Streets volunteers
Agree actions with volunteers, and equip / train them to report issues or to take direct action on clean ups with Council support
Work with Keep Britain Tidy as part of campaign approach and utilise their online, written and other resources including examples of best practice
Identify and look to increase community groups and activity in the area.

ENCOURAGE AND NURTURE EFFECTIVE COMMUNITY ENGAGEMENT – WORKING WITH NEW AND ESTABLISHED COMMUNITY GROUPS TO JOINTLY CREATE AND DELIVER SUSTAINABLE SOLUTIONS
Enhance the feeling of pride in Eastwood and encourage volunteers to work in partnership with the Council
Action
An Early Help Plan that includes the following priorities: • Support children and young people in Eastwood so that they are healthy and safe from harm • Support children and young people in Eastwood to start school ready to learn for life and maintain positive engagement with school • Support children and their families in Eastwood so that they are ready for the world of work • Support children and their families to engage in positive mainstream community life Deliver an Early Help Targeted Youth Programme in Eastwood to address anti-social behaviour and reduce vulnerability. Ensure that children, young people and families in the area are engaged in positive learning and contribute positively to their community

IMPROVE THE QUALITY OF THE LOCAL ENVIRONMENT AND IMPROVE RESIDENTS PERCEPTIONS OF THE ENVIRONMENT
Communication – celebrating achievement with Eastwood's communities
Action
Create simple but effective communication plan using existing resources
Online and print media campaign to highlight the results of the Plan for Eastwood

IMPROVE THE QUALITY OF THE LOCAL ENVIRONMENT AND IMPROVE RESIDENTS PERCEPTIONS OF THE ENVIRONMENT
Community engagement – working with new and established community groups to jointly create and deliver solutions
Action
Join up with Canals / Rivers Trust to improve river banks and clear waste, engaging residents (especially young people) to deliver improvements and increase ownership
Use best practice to produce an Eastwood Deal – in partnership with local residents / groups (e.g. Clifton Learning Partnership (CLP)and school) - describing what residents can expect from Council and what Council expects from residents / community organisations
Plan campaigns and events aimed at increasing rate of recycling and correct waste disposal
Jointly identify ways of improving green spaces – Eldon Rd playing fields and Pocket Park - so that the areas are more attractive and used by all communities to reduce anti-social behaviour. Work with schools and CLP, and incentivise involvement through competitions, sponsorship.
Encourage positive relationships between the all staff working in the area (across agencies) with the community adopting a positive 'I'm here to help' approach
Engage with all faith groups regarding this action plan and opportunities for involvement
Engage all businesses in the local community
Develop translation / outreach resources from within the local community
Identify empty and disused properties to reduce impact on local community

REDUCE LEVELS OF CRIME AND ANTI SOCIAL BEHAVIOUR
Action
Develop and appropriately share intelligence
Ensure all information is captured and considered when deciding on interventions and use of enforcement powers including powers within anti-social behaviour legislation
Develop processes via Case Identification Meeting (CIM) which will result in joint visits to: • properties with either 3+ reports to the police or Council in less than 12 months or who are hitting a number of triggers ensuring early enforcement or support as appropriate • repeat / vulnerable callers

REDUCE LEVELS OF CRIME AND ANTI SOCIAL BEHAVIOUR
Action
Consider options to pool resources to create a sustainable 'Team Eastwood' approach with a base in the heart of the community
Maximise the use of ASB tools and powers where appropriate as part of a package of measures e.g. dedicated patrol resources, CCTV, Detached Youth Team based and diversionary/targeted youth provision
Develop partner patrol plans, as far as possible, geared to intelligence led times and locations
Continue to monitor the running of Operation Keepsafe
Develop a Youth Forum co-ordinating delivery of youth provision, including a Youth Offer promoting activities and positive parenting
Convene a meeting of housing providers to review current situation and suitability of placements / properties

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

	Meeting:	**HEALTH AND WELLBEING BOARD**
	Date:	**8th March 2017**
	Title:	**Better Care Fund DRAFT Plan 2017-19**

1. Summary

The purpose of this report is to introduce the current draft version of the Better Care Fund Plan 2017-19 for information and feedback. Feedback from the BCF Executive Group has already been incorporated into the draft plan.

The national guidance has yet to be issued; NHS England has confirmed that the earliest expected date will be in the middle of March 2017 with a minimum of 6 weeks to complete and submit the plan to NHS England.

2. Recommendations

The Health and Wellbeing board is asked to note the current iteration of the plan, the strategic direction and offer feedback

3. Introduction/Background

NHS England have requested for a two year Better Care Fund plan covering the financial years 2017/18 and 2018/19. The intention is to "simplify the guidance and assurance process but plans are expected to be an evolution of the 2016/17 plan and not require significant rework".

The number of National Conditions will be reduced to 3 from 2017/18 and will consist of:

- A requirement for a jointly agreed plan, approved by the Health and Wellbeing Board.
- Real terms maintenance of transfer of funding from health to support adult social care
- Requirement to ring-fence a portion of the CCG minimum to invest in Out of Hospital services

Rotherham's BCF plan sets out key schemes, and how each of these will be measured and managed.

It has been confirmed that when guidance is published, a template will be issued, but that the use of this will not be mandatory. The current version has been adapted to include the recently issued guidance regarding the narrative plan.

4. Budget Arrangements

The BCF funds will be pooled under the Section 75 agreement which will be signed by the Council and the Clinical Commissioning Group.

5. Current Progress

Rotherham is continuing to update all aspects of the current plan, including finalising reviews and updating financial and activity information in close collaboration with partners.

With specific regard to the three National Conditions:

Jointly Agreed Plan

- All minimum funding requirements met - these have been achieved.

Social Care Maintenance-

- Rotherham's local plan is higher than the contribution required and there are no plans to reduce this. We continue to fund several social care services, which are strategically relevant and performing well, including social workers supporting A&E, case management and supported discharge.

NHS Commissioned 'Out of Hospital' Services

- In Rotherham there are three admission prevention and supported discharge pathways. These are all supported by the Better Care Fund and are backed by the wider initiatives within Rotherham's Integrated Health and Social Care Place Plan.

What is included in the BCF?

The following is a summary of the information included in the plan:

Evidence Base

Inclusion of the:

- Rotherham Integrated Health and Social Care Place Plan
- South Yorkshire and Bassetlaw Sustainability and Transformation plan
- Rotherham Carers strategy
- Health and Wellbeing strategy

(Reference has also been made to the development of the Accountable Care System although it is recognised that this is currently under development.)

- Integrated Commissioning - including joint commissioning and fee setting of domiciliary care and continuing health care placements, joint medication policy and personal health budgets
- Examples of deep dive reviews carried out in 2016-17
- Case for Change
- Analysis of out of hospital services
- Prevention and early intervention
- Adult social care improvement programme
- Improving quality and reducing costs - including supporting people with dementia

6. What has the Better Care Fund achieved this year?

- Reviews of some of the jointly commissioned services during 2016/17. The reviews have highlighted where BCF schemes are strategically relevant, those services that have performance issues and those that require further investigation in 2017/19.
- Directory of Services for BCF - providing clear visibility to all key stakeholders on what services are funded.

- Matched around 5,495 adult social care records with their NHS number, providing a single identifier that can be used across health and social care.
- The Local Authority's new social care case management system (Liquidlogic) went "live" on 13.12.16, and this 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 and we are now using the NHSN on our correspondence.
- Working towards better data sharing and ensuring that users have clarity about how data about them is used.
- 7 day social care working is in place and embedded at the hospital with on-site social care assessment.
- Expansion of Mental Health Liaison Service
- Development of an integrated falls and bone health care pathway.
- The Better Care Fund has been used to maintain provision of social care. This includes the use of direct payments, residential care and social work in case management programmes.
- The BCF Fund has supported the recruitment of a Clinical Quality Advisor within the Care Home Support Service from February 2017. This post is integral in ensuring that health issues are addressed when monitoring contract quality and performance.
- Through use of BCF we have commissioned three Adult Social Care Assessment beds to support discharge patients who require further assessments to optimise independence.
- Extended the eligibility criteria for intermediate care services. Patients who are unable to take part in rehabilitation can now be transferred to an intermediate care unit provided they have rehabilitation potential. There are two designated "delayed rehabilitation" beds within each intermediate care unit that can accommodate patients who are non-weight bearing, receiving pain management medication or recovering from illness.
- Re-commissioned the social care prescribing service to provide people with long-term conditions access to voluntary and community sector support. We recently established a mental health social care prescribing pilot creating opportunities for mental health service users to sustain their health and wellbeing outside secondary mental health services.
- Increased the number of adults receiving a Personal Health budget so that they can commission their own continuing health care support.
- Established a community end-of-life hospice team to support families and carers allowing patients to die in their place of choice. This also contributes to reducing hospital admissions.

7. What are the key priorities for 2017-19?

- A single point of access into health and social care services
- Integrated health and social care teams
- Development of preventative services that support independence
- Reconfiguration of the home enabling service and strengthening the seven day social work offer
- Consideration of a specialist reablement centre incorporating intermediate care
- A single health and social care plan for people with long term conditions
- A joint approach to care home support
- A shared approach to delayed transfers of care (DTOC)

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Rotherham Better Care Fund Plan- DRAFT

March 2017

Local Authority

Rotherham Metropolitan Borough Council

Clinical Commissioning Group

Rotherham Clinical Commissioning Group

2017/19

Contents

1. Plan Details

Local Authority	Rotherham Metropolitan Borough Council
Clinical Commissioning Groups	Rotherham CCG
Boundary Differences	The map in the attached document below shows that the geographical boundary of Rotherham MBC is co-terminus with Rotherham CCG.  Map of Rotherham.docx
Date agreed at Health and Well-Being Board:	08/03/2017
Date submitted:	31/03/2017
Total agreed value of pooled budget: 2016/17	£24,323,000

2. Authorisation and sign off

Signed on behalf of the Clinical Commissioning Group	
By	Chris Edwards
Position	Chief Officer
Date	31st March, 2017

Signed on behalf of the Council	
By	Sharon Kemp
Position	Chief Executive
Date	31st March, 2017

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor David Roche
Date	31st March, 2017

3. Vision for Adult Services

The integration work that brings together Rotherham Metropolitan Borough Council (know herein as the Council) and Rotherham Clinical Commissioning Group (known herein as the CCG) through the Better Care fund is a fundamental aspect of pooling budgets and resources to ensure that we have a robust alignment across the health and social care system in Rotherham. This opportunity enables us:

- To reduce duplication and target resources effectively and efficiently to impact on the lives of those that need it the most
- To ensure there is a greater impact on prevention
- To have a systematic approach to the sustainability of social care and health systems which shares responsibilities with partners, community and voluntary sector organisations, and supports residents to take control of self-care and self-management.

In order to deliver our aspirations of a fully integrated system across health and social care we have developed key strategic documents outlining our ambitions in the form of an Integrated Health and Social Care Place Plan and Sustainability and Transformational Plan (STP) which is a 5 year forward view.

The five joint priorities within the Integrated Health and Social Care Place Plan are as follows:

- Prevention, self-management, education and early intervention
- Rolling out our integrated locality model – "The Village" pilot
- Opening an Integrated Urgent and Emergency Care Centre
- Further development of a 24/7 Care Co-ordination Centre
- Building a Specialist Re-ablement Centre

Both these documents will identify key integration work, which will bring the opportunity to jointly commission services to deliver:

- joined up working practices and multi-disciplinary teams
- efficient and effective service pathways for people; which includes "step up" and "step down"
- reduce duplication and ensure targeted interventions which are value for money; where people get the right service, from the right place and at the right cost

The vision shared across Rotherham's health and social care is to ensure we have a fully integrated health and social care system in place now, but also fit for the future. Working in this way will support our vision "to support people and families to live independently in the community, with prevention and self-management at the heart of our delivery". This vision is contained within various strategic documents which encompass the transformational work that needs to happen in order to achieve a fully integrated health and social care system. We have worked collectively and developed our ambition through a period of transformation which is contained in the:

- Rotherham Integrated Health and Social Care Place Plan
- South Yorkshire and Bassetlaw Sustainability and Transformational Plan (STP)
- Better Care Fund Plan (BCF)
-

Better Care Fund (BCF)

The Better Care Fund (BCF) provides us with an opportunity to further improve the lives of 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 an improved service and better quality of life. We will achieve this through a strong focus on implementing services which deliver early intervention and prevention as well as information and enablement. 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.

The BCF will enable us to implement effective joint commissioning services across the Council and CCG which will inevitably drive the integration of services. This will bring together specialists within multi-disciplinary working arrangements from primary care, social care, community health services and the voluntary sector. We will expand community based services, reducing reliance on the acute sector.

We will streamline and simplify care pathways, and ensure that the discharge home and step up and step down approach is embedded so that people are well managed through the care system rather than it escalating to the point of crisis. We will ensure better information sharing between health and social care services. Service integration will be used as a vehicle to deliver "parity of esteem", whereby 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.

We will ensure that the appropriate care pathway is selected to support both the patients' physical and mental health. Our vision is consistent with that set out in Rotherham's Mental Health Adults and Older People's Transformation Plan which is available at:
http://moderngov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=103679

The Rotherham BCF Plan is consistent with the aims of the NHS Five Year Forward View. The Forward View emphasises the need to develop new care models to support integration. A central theme of our plan is the further development of integrated service models, intermediate care services, locality teams, rapid response, carer support and first point of access.

The overarching vision for Rotherham's BCF Plan can be translated into the following local priorities. These are aligned with the outcomes set out in Rotherham's Health and Well Being Strategy and Rotherham's Integrated Health and Social Care Place 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. Social Prescribing
8. Broader use of new technology to support care at home
9. A financially sustainable model that targets resources where there is greatest impact

The impact of implementing the BCF Plan will improve patient and service user experience significantly. As a result of the changes we will make, we expect that all service users, patients and their family carers will have confidence in the care they receive and feel supported to live independently, manage their conditions and participate in their community. We want to reduce the need to rely on acute services, resulting in a reduction in overall pressure on the hospital and health budgets. Although, when acute care is the best option for people, they are helped to move quickly back into their community when they are ready to do so. We will see a greater shift from high cost reactive care, to lower cost, high impact preventative activity. Our expectations are reflected in the service users feedback collected on a regular basis; for example through the Friends and Family Test carried out across hospital and community services.

4. Evidence Base

4.1 Health and Wellbeing Strategy

The Rotherham Health and Wellbeing Strategy (2015-18) sets out Rotherham's overarching vision to improve health and well-being of its population, enabling people to live fulfilling lives, to be actively engaged in their community and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board has made a commitment to ensure the commissioning and delivery of services which are more integrated, person-centred, providing high quality care and accessible to all.

The Better Care Fund Plan contributes to the following strategic objectives identified in the local Health and Wellbeing Strategy.

- All Rotherham people enjoy the best possible mental health and wellbeing
- Healthy life expectancy is improved for Rotherham people and the gap in life expectancy reduced
- Rotherham has healthy, safe and sustainable communities and places.

The full Health and Wellbeing strategy is available at:

http://www.rotherham.gov.uk/hwp/downloads/file/4/rotherham_borough_joint_health_and_wellbeing_strategy_2015-18

There are also several new Public Health England fingertip guides available which outline Rotherham's position. These tools enable us to track progress and benchmark Rotherham's position against statistically similar areas. These are available at:

https://fingertips.phe.org.uk/profile/older-people-health

https://fingertips.phe.org.uk/profile/adultsocialcare

4.2 The South Yorkshire and Bassetlaw Sustainability and Transformational Plan

The South Yorkshire and Bassetlaw (SY&B) Sustainability and Transformational Plan (STP) is now published, and can be found at the following website address: http://www.smybndccgs.nhs.uk/what-we-do/stp

Our STP sets out the vision, ambitions and priorities for the future of health and care in the SY&B region and is the result of many months of discussions across the STP partnership. Between December

2016 and March 2017, discussion will take place with staff in each partner organisation and local communities about the plan. In addition, work will take place with Healthwatch and voluntary sector partners to ensure input and views from a wide range of communities. The feedback will be taken into account and incorporated into the STP.

The five STP transformational initiatives are listed below and in section 10.2 of Rotherham's Integrated Health and Social Care Place Plan we describe Rotherham's direction for each of these five challenges:

- Urgent and Emergency Care
- Elective Care
- Cancer
- Children and Maternity
- Mental Health and Learning Disability

4.3 Rotherham Integrated Health and Social Care Place Plan

At a local level Rotherham's Health and Social Care Community has been working in a collaborative way for the past several years to transform the way it cares for its population of 261,000. Our aim is to provide the best possible services and outcomes for our population; we are committed to a whole system partnership approach, as we recognise that it is only through working together that we can provide sustainable services over the long term.

Our common vision is: ***'Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery'***

Our approach to transformation is based on a multi-agency strategy of prevention and early intervention of health and social care services and we recognise the importance of addressing the wider determinants of health. We aim to champion prevention and integration and establish a range of initiatives in Rotherham to serve as a proof of concept that can then be rolled out further across South Yorkshire and Bassetlaw.

Since the publication of the BCF Plan 2016-17, we have developed the Rotherham Integrated Health and Social Care Place Plan (Place Plan) which can be found at the following website address http://www.rotherhamccg.nhs.uk/rotherhams-place-plan.htm. This details our joined up approach to delivering five key initiatives that will help us achieve our Health and Wellbeing Strategic aims and meet the region's STP objectives. The five initiatives (see list below), aim to maximise the value of our collective action and transform our health and care system so that we can reduce demand for acute services and achieve clinical and financial sustainability. Further detail of the initiatives can be found in our Place Plan.

1. Prevention, self-management, education and early intervention
2. Rolling out our integrated locality model 'the village' pilot
3. Opening an integrated urgent and emergency care centre
4. Further development of a 24/7 care co-ordination centre
5. Building a specialist re-ablement centre

Planning and delivery at an overarching STP level must be coordinated with planning and delivery at a local (Rotherham) level, as they represent different elements of the same system.

Rotherham partners view themselves collectively accountable for the health and wellbeing of our population and consider the Place Plan to be our framework for jointly providing acute, community and primary care services forming an integrated partnership. Our new governance arrangements will support us towards becoming an Accountable Care System, which will enable us to design and deliver services to meet the needs of our population and improve health and wellbeing outcomes, within agreed budgets.

We have developed an interactive infographic and animation, which can be found at the following website address: http://preview.beach-design.co.uk/nhs_rotherham/ that will be used across the health and social care system as a key tool in articulating how our five priorities are closely interlinked to deliver better, more accessible services in the coming years.

As well as the Rotherham Place Plan the CCG's Commissioning Plan remains the cornerstone of the CCGs strategic direction, and can be found at the following website address: http://www.rotherhamccg.nhs.uk/our-plan.htm

4.4 Rotherham Carers Strategy 2016-21

Rotherham's Carers' Strategy "Caring Together" (Appendix X) is a partnership strategy which sets out the intentions and actions necessary to support carers and young carers. We recognise that informal carers are the backbone of the health and social care economy. The ambition is to build stronger collaboration between carers and other partners in Rotherham, and formally start to recognise the importance of whole family relationships.

The strategy lays down the foundations for achieving these partnerships and sets the intention for future working arrangements. It aims to makes a difference in the short term and start the journey towards stronger partnerships across formal services for people who use services and their carers

"Caring Together" has been co-produced between Adult Services, Children's Services, Customer Services, Rotherham Carers groups, including Young Carers, the Voluntary Sector, Rotherham Doncaster, and South Humber Foundation Trust, The Rotherham Foundation trust and Rotherham Clinical Commissioning Group

4.5 Vanguards

Two new care vanguards have been developed to support the local health and care economy system. It takes the learning from nine PACS vanguards which are both central to the delivery of the vision of the NHS five year forward view. The success of this will include a core element of GP registered listed and a core GP practice at its core. The aim will be to improve the physical, mental and health and well-being and focus on reducing health inequalities for local residents. The two vanguards are:

1. Integrated Primary and Acute Care System (PACS) and
2. Multi-specialty Community Providers (MCPS)

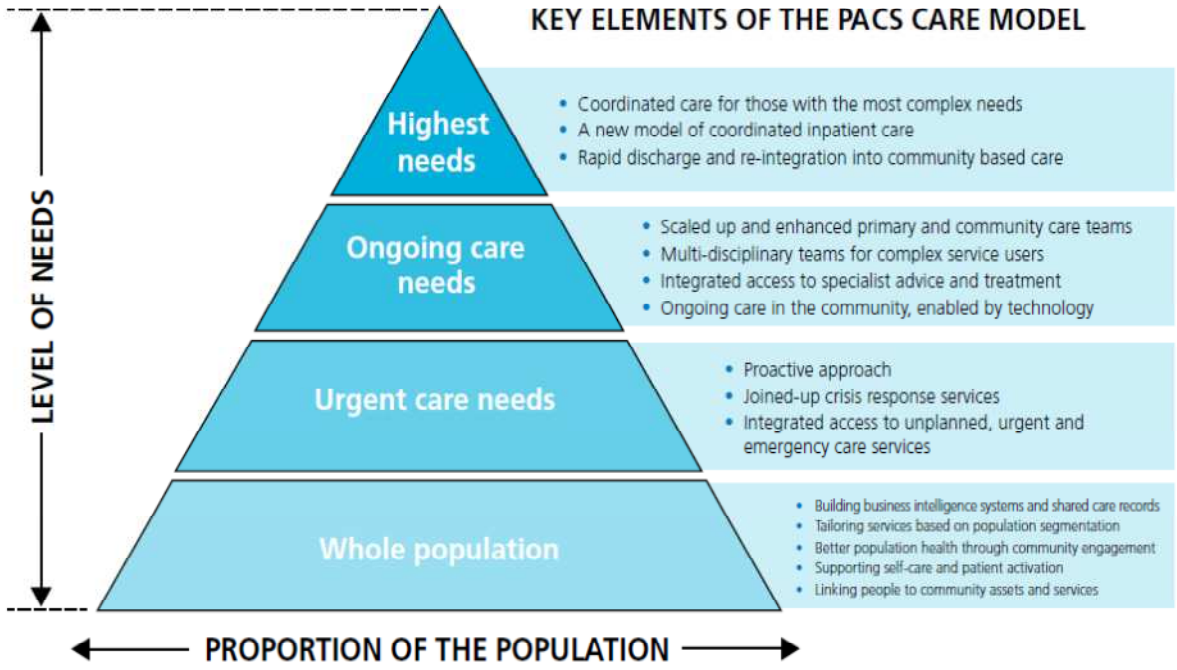
The PACS and the MCPS vanguards now cover 8% of England and nearly all sustainability and a transformational plan (STPs), involve population based accountable care models. Therefore, the national coverage of these models is to grow to 25% next year to 50% per cent by 2020. Linked to STPs, funding will be made available to support new sites from 2017/18 to achieve growth.

PACS

The PACS brings together health and social care providers with shared goals and incentives, which focus on best solutions for the local population. The current fragmented and complex contracting, funding and governance system within the NHS, and between NHS and Social Care, frustrates a focus on population health. Joining up services in a PACS allows better decision making and more suitable use of resources, with a greater focus on prevention and integrated community based care, and less reliance on hospital care. The PACS will:

1. Focus on prevention and health management. Better relationship and joined up working across health and social care services. PACS will connect people to community assets and resources to help keep people well, working with local government and the voluntary sector, using social prescribing
2. Provide urgent care that is integrated with primary care, community, mental health services and social care, reducing the need for emergency or unplanned interventions.
3. Ensure people with ongoing care needs receive more co-ordinated care, with more services in settings such as their own homes and community. It will deliver this through integrated, multi-disciplinary community teams, by linking hospital specialists to community based care, and making greater use of technology to deliver care remotely
4. Ensure those people with complex health needs are managed in the community. The PACS may reduce the number of hospital beds, with inpatient care only for those who need intensive or complex care.

The PACS care model operated at four levels of the population which is visualised below based on the population need. The diagram below summarises the key elements.



4.6 Joint Strategic Needs Assessment

The JSNA predicts a substantial increase in the number of adults with additional health and social care needs over the next five years. The JSNA shows that the population of Rotherham is at its highest ever level, at an estimated 260,800 in 2016. 50,800 people are aged 65 or over and 5,700 are aged 85 and over. By the year 2020, the number of older people is predicted to increase to 54,200 and the 85 year and over age group will increase to 6,900.

This prediction is made on a backcloth of substantial reductions in social care investment. Also, increases to the NHS budget are unlikely to keep pace with the rising demand for services. So this strategy is important. If the demographic challenge is to be met it will require a joint approach to commissioning service delivery. Effective joint commissioning can remove duplication, increase economies of scale and, through early prevention, reduce interventions further up the care pathway.

The health and well-being needs of the ageing population continues to increase as older people are likely to experience disability and limiting long-term illnesses and lower quality of life. The JSNA highlights that falls in older people are of particular concern because of the risk of hip fracture and subsequent morbidity and mortality. We are below the national average for injuries due to falls in older people. Our Integrated Falls and Bone Health care pathway is crucial in improving patient outcomes, providing early intervention to restore independence and prevent frailty.

Rotherham also has a significant part of its population with a learning disability. There are currently 724 Learning Disability customers aged over 18 accessing 1067 placements/service.

Rotherham has a higher rate of Adult Learning Disability customers per 100,000 head of population at 371.77 than neighbouring authorities and is ranked 28th Highest out of 152 local Authorities.(ref: SALT Return 15/16).

Rotherham's Market Position Statement highlights that there is a predicted increase of 25% for formal support required by 2020 and a 58% increase in demand by 2030, particularly for those people with conditions such as dementia, depression, mobility, hearing impairment, incontinence and diabetes.

The Rotherham BCF plan is aligned with all of the above emerging population needs. The services currently funded through BCF and all the local priorities focus on addressing the impact of the ageing population. Through a combination of integration, prevention and case management the BCF Plan can deliver better outcomes for the growing population of older people and reduce pressure on the local health and social care economy.

4.7 Market Sustainability

The Market Sustainability report is based on the Cordis Bright framework which assists Local Authorities to support the adult social care market. The framework pulls various intelligence from various sources that is readily available to carry out an analysis of each market segment consisting of commissioning building based services (Residential and Nursing, Supported Living and Extra Care) and non-building based services (Domiciliary Care) for each client group.

This intelligence enables commissioners to develop a risk matrix with the market and ensure contingency planning is in place to reduce provider failure.

4.8 "Deep Dive" Reviews in 2016-17

As acknowledged in the BCF Plan 2016-17, significant work has been undertaken to complete 'Deep Dive' reviews on a number of identified BCF services. These were highlighted from the 2015-16 review as requiring further analysis for one or more of the following:

- Concerns over strategic relevance/fit for purpose
- Lack of a clear service specification
- Concerns over the performance of the service including; requirement to realign service priorities to meet emerging demand
- Lack of performance management framework

All reviews undertaken in 2016-17 have included key stakeholders from across the system including, where appropriate, patients and their carers. The reviews have led to changes in working practices, reconfiguration of services, improvements in the outcomes for the Rotherham population (i.e. reductions in waiting times for COT), flexibility in accessing services, integration of provision, reductions in bureaucracy and increase in efficiency.

The 'deep dive' reviews taking place in 2016-17 which were identified through the 2015-16 service review have involved changes in service provision. However, this has not impacted on the funding provided within the BCF as a whole. A robust monitoring tool has been developed to ensure that impact of each review is closely monitored through the BCF governance structure.

Some examples of the reviews undertaken are detailed below (not an exhaustive list);

Intermediate Care

There has been significant work undertaken in 2016-17 to further improve the intermediate care provision within Rotherham. The eligibility criteria have been widened, the service specification and referral/allocation criteria updated and the referral process streamlined. A decision was taken to close one of the 3 sites for intermediate care (provided by the Council, and jointly commissioned between CCG and the Council) in July 2016. The rationale for this was a move to a more wrap around integrated rehabilitation provision that was fit for purpose and strategically relevant. The number of beds has increased by 4 in this new model.

However, there are still issues with the service as it does not provide nursing care, which can be attributed to the delays with patient flow in the acute sector. CCG audits taken place in 2016 show that there are still a number of hospital admissions that could be redirected to intermediate care. For example, an audit carried out last year showed that 23% of MAU admissions were avoidable. 14% of these patients were subsequently admitted to hospital despite the fact that they did not have an acute medical need. The audit concluded that 29% of MAU admissions could have been dealt with in an alternative setting. The alternative settings identified included intermediate care services.

Therefore, Rotherham Place Plan has an aspirational priority to consider options for the development of a Specialist Reablement Centre. The desire is to provide a single centre for all community intermediate care services would be a fully integrated provision. This would deliver economies of scale, broaden the range of people who can receive support and act as a vehicle for health and social care integration. This objective is likely to be delivered in 2018-19.

Community Occupational Therapy Services

The service review carried out on the Community Occupational Therapy Service shows that the service is performing well on the majority of key performance indicators but is struggling with the waiting times for assessment, due to the sharp rise in the number of referrals of older people living with long-term conditions living in the community. However, there are still a significant number of contacts which could be signposted to alternative services. For example, 555 assessments were terminated in 2015/16, 128 by adult social care, 104 by carer and 192 by client.

The Occupational Therapy Backlog group has been set up to address this issue and this has reduced the numbers from 599 in June 2016 to 135 in January 2017. The agreed rectification actions include:

- The Single Point of Access Team can issue equipment at first point of contact.
- Housing Repairs are able to directly issue lever taps, half step, grab rails and key safes.
- Home Improvement Agency to pick up on toileting assessments and tubular path rails.
- Support staff to start assessing for level access showers.
- The Adult Care Performance & Quality Team is currently exploring data requirements, with a view to reducing the amount of paperwork Occupational Therapists are required to complete for each assessment.

The Community Occupational Service review considers options for future development of the service, and therefore an options appraisal will be developed to consider future commissioning arrangements. The ambition is to integrate the service into the locality model and working closely with adult social care by providing additional resources into the Council's Single Point of Access by signposting potential or existing service users to alternatives services and to reduce home care packages by identifying alternative solutions to address needs.

4.9 Directory of Services

The Directory of Services (DoS) for BCF that came from the review in 2015-16 describes a new structure for categorising BCF funded schemes explained within the BCF Plan 2016-17. The schemes continue to be grouped using the following themes.

1. Mental Health Services
2. Rehabilitation, Reablement and Intermediate Care
3. Supporting Social Care
4. Case Management and Integrated Care Planning
5. Supporting Carers
6. BCF infrastructure

The Directory of Services provides clarity on where BCF funding is currently being invested and the strategic relevance of each scheme. Commissioners have prepared an ongoing review schedule, a monitoring tool and review template, which were used throughout 2016-17 and will continue to be used where appropriate. The next steps are:

(i) To develop a Memorandum of Understanding (MoU) between the Council and the CCG to clearly define the expectations of each service area where there is no service specification in place which are funded through the Better Care Fund.

(ii) To continue undertaking a series of individual reviews on services where there are funding or performance issues or where there are concerns regarding strategic relevance.

(iii) For commissioners to continue to monitor and review progress of reviews throughout 2017-19

5. Case for Change

5.1 Record on Joint Commissioning

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

The Council is currently conducting a review of adult social commissioning to achieve an increasingly strategic and corporate approach by 2017/18, this is interconnected with the CCG restructure and will incorporate several new joint commissioning posts across adults, children's, mental health and learning disabilities. In order to underpin the desired model there will need to be a skilled workforce that is sufficiently structured and resourced to deliver key commissioning priorities. Integrated commissioning in Rotherham will need to align and embed the principles and approaches outlined in commissioning best practice guidance across public services. Commissioning activity needs to be targeted to tackle priorities in an integrated way predicated on a predetermined outcomes framework.

Services that are already subject to joint commissioning and/or pooled budget arrangements include the Rotherham Intermediate Care Service, Community Occupational Therapy Service and the Integrated Community Equipment Service. All jointly commissioned services provide support on activities of daily living, ensuring that patents achieve the highest level of independence. All services help prevent deterioration and minimises loss of function caused by illness or disability. They reduce the risk of admission to hospital by ensuring that people are living in a low risk physical environment where they can function autonomously. The service empowers patients so that they maximise their potential to engage in meaningful and productive activities/occupations. These services deliver health and social care outcomes. They perform well within a robust joint performance management framework.

There has been substantial investment in additional community services supporting the BCF Plan over the past 2 years. The continued investment through the CCG's Community Transformation Programme will improve outcomes for service users and prevent future increases in hospital admissions that would otherwise be expected from the demographic changes.

5.2 Development of New Care Models

Current models of care are not designed for the health challenges of today. Rotherham is currently intending to move towards and Accountable Care System in order to deliver the Integrated Health and Social Care Place Plan. The ageing population, changing disease burden, and rising expectations demand fundamental change. For example the following community transformation performance indicators can be driven down further through effective implementation of the BCF Plan.

Table 1: Community Transformation KPIs Influenced by the BCF Plan ** Performance data as at November 2016*

KPI	Performance 16/17	Target 16/17
People >50 years attending A&E with a fragility fracture	98/month	111/month
No. of people over 55 with a fractured neck of femur	19/month	23.0/month
No. of GP referrals to the Medical Assessment Unit	205/month	265/month
No. of unscheduled admissions of patients >65years	839/month	730/month
No. of long stay patients over 14 days	68/month	212/month

A focus on community services has helped to support the other parts of the system (acute) in dealing with the increasing demand presenting at the front door. For example the performance against KPI No. of long stay patients over 14 days has significant improved since 2015-16 from an average of 86 per month to 66 in 2016-17 to date. The BCF Plan 2017-19 will be instrumental in supporting further initiatives to reduce attendances.

Changes to the traditional models of care have already started to gain traction. For example, in 2014/15 469 older people were permanently admitted to residential and nursing care which, reduced in 2015-16 to 401 people. In Quarter 2 2016/17 110 older people had been admitted to permanent residential care. 537 adults were in receipt of day care in 2015/16, compared to 644 the previous year. In 2015/16 we saw a slight increase to 86.1% in the proportion of adults who received home care enablement services who were discharged without needing any long-term formal care from social care services.

We have increased patient utilisation of residential intermediate care from 587 in 2014/15 to 613 2015/16, with a predicted out-turn of 664 in 2016/17. This has been achieved within the same cost envelope. Similarly, in 2015/16 550 adults received community and day rehabilitation services in Rotherham, compared to 500 2014/15. It is predicted this is likely to increase to around 600 in 2016/17.

6 Analysis of Out of Hospital Services

Rotherham has a range of high quality Out of Hospital Services which promote independence, prevent hospital admission and support hospital discharge. Out of Hospital Services fit into 3 main categories:

1. Admission Prevention and Supported Discharge Care Pathways
2. Single points of access i.e. The Care Coordination Centre
3. Locality Based Community Nursing Teams including the integrated locality pilot

Our Out of Hospital Services support the reduction of avoidable non-elective hospital admissions and re-admissions. They promote 7 day working, facilitate timely hospital discharge and improve patient experience.

6.1 Admission Prevention and Supported Discharge Pathways

In Rotherham there are three admission prevention and supported discharge pathways. These are all supported by the Better Care Fund.

Pathway 1: Hospital to Home

Pathway 1 supports patients who are medically stable, but cannot be supported at home with generic health and social care services. The CCG and the Council jointly commission an Integrated Rapid Response Service to support discharge and prevent admission for this cohort of patients. The Integrated Rapid Response Service operates 24/7, 7 days/week, providing short term therapy, nursing and social care support.

Pathway 2: Intermediate Care

Pathway 2 provides residential rehabilitation to patients who cannot return home. The aim is to maximise independence and optimise patients who do not have nursing needs. The Intermediate Care Residential service supports all patients on Pathway 2.

Intervention focuses on active enablement with view to maximising independence and returning home. The service is provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy and treatment.

The care plan sets out agreed rehabilitation goals and milestones. The service is time-limited, normally no longer than six weeks with average stay of 19 days. There are currently 54 beds across the borough, with an element of this for social care assessment, commissioned jointly by the CCG and the Council. The Intermediate Care Residential Service accepts admissions 7 days/week.

Pathway 3: Discharge to Assess

Pathway 3 provides a 24/7 nurse-led care model for adults with complex care needs who are medically stable. The pathway is for patients who need a place to recover from an acute illness before an assessment can be made about their long term care needs.

Pathway 3 provides residential assessment and rehabilitation for patients with nursing needs. It also supports patients who trigger positive for the CHC checklist but have not yet had an assessment.

Pathway 3 services are delivered by The Oakwood Community Unit, Breathing Space Inpatient Beds and Waterside Grange Residential and Nursing Home.

Oakwood is a 20 bed nurse-led unit situated in the grounds of Rotherham District General Hospital. Work is currently underway to reconfigure the unit so that it is better able to meet the needs of Pathway 3 patients.

Breathing Space is a 20 bed nurse-led unit focusing on patients who have COPD and other respiratory conditions. It is both a step-up and step-down facility for this cohort of patients.

The CCG and the Council also jointly commission, through BCF, 6 independent sector nursing home beds at Waterside Grange Residential and Nursing Home to support Pathway 3 patients.

The Community Unit, Breathing Space and Waterside Grange play a pivotal role in facilitating timely discharge from hospital for those patients who no longer require specialist acute care. All Pathway 3 services will receive admissions 7 days/week.

Figure 1 summarises the pathways that Rotherham currently operates for admission prevention and supported discharge.

Figure 1: Admission Prevention and Supported Discharge Pathways

Pathway 1: Hospital to Home

Integrated Rapid Response Service provides early supported discharge at home. Active in-reach into hospital, identifying patients who are medically stable and can be cared for at home. Delivered by an MDT for up to 6 weeks. Supported by specialist home care provider. Incorporates community rehabilitation.

Pathway 2: Intermediate Care

Intermediate Care provides residential rehabilitation to patients who can not return home. Aim is to maximise independence. Patients do not have nursing needs. Delivered by an MDT for up to 6 weeks. 50 community based beds

Pathway 3: Discharge to Assess

24/7 nurse-led care for adults with complex care needs who are medically stable. Delivered from The Community Unit and Breathing Space. Residential assessment and rehabilitation for patients with nursing needs. Supports patients who are preparing to undergo Continuing Health Care assessments.

Winter Pressures Initiatives

In autumn 2016-17 as part of the system wide response to Winter Pressures two further initiatives were agreed through the A&E Delivery Board as follows;

1. 10 nursing care beds at Ackroyd House (independent sector provider) providing short term support for patients who have passed the acute phase of illness and no longer require consultant led care, but who need a further short period of nursing led support prior to returning home. This pathway is overseen by the Rotherham Foundation Trust in collaboration with the Council and partners.

   The desired outcome for patients is that they return home within a 10-14 day period of admittance, within this time the MDT will have identified any appropriate support is needed to enable this transfer to take place. A trusted assessor model is also used to facilitate timely discharge.

2. 12 beds at Woodlands (RDaSH) providing a short term placement for patients with physical conditions and cognitive issues to:
    - Facilitate recovery in a more conducive environment with input from specialist expertise
    - Assess needs to facilitate discharge
    - This option could be tested over the winter and, if successful, developed as a pathway modelled on some of the benefits of discharge to assess approaches.

6.2 Care Coordination Centre

The Care Coordination Centre (CCC) has been a key vehicle for delivering BCF outcomes.

The CCC acts as an access hub for community health services. On supported discharge the CCC holds a register of patients in an acute bed, whose medical episode is complete. It actively engages with the relevant community services to ensure that patients are placed on the right discharge pathway.

The CCC coordinates transfer to the relevant service. It monitors outcomes and identifies where there are capacity issues within each care pathway. The CCC supports the commissioning process by identifying where there is under and over-utilisation of services on each care pathway.

The CCC also receives all hospital based referrals for community nursing services. Transferring responsibility to the CCC for these calls will ensure that health professionals and patients are able to speak to a clinician about the most appropriate level of service. Figure 2 summarises the full functionality of the Care Coordination Centre

Figure 2: Current Functions of the Care Coordination Centre

GP Support Service

Access point for GPs requires an alternative level of care for a patient. Advises on available range of services. Makes referrals, arranges placements and co-ordinates transport. Includes community pathway for suspected DVT.

Telehealth

Telehealth hub for patients with heart failure. Patients submit health data electronically. Collated and assessed to establish whether defined thresholds have been reached. Response coordinated.

Urgent Response Service

Single point of access for NHS 111 and the 999 ambulance service into alternative levels of care. CCC forms part of the YAS Pathfinder Project which supports ambulance crews when patients do not require A&E services

24/7 Service

Service will receive out-of-hours calls from patients and health professionals who require access to comunity health services or who have an urgent health need.

Supported Discharge

Service holds a register of patients in an acute bed, whose medical episode is complete. The CCC will actively engage with relevant services to ensure that patients are place on the right discharge pathway.

Single Point of Access for Community Nursing Referrals

Receive all hospital based referrals for community nursing services. The CCC carries out task allocation for all community nursing teams. Primary care referrals can be submitted to the CCC or direct to teams

6.3 Locality Based Community Nursing Teams

In Rotherham, our newly reconfigured, locality based community nursing teams support the transition from hospital to community. Although not currently funded through the BCF, they continue to be key vehicle for delivery of the 2017/19 BCF programme. The current service model incorporates 7 community nursing teams serving GP practice populations. The teams service geographical clusters of GP practices.

Over the past 2 years there has been significant investment in community nursing to deliver more effective leadership and clinical supervision, create an environment where nurses can safely care for patients with a higher level of need and reduce administrative burden. The focus on practice populations has supported partnership working between community and primary care. The service model uses an allocation formula which ensures equitable distribution of community nursing

resources across the borough. Finally the work in 2016-17 to pilot an integrated locality is providing insight into the opportunities and challenges for roll out across the health and social care system. This work will take place throughout 2017-18.

7. Integrated Commissioning

It is now universally recognised that health and social care services need to be much better co-ordinated around the individual to ensure that the right care is offered at the right time and place to promote better outcomes. This can only be achieved through greater integration of services. It is clear that commissioning has a key role to play in developing integrated services, and that the ongoing separation between the health and social care systems is a major obstacle to achieving better outcomes for individuals. People often require health and social care services at the same time so ensuring an integrated approach to how services are commissioned including jointly commissioning, planning and reviewing services.

The adequacy of current commissioning arrangements is also called into question by the development of the new delivery models proposed in the Forward View. All of these models will require fundamental changes to commissioning so that there is a much more strategic and integrated approach to the planning and use of resources, both within the NHS and between the NHS and local government.

With this in line Rotherham's health and social care system will focus on integrated commissioning activities in the following areas:

7.1 Joint Commissioning and Fee Setting of Domiciliary Care/Residential & Nursing Home/Continuing Health Care Placements

The Council currently contracts with 8 domiciliary care organisations on a framework agreement for a 3 year period until 31st March 2018, with an option to extend for a further year until 31st March 2019. There is also a block contract financial agreement in place for the 'night visiting' service. The Community and Home Care Service Framework respond flexibly to changes in demand. Providers appointed to the framework currently deliver around 12,800 hours of home care per week to approximately 1,166 people.

The Council has been consistent in its approach with the contracted sector and has awarded an inflationary uplift each year, however in 17/18 a discretionary uplift has been included rather than an inflationary one. There is no nationally prescribed formula for calculating care, but there is a Funded Nursing Care (FNC) rate prescribed by the Department of Health. Currently, both the CCG and the Council commission domiciliary care differently and each area has set rates. Both parties already liaise regarding fee setting, but there is recognition that the CCG and the Council need to develop a joint and consistent approach to fee commissioning and fee setting for domiciliary care providers.

The Council is currently working with a neighbouring authority (Sheffield) to redesign the home care provision and develop a model that is effective in preventing hospital admission/premature admission to a care home environment. This will require a workforce with enhanced skills/increased responsiveness to change in need i.e. a trusted assessor approach that involves home care providers in

the assessment process to prevent waiting times and address duplication issues. The model will promote enabling and will require allied health professionals to work alongside the home care providers and collaborate to achieve good outcomes for the people who use services. In this model Assistive Technology and Health technology i.e. monitoring of BP/Blood Glucose will be a feature and the administering of medication and this will be an integrated model. Consideration will be taken throughout the lifetime of the BCF plan as to how we will promote home carers to work more closely with District Nurses. The locality pilot in the Village provides an opportune time for this to be piloted as part of the review of the model prior to full roll out.

In relation to CHC funding for nursing care homes the Council and CCG have begun discussion to understand the risks associated with the current costing model; this includes but is not exclusive to market sustainability, reputational and financial risks. Together we will examine the options to realign the CHC rate so that it reflective of the increases Nationally in FNC since 2016-17.

7.2 Medication Administration in Care Homes and for People Receiving Care at Home

The administration of medication in care homes and to people receiving care in their own homes is dependent on the medication policies of the individual care agencies. Both RMBC and the CCG have agreed to undertake the development of a joint commissioning policy that will ensure greater flexibility in the administration of medicines whilst guaranteeing patient safety. This is a complex multi-agency problem that will need the full co-operation of all stakeholders to agree a way forward.

Rotherham Council, Clinical Commissioning Group and the Rotherham Foundation Trust will work together to review the medication policy for domiciliary care services. They will develop a business case to upskill care workers to administer medications which will reduce the burden placed on District Nurses and Pharmacists. The initiative will support safe hospital discharge, help prevent admissions to residential care and acute hospital beds and support appropriate and safe administering of medication in the community to help people stay at home longer.

7.3 Personal Health Budgets/Direct Payments

A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual. It is planned and agreed between the individual and the local CCG. This is a different way of spending health funding to meet the needs of an individual.

Co-produced, personalised care and support planning is at the heart of making personal health budgets work well. The plan helps people to identify their health and wellbeing goals, working with their local NHS team, and sets out how the budget will be spent to enable them to reach their goals and keep healthy and safe.

Adults eligible for NHS Continuing Healthcare and children in receipt of continuing care have had a right to have a personal health budget since October 2014. There is a longer term objective to widen the availability of personal health budgets to others who could benefit. In line with the rest of the country, the most significant demographic change occurring in Rotherham is the growth in the number of older people. 18.8% of the population are aged 65 and over but this will raise to a projected 20.7% by 2021.

The Integrated Personal Commissioning (IPC) programme was formally launched in April 2015 as a partnership between NHS England and the Local Government Association. IPC is a new approach to joining up health, social care and other services at the level of the individual. It enables people, carers and families to blend and control the resources available to them across the system in order to 'commission' their own care through personalised care planning and personal budgets. IPC also supports people to develop their knowledge, skills and confidence to self-manage through partnerships with the voluntary and community sector (VCSE), through community capacity-building and peer support.

IPC is one of the key steps towards delivering the NHS Five Year Forward View. It supports the Joint improvement, integration and personalisation of services, building on learning from personal budgets in social care and progress with personal health budgets.

Each demonstrator site is working with one or more of the following groups who typically have high levels of need from both health and social care:

- Children and young people with complex needs, including those eligible for education, health and care plans.
- People with multiple long-term conditions, particularly frail older people
- People with learning disabilities with high support needs, including those who are in institutional settings or are at risk of being placed in these settings.
- People with significant mental health needs, such as those eligible for the Care Programme Approach (CPA), or those who use high levels of unplanned care.

The goals of IPC are:

- People with complex needs and their carers have better quality of life, and can achieve the outcomes that are important to them and their families
- Prevention of crises in people's lives that lead to unplanned hospital and institutional care
- Better integration and quality of care.

Rotherham CCG will closely monitor the learning from demonstrator sites in order to develop its own integrated personal commissioning approach.

The Local Offer

There is an expectation that Personal Health Budgets should expand towards 1 in 1,000 people, this equates to approximately 260 people in Rotherham. The national pilots have demonstrated that benefit from a PHB derives from the level of need rather than particular diagnosis or condition. The planning guidance for 2015-16 allows local flexibility on which groups will be offered personal health budgets.

Continued consultation on this Local Offer will help determine our priorities for the future expansion; this will be partly dependent on the freeing up of resources to fund budgets.

Plans are in place through existing target groups and projects, which in part is increasing the uptake of Personal Health Budgets in groups where we already have an agreed process. From 2017 onwards plans will be developed in line with the analysis in the table above of benefits to individuals which will be included in the Local Offer. Current targets of expansion will be monitored by the BCF Operational and Executive group.

There is also opportunity to jointly develop the approaches between the CCG and the Council for personal budgets and self-directed support, which is part of the Adult Care Improvement Plan. The membership of the CCG PHB working group (working on development and governance) is being expanded to include the Council with a view to rolling out PHBs to the wider population.

7.4 Learning Disability High Cost Care Packages

Residential Care

This service provides care commissioned for people with Learning Disabilities by the Council and relates to Adult Service Users in both long term and short term care. The primary objective of the service is to achieve the outcomes identified by the process of Community Care Assessment, detailed in the consequent Support Plan and agreed with the Service User and any named third party.

Supported Living Schemes

Supported Living schemes are seen as a viable and value for money alternative to care homes, with the potential to provide a more personalised approach and better outcomes for people.

Supported Living establishments provides people with somewhere to live with their own front door and is usually for 1-6 people with domiciliary care provided either by the accommodation owner, or by another provider chosen by the service user. Choice and control is key, with quality monitored by commissioning to ensure a good standard of care.

Domiciliary care is provided in communal supported living establishments, in hub-and-spoke models of clustered supported living, and in people's own family homes.

The main outcomes are:

- Enhancing quality of life for people with care and support needs through promoting independent living skills
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support.
- Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm.

All Learning Disability residential homes and supported living are contract monitored by the Council using a quality monitoring framework. The Rotherham LD Partnership Board is actively involved in

service redesign and strategy development. Rotherham Transforming Care Board oversees this work locally to ensure tasks are kept on track.

The current service in Rotherham is moving towards the promotion of independent living but is still heavily reliant upon residential care. Further work will need to be undertaken to support adults to make different choices and to optimise their independence in a safe way i.e. supported living.

All Learning Disability residential homes and supported living are contract monitored by the Council using a quality monitoring framework. The Rotherham LD Partnership Board is actively involved in service redesign and strategy development. Rotherham Transforming Care Board oversees this work locally to ensure tasks are kept on track.

The current service offer in Rotherham is moving towards promoting independence, but is still heavily reliant on a residential care rather than independent living approach. Further work will need to be undertaken to support adults to make different choices and to optimise their independence in a safe way i.e. supported living.

The Council will work to commission a new provider for the people living in supported living schemes at John Street and Oak Close which is currently being provided by the NHS Mental Health provider (RDaSH) via a competitive tender process. Full analysis is required to understand how this should be commissioned. All relevant stakeholders will be involved in the process.

Oak Close is a Supported Living Scheme for people with learning disabilities situated in the North of the Borough. The scheme comprises of 16 purpose built, self-contained apartments that were built in 2015, together with an additional four beds in a house also on the site. The property is owned by South Yorkshire Housing Association and the service is run by and CQC Registered with RDaSH.

John Street is a Supported Living Scheme for people with learning disabilities situated in the South of the Borough. The scheme comprises of three five bedded bungalows totalling 15 beds. The property is owned by South Yorkshire Housing Association and the service is run by and CQC Registered with RDaSH.

The Supporting Living market is small in Rotherham with only 7 providers. We want to engage with more person centred, value for money and good quality providers. The Council is currently exploring the opportunity to work in partnership with Sheffield City Council to develop and ultimately procure a supported living framework covering both areas from April 2017. We have a very similar supply base and a shared border so there are potential efficiencies from this approach in terms of economies of scale and consistency.

Direct Payments

Direct payments allow people with learning disabilities between the ages of 16 and 65 years, to have more choice and control over their day-to-day life through flexible care arrangements. Instead of the council commissioning their care services, the money is given to an individual to buy the care they need and they choose the kind of support that is right for them.

The following are some examples of how people have used direct payments to meet their assessed needs:

- Employing a personal assistant to support and help with everyday living skills agreement with a care agency to purchase help with personal care
- To buy a piece of equipment
- Support to access the local community, such as leisure and social activities
- Help with caring, such as respite care and taking a break from caring
- Assistance to access further education and employment opportunities.

Support and advice is also available for individuals to support them with all aspects of managing their direct payments including:

- Help with recruiting and employing staff and agencies
- Support and advice in employment law
- Developing appropriate contacts of employment
- Advice and support to sort out any difficulties you may have with your employee
- Calculate holiday entitlement, notice and redundancy pay to your employees
- Payroll support

7.5 Mental Health Section 117 placements

The legal responsibilities placed on Health and Social Care Services by Section 117 of the Mental Health Act 1983 requires Local Clinical Commissioning Group and Local Authority's Social Services, in conjunction with voluntary agencies, to provide aftercare for patients admitted under Section 3, 37, 45A, 47 and 48. This includes patients given leave of absence under Section 17 and any other section of the mental health act which entitles patients to provisions for aftercare under section 117 of the act.

After-care services must have both the purposes of meeting a need arising from or related to the person's mental disorder and reducing the risk of a deterioration of the person's mental condition and accordingly reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder.

The principles of self-directed support will apply to section 117 after care services including Personal Health Budget and Integrated Health and Social Care Budgets

8. Prevention and Early Intervention

8.1 Shaftesbury House/Short Stay Project

We have developed a "Short Stay" Project at Shaftesbury House from November 2016, which provides support through enablement and housing for a maximum of up to six weeks. The purpose of this project is to provide a safe, appropriate and short term housing support for people who are unable to return home to their own home, providing time and a period of adjustment after a change in their health or social care needs.

This scheme contributes to the BCF metrics by facilitating hospital discharges, avoiding unnecessary admissions to respite and residential care provides a safe environment to facilitate a short-term risk assessment due to high falls risk or cognitive impairment and provides a period of enablement that cannot be delivered in the person's own home.

8.2 Review of Therapy Services

The Rotherham Foundation Trust currently employs a large number of therapists working in the acute and community sector as follows:

- Domiciliary Physiotherapy
- Musculoskeletal Services
- Stroke and TIA service
- Falls, Fractures and Bone Health
- Integrated Rapid Response
- Breathing Space – beds, community rehab, domiciliary rehab
- Integrated Neurorehabilitation
- Cardiac Rehabilitation
- Community Occupational Therapy
- Intermediate Care – residential, community rehab team, day service rehab.
- Community Unit
- Waterside Grange – Discharge to Assess beds
- Hospital

Therapy is essential to the prevention and early intervention priority, Rotherham has a wealth of therapy services across community and acute however, at present there is no consistency in approach to therapy provision, integration and performance particularly on waiting times. As such therapy as a cross cutting service provision has been identified as an area of review for 2017-19, to ensure that where appropriate therapists are integrated into the locality way of working i.e. community locality teams, are able to provide flexibility in the cohort of patients they see and provide a more effective and efficient working arrangement across the services.

9. Adult Social Care Improvement Programme 2016-20

The Adult Social Care Improvement programme has been established to redesign the Rotherham arrangements for supporting the adult social care journey, to ensure Care Act compliance, provide better outcomes for customers and generate efficiencies/savings. The programme direction is based on good practice nationally and pulls on resources regionally and further afield to support the delivery of improved outcome and best value.

The four key themes which have been identified:

- Prevention – This involves ensuring right information is available in all formats, that a range of options across the Borough that promote healthy lifestyles are available and increased use of digital channels.
- Integration – This focuses on future models for integrated health and social care teams, including hospital discharge team and mental health services, future role of configuration of

therapy across the Borough, integration of systems, sharing of data, information governance, understanding our people and place and future role of care homes.

- Care co-ordination – This will provide clarity on how the Care Co-ordination Centre forms part of a wider Single Point of Access for hospital admission.
- Maximising independence and reablement – This includes development of specialist reablement and recovery services, extra care supported living, best use of the Rotherham pound (CHC, joint funding, social care), working with providers and health partners to offer value for money, drive and manage the market, making sure there are the right support options available for people, personalisation of individual options, telecare/telehealth, internet, digital communication, skype/face time.

The Local Authority have also established regular Practice Scrutiny Groups which are held on a twice weekly basis to carry out quality assurance checks to ensure Care Act compliance, ensuring best value, effective use of resources and promoting better outcomes. The group is focusing on developing a strength based approach, in partnership with staff, to ensure that community assets are utilised and self-directed support is maximised.

The Practice Scrutiny groups focus on greater promotion of the use of individual budgets via a direct payment provides strength based, focussed assessment on well-being and clear evidence of person's needs, eligibility criteria, support plans, completion of Continuing Health Care and Decision Support Tool checklists, alternatives to standard service provision and greater use of assistive technology.

Delivery of this programme in full is likely to take around four years, the direction and scope of changes will need to be reviewed and reshaped through the programme. There are key decisions that will need to be taken around the size and shape of the in-house offer. Options will need to be worked up, consulted on and decisions made. Some changes which will improve the offer for the citizens of Rotherham are likely to cause significant concerns for customers already in the system and this need to be carefully balanced to ensure long-term sustainability. The timing of decision making will impact on the overall delivery of the programme. A development board consisting of partners within health and social care in Rotherham has been established to monitor delivery of the programme.

10. Improving Quality and Reducing Costs

This section of the BCF Plan considers some of the initiatives which have improved quality whilst at the same time increasing levels of efficiency. These initiatives support the reduction of avoidable non-elective hospital admissions and re-admissions. They promote 7 day working, facilitate timely hospital discharge and improve patient experience.

10.1 Risk Stratification

Rotherham has a well-established risk stratification tool, which uses a combination of primary and secondary care data to select the top 3% of the population who are at highest risk of hospital re-admission. This has enabled the targeting of case management on those who are likely to require intensive support further down the care pathway. It is expected that further opportunities will be considered to expand the current risk stratification model to support prevention and early intervention as this is key to promoting self-management and increased independence for longer.

10.2 The Rotherham GP Case Management Programme

Having identified those people who are at greatest risk of being a high user of health and social care services, Rotherham' Case Management Programme places GPs at the forefront of care planning, self-management and care coordination. The main aims of the Case management Programme are;

- To reduce the unnecessary utilisation of secondary care services and therefore cost
- To facilitate improved quality and co-ordination of care in the community setting
- To improve the quality of care for older people
- To improve self-care by patients

The Case Management Programme is fully funded through the Better Care Fund. A key function of the programme is to empower GPs to act as care coordinators, taking overall responsibility for all health and social care input. The GP has a full understanding of the role of other parties in the care of an individual patient. The Case Management Programme relies on the development of an integrated care plan which incorporates; medical review, analysis of social factors, exacerbation plans and place of care preferences. The integrated care plan is reviewed every 4 months and supported by regular MDT meetings with the full range of health and social care professionals.

10.3 The Social Prescribing Programme

The Rotherham Social Prescribing Programme is funded through the Better Care Fund. Social prescribing is an approach that links patients in primary care with non-medical support in the community. The Rotherham social prescribing model particularly focuses on secondary prevention, commissioning services that will prevent worsening health for those people with existing long term conditions, and thus reduce costly interventions in specialist care. Voluntary Action Rotherham (VAR) have been commissioned to employ a social prescribing team which maps voluntary and community services across the borough. The team will attend case management MDTs and link patients into services that promote community integration and re-ablement. VAR provide a one-to-one service to people on the GP Case Management Programme, motivating, signposting and supporting them to access services in the voluntary and community sector.

Rotherham CCG is also running a pilot within Mental Health. The Rotherham Social Prescribing Mental Health Pilot was developed to help people with mental health conditions overcome the barriers which prevent discharge from secondary mental health care services. It initially ran from April 2015 to March 2016 but has since been extended to March 2017. The service helps service users build and direct their own packages of support, tailored to their specific needs, by encouraging them to access personalised services in the community provided by established local voluntary and community organisations, and to develop their own peer-led activities.

Voluntary Action Rotherham, on behalf of NHS Rotherham CCG, co-ordinates both schemes. By connecting people with a range of voluntary and community sector-led interventions, such as exercise/mobility activities, community transport, befriending and peer mentoring, art and craft sessions, carer's respite, (to name a few), the scheme aims to lead to improved social and clinical outcomes for people and their carers; more cost-effective use of NHS and social care resources and to the development of a wider, more diverse range of local community services.

Within the Long Term Conditions service, participants are identified by GP surgeries using a risk stratification tool. Advisers discuss patients at risk of unplanned hospital admission within the integrated case management teams and patients identified as needing non-clinical means of support to improve their health and wellbeing are referred to the social prescribing scheme. Advisers then carry out a home visit to undertake a guided conversation to help patients identify what areas of their lives they would like to change/improve.

The services they connect people to are provided through contracts with a range of local voluntary and community sector organisations, including local branches of Age UK, Citizens Advice Bureau, Alzheimer's Society and Sense. As well as the services listed above, people can be linked to dementia services; advice and information; advocacy; sensory services; therapeutic services and community hubs based on an asset based community development (ABCD) model. Where the main providers are not able to meet a particular need or goal, advisers may spot-purchase more appropriate solutions.

The Mental Health Pilot is funded by NHS Rotherham Clinical Commissioning Group (CCG) and delivered in partnership between Rotherham, Doncaster and South Humber Foundation Trust[1] (RDASH) and a consortium of 17 local voluntary sector organisations led by Voluntary Action Rotherham.

Both services have been independently evaluated by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. Both evaluation reports are available here

This initiative has recently been recognised nationally and is being recommended for inclusion in Sustainability and Transformational Plans (STPs).

10.4 Supporting People with Dementia

Rotherham has invested in a wide range of initiatives aimed at supporting people with dementia. Many of these are funded directly through the Better Care Fund. All of these services contribute to the evolving multi-agency approach to dementia care.

Dementia Enablement Service

The service is provided by Crossroads Care Rotherham (voluntary and community sector provider), which provides emotional support and respite breaks to carers of people with dementia. The service supports people with dementia to be more independent at home and in the community and aims to reduce inappropriate admissions to hospital or premature admission to long term residential care. The service is available on a 24 hours a day, 7 days a week basis. .

Dementia Enabling

This service offers personal care, assistance with medication, social stimulation and carer breaks. The service is available 24/7.

[1] RDASH as historically provided mental health and learning disability services across South Yorkshire and North East Lincolnshire, but recently expanded its remit to include community services such as district nursing and health visitors.

Dementia Re-ablement Service

This service is also delivered by Crossroads Care Rotherham and is available for 6 weeks. The service aims to support hospital discharges, offers support to prevent admission to hospital/residential care and to prevent re-admissions to hospital. The service will work to re-establish routine and support the family/carer. The service is available on 24 hours, 7 days a week basis.

Discussions are ongoing around Dementia Reablement ceasing and being absorbed into Dementia Enablement but this has yet to be confirmed. The position will be clear by around January 2017.

Carer Support Service

This service is also provided by Crossroads Care Rotherham, which provides emotional support and respite breaks. The service aims to enable people to enjoy a life of their own alongside their caring role. It also helps to reduce social isolation and improve health and wellbeing. The service is available for 30 hours over a 10 week period.

Dementia Carers Resilience Service

This service is provided jointly by three voluntary and community sector providers which are Crossroads Care Rotherham, Alzheimers Society and Age UK. Each GP practice has a named link worker who identifies and supports carers of people with dementia. The service provides information, advice and practical support including respite care at home, as appropriate. When a carer is referred by their GP they are contacted by a Dementia Adviser within 5 days of the referral being received. An initial assessment of need is carried out. The period of support will be one month. Where appropriate, carers are then signposted to other organisations who can offer support e.g. Single Point of Access, aids and equipment, social activities, benefits checks for longer term support to be arranged, as required.

Memory Cafes

Monthly Memory Cafes are provided across four areas along with two Singing for the Brain Groups. The service aims to help people to come to terms with their diagnosis, live well with dementia, offers choice through person centred support planning, reduces social isolation, increases access to information, helps maintain independence and life skills, improves and maintains health and well-being, helps maintain hobbies and interests and helps avoid crisis such as unplanned admission to residential or hospital care.

The Alzheimers Society employs Dementia Support Workers who assist people with dementia and their carers to identify their needs and to access services. The workers give information, support and guidance and signpost service users and carers to other services for further support.

Community Cafes

The Local Authority have commissioned a new Community Café service from the voluntary sector since April 2016, which includes the development of 6 community cafes, providing support, structured activity, information giving, open discussion and social engagement in a group setting, at various locations in the community to support people living with dementia and their carers.

Community Cafes are a more informal version of Memory Cafes and are arranged by a Café Co-ordinator and attended by Dementia Support Workers

5 out of the 6 cafes are now established and fully operational as follows:

- The café at New York Stadium has a health/exercise programme to improve health and well-being
- Swinton has a social and creative programme with one to one activity for both carers and people with dementia
- Chislett Centre has an excellent network of community activity for service and carers to access and have been introducing those opportunities within the group.
- Kiveton Park is now well established within the community with 33 attending the first session in October 2016. The environment is set out well with an appropriate number of volunteers to support the activity.
- Rotherfed held its first café in November 2016, which offers an opportunity for people to eat together, as well as linking in other activities such as quizzes, games, speakers and opportunities to liaise with the dementia support worker for advice, support and guidance.

The sixth café will be located at the Methodist Church in Wickersley from January 2017. The dementia support worker is currently supporting the group to get the service fully operational.

Carers Information and Support Programmes (CrISP 1 & 2)

CrISP courses are for carers, family members or friends of people with dementia to improve knowledge, skills and understanding. CrISP 1 is designed for recent diagnosis of dementia. There are four sessions delivered by the Alzheimers Society covering understanding dementia, legal and money matters, providing support and care, coping day to day and next steps. CrISP 2 is designed for families, carers and friends of people who have been living with dementia for some time. There are three sessions covering understanding how dementia progresses, living with change as dementia progresses, living well as dementia progresses including occupation and activities.

An enhanced service in primary care service for diagnosing dementia is in place to provide early access to services. This is separate to the Better Care Fund but closely links to its objectives.

Carers Resilience Service

This service is provided jointly by Crossroads Care Rotherham, Alzheimer's Society and Age UK. Each GP practice has a named link worker who identifies and support carers of people with Dementia. The link worker takes referrals and can provide information sessions to staff as required.

When a carer is referred by their GP they are contacted by a Dementia Advisor within 5 days of the referral being received. An initial assessment of need is carried out. The period of support will be 1 month. Where appropriate carers are then signposted to other organisations who can offer support e.g. Assessment Direct, aids and equipment, social activities, benefits checks.

Cognitive Stimulation Therapy (CST) Sessions

These are provided in the community and offered to all patients and families as clinically appropriate following diagnosis. Sessions are led by OT's and nurses from the Memory Service. Sessions are delivered in line with the 'Making a Difference' programme, but with the added option of including relatives/carers if appropriate.

Memory Service - Occupational Therapy

The Memory Service has dedicated OT resources. OTs contributes to MDT case discussions and reviews. In terms of their direct clinical work with patients and carers the OTs offer a range of assessments and interventions focusing particularly on promoting and maintaining safety, meaningful activity, independence and well-being. The OTs are involved in a range of ways, for example they work collaboratively with social care re assessment and provision of assistive technology and other equipment/adaptations. They carry out ADL home assessment and environmental safety and improvement work, give input and guidance on a wide range of therapeutic interventions to support health promotion, falls prevention, well-being and quality of life

11. What has the Better Care Fund Achieved This Year?

There have been significant achievements since the last BCF plan in 2016/17.

We have reviewed some of the jointly commissioned services during 2016/17. The reviews have highlighted where BCF schemes are strategically relevant, those services that have performance issues and those that require further investigation in 2017/19.

We have developed a Directory of Services for BCF. The directory provides clear visibility to all key stakeholders on what services are funded. It provides a summary specification for each service, sets out objectives and describes relevance to the BCF metrics (Appendix X).

We have now successfully matched around 5,495 adult social care records with their NHS number, providing a single identifier that can be used across health and social care. We have already started to look at how we can match records to improve the quality of joint commissioning. We are also identifying the highest cost individuals across the health and social care economy with a view to providing a more integrated and cost-effective service.

The Local Authority's new social care case management system (Liquidlogic) went "live" on 13.12.16, and this 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 and we will begin using the NHSN on our correspondence.

We are also working towards ensuring that better data sharing data includes ensuring that patients/service users have clarity about how data about them is used, who may have access and how they can exercise their legal rights. Significant progress is under way, with an expected full implementation date of 31st January, 2017, to ensure that we fully meet the national condition.

The work carried out includes The Proposed Consent Model was fully approved at the Rotherham Interoperability Group on 31st August, 2016. The Model states that the ability to access a patient's information may be done via implied consent for direct care. The public must, however, be effectively informed that the data is in use and have the option to object to their records (from any organisation) being shared. Access of a record must be done on the explicit consent of the individual for each episode of care, wherever this is possible (and practical).

Where a patient requires emergency treatment and is unable to give consent, or when a record is being reviewed in response to a test result when the patient is not present, a professional clinical decision can be made considering whether the duty to share or implied consent may be justified. Such access without explicit consent should be documented. This should be fully auditable and monitored accordingly.

A Communications and Engagement plan has been drafted and information will be made available in a variety of formats covering:

- The system "Rotherham Health Record" (RHR) that we will be using to share data
- How it works
- What information will be shared within it (details such as name, address, medication)
- Who will have access to it
- Reassurance on the security of the RHR (both technical within the system and organisational in terms of duty of confidentiality)
- How to opt out
- Who to contact with any concerns/queries

We have a 7 day social care working in place and embedded at the hospital with on-site social care assessment available to support patients. This has become "business as usual" from October 2016, following the implementation of a social care restructure. Support over the full 7 days is provided by the same core team, ensuring that there is consistency of process over this period. Additional support over and above the dedicated resources identified can be accessed through the out of hours service on an as needed basis.

We have expanded the Mental Health Liaison Service. The service supports wards and care homes when delivering care to people who have mental health issues. It focuses on those parts of the health and social care economy that work with people who have a physical condition. One of the key aims of this service is to reduce admissions to hospital and to limit average length of stay.

We have developed an integrated falls and bone health care pathway. There is evidence that reducing the number of fragility fractures among people over 55 years has an impact on health and social care costs later in life. The integrated falls and bone health service tracks older people who have had a fragility fracture and offers follow-up support to reduce the risk of falls and osteoporosis.

The Better Care Fund has been used to maintain provision of social care. This includes the use of direct payments, residential care and social work in case management programmes. All social care domiciliary care providers are now contracted to respond to urgent hospital referrals over the weekend to facilitate discharge. The BCF Fund has supported the recruitment of a Clinical Quality Advisor within the Care Home Support Service from February 2017. This post is integral in ensuring

that health issues are addressed when monitoring contract quality and performance. The post will work flexibly across health and social care and will improve the standard of care for residents. The Advisor will monitor quality standards of care and will undertake audits, reviews, assessments and provide advice, training and support to care homes. The Advisory will also work with the Local Authority contracting team and will contribute to co-ordinated patient pathways.

Through use of BCF we have commissioned 3 Adult Social Care Assessment beds to support discharge patients who require further assessments to optimise independence. All beds are designated to support hospital discharge for patients who require optimisation and further assessment and for step-up provision to prevent hospital admissions. The step-up beds are used for patients who have a combination of health and social care needs but do not require rehabilitation within an intermediate care facility.

This year we have extended the eligibility criteria for intermediate care services. Patients who are unable to take part in rehabilitation can now be transferred to an intermediate care unit provided they have rehabilitation potential. There are 2 designated "delayed rehabilitation" beds within each intermediate care unit that can accommodate patients who are non-weight bearing, receiving pain management medication or recovering from illness.

We have recommissioned the social care prescribing service to provide people with long-term conditions access to voluntary and community sector support. This service helps promote self-management and community integration, thus reducing hospital admissions and reliance on social care. We recently established a mental health social care prescribing pilot creating opportunities for mental health service users to sustain their health and wellbeing outside secondary mental health services.

Using the Better Care Fund we have increased the number of adults receiving a Personal Health budget so that they can commission their own continuing health care support.

Finally, we have established a community end-of-life hospice team to support families and carers allowing patients to die in their place of choice. This also contributes to reducing hospital admissions.

12. Key Priorities: 2016-19

The BCF Executive has identified the following priorities for 2016-19. These include:

1. A single point of access into health and social care services
2. Integrated health and social care teams
3. Development of preventative services that support independence
4. Reconfiguration of the home enabling service and strengthening the seven day social work offer
5. Consideration of a specialist reablement centre incorporating intermediate care
6. A single health and social care plan for people with long term conditions
7. A joint approach to care home support
8. A shared approach to delayed transfers of care (DTOC)

12.1 A single point of access into health and social care services

Rotherham has high ambitions for being a cohesive community with strong partnerships and joined up support delivered around localities. Key to this is to ensure a good understanding of what the options are to support people appropriately to remain healthy, well and outside of services for as long as possible.

The vision for Rotherham Single Point of Access is for one hub that citizens of Rotherham who have concerns about their own, or others health and social care needs can contact. Citizens will receive immediate advice which will allow them to self-serve and if required further timely advice or intervention to prevent, reduce and delay needs and safeguard as necessary. The key features of this offer are that Rotherham citizens:

- Tell their story once and make every contact count;
- Are supported at each stage to maximise own strengths, assets and ability to self-manage / self-care;
- Receive just enough support to maximise independence and self-reliance;
- Receive the right care in the right place at the right time;
- That Rotherham health and social care professionals;
  - Can access a pool of knowledge and resources outside of their own profession, or local area of expertise;
  - Can appropriately advise customers / patients / service users how to access different parts of the system;
  - Can manage system demands and prioritise resources appropriately.

If the vision is achieved the single point of access should be able to facilitate citizens to access the most appropriate advice, onward referral to meet their needs and prevent reliance on acute services (i.e. prevention of attendance and admission to hospital).

What are we going to do?

There are a number of "services" across the system currently that provide some of the functions identified in the model however there are gaps in provision across the wider system response and differing entry points makes navigating services confusing. It is the intention of all partners to examine the options for extending the current Care o-ordination Centre discussed in 6.2 and to further integrate the Integrated Rapid Response service discussed in 6.1 with mental health, social care and enabling.

The single point of access cross cuts several Place Plan Priorities. It is a key to prevention and self-serves, has strong interdependency with the model of an enhanced care coordination centre, could maximise the benefits of a single reablement hub and provides solutions to support the emergency and urgent care centre. Crucially the localities model will not be sustainable unless demand is managed and dealt with more effectively and these resources can be prioritised.

The proposal is to phase this work, concentrating first on developing a single point of access for the out of hours response (integrated rapid response). The rationale for this approach is detailed below;

- Outside of standard working hours there is a significantly smaller set of services and is therefore easier to manage implementation
- A number of these services have already started to look at working more closely so there is willing and some progress towards this.
- Out of hours citizens often access a more intensive level of support e.g. residential care or hospital in order to ensure safety and if as system we can close this loop it would have significant positive outcomes.

The learning from bringing together the out of hours service can be used to shape the vision for what the wider single point of access model needs to achieve alongside the planned review of the Care Coordination Centre. It is the intention to expand the integrated rapid response service to provide an enabling function which will support discharge home ensuring that people are appropriately supported to reach their full rehabilitation potential in a more applicable setting (home) to inform the assessment (i.e. DST) and support process.

12.2 Integrated Health and Social Care Teams

Evidence suggests that integrated health and social care teams are likely to achieve better results than those that operate within strict organisational boundaries. The Kings Fund identifies some of the key characteristics of a successfully integrated team.

- Community-based multi-professional teams based potentially around practice populations
- A focus on intermediate care, case management and support to home-based care
- Joint care planning and coordinated assessments of care needs
- Named care coordinators who retain responsibility throughout the patient journey
- Clinical records that are shared across the multi-professional team.

What have we done?

A fully integrated health and social care team has been piloted to support the Health Village. The team is co-located and supporting the same population as the current community nursing locality team. The team has a single line management structure and joint service specification. A portal has been developed that can store the integrated care plan and provide full visibility on the range of work being done on the individual. The Rotherham Health Record now imports the Virtual Ward flagged patients and displays them within its existing Patient Lists functionality. This is currently being assessed to see if it meets the needs of the MDT and once signed off it will be ensured that there is appropriate access for MDT staff.

The integrated health and social care team includes community nurses, a community matron, social workers and allied health professionals. It will have a single point of access for all referrals. As well as focusing on structure, the process of integration will include a programme of relational transformation aimed out enhancing interpersonal relationships and breaking down cultural/ organisational barriers.

12.3 Development of preventative services that support independence

Rotherham has developed a "Healthy Ageing Framework" Reference to improve the health and wellbeing of the ageing community. The framework

supports the delivery of the ambitions within the RMBC Corporate Plan and Joint Health and Wellbeing Strategy. It will be used as a vehicle to optimise the impact of services and generate further investment through external funding applications. The framework and will help to ensure that Rotherham services work together seamlessly to create healthy, independent and resilient citizens.

Rotherham has a range of community services that focus on early intervention and prevention. These services promote independence by providing support with activities of daily living, physical activity initiatives, community equipment and community integration.

Occupational Therapy

The Care Act (2014) "Guidance for Occupational Therapists", endorsed by ADASS, highlights that "It is critical that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point. It is vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence and prevents needs or delays deterioration wherever possible. The statutory guidance also states that they must consider the principle of prevention from the first point of contact and throughout their ongoing involvement.

The Care Act also highlights that practitioners need to share their skills so that others can meet particular areas of need e.g. equipment provision. We need to work across other statutory and voluntary services to maximise capacity and reduce duplication.

We also need to have a greater awareness of what is available in our local area e.g. community assets which can help and support service users and/or their carers, for example charities, faith and social groups, health promotion and volunteer services..

What are we going to do?

The Community Occupational Service review considers options for future development of the service. The ambition is to integrate the service into the locality model and working closely with adult social care by providing additional resources into the Local Authority's Single Point of Access by signposting potential or existing service users to other alternative services and to reduce home care packages by selecting alternative solutions to address needs. An options appraisal will be carried out in 2017-18 to determine a new service model and future commissioning arrangements. The service will also form part of the overall review of all community therapy services in Rotherham.

Community Equipment

The Care Act (2014) stipulates that Local Authorities must provide or arrange services, resources or facilities that maximise independence for those already with such needs, for example, interventions such as rehabilitation/reablement services, e.g. community equipment services.

These preventative type services also provides effective rehabilitation, improves quality of life, enhances their life chances through education and employment and greatly reduces morbidity at costs that are low compared to other forms of healthcare.

There is clear evidence that a good community equipment service

- Maximises a patient's ability to live independently
- Maintains health and improves quality of life.
- Reduces likelihood of further health problems (immobility, muscle contractures, pressure sores).
- Promotes social inclusion.
- Prevents accidents and falls-related admissions to secondary care.
- Reduces the need for 24 hour care from health and social care.
- Facilitates early hospital discharge as well as access to service in a planned way.

What are we going to do?

We will review the Integrated Community Equipment Service and Wheelchair Service to ensure there is sufficient funding on a recurrent basis to respond to increase needs and demands. The review will focus on increasing needs, funding, risks, business continuity, identify savings or additional investment and customer experience to provide a service that is sustainable and fit for purpose.

Activities of Daily Living Tool

We have commissioned an innovative web-based tool to help us to encourage people to maximise their independence by acting early. This is a nationally recognised tool which is in the process of being localised. The working title is "Iagewell-Rotherham", which will use with people across the health, social care and voluntary sector workforce. This tool will help to link individuals to services or technology that will maintain their wellbeing and reduce the onset of ageing. The tool is strongly linked to the evidence on healthy ageing and the life curve and has been shown to deliver savings to the health and social care economy when embedded in our service delivery. The tool had its soft launch in November 2016 and will be fully launched in early 2017.

Promoting physical activity

Public Health and partners have developed a post rehabilitation support for patients with seven long term conditions (Stroke, Cardiac, Heart failure, COPD, MSK, Falls, and Cancer). This research project started in November 2015 and provides tailored exercise programmes for patients post-rehabilitation. Patients on the programme will undergo condition specific group exercise activity aimed at optimising physical function and embedding a long term culture of regular exercise. The programme supports patients to access appropriate exercise activity in their local community. The service is accessible to GPs as part of the case management programme. It will also be available to patients on specific health care pathways. The intention is that referrals from health professionals will be made through the Care Coordination Centre.

The main elements funded by the programme include;

- 12 week condition specific group exercise programme
- Community buddies who provide individual support to patients requiring support with exercise
- Support with accessing appropriate exercise activity in the local community
- Targeted support for patients on the stroke, respiratory, falls and cardiac rehab, heart failure, MSK and cancer care pathways
- Research project being externally evaluated by Sheffield Hallam University.

Over 500 patients have completed the programme in Year 1, resulting in some positive outcomes and excellent case studies. A short video has been developed to bring the project to life and this is available on http://www.rotherhamgetactive.co.uk/activeforhealth

What are we going to do?

We are committed to maintaining and improving these services despite the challenging financial framework within we operate. We will review our occupational therapy and equipment services so that they are fit for purpose. We will make best use of the resources available within Rotherham to include not just health and social care, but housing support. We will free up the occupational therapy service so that it provides more direct support to people struggling with activities of daily living. We will properly resource the equipment service so that it supports the work of the occupational therapy service. Finally we will continue to promote physical activity pathways for people who have had major health events.

12.4 Reconfiguration of the home enabling service

Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities and those who are frail or recovering from an illness or injury.

The purpose of reablement is to help people who have experienced deterioration in their health and/or have increased support needs to relearn the skills required to keep them safe and independent at home. People using reablement experience greater improvements in physical functioning and improved quality of life compared with using standard home care.

Reablement is usually free for the first six weeks.

What are we going to do?

We will implement the outcomes of a recent service review, ensuring that the enabling service is fit for purpose and promotes value for money. The service will support people to maximise their independence using the "i-age-well" tool. We will ensure that the service is able to respond in a timely way to hospital discharges 7 days per week. We will rebrand the service so that it is incorporated into the intermediate care portfolio of service provision. We will link the service with mental health services, providing important psychological support to people who struggle with motivation or depression.

12.5 Consideration of a Specialist Reablement Centre incorporating Intermediate Care

With an ageing population, people living longer with more long term conditions and a significant efficiency challenge we want to develop a more integrated approach to the provision of intermediate care services. This ambitious transformation of services will support our joint priorities of promoting independence, prevention of avoidable hospital admission and delayed discharges.

Our aim is to support recovery in a non-acute setting, enabling people to achieve optimum levels of independence. Building the right capacity and capability for an integrated intermediate care service is a key element in driving this forward. In 2016-17 we have moved forward in this journey by flexing the eligibility criteria to our intermediate care (bed base), removing bureaucracy in the referral process and amalgamating provision across 3 sites to 2 to support effective integration of teams.

What are we going to do?

We will further review our intermediate care offer over 2017-19 considering other community bed based provision such as the nurse-led provision (Community Unit & Breathing Space) in conjunction with the review of hospital to home (Integrated Rapid Response). This is to ensure that services are future proof and fit for purpose. We will ensure that the right numbers of beds are commissioned to meet demand, more flexible eligibility criteria is in place, increased provision of services in the home and more choice of housing.

We will build on our intermediate care offer to support more people to regain control over their lives based on self-determined outcomes enabling people to remain in control of their lives, promote their health and well-being and remain outside of statutory services.

We will increase options for move-on Extra Care Housing provision, incorporating access to telecare and telehealth service.

We will consider the options for merging existing intermediate care provision, including the Rotherham Intermediate Care centre (RICC) onto a single site, creating a specialist reablement centre. This is one of the key priorities contained with the Integrated Health and Social Care Place Plan. Eligibility criteria for the new intermediate care service will be extended to include:

- People with 24/7 nursing needs
- People with dementia
- People who require a period of recovery/recuperation

12.6 Rotherham Carers' Strategy

The National Carers Strategy Carers sets out the strategic vision and outcomes for carers. It states that carers will be universally recognised and valued as being fundamental to strong families and stable communities. Support will be tailored to meet individuals' needs, enabling carers to maintain a balance between their caring responsibilities and a life outside caring, while enabling the person they support to be a full and equal citizen.

The key outcomes associated with this strategy are;

- Carers are actively sought and identified
- Carers are provided with appropriate up-to-date information, advice and guidance
- Carers receive Carers Assessments
- Carers are engaged and supported to plan for the future
- Carers' wellbeing is improved through the provision of emotional support
- Increased knowledge, skills and behaviours for Carers through training and development

- Carers Receive Health Prescribed support when appropriate

We have developed and approved a Carers Strategy "Caring Together". The plan focuses on three outcomes:

- Carers in Rotherham are more resilient and empowered
- The caring role is manageable and sustainable
- Carers in Rotherham have their needs understood and their well-being promoted

What are we going to do?

"Caring Together" is a partnership document recognising that Carers form an essential part of the overall health and social care offer within Rotherham and should have a voice in how they are supported. The strategy identifies 6 desired outcomes which have been developed with Carers:

1. Carers in Rotherham are more able to withstand or recover quickly from difficult conditions and feel empowered.
2. The caring role is manageable and sustainable
3. Carers in Rotherham have their needs understood and their well-being promoted
4. Families with young Carers are consistently identified early in Rotherham to prevent problems from occurring and getting worse and that there is shared responsibility across partners for this early identification.
5. Our children are recognised and safeguarded in their challenging role and receive appropriate intervention and support at the right time.
6. Children and young people in Rotherham that have young carer roles have access to and experience the same outcomes as their peers.

We will work collaboratively to commission services that meet the desired outcomes identified within the strategy.

12.7 A Single Health and Social Care Plan for People with Long Term Conditions

When done well, care planning can be effective in improving the quality of life of people with long term conditions. Over the next two decades, shifts in demographics and disease management will result in a greater proportion of people than ever before, living well into their eighth and ninth decades of life. The majority of these people will also be living with at least one long term condition. Ensuring their care is well managed over the long term, including the approach to the end of their lives, will become an increasing challenge for the CCG and the local authority.

One major barrier to supporting this cohort of is the fragmented approach to care planning. Health and social care still have separate systems for preparing care plans. Although communication and connectivity has improved between health and social care professionals, they are hampered by a requirement to have separate care plans.

The Cochrane Review on integrated care planning found that it leads to improvements in physical, psychological and subjective health. Integrated care planning also affects people's capability to self-

manage their condition. The studies showed that the effects were greater when it incorporated a single health and social care plan.

What are we going to do?

Rotherham will develop integrated health and social care plans for people on the long term case management programme. Now that social care and health records can be matched using the NHS number there is an opportunity to develop single care records and care plans. Using integrated care planning we can avoid duplication and multiple monitoring regimes.

12.8 A Joint Approach to Care Home Support

An important part of our new integrated locality model of care and of ensuring there are appropriate care solutions in the community, is the transformation of our care home sector. Approximately 15% to 18% of emergency admissions into the hospital are from care homes and the length of stay for these people tends to be higher than for average admissions. Most people want to be cared for in their own homes and we know that this is best for their wellbeing. Partnership with the care home sector is therefore critical to reducing demand for acute services. Our aim is for:

- Fewer admissions from care homes into hospital
- Patient length of stay to be more proactively managed through technology (e.g. automated systems from providers to case management systems to alert on bed availability)
- Less people to be automatically placed in care homes when they could stay in their own home and be supported within their community

A&E attendances and admissions from care homes have increased on previous years, the predicted outturn is currently 1503 (data to Oct 2016) against a target of 1250. This has significantly improved in the last three months from an average of 136 per month from April to June 2016 to 112 in August to October 2016. The number of those admitted after attendances is high and reflects the increasing level of complexity and acuity in those that access emergency care. On a positive note the number of emergency admissions out of hours is predicted to be under plan at 5232 against a target of 8760.

To help us achieve this, we will further develop our **care home support service** linking medical staff into care homes and also linking in with mental health liaison services (described in Section 4.3.1) and with the integrated locality team. Currently physiotherapy assessment is carried out in the hospital ward and then another one upon admission to the intermediate care beds. We plan to introduce a 'Trusted Assessor' model to streamline the assessment – defined as one person/team appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols.

We are also aware that a number of care home staffs remain uncomfortable in managing a care home resident who is frail and experiencing deterioration in their health due to an 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 to help **upskill staff in some of our care homes** and for them to develop a subspecialty interest in higher acuity patients in order to reduce transfers to different levels of care and also to facilitate earlier discharge from hospital. One option being

considered is to increase opportunities for care home staff to work within the hospital and develop the necessary skills to take back within the care home setting.

There are presently around 1,800 older people living in residential and nursing care homes in Rotherham. The number of residents is predicted to increase to 2,100 by 2020. This figure includes those residents that are financially supported by the Local Authority, self-funders and out-of-authority placements. Around 400 older people are admitted to residential care each year with complex needs.

Rotherham has a Care Home Support Service, funded through the Better Care Fund. The main aims of the Care Home Support Service are to:

- Ensure that the appropriate quality of care is provided in our residential and nursing homes
- Reduce A&E referrals, ambulance journeys and hospital admissions from care homes
- Meet the mental health needs of residents (via agreed Mental Health pathways)
- Develop personalised care planning residents at high risk of hospital admission
- Address health training needs of care home staff
- Ensure appropriate access to falls prevention services
- Promote healthy living initiatives
- Ensure quality of health and social care is being provided in residential and nursing care homes through contract compliance and care home support

What are we going to do?

We will carry out targeted interventions on residential and nursing homes who are outliers on emergency admissions. We will support GPs in the case management of patients who are at high risk of hospital admission.

These patients will be allocated a Care Co-ordinator from within the Care Home Support Service. The Care Co-ordinator will combine advanced clinical nursing and therapy practice with the co-ordination of personalised and integrated care plans. The Care Co-ordinator, alongside the Case Manager, will be responsible for co-ordinating the journey through all parts of the health and adult social care system.

We will support residential and nursing homes in meeting the needs of residents with organic and functional mental health problems. We will conduct an annual mental health assessment of all care homes. The assessment will identify residents with depression and dementia. We will monitor these residents, ensuring that they are sign-posted to appropriate health and adult social care services for support. We will identify residents who have memory problems and ensure that they are referred to the Rotherham Memory Service for a comprehensive dementia assessment.

We will deliver an extensive and comprehensive training programme agreed with CCG and the Council's commissioners. Training courses will include: safeguarding, communication and dementia, life story sessions, active ageing, Parkinson's disease, safe feeding, swallowing and positioning, peg feeding, falls management and prevention, diabetes, oxygen therapy, hand hygiene, chest infections/respiratory conditions, infection control, oral hygiene, continence, ophthalmic care, oral care, equipment assessment including installation, cleaning and maintenance and tissue viability including effective use of mattresses and pressure area care.

We will have clear protocols with Rotherham's integrated stroke care pathway so that patients discharged from the stroke unit into residential/nursing care receive continued support and are reviewed after 6 months. Such patients are likely to have substantially different needs from those who return to their own home so the focus of intervention will be different.

12.9 A Joint Approach to Care Home Fee Setting – Residential/Nursing/EMI/FNC/CHC

The Local Authority currently contract with 35 independent sector care homes to support older people in Rotherham. This includes a range of care types including residential, residential EMI, nursing and nursing EMI placements.

The independent sector care home market supplies around 1,779 beds and accommodates around 1,593 older people.

The Rotherham NHS Foundation Trust (TRFT) are required to carry out timely discharge of patients from acute beds to alternative forms of care and prevent admissions to acute bed capacity. A solution to increasingly complex care needs would be to increase nursing type capacity in the independent sector care home market. The high levels of occupancy in nursing type provision mean that there is a requirement to work with the Rotherham independent sector market to incentivise immediate growth in this area.

With this in mind, the Local Authority and the CCG need to develop a joint approach to fee setting of care home placements for residential, EMI, nursing, FNC and CHC placements in light of the increase in the National Living Wage since April 2016 and the introduction of compulsory employers' contributions to pensions from April 2018.

12.11 A Shared Approach to Delayed Transfers of Care (DTOC)

The number of recorded Delayed Transfers of Care (DTOC) from the December 2015 National DTOC report shows that 2.2% of transfers were delayed. This is significantly lower than the national average of 3.5%. There has been significant progress in the last 12 months to support the reduction in DTOCs within Rotherham.

Rotherham CCG and its partners will monitor DTOCs through the A&E Delivery Board. A&E Delivery Board endorsed a Memorandum of Understanding (MoU) (Appendix X) between Rotherham Foundation Trust, Rotherham CCG and the Local Authority on hospital discharge which was signed up to in 20161-7. The MoU covers DTOC and all other patients who are 'medically fit for discharge'. This figure for patients who are " medically fit for discharge" is usually higher than the DTOC figure, because it includes the following cohorts of patients

- Patients who require assessment for a new or existing care package (DTOC)
- Patients who need to have an existing care package restarted
- Patients who do not require a social care package
- Patients who may require a Continuing Health Care
- Patients waiting for an intermediate care or discharge to assess bed
- Patients who have been assessed as needing residential care but the actual home has not been selected.

The main purpose of the MoU is to ensure that patients are discharged as soon as they are medically fit and that they have the appropriate care packages in place which reduces the risk of readmission. We have developed robust reporting systems which incorporate data on DTOC and other patient cohorts who have an impact on patient flow.

What are we going to do?

We are currently reviewing the effectiveness of the MoU through audits of particular ward discharge process which will inform any future iteration of the document. This robust review process will make further steps to embed the Trusted Assessor model and provide evidence of the need for discharge co-ordinators on each ward (currently being piloted) to support the Transfer of Care Team (which incorporates the Hospital Social Work Team).

Future iterations will consider issues that expedite discharge, for example predicting times of discharge to enable effective community planning, the interfaces with integrated rapid response and management of MDT's for patients who change wards during their acute stay, effective discharges from Intermediate Care.

We will continue to work with partners through the "GP ward round" weekly meetings which has been successful in supporting complex discharges 2016-17. This is a multi-disciplinary meeting which brings together front-line staff and senior managers to focus on facilitating discharges from hospital. The main aims of the meeting are to remove barriers to discharge and identify systemic issues that restrict patient flow. The "GP Ward Round is a key vehicle for achievement of BCF Metrics. An example of success is that we have been able to reconfigure the provision of Keysafes from the local provider to ensure that complex patients can access a Keysafe within 24 hours of referral to expedite a discharge.

12.12 Relevance to The Health and Wellbeing Strategy

The BCF priorities will support the aims and objectives of Rotherham's Health and Wellbeing Strategy. Table 2 shows how the BCF priorities line up with those of the Health and Wellbeing Board.

Table 2: Relevance to Health and Wellbeing Strategy

HWB Aim	BCF Priority	Impact on HWB objectives
All Rotherham people enjoy the best possible mental health and wellbeing	A single point of access into health and social care services	• Improved support for people with enduring mental health needs, including dementia • Reduction in common mental health problems among adults • Reduction in social isolation
	Reconfiguration of the home enabling service	
	Integrated health and social care Teams	
	Shared approach to delayed transfers of care (DTOC)	
Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reduced	Preventative services that support independence	• Reduction in early death from cardiovascular disease and cancer • Improved support for people
	Consideration of the development of a specialist reablement centre	

HWB Aim	BCF Priority	Impact on HWB objectives
	incorporating intermediate care	with long term health and disability needs
	A multi-disciplinary rapid response service	
	A single health and social care plan for people with long term Conditions	
	A joint approach to care home support	

12.13 Milestones and Timelines

This section of the BCF Plan maps out the key milestones associated with the key priorities.
Table 3 sets out the key milestones for delivery of this strategy.

Table 3: Key Milestones

Priority	Description	LEAD	Milestones 2016	Date
1	A single point of access into health and social care services; including the integration of Integrated Rapid Response		Project Group established of senior leads across CCG, Council, RDaSH, Primary Care	01.01.17 **Completed**
		Project Group	Scoping and planning expansion of services to other health and social care services	30.09.17
		Project Group	Agreement of expansion and service reconfiguration	31.10.17
		Project Group	Service reconfiguration begins	01.11.17
		Project Group	Evaluation of new models	01.04.18
2	Development of integrated health and social care teams		Development of project group – RDaSH, CCG, Council, VAR, TRFT senior leads	01/01/17 **Completed**
		TRFT – with partners	Development of Standard Operating Procedures, Job descriptions, process mapping	01.06.17
		TRFT - with partners	Analysis of demographics and population need across Rotherham and specific to locality area, to inform roll out model.	01.06.17
		External support	Evaluation of pilot	01.07.17
		Project Group	Roll out of the integrated locality teams across Rotherham	01.01.18

Priority	Description	LEAD	Milestones 2016	Date
		Project Group	Care Home transformation timecscales to be defined as part of project group	01.6.17
3	Consideration of a Specialist Reablement Centre incorporating intermediate care beds		Project Group established of senior leads across CCG, Council, RDaSH, Primary Care	01.01.17 **Completed**
		Project Group	Further review of Intermediate Care model incorporating Nurse-Led provision	31.05.17
		Claire Smith	Review of acute and community respiratory pathways	31.05.17
		Project Group	Proposals for future development of Reablement Centre	31.07.17
		Project Group	Service reconfiguration begins	01/01/18
4	Preventative services that support independence	Karen Smith RMBC	OT Review approved by BCF Executive	17.02.17
		Karen Smith RMBC	New service model agreed by BCF Executive	17.2.17
		Karen Smith RMBC	Project plan agreed for implementation of new service model	17.2.17
		Karen Smith RMBC	New service model fully operational	01.04.17
		Karen Smith RMBC Claire Smith CCG	ICES and Wheelchair Review approved by BCF Executive	23.05.17

Priority	Description	LEAD	Milestones 2016	Date
		Karen Smith RMBC Claire Smith CCG	New service model agreed by BCF Executive	23.05.17
		Karen Smith RMBC Claire Smith CCG	Project plan agreed for implementation of new service model	23.05.17
		Karen Smith RMBC Claire Smith CCG	New service model fully operational	01.07.17
5	Reconfiguration of the home care enabling service	Chris Corton RMBC	Home care enabling Review approved by Adults Transformation Board	31.07.16
		Chris Corton RMBC	New service model agreed by Board	31.07.16
		Chris Corton RMBC	Project plan agreed for implementation of service model	01.10.16
		Chris Corton RMBC	New service model fully operational	01.04.17
7	Single health and social care plan for people with long term condition	Dawn Anderson CCG	Scoping exercise completed on integrated care plan	01.09.16
		Dawn Anderson CCG	Develop common template for case management	31.11.16
		Dawn Anderson CCG	Develop IT solution for sharing care plan across systems	31.12.16
		Dawn Anderson	Implement integrated care plan for case	01.04.17

Priority	Description	LEAD	Milestones 2016	Date
		CCG	management	
8	A joint approach to care home support	Karen Smith RMBC	Development of care coordinator role	01.04.17
			Introduction of annual mental health assessments	01.06.17
			Development of a targeted care home training programme	01.09.17
			Introduction of protocols for stroke patients in care homes	01.09.17
9	Shared Approach to Delayed Transfers of Care (DTOC)	Dominic Blaydon	Review of implementation of MoU through audit of a ward	01.03.17
		Dominic Blaydon	Review findings from pilot of discharge coordinator on one ward to link with Transfer of Care Team and recommendations for future model	30.06.17
		Dominic Blaydon	Examine assessment process to streamline and integrate functions of health and social care	30.06.17
		Dominic Blaydon	Further work to embed “trusted assessor” role to reduce duplication and improve patient flow	30.06.17

13 National Conditions

13.1 Supporting Social Care Services

Rotherham's BCF Plan supports social care in three ways;

- Ring-fencing resource in the BCF budget for social care activities that support health outcomes
- Supporting integration, reducing duplication and generating efficiencies that can be reinvested
- Enlisting the support of the 3rd sector through effective social prescribing

Ring-Fencing

Theme 3 of Rotherham's BCF Service directory is "Supporting Social Care " This identifies a range of social care services that are strategically relevant and performing well. Decisions on future funding can only be taken if agreed between RCCG and RMBC. More importantly there would have to be drift in relation to performance or strategic relevance to precipitate a decision to remove these services. There has been no reduction in the funding made to this category of service from the 2015-16 BCF plan, the main difference is how the services have been categorised into 6 new Themes as discussed earlier in the plan.

Supporting Integration

Rotherham's Better Care Fund Plan includes a range of initiatives which support joint working across health and social care. These include; integrated locality teams, the care home support service and social care assessment beds. All these initiatives support social care by using resources from partner organisations to achieve social care outcomes. For example, the integrated locality teams will be responsible for initiating and reviewing social care assessments. Social workers will be able to access therapists and other health care professionals to assist with these assessments, delivering a more holistic service and reducing duplication.

3rd Sector Support

The Rotherham Social Prescribing Programme is funded through the Better Care Fund. The service protects social care because it intervenes early, before the need for formal care services. The Social Prescribing Service addresses directly those social needs that arise after significant life events; e.g. after loss of a partner or after diagnosis of a long term condition. The service promotes self-care, community integration and a holistic approach to care planning. There is local evidence that it has successfully reduced the cost of social care packages. Even where someone already has a social care package in place, the service can play a complementary role, reducing levels of dependence, maintaining engagement with informal support networks and boosting resilience.

13.2 Disabled Facilities Grant

The Disabled Facilities Grant is embedded within the 3 year Housing Investment Plan (HIP) which is approved by members. The funding is used for the provision of adaptations to disabled people's homes to enable them to live independently and to improve their quality of life. This will include the provision of Assistive Technology from 2016/17 due to the ending of the PSS Capital Grant in March 2016. The Strategic Director of Adult Social Care and Housing has been fully involved in the

development and approval of the BCF plan for 2017/19 and is a member of the Health and Wellbeing Board, BCF Programme Board and BCF Executive Group. Both the Boards and group includes representatives from the CCG including the Chief Officer and Chief Finance Officer. This ensures there is a joined up approach in improving outcomes across the health, social care and housing sector.

Assistive Technology

Assistive Technology is one way which can support people to live independently in their homes/accommodation for as long as possible. Assistive technology promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish, or had great difficulty accomplishing, by providing enhancements to, or changing methods of interacting with devices needed to accomplish such tasks. Examples of assistive technology include standing frames, text telephones, accessible keyboards, large print, Braille and speech recognition software.

We would like to encourage providers to think about technology devices which can be used to support people and their carers. The Local Authority will ensure for people who access support and services, assistive technology will be a consideration as an option identified in their support plan identified through the assessment process. This can also be used as a preventative measure to keeping people at home. Currently we support people with physical and sensory disabilities, and older and frail people through aid and devices.

There are many technology solutions which provide innovative and bespoke packages depending on the individual need and their family's needs and aspiration; this can be achieved through exploring a holistic approach to care and support. Rothercare (Local Authority 24/7 contact centre) is leading on assistive technology for Rotherham and will be identifying numerous ways of expanding the use of technological equipment.

The term "assistive technology" also includes technology that enables the use of automatic, remote monitoring of emergencies as they happen, as well as general practical equipment. The ranges of options are:

- raising an alarm through to a monitoring system in cases of emergencies such as falls, or
- standalone equipment which does not send signals to a response centre but supports carers through providing local alerts in a person's home, to let the carer know when a person requires attention.

The assistive technology is a crucial element of support for our clients especial for those with disabilities which will include sensory impairment. It enables people to still lead equal and independent lives, feeling safe in their own home, community and enable them to remain in the community.

13.3 Delivery of 7 Day Services Across Health and Social Care

Health and social care both recognise the need to improve the process for planned hospital discharge for vulnerable adults. At any one time, there are a number of patients in an acute bed, whose medical episode is complete, but who are awaiting further assessment, initiation of a care

package or decisions on choice of a care home placement. The following services, funded through BCF operate 7 days/ week.

Integrated Rapid Response Service (IRR)

The IRR service supports people who are unable to remain at home because they have a temporary health and/or social care need. The service supports people to remain at home until they have recovered or until a long term care plan can be put in place. The service operates 7 days/week, 24 hours/day. It provides immediate support to patients who exacerbate in the community and has access to community beds which are also available 7 days/week.

Intermediate Care

Intermediate Care Services in Rotherham now receive referrals 7 days/week. Historically hospital discharges could only take place during the working week. Extending the time frame for referrals supports timely discharge and can prevent admissions during the weekend. There is a specialist Mental Health OT and CPN which carry out assessments and management of mental health for individuals whose needs affect their function and ability to undertake rehabilitation. This service also covers the Integrated Rapid Response service.

Hospital Social Work Service

The Hospital Social Work team can now carry out social care assessments and co-ordinate packages of care 7 days a week. Domiciliary care providers are also now contracted to respond to urgent referrals on a 7 day a week basis, delivering urgent packages of care.

A 7 day community, social care and mental health pilot to support hospital discharge and reduce delays has now been operational since December 2015. The hospital and Hospital Social Work Team now provide a joint approach to assessments and care planning on a 7 days a week basis. This new pathway also reduces length of stay in hospital medical wards.. The 7 day social care working is now fully in place and embedded at the hospital with on-site social care assessment available to support patients. This has become “business as usual” from October 2016, following the implementation of a social care restructure. Support over the full 7 days is provided by the same core team, ensuring that there is consistency of process over this period. Additional support over and above the dedicated resources identified can be accessed through the out of hours service on an as needed basis.

Rotherham Equipment and Wheelchair Service

A review of the Integrated Community Equipment Service will be carried out in 2016/17 which will identify demand for community equipment to facilitate hospital discharge, in particular over the weekend. A review of the satellite office provision enabling practitioners to collect health and social care equipment will also be carried out.

Mental Health Liaison Service/Learning Disability

The Adult (including older peoples) Mental Health Liaison Service pilot will continue in 2017/18. This service is to be externally evaluated by Sheffield Hallam University (SHU) in 2016-17. This service in conjunction with the Crisis Team provides a 7 day service. There are also several other health and social care commissioned Mental Health and learning disability Services that provide 7 day services

to support this agenda that are not currently part of the BCF programme but contribute to meeting the objectives of the BCF.

13.4 Improving Data Sharing Between Health and Social Care

Improved data sharing between health and social care is a national condition of the Better Care Fund. All BCF adult social care records now have an NHS number assigned. The health and Well Being Board has agreed that the NHS number be used as a primary identifier.

The new social care system is now live. Early in 2017 we will be integrating the new system with the NHS "Patient Demographic Service" (PDS) allowing access to NHS numbers on the NHS spine. Whilst we are awaiting for that facility to go "live" we will add new NHS numbers manually and continue to use the local informatics team matching bureau for batch processing.

An operational data sharing agreement has now been developed and agreed by the CCG and Local Authority (Appendix 7) which sets out how data can be seen, when and how the data will be used. This ensures that Information Governance controls are in place for information sharing in line with Caldecott 2.

Training materials have been issued which demonstrate to practitioners in adult social care how to use the NHS number field. This includes mechanisms for maintaining the NHS number. A weekly report is issued to managers detailing the number of NHS numbers updated each week. Managers are reminded to encourage practitioners to check/complete the NHS number field, wherever possible.

We will continually improve data sharing between health and social care through the use of NHS numbers in all correspondence. The use of the NHS number is an important stepping stone towards our main objective, the rapid and easy exchange of data between health and social care.

Rotherham MBC's strategy "Your Digital Council (Appendix 8) highlights the continuing importance of a digital infrastructure. This includes "broadband, online services, access and skills". The strategy describes opportunities which digital offers and the dependencies that exist between a strong economy, social well-being and modernised public services. The strategy includes the following commitments:

- Partners have developed a NHS "Local Digital Roadmap", ensuring that all electronic health and social care records are interoperable and ultimately paperless
- NHS staff will have real-time access to local authority client data where it is appropriate and legal to do so
- Local authority staff will be able to access NHS systems where it is appropriate and legal to do so, creating a single view of the Rotherham citizen
- Partners will work together to create a common sets of standards, which support the sharing of data cross local services. This will be enhanced by the adoption of a common identifiers such as NHS numbers and unique property reference numbers.
- Partners will work together to develop a web portal that allows multiple data sources to be interrogated from one location

The CCG and Local Authority have long recognised the importance of open APIs (application programming interfaces) in facilitating data sharing between systems and we have a long standing policy of mandating that suppliers provide open APIs wherever possible. The new social care system

includes access to open APIs. Similarly the NHS has written the provision of open APIs in to the current national contract for the supply of GP clinical systems.

One of the commitments of the Rotherham CCG IT Strategy (2016/18) is to develop a clinical portal that will integrate information from health and care services across the local health community. As the system is developed it will give professionals access to all the data and information they need to deliver safe, high quality care. We also aim to develop patient access to the portal allowing them a common view of their health information for Rotherham health and care services. Work on the clinical portal has been on-going since June 2015. A single view of a patient's secondary care information has been developed and this has been linked with risk stratification data to provide a system for GPs to view the hospital activity of their patients who are at a high risk of hospital admission. In addition GPs can view details of their patients who have been admitted to hospital, attended A&E and recently discharged patients. There is also the capability to see safeguarding flags.

The clinical portal has been made available in Rotherham Hospice allowing their clinicians to view secondary and community care records.

The Detailed Care Record Service of the Medical Interoperability Gateway (MIG) has been developed for primary care data to be viewed in the clinical portal. GP Practices have been contacted with guidance on how to register to gain access to the clinical portal. Over the period of this plan we will develop the clinical portal to provide end of life information, ensuring information governance is place to ensure security and confidentiality.

We will carry out a feasibility study for development of the patient portal. This will a provide results tracker for chronic patients and an ability to sign-post patients to appropriate service.

The use of integrated records, information and technology will support the reduction of unnecessary non-elective hospital admissions, promote 7 day working, support out of hospital/community based services and facilitate timely hospital discharge.

A joint working group known as "Rotherham Health and Care Interoperability Group" is in place. The membership of the group includes clinicians, GP's, Directors, IT Programme Managers from the Local Authority, CCG, TRFT, RDaSH and Rotherham Hospice. This group is the "parent" to a subsidiary group which is the "Information Governance Sub-Group" which ensures that all aspects of data sharing are properly considered at every stage of the development of our Local Digital Roadmap (which the BCF will form an important part of).

An Overarching Information Sharing Protocol is in place – this is a Tier 1 agreement that was created through the Council's 'Corporate Information Governance Group' and has been adopted across the local partners. In addition we have a specific Tier 2 agreement relating to data sharing for the BCF initiative. An inter-agency information sharing protocol that covers public sector organisations across South and West Yorkshire has been proposed as a successor to the current Rotherham information sharing protocol and this is currently undergoing approval across Rotherham's local partners.

All relevant IG controls are in place and we are fully compliant. RMBC is accredited against the PSN code of connection. Further, the Council complies with and meets Caldicott requirements via our submission to the IGSoC and via the IGToolkit

As part of our Local Digital Roadmap programme we have developed a communication and engagement plan (Appendix 10). This plan has yet to be formally signed off and the communication described within has yet to begin.

At the heart of all the communications on these issues is our desire to ensure that citizens are educated and comfortable with regards to the way their data is being used. Throughout the campaigns we will put the following principles front and centre:

- Explain to people why data is being shared between partners and how this will benefit everyone
- Ensure that local people have clarity about how data about them is used – this will include
- Description of the personal confidential data shared
- Description of the de-identified data shared on a limited basis
- Explain who may have access to their data (i.e. who we are sharing with)
- Explain how people can exercise their legal rights with regards to their data

14. Measuring Success

14.1 BCF National Metrics

As part of the Better Care Fund Plan we will measure against the national metrics and Rotherham's agreed local metrics. The BCF Policy Framework establishes that the national metrics will continue as they were set out for 2015-16. In summary these are:

a. Non-elective admissions (General and Acute)
b. Admissions to residential and care homes
c. Effectiveness of reablement
d. Delayed transfers of care

The detailed definition of the non-elective admissions (NEA) metric is set out in the Planning Round Technical Definitions. The level of non-elective activity which BCF plans seek to avoid, in addition to reductions already included within the calculation of CCG operating plan figures, are clearly identified in the BCF planning return. The detailed definitions of the other three metrics are set out in Table 4

Table 4 – BCF Metrics Definitions

	Metric	Numerator	Denominator
2	Admissions to residential and care homes	The sum of the number of council-supported people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year. Data from Short- and Long-Term Support (SALT) collected by HSCIC	Size of the older people population in area (aged 65 and over). This should be the appropriate ONS mid-year population estimate or projection

	Metric	Numerator	Denominator
3	Effectiveness of reablement	Number of older people discharged from acute or community hospitals to their own home or to a residential home for rehabilitation, with a clear intention that they will move on/back to their own home who are at home 91 days after the date of their discharge from hospital.	Number of older people discharged from acute or community hospitals to their own home or to a residential home for rehabilitation, with a clear intention that they will move back to their own home.
4	Delayed transfers of care	The total number of delayed days (for patients aged 18 and over) for all months of baseline period	ONS mid-year population estimate (mid-year projection for 18+ population)

Non-Elective Admissions

The metric reflects the overall CCG plan as submitted to UNIFY2 on the monthly activity template. The UNIFY2 submissions have been triangulated with current contract plans. There is the wider footprint of the South Yorkshire and Bassetlaw STP to take into consideration. The setting of CCG plans has been undertaken with consideration to previous year's activity levels, in the context of the 2016/17 financial challenge.

Delayed Transfers of Care (DTOC)

The Delayed Transfers of Care Plan is set to a level of realistic achievement within the financial challenge of 2017/19. Trend analysis has been undertaken prior to the setting of targets. The Delayed Transfers of Care Plan has set a target which is realistic within the challenges anticipated from demographic and service changes.

Permanent admissions of older people to residential and nursing care homes (per 100,000)

Rotherham MBC year end outturn for 2015/16 resulted in 68 fewer admissions compared to 2014/15. An outturn of 401 admissions equates to a rate of 819.52 per 100,000. Further improvements through BCF initiatives will potentially deliver an additional reduction of 20 admissions next year giving an estimated total of 390 for the year. This results in an overall rate of 767 per 100,000. These figures take account of the increase in admissions rate resulting from the definition change in 2014/15. It also takes account of the estimated increase in the over 65 population for 2016/17.

Proportion of older people still at home 91 days after discharge from hospital into rehabilitation and reablement services

Rotherham MBC 2015/16 year end outturn was 89.6%, which reflects an increased number of people benefitting from using rehabilitation and reablement services in 2015/16. This improves on our 2014/15 score of 83.5% but is just below our target of 90%. Rotherham MBC estimates that

improvements to our service 'offer' will result in further improvement in 2016/17, making a target of 91% realistic. There is a need to strengthen our analysis on the longer term trend, in order to provide evidence based findings that support our projections.

Proportion of older people still at home 91 days after discharge from hospital into rehabilitation and reablement services

Rotherham MBC is projecting a year end outturn of 89.6%, which reflects an increased number of people benefitting from using rehabilitation and reablement services in 2015/16. This improves on our 2014/15 score of 83.5% but is just below our target of 90%. Rotherham MBC estimates that improvements to our service 'offer' will result in further improvement in 2016/17, making a target of 91% realistic. There is a need to strengthen our analysis on the longer term trend, in order to provide evidence based findings that support our projections.

In-patient Experience – proportion of people reporting poor patient experience of in-patient care

The 2014 score was published in late 2015 showed an improvement beyond the 2015/16 plan, with a score of 115.9. Current plan is to sustain this level of achievement. Numerator and denominator are not available until published nationally.

14.2 Impact on Local Metrics

Rotherham CCG Commissioning Strategy

The CCG Delivery Dashboard incorporates metrics which the BCF has an impact on:

- Number of patients admitted to hospital for non-elective reasons discharged at weekends/bank holidays
- Health related quality of life for people with long-term conditions
- Proportion of people being supported to manage their condition
- Proportion of deaths at home
- Hospital spells resulting from fall-related injuries patients aged 65 and over
- Additional years of life secured in conditions considered amenable to healthcare.
- All people over 65 or those under 65 living with long term conditions have their own co-ordinated care plan where the priorities set by the individual are supported by the care that they receive, resulting in improved health related quality of life.
- Emergency admissions and length of stay reduced by managing care more proactively in other settings.
- Proportion of people having a positive experience of care in all settings increased.
- Parity of esteem for people suffering with mental health conditions alongside those with physical health conditions

RMBC Adult Social Care Metrics

A number of Key Performance Indicators from the Adult Social Care Outcomes Framework (ASCOF) will be supported by the initiatives identified in the BCF Plan as will some local performance measures and include the following:-

- Proportion of people using social care who receive self-directed support and those receiving direct payments
- A range of Service User and Carer survey ASCOF measures for example: reporting that they have a good quality life, the proportion of people who use services who feel safe, social care service users who feel they have control over their daily lives.
- Proportion of people aged 65 and over requiring social care support, plus impact on ASCOF relating to employment, settled accommodation, delayed transfer of care and rehabilitation measures.
- Supported housing placements - Learning Disability (18-64)

RMBC Corporate Plan

The Local Authority's Corporate Plan also measures:

A number of Key Performance Indicators from the Local Authority's Corporate Plan will be supported by the schemes funded by the Better Care Fund as follows:

- Number of people provided with information and advice at first point of contact (to prevent service Needs).
- Proportion of carers in receipt of carer specific services who receive services via self-directed support.
- Number of carers assessments completed.
- Proportion of new clients who receive short-term (enablement) service in year, with an outcome of no further requests for support.
- Number of adults with learning disabilities supported into employment, enabling them to lead successful lives.
- Improved satisfaction levels of those in receipt of care and support.

15. Impact Assessment

Table 5 provides a summary of the impact that BCF Change Programme will have on patients and the local health economy. We expect our changes to improve the delivery of NHS services. Specifically, we expect them to reduce activity in acute care, reduce reliance on formal social care, increase access to primary and community services and improve outcomes for people with long-term conditions.

If we do not deliver activity reductions in acute and social care, we anticipate significant financial pressures in the local health and social care economy. We anticipate that the changes proposed will have a significant impact on community services. Statutory and independent providers of health and social care will be partners with us in delivering this Better Care Fund Plan.

Rotherham partners have a commitment to ensuring that the impacts of our local plans are understand throughout organisations.

Table 5: Summary Impact Assessment

No.	Project	Patients and Service Users	Providers and Local Health Economy	BCF Metrics
1	Single point of access into health and social care services	• People can access the right care first time • Reduced duplication of assessments and visits to patient homes through better care co-ordination • Facilitates discharge and prevent unnecessary admission • Can respond to people who require support after using the community alarm system	• More controlled access to urgent care services • Reduces the time currently spent by the referrer in identifying and arranging appropriate care. • Improved access for professionals to a range of services. • Health professionals can make informed choices about the most appropriate level of care	• Non-elective admissions • Effectiveness of reablement • Delayed transfers of care
2	Integrated Health and Social Care Teams	• People don't have to re-tell their story every time they encounter a new service • People get the support they need because different parts of the system are now talking to each other • Home visits from health or care workers are combined	• Professionals can support patients to stay at home and minimise the need for hospital admission to hospital. • Increase in face to face clinical time. • Improved organisational reputation through delivering a responsive service and providing alternative to acute admissions.	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of care
3	A Reablement Hub Incorporating Intermediate Care	• Single rehabilitation coordinator who supports individual through whole care pathway • All therapists and carers on-site and accessible • More holistic approach to rehabilitation	• Generates efficiencies that can be reinvested • Reduced length of hospital stay for step-down patients • Greater impact on reducing hospital admissions because of increased use of	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of

No.	Project	Patients and Service Users	Providers and Local Health Economy	BCF Metrics
			step-up beds	care
4	An Integrated Carers Support Service	• Better access to benefits, information and advice • Reduction in social isolation for both carer and those being cared for • Improved health and well being	• Reduced likelihood of carer breakdown, which could lead to increase in costs of formal care • Care being used effectively as a resource to support people with long term conditions • Reduction in cost of social care packages	• Non-elective admissions • Admissions to care homes
5	A Single Health and Social Care Plan for People with Long Term Conditions	• One plan covering all aspects of care • Less confusion and duplication • Includes support with self-management and urgent response	• Greater visibility of what other professionals are doing • Reduces risks that arise from fragmentation of service • Reduction in bureaucracy	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement
6	A Joint Approach to Care Home Support	• More likely to see and treat at home • Single care coordinator who can support a resident throughout their stay • Better quality care and holistic approach	• Specialist team will have correct skill set to support people in residential care • Case management approach to care in residential homes • Better support for care home staff	• Non-elective admissions • Effectiveness of reablement • Delayed transfers of care
7	A Shared Approach to Delayed Transfers of Care (DTOC	• Shorter hospital stay • Better quality care packages delivered in a timely manner • Reduced risk of readmission	• Better patient flow through the hospital • Reduction in cost of acute care • Reduction in readmission costs for RFT	• Delayed transfers of care

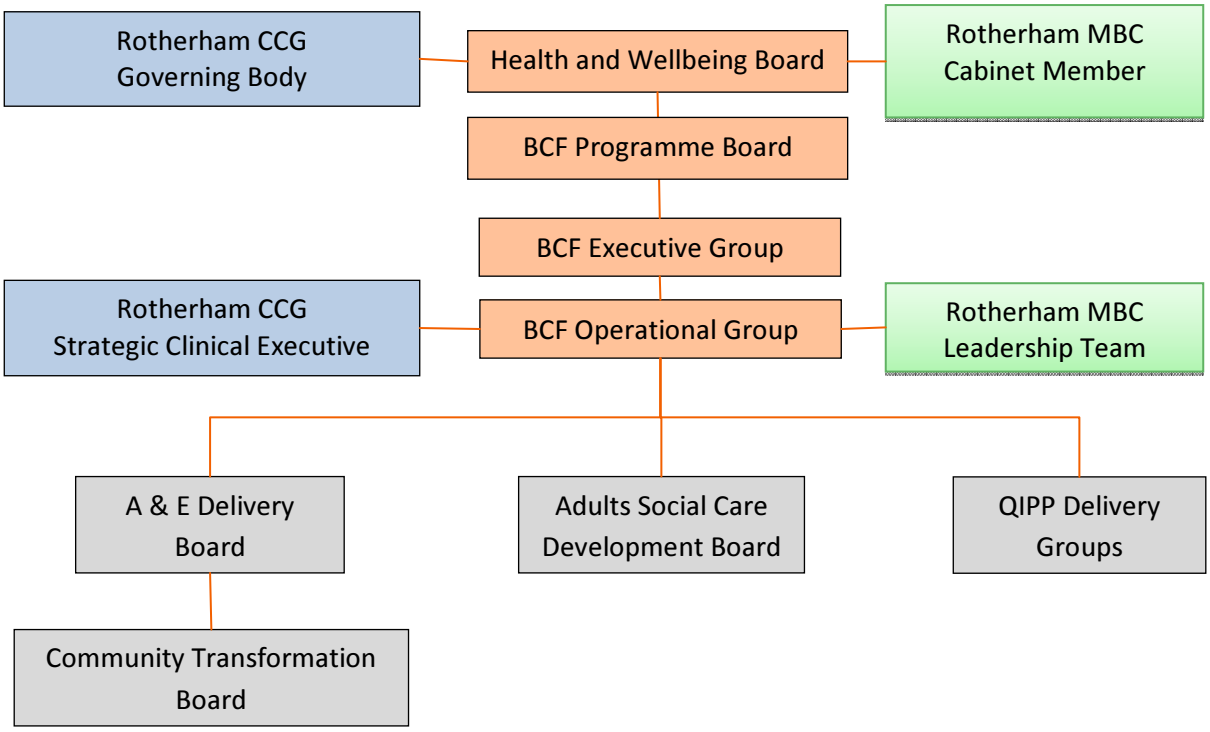
16. Governance Arrangements

16.1 Description of Current Governance Framework

The delivery of the BCF is fully integrated with the delivery of the Health and Wellbeing Strategy. In Rotherham the Health and Wellbeing Board has overall accountability for the BCF Plan.

Figure 4 sets out the current governance arrangements.

Figure 4: Current BCF Governance Structure



Role of Health and Wellbeing Board

Key responsibilities of the Health and Well Being Board include;

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

Role of BCF Programme Board

Key responsibilities of the Programme Board include;

- Agree strategic vision and priorities for the future
- Make decisions relating to the delivery of the plan

Role of BCF Executive Group

The BCF Programme Board is supported by the BCF Executive Group, which has been meeting since July 2015. Both Board and Group consist of Chief Executives, Elected Members, Chief Finance

Officers, Directors from both the Local Authority and the Clinical Commissioning Group. Key responsibilities of the Executive include;

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

Role of BCF Operational Group

The BCF Executive Group is supported by the BCF Operational Officer Group which meets every 6 weeks. The Operational group is made up of the identified lead officers for each of the BCF priorities, plus other supporting officers from the council and CCG.

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

16.2 Review of Governance Framework

During 2016/17 The Health and Wellbeing Board will review the current governance arrangements. The review will identify where there are areas of duplication and put forward proposals for a streamlined governance framework that incorporates all elements of the commissioning cycle.

The review will make recommendations on a joint performance framework so that we can build on the outcomes of the service review and continue to monitor the performance and strategic relevance of BCF funded services.

The review will incorporate the development of a full suite of combined health and social care metrics for those services that have been integrated. The new governance framework will show clearly where joint decisions are made. It is really important that there is full visibility in relation to the decision making process. A streamlined and coherent governance framework will speed up decision making and create a positive environment within which commissioners collaborate.

17. Risk Assessment

Table 6 provides a summary of the risks associated with the development of the Better Care Fund

Table 6: Major Risks to BCF Action Plan

KEY				
Consequence score				
1 Negligible	2 Minor	3 Moderate	4 Major	5 Extreme
Likelihood Score				
1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
Strategic Risks					
1	Poor alignment between service budgets and actual cost; resulting in overspend	4	3	12	The review process timetabled throughout 207-18 will ensure the alignment of budget with actual costs. Monthly budget monitoring is in place and reports are regularly taken to the Operational and Executive groups regarding finance and any risks which require mitigation.
2	Shortfall of resources to fund the priorities identified in the plan	3	4	12	As above. The review process will seek to identify areas where budgets can be appropriately aligned to BCF priorities; this may include

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
					reconfiguration of service provision in year.
3	BCF services are not 'fit for purpose'	4	3	12	New governance and performance framework will highlight those services that are not performing and set out a new structure for performance management
4	The introduction of the Care Act will result in a significant increase in the cost of care provision onwards that is not fully quantifiable currently	4	4	16	The financial implications of the Care Act have been included in the financial plan (£0.7m) Work to address Care Act compliance is incorporated in Adult Social Care Development Board Programme. Various models have been populated and provided evidence of demand for additional assessments (including carers' assessments and respite) at an approx cost of £0.850m. This information ensured that sufficient funds were established in 2015-16 and remain in BCF for 2016-17.
5	Operational pressures restrict capacity to implement key projects identified in the BCF Plan	4	5	20	Our schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development. BCF Ops Group will oversee implementation of the 2017/18 programme, identifying areas where operational pressures are impacting on implementation and developing targeted strategies to free up the change process. Monitoring template in place for all BCF reviews and will be taken to Operational Group meetings to ensure early identification the risks associated with implementation/achievement.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
7	Failure to achieve planned savings due to overspends in the system/ inability to meet targets will create financial risks (budget pressures) for the respective parties	3	5	15	Performance management framework via the A& E Delivery Board in place to monitor progress to ensure targets are achieved. Good forward planning with providers on activity reductions through regular contract performance meetings. BCF Operational Group will oversee implementation of the 17/18 programme. If service improvements do not have the intended impact on hospital and care home admissions the BCF Operational Group will make recommendations on where service restrictions should apply, ensuring that the programme remains within budget.
8	Achieving savings in one area of the system, can cause unintended consequences of higher costs elsewhere.	3	3	9	All partners have made a commitment to ensure that if evidence of these consequences is seen, cash will flow to the right place across the system that all partners will benefit from. Both partners have agreed a 'risk pool' of £500K which has been included in the financial plan to mitigate the risk of non-delivery of non-elective savings and social care packages. The "risk pool" forms part of the BCF plan, which can be used if the plan results in any unfunded consequences on any part of the system. The BCF plan is monitored on a quarterly basis by the BCF Executive group, and any consequences will be reviewed.
9	Failure to meet the national conditions and performance outcomes agreed with NHSE	3	5	15	Joint governance arrangements and new performance framework will help mitigate this risk. Financial risk sharing is in place through the Risk Pool.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
10	Lack of engagement from front line staff because do not 'buy in' to the integration agenda or lack the skills	3	4	12	Changing organisational structure is not sufficient to achieve integration. We will work with local education and training institutions and with service providers to develop integrated ways of working and behaviours to transform the quality of health and social care. Strong links are in place with all partners' communication teams to ensure that change management occurs in the most effective and transparent way.
11	Social care not being adequately protected	3	5	15	No change in 2016-17 to the services that were identified in the BCF plan 2015-16 as fundamental to the protection of Social Care. BCF governance groups to take regular stock-take on current state of social care provision. Regularly review strategies for how the BCF can be enhanced to protect key services, particularly those that support admission prevention and reductions in formal social care.
12	Governance arrangements are insufficient to make investment decisions, ratify the vision and deliver key metrics	3	4	12	Governance arrangements scheduled for review this year. Programme has clearly defined purpose. Full engagement at CEO level. Clearly defined process for decision making with appropriate scheme of delegation. Clear system for disagreement resolution. Rules on data and performance management agreed.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
Performance Risks					
13.	*Non-elective target not met;* BCF Schemes do not deliver the planned reduction in non-elective admissions resulting in higher cost. This is complementary to the programme within the A&E Delivery Board which focuses upon avoiding emergency admissions amongst other wider system issues of the CCG.	4	5	20	BCF commissioning intentions and investment in a number of work-streams have already taken place in 2015/16 including Integrated Rapid Response, Care Co-ordination Centre. The focus on out of hospital services will continue in 2016/17 through the BCF plan including Integrated Locality Pilot, rehabilitation and re-ablement hub.
14.	*Residential Care target not met;* BCF Schemes do not deliver a reduction in permanent admissions to residential care increasing costs to the LA. This may be due to delays in implementation of schemes i.e.	3	3	9	BCF Schemes aligned with Care Act (2014) and Joint Health and Wellbeing Strategy 2015-19. Change Management leads have been appointed to ensure successful implementation of projects that will complement the BCF objectives. Any delays in scheme progress will be mitigated by appropriate Working Groups including closer working relationships with Housing.
15.	*Delayed Transfers of Care (DTOC) target not met*; BCF Schemes do not deliver the planned reduction in DTOC which will result in higher cost to the CCG and/or The Rotherham Foundation Trust. This may be due to poor collaboration/ communication between health and social care staff or ineffective/ insufficient out of hospital services i.e. intermediate care.	3	3	9	Review of pathways from hospital to community to ensure that they meet patient demand and are fit for purpose is underway. Action planning taking place to reconfigure services as part of the review process. This includes development of social care assessment beds, changes to the hospital discharge team to support integration. A& E Delivery board objectives complement the Better Care Fund objectives. Memorandum of Understanding in place which ensures a clear, effective integrated discharge process which considers both hospital and community and cross sector provision.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
16.	*BCF schemes are delayed;* Delay in implementation of BCF schemes results in underspends, creates inefficiencies in service delivery and hinders integration. There is likelihood that targets will not be met if scheme implementation is delayed.	2	3	6	Regular reporting on progress of all BCF schemes through the BCF Operational and Executive Group Meetings to ensure that underspends are managed and risks mitigated through the risk share agreement. A review of BCF schemes has taken place which identified those schemes requiring a deep dive review to be undertaken in 2016-17.
OPERATIONAL RISKS					
17.	*Data sharing between health and social care;* Target on number of patients with NHS identifiable number is not met. This is a national condition, in not meeting the target there would be significant impact on the ability for integration /communication.	2	3	6	The officer lead for this objective at RMBC has provided updates at every operational group meeting throughout the 2016-17 and has given assurance that this target has been achieved.
19.	*Community Services;* BCF schemes increase demand on community services resulting in increased waits for health and social care assessments/ services	3	4	12	The BCF has identified new funding for social care and this will be reviewed as part of the work plan for 2016/17. Investment in community transformation programme through the CCG in 2015-16 will provide more targeted resource into the community in order to better meet demand.
20.	*Rotherham Population;* Schemes not targeted at the right populations resulting in pressures on the acute services	1	3	3	Using Joint Strategic Needs Assessment, Commissioning Plans/Strategies to support rationale for scheme development – incorporating intelligence of local population and demand in to service specifications to target appropriate cohorts of patients. Review of service implementation takes place once a scheme is up and running. Performance, quality and outcomes

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
					regularly monitored through performance submissions and meetings with providers.
QUALITY RISKS					
21.	*Provider destabilisation;* Shifting of resources could destabilise current service providers. For example force viability issues due to loss of funding in one area, cause issues with performance against contracts.	2	4	8	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. CCG received Quality Impact Assessments from providers regarding their respective efficiency plans. LA will continue to engage with providers to ensure potential impact is understood and planned for.
22.	*Carers;* Risk that BCF impacts negatively on the support and experience of carers leading to a reduction in the number of carers. Carers may not be supported to continue to care through the various services currently in place, or the new services implemented, i.e. 7 day support for adult social care. If they cease to care this could result in increased costs for the LA and CCG	2	2	4	Existing support for carers is delivered through a number of services including respite, short break, carers emergency scheme, carers centre, carers assessment officers. The risk that services may be disrupted through the transformation/ integration process was identified and a risk pool allocated to ensure that carers and customers could continue to access services that they need throughout the process of change in 2017-18. They would also be able to benefit from any new services delivered, through the BCF and Care Act implementation. A revised Joint Carers Strategy has been developed which will link in to the BCF and other strategic objectives for Health and Social Care.

16. Contingency Planning and Risk Sharing

A risk pool of £500,000 has been included in the BCF financial plan for 2017/18 to mitigate the risk of non-delivery of the non-elective savings requirement which is to dampen down growth and demand (rather than reduce admissions from 2015/16 outturn).

The risk pool is also in place to support any unintended consequences of successful initiatives on other parts of the system e.g. demand created from improved case management. Financial monitoring of schemes is in place and risks materialising in year will be monitored and mitigated through the risk pool and expected slippage on new investment through BCF. Planned analysis completed and proposals for use of year-in slippage to support risks in BCF will be agreed through the BCF governance structure as appropriate.

Risks are to be supported by the fund through the CCG, with cases for additional support to be considered through the appropriate governance structure in 2017/18.

A financial governance process is in place and the financial monitoring and performance information is to be provided at monthly operational group meetings and quarterly at Director and Member level. The financial framework will expose those areas of high risk in year and identify areas where slippage may be available to balance the financial pressure in year. The recurrent plans will be modified, where appropriate, as part of the planning cycle for both Health and Social Care in totality, with the introduction of a Section 75 pooled budget agreement from 2017/18.

The CCG has comprehensive plans with regards to dampening down growth of emergency admissions has been successful in previous years when compared to the national levels. All local stakeholders are key players in delivering these plans through the A&E Delivery Board. The way in which RCCG will contract for urgent and emergency care will change markedly in 2017. A new purpose built £12m capital development will open in July 2017 housing the new urgent and emergency care centre (UECC). This will bring the existing Walk-in-Centre service together with the ED to deliver a new service model with Advanced Care Practitioners and GPs as senior clinicians to prevent admission. The UECC business case was predicated on a reduction of 5 emergency admissions per day. To allow these changes to happen without financial consequence for TRFT, RCCG and TRFT have agreed to a block contract across urgent and emergency care at 2016/17 forecast outturn levels. This limits RCCG's financial exposure over 2017/18 and 2018/19. The threshold for the block contract is 2% higher than contracted activity levels. If activity reaches the 2% threshold, RCCG and TRFT will undertake a joint review of emergency activity.

All local stakeholders are members of the A&E Delivery Board. This plan has been approved by the BCF Executive Group, comprised of Health and Wellbeing Board members and will be formally approved by the Board at its next meeting.

17. Patient Engagement

Integration Locality Engagement

The integrated locality pilot commenced in June 2016 , to ensure patient engagement was central to the integration of community services within one locality and the impact this may have on Rotherham people. For example; streamlining of assessments, better communication, more effective support. Leading on from the consultation at the AGM is a focused workshop to take place at the next Patient Participation Group on the 6th December 2016. This will include a presentation to members on the purpose of the pilot and the expected outcomes and then several discussion groups looking at different questions relating to the service i.e. in- reach into hospital.

Rotherham CCG and its partners are also examining opportunities to involve an external organisation in the review of the pilot which will include evaluation of patient feedback to inform future commissioning arrangements. The evaluation is due to be completed by June 2017, with various participation to be planned in early 2017.

Our Better Care Fund vision will enable us to deliver on our Health and Well-Being Strategy and vision. It is based on what Rotherham people have told us is most important to them. Rotherham partners have a commitment to make sure that the views and reported experience of people who use local services are heard and acted upon.

We engage with local people in a number of forums, both formally brokered such as the the Council's Customer Inspection Team and Speak Up and informally, to understand the barriers for local people in accessing the most appropriate support, staying safe; and keeping well. We have used a variety of methods to capture the views and experiences of local patients, service users and their carers to inform our local plans.

Through the mapping of service users' views and experiences and understanding the journeys people take, we have identified a number of 'I statements' which demonstrate the outcomes local people want from better integrated, person-centred services. The BCF Plan will focus on achieving the following outcomes for patients and service users.

''I am in control of my care'

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

'I only have to tell my story once'

People want all organisations and services to talk to each other and share access to their information, so that they only ever have to tell their story once.

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

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

'I am listened to and supported at an early stage to avoid a crisis'

People want support, advice and information at an early stage to help them look after their mental health and wellbeing, avoiding the need for more intense, high-level services when they reach crisis pint.

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'

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

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

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

Customer experiences will be closely monitored throughout the delivery of the BCF Plan via the 6 'I statements'. This will involve the Local Authority's Performance and Quality Team contacting service users and obtaining their views regarding the services they are receiving. This will help us to see the real impact of service reconfiguration and help us improve delivery based on customer feedback.

Through a number of techniques, the team will measure the customer defined i-statements , to identify the positive and negative impacts that the BCF plan has had on customer experiences and help shape integrated services

The paper 'Working Towards Integration in Rotherham', presented to the Health and Wellbeing Board in February 2016 referenced the Better Care Fund in promoting and strengthening integrated working.

The Lead Executives identified a number of priorities for further development of integrated services including the development of a reablement hub, incorporating intermediate care beds. It was agreed at the BCF Operations Group to initially focus customer insight activity on Intermediate Care Services.

We engaged with a sample of 35 people in receipt of Intermediate Care Services between March and May 2016, through a telephone and postal survey. To supplement this, 81 customer journeys were mapped.

Survey results confirmed that 62% of people rated the service 'excellent', 21% 'good', 2% 'satisfactory' and 1% 'poor' (14% of people did not provide a rating). The customer journey mapping provided key information about referral routes in to Intermediate Care, reason for referral, length of stay, discharge information including destination and levels of re-admission to acute care. The results were reported to the BCF Operational Group and were accepted to be used by commissioners in the review of Intermediate Care Services.

Customer engagement will continue to be captured for services under the BCF umbrella; activities will be ordered in line with the action plan to ensure the customer insight informs the future shaping of services.

18. Engagement with Providers and Stakeholders

18.1 Evidence of Engagement

The Rotherham Health and Wellbeing Board has had consistent representation from the main local health providers (RDaSH) and the voluntary sector (Voluntary Action Rotherham). They are each represented at board meetings, and their contribution has been embedded through the key theme groups, and the ongoing discussions regarding BCF. This involvement has ensured they have been engaged throughout the process and are fully signed up to the principles and vision of the BCF Plan. Healthwatch Rotherham are key partners at the Health and Wellbeing Board, bringing added value and independence through their direct relationship with people who are using services.

Local health providers understand that Rotherham CCG has identified a range of services which now form part of the BCF. They are aware that the commissioning arrangements, specifications and targets for these services are likely to change significantly over the coming years. Locally the BCF will affect services delivered by Rotherham Foundation Trust (TRFT) and key voluntary sector partners. All provider organisations continue to express a willingness to work under the new commissioning framework, recognising the potential opportunities to improve outcomes for Rotherham people. TRFT is committed to delivering integrated health and social care pathways and regard the BCF as a vehicle through which these can be achieved. This is reflected in the Community Transformation Programme underway where TRFT are playing a lead role (Appendix X).

Local healthcare providers are engaged through monthly clinically led QIPP (Quality, Innovation, Productivity and Prevention) groups where pathway redesigns, innovation and efficiency are key deliverables.

Rotherham CCG is working in partnership with RDASH, transforming mental health services in the borough. Regular transformation events are taking place with commissioners, providers (independent/VCS), service users and carers on this programme (Appendix X).

Rotherham commissioners have a long established relationship with the local voluntary and community sector (VCS), both as partners in working to improve social capital locally, and directly as provider organisations. Commissioners engage formally through the Council's Provider Forums, partnership groups and "Meet the Buyer" events Commissioners engage formally through the Council's Contracting for Care and Provider Forums. There is additional engagement through the Adult Social Care Consortium. The VCS has a strong local voice with Elected Members and Trust Boards. We understand that the remit of the VCS extends far beyond that of our public services. VCS acts as an interface with people in our communities who do not use statutory services and who arrange their own care.

Voluntary sector partners have engaged with us in delivering a wide range of services, some of which are included in the BCF Directory of Services. The sector forms part of integrated care pathways in stroke, dementia care, carer support, and crisis services for people with mental health problems. We see BCF as a catalyst, helping to embed voluntary sector services into condition specific care pathways. The sector is also a key partner in prevention and early detection, signposting and offering advice and support to people who may be at risk of needing acute intervention. The BCF Plan supports this specifically through the Social Prescribing Programme.

One example of good practice in relation to provider/stakeholder engagement is the "Meet The Buyer" events which included representation from across the health and social care sector. These events also included independent and voluntary sector providers responsible for delivering social care services. The purpose of the meetings was to consult on the Health and Wellbeing Strategy, the impact of the Care Act, Better Care Fund and the adult social care development programme.

Providers and stakeholders are fully sighted on plans to transfer resources from acute services to the community. This includes community assets and workforce requirements. Assessment of workforce and capacity issues resonates through provider operating plans and will be an integral part of all BCF service reviews which take place in 2016-17 and 2017-18.

18.2 Provider/Stakeholder Engagement Strategy

This section of the Rotherham Better Care Fund Plan sets out the communication and engagement strategy for 2016/17. It includes a range of ways in which provider representatives, including front line staff, can be involved in the development, implementation and evaluation of our programme. Clinicians and other practitioners will play a key role alongside service users and carers in ensuring that the BCF makes a positive difference to people's lives. As well as providers there is great interest and enthusiasm from the voluntary and community sector, services users and carers, and representatives such as Healthwatch. We have used a variety of methods to capture the views and experiences of local patients, service users and their carers to inform our local plans.

We will build on existing approaches to develop a strong service user and community voice within the Better Care Fund. This plan sets out our basic communications and engagement objectives, identifies the stakeholders we hope to work with, and confirms our commitment to the adoption of co-design principles.

In Rotherham we have identified 6 themes which incorporate all existing provision and the key priorities.

Theme 1:	Mental Health
Theme 2:	Rehabilitation and Reablement
Theme 3:	Supporting Social Care
Theme 4:	Case Management and Integrated Planning
Theme 5:	Supporting Carers
Theme 6:	Infrastructure (including Care Act)

Our communication and engagement programme will be based around these key themes, creating service user and stakeholder strategies for each. The overall strategy will be based on the following principles;

Collaboration	Bringing together clinicians, staff, patients, service users and the community together as equal partners
Evidence-based	Co-design an evidence base which will support service redesign
Capability	Developing the capacity of patients, service users and the community to engage effectively in identifying needs, planning, procurement, implementation and evaluation.

Review	After redesign has been implemented, using stakeholders and service users to evaluate impact, monitor quality and support performance management

Table 7 sets out a local map of all stakeholders, channels of communication and how we will keep people informed. Funding for communications and engagement activity and support will be part of the programme costs for the Better Care Fund Programme and will be confirmed once further development work has taken place.

Over the next few months we will be briefing stakeholders on the journey so far – how the Better Care Fund has been put together and where it is going. We will then work with them to refine the programme and develop an approach for involving relevant people from all the stakeholder groups in the development of each theme.

The BCF Plan is fully consistent with our provider's operational plans. Chief Executives of The Rotherham Foundation Trust (TRFT) and Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) (our two biggest health providers) support the Better Care Fund submission and clinicians and managers from TRFT and RDasH are fully engaged in delivery. TRFT and RDaSH are also members of the Health and Well-Being Board, A&E Delivery Board, Clinical Referral Management Committee and Joint Commissioning Performance Groups.

Table 7: Stakeholder Map

<table>
<tr><th>Stakeholder</th><th>Channels</th><th>Reporting</th></tr>
<tr><td>Service users / patients</td><td rowspan="2">Briefings, newsletters, websites. Range of participative events which are general and specific to the BCF themes/priorities. Use of existing for and meetings.</td><td rowspan="2">No set reporting periods</td></tr>
<tr><td>Health watch</td></tr>
<tr><td>CCG Governing Body</td><td>Formal governance</td><td>6 monthly reports</td></tr>
<tr><td>Council, Cabinet and Scrutiny</td><td>Formal governance</td><td>6 monthly reports</td></tr>
<tr><td>Health and Wellbeing Board</td><td>Formal governance</td><td>6 monthly reports</td></tr>
<tr><td>MPs and Councillors</td><td>Briefings</td><td>Annual</td></tr>
<tr><td>NHS clinicians and staff</td><td rowspan="4">Briefings, newsletters, websites. Range of participative events which are general and specific to the BCF themes/priorities. Use of existing for and meetings.</td><td rowspan="5">No set reporting periods</td></tr>
<tr><td>RMBC staff</td></tr>
<tr><td>Service providers</td></tr>
<tr><td>3rd sector organisations</td></tr>
<tr><td>Public</td><td>Website, newsletters and local publicity</td></tr>
</table>

We will work with our provider partners adhering to best practice guidelines and relevant legislation (Health and Social Care Act 2012) to ensure that, when services change, we will engage, inform and consult. We will endeavour to secure the confidence of patients, staff and the public in change proposals. We will use NHS England's guidance for building proposals for major service change including the 'four tests'.

19. Funding Arrangements

Financial Risk Sharing and Contingencies

There is a risk sharing policy in the Section 75 Partnership Agreement (Appendix 14) and this has worked well in 2016/17, can be evidenced and has been audited twice in the last 12 months with significant assurance given on both occasions that the governance arrangements are in place and working within the framework and policies.

There will be two pools as in 2016/17 but the content and financial allocations have be re-classified following the review of the services in 2015/16. This change to the plan was approved by the BCF Executive Group on 16th March 2016.

Protection of Social Services

In 2015/16, all BCF schemes were reviewed and re-classified from 15 to 7 key themes. This included the definition of 'Protecting Social Care' which is embedded throughout the BCF themes. Services funded through the BCF which help maintain essential social care services include Community based services, residential care, equipment and assistive technology, services for carers and 7 day social work support. More detail is shown in Table 9 including additional investments.

Total investment in social care has increased from £8.6m in 2015/16 to £9.3m in 2016/17, mainly in respect of equipment and adaptations and to meet additional cost pressures arising from the Care Act 2014. This investment remains in 2017/18, with a slight increase in overall funding within the BCF.

The detailed financial plans will be submitted in the tables but the movement between 2016/17 and planned BCF for 2017/18 is provided below:

Table 8: Summary of Financial Plan

			ADDITIONAL INVESTMENT			ALLOCATION OF POOLED BUDGETS		
	THEME	2016/17	RMBC	RCCG	2017/18 BCF PLAN	RCCG POOL	RMBC POOL	TOTAL
		£000s	£000s	£000s	£000s	£000s	£000s	£000s
1	MENTAL HEALTH SERVICES	790		1	**791**	**791**		**791**
2	REHABILITATION AND REABLEMENT	13,391		138	**13,529**		**13,529**	**13,529**
3	SUPPORTING SOCIAL CARE	3,682			**3,682**	**3,682**		**3,682**
4	CASE MANAGEMENT AND INTEGRATED CARE PLANNING	5,028		0	**5,028**	**5,028**		**5,028**
5	SUPPORTING CARERS	690		(40)	**650**	**650**		**650**
6	INFRASTRUCTURE (including Care Act)	242		0	**242**	**242**		**242**
7	RISK POOL	500		0	**500**	**500**		**500**
	TOTAL	**24,323**	**0**	**99**	**24,422**	**10,893**	**13,529**	**24,422**

Table 9: Summary of Investment Profile

	Service Area	2016/17 BCF £000	Additional costs	2017/18 BCF £000	Strategic Relevance	Service Spec	Perf F/work	Perf Issues	Recommendation
		£000	£000	£000					
Theme 1: Mental Health Services									
1	Adult Mental Health Liaison	**790**	**1**	**791**					Ok
Theme 2: Rehabilitation and Reablement									
2	Home Improvement Agency	75		**75**					Ok
3	Falls Service	432	12	**444**					Ok
4	Home Enabling Services	1,556	37	**1,593**					Under Review
5	2 SSO reviewing officers to fast track assessments during reablement	98		**98**					Ok
6	Community Stroke Service	175		**175**					Ok
7	Community Neuro Rehab	154		**154**					Ok
8	Breathing Space	2,256	88	**2,344**					Under Review
9	Expert Patient Programme	50		**50**					Ok
10	REWS	939	1	**940**					Under Review
11	Community OT	746		**746**					Under Review
12	Disabled Facilities Grant	2,119		**2,119**					Encorporates PSS adult services capital grant
13	Age UK Hospital Discharge	163		**163**					Ok
14	Stroke Association Service	50		**50**					Ok
15	Stroke Social Work Support	27		**27**					Ok
16	Intermediate Care Pool	4,531		**4,531**					Ok
17	Otago Exercise Programme	20		**20**					Ok
	Total	**13,391**	**138**	**13,529**					
Theme 3: Protecting Social Care									
18	Direct Payments	1,643		**1,643**					MOU in development
19	Care Act Implementation	700		**700**					Carer Strategy in place, now under review
20	Residential Care	274		**274**					MOU in development
21	Learning Disability Services	1,065		**1,065**					MOU in development
	Total	**3,682**	**0**	**3,682**					
Theme 4: Case Management and Integrated Care Planning									
22	GP Case Management	2,145		**2,145**					Ok
23	Care Home Support Service	267		**267**					Ok
24	Death in Place of Choice	788		**788**					Ok
25	Social Prescribing	750		**750**					Ok
26	Social Work Support (A&E, Case management, Supported Discharge)	1,078		**1,078**					MOU in development
	Total	**5,028**	**0**	**5,028**					
Theme 5: Supporting Carers									
27	Day Care Services	350		**350**					MOU in development
28	Carers Centre	100		**100**					Carer Strategy in place, now under review
29	Carers Support Service	200		**200**					Carer Strategy in place, now under review
30	Reablement – Crossroads	40	(40)	**0**					Paid directly to Crossroads, not part of BCF
	Total	**690**	**(40)**	**650**					
Theme 6: Infrastructure									
31	Joint Commissioning Team	49		**49**					Under Review
32	IT to support Comm Trans	193		**193**					Ok
	Total	**242**	**0**	**242**					
33	Contingency Fund	**500**		**500**					Managed in year
	Total	***24,323***	***99***	***24,422***					

20. Appendices

Ref.	Document	Synopsis and links
Page 3 **(embedded document)**	**Map of Rotherham**	This map was produced by Rotherham Borough Council to illustrate the 7 Area Assemblies across the borough
Page 4 **(web links provided)**	Rotherham Mental Health Adults and Older People's Transformation Plan	The plan sets out a plan on a page for the transformation of services to ensure people of all ages are able to live as normal and inclusive a life as possible. http://moderngov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=103679
Page 5 **(web links provided)**	**Health and Wellbeing Strategy**	The joint strategy which sets out the priorities of the health and wellbeing board for 2015 – 2016. http://www.rotherham.gov.uk/hwp/downloads/file/4/rotherham_borough_joint_health_and_wellbeing_strategy_2015-18
Page 5 **(web links provided)**	**CCG Commissioning Plan 2015-19**	The Rotherham CCG Commissioning Plan 2015-19 http://www.rotherhamccg.nhs.uk/
Page 5 **(web links provided)**	**Joint Strategic Needs Assessment**	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
Page 6 **(web links provided)**	**Market Position Statement for Older People**	The Market Position Statement has been developed by Rotherham Council to inform current and potential providers of social services in the borough of the direction of social care services for older people over the next few years. http://www.rotherham.gov.uk/downloads/file/959/market_position_statement_for_older_peoples_services_2014
Page 41	**RCCG Communication and Engagement Plan**	Rotherham CCG communication and engagement plan 2015-19 sets out how the NHS Rotherham Clinical Commissioning Group (RCCG), are committed to engaging, communicating and consulting with a wide range of audiences, using the right platforms and mechanisms. http://www.rotherhamccg.nhs.uk/Downloads/Publications/comms%20and%20engagement%20plan%20final%202015-16.pdf

Ref.	Document	Synopsis and links
Appendix 1	**BCF Service Review Programme**	The service review report sets out recommendations for the reconfiguration of the Better Care Fund. The report provides a breakdown of current funding identified within the BCF programme, overall cost of the service and costs that are covered through alternative funding streams.
Appendix 2	**Review of Social Prescribing Service**	Review details analysis, impact, outcomes, case studies, costs, and benefits.
Appendix 3	**BCF Directory of Services**	The BCF Directory of Services provides clarity on where BCF funding is currently being invested and the strategic relevance of each scheme.
Appendix 4	**Analysis of BCF Schemes**	Analysis shows re-categorisation of existing BCF schemes, showing no negative impact on provision
Appendix 5	**Delayed Transfers of Care Action Plan**	This is a local DTOC action plan which shows actions taken to delayed transfers of care from hospital.
Appendix 6	**Memorandum of Understanding**	Agreement between CCG, LA and Rotherham Foundation Trust which sets out roles and responsibilities in relation to hospital discharge for all patients who are medically fit for discharge..
Appendix 7	**Tier 2: Data Sharing Agreement**	An agreement between CCG and LA around sharing adult social care information with the Rotherham NHS Foundation Trust for the purpose of assigning NHS numbers to social care6records.
Appendix 8	**RMBC Digital Council Strategy "Your Digital Council"**	The Strategy shows the continuing importance of a digital infrastructure in Rotherham which includes "broadband, online services, access and skills to provide a modernised public service.
Appendix 9	**RCCG IT Strategy (2015/16)**	The strategy ensures that CCG has IT capabilities to support the delivery of its commissioning plan including the development of a clinical portal that will integrate information from health and care services .
Appendix 10	**Digital Road Map Communication and Engagement Plan**	A plan which details the benefits of a clinical portal and managing patients. Consultation with Healthwatch, community, voluntary sector and care homes.
Appendix 11	**Rotherham Engagement Event**	Presentation on evidence of need, with a focus on access to services for vulnerable carer groups.
Appendix 12	**Community Transformation 2**	Presentation on Stage 2 of Transforming Unscheduled Care

Ref.	Document	Synopsis and links
Appendix 13	**Rotherham Mental Health Transformation Event**	Paper showing updating on adult and older people's Mental Health transformation agenda.
Appendix 14	**Section 75 Partnership Agreement**	The agreement has been signed and agreed by CCG and Local Authority setting out commissioning intentions in the use of the BCF

Rotherham Metropolitan Borough Council

NHS Rotherham Clinical Commissioning Group

1.	**Meeting:**	**HEALTH AND WELLBEING BOARD**
2.	**Date:**	**8th March, 2017**
3.	**Title:**	**Better Care Fund Quarter 3 Submission**

4. Summary

The purpose of this report is to note the contents of the second quarterly report to NHS England regarding the performance of Rotherham's Better Care Fund in 2016/17.

5. Recommendations

That the Health and Wellbeing Board note the:

(i) Details for submission to NHS England on or before Friday, 3rd March, 2016.

6. Introduction/Background

6.1 Rotherham's BCF plan sets out key schemes, and how each of these will be measured and managed.

6.2 The BCF quarterly reporting template covers reporting on: income and expenditure, payment for performance, supporting metrics, integration measures, national conditions, income and expenditure.

6.3 Below is a summary of information included within the BCF submission:

7. Budget Arrangements

7.1 Confirmation that the BCF funds have been pooled by a Section 75 agreement signed by the Local Authority and the Clinical Commissioning Group.

8. National Conditions

Rotherham is fully meeting 7 out of the 8 national conditions as follows:

8.1 Plans are still jointly agreed between the Local Authority and the Clinical Commissioning Group.

8.2 Maintaining provision of social care services (not spending)

8.3 A joint approach to assessments and care planning are taking place and, where funding is being used for integrated packages of care, there is an accountable professional.

8.4 An agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans.

8.5 Agreement to invest in NHS commissioned out-of-hospital services.

8.6 Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan.

8.7 7 day social care working is now in place and embedded at the hospital with on-site social care assessment available to support patients. This has become “business as usual” from 3rd October, 2016, following the implementation of a social care restructure. Support over the full 7 days is provided by the same core team, ensuring that there is consistency of process over this period. Additional support over and above the dedicated resources identified can be accessed through the out of hours service on an as needed basis.

Rotherham is currently partly meeting 1 out of the 8 national conditions which comprises of two elements as follows:

8.8 The first element (which is fully met) includes better data sharing between health and social care, based on the NHS Number (NHSN). This is being used as primary identifier for health and social care services Work now completed to ensure better sharing between health and social care. There are 5,495 adults who were in the scope of the NHSN matching project and all BCF records now have an NHS number assigned. Our new social care system will go "live" on 13th December, 2016, and this 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. We will begin using the NHSN on our correspondence when the new Liquidlogic system is "live" (Liquidlogic includes the facility to add NHSN to correspondence with little extra work).

8.9 The second element (which is partly met) around better data sharing includes whether we ensure that patients/service users have clarity about how data about them is used, who may have access and how they can exercise their legal rights. This second element of the national condition has recently been introduced since August 2016.

Significant progress is under way, with an expected full implementation date of 31st May, 2017, to ensure that we fully meet the national condition. The original date for full implementation was 31st January, 2017, and the reasons behind the delay are as follows:

- It is taking IG and IT leads longer than anticipated to agree the models of data sharing and content. In part, this is due to confusion as to what is allowable. In a report dated 8th February, 2017, The National Audit Office identified that there has been “insufficient support from the centre to tackle information governance issues” and that the Department of Health “recognised that it has not done enough to explain the rules around information gorvenance”.

- The National Audit Office has commissioned a report from the National Data Guardian on this issue and IG and IT leads are hopeful that this will add clarity. In the meantime, IG and IT leads have convened a meeting which will take place on 15th February, 2017, to take this issue forward.

The work that has already been carried out on this initiative includes:

The Proposed Consent Model was fully approved at the Rotherham Interoperability Group on 31st August, 2016. The Model states that the ability to access a patient’s information may be done via implied consent for direct care. The public must, however, be effectively informed that the data is in use and have the option to object to their records (from any organisation) being shared. Access of a record must be done on the explicit consent of the individual for each episode of care, wherever this is possible (and practical).

Where a patient requires emergency treatment and is unable to give consent, or when a record is being reviewed in response to a test result when the patient is not present, a professional clinical decision can be made considering whether the duty to share or implied consent may be justified. Such access without explicit consent should be documented. This should be fully auditable and monitored accordingly.

A Communications and Engagement plan has been drafted and information will be made available in a variety of formats covering:

- The system "Rotherham Health Record" (RHR) that we will be using to share data
- How it works
- What information will be shared within it (details such as name, address, medication)
- Who will have access to it
- Reassurance on the security of the RHR (both technical within the system and organisational in terms of duty of confidentiality)
- How to opt out
- Who to contact with any concerns/queries

9. Income and Expenditure

9.1 There is a total of £24,323,269 in the Better Care Fund for 2016/17.

9.2 There is a forecast expenditure of £6,080,817 per quarter for 2016/17.

10. Performance Data

10.1 Our performance on most metrics is on target as follows:

10.2 ***Non-elective hospital re-admissions*** – Performance is currently under target, so non-elective admission levels are within contract plans. This is being reviewed closely as activity at some providers for Rotherham CCG only, in some specialties is above contractual targets. This activity above contracts is generating pressure within the healthcare system.

10.3 ***Emergency re-admissions*** – This indicator is now demonstrating a level of readmissions, very slightly over target, rather than significantly over target as previously thought. There is still felt to be value in a piece of work to review which groups of patients have higher readmissions.

10.4 ***Delayed Transfers of Care*** from hospital - on track to meet the target. August Year to Date performance (1102.6) is below target (1241.3). Performance against this indicator remains positive in this financial year.

10.5 ***Admissions to Residential Care*** – on track to meet target. Q3 figures (as at end of November 2016) which is significantly lower than 390 target and equates to a current rate per 100,000 of 320.4 compared to the year end target rate of 797. Whilst some winter pressures may well result in a seasonal increase by year end, we estimate that the targets will be achieved.

10.6 ***The proportion of older people still at home 91 days later after hospital discharge into rehabilitation*** - this is an annual measure and is reported at year end, with indicative data becoming available during January to March 2017. The outcome of this indicator will become known by April/May 2017.

10.7 Latest public information around the NHS Family and Friends Test shows a reduction of 123.08 to 115.9 in the rate of negative responses. Unfortunately the national data required to monitor this indicator has not been as frequently published as originally indicated.

11. Additional Measures

11.1 Personal Health budgets, use and prevalence of multi-disciplinary and integrated care teams and use of integrated digital care records across and health and social care are

additional measures that have been introduced. Rotherham can report favourably on the first two measures.

11.2 We are now providing Personal Health Budgets to 62 adults and 19 children.in Rotherham during Quarter 3. All assessed CHC or CCC individuals and/or representatives are offered information regarding requesting a PHB from Rotherham CCG. The CCG has approved the PHB 'Local Offer' which highlights the plans to rollout PHBs outside of CHC/CCC.

12. Service Reviews

12.1 We are now carrying out a series of individual "deep dive" service reviews on BCF schemes which will identify if there are any funding or performance issues or where there are concerns regarding strategic relevance.

12.2 Service reviews will take place between July 2016 and May 2017.

13. Conclusion/Next Steps

13.1 The quarterly format, and the timetable for submitting the quarterly and annual returns have been included within the new Section 75 Partnership Framework Agreement for the BCF for 2016/17, thus ensuring both the CCG and Local Authority are jointly responsible for compiling and submitting these reports to the HWB and NHS England.

13.2 The return will need to be fully completed and submitted to both the BCF Executive Group and Health and Wellbeing Board.

14. Background Papers

14.1 BCF Quarterly Data Collection Quarter 3 2016/17 – attached below

HWB BCF Q3 Data Collection.xlsb

Officer Contacts: Keely Firth, Chief Finance Officer, RCCG
Tel. No: 302025

Officer Contacts: Nathan Atkinson, Assistant Director of Commissioning, RMBC
Tel. No: 822270

Rotherham Metropolitan Borough Council

Public Report

Health and Wellbeing Board Report

8th of March 2017

Title

Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND)

Is this a Key Decision and has it been included on the Forward Plan?

This is not a key decision

Strategic Director Approving Submission of the Report

Ian Thomas, Strategic Director, Children & Young People's Services (CYPS)

Report Author(s)

Linda Harper, Interim Assistant Director, Commissioning, Performance and Quality, Children and Young People's Services

Ward(s) Affected

All wards

Executive Summary

This report presents the Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND). The Strategy provides an overview of how the joint commissioning of services for children and young people with SEND in Rotherham will be developed and implemented in line with the requirements of the Children's and Families Act 2014 and the associated Code of Practice for SEND.

The Strategy, through a mapping exercise, consultation and a review of transitions with parents/carers and stakeholders, has identified nine priority areas of work that will be implemented over the next three years. The Strategy has been previously approved by the Clinical Commissioning Group's Operational Executive, the Council's Children and Young People's Services leadership team and the Children and Young People's Partnership Board, and endorsed for sharing with the Health and Wellbeing Board.

Recommendations

It is recommended that the Health and Wellbeing Board note the refreshed Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND).

List of Appendices Included

Appendix 1 - Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND)

Background Papers

Children and Families Act 2014

Rotherham Joint Commissioning Strategy for Children and Young People – Our Journey to Excellence – August 2015 to August 2018.

Consideration by any other Council Committee, Scrutiny or Advisory Panel

None.

Council Approval Required

No

Exempt from the Press and Public

No

Title: Rotherham Joint Commissioning Strategy for Children and young People with Special Educational Needs and/or Disabilities (SEND)

1. Recommendations

1.1 It is recommended that the Health and Wellbeing Board endorse the refreshed Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND).

2. Background

2.1 The biggest educational reforms in a generation for children and young people with special educational needs and disabilities (SEND) became law in September 2014, following the Children and Families Act 2014. The requirements of the Act, and associated Code of Practice for SEND, include extending provision from birth to 25 years of age and giving families greater choice in decisions and ensuring needs are properly met. The new system extended rights and protection to young people by introducing a new education, health and care plan.

2.2 The SEND Joint Commissioning Group, which includes representation from education, health and social care services, and the Parents' Forum, undertook a mapping exercise of both Local Authority and Health SEND provision in Rotherham. This included consultation with parents, carers and stakeholders from across education, health and social care, in relation to what works well and not so well around SEND provision.

2.3 Furthermore, a review of Transition, which completed in 2016, provides insight and recommendations into how the Rotherham system could work in a more integrated way to better prepare children and young people for adulthood.

2.4 The mapping and consultation work, and the review of Transition, informed the development of the Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND). This Strategy provides an overview of how the joint commissioning of services for children and young people with SEND in Rotherham will be developed and implemented in line with the requirements of the Children's and Families Act 2014.

2.5 The Strategy outlines what is joint commissioning, the partners involved in the arrangement, the governance structure, the current Rotherham SEND Local Offer and how the Strategy will be implemented.

3. Key Issues

3.1 The full implementation of the Strategy will require a phased approach to move from the current position. There are nine priority areas of work,

which will be taken forward over the next three years, and are described in section four of this report.

3.2 Work has already commenced in taking forward a number of the priority areas, namely the creation of a joint SEND Assessment Hub, the re-modelling of services that provide support for children and young people with challenging behaviour, the development of personal budgets, the development of aligned Service Specifications for education, health and social care services, and the development of pathways to adulthood.

3.3 The development of the SEND Assessment Hub is key to improving the co-ordination of SEND provision, as well as formalising joint working arrangements and the streamlining of assessments. The SEND Assessment Hub is based at Kimberworth Place.

4. Options considered and recommended proposal

4.1 The nine priority areas of work contained within the Rotherham Joint Commissioning Strategy for Children and Young People with SEND are as follows:

4.1.1 Create a joint SEND Education, Health and Social Care Assessment hub at Kimberworth Place.

4.1.2 Review and re-model services that provide support for children and young people with challenging behaviour.

4.1.3 Develop a Performance and Outcomes Framework that will be applied across all local authority and CCG SEND provision.

4.1.4 Align local authority and CCG Service Specifications for SEND service provision, to facilitate commonality of practice and a consistent approach (thus reducing duplication, improving efficiencies and developing clearer pathways).

4.1.5 Audit the Education, Health and Care Planning (EHCP) process to look at how the assessment process (including the decision making process/panels and allocation of resources) can be streamlined, so as to reduce the multiple assessments that young people and their families have to undertake.

4.1.6 Ensure that there is a co-ordinated joint Workforce Development Plan.

4.1.7 Develop and implement Personal Budgets.

4.1.8 Develop pathways to adulthood.

4.1.9 Develop approaches to improving life experiences which are person centred.

4.2 The priorities outlined in section 4.1 are detailed, along with comments from parents/carers and stakeholders, on pages 11 to 17 of the Strategy and in the associated joint Commissioning Plan from page 20 onwards.

5. Consultation

5.1 There was consultation with parents/carers, staff within SEND provision and wider stakeholders as part of the development of the Strategy and the nine priority areas of work were based on the feedback from consultation.

5.2 The draft Strategy was consulted upon with the Rotherham Parent and Carer Forum, staff within SEND provision and wider stakeholders. The feedback from this consultation was taken into account when refining and refreshing the Strategy.

6. Timetable and Accountability for Implementing this Decision

6.1 It is anticipated that should the refreshed Strategy be endorsed by the Children and young People's Services Directorate Leadership Team and by the Clinical Commissioning Groups Executive Officer Team, it will be submitted to the Children's Partnership Board meeting in January 2017 for consideration and then to the Health and Wellbeing Board meeting in March 2017 for approval.

7. Financial and Procurement Implications

7.1 The financial implications arising from implementing the Strategy will be fully explored and identified as part of developing the nine individual priority areas of work.

8. Legal Implications

8.1 There are no identified legal implications.

9. Human Resources Implications

9.1 Any human resource implications that are identified as part of the development of the priority areas of work will be fully explored and contained within future reports.

10. Implications for Children and Young People and Vulnerable Adults

10.1 The Strategy aims to impact positively on children and young people, through maximising SEND resources to improve the outcomes for children and young people with SEND and their families.

11 Equalities and Human Rights Implications

11.1 The Strategy focuses on children and young people with disabilities, which is a protected characteristic under the Equality Act 2010. The refreshed

Strategy seeks to mitigate the disadvantage faced by children and young people with disabilities.

12 Implications for partners **and Other Directorates**

12.1 The priority areas of work arising from the Strategy have implications for Rotherham Council, Rotherham Clinical Commissioning Group, RDASH CAMHS, Rotherham Foundation Trust, Schools, Further Education Colleges and the Voluntary and Community Sector. The services that form part of the SEND Local Offer are within scope and are outlined on page 8 of the refreshed Strategy.

13. Risks and Mitigation

13.1 Failure to gain endorsement and subsequent approval of the Strategy may result in a delay in implementing the priority areas of work within reasonable timescales.

13.2 There is a risk that the full range of SEND services as outlined in section 12.1 do not fully engage in taking forward the Strategy. This will be mitigated through a robust communication and engagement plan.

14. Accountable Officer(s)

Linda Harper, Interim Assistant Director, Commissioning, Performance & Quality

Approvals Obtained from:-

Strategic Director of Finance and Corporate Services –

Director of Legal Services -

Head of Procurement -

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Rotherham Metropolitan Borough Council
Where Everyone Matters

NHS
Rotherham
Clinical Commissioning Group

Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities.

July 2015- July 2018

Rotherham Joint Commissioning Strategy for Children and Young People with Special Educational Needs and/or Disabilities (SEND)

Introduction

Rotherham is committed to working collaboratively to support children and young people with Special Educational Needs and Disabilities (SEND), and their families. This document provides an overview of how the joint commissioning of services for children and young people with SEND in Rotherham will be developed and implemented in line with the requirements of the Children's and Families Act 2014. Effective joint commissioning will ensure that resources are maximised across our services to improve outcomes for children and young people (0 – 25 years of age) with SEND and their families.

The arrangements will be subject to external scrutiny through a new SEND Ofsted and Care Quality Commission Framework.

What is Joint Commissioning?

Joint commissioning in the context of SEND, consists of two types of commissioning:

1. Individual commissioning for a young person which takes the form of an Education, Health and Care Plan.

2. Joint commissioning in terms of the population of Rotherham SEND population, which is the process for deciding how to use the total **partnership** resources available for families, in order to improve their outcomes in the most efficient, effective, equitable and sustainable way.

Individual Commissioning

Individual commissioning is a person-centred and joined up approach to identifying and meeting the needs of an individual child or young person and their family. The Education, Health and Care (EHC) Planning pathway facilitates a clear understanding of individual needs and the support and provisions necessary to achieve agreed outcomes. An EHC plan clarifies roles, responsibilities, accountabilities and represents a clear joint commissioning plan for an individual.

The representation of the current SEND Local Offer on page 9 of this document, describes the relationships between the EHC Assessment Team and commissioners within SEND across Children and Young Peoples and Adult Services. It is a representation of how individual commissioning arrangements through the Education, Health and Care Plan process should inform the arrangements for population commissioning.

Joint Commissioning for the population

Joint commissioning is based on key partners (Education, Health and Care and others) working together to identify the outcomes that matter to and for children and young people with SEND, their families and communities and the planning, delivery and monitoring of services effectively against how the outcomes are being achieved.

Joint commissioning involves:

- Shared commitment to improve the experience and outcomes for children, young people and their families.
- Common Strategies underpinning a Joint Strategy.
- Partners jointly designing and managing consultation and feedback activities.
- Jointly designed population needs analysis, which will identify gaps, including the Joint Strategic Needs Assessment.
- Joint working groups to review and develop the market.

- Partners identifying pooled budgets for particular areas, and a joint approach to decision making on budget allocation to meet common objectives.
- Use of Health Act Flexibilities to underpin the development of pooled budget arrangements.
- Multi-agency review groups including children, young people, parents and carers ensuring robust joint arrangements for the collection and interpretation of performance information.
- Sharing of risk across partners with market development.
- Partners issuing joint block contracts or share contract risk.
- Standard joint contract terms that are realistic and deliverable by providers.
- Emerging hybrid roles supporting a joint strategic commissioning function across partners.
- Clear understanding of the resources and skills required to provide support to Joint Strategic Commissioning
- Joint appointments of commissioning staff.

The Joint Commissioning Framework outlined on the next page uses a typical commissioning cycle across four key steps of understand, plan, do, review. For each of these steps the Framework explains what partners will do to jointly commission services for children and young people with SEND and their families. This will be developed into a work plan taking account of the findings from the service mapping work.

Who are the Partners?

The statutory partners, NHS Rotherham Clinical Commissioning Group and Rotherham Council, are committed to improving outcomes for children and young people with SEND and their families. The Children and Families Act, 2014, sets out clear requirements for each of the partners.

Key to joint commissioning will be the co-production and engagement with children, young people and their families. The Strategy will enable a clear relationship and seek to develop a joint commissioning approach.

Section 1.22 of the revised Code of Practice 2014 outlines the principle of joint working:

'If children and young people with SEN or disabilities are to achieve their ambitions and the best possible educational, health and other outcomes, including getting a job and living as independently as possible, local education health and social care services should work together to ensure they get the right support'

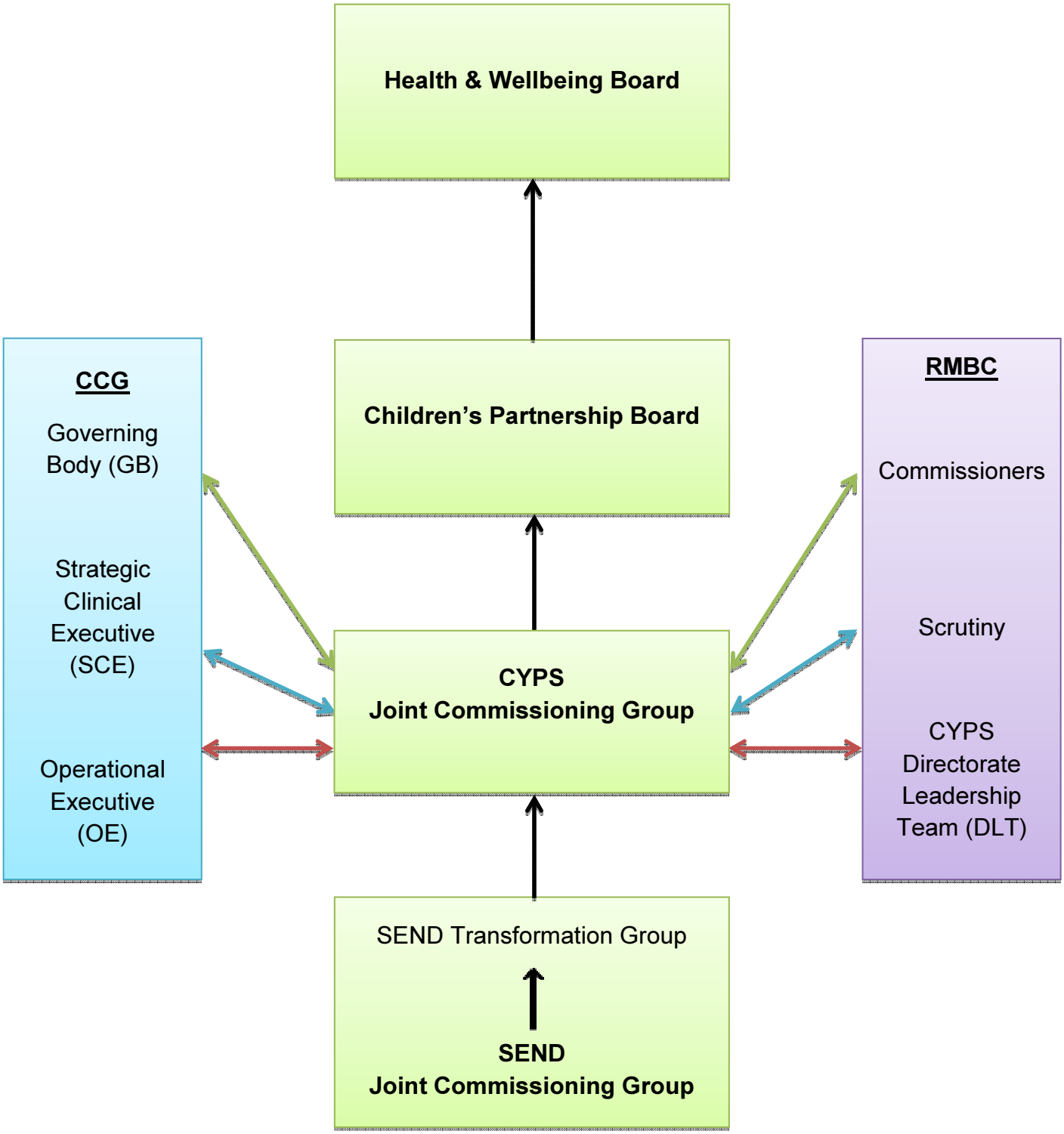
Section 3 of the Code details the requirements for working together across education health and care for joint outcomes. In particular, that the joint commissioning cycle will rely on partnerships being established between education, health and social care together with parents groups, children and young people. Involvement with and feedback from schools, pre-school settings and post-16 education providers will be vital in helping to inform the commissioning cycle of 'joint understanding, joint planning, joint delivery and joint review'.

Covering 0-25 the Act makes the provision of effective transitions and the development of further joint commissioning across children and adult commissioning structures vital.

The arrangements will be subject to external scrutiny through a new SEND Ofsted and Care Quality Commission framework.

RMBC/CCG Governance Structure

The diagram below shows the governance structure for the joint commissioning process. Papers will be sent through the governance process to the corresponding meeting of each organisation, at the same time.



What are the benefits of Joint Commissioning?

Through working together and putting in place joint decision-making processes, stakeholders can use Joint Commissioning to support early identification of needs, prevention and outcome focused service delivery and work to improve the experiences of services that support children, young people and their families. Joint Commissioning can reduce unnecessary duplication of, or barriers between provision and the development of more efficient and effective service provision. It reduces the burden on small local community groups of multiple reporting requirements and the management of competing funding streams and expectations of commissioners.

What are our SEND Joint Commissioning Vision and Principles?

The Vision

Our Vision for Rotherham children and young people with SEN and disabilities is the same for all of our children and young people; that they be safe, happy, healthy, confident and successful, contributing to a thriving, inclusive community that is welcoming to all, recognising the capability of everyone to contribute to their local community based on an asset based approach.

The Vision is underpinned by the ambition of the Borough to be child friendly across everything we do.

The achievements of our children and young people, supported by effective settings and services working in partnership with families and communities, will enable them to enjoy independence and fulfilling lives.

We aim to:

- **L**ift aspirations and build on existing strengths
- **I**ncrease Personalisation – such that provision and support is co-designed and delivered in collaboration with children, young people and their families so that it is person centred, responsive and better matched to need
- **F**ocus on and improve outcomes that are important to, and for, children, young people, families and communities
- **E**nhance Partnerships – so that we can jointly commission to collaboratively and collectively achieve and sustain our vision

The Principles

- Provision and service development and delivery will be driven by our collective ambition to achieve the best possible outcomes for children, young people, their families and carers.
- Services will be commissioned in line with the spirit and requirements of the Children and Families Act 2014.
- To encourage education, health and care commissioners and providers to only make changes to SEND structures, provision and entitlements following discussion with partner organisations.
- We will work in partnership with providers who also commission SEND activities, including colleges.
- The joint commissioning approach will involve co-production with parents/carers and young people.
- We will enhance information sharing and communication
- We will reduce duplication and streamline service management

- Service development and delivery will be driven by the best possible outcomes for children, young people and their families and carers.
- All partners and services will communicate clearly and regularly with others about their roles

What are our Joint Commissioning objectives?

- To ensure that children, and young people with SEND gain maximum life chance benefits from educational, health care and social care and have the opportunity to achieve their full potential.
- To ensure that children and young people with SEND are fully informed and engaged.
- To ensure progression and continuity of support and care as young people move into adulthood.
- To enable children and young people with SEND to have as much choice and control over their lives as possible.
- To ensure that families and carers are supported.
- To enable children and young people with SEND to benefit from high quality services that are designed around their individual needs.
- To enable children and young people with SEND to be included within and contribute to their community, supporting positive activities, friendships and relationships.
- To ensure that the workforce across partners is appropriately skilled, trained and qualified, to promote a better understanding of, and meet the needs of children and young people with SEND.
- To develop and implement clear joint performance reporting to evidence individual experience, outcomes and their life journey, as well as value for money.

Where are we now?

The introduction of Education, Health and Care Plans in September 2014 has resulted in improved arrangements for tailored SEND packages for children and young people.

The Local Offer for Rotherham describes the current range of services and provision available to families, which represents the totality of commissioned services in Rotherham.

There is a newly established advice and information service and currently there are two independent parental support workers.

However, there is little evidence of joint commissioning of SEND services. The services that are commissioned based on joint commissioning arrangements and aligned budgets, is the Child and Adolescent Mental Health (CAMHS) Service, the Specialist Equipment provision and Continuing Health Care packages.

There has been a mapping of SEND services and also a review of SEND arrangements, which has enabled a more detailed understanding of how these services are configured, including information on service delivery, the cohort of service users and their complexity of need, unmet need, service costs and funding source. The key findings from the mapping work are as follows:

Rotherham families tell us that we have:

- A lack of opportunities for supported employment packages
- Gaps in service for those who don't meet the criteria for Targeted Family Support
- A need to improve transitions

The Rotherham Inclusion Focus February 2015 told us:

- The current model of provision for young people with Social, Emotional and Mental Health needs is financially unsustainable and it does not appropriately meet the needs of this very vulnerable group.
- There is more work to do to further develop and implement the SEND Reforms in Rotherham. This includes enhancing the EHC Assessment Team to provide a 0-25 assessment service.

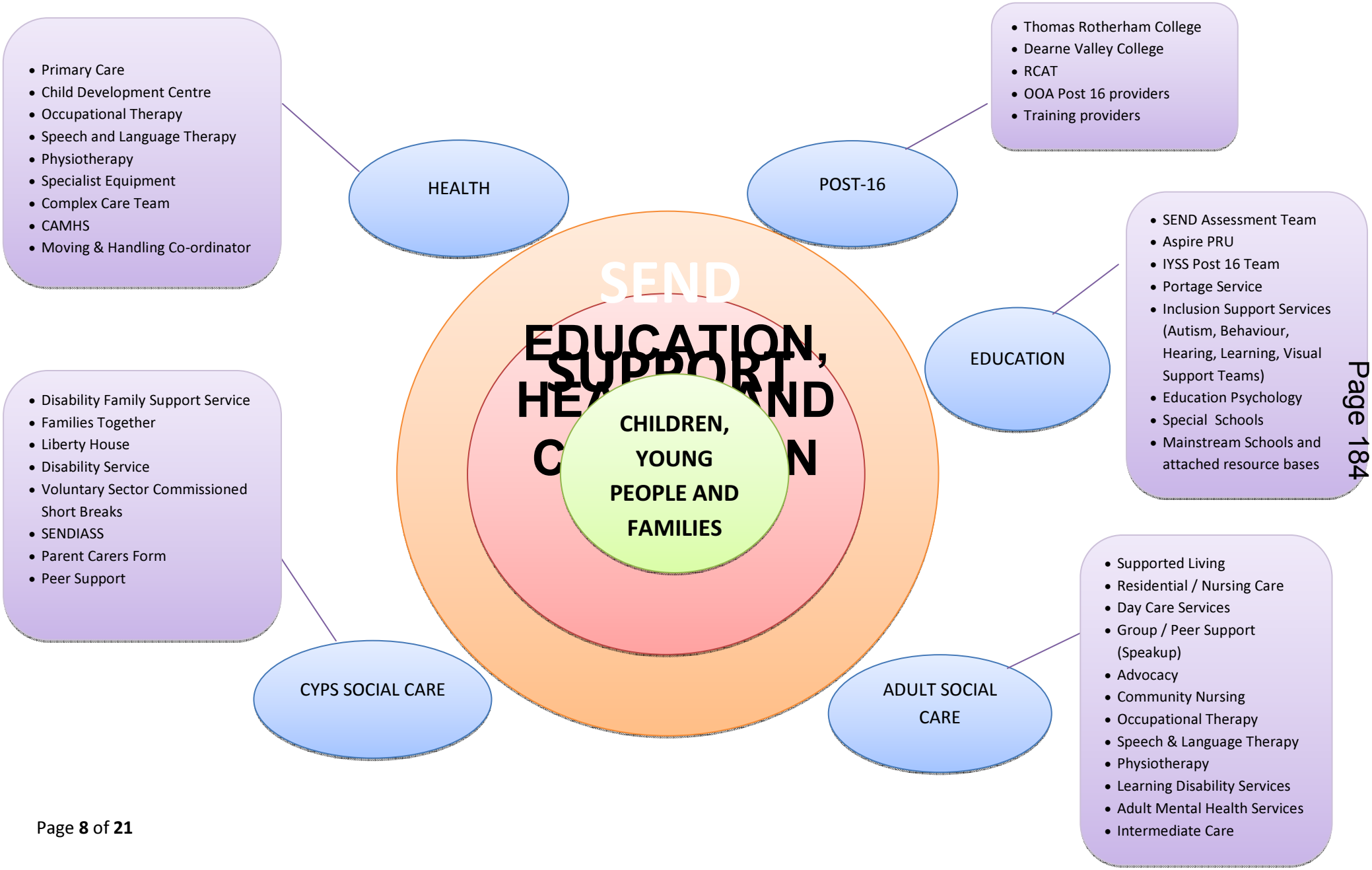
SEND Mapping Exercise October 2014 to February 2015 told us:

- There is limited out of school support for families post Autism Spectrum Condition (ASC) diagnosis
- Individual service links with the Child Development Centre (CDC) are not strong and there is a view that the CDC is inflexible towards their working with families. The CDC provides a service up to the age of 5 and there is a marked difference in the way that assessment is undertaken by CAMHS for those who are over 5 years of age.
- Hearing Impaired young people: a lack of technical aids for the home and no funding source for extracurricular activities to enhance life experience
- Visually Impaired young people, resources and equipment is reaching the end of its life. There are good links with the Sheffield eye clinic, but there is less collaboration with the Rotherham eye clinic
- The Education Psychology Service is unable to provide a service to pre-school children, the Aspire Pupil Referral Unit9 young people who are out of authority and unable to respond to requests from Health (e.g. Paediatrics) for input that does not meet school thresholds
- Opportunity to create efficiencies and flexibility in the way in which home to school transport is delivered
- The Speech and Language Therapy Team does not provide a service above age 11 unless the child has specific needs with regard to ASC. There are long waits for group therapy and intensive therapy is restricted.
- The services at Kimberworth Place (Children's Disability Team, CAMHS, Hearing Impairment Team, Visual Impairment Team, Autism Communication Team and the Child Development Centre) work well together on an informal basis, however a number of key teams may also benefit from being based in Kimberworth Place including the ISS (currently based in Rockingham Development Centre), and the EHC Assessment Team (currently based in Riverside)
- There is a gap for those who don't meet the targeted family support criteria, the Children's Disability Family Support Service criteria or are not the right age for Children's Centres.

A sample of the Current SEND Local Offer

The diagram on page 8 outlines a sample of the key services that form a part of the current SEND Local Offer and that are involved in the development of Education, Health and Care Plans. These services are provided by a range of providers across the statutory and voluntary sector.

A sample of the current Rotherham SEND Local Offer



How will we implement the Framework? * See diagram on page 10

Implementation will require a phased approach to move from the current position, which is a mixture of single, aligned and joint commissioning approaches to more formal, planned and fully coordinated joint commissioning covering the whole of the needs for children and young people with SEND and their families through to transition and Adulthood.

The initial focus is the further development of joint commissioning arrangements between the Local Authority, Rotherham CCG and NHS England. However, consideration will be given to how this can be extended to work with schools to understand their potential role and contribution to joint commissioning arrangements.

The following list of priority areas of work have been identified through the SEND Mapping exercise and consultation with key stakeholders:

Priority 1 Create a joint SEND Education, Health and Social Care Assessment Hub at Kimberworth Place.

Priority 2 Review and re-model services that provide support for children and young people with challenging behaviour.

Priority 3 Develop a performance and outcomes framework that will be applied across all Local Authority and CCG SEND provision.

Priority 4 Align local authority and CCG Service Specifications for SEND service provision, so as to facilitate commonality of practice and a consistent approach (thus reducing duplication, improving efficiencies and developing clearer pathways).

Priority 5 Audit the Education, Health and Care Planning (EHCP) process to look at how the assessment process (including the decision making process/panels and allocation of resources) can be streamlined, so as to reduce the multiple assessments that young people and their families have to undertake.

Priority 6 Ensure that there is a co-ordinated joint Workforce Development Plan.

Priority 7 Develop and implement Personal Budgets.

Priority 8 Develop pathways to adulthood

Priority 9 Develop the approach to improving life experiences

The priorities, along with comments from parents/carers and stakeholders that relate to those priorities, are detailed on pages 11 to 17.

Overarching SEND Joint Commissioning Framework

UNDERSTAND - We will:

Use the Rotherham Local Offer (LO) to further map all provision including that provided in schools and colleges. Find out how it is used and the outcomes it achieves. Identify gaps in provision and understand the impacts of these across the system.

Use quantitative and qualitative needs analysis to identify current and future needs and unmet needs of children and young with SEND and their families and understand what is important to children, young people and their families.

Develop ways of gathering more informative commissioning intelligence across partners and from EHCP's, actively sharing information and working to fill in information gaps.

Work out the real cost of in-house and externally commissioned services and the outcomes they achieve, assessing their effectiveness and value for money.

PLAN - We will:

Agree the 'must do' outcomes we expect providers to deliver, and how they will contribute to the identified outcome indicators.

Explore how different procurement techniques might be used to improve efficiencies. Ensure user involvement to improve outcomes. Ensure the most effective and proportionate approaches are taken to meet the desired outcomes.

Co-produce services with children, young people and their families.

Develop a clear strategy for the provider market and publish future joint commissioning intentions.

Co-produce a strategy, which includes a commitment to the provision of personal budgets, personalisation, co-production and self-directed support.

Plan the timings of procurement activity across partners and ensure effective risk identification and risk management systems are developed and embedded in future service planning.

DO - We will:

Co-develop a process for the use of personal budgets and a resource allocation system (RAS) which provides transparency and equity in terms of decisions about the allocation of personal budgets.

Publish commissioning decisions – provide transparent reasoning's for decisions made.

Procure/re-shape services where necessary - make investment decisions.

Ensure that workforce needs are effectively embedded into joint commissioning plans and that clear developments are made to embed key working within provider services.

Enable children, young people and their families to have control and choice relating to the care and services they receive.

REVIEW - We will:

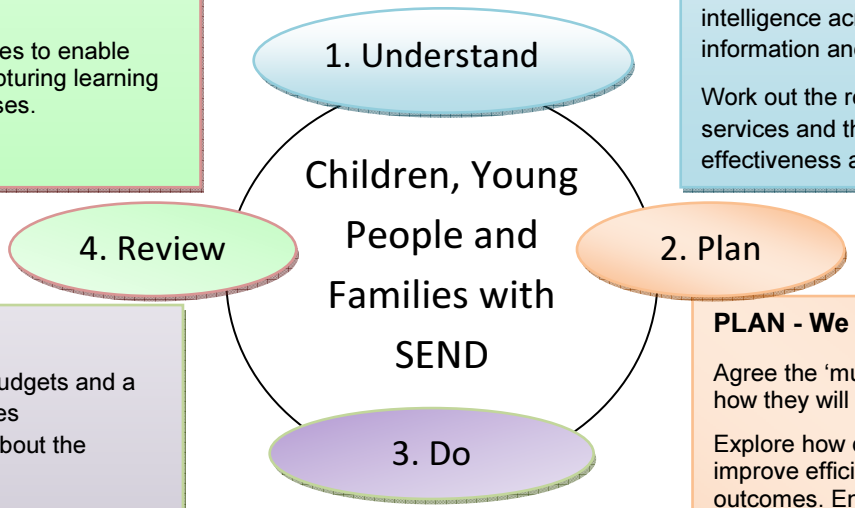
Jointly monitor service delivery against expected outcomes and report on how well it is doing, using this to improve the Rotherham Local Offer and delivery.

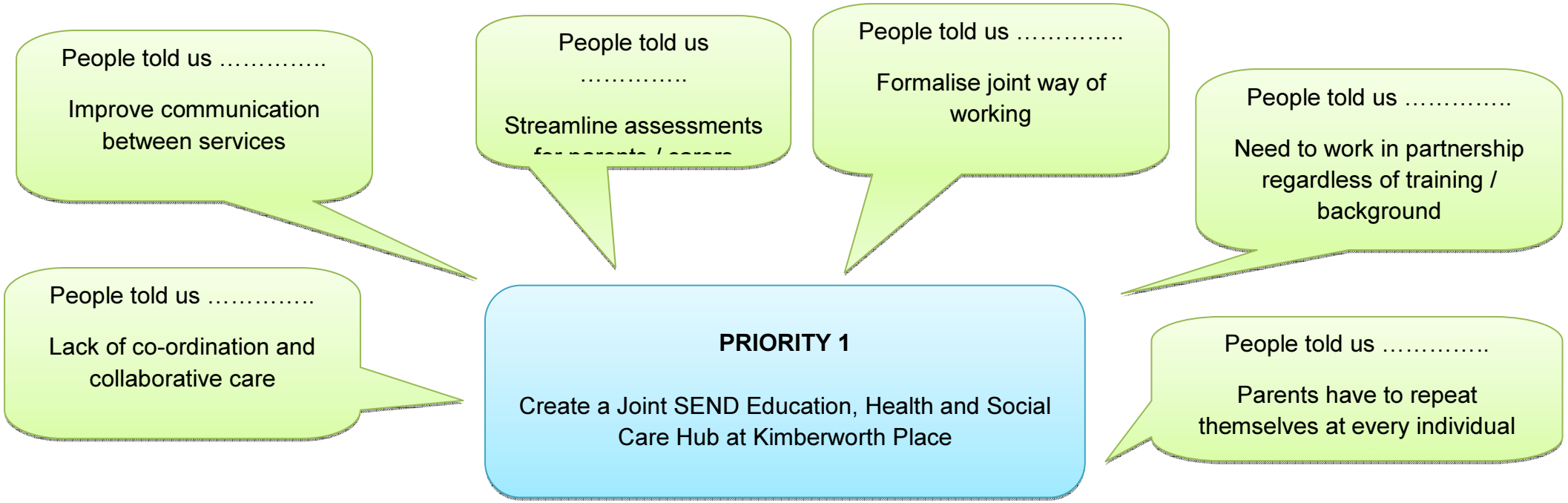
Review and monitor workforce developments and the implementation of key working within provider services.

Use evidence from the Rotherham Local Offer as part of or joint approach to reviewing the effectiveness of services provided.

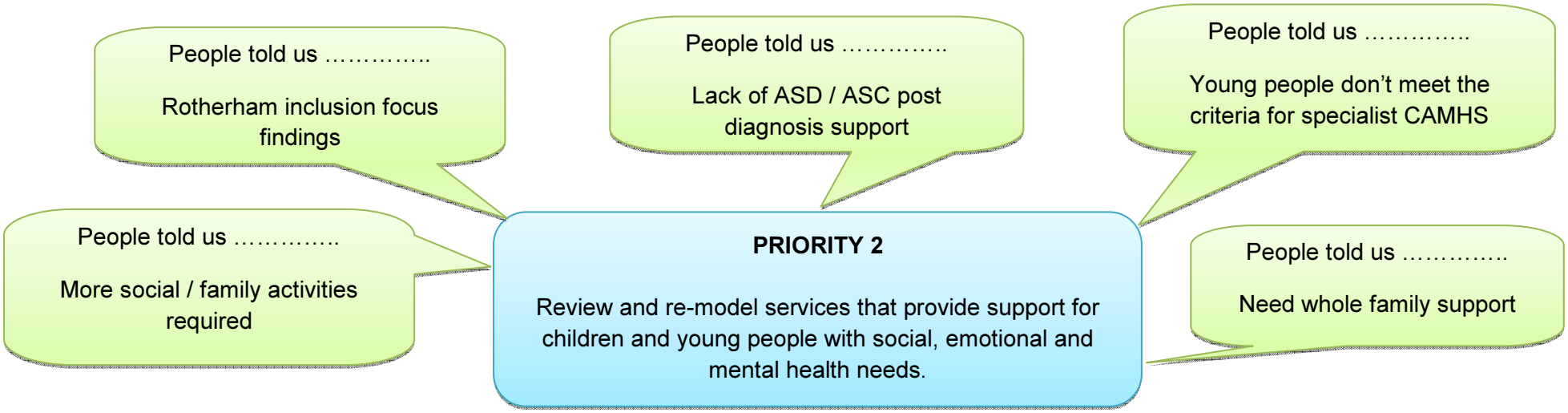
Develop a shared monitoring and performance management framework, which monitors outcomes achieved including those with

Work with children, young people and their families to enable them to review services with Commissioners, capturing learning from existing work and developing future processes.

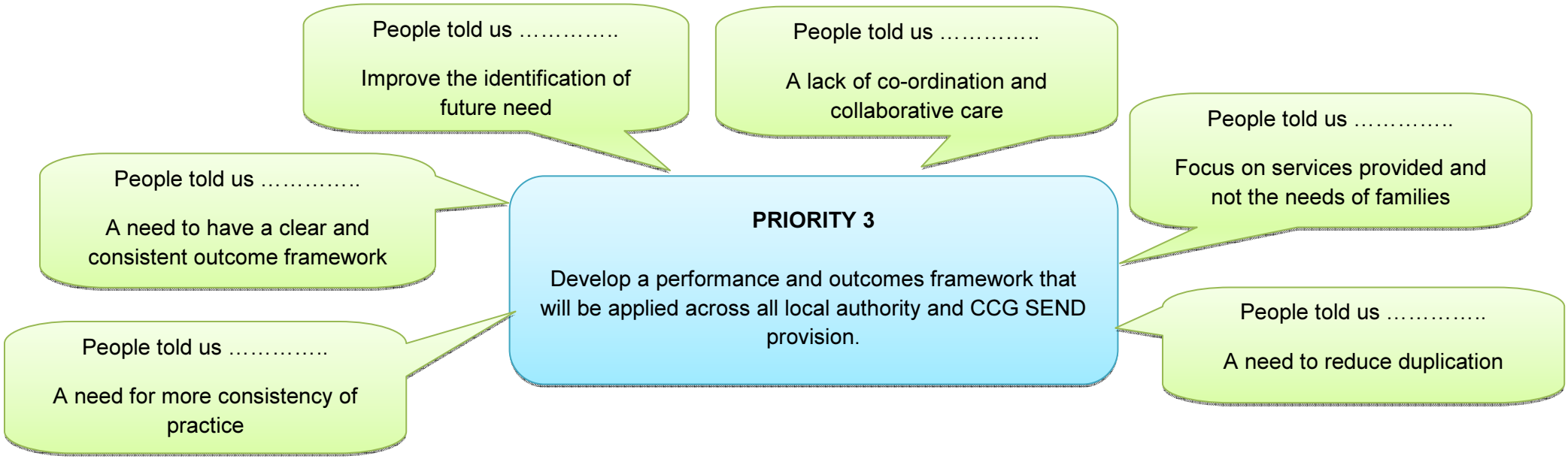




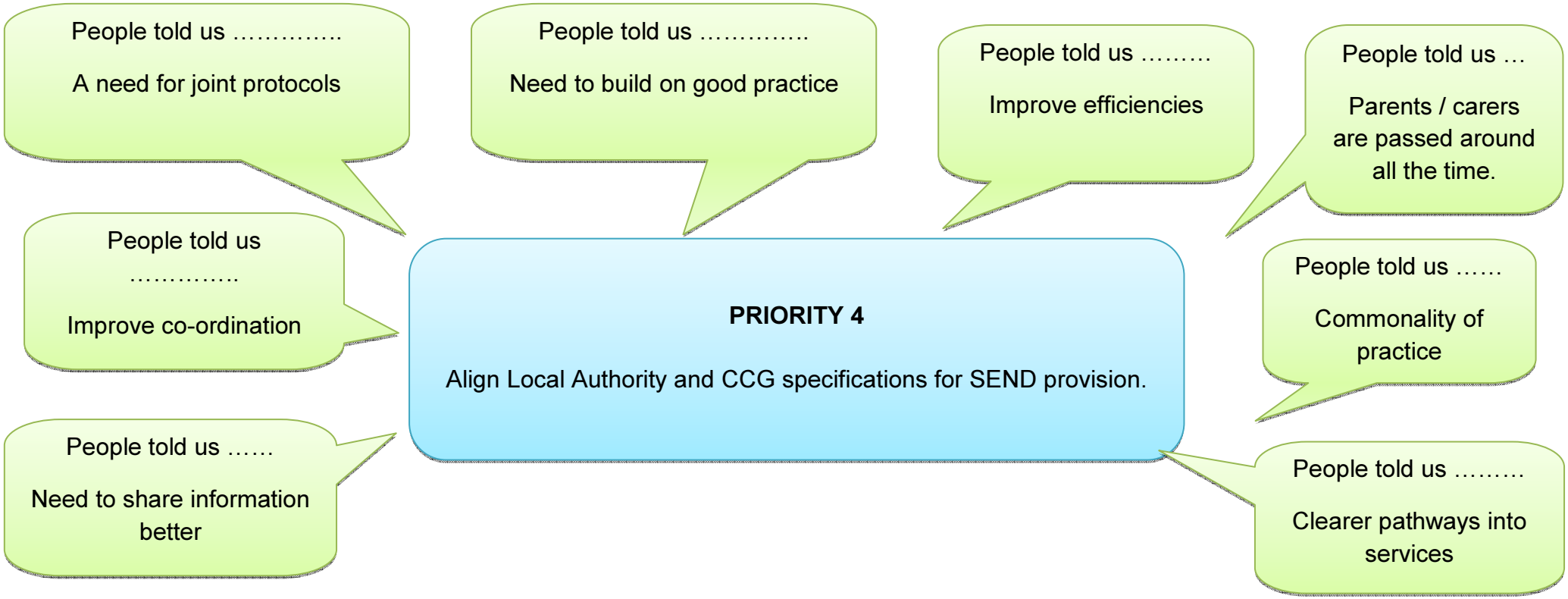
This is how we get there	This is where we want to be
Map services and relationship between services at Kimberworth Place	• Streamlined decision making process / panels (Continuing Care, Education Health and Care Plans, Short Breaks, Equipment and transitions) • Hub for personal budgets • Services understand the offer for partner agencies and have shared values and priorities • Education Health and Care Team work in strong collaboration and families • Plans are quality assured • Locality assessments feed into the assessment hub • Individually commissioned plans for children and young people and families are co-ordinated in one place
Audit use of space at Kimberworth Place	
Develop shared values and principles for staff to be located at Kimberworth Place	
Consider benefits of moving Education, Health and Care staff to Kimberworth Place and identify the staff involved	
Identify co-ordinator of provision at Kimberworth Place	
Consider solutions for information sharing	
Co-ordinate decision making processes	
Develop a robust quality assurance process	
Establish a hub for personal budgets	



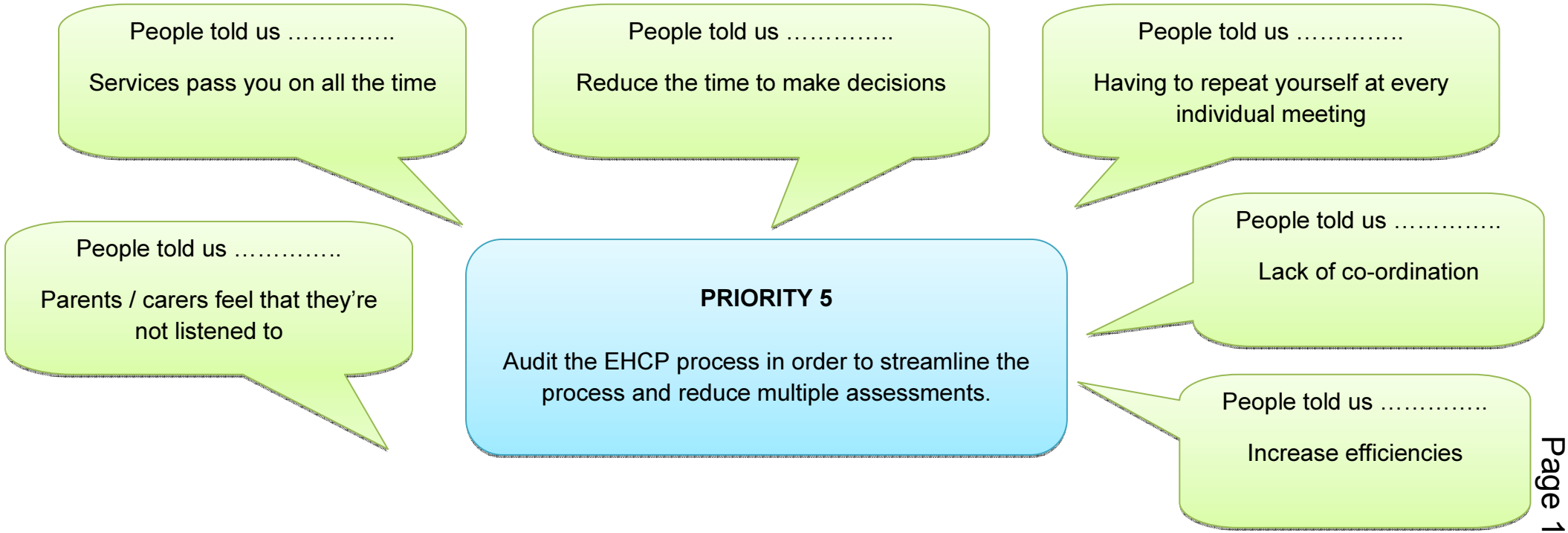
This is how we get there	This is where we want to be
Use the CAMHS / Schools Pilot Project to develop new ways of working and increase understanding of social, emotional, mental health.	• Collective responsibility for C&YP with social, emotional, mental health issues. • Clusters of learning communities work in partnership to meet needs locally. • Strong collaboration with partners, including CAMHS, school nursing and youth start. • Build school resilience • Develop alternative provision • Exclusions are rare • C&YP mental health needs supported locally in a trusted environment • Schools develop a graduated response • Schools have a whole school approach • Early help linked to school clusters • Young people and Children have access to support outside the school environment from the 1st of April, 2017.
Earl Help Offer clearly understood	
Develop training package and information and advice	
CAMHS restructure to align provision against school clusters	
Schools develop a graduated response to social, emotional and mental health	
Pathways into specialist interventions shared and understood	
GP's, social care and other services aware of social, emotional and mental health developments. Establish a post autism diagnosis service aimed at Children and Young People outside the school environment.	



This is how we get there	This is where we want to be
Ask families what the performance measures should be	• To understand employment / education destinations for C&YP with SEND. • To understand if outcomes in Education, Health and Care Plans are achieved. • To understand learning outcomes for SEND. • To understand number of exclusions. • Use POET to understand the views of families and providers
Create an SEND dashboard, including quantitative and qualitative data	
Quality assure Education, Health and Care Plan	
Audit a sample of Education, Health and Care Plans on a 12 month basis	
Review data of learning outcomes (Closing the Gap)	
Monitor and collate data on exclusions	
Introduce POET and analysis data	
Link with performance team	



This is how we get there	This is where we want to be
Identify a set of principles (golden thread) and align across all SEND services	• Shared values and priorities that underpin SEND services. • Clear communication of joint intentions and expectations in specifications • Clear pathways • Service specifications reference new duties and responsibilities e.g. joint assessment and collaboration. • There are specifications for in-house and external services • A golden thread runs through the commissioning strategy to individual service specifications in all areas • Service specifications have SEND non-negotiables
Identify dates of review of service specifications and include the principles and priorities	
Issue service specifications for in-house services	
Include quality control process to Education, Health and Care Plans	



This is how we get there	This is where we want to be
Review a sample of 20 completed Education, Health and Care Plans, to look at quality, outcomes, contribution from partners and C&YP and parental contribution	• All Education, Health and Care Plan partners make quality contributions to the process • Completed Education, Health and Care Plans are signed off by the appropriate lead within Education, Health and Social Care, based on the normal offer, exceptional support or provision and continuing care.
Identify learning from the review and take forward	
Build in to service specifications the need to contribute to the Education, Health and Care process	
Explore sign off procedure for Education, Health and Care Plans (two tiered approach)	
Identify the kind of decisions that sit above the normal arrangements	

People told us ……..

Avoid mixed messages

People told us ……..

Shared understanding of the SEND agenda and process

People told us ……..

Lack of understanding of each other's roles

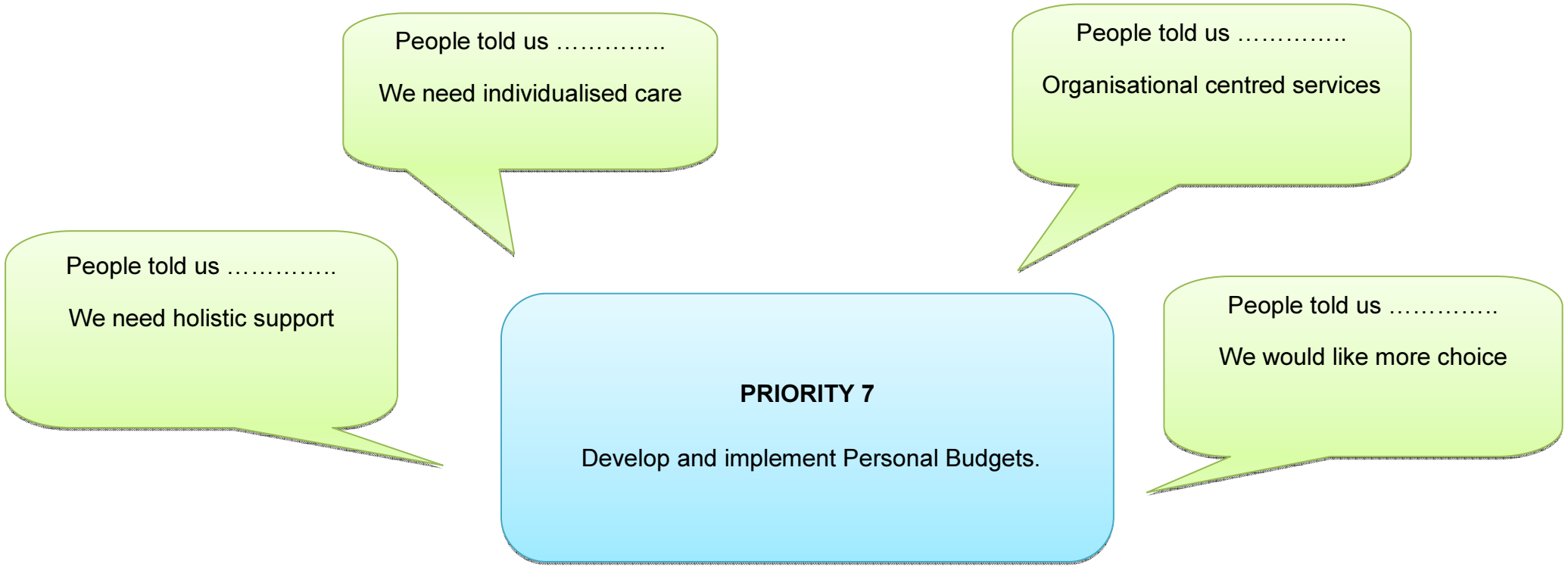
PRIORITY 6

Ensure that there is a co-ordinated joint workforce development plan.

People told us ……..

Joint training – pooling of resources

This is how we get there	This is where we want to be
Pooled CPD budgets	Have joint CPD around key areas of development e.g.: • Social, Emotional and Mental Health • Education, Health and Care Planning Process • Parental engagement • Personal budget • Safeguarding disabled children • SEND support • Local Offer • Outcome focussed planning
Develop and renew an annual training schedule	
Focus CPD on joint issues	
Invite colleagues from other service areas to training events	
Ask staff working on the SEND agenda what matters most	
Ask families what matters most	
Develop year 2 CPD programme	



This is how we get there	This is where we want to be
Develop a Personal Care and Health Budget Policy and Strategy	Personal Budget Strategy developed and included on the local offer.
Develop and embed a Resouce Allocation System (RAS)	Resource Allocation System enables parent and carers to access support on an individual basis at the right price.

People told us …….

Transitions work doesn't happen early enough

People told us …….

Services aren't co-ordinated at the point of transition

People told us …….

That young people don't meet the thresholds for access into adult services

PRIORITY 8

Develop pathways to adulthood.

People told us …….

There is a lack of opportunities for supported employment packages

This is how we get there	This is where we want to be
Education Health and Care planning team with input from children's and adult's social care	• A planned approach for transition to adult services. • Education, Health and Care provide a 0-25 plan • Good connections between Education, Health and Social Care • Need to understand criteria for adult services
Develop links with Young Adults Transitional Team	
Establish dialogue between Education, Health and Adult and Children's Social Care	
Develop a strategy	
Develop opportunities for supported employment	

People told us ……..

Limited out of school support for families post Autism Spectrum Condition (ASC)

People told us ……..

A gap in service for those who don't meet criteria for Targeted Family Support

People told us ……..

The links with Housing aren't strong

PRIORITY 9

Develop approaches to improving life experiences.

People told us ……..

The Local Offer doesn't include links to wider leisure and positive activities

This is how we get there	This is where we want to be
Audit services that provide information, advise and support and consider re-commissioning (possibly managed by the voluntary sector)	• Families know where to go for information, advice and support. • SEND independent information and advice service should be linked to other information services. • Young people have support in moving towards independent living • Young people have access to enriching leisure activities • Appropriate levels of family support available
Work with housing to ensure that housing is on the local offer	
Ensure that the local offer is populated with services that provide leisure activities	
Link with Early Help to support the development of positive activities	
Research and develop a model of support for families post Autism Spectrum Condition diagnosis	

How will we know we have made a difference?

The SEND Joint Commissioning Sub Group will lead on the implementation of this strategy and pending work plan. As joint commissioning projects are implemented, agencies will provide information to measure progress regarding the impact of services and interventions. Performance reports will be shared through the necessary governance routes within agencies.

The Sub Group will also actively receive feedback from children, young people and their families, as well as from practitioners working with children and young people with SEND, to help further assess needs and challenges. This, along with the performance management will inform future joint planning, commissioning and decommissioning of SEND services within Rotherham.

Joint Commissioning Plan 2015-18

	Milestones	Resources	Lead	Update
1. Create a formalised joint SEND Education, Health and Social Care Assessment Hub at Kimberworth Place. **Develop an Integration Plan** **Strengthen the interface with the CAMHS Service**	**July 2017** **August 2017** **September 2017**	**Estates Support**	**Paula Williams** **Emma Royle/ Paul Theaker**	
2. Review and re-model services that provide support for children and young people with challenging behaviour	**March 2018**	**Partner Support** **Estates Support**	**Paula Williams**	
3. Develop a Performance and Outcomes Framework that will be applied across all local authority and CCG SEND provision.	**June 2017**	**Staff Capacity**	**Sue Wilson**	
4. Align local authority and CCG Service Specifications for SEND service provision, to facilitate commonality of practice and a consistent approach (thus reducing duplication, improving efficiencies and developing clearer pathways).	**April 2017**	**Staff Capacity**	**Paul Theaker** **Emma Royle**	

	Milestones	Resources	Lead	Update
5. Audit the Education, Health and Care Planning (EHCP) process to look at how the assessment process (including the decision making process/panels and allocation of resources) can be streamlined, so as to reduce the multiple assessments that young people and their families have to undertake.	**March 2017**	**Staff Capacity**	**Paula Williams** **Mary Jarrett**	
6. Ensure that there is a co-ordinated joint Workforce Development Plan	**March 2017**	**Staff Capacity**	**Paula Williams**	
7. Develop, implement and embed Personal Social Care and Health Budgets	**March 2018**	**Staff Capacity**	**Mary Jarrett** **Alun Whindle**	
8. Develop a Direct Payment Strategy	**March 2017**	**Staff Capacity**	**Mary Jarrett**	
9. Develop the market to ensure there is choice for personal budget holders, including transport	**April 2018**	**Procurement**	**Linda Harper**	
10 Develop and embed strong transition pathways	**April 2018**	**Staff and partner capacity**	**Jo Smith**	

BRIEFING PAPER FOR HEALTH & WELLBEING BOARD

Date of meeting:	**8 March 2017**
Title:	**Information regarding Specialist Residential & Nursing Care for Adults in Rotherham**
Directorate:	**Adult Care & Housing** **Strategic Commissioning**

1. Introduction

Following the Health & Wellbeing Board meeting in January 2017, an action was raised for the Adult Care & Housing Commissioning team to provide an update to the Board on the current position of commissioned Care homes in Rotherham. The scope of the update includes Residential, Nursing, Residential with Dementia Care and Nursing with Dementia Care for Adults i.e. 18-64 and older people.

2. Recommendation

It is recommended that the Health & Wellbeing Board note the information provided in this report.

3. Background

3.1 There are a total of 35 independent sector care homes (owned by 23 Organisation's) contracted to support older people in Rotherham. They provide a range of care types categorised as Residential Care, Residential Care for people who are Elderly and Mentally Infirm, Nursing Care and Nursing Care for people who are Elderly and Mentally Infirm.

3.2 There are a total of 36 Independent sector homes (owned by 24 Organistions) contracted to support Adults with specialist needs. They provide a range of care for Adults who live with Learning Disabilities, Physical Disabilities, Mental Health and Sensory conditions (including Aquired Brain Injury).

3.3 The independent sector care home market in Rotherham supplies 1779 Beds and accommodates around 1593 older people. The Council is the dominant purchaser with the majority of the population placed by the Council. There is currently a vacancy factor of 186 beds or 10.5% of the total capacity:

As of February 2016, the total Older People's care home population is made up of:

- 26% (409 people) private paying clients including from out of Borough.
- 4.5% (72 people) placed and funded by other local authorities.
- 62% (987 people) placed and funded by the Council – this includes
- people who receive Funded Nursing Care.
- 7.5% (125 people) placed and funded by our health partners under
- Continuing Health Care arrangements (fully funded by Rotherham CCG).

3.4 The independent sector care home market in Rotherham supplies 397 Beds and accommodates around 366 Adults with specialist needs. The Council purchases 37% (145) beds, with the remaining 63% (252) beds occupied by residents who are fully funded by health Continuing Health Care and Out of Authority placements. There is currently a vacancy factor of 31 beds or 8% of the total capacity.

As of February 2016, the specialist care home population placed by the Council is made up of:

- 21% (31 people) funded fully by the Council (no client contribution) – this includes people who receive Funded Nursing Care.
- 7% (10 people) jointly funded by the Council and Continuing Health Care.
- 72% (104 people) funded by the Council and a financial contribution
- from the service user.

4. Quality Assurance

4.1 All Council commissioned providers are registered with, monitored and inspected by the Care Quality Commission (CQC). The commissioned Residential and Nursing Providers for Older People and Adults with specialist needs have been rated by CQC as follows:

Inadequate	1
Requires Improvement	18
Good	51
Outstanding	1

4.2 In addition to CQC's inspection and monitoring regime, all commissioned providers are monitored and inspected by a team of Contracting Compliance Offcers (CCO's) overseen in the Strategic Commissioning Team. Providers are monitored against standards set out in the Council's service specification(s) and the associated contract(s) terms and conditions. Deviation away from the standards results in intervention with providers which may include action plans, special measures improvement plans, contract default action and/or embargoes. Action undertaken by the Strategic commissioning Team may ultimately result in contract termination should providers continue fall below the required standard.

4.3 All Commissioned providers are scrutinised through the Council's Provider Risk Matrix. This system collates intelligence direct from source of entry (i.e. the Contract Concerns database, the social care recording system – Liquid Logic, Adult Safeguarding database), and from manual entries (CQC intelligence (Warning Notices & Compliance Actions), local intelligence (Contract Default, Manager leaving/Administration).

4.4 All categories of intelligence that are collated carry a "weighted" score, the total scores allow each provider to be "RAG" rated, which is an instant alert to providers who are at risk due to quality of care.

The Adult Provider Risk Matrix is a live system and the scores change as:

- concerns are either substantiated or unsubstantiated
- safeguarding alerts are screened
- investigated and concluded
- CQC or local intelligence changes.

The CCO's have an annual inspection programme in place for all Commissioned services. This programme is supported by a programme of Planned Provider Meetings, which are arranged according to a providers status on the Provider Risk Matrix, as follows:

Red	Monthly Planned Provider meetings	Full Annual Inspection by the allocated CCO, using the established toolkit
Amber	Bi-monthly Planned Provider meetings	Discretion used by CCO whether a full inspection is required, or self assessment, depending upon overall "amber" score
Green	Quarterly Planned rovider meetings	Self assessment by Provider using established toolkit

4.5 Planned Provider meetings follow an established and agreed agenda,and the CCO will use the meeting to verify information provided during any self assessment, check improvements against any Contract or Special Measures Improvement Plans.

4.6 Information is shared between the Contract Compliance Team, the Adult Safeguarding Team and CQC on an adhoc basis, and more formally at the Bi-monthly CQC risk meeting hosted by the Council.

5. Recent Developments in the sector

5.1 The Rotherham Foundation Trust has commissioned 10 step-down nursing beds at Ackroyd Care Home from January to March 2017 on a spot purchase contractual arrangements to alleviate winter pressures and to facilitate hospital discharges. These are new beds located within the new unit (new extension).

5.2 The contract held by the Rotherham CCG for 6 Discharge to Assess nursing beds at Waterside Grange will be extended for a further year up to and including March 2018.

5.3 The Rotherham Foundation Trust has employed a Nurse Quality Advisor within the Care Home Support Service from February 2017. This will improve the standard of care for residents of Rotherham's Care Homes for Older People and the role holder will have responsibility for providing support with current quality assurance systems to ensure robust mechanisms are in place to monitor quality. They will undertake audits, reviews and assessments and provide advice, training and support to care homes and work closely with the Council's Contract Compliance Officer Team.

5.4 All Older People's care homes are fully aligned to GP practices to provide medical cover for residents in older's peoples care homes.

5.5 A new Supported Living Framework for Learning Disabilities and Autism is currently under development, jointly with Sheffield City Council with the intention to tender for services to commence September 2017. This will enable the expansion of an alternative market to residential care. As a consequence, some specialist residential providers in Rotherham are considering a change of registration from residential provision to Supported Living.

5.6 In response to immediate demand, pending the tender process for Supported Living, Eden Supported Living, part of the Eden Futures Group, are working in partnership with registered social landlords Bespoke Supportive Tenancies (BeST) to bring to the sector twelve single-person apartments in Dinnington. This will provide an excellent alternative to the residential care options in the area. The service is for people with:

- Learning disabilities
- Complex behaviours
- Autistic spectrum conditions

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NHS Rotherham CCG - CAMHS Local Transformation Plan - Update Report Quarter 3, 2016/17

1. Progress to date –

a. General progress made in respect of implementation of the plan.

The LTP Action Plan continues to be closely monitored and updated on a bi-monthly basis. It is now published on the NHS Rotherham CCG website, alongside the local transformation plan itself. It reflects all the proposed developments in the 'Future in Mind' report and goes beyond the specific priority development areas outlined in the LTP and to which extra funding is attached.

Further detail is included on each local priority scheme in the section below.

b. Progress for each Local Priority Scheme.

Local Priority Scheme 1 – Intensive Community Support

RDaSH CAMHS continues to provide the combined Intensive Community Support/Crisis service (see local priority scheme 2 below). The service also links with the CAMHS Interface & Liaison post (see local priority scheme 14 below).

The pathway dealt with a caseload of 30 during Quarter 3. Support and interventions are offered on an individual basis as per client need and further development of the pathway is planned for the next 6 months, including case management and interventions offered.

The service has also responded to a very difficult situation in January relating to a recent murder in Rotherham and has provided tailored support to children & young people, teachers and parents at a specific school.

RDaSH CAMHS continued to develop the monitoring information relating to the Intensive Community Support service during Quarter 3.

The numbers of Rotherham children & young people in inpatient facilities remained at a low level during Quarter 3 and it is still the view that these low numbers are a direct consequence of the new service.

The CCG met with NHS England Specialised Commissioning, along with other CCGs in Quarter 3 to discuss potential future collaborative commissioning work. Further meetings are planned to take forward this piece of work.

Local Priority Scheme 2 – Crisis Response (Including Liaison)

A Crisis response service continues to be provided through the Crisis/Intensive Community Support pathway. This links to Priority Scheme 1 above and Priority Scheme 14 below.

For Quarter 3, there were 5 patients referred to CAMHS services via A & E and all were assessed within 24 hours.

The out of hours on-call service continues to be provided and will be phased out and replaced with an all-age Crisis service. This is planned to be provided from June 2017. It will also link to the Intensive Community Support service and be provided from 8pm to 8am. In Quarter 3, there were 4 face to face assessments out of hours and 1 telephone assessment by RDaSH CAMHS.

Local Priority Scheme 3 – Autism Spectrum Disorder (ASD) Support

During Quarter 3, the structure of the new service was finalised as 2 x 0.6wte family practitioners, 1 x 0.2wte information officer and 1 x 0.2wte admin and one of the family practitioner posts was recruited to. The Family Practitioner posts will work primarily in the community. Clinical supervision of these posts will be through RDaSH CAMHS.

Two follow up workshops for the sensory assessments took place at the end of November. Request forms for Sensory kits were distributed at sessions. School SENCOs will get the kits in secondary, primary and special schools, and FE colleges and it is hoped that this sensory work will help to negate the need for full sensory assessments.

The Service was officially rolled out on the 1st January, 2017 and will be the key contact for parents following ASD diagnosis. Initial contact will be made within 6 weeks of diagnosis and then at 6 months after diagnosis. The service will also start to work with families of children & young people with a previous diagnosis.

Local Priority Scheme 4 – Prevention/Early Intervention

Six schools in Rotherham signed up to a 'Whole School Approach' pilot in 2015/16. Action Plans' are being rolled out in 2016/17 and full reviews will be undertaken in July 2017.

At a recent meeting with schools representatives the pilot was discussed and it was acknowledged that there has already been a sharing of experiences and learning from good practice between schools. Part of the review process also involves the participating schools promoting the 'Whole School Approach' to other schools.

The RDaSH CAMHS service continues to develop the 'Locality Worker' model and a Locality Pathway lead is now in place. Locality Workers link with specific schools, GP practices and Early Help teams and provide local support to children & young people and their families.

Part of the development of the pathway also includes a 'Consultation and Advice' element, which aims to provide early intervention and prevention work. This has been successfully implemented in the Doncaster service and the Locality Pathway lead is meeting with the Doncaster service to look at how the Rotherham service can be improved.

Local Priority Scheme 5 – Family Support Service

The service (being provided by the Rotherham Parents Forum) is fully established with three Co-ordinators now in place. A 'Volunteer' training package was developed but the recruitment has been delayed due to the high volume of families being supported.

39 families were supported in Quarter 3, with a total of 48 children. Most families had 1 child supported and the majority were aged 5 to 11 as was seen in Quarter 2, although in Quarter 3 there were more children in the 5 to 7 age group than 8 to 11. This is due to an increase in referrals for children currently in the Child Development Centre (CDC). Of the children supported, 34 were male & 14 female. A very high proportion of the cases supported related to ASD (40).

The Parents Forum has continued to forge excellent links with providers and other stakeholders across Rotherham in Quarter 3, including; Adult and Children & Young Peoples mental health services, Health Visitors, the Autism Communication Team (ACT), Autism Post Diagnostic support Team, Educational Psychology services and various schools.

Some challenges remain, particularly relating to acceptance of the parents forum as a 'serious' support provider and also capacity. The latter is being hopefully addressed through further additional recurrent funding of £15,000 from 2017/18.

Local Priority Scheme 6 – Workforce Development

A draft workforce development plan has been developed and presented to the CAMHS Strategy and Partnership Group. There has been some limited further work in this area, but we are awaiting the results of the Yorks & Humber area wide work which is developing a 'framework for Education' by February/March 2017. It was felt it would be helpful if this could inform the local work in Rotherham.

Local Priority Scheme 7 – Hard to reach groups

There has been no further specific follow-up to the work that was completed in 2015/16 with non-recurrent funding.

Other local priority schemes by their nature do focus on Hard to reach groups such as the Family Support Service (priority scheme 5), the advocacy service (priority scheme 9) and the CSE pathway (priority scheme 10).

In addition, the CCG is actively involved in the Yorks & Humber work with the NHS Health & Justice and an event is planned for the 1st March, 2017.

Local Priority Scheme 8 – Looked After Children

A pilot has started in November, to prioritise the treatment of LAC in the CAMHS service. This will run for 3 months and then be evaluated. During November and December, 11 LAC have been referred to the CAMHS service and their assessments have been prioritised as urgent and completed within 24 hours.

RDaSH CAMHS and the RMBC Looked After and Adopted Children's Therapeutic Team (LAACTT) continue to work closely together to develop collaborative approaches to best support the needs of LAC. A clear threshold criterion has been established to identify when children and young people require support from which specific service.

The CCG is proposing to provide £10,000 of funding for this area from 2017/18. This will be used to support LAC placed outside of Rotherham.

Local Priority Scheme 9 – Development of services through input from Children & Young People and parents/carers.

The 'Engagement scoping' work was completed and the recommendations are being taken forward accordingly.

RDaSH have benchmarked themselves against the recommendation which came out of the scoping work and are preparing an action plan to take forward work on any gaps identified. The key areas where work is required are:-

- Goal settings & outcomes monitoring.
- Involving Young people in the design, delivery & evaluation of staff training.
- Involving children & young people in the supervision and appraisal of staff.
- Influencing senior managers in strategic decision making.

- Having a mission statement/Charter in place about the involvement of children & young people in the services.

Funding is continuing in 2016/17 for the Healthwatch Rotherham advocacy service for children & young people. The service supported a total of 12 children & young people and their families during quarter 3 and 4 cases were closed. The advocacy work was concerned with CAMHS services, but also the Child Development Centre (CDC), The Rotherham Foundation Trust and Adult Mental Health services. Work has started to look at the option of using the local Authority Young Inspectors to assess the service in the future.

Local Priority Scheme 10 – Increased funding for working with children & young people and adults affected by Child Sexual Exploitation.

The CAMHS Practitioner role within the CSE pathway has now been recruited to.

The service continues to directly support the victims of CSE as well as staff in other services who provide support. It also works directly with the voluntary sector in Rotherham, working with organisations such as GROW and Rotherham RISE.

RDaSH provides monthly reporting relating to children & young people (and adults) affected by CSE. In Quarter 3, the CSE pathway had 22 first appointments and 58 follow-up contacts with CAMHS patients and 2 first appointments and 13 follow-up contacts with Adult patients.

The service also had 92 consultations in Quarter 3 with other services about CAMHS patients and 33 about Adult patients. These 'consultations' could be with one practitioner or a number in a specific service at the same time, so the numbers are indicative only.

The work in this area also (by it's nature) is closely linked to the 'hard to reach' and 'vulnerable' groups in priority scheme 7 and there are challenges relating to engagement with these groups.

The service is committed to developing a tailored service response to the adult survivors and partnership working has developed with adult Intensive Community Therapies service.

Local Priority Scheme 11 – Increased general CAMHS capacity

This funding is continuing in 2016/17 and is now fully integrated into the overall RDaSH CAMHS service.

Local Priority Scheme 12 – Increased funding for the CAMHS 'Out Of Hours' service.

This funding is continuing in 2016/17 and links to Local Priority Scheme 2.

Local Priority Scheme 13 – Single Point of Access (SPA)

This funding is continuing in 2016/17 and links to Local Priority schemes 1 & 2.

Plans were in place for integrating the CAMHS SPA and RMBC Early Help function early in January, 2017. However, this move has since been delayed and further discussions are ongoing. Representatives from CAMHS and Early Help continue to meet regularly to discuss the appropriateness of referrals into each service. This was once a week but is increasing to twice a week to ensure timeliness of response to families and referrers.

Local Priority Scheme 14 – CAMHS Interface & Liaison post

This funding is continuing in 2016/17 and links to Local Priority Scheme 2.

Local Priority Scheme 15 – Pump prime investment in an all-age 24/7 liaison mental health service.

The funding for this scheme was non-recurrent for 2015/16 so is not continuing in 2016/17.

Local Priority Scheme 16 – Children & Young Peoples IAPT (CYPIAPT)

An MOU is in place with NHS England (due to expire at the end of March 2017) and training is ongoing with three members of staff from RDaSH CAMHS. These are:-

- 1 X Enhanced Evidence Based Practice (EEBP) for children & young people.
- 1 X Interpersonal Psychology for Adolescents (IPT-A) therapist.
- 1 X Systemic Family Practice (SFP) Supervisor.

A 'Specification' is currently being signed off between NHS Rotherham CCG and NHS England covering the period between 1st July 2016 and 31st march 2018, relating to the training costs of 2 Enhanced Evidence Based Practice Trainees within the RDaSH CAMHS service. This will ensure that the appropriate funding can be directed through the CCG to the provider service at the appropriate times.

Local Priority Scheme 17 – Eating Disorders Service

The Eating Disorder Service, established jointly with Doncaster CCG and North Lincolnshire CCG, is now in place and all staff have been recruited. RDaSH hosted an official service launch at the Kimberworth place facility on the 25th January, 2017.

The South Yorkshire Eating Disorder Association (SYEDA) is jointly providing services alongside RDaSH and is now working closely with schools.

Numbers being referred to the RDaSH service remain relatively low. RDaSH provides monthly data relating to the Eating Disorders service which indicates that across the three geographical areas there were a total of 20 referrals in Quarter 3 (compared to 13 in Quarter 2). All of those referrals in Quarter 3 were seen within the 4 week target.

Local Priority Scheme 18 – Transition from CAMHS to Adult services

A transition service specification is being developed and will be agreed with the CAMHS provider during 2016/17. A national CQUIN covering transition will also apply from April 2017/18.

A Transition 'Task & Finish' group is also being established to oversee work in this area, including representation from the Local Authority, statutory and voluntary mental health services and the commissioners. This will reference the Yorkshire and Humber transitions toolkit and also link into a general transitions piece of work being undertaken by the Local Authority.

The CCG is also proposing to fund a new service based around social prescribing and supporting children & young people who don't transition from CAMHS services to adult mental health services but still require support.

c. Schemes not intended for implementation until 2017/18 or beyond.

All of the priority schemes identified above started their implementation in 2015/16.

There are a number of other identified areas for development, which are included in the CAMHS LTP Action Plan, which are scheduled to start in 2017/18 or beyond. These include:-

- Undertaking a scoping exercise to understand if the 'Thrive' model or something similar could be developed in Rotherham.
- Undertaking a scoping exercise to understand how 'One-stop-shops' could be developed in Rotherham.
- Implementing a social prescribing service during 2017/18 to support children & young people who transition out of CAMHS services but not into adult services. This will involve new funding from the LTP monies.
- A new service to be developed from 2017/18 providing education and prevention around self-harm. This will probably be delivered in school settings by voluntary sector CAMHS providers. Specific details are being developed and new LTP funding will be allocated to this area.

2. Areas of most challenge in implementation.

- **Staff Recruitment & Retention** is less of an issue than in the past, and the RDaSH CAMHS service has only one vacancy as at January, 2017, which is due to be filled by the end of May, 2017. However, the CCG continues to have regular (bi-weekly) update meetings to monitor progress in the CAMHS service. The CCG is also supporting RDaSH to recruit 2 Psychological Wellbeing Practitioners (PWP) starting in April 2017 under the scheme being provided by Health Education England (HEE). One of the two CAMHS Consultant Psychiatrists may shortly retire and will need to be replaced, which may be a challenge.

- **Mental Health Provider overall reconfiguration** – The main mental health provider in Rotherham is still undertaking a major reconfiguration of its services. This has impacted on the CAMHS service as the current CAMHS Operational Manager (who has been a key influence in the CAMHS service improvements) will be moving away from the CAMHS area. The CCG is working closely with the provider to ensure that this does not affect the further development of the CAMHS service. RDaSH has also recently reconfigured its services across its geographical footprint and Adult and Older Peoples services in Rotherham are now under a Rotherham locality structure. However, the CAMHS service is not part of this locality and is part of a children's locality structure across Rotherham, Doncaster and North Lincolnshire.

- **Waiting Times** - As at April 2016, in the RDaSH CAMHS service there were 240 patients without an assessment appointment. This had reduced to 85 at the end of Q1 and 53 at the end of Q2. By the end of Quarter 3 this number was at 56, although it had been as low as 40 in November. It was expected that the reduction in the waiting list would have been sustained. This remains a priority for the CCG and CAMHS update meetings with RDaSH still take place every two weeks to monitor this situation. As at the end of Quarter 3, the average waiting time for an assessment was 6.6 weeks and for treatment 12.4 weeks. The CCG is benchmarking these waiting times against other local and national information and non-recurrent funding from NHS England has specifically been targeted in this area.

- **Thresholds for referrals into the CAMHS service** – There is a high percentage of referrals into the CAMHS service which are then signposted to other services and there needs to be a better understanding of whether this signposting is appropriate and if children & young people are being supported by these other

services. At the request of the CCG, the CAMHS service is completing an exercise to outline thresholds it applies and how these relate to other service provision.

- **Project Management time** – The increasing focus on CAMHS commissioning nationally has put pressure on the CCG CAMHS lead in terms of taking forward all of the CAMHS LTP actions alongside other priorities. However, CAMHS work continues to be prioritised over other areas as much as possible and remains a high priority for the CCG.

- **Overall Funding Issues** – Whilst the CCG is increasing CAMHS funding in line with the expected levels, the continuing tight financial situation facing the CCG means that there is no flexibility to further invest in CAMHS services over and above the LTP monies even where some additional investment would be very beneficial.

3. Finance and activity review.

All of the Rotherham 2015/16 LTP allocation was spent in 2015/16 and all of the 2016/17 allocations have been committed.

The following table shows expenditure by local priority scheme. It also includes proposed extra investment in 2017/18.

Local Priority Scheme	Description	Investment in 2015/16	Investment in 2016/17	Investment in 2017/18
1	Intensive Community Support Service	£63,000	£170,000	£170,000
2	Crisis response			
3	Autism Spectrum Disorder (ASD) Post diagnosis Support	£60,500	£54,000	£54,000
4	Prevention/Early Intervention	£80,000		
5	Family Support Service	£32,000	£70,000	£85,000
6	Workforce Development	£32,000		
7	Hard to reach Groups	£21,000		
8	Looked After Children (LAC)	£50,000		£10,000
9	Provision of Advocacy Services	£5,000	£20,000	£20,000
10	Child Sexual Exploitation (CSE)	£15,000	£50,000	£50,000
11	Increased General Capacity		£80,000	£80,000
12	Increased Funding for Out of Hours services	£30,000	£30,000	£30,000
13	Single Point of Access	£35,000	£35,000	£35,000
14	Interface & Liaison Post	£55,000	£55,000	£55,000
15	24/7 Liaison Mental Health	£68,000		
16	CYPIAPT	£37,000	£37,000	£37,000
17	Eating Disorder Service	£145,000	£139,000	£139,000
18	Transition			£20,000
19	Perinatal Mental Health			TBC
20	Self-Harm			£40,000

Most activity is picked up in the specific priority scheme areas above, but the following highlights any additional activity information relevant to particular priority schemes.

Local Priority Scheme 13 – Single Point of Access (SPA)

In Quarter 3the CAMHS service received 460 referrals, of which 41 were inappropriate and returned to the referrer and 204 were signposted to other services.

Local Priority Scheme 14 – CAMHS Interface & Liaison post

In Quarter 3, 9 referrals were made from the acute hospital to the Liaison nurse. All of these had a joint TRFT/RDaSH Discharge plan.

4. Review of partnerships –

The Rotherham CAMHS LTP Action Plan has been developed to monitor implementation of the LTP in Rotherham and is updated on a bi-monthly basis. This is a jointly owned document and each stakeholder involved – including RDaSH, RMBC, Healthwatch, Rotherham parents forum and Public Health – has a lead person whose job is to update the Action Plan. The Action Plan is circulated to members of the CAMHS Strategy & Partnership Group, which includes all stakeholders, including statutory bodies as well as the voluntary sector and Youth Cabinet representation. This group meets quarterly and a copy of the minutes from the meeting on the 18th January, 2017 is attached as Appendix 1.

The CCG, RDaSH and RMBC continue to meet with schools and Colleges representatives to discuss CAMHS related issues, who then feedback to all Rotherham schools. Much of the schools related work centres around CAMHS Locality Workers and how they interface with Schools across Rotherham. These meetings take place every 2 months.

5. Eating Disorders –

See Local Priority Scheme 17 above for a general update on this area.

Appendix 1

NHS
Rotherham
Clinical Commissioning Group

Minutes		
	Title of Meeting:	CAMHS Strategy & Partnership meeting
	Time:	1pm – 3pm
	Date:	Wednesday 18th January 2017
	Venue:	Elm Room, Oak House
	Chairman:	Dr Richard Cullen

Present		
Gavin Portier	GP	CAMHS Operational Manager, RDaSH
Kirsty Gleeson	KG	Project Support, RCCG
Nigel Parkes	NP	Senior Contracts Manager, RCCG
Barbara Murray	BM	Deputy Assistant Director, RDaSH CAMHS
Lisa Morris	LM	Educational Psychologist, EPS
Sara Whittaker	SW	Team Manager, RMBC
Sara Graham	SG	Associate Senior Leader Designated Safeguarding and Wellbeing Lead, Maltby Academy
Juliette Penney	JP	Matron IPHNS, TRFT
Mike Horne	MH	Children & Young People's Advocacy Officer, Healthwatch
Teresa Brocklehurst	TB	Strategic Co-ordinator, Children & Young People & Families Consortium
Richard Cullen	RC	GP Lead, RCCG

		Actions
1.	**Apologies:** Sarah McCall, Nanette Mallinder, Paula Williams, Tony Clabby, Ruth Fletcher-Brown, Mel Meggs, Karla Capstick, Paul Theaker, Katie Simpson	
2.	**Declarations of conflicts of Interest** None declared.	
3.	**Rotherham CAMHS Local Transformation Plan (LTP)** **LTP Refresh –** The LTP had been refreshed and circulated to members for information. NP provided a brief overview of key areas. Activity, workforce and finance figures had	

	been updated and a number of gaps identified. Need to be smarter to understand activity from non NHS provider services. Further discussions to be had around collecting and understanding activity from non NHS provider services and how this reports into the NHS network. RC to discuss with Andrew Clayton (Head of Health Informatics, Doncaster & Rotherham CCG's) possibility of building this into the new IT Interoperability system which is being designed. Investment areas for 2017/18 have been agreed and submitted as part of the LTP refresh. NP informed members that all monies are recurrent with a caveat that they will be reviewed annually against RCCG's financial position. There has been a commitment made from RCCG to RDaSH to recruit 2 Psychological Wellbeing Practitioners (PWP's). These posts will be funding by Health Education England for 2017/18 and RCCG 2018/19 onwards. BM reported that the posts have been agreed and adverts will go out shortly in time for April training dates. RDaSH received extra funding from NHS England, via RCCG, in 2016/17 to reduce treatment times for children in CAMHS. GP confirmed additional appointments are now being offered on Saturday's and Tues/Thurs evenings to improve access to the service. ADHD parenting courses have also been set up. **LTP Action Plan (v18) –** NP provided an update. The action plan is circulated bi-monthly for update and 6 month review meetings take place, the next one is scheduled for 8th February 2017. NP provides NHS England with quarterly reports. A copy of the LTP refresh and LTP action plan is available to view on the RCCG website http://www.rotherhamccg.nhs.uk/mental-health_2.htm	RC
4.	**Rotherham Public Health** The Suicide Prevention and Self Harm and the Public Mental Health and Wellbeing Strategy were circulated prior to the meeting for information. The Public Mental Health and Wellbeing strategy is out for consultation until the end of March, comments to be sent direct to Ruth Fletcher-Brown. The amended Universal Top Tips were also circulated. Amendments to be sent back to	ALL

	Ruth by the end of January.	ALL
5.	**Service Capacity Issues – Statutory & Voluntary** **Schools –** SG reported waiting list pressures in both secondary and primary schools. Schools are currently working with their locality workers to address this issue. **CAMHS –** GP reported CAMHS now have a better grasp of children coming in and out of services and appeal numbers have now decreased. Need to encourage schools to accept CAMHS consultations slots. Members were asked to re-enforce this message when going into schools. NP/GP to raise at the Schools/College Interface meeting on 19th January 2017. **Health Visiting & School Nurses –** JP informed members that the service is moving to a 0-19 years' service from 1 April 2016 and proposed service changes are currently going through the consultation process. **HealthWatch –** MH reported that there has been no change to Healthwatch's position, budgets have been significantly reduced and a part time service is being considered. **Looked after and adopted Children –** SW reported funding and staffing issues. Currently awaiting outcome of transformation and expansion proposal to provide an enhanced therapeutic programme and employ a special guardianship order worker. **Psychology Service –** LM reported staffing pressures and lack of SLA session times as we approach the end of the financial year.	
6.	**Crisis Care Concordat – for information** Document circulated for information. Meeting scheduled 7th February 2017 with key organisations to discuss progress against the action plan.	
7.	**Looked after and adopted Children's Therapeutic Team (LAACTT)** Pilot currently underway prioritising LAC coming into the CAMHS services. Identified a small cohort of patients (12) who currently receive core CAMHS mental health interventions. Concluded that there are good links between CAMHS and the LAC	

	Therapeutic Team. Looked at pathways for referrals coming into the service and identified a range of referral sources. Considering implementing one point of referral through the Looked after and adopted Children's Therapeutic Team. TB suggested examples of good practice be shared with the Safeguarding Children's Board to provide assurance. NP in contact with the NSPCC who have agreed to share good practice examples from other areas.	
8.	**RDaSH CAMHS Reconfiguration** **CAMHS SPA / Early Help –** It is still proposed to locate the CAMHS SPA with Early Help, but this has been delayed. BM reported that the CAMHS reconfiguration is almost complete, new pathways and the majority of staff is now place. The Pathway Lead for locality workers is due to commence in post next week and part of the role will involve making links with other agencies.	
9.	**Children & Young People's Improving Access to Psychological Therapies (CYPIAPT)** **RDaSH self-assessment tool –** To be brought to the April meeting.	BM
10.	**Tier 4/Complex Cases feedback** Discussion took place around the current process for monitoring Tier 4 patients in the system. NP explained that the spreadsheet is circulated monthly for update but unfortunately it is no longer updated by individuals. It was agreed that given the information is captured in the RDASH report which is received through monthly monitoring, the spreadsheet system will cease. Members identified a specific requirement to monitor patients with more complex needs closer. NP to pick this up.	

		NP
11.	**Directory of Services & 'Top Tips'** Final version circulated for information.	
12.	**Youth Cabinet Update** No representative present.	
13.	**Commissioner updates** **RMBC –** No representative present. **RCCG –** NP is working with NHS England to put in place a collaborative commissioning agreement which will link to and potentially strengthen the Intensive Support Home Treatment Service. This was a theme identified in the LTP refresh. The RDaSH contract for 2017/18 has now been signed and a CQUIN around transition from Children's to Adult's services has been included.	
14.	**Rotherham Eating Disorders Service** An invitation to the service launch on 25th January 2017, 10am – 12pm, Kimberworth Place had been circulated to members. Anyone interested in attending to contact Tracy.dodsley@rdash.nhs.uk BM explained it will be a bespoke hub providing services across the RDaSH footprint.	
15.	**CAHMS Articles** Articles to be circulated for information.	KG
16.	**Actions Log of the meeting held on 12 October 2016** **3. Rotherham CAMHS Local Transformation Plan (LTP) -** Concerns previously raised around TRFT being unable to contact CAMHS for assessment of an adolescent who had self-harmed. BM picked up with CAMHS switchboard, concluded that there is no record of the call being received.	

	5. Stigma – RFB circulated Mental Health Strategy to members for comment. **6. RDaSH CYPIAPT self-assessment tool –** BM circulated Self-assessment tool for information to inform members how RDASH/CAMHS delivers services. No comments/questions received.	
17.	**Any Other Business:** **Perinatal mental health bid –** BM reported pilot work is currently being undertaken to scope a potential service. **CAMHS CQC Inspection –** Noted that RDaSH CAMHS achieved good in a recent CQC report.	
18.	**Date and time of Next Meeting:** 26th April 2017, 9am - 11am, Willow Room, Oak House	