HEALTH AND WELLBEING BOARD

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

Date: Wednesday, 20th September, 2017

Time: 9.00 a.m.

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with Part 1 of Schedule 12A to the Local Government Act 1972

2. To determine any item(s) which the Chairman is of the opinion should be considered later in the agenda as a matter of urgency

3. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Minutes of the previous meeting 5th July, 2017 (Pages 1 - 13)

7. Communications

For Discussion

8. South Yorkshire and Bassetlaw Hospital Review
   Alexandra Norrish, Programme Director, SY&B Hospital Services Review – verbal update

9. Health and Wellbeing Strategy Aim 4 Update (Pages 14 - 23)
   Dr. Richard Cullen and Giles Ratcliffe

10. Refreshing the Health and Wellbeing Strategy and Integrated Health and Social Care Plan - 'Plan for a Plan' (Pages 24 - 28)
    Chairman to present

11. Plan for Producing the CCG Commissioning Plan (Pages 29 - 36)

Ian Atkinson, Rotherham CCG to present

12. Housing Strategy
    Presentation by Sarah Watts, Housing Intelligence Officer

13. Healthwatch Rotherham Annual Report (Pages 37 - 76)
    Tony Clabby, Healthwatch Rotherham, to present

14. Equity of Public Health Services (Pages 77 - 106)
    Giles Ratcliffe, Public Health, to present

15. Better Care Fund (BCF) Plan 2017-19 (Pages 107 - 237)

15A Rotherham Improved Better Care Fund 2017-19.

For Information

16. Rotherham CAMHS Local Transformation Plan - Update - September 2017 (Pages 246 - 288)

17. Date and time of next meeting
    Wednesday, 15th November, 2017, at 9.00 a.m., venue to be confirmed.

SHARON KEMP,
Chief Executive.

HEALTH AND WELLBEING BOARD
5th July, 2017

Present:-

Councillor D. Roche	Cabinet Member for Adult Social Care and Health **(in the Chair)**
Dominic Blaydon	Associate Director of Transformation, RFT (representing Louise Barnett)
Tony Clabby	Healthwatch Rotherham
Dr. Richard Cullen	Strategic Clinical Executive, Rotherham CCG
Chris Edwards	Chief Operating Officer, Rotherham CCG
Diane Graham	RDaSH (representing Kathryn Singh)
Carole Lavelle	NHS England
Mel Meggs	Deputy Strategic Director, CYPS (representing Ian Thomas)
Robert Odell	South Yorkshire Police
Dr. Jason Page	Governance Lead, Rotherham CCG
Terri Roche	Director of Public Health, RMBC
Councillor G. Watson	Deputy Leader
Janet Wheatley	Voluntary Action Rotherham

Report Presenter:-

Ruth Fletcher Brown	Public Health Specialist, Public Health, RMBC

Officers:-

Kate Green	Policy Officer, RMBC

Observers:-

Ian Atkinson	Rotherham CCG
Robin Carlisle	Rotherham CCG
Councillor S. Sansome	

Approximately 10 members of the public were in attendance.

Apologies for absence were received from Louise Barnett, (Chief Executive, TRFT), Sharon Kemp (Chief Executive, RMBC), AnneMarie Lubanski (Strategic Director, Adult Social Care), Councillor J. Mallinder and Kathryn Singh (Chief Executive, RDaSH).

13. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

14. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from the members of the public in attendance.

15. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board, held on 31st May, 2017, were considered.

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

Minute No. 3 (Sensory Impairment Centre), it was noted that the keys had been handed over to the Royal Society for the Blind and was due to open very shortly. The official opening would be in October by the Earl of Scarborough.

Minute No. 3 (National Review of Children's Mental Health Services), it was noted that the review was progressing well.

Minute No. 4 (I Age Well), it was the noted that the event had been very well attended.

Resolved:- That the minutes of the meeting held on 31st May, 2017, be approved as a correct record subject to the following clerical correction:-

Minute No. 11 (Better Mental Health for All Strategy) should read "… 2017-2025" and not 2020 as stated.

16. COMMUNICATIONS

There were no communications to report.

17. ROTHERHAM PLACE BOARD AND ACCOUNTABLE CARE SYSTEM

Chris Edwards, Chief Officer, RCCG, submitted for information, the draft terms of reference for the Rotherham Integrated Health and Social Care Place Plan Board ("Place Board") which was the forum where all the partners across the health and social care system would come together to undertake the regular planning of service delivery.

The Place Board's role would be:-

- Agreement and sign off of Rotherham Health and Social Care delivery plans
- Ensure a proactive approach to establishing the health and social care needs of Rotherham citizens and to react to the changes within the health and social care agenda
- Operate cost of care effectively in the context of the Rotherham health and social care financial circumstances
- Realise cost saving opportunities through system redesign to meet the Rotherham-wide efficiency challenge ensuring no adverse impact in regard to patient safety and experience

The report also set out the principles the Board would adhere to.

Recommendations for funding would need to be made by the Board to the relevant statutory bodies through individuals where responsibility was delegated by relevant statutory bodies. All recommendations from the Board would need consensus from its membership.

Each member organisation would have one representative on the Board with the joint Chairs of the Health and Wellbeing Boards attending to ensure the delivery was consistent with the strategic direction:-

NHS Rotherham CCG	Chief Officer, Chris Edwards (Joint Chair)
Rotherham Metropolitan Borough Council	Chief Executive, Sharon Kemp (Joint Chair)
The Rotherham Foundation Trust	Chief Executive, Louise Barnett
Voluntary Action Rotherham	Chief Executive, Janet Wheatley
Rotherham Doncaster and South Humber NHS Trust	Chief Executive – Kathryn Singh
Connect Healthcare Rotherham Ltd. (Rotherham GP Federation)	Rotherham GP Chair Dr. Robert Thornton
Participating Observers	Joint Chair, Health and Wellbeing Board, RMBC – Councillor David Roche Joint Chair, Health and Wellbeing Board, RCCG – Dr. Richard Cullen
In Attendance	Deputy Chief Officer, RCCG – Ian Atkinson (as Chair of the Rotherham Place Plan Delivery Team) Director of Legal Services, RMBC – Dermot Pearson Chair of Partnership Communications Group – Gordon Laidlaw Senior Planning and Assurance Manager, RCCG – Lydia George (as Place Plan Board Manager) Policy and Partnership Officer, RMBC – Kate Green (H&WB Board Manager)

It was suggested that consideration should be given to the holding of a health conference in Rotherham to showcase its Place Plan and what work was taking place within the Borough

It was noted that the Council had approved its side of the Place Plan which included a joint post of Deputy Director of Adult Social Care.

Resolved:- (1) That the report be noted.

(2) That the Board acknowledges that the Place Board should encompass all commissioners and providers who commissioned or provided health and social care across Rotherham and as such recognised that the membership of the Board may need revising periodically to include additional members.

18. UPDATE ON AIM 3: MENTAL HEALTH

Ruth Fletcher-Brown, Public Health, gave the following updates on Aim 3: Mental Health:-

Suicide Prevention and Self-Harm Action Plan Update 2016/18
Ruth highlighted the following issues contained within the report:-

- The Rotherham Suicide Prevention and Self-Harm Group met quarterly to review progress on the action plan, receive suicide audit data and recommend any necessary response, for example, for high risk groups

- Rotherham had an early alert approach to suspected suicides resulting in a response being made as soon as notification was received

- Partner organisations of the Rotherham Local Safeguarding Children's Board signed up to the Rotherham Suicide and Self-Harm Community Response Plan in September 2015. The process for activating the plan was the responsibility of RMBC's Early Help

- The My Mind Matters website had been reviewed and updated with input from the Youth Cabinet

- The Top Tips on suicide prevention for General Practitioners had been updated to include risk factors and at risk groups in Rotherham

- The campaign to target men, 'Breaking the silence on suicide' launched in July 2016 with resources distributed across the Borough and advertisements in local press in December, 2016

- 50 workplaces had engaged with the Workplace Wellbeing Charter

- Children and Youth People's Bereavement pathway continued to be positively received by families

- Families were visited within 48-72 hours of the suspected suicide by officers from the Vulnerable Persons Unit (South Yorkshire Police) and each family offered the Help is at Hand resource and offered telephone support from Rotherham Samaritans

Discussion ensued with the following points raised:-

- There had been an increase in adult suicides of those who had used Drug and Alcohol Services

- For those known to the Mental Health Services wraparound support was provided as much as possible to the people that self-harmed or felt suicidal. They were a high risk group and agencies wanted to make sure they could be supported

- A piece of work recently completed by RDaSH showed that people who suffered any kind of loss were at more risk of suicide. Work was now taking place on post-prevention of suicide. Officers from the VPU offered families telephone support from Rotherham Samaritans

- GPs were notified of any suspected suicide so they were aware should any family members registered with the practice request an appointment

Carole Lavelle commented on the fact that work on suicide prevention in Rotherham was further ahead than many other areas she visited.

Resolved:- (1) That the report on actions taken by the Rotherham Suicide Prevention and Self-Harm Group since the update submitted in May, 2016, be noted and endorsed.

(2) That the areas for future activity, including a commitment to continue Rotherham's early alert surveillance work, bereavement support and the social marketing campaign work be endorsed.

(3) That an update be submitted on the work of the Rotherham Suicide Prevention and Self-Harm Group annually and exception reports as appropriate.

Better Mental Health for All – Action Plan 2017-2020
Ruth presented the action plan which focussed on work that brought added value, used community assets and provided opportunities for the health and wellbeing partners to work collaboratively.

The action plan used the three tiered approach to mental health promotion and prevention. It took a whole life course approach from pre-birth to ageing well. Partner organisations had been encouraged to look at opportunities within their current interventions to promote good mental health.

The action plan aimed to link into community assets and connected people within their local community. It recognised the skills, knowledge and expertise of individuals and the assets that communities and organisations had to improve mental health and wellbeing.

Indicators from the Public Health Outcomes Framework and Quality Outcomes Framework would be used to monitor the overall progress of the strategy. Output targets would measure progress of each action in the action plan.

Discussion ensued with the following issues raised/clarified:-

- There was contact with colleges with several engaging with the Youth Mental Health First Aid training which had been very popular. Schools and colleges would be visited as part of the launch of the Still campaign

- The work done across Rotherham had been referenced across South Yorkshire and the Humber

- VAR, Crossroads, Age Concern and the Council had been meeting to draw up an integrated action plan for isolation and loneliness which would be a key strand of Aim 3

Resolved:- (4) That the action plan be endorsed.

(5) That member organisations commit to lead by example and ensure that they follow best practice in relation to the Workplace Wellbeing Charter.

(6) That it be noted that there were some actions within the plan which required financial investment. The Better Mental Health for all sub-group would work with lead organisations to develop business cases accordingly.

(7) That the Health and Wellbeing Board continue to support Champions from their organisation to assist with the implementation of the action plan. It was envisaged that this would be quarterly meetings to update on progress and look at opportunities for collaborative working.

(8) That the Health and Wellbeing Board receive annual updates on progress.

19. SOCIAL PRESCRIBING

Janet Wheatley, Chief Executive, Voluntary Action Rotherham, gave the following powerpoint presentation:-

Rotherham Social Prescribing

- Sits alongside clinical interventions – helps people live their lives in a way that feels like living rather than coping and surviving. It provides an integrated response to patient care
- Where the NHS ‘meets’ the community and its assets – shifting the focus from conditions or ages to localities and communities
- ‘what matters to me’ as well as ‘what is a matter with me’

- Involved a leap of faith to working differently – there had to be another dimension to meeting patient needs
- Co-produced – between Rotherham CCG, VCS and service users
- Builds on/enhances local relationships, respect and trust between public sector and voluntary and community sector partners
- Flexible to meet changing needs – embedded within CCT and STP
- Supports and resources VCS – works with groups and patients
- Independent evaluation base – evaluated from onset

The 'Rotherham Model'

- Voluntary Action Rotherham (VAR) on behalf of Rotherham CCG delivers 2 Social Prescribing (SPS) programmes. VAR manages the programme and micro-commissions activity from the VCS – contracts/spot purchases/grants
- LTC SPS works with all GP practices as part of integrated case management approach. Referral pathway identifies patients referred to a VCS advisor aligned to each GP practice. Started 2012 – 5,835 referrals
- Mental Health SPS works with 2 cluster groups of patients referred by RDaSH to a VCS advisor. Operating since 2014 – 328 referrals
- Patients/service users build and direct their own packages of support, tailored to their specific needs by encouraging them to access services provided by the VCS

Rotherham SPS Research

- We have a rich and systematic evidence base to support our work – both schemes have been independently, academically evaluated from the start
- The evaluations track two main element:-
  Improvement in wellbeing and quality of life
  Impact on services either in reduction in demand or potential for discharge/step down
- Plus patients/users stories through case studies

Research Findings

- Health and wellbeing – consistently large improvements in wellbeing for all patients/service users referred. Over 80% improvement for LTC patients and over 90% for MH service users
- Reduction in demand for services – for the LTC service consistent reductions in use of services 6-11% reduction in non-elective inpatient stays and 13-17% reduction in use of A&E services – more detailed analysis shows higher reductions in certain types of patients. For the MHS over 50% discharge from services for those eligible for discharge review
- Financial savings – the above evidence translates into definitive cost avoidance savings for the NHS

Additional Research Findings – Impact on Primary Care
Latest evaluation looks at impact from a GP perspective

- Face to face appointments reduced 28%/telephone consultations reduced 14% (tracked in 1 GP practice)
- Opportunity for holistic response to patient care. A person centred service especially for those with complex needs
- Helps patients manage symptoms. Some impact on medication usage
- Rotherham SPS also supports carers – helps with family and care breakdown

Additional Research Findings – Impact – Voluntary/Community Sector

- SPS is a route into delivering a community asset based approach to health – connects, through a single gateway, voluntary and small community groups into wider healthcare delivery. It taps into the potential out there in communities and within individuals
- It supports the VCS to deliver options and solutions to people's needs. Rotherham's model provides funding to front line VCS organisations. It is a resourced intervention rather than just signposting to already overstretched VCS services
- We work with VCS groups alongside SPS users – help secure additional funding, volunteers, diversify income, new activities, increase citizen engagement/independence/resilience. It helps rather hinders VCS sustainability

Essential Lessons Learned

- Be clear about the outcomes/target population and clarity on the model – is it SPS 'lite' or intensive/signposting or prescription
- Keep the model and referral mechanisms simple – single gateway
- Keep it local – knowledge and expertise out there from local VCS. The perils and benefits of scaling up
- Role of link workers/advisors – linked to practices/localities part of MDT team – build the relationships and combine expertise
- Importance of patient/user to be in charge/have responsibility for their care – do not overcomplicate some of the solutions
- Resource the sector to deliver the solutions – this will enable them to come up with further sustainable options
- Evidence base – what target needs are and what works
- 3 Rs – Relationship, Research, Resources

Rotherham's Success Story

- The Rotherham SPS model is seen as leading the way across England in the delivery of SPS. Praised in NHS Five Year Forward View
- We have been visited/visit over 120 different areas across England and Wales. We receive 2/3 enquiries monthly about our work
- We have presented at numerous conferences including Kings Fund major conference, met with the Secretary of State, attended a launch at the Home of Commons and won awards

- We anticipate a roll out of SPS nationally and we believe Rotherham will be asked to be at the forefront of it

SPS where next – National/Regional/Local
- Nationally – announcements on a national rollout of SPS are due
- Regionally via STP – inclusion in the Place Plans and STP workstreams. Also link between SPS and the Work and Health programme
- Locally – potential to target other cohorts e.g.
  Isolated and lonely/vulnerable/socially excluded/disadvantages – linked to MECC
  People with mild to moderate mental health conditions
  People with health related employment issues e.g. MSK/Mental Health – linked to work and health
  Certain health conditions – e.g. cancer patients/Diabetes or a specific community/locality based approach
  Children and young people

Discussion ensued with the following issues raised/clarified:-

- Social Prescribing was not available to everyone. There was an ‘at risk’ register of intensive users of services

- £1M of identified benefits and thought that the GP benefits was understated – the social benefit had not been identified as yet

- This cohort of patients were the ones that medicines were not working for

- Opportunity to explore how it might work with children and families

- Ongoing discussions as to whether the resources could be utilised for those in mental health crisis and linking into prevention of suicides

Resolved:- That the presentation be noted.

20. BETTER CARE FUND

Nathan Atkinson, Assistant Director Strategic Commissioning, RMBC, presented the 2017-19 Better Care Fund Executive Summary and Plan on a Page which gave an overview of the direction of travel and key priorities for delivery.

The definitive guidance and submission template were still awaited but a draft plan had been prepared in anticipation of the release of the national guidance from NHS England.

The Executive Summary and Plan on a Page had been updated in line with the 2017-19 Integration and Better Care Policy published in March 2017.

The key priorities for 2017-19 were:-

- 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 home enabling service and strengthening the 7 day social work offer
- Consideration of a specialist reablement centre incorporating intermediate care
- An integrated carers support service
- 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

The following points were highlighted:-

- There was additional funding but it was for 3 years and was a year on year reduction i.e. £6.2M, £3.7M and £1.9M

- Some of the guidance had only been released the previous day. There were 3 areas where spend could be made:- sustainability of Adult Social Care, the market/commissioning and delayed transfers from hospital

- Discussions would continue between the Council, Foundation Trust and CCG as to how the funding would be spent

- The Foundation Trust were looking at taking part in the national discharge process so as to use some of the findings

- Need to involve the voluntary and community sector

Resolved:- That the Better Care Fund Executive Summary and Plan on a Page be noted.

21. WORK AND HEALTH

Terri Roche, Director of Public Health, gave a verbal update on work and health.

In Marmot's Fairer Society, Health Lives (2010) he talked a lot about the benefits of work to health and the importance of work to address health inequalities and the social gradient of inequalities.

This could be summarised as: work good, unemployment bad for physical and mental health but the quality of work matters getting people off benefits into low paid, insecure health challenging work was not a desirable option.

One of the roles of the Board going forward might be to look at the wider determinants of health one of which was work. Good quality employment was key to addressing health inequalities. Work and Health was included within the Rotherham Plan 2025 and was a vital part of building stronger communities.

The Sheffield City Region's long term economic plan was for more jobs, more businesses, more highly skilled occupation and higher productivity. As part of this there was funding for working health projects which included:-

SCR Employment Support Pilot

- £8.7M DWP/European Social Fund
- Aim – to provide early intervention for claimants at risk of long term unemployed
- Key cohorts could include claimants with health conditions and disability, low skills, unstable housing, weak work history, lone parents
- Work taking place in Rotherham as to how this project could work alongside the Troubled Families Programme in the first instance
- Go live date expected September/October with a plan to see approximately 4,500 individuals over the 2.5 years of the programme = 736 Rotherham people
- Voluntary scheme with the referral route to be confirmed but could be Job Centre Plus as well as self-referral, Local Authority, third sector and college referrals
- Clients would be offered up to 18 months personalised support from an employment advisor
- Consideration being given in Rotherham to building on the learning from Social Prescribing projects to support the more holistic approach

Work and Health Unit Employment Trial

- £7M DWP and Department of Health
- Only one of two in the country
- Will introduce a new work health support service consisting of employment specialists working to individual placement support principles located within local health care settings e.g. GP practices, IAPT teams, MSK teams, community hubs
- Referrals primarily from the health system and also self-referral
- Voluntary participation and no implications for an individual's entitlement to DWP benefits or benefit conditionality
- There would be a Randomised Control Trial with 50% of referrals going onto the IPS trial and 50% being supported by existing mainstream employment and health support

- Aim – to provide innovative and evidence-based form of voluntary health aligned employment support to individuals with mild to moderate mental health and/or musculoskeletal (MSK) conditions who were either unemployed and seeking work or were in work but struggling or off sick
- 12 months personalised support focussed on what individuals needed to help them find or stay in work
- Improve links between work and health support by building better collaboration and connectivity for the work health system
- Go live date expected November/December 2017 and end Spring 2019 – 7,500 in total across the SCR, 3,750 seen by new services with the remainder seen by existing services
- Many issues still to be resolved

Local Integration Board
- A Rotherham group must be set up to oversee the work of the programmes
- SCR recommend setting up of a Local Integration Board (LIB) primarily for the Employment Support Pilot
- The LIB should consist of representatives of health, DWP (Job Centre Plus), Citizens Advice Bureau, Local Authority (including Troubled Families) and other voluntary and community sector organisations
- Aim – to receive cases from the Employers Advisors where they were encountering organisational barriers
- Workshop held on 29th June in Rotherham to discuss how the LIB might work

Discussion ensued with the following issues raised/clarified:-

- When the Work and Health Unit Employment Trial was discussed at the CCG some time ago, it was initially felt to be a good idea, however, subsequently when it became apparent there would be Randomised Control Trial the optimism amongst GPs had decreased. Jackie Tufnell at the CCG had done some work on the proposal

- Concerns regarding the ethical nature of the Randomised Control Trial

- It was not known as yet who would be running the Randomised Control Trial

- Need to understand the governance of the projects and links to what was already happening in Rotherham's communities

- Rotherham's educational outcomes were considerably better than the other areas of South Yorkshire, therefore, putting the young people in a better position to access the opportunities

- Concern that those people that, with a little intervention, would get the support they needed leaving those that needed harder intervention. Hopefully this would be assisted with the linkage to the Troubled Families work

Resolved:- (1) That the update be noted.

(2) That Terri Roche feedback the concerns raised regarding the Randomised Controlled Trial to the Sheffield City Region.
Action:- Terri Roche

22. DATE AND TIME OF NEXT MEETING

Resolved:- That the next meeting of the Health and Wellbeing Board be held on Wednesday, 20th September, 2017, venue to be agreed.

Health and Wellbeing Strategy
Action Plan 2017-18

The health and wellbeing strategy sets the strategic direction of the local Health and Wellbeing Board.

This plan demonstrates the actions which are being delivered to contribute towards each of the five strategy aims for the years 2017 and 2018.

Aim 1	**All children get the best start in life**
Aim 2	**Children and young people achieve their potential and have a healthy adolescence and early adulthood**
Aim 3	**All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life**
Aim 4	**Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing**
Aim 5	**Rotherham has healthy, safe and sustainable communities and places**

Aim 1 All children get the best start in life

Board sponsor: Ian Thomas, RMBC
Lead Officer: Karla Capstick, RMBC

Health and wellbeing objective	Action/s	lead/s	Timescale	Progress to date	RAG
1. Improve emotional health and wellbeing for children and young people **2. Improve health outcomes for children and young people through integrated commissioning and service delivery**	Refresh and re-establish a 'Best Start Partnership' to include representatives from Health, Early Help, Early Years, Public Health, CCG, Child Development Centre, Disability Services, Education and the Voluntary Sector.	Karla Capstick, CYPS	Jan-17	Workshop took place January 2017 which identified all the key stakeholders/partners and nominated leads from each to form the partnership. Discussions began around shared understanding of 'best start' and how thr group could addres the 3 objectives in the strategy.	G
	Best Start Partnership to meet for the first time officially in May 2017.	Karla Capstick, CYPS	May-17		A
	Best start partnership to agree approriate method for consulting with Rotherham parents, children and young people and consult with them to develop a shared understanding of … What is 'a best start in life?' What do we mean by 'happier?' What is 'emotional health?' What does 'school readiness look like?'	BS Partnership (with advice from Emma Hollingworth, Comms.)	May-17		A
	Use and develop upon the good practice developed by Education and Skills for schools on definition of 'school readiness'	Jane Moore, CYPS	May-17		A
	Launch consultation period June - August 2017 and publish findings.	BS Partnership	Sep-17		A
3. Ensure children and young people are healthier and happier	Reduce the number of parents (and significant others) smoking during pregnancy and immediately after birth by having a quit smoking support offer in each childen's centre across the borough, to include:	Sue Smith, PH / Emma Royle, CCG	TBC	Pathway development underway.	A
	a. Working with midwifery and Yorkshire Smoke Free to ensure approriate pathways are developed and a vouncher scheme put in place.				
	b. Train nominated staff from each children's centre (and health practitioners) to offer quit smoking support in the community.	Ann Berridge / Sue Smith, PH	May-17	Training being delivered April/May 2017	A
	c. To offer additional opportunity to pregnant women and their significant others to attempt to quit smoking for those who 'opt-out' of the midwifery pathway or who lapse at anay point.	Karla Capstick, CYPS	TBC	Will commence once training is complete.	A
	Work across the partnership and with national children's sleep charity to bid for additional funding from the early Years Social Action Fund - to develop a pool of volunteers to support imporved sleep and therefore imporved emotinal and mental health for parents and children.	Vicky Dawson/Karla Capstick, CYPS	TBC	Pending funding	R

Aim 2 Children and young people achieve their potential and have a healthy adolescence and early adulthood

Board sponsor: Ian Thomas, RMBC
Lead Officer: Shafiq Hussain, VAR & Teresa Brocklehurst, CYPF Consortium

Health and wellbeing objective	Action/s	lead/s	Timescale	Progress to date	RAG
1. Reduce the number of young people at risk of child sexual exploitation					
2. Reduce the number of young people experiencing neglect	Develop a common framework to support understanding of neglect through implementation of the graded care profile across all partners agencies	Mel Meggs, CYPS (to identify specific actions/leads/timescales)			
	Increase awareness of early help assessment tool	Early Help TBA		Reviewed at Practice Review Group (sub-group of LSCB) to look at single point of access between early help/social care.	
3. Reduce the number of young people who are overweight and obese	Engage with obesity strategy group to support development of a local plan for reducing childhood obesity.	Jacqui Wiltchinsky, PH			
4. Reduce the risk of self-harm and suicide among young people **5. Increase the number of young people in education, employment or training** **6. Reduce risky health behaviours in young people**	Different but Equal Board' (young people's sub group of the Voice and Influence partnership) to plan an event for young people, which will look at being proud of Rotherham/becoming a child friendly borough/herritage bid, and can also include informaton about the strategy's objectives (i.e. risky health behaviour, self-harm, CSE)	Teresa Brocklehurst, CYPF Consortium	Jul-17		
	Produce set of recommendations following the Different but Equal Board's event in July - to address the strategy's objectives.	Teresa Brocklehurst, CYPF Consortium	Sep-17		
	Use lifestyle survey and difficulty queastionnaire (LAC) to develop a score card in relation to self-esteem - what it means/how we measure	TBA			

Aim 3 All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

Board sponsor: Kathryn Singh, RDaSH
Lead Officer: Ian Atkinson, CCG

Health and wellbeing objective	Action/s	lead/s	Timescale	Progress to date	RAG
1. Improve support for people with enduring mental health needs, including dementia, to help them live healthier lives	Dementia Diagnosis in the Community (GP Practices)	Ian Atkinson - Rotherham CCG	Mar-18	Diagnosis taking place in 21 of 31 Practices	A
	Delivery of national targets for Improving Access to Psycologial Therapies	Ian Atkinson - Rotherham CCG	Mar-18	6ww targets and 18ww currently being achieved (April 2017)	A
	Plan to very challenging national targets for Early intervention Psychosis	Ian Atkinson - Rotherham CCG	Mar-18		A
	Delivery of CAMHS Transformational Plan	Ian Atkinson - Rotherham CCG	3 year plan 2017/18 year 2	CAMHS Action Plan on Track at q4 16-17	A
2. Reduce the occurrence of common mental health problems	Making Every Contact Count	Giles Radcliffe - RMBC Public Health	See Aim 4 Detail	See Aim 4 Detail	A
	Deliver Suicide Prevention Strategy	Ruth Fletcher Brown - RMBC Public Health	3 Year Strategy	Young People's Mental Health Campaign (May 2017), Safe Talk Suicide Prevention Training (100 Frontline Workers), Samaritans Pilot	A
	Development of Public Mental Health and Well Being Strategy	Ruth Fletcher Brown - RMBC Public Health	On-going	Action Plan in development	A
3. Reduce social isolation	Wellness Impact Asessments	RMBC / RCCG	Sep-17	Discussion required across partners re: introducing Wellness Impact Assessments	R
	Rotherham Social Prescribing	RCCG and VAR	On-going	Positive Evaluatiuon of Social Prescribing	G

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

Board sponsor: Dr Richard Cullen, CCG
Lead Officer: Giles Ratcliffe, RMBC PH

Health and wellbeing objective	Action/s	lead/s	Timesca	Progress to date	RAG
1. Reduce the number of early deaths from cardiovascular disease and cancer **2. Improve support for people with long term health and disability needs to live healthier lives** **3. Increase the opportunities for participation in physical activity** **4. Reduce levels of alcohol-related harm** **5. Reduce levels of tobacco use**	Roll out Making Every Contact Count model in Rotherham, including: Develop online training tool Establish steering group with key stakeholders inc. CCG, GPs, RMBC, VCS Develop train the trainer resources and begin roll-out of training	Giles Ratcliffe, RMBC PH	Oct 17 Jan 17 Jul 17	Researched training tools from neighbouring authorities and investigating training platform options with IT. Virtual external partners steering group established January 2017. A further RMBC internal group established May 2017. Resources in development and internal champions being identified through May. Update Aug 2017: Train-the-trainer training and resources developed. Cohort of PH staff trained as train-the-trainers. 20 min Digital training developed by RMBC HR to go live September, initially focused on specific staff groups before being rolled out as mandatory training. Key staff groups identified in RMBC for initial roll-out including: Libraries staff; leisure services providers/staff; Childrens centre staff including Early Help and Health Visitors, and City Centre staff (wardens, ambassadors etc) (All to roll out from September/October). Development of Intranet page in progress. Lead appointed to roll out MECC across TRFT/RDaSH and relevant managment metings scheduled to plan roll-out.	G
	Ensure all statutory and provider organisations are prioritising workplace health and wellbeing and aiming for the Charter by Jan 18	Jacqui Wiltschinsky, RMBC PH	Jan-18	RMBC aiming for December 2017. TRFT currently working towards the Charter. Further work to engage provider organisations.	A
	Incorporate MECC tools and approach into Workplace Charter	Jacqui Wiltschinsky, RMBC PH	Jan 18 onwards	Following roll out of MECC training and resources in July 2017	G
	Develop a network of care 'navigators' within priority communities of Rotherham, including the training and upskilling of relevant staff (action included in the 5yr Forward View).	CCG	TBC	TBC	TBC
	Review the existing Health trainer offer to ensure increased prioritisation of health behaviour change across the borough, and it aligns where possible to the neighbourhood working model for Rotherham (currently being developed). (Health Trainers will become part of the wellness service to be commissioned from April 2018)	Jacqui Wiltschinsky, RMBC PH	Apr-18	Further servcie re-organisation underway to prioritise working in GP Practices in areas of high deprivation. From April 2018 HT service to be part of Wellness Service, whose outcomes and KPI's will focus on reducing inequalities and prioritising areas of disadvantage.	G
	Undertake Equity Audit of PH services in relation to identified priority communities	Giles ratcliffe, RMBC PH	Jan-17	Audit and analysis complete - Paper being produced for DLT/SLT/H&WBB	G
	All HWb partner organisations to undertake equity audits of services, ensuring the HWB system is delivering equitable services across the borough.	Each Organisation to nominate lead	Mar-18	Findings of P Equity Audit to be shared with H&WBB by August 2017, with intention to encourage sign-up of other organisations and Directorates to do the same.	A

	Request the Knowledge Service undertakes a review of evidence base of effectiveness of different measures to address health inequalities.	Giles Ratcliffe, RMBC PH	Oct-17	Knowledge Service has undertaken the literature search and collation of evidence and PH are reviewing the strength of the evidence.	G
	Communications programme delivered to promote Health Checks in relevant communities.	CCG	TBA		TBC
	Health Checks to become part of the Wellness Service which will be commissioned in 2018 in a way that ensures approriate taregting of health checks to relevant communities.	Anne Charlesworth, RMBC PH	Apr-18	See update on Wellness Service below.	G
	Establish a task and finish group to look at 'self-care' and the approriate actions needed.	BCF/PH/ASC/CCG	TBC	TBC	TBC
	Commissioning the Wellness Service to support self-care amongst communities and help people make behaviour/lifestyle changes.	Anne Charlesworth, RMBC PH	Apr-18	Update Aug 2017: Wellness service went out to tender and thescoring panel met on 16th August. Currently undertaking due dilligence and Alcatel period prior to issuing of intend to award notices and signing of contracts/informing Cabinet	G

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

Board sponsor: Rob Odell, SY Police
Lead Officer: Karen Hanson, RMBC

Health and wellbeing objectives	Action/s	lead/s	Timescale	Progress to date	RAG
1. Develop high quality and well-connected built and green environments **2. Ensure planning decisions consider the impact on health and wellbeing**	Planning policies in the Local Plan aim to create sustainable quality development and: Require the creation of safe accessible and well managed places buildings and public spaces Protect and enhance the boroughs green infrastructure and recreation facilities to help improve the health of Rotherham's population Protect green infrastructure corridors across the Borough Ensure Green spaces are provided near to new homes	Bronwen knight, RMBC	Bronwen to add detail	Bronwen to add detail	
	Health is a cross cutting theme in Rotherhams Local Plan - which guides all future development. Planners have also developed "Promoting Healthy Communities Good Practice Guidance" which provides for health and well being in new development through health impact assessment and consideration of health and well being through the planning application process.		Bronwen to add detail	Bronwen to add detail	
3. Increase opportunities for people in Rotherham to use outdoor space for improving their health and wellbeing	Steve/Polly to include detail	Steve/Polly to include detail	Steve/Polly to include detail	Steve/Polly to include detail	
4 Increase the number of residents who feel safe in their community **5. Reduce crime and antisocial behaviour in the borough**	The HWbB to support the delivery of the local Safer Rotherham Partnership Plan whose vision is to: *Work together to make Rotherham safe, to keep Rotherham safe and to ensure the communities of Rotherham feel safe.* The HWbB to receive annual update reports on the impact of the SRP Plan.	Rob Odell	Ongoing	Karen to include update on the SRP Plan - and what is an appropriate timescale for reporting the SRP to HWB?	A
	For the SRP to ensure it continues to align its plans with the HWb Strategy; ensuring improving the health and wellbeing of local people is a key focus of priority areas.		Current plan 2016-19	This will be done via the lead for this action being a member of the Health and Wellbeing Board, and ensuring the links are made between the SRP and HWb Strategy.	A

REPORT FOR HEALTH AND WELLBEING BOARD

Date of meeting:	**20 September 2017**
Title:	**Health and Wellbeing Strategy refresh and aligning with the Integrated Health and Social Care Place Plan**
Directorate:	**Assistant Chief Executive's / Public Health**

1. Summary

This report presents a proposed plan and timeline for refreshing the local Health and Wellbeing Strategy and aligning it to the Integrated Health and Socal Care Place Plan.

2. Recommendations to Health and Wellbeing Board

- To consider and agree the proposed plan for refreshing and aligning the Health and Wellbeing Strategy and Place Plan – demonstrated by the diagram in appendix A – including governance arrangements
- To agree the proposed timescales for this work – demonstrated in appendix B

3. Background

The Health and Wellbeing Board (HWbB) received a report on 31st May 2017 which included a proposal to begin an early refresh of the local Health and Wellbeing Strategy (strategy).

Although the existing strategy runs until end of 2018, it was suggested that due to a number of national and local strategic drivers influencing the role of the HWbB, an early refresh would ensure the strategy remained fit for purpose and strengthened the HWbBs role in relation to high level assurance and holding partners to account, as well as influencing commissioning across the health and social care system, and wider determinants of health – and to do this it needed to be clear about its strategic vision and priorities.

To begin the process of a refresh, the original strategy's principles have been reviewed. It is proposed that these do not need to change significantly, but the refreshed strategy will need to set out what the HWbBs strategic priorities are in line with these.

- To reduce health inequalities we need to ensure that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, is improving the fastest
- Prevention of physical and mental ill-health should be our primary aim, but where it is already an issue, we should intervene early to maximise the impact of services for individuals and communities
- We will work with individuals and communities to increase resilience and enable people to better manage and adapt to threats to their health and wellbeing, using an asset-based approach that values the capacity, skills, knowledge, connections and potential within communities
- Integrating our commissioning of services wherever possible to support improvements in health and wellbeing and the reduction of health inequalities
- We need to ensure pathways are robust, particularly at transition points (e.g. from children and young people's services into adult services), to be sure that nobody is left behind
- All services need to be accessible and provide support to the right people, in the right place, at the right time

4. Aligining to Rotherham's Integrated Health and Social Care Place Plan

Rotherham's Integrated Health and Social Care Place Plan (Place Plan), was published November 2016, and details the joined up approach to delivering key initiatives that will help achieve the health and wellbeing strategic aims.

The Place Plan is also now due to be refreshed (where necessary), it has therefore been agreed that the two documents will be refreshed together and better aligned.

The diagram on appendix A demonstrates how this will look for the two documents.

There is more work needed to consider the other areas which the Place Plan will not deliver on (suggested in the grey box to the right of the diagram), and this will be done with relevant key stakeholders as the work progresses.

5. Next steps

Appendix B sets out a timeline of activity for both the strategy and Place Plan refresh.

Following the recommendations in this report being agreed, work will progress on developing the strategy; using the Joint Stratgeic Needs Assessment (JSNA) to ensure key issues and/or any emerging issues are being considered. A framework for the priorities/aims will then be produced and presented back to the HWbB in November – where other relvant stakeholders wil also be invited to consider and help develop the strategy further.

Other relevant stakeholders could include members of the Place Plan Board and Delivery Group (who do not already sit on the HWbB) who will be crucial in considering how the Place Plan will deliver the strategy's priorities/aims and therefore ensuring the two documents are better aligned.

It is proposed that the refreshed strategy will be formally signed off at the March 2018 HWbB.

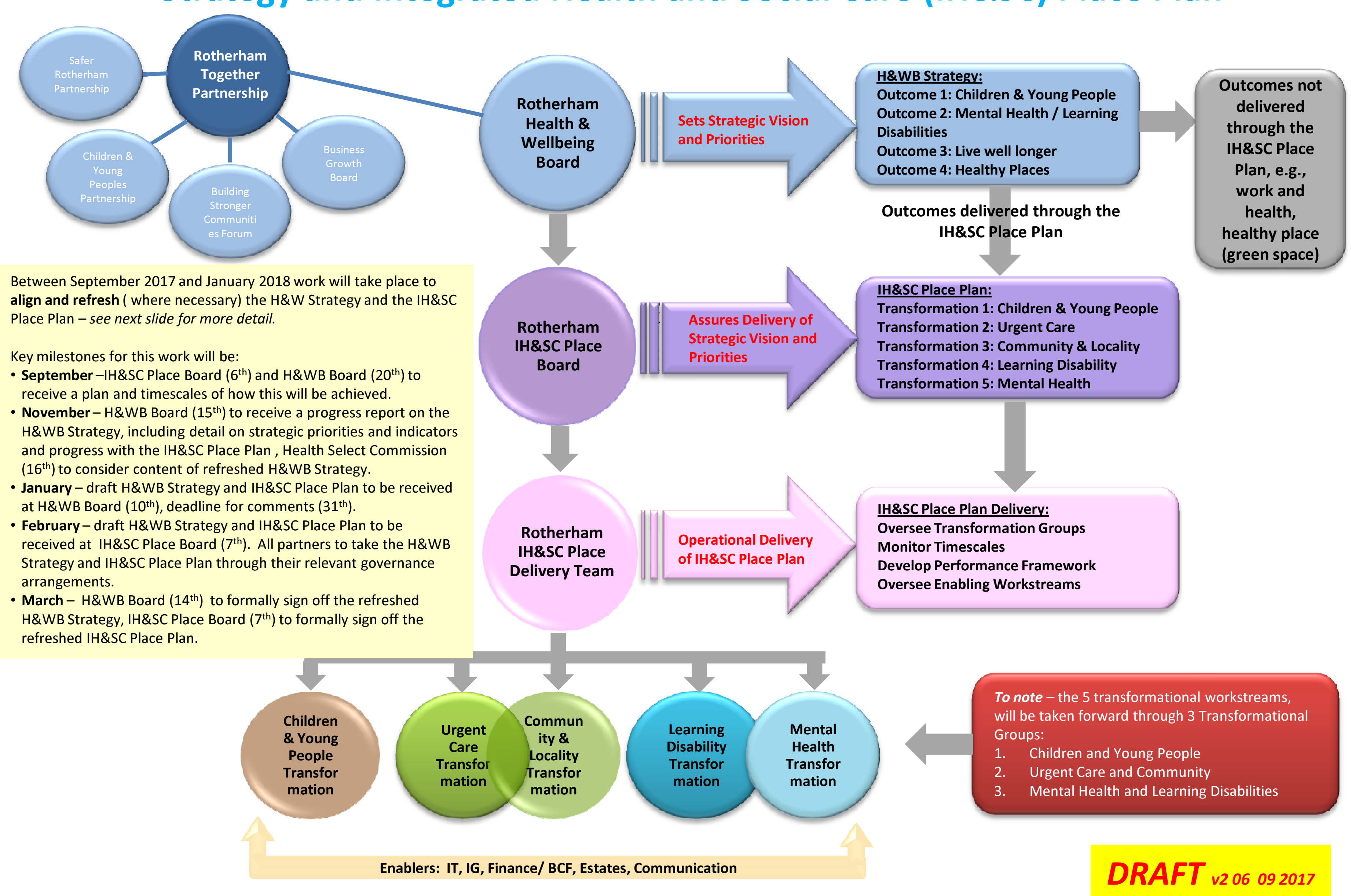
6. Names and contact details

Terri Roche
Director of Public Health, RMBC
Teresa.roche@rotherham.gov.uk

Kate Green
Policy and Partnership Officer, RMBC
Kate.green@rotherham.gov.uk

Lydia George *(for Place Plan queries and information)*
Planning and Assurance Manager, NHS Rotherham CCG
Lydia.george@rotherhamccg.nhs.uk

Plan of how we will align the Rotherham Health and Wellbeing (H&WB) Strategy and Integrated Health and Social Care (IH&SC) Place Plan



Timescales for the alignment of the H&WB Strategy and IH&SC Place Plan

August 2017

- 09/08 /17– first discussion on proposal to align the H&WB Strategy and IH&SC Place Plan at the H&WB Board Executive Group.
- Develop a 'plan for a plan' and timescales for how the H&WB Strategy and IH&SC Place Plan will be aligned and refreshed (where necessary).
- 23 /08/17 – STP Update meeting to have early discussion about the H&WB Strategy and IH&SC Place Plan alignment.

September 2017

- 06 /09/17 – IH&SC Place Board to receive 'plan for a plan' and timescales for how the alignment of the H&WB Strategy and IH&SC Place Plan will be achieved.
- 20 /09/17 – H&WB Board to receive 'plan for a plan' and timescales for how the alignment of the H&WB Strategy and IH&SC Place Plan will be achieved.
- 20/09 /17– H&WB Board will also receive a 'plan for a plan' on how the CCGs Commissioning Plan will be updated.

October 2017

- Begin to develop the detail of the H&WB Strategy, including wording for 'outcomes' and identifying what the strategic priorities are (based on JSNA and other intelligence.
- Begin to align the IH&SC Place Plan to the H&WB Strategy.

November 2017

- 15/ 11/17 – H&WB Board to receive progress update on the H&WB Strategy update including detail on strategic priorities and indicators and the IH&SC Place Plan alignment.
- 15/ 11 /17– H&WB Board to receive the Consultation Version of the CCG Commissioning Plan.
- 16/ 11/17 – Health Select Committee to consider the H&WB Strategy , the IH&SC Place Plan and the CCG Commissioning Plan (TBC)

December 2017

- Re-write of relevant sections of the H&WB Strategy and the IH&SC Place Plan.

January 2018

- 10/01/18 – H&WB Board to receive the draft H&WB Strategy and IH&SC Place Plan.
- 10/01/18 – H&WB Board to receive draft version 1 of the CCG Commissioning Plan
- 31/01/2018 – deadline for comments on the draft H&WB Strategy and IH&SC Place Plan

February 2018

- Final version of the H&WB Strategy and IH&SC Place Plan to be produced.
- 07/02/2018 - CCG Governing Body to endorse the final CCG Commissioning Plan.
- 07/02/2018 – final H&WB Strategy and IH&SC Place Plan to be received at the IH&SC Place Board.
- All partners to take the IH&SC Place Board through their governance structure.

March 2018

- 14/03/2018 – H&WB Board to formally sign off the H&WB Strategy and the IH&SC Place Plan.
- 14/03/2018 – H&WB Board to receive the final version of the CCG Commissioning Plan.

April 2018

- 04/06/2018 – first formal IH&SC Place Board meeting in public.

DRAFT *v2 06 09 2017*

Agenda Item 11

NHS Rotherham Clinical Commissioning Governing Body

Operational Executive – 11 08 2017

Strategic Clinical Executive - 16 08 2017

GP Members Committee (GPMC) – 27 09 2017

Clinical Commissioning Group Governing Body (Development Session) – 06 09 2017

Integrated Health and Social Care Place Board – 06 09 2017

Health and Wellbeing Board – 20 09 2017

Plan for producing CCG 2018/19 CCG Commissioning plan.

Lead Executive:	**Ian Atkinson**
Lead Officer:	**Lydia George**
Lead GP:	**Richard Cullen**

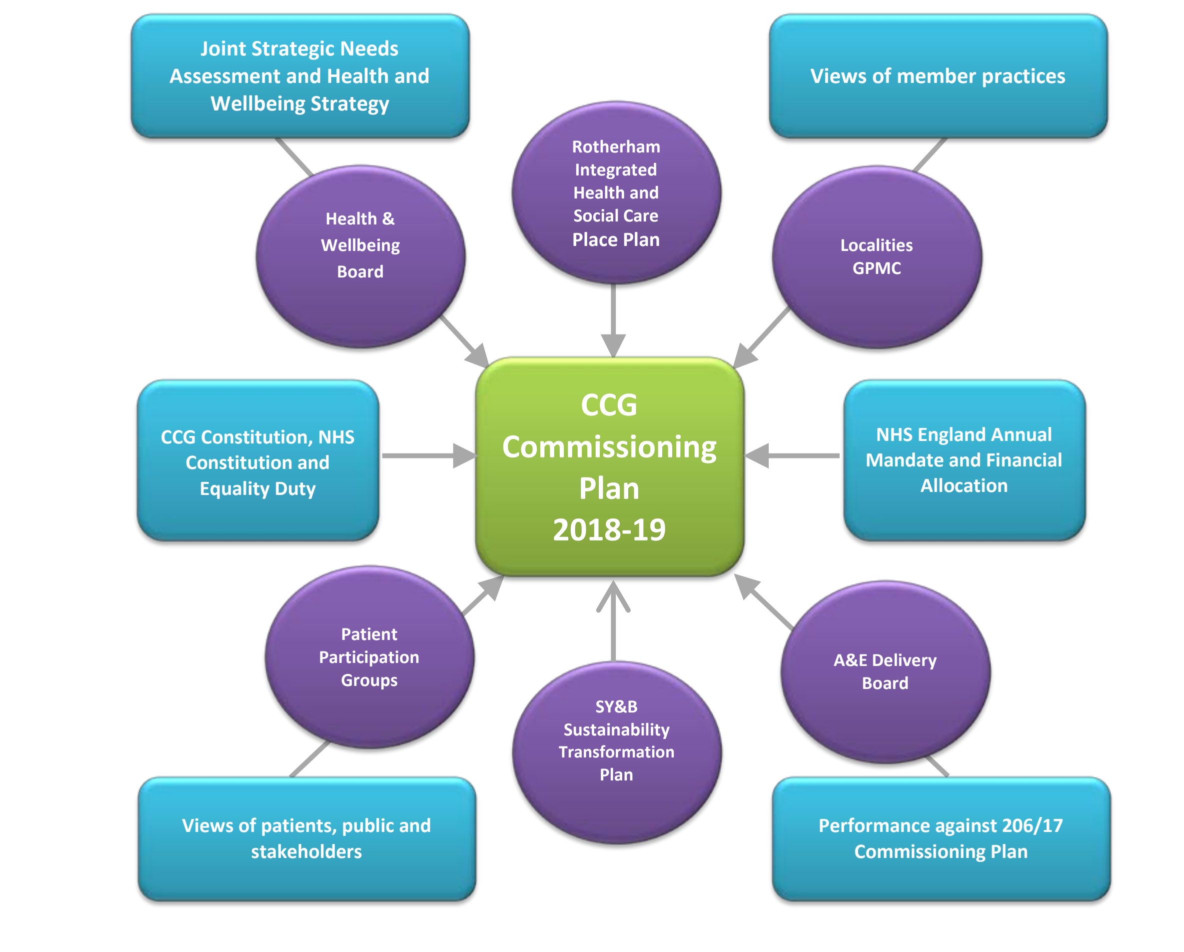
Purpose:

To set out how the CCG should produce a new Commissioning Plan for 2018/19.

Background:

The CCG constitution requires an annual Commissioning Plan recommended to the CCG Governing Body by the GP Members Committee. The plan is required to be endorsed by the Health and Well Being Board and is then subject to discussion with NHS England.

Figure one shows the inputs and stakeholders involved:



The established process for developing the Commissioning Plan has the following strengths:

- Timescales are shared with partners which allows time for meaningful feedback.
- The Commissioning Plan is endorsed by all relevant groups.
- The Commissioning Plan has consistently received positive feedback in the 360 stakeholder survey.
- Engagement with localities (e.g. via Chief/Deputy Chief Officer and Chair of GP Members Committee attendance at locality meetings) resulted in increased knowledge of and involvement in the plan, evidenced by feedback in the 360 stakeholder survey.
- The Staff survey showed a high degree of awareness among CCG staff.
- NHS England gave strong positive feedback on the Commissioning and Operational Plans.

Analysis of key issues and of risks

In light of the organisational and leadership changes across Rotherham the CCG feels it is important to set out to CCG officers, GP members, co-commissioners and partners the timelines the CCG will work to in the 2018/19 planning round so that stakeholders can input effectively.

Planning guidance has historically been issued each year in December, however, in 2017/18 the guidance was issued in September with a requirement to submit an Operational Plan by December. The timescales set out for the update of the Commissioning Plan means that should this requirement be mirrored in 2018/19 we will already have undertook a significant amount of work towards the development of the Operational Plan and narrative.

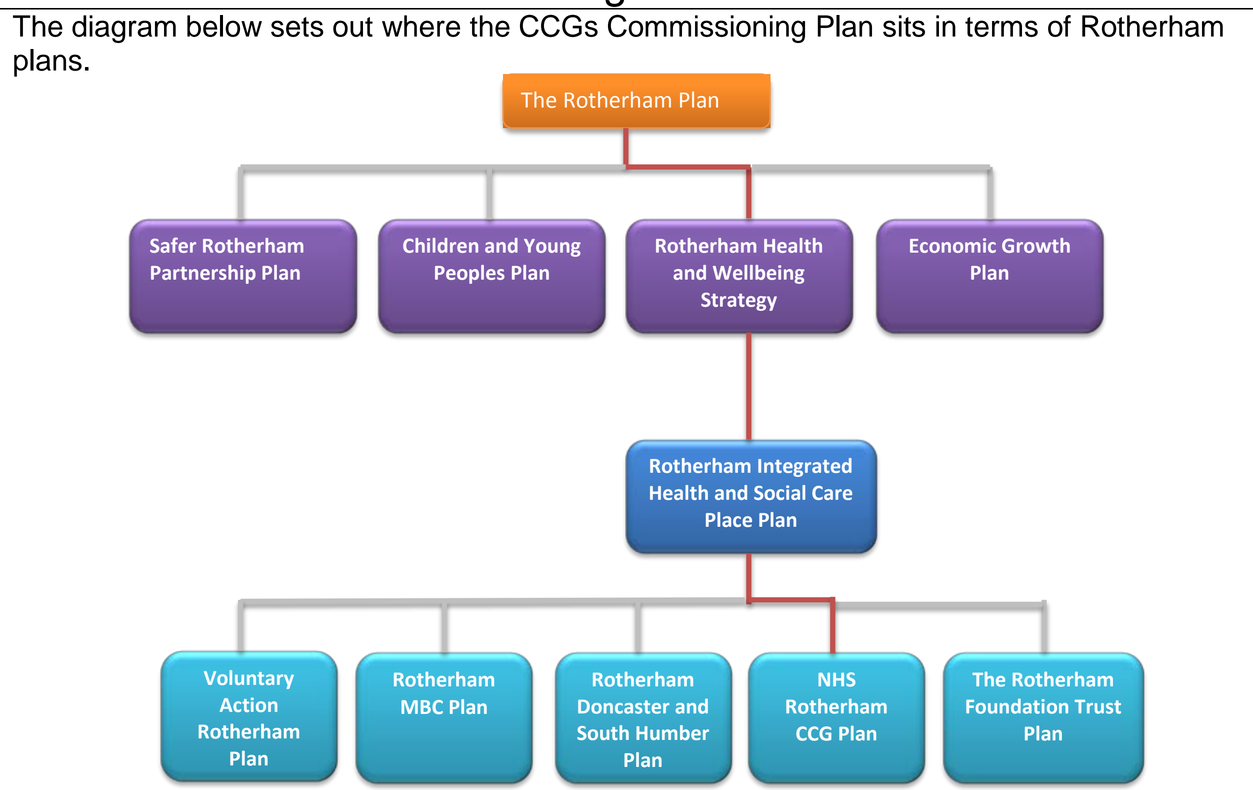
As in previous years, the process will require that we develop the following versions of our Commissioning Plan:

Version	Timescale	Purpose
Plan for Plan (P4P)	August	To be used internally and externally to share the process and timescales for the production of the Commissioning Plan.
Consultation Version (CV)	Mid-September	This will be the product of the discussions from the GB/SCE Development Session on the 6 September and will be used primarily to gather feedback from localities, but also to engage with key stakeholders.
Draft Version 1 (V1)	End November	This will be the first version of the Commissioning Plan, it will include locality and stakeholder feedback and will be shared internally and externally for comment.
Final Version 2 (V2)	Early February	This will be the final version, to include all stakeholder feedback and to include finances, activity etc. This will be approved at GPMC in February and signed off at GB in March. It will then be disseminated to partners and uploaded to our website.

The landscape has changed significantly since the current Commissioning Plan was produced. The planning process has been built around Sustainable Transformation Plans so that the commitments and changes coming out of these plans translate fully into operational plans and contracts. It is therefore important that the CCGs Commissioning Plan is aligned to the Rotherham Integrated Health and Social Care Place Plan and the Rotherham Health and Wellbeing Plan.

Early discussions have taken place on the update and alignment of the Health and Wellbeing Strategy and the Integrated Health and Social Care Place Plan. A plan for how this will be achieved and timescales were received at the IH&SC Place Board in September, ahead of the H&WBB in September.

The diagram below sets out where the CCGs Commissioning Plan sits in terms of Rotherham plans.



Attached are two documents:

- Rotherham CCG plan for a plan – app A
- High level timeline for the production of the plan – app B

Patient, Public and Stakeholder Involvement:

Current engagement intelligence will be used and a summary log will be kept of the engagement and feedback from the process of developing the Commissioning Plan.

Equality Impact:

Will be part of each section of the commissioning plan.

Financial Implications:

Will be a section in the plan

Human Resource Implications:

Will be included in the plan

Procurement:

Applicable to individual proposals.

Approval history:

- OE 11 August 2017
- SCE 16 August 2017
- CCG Governing Body (Development Session) 6 September 2017
- GPMC 27 September 2017
- H&WBB 20 September 2017
- IH&SC Place Board 6 September 2017

Recommendations:

Health and Wellbeing Board are asked to note the plan for producing the 2018/19 CCG Commissioning Plan and the timescales for consultation.

Rotherham CCG Commissioning Plan Refresh 2018/19: 'Plan for a Plan' as at 03 08 2017

Appendix A

There will be 4 versions of the plan produced, their purpose and timescales are shown below:

P4P	**'Plan for a Plan'**- (this paper) to outline the necessary consultation/approvals process and timeframe	CV	**Consultation Version** of the plan – powerpoint presentation to encourage initial feedback regarding progress and issues to date and future considerations (produced in September for use up to November)	V1	**Version 1** of the plan- for first submission (produced by relevant SCE and officer lead from members feedback by end November)	V2	**Version 2** of the Plan - for final submission (produced in February for March sign off and submission)

The consultation and development periods are outlined as follows:

	Develop and approve 'plan for plan'
	Views from member practices, patients, public and stakeholders
	Production of plan to meet national and local requirements
	Suggested meeting and version

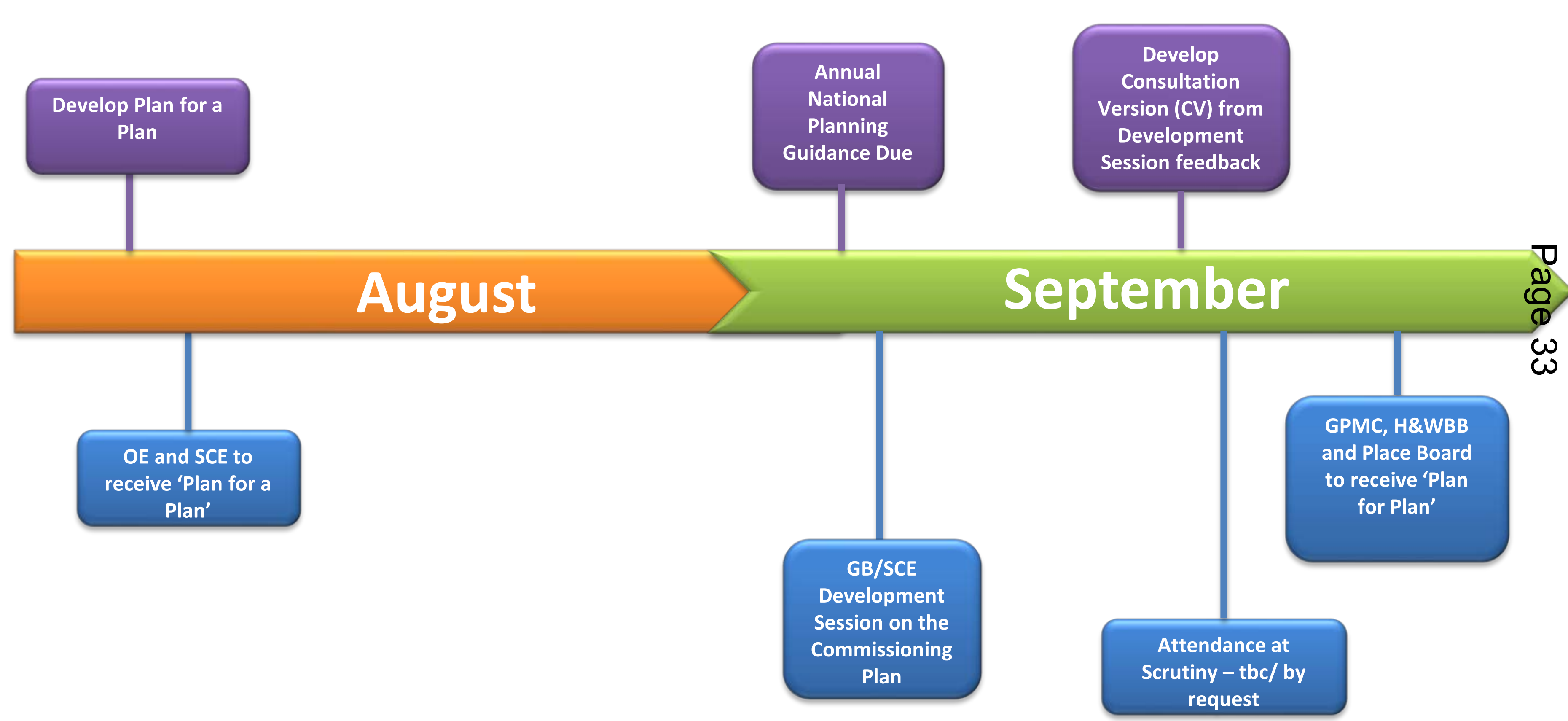
The following table outlines the consultation, approvals process and timescales for the development of the Commissioning Plan (some meetings for 2018 have not been fixed, so dates are estimates):

	Frequency (if a meeting)	AUGUST 2017	SEPTEMBER 2017	OCTOBER 2017	NOVEMBER 2017	DECEMBER 2017	JANUARY 2018	FEBRUARY 2018	MARCH 2018	APRIL 2018
Approval / Sign Off										
GPMC	Monthly		**P4P** 27.09.17	**CV** 25.10.17		**V1 20.12.17**		**V2 28.02.17**		
CCG Governing Body (*Development Session)	Monthly		**P4P 06.09.17***		**CV** 01.11.17		**V1 03.01.18**		**V2 07.03.18**	
Meetings										
OE	Weekly	**P4P** 04.08.17		**CV** 06.10.17		**V1 01.12.17**		**V2** 16.02.17		
SCE	Weekly	**P4P** 09.08.17		**CV** 11.10.17		**V1 06.12.17**		**V2 21.02.17**		
Locality Meetings	Monthly			**CV** tbc						
H&WBB	Monthly		**P4P** 20.09.17		**CV** 15.11.17		**V1** 10.01.18		**V2 14.03.18**	
Integrated Health and Social Care Place Board	Monthly		**P4P** 06.09.17		**CV** 01.11.17				**V2 07.03.18**	
CRMC (only relevant sections – activity review)	Every 4 weeks			**CV** tbc		**V1 tbc**				
MMC (only relevant sections)	Every 4 weeks			**CV** tbc		**V1 tbc**				
A&E Delivery Board (only relevant sections)	Every 4 weeks			**CV** tbc		**V1 tbc**				
MH/LD QIPP Committee (only relevant sections)	Every 4 weeks			**CV** tbc		**V1 tbc**				
Primary Care Committee (only relevant sections)	Monthly			**CV** tbc		**V1** tbc				
IT Strategy Group (only relevant sections)	Bi-Monthly			**CV** tbc		**V1** tbc				
PPG Network	Bi- Annually				**CV** 28.11.17					
PLTC Event	Every 2 months				**CV** 09.11.17					
Health Select Committee	By request				**CV** tbc					
Stakeholder Engagement /Communications										
CCG Employees	ASM / SMT			**CV** 16/17.10.17						
RMBC (also via membership of above groups)	n/a					**V1** as above				
TRFT (also via membership of above groups)	n/a			**CV** 19.010.17		**V1** as above				
RDaSH (also via membership of above groups)	n/a					**V1** as above				
VAR (also via membership of above groups)	n/a					**V1** as above				
Hospice (also via membership of above groups)	n/a					**V1** as above				
Special Interest Groups	n/a			***Via***	***CCG Website***					
General Public	n/a			***Via***	***CCG Website***					
NHSE/DH	n/a					****Note***			**V2 final**	
Website	n/a								Mid-March	
Annual Report and Event	Annually									

Produce 'P4P' — Produce 'CV' — Produce 'V1' — Consult on 'V1' — Produce 'V2' — Submit 'V2'

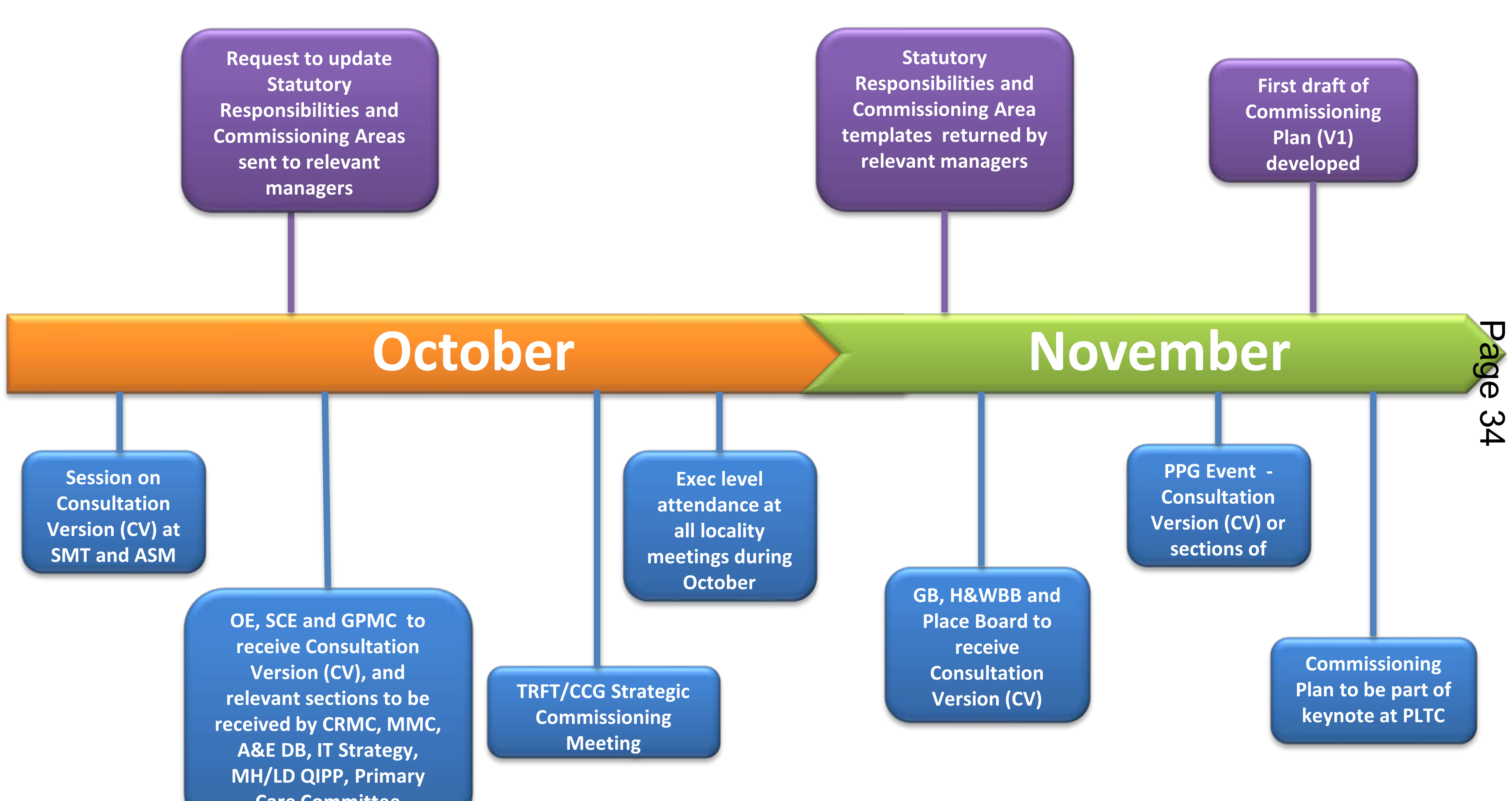
***Note** - the 2016/17 Planning Guidance required an Operational Plan submission in December. If this is mirrored in 2017/18 we will have gathered the necessary information to support development of the narrative part of the plan.

Timeline for the 2018/19 Commissioning Plan



Timeline for the 2018/19 Commissioning Plan

NOTE:
We will need to check closer the time whether papers go to confidential or public meetings, this will be dependent upon planning guidance and financial plan



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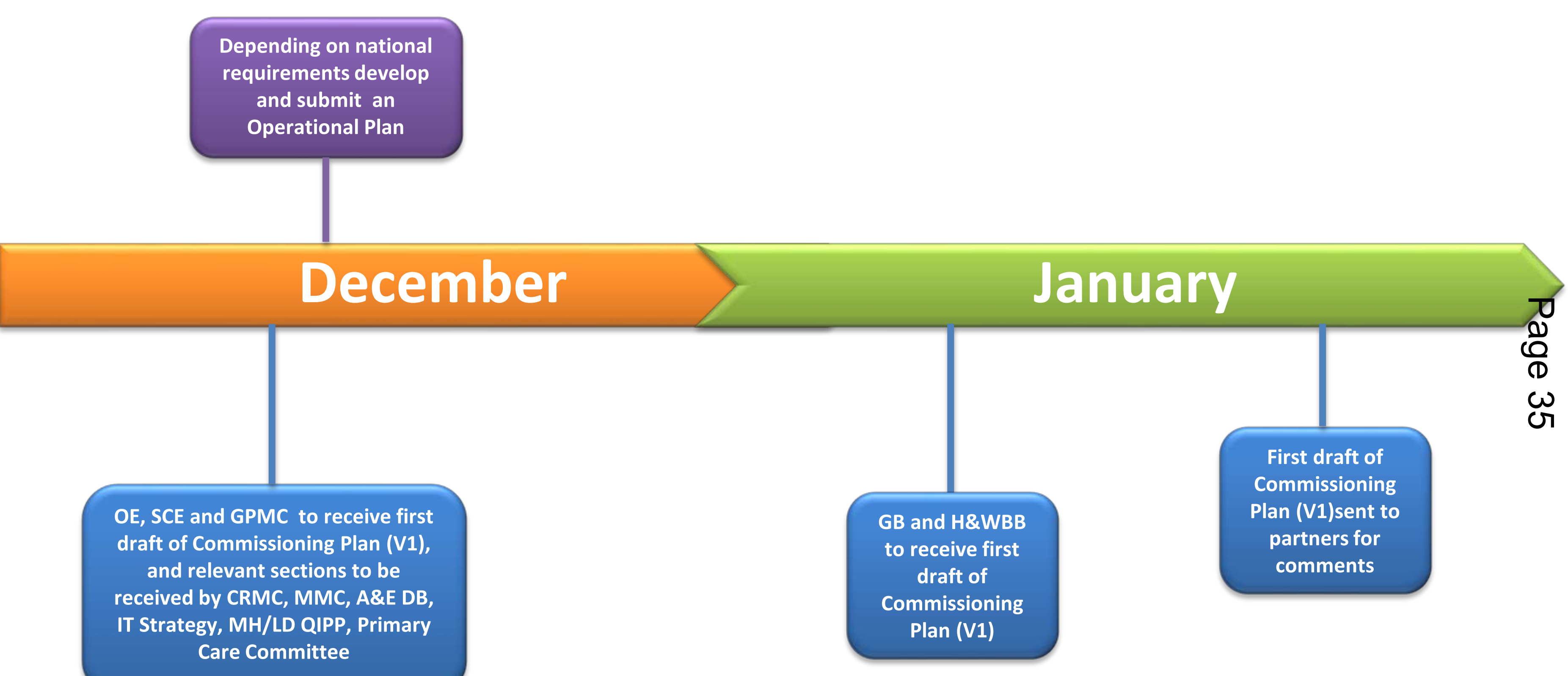
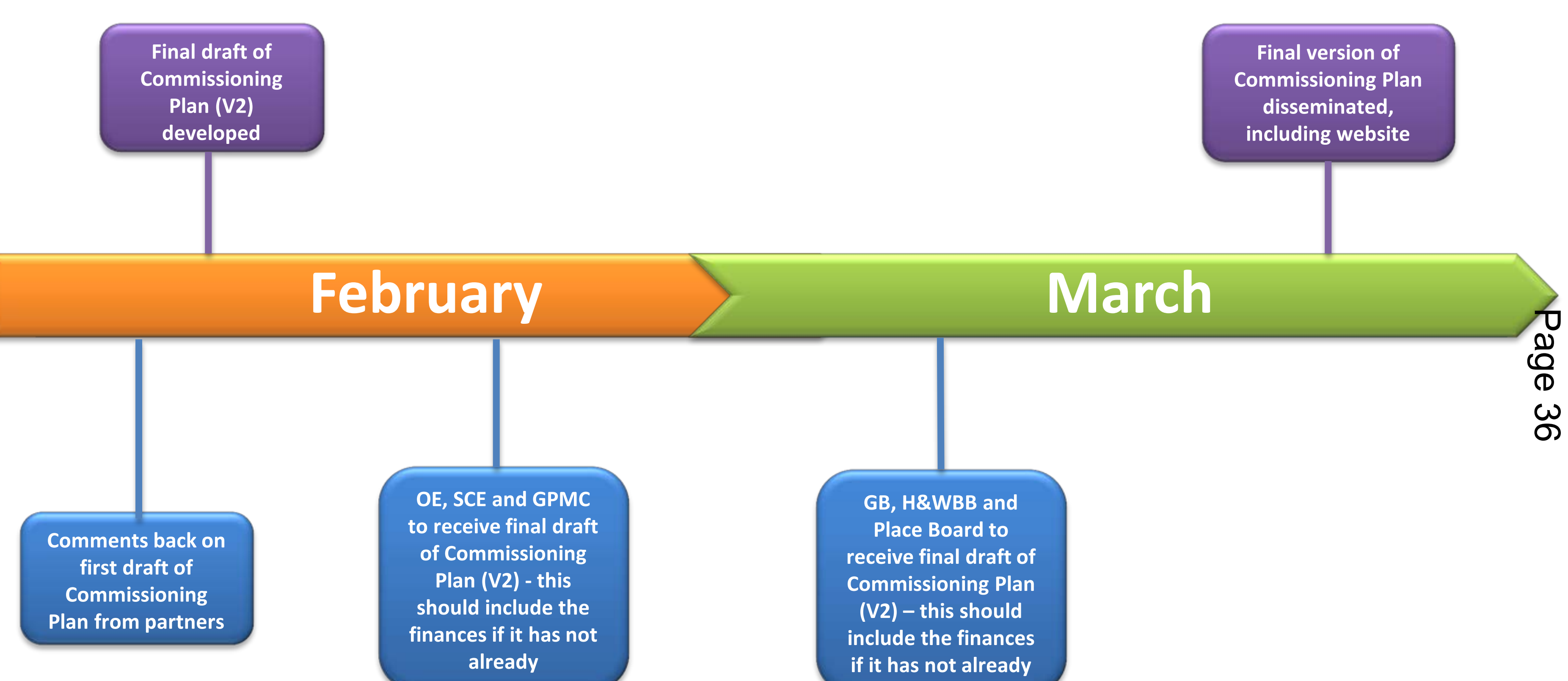


Timeline for the 2018/19 Commissioning Plan



Agenda Item 13

Annual Report 2016/17

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Message from our Chief Executive

This report details just some of the changes that we have helped to bring about. Our limited resources have been reduced once more but we will endeavour to achieve maximum impact with what is available to us.

Since the last annual report we said "Bon Voyage" to our Chair Naveen Judah and fellow director Gary Kent. They both started with Healthwatch Rotherham (HWR) from the beginning. I thank them personally for the strong contribution and support they have both given to me. Replacing them on the Board are Karen Biddle and Phil Turner. Many thanks goes to the Board for all the support they have offered.

At a time when health and social care budgets are being cut, the need to work collaboratively becomes essential. We have won the respect of the key stakeholders and sit in the unique position of having a clear view, without any conflict of interests.

We are delighted that the local authority had the confidence in HWR to reward us with a new contract but sadly it comes with a further 10% reduction in our budget in the forthcoming financial year and another 10% reduction for 2017-18. This has resulted in having to make one of our staff members redundant thereby reducing our capacity to deliver the service that the public deserves.

Prevention is high on the agenda of all of our key stakeholders. The challenge of balancing the pressure to make savings now, against investing in prevention, is often debated. This is reflected in strategic discussions and provides opportunities for us to be 'a critical friend' in these processes.

We have had very positive responses so far to the Mental Health directory and the Health and Social Care signposting directory that we have produced. They are available our website to download and we have a few printed copies in the office.

During the year we have seen huge success for two invividuals. Sharon Cope was highly commended winner in the Athena International Leadership Awards coinciding with International Womens Day and Georgia Pell (one of our young ambassadors) was winner of the Voluntary Action Rotherham Young Volunteer award.

Our priority is always to listen to people's concerns and feedback. Remember to let us know about your experiences of health and social care. The feedback we receive helps us to improve and they are included within the report.

Tony Clabby

The year at a glance

This year we have produced a mental health services directory and a general health & social care directory

24 volunteers supported us during the year

Our volunteers gave us 792 hours of exceptional service

We supported 116 advocacy cases in the last year

We have gathered 27,859 comments in the past 12 months about health and social care in Rotherham

We've met hundreds of local people at our community events

NHS Services

Family doctors
NHS Choices website
NHS Walk-In Centre
Hospitals
Accident and Emergency
999 - Ambulance
Dentist
Pharmacy
Optician
NHS 111

Social Care for Children and Families

Family Information Service
Children with disabilities
Parenting and family support
Childcare advice and information
Adoption and fostering
Counselling and support
Young carers

Public Health

Stop smoking services
Health Checks
Wellbeing service
Sexual health services
Substance misuse services
Health trainers
Child health

Adult Social Care

Home care
Supported living
Equipment and home adaptations
Support services for carers
Residential care
Day centres

01709 71 71 30
www.healthwatchrotherham.org.uk

Who we are

We are here to make health and social care better for Rotherham people. We believe that the best way to do this is for local services to be designed for local people's needs and experiences.

We exist to make health and care services work for the people who use them.

Everything we say and do is informed by our connections to local people. Our sole focus is on understanding the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf.

We are uniquely placed as a national network, with a local Healthwatch in every local authority area in England.

Our role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work.

We believe that asking people more about their experiences can identify issues that, if addressed, will make services better.

Our vision

Healthwatch Rotherham (HWR) will be known by all communities and individuals as delivering on its promises backed up by robust action and supported by improvements in local services.

HWR will be the first point of contact for all of Rotherham's communities and individuals, to support them to have a means of improving their own and others quality of health, wellbeing and social care.

We will do this by promoting local people's rights to the following:

- ✓ The right to essential services
- ✓ The right of access
- ✓ The right to a safe, dignified and quality service
- ✓ The right to information and education
- ✓ The right to choose
- ✓ The right to be listened to
- ✓ The right to be involved
- ✓ The right to live in a healthy environment

Our Values

To be an impartial and trusted friend to help communities and individuals achieve their desired outcomes and be recognised for being a fiercely independent organisation by the citizens of Rotherham.

Our Strategic priorities

Issues raised by the public have been prioritised by Healthwatch Rotherham, and have formed the basis of our work during the year.

Our Role

Involving

To promote and support local people to be involved in the planning and delivery of health and social care services

Listening

To gather your views, needs and experiences of health and social care services

Reporting

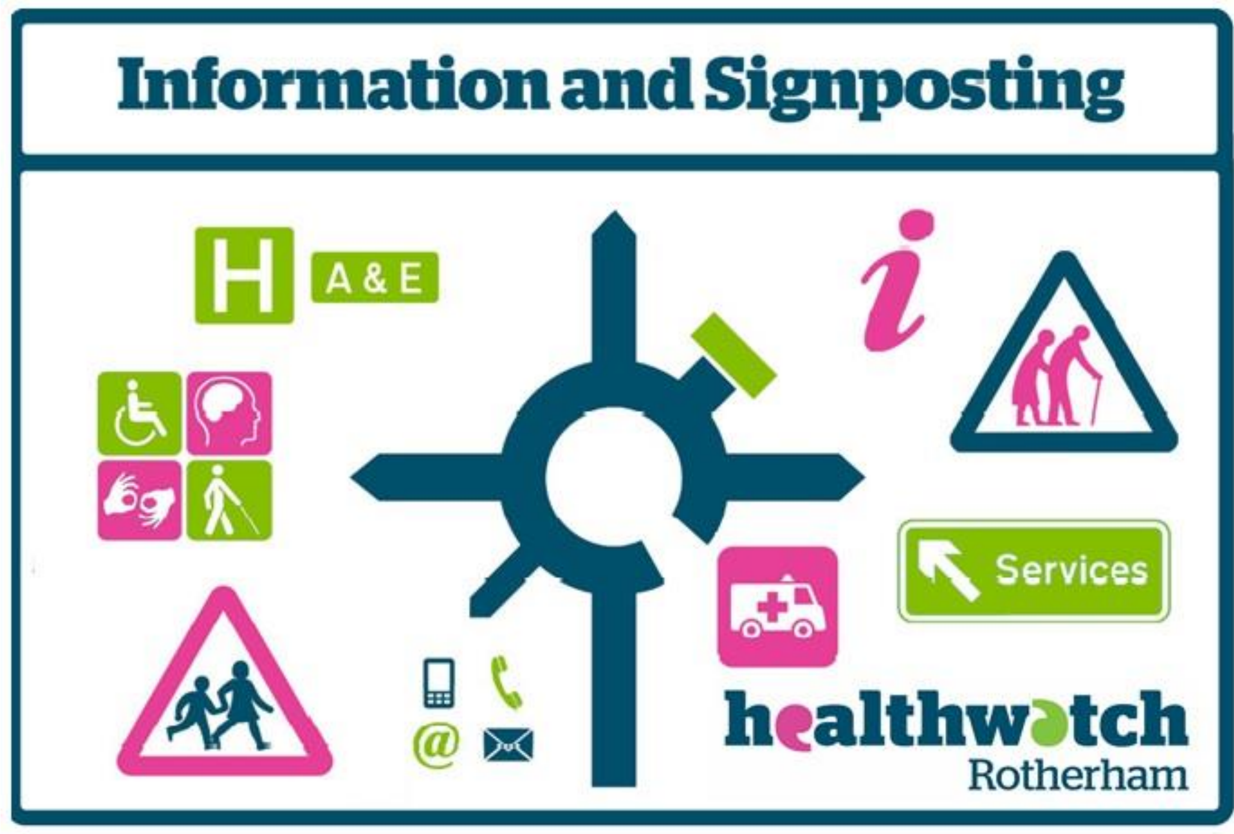
To report your views, needs and experiences to the people who plan, commission and provide health and social care services

Monitoring

To help local people check the quality of health and social care services

Signposting

To provide information about local health and social care services so that you informed choices can be made.



Listening to people who use health and care services

Gathering experiences and understanding people's needs

The key to our success is the number of people we hear from. To ensure we get the views of all people we have to make sure Healthwatch is accessible. We use many methods to collect views from the people of Rotherham, these include:

- Website
- Facebook
- Twitter
- Local events
- Telephone
- Email
- Town Centre shop
- Friends and Family comments from The Rotherham NHS Foundation Trust
- Radio
- Older People's Summit
- Permanent display at Rotherham Hospital

We recognize that social media is becoming more widely used by the population as a source of information and contacting services. Our new CRM System identifies comments posted on social media about Rotherham services which are able to be used.

A significant investment was made in a new innovative CRM System, provided by LHM Media. This system allows Rotherham people to use the website to leave reviews about services and sentiment analysis is performed on comments collected.

Healthwatch Rotherham has been gathering local people's views over the last 12 months. We have gathered 27,859 comments (last year it was 4,557) about experiences of services which local people have received. Within these comments there are several issues. The issues have been a mix of positive and negative and relate to many care services, as people tell us about their whole journey.

We share appropriate intelligence with strategic partners to influence the planning of statutory NHS and social care services ensuring that the information gathered is used to improve services.

We had to cancel our drop in sessions across Rotherham Borough as demand on advocacy meant the engagement officer job role changed to that of advocate to cope with demand.

Healthwatch Rotherham attended the Freshers Fair held by Rotherham College. The stand was manned by Healthwatch Rotherham Young Ambassadors.

We use all these methods to help Healthwatch Rotherham communicate with young people (under 21) and older people (over 65) as well as people volunteering or working in the area but who may not live in Rotherham.

People who are seldom heard can have the opportunity to make their views known through the drop in sessions, visiting the town centre shop or using electronic methods, whichever method they feel comfortable using.

Town Centre Shop

The shop is open for public access 5 days a week Monday to Friday 9.30 - 4.30. We are on the High Street, with disabled access. The shop is also contactable via phone and email during opening times.

The shop provides a fantastic opportunity to engage with local people and promote Healthwatch. We advertise numerous events in our shop and on our notice boards and offer a full range of information on health and social care issues and services.

"Healthwatch Rotherham organised for Cartoonist Tony Husband to present an animated depiction of his dad to help spread dementia awareness. The new addition to the street scene is above the offices of Healthwatch Rotherham, which promotes awareness of dementia."

(RMBC Cabinet and Commissioners Decision Making Meeting - 10 October 2016)

Enter and View

Section 186 of the Health and Social Care Act 2012 provides for local Healthwatch to carry out Enter and View: Enter and View visits can be announced and arranged in advance with the service provider or unannounced if there is a serious concern. Enter and View is the opportunity for staff and volunteers to visit Health and social care premises, observe the nature and quality of care and to collect views from service users, visitors and staff

As a critical friend our approach is to speak to the service provider first.

We realise that it is the service provider that will make changes to improve. The quicker they can do this the more people will benefit. That is why we aim to always talk to the provider first. We have found that some providers are not aware

of what people's views are of their service, but they all welcome feedback from their customers.

Healthwatch Rotherham has not undertaken any Enter and View activies. The decision of when to use Enter and View is detailed in our Escalation policy. We have had responses from all the providers we have contacted. Changes have been made to services following the comments from the public we have passed on.

The Board have not had enough evidence to support the use of our statuory power to Enter and View a health or social care setting.

NHS Advocacy Service

Healthwatch Rotherham provides local people with an Advocacy service to help people make NHS complaints. We understand that making an NHS complaint can be difficult for some people for many reasons. We also take into account the comments we receive about services when a complaint is made. Within these comments, there is usually a positive issue.

"The service provided by Michael my advocate and other Healthwatch staff was fantastic. The knowledge of my advocate was really impressive, if there was anything he was unsure of, he would find out the answer and come back to me. Without Healthwatch, I would have really stuggled to express my feeling and complaints in a calm and professional manner to other services. Having Mike there with me to attend any face to face meetings was a huge bonus, without him I would have gone alone. I would highly recommend Healthwatch to friends and family"

Laura (Client)

The Advocacy service has helped 116 (last year 114) people to make an NHS Complaint. An additional 74 issues were raised informally and they all achieved their desired outcome.

"Healthwatch get things done, they are like superheros - they listen"

(A parent)

"Dear Anne, Thank you so much for the moral support and for making me laugh."

Felicity (Client)

Child And Adolescent Mental Health Service (CAMHS) Advocacy

Healhwatch Rotherham provide an advocacy support service to children and young people and families who are accessing or about to access mental health services.

The service is funded by the Rotherham NHS CCG and is part of the CAMHS Transformational Plan.

To date the CAMHS advocacy service has dealt with 28 cases. All clients who have used the CAMHS advocacy service are asked to give a satisfaction score. So far all the statisfaction scores have been 5 out of 5 in terms of postivie statisfaction with the service offered by Healthwatch Rotherham.

The service works to help with understanding the CAMHS process and decisions.

"I would like to say a massive thankyou for all your help given to us with our complaint to CAMHS over the lack of help and support received from them. Since you have been involved my daughter has received a lot more support, an apology from CAMHS themselves and better provision for her future treatment, something which I would have been unable to do myself. Also a big thanks for the information you sent signposting other services for us to access, greatly appreciated Thanks very much

A Parent

Giving people advice and information

"I agree that Healthwatch provide a crucial service to Rotherham ... NHS structures and complaints procedures can be extremely complex and it is important that people are able to obtain expert advice and guidance to help them navigate the process" (Sarah Champion, Rotherham MP)

Supporting people get what they need from local health and care services

Healthwatch Rotherham aims to provide people with as much information as needed and in a format which is best suited to help people to access the right services and make decisions about their care.

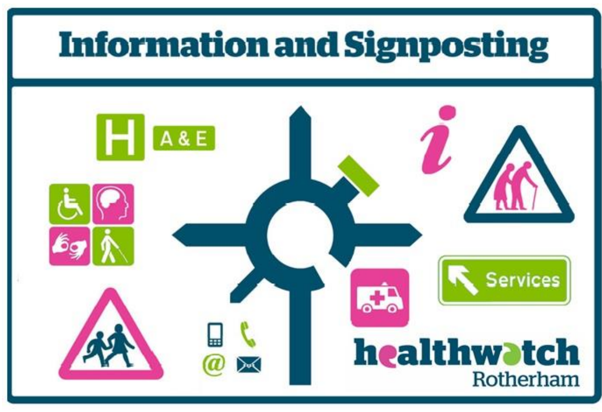
Healthwatch Rotherham provides information and signposting in diverse ways to reach as many residents as possible. We have excellent links to and knowledge of service providers in the area, enabling us to empower people to make choices about their care.

"I would like to say a big thank you for your support and coming to a meeting with me with the Integrated Youth Support Service worker regarding transgender. The information was great and very helpful. I really appreciate the meeting with the young man going through his journey and the way he explain things to me was eye opening. If it wasn't for you I wouldn't have known where to find the information as to who to talk to and what direction to take. Your continuing support with introducing me to the transgender parents group. I really appreciate all your work."

Anon

Key methods used to provide information and signposting include:

- our shop on the High Street
- attendance at community events
- our stalls in the reception areas of Rotherham Hospital
- our user-friendly website
- presentations to community support groups.
- prompt replies to email and telephone queries
- directories



"Healthwatch is worth its weight in gold and we will forever be grateful. I would recommend anyone to your service as you give 100 percent to your families. Again "Thank you" even if it does not feel like I can show you how grateful. Lastly it's great to meet people who do and say what they promise.''

Gemma (Parent)

One of our key challenges is recording the referral and signposting activity we perform. We have recorded signposting of 298 people (last year 301) to services. The most popular services are:

- Dentists Accepting NHS Patients
- NHS Choices
- Lifeline
- CAMHS
- Independent Age
- British Heart Foundation
- Age Concern
- Action on Hearing
- Cloverleaf Absolute Advocacy
- Rotheham Parents Forum
- RMBC Complaints Officers

We have a large selection of information leaflets and posters in our High Street Shop, plus our website, facebook and twitter accounts are upated regularly.

We have produced a Mental Health Services Guide listing all the services available and also created a Health and Social Care Signposting Directory. These guides were sent to the GP Practices and other agencies as well as hard copies in the Healthwatch Rotherham office and downloadable on the website.

"The directory of mental health services provides an excellent resource for the public and clinicians alike"

Julie Kitlowski
(Rotherham NHS CCG Chair)

Healthwatch Rotherham supported Worlds AIDS Day, with a display in the Office window and with the Young Ambassadors doing a reading at the awareness event that took place in Rotherham.

How we have made a difference

Our reports and recommendations

Your voice counts. From all the views, comments, compliments and complaints Healthwatch Rotherham has collected, we have seen many changes in health and social care.

These impacts benefit the citizens of Rotherham and ensure services are more effective in saving public money.

Some of these changes are...

A GP Practice reviewed its procedures following a complant raised. The person who made the complaint said the practice cannot do enough for her dad now as a result.

Another GP Practice reviewed its procedures following an issue around childhood cancer.

- As a result of complaints made regarding A&E at Rotherham Hospital the following has been put in operation:
- International rounding has been introduced every hour
- Developing a patient champion role
- Lead co-ordinator for communication
- Increased nursing numbers

Following an advocacy case, The Rotherham NHS Foundation Trust have put in place a new pathway to support patients presenting with stroke symptoms. The doctor concerned during a meeting held with the complainant and the doctor, reflected upon his interventions and actions and acknowledged that in hindslight would have managed the situation differently.

Outcomes following a complaint raised about a miscarriage:

- Reminder regarding patient copy of the consent form to be given to patients
- Only gynaecologyically trained staff to give telephone advice regarding miscarriage management
- Feedback to teams regarding sensitive use of terminology following pregnancy loss
- Include “how do parents want baby refered to e.g. name” in miscarriage pathway documentation.
- Keep patients up to date

A person who had transgender treatment agreed had been waiting 3 months for a letter to confirm the treatment. Healthwatch made a phone call and the letter was sent out the following day.

Concerns raised in relation to the care and treatment received from the Gender Identity Service especially around the length of time for a referral letter to be sent out. As a result of the issue raised the administrative team has reviewed its procedures and will aim to ensure correspondence is issued within three working days of any intervention. The deadline to be moved to a maximum of seven working days should staff shortages exist.

Healthwatch Rotherham contributed to the National Healthwatch England report

of dentistry. Issues identified by Healthwatch Rotherham and other members of the Healthwatch network has resulted in the following changes occurring on NHS Choices on the dental practice records:
NHS Choices

- any dental practice that hasn't updated their information for more than 3 months will then display ' data not available - the practice hasn't provided information in the last 90 days';
- introduce a mandatory 3 month review cycle, and reset information for any practice that hasn't reviewed their information within 90 days;
- will overhaul the descriptions on the site to make them more user friendly and meaningful:
- improve the editing interface for dental practices and build an automated email reminder system that will allow practices to validate or update their information in the most convenient way possible.

Rotherham Doncaster and South Humber NHS Foundation Trust have made the following changes when an issue was brought to their attention:

- All staff to record discussions regarding the potential side effects and risk associated with prescribed medication of any dosage within the daily record in patients' electronic records. This should include details of any patient leaflets etc given.
- Information given by patients that they they are taking an above prescrived dose of any any prescribed medication should be brought to the attention of the prescribing doctor or non medical prescriber. Advice should be sought as to how to safely reduce the dosage to the prescribed level.
- All staff to complete information governance training regarding the sharing of confidential information.

A young person was successfully re-assessed for autism and another young person as placed back on to the care pathway following discharge.

''I would first like to make you aware of the excellent service provided by Healthwatch Rotherham. Their help in getting accountability and responsibility for my son's death has been invaluable, especially my appointed advocate Mr Michael Horne. I will be forever grateful for Healthwatch's professional handling of my case. The work Healthwatch do in helping people from the community of Rotherham is invaluable.''

Patricia (Client)

Working with other organisations

Rotherham National Citizen Services visit

Rotherham National Citizen Service group visited Healthwatch Rotherham to see how the two services could work together.

Healthwatch Rotherham identified that no (statutory) Autism strategy was in place for Rotherham and are working with RMBC and Rotherham NHS CCG on the Autism All Age Strategy working group.

When we identify significant concerns or a member of the public requests it, we share information with the Care Quality Commission.

The Care Quality Commission (CQC) monitor services' performance against national standards. They regulate:

- Treatment, care and support provided by hospitals, GPs, dentists, ambulances and mental health services.
- Treatment, care and support services for adults in care homes and in people's own homes (both personal and nursing care).
- Services for people whose rights are restricted under the Mental Health Act.
- Registered care homes and commissioning activity.

They have the power to enforce change and in some cases closure of services which do not meet the standards of good quality and safe services.

We have passed concerns to The CQC which has aided their visits to care providers.

The working practices between Healthwatch Rotherham and the CQC are highlighted in case studies presented to other local Healthwatch as good practice. The report was called "Local Healthwatch and CQC Working Together". Healthwatch Rotherham helped CQC to gather information reaching groups across the outlying areas of Rotherham.

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Dear Anne,

Thank you so much for the moral support and for making me laugh.

The directory of mental health services provides an excellent resource for the public and clinicians alike

healthwatch Rotherham

It will be strange not having contact with the healthwatch crew! You really have been amazing. I know you'll say, you're only doing your job, BUT to me you've been a little lifeline. I couldn't have achieved what I have, without your help and I'll be forever grateful for that.

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Rotherham Healthwatch shared a significant amount of good quality information about local people's experience of using and accessing services at their local hospital. It included 77 pages of themed comments that were dated and related to specific services and wards - valuable and easy to use intelligence that we couldn't have accessed anywhere else.

The service provided by Michael my advocate and other Healthwatch staff was fantastic. The knowledge of my advocate was really impressive, if there was anything he was unsure of, he would find out the answer and come back to me. Without Healthwatch, I would have really stuggled to express my feeling and complaints in a calm and professional manner to other services. Having Mike there with me to attend any face to face meetings was a huge bonus, without him I would have gone alone. I would highly recommend.

your voice counts

Healthwatch get things done, they are like superheros they listen

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CQC Information Analyst

Healthwatch Rotherham attends the Quality Summit's that are arranged to discuss CQC reports.

The views and comments we have received from the people of Rotherham have been used to feed into The Rotherham NHS Foundation Trust Quality Acounts. Quality Accounts tell the public which areas of quality the organisation has worked on over the last year and what they plan to work on in the coming year.

Healthwatch Rotherham has assisted with PLACE assessments at Rotherham Hospice and The Rotherham NHS Foundation Trust. PLACE assessment are in place for assessing the quality of the patient environment. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care.

The assessments will see local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job.

Healthwatch CEO took part in a day long mock inspection of the Hospital.

Healthwatch Rotherham has made strong links with the organisations which commission health and social care services in Rotherham.

Regular meetings take place with commissioners and quality leads, giving us the opportunity to raise the issues and comments that the people of Rotherham give to us.

Healthwatch Rotherham has supported Rotherham Parents Forum, by providing space for drop-ins to be hosted on a Wednesday evening in our town centre office. Regular meetings between Healthwatch Rotherham and Rotherham Parents Forum take place to share learning and understanding and to prevent duplication of work.

Healthwatch Rotherham has also built up a relationship with Rush House, with the Young Ambassadors hosting weekly voice and influence session.

In conjunction with Rotherham NHS CCG, Healthwatch Rotherham performed a survey around prescriptions and if certain items should be included on prescription. The results of the survey fed into the Rotherham NHS CCG decision making on this topic.

Healthwatch Rotherham were part of the Rotherham Older People's month in October, working together with Age UK Rotherham and Rotherham Older Peoples Forum. The summit is covered within this annual report (page 26)

Healthwatch Rotherham is a member of the:

- Rotherham Health and Wellbeing Board and Sub Groups.
- Rotherham Adult Safeguarding Board and Sub Groups.
- Rotherham NHS CCG Patient, Public Experience & Communications Sub-Committee.
- Urgent Emergency Care Network Board.
- Rotherham Dementia Alliance.

Healthwatch Rotherham attends:

- Rotherham NHS CCG Primary Care Sub-Committee.
- Rotherham NHS CCG CAMHS Transformation Plan.
- NHS England (North Region, Yorkshire & the Humber) Patient Experience Forum.
- The Rotherham NHS Foundation Trust Patient Experience Group.
- The Rotherham NHS Foundation Trust Clinical Goveranance Committee.
- Rotherham NHS CCG Patient Participation Group.
- Healthwatch England Regional and national update meetings.
- Rotherham NHS CCG PPG Network.
- Rotherham Working Together Partnership.
- CQC and Healthwatch England Joint Working Together.
- RMBC Child Centre Borough Group.
- Living with and Beyond Cancer Steering Group.
- Sexual Health Group.
- Rotherham Early Years and Help Group.

"For Healthwatch Rotherham to be delivered effectively, local relationships with stakeholders are required to build legitimacy and influence impact. Healthwatch Rotherham has built positive cooperative working relationships with RMBC, Rotherham CCG, The Rotherham Foundation Trust, and Public Health. Healthwatch Rotherham is a full member of the Rotherham Health and Wellbeing Board and a briefing is provided on the views of local people relevant to the agenda."

(RMBC Cabinet and Commissioners Decision Making Meeting - 10 October 2016)

At the Healthwatch England National Conference, Healthwatch Rotherham hosted a session on the CAMHS service seeking debate on the issues across the network. The challenge was made to Healthwatch England to take forward CAMHS as a national issue.

"This session was very good ….. Rotherham has had some issues with CAMHS. There were many people in the room from other Healthwatch and it seemed common that people have issues with CAMHS all over so further work could highlight these issues."

Healthwatch Blackpool

Rotherham Health and Wellbeing Board

Healthwatch Rotherham is a full member of the Rotherham Health and Wellbeing Board with Tony Clabby (CEO) attending.

Healthwatch asks questions of the other members of the board with the comments and issues the citizens of Rotherham bring to us.

All the team at healthwatch
Thankyou for all your help and Support through our bad times We appreciate it so much

This heartfelt message
comes to you today,
To thank you more than
words can say.

Love
Paul + Tracy
xxx
xx.

Our work in focus

Our work in focus:

Older People Summit

On Friday 7th October, Healthwatch Rotherham held an Older People's Summit at the New York Stadium. The event formed part of Older People's month in Rotherham.

62 people attended as participants in the listening table discussions. 22 people attended to host and be involved with the listening tables. A guest speaker was also in attendance from Age Friendly Manchester. 5 members of Healthwatch Rotherham staff were present along with 2 volunteers. In total 92 people were present.

The event was opened by Councillor David Roche, Chair of Rotherham Health and Wellbeing Board and Cabinet Member Adult Social Care and Health. A short presentation took place from Rotherham Public Health before Paul McGarry – Strategic lead, Age Friendly Manchester gave a speech on the work taking place to make Manchester an age friendly city.

People then walked around the room visiting the various listening tables. On each table were very senior lead officers from The Rotherham Foundation Trust, Public Health, Safeguarding Adults, RDASH, CCG, RMBC Councillors, South Yorkshire Police and Age UK.

"It gave an insight into what is available for older people in Rotherham."

The themes and comments from each table were verbally fed back on the day and in a subsequent report. Following the event the providers in attendance were asked what actions they had taken.

"I did not know what to expect. It was brilliant. Lots of information and very nice people."

Actions from the summit were:

The Rotherham Foundation Trust reviewed the content and updated the outpatient letter.

The Rotherham Adult Safeguarding board is to work with Age UK and Rotherham Older People's Forum to look at scams and what can be done in the Borough to protect and help victims.

Rotherham Public Health are building all the feedback that they have received into their Ageing Better Framework for Rotherham.

Saturday 1st October at Rotherham Minster

Older People's Day

10.00am to 12.00pm

A free drop-in event in partnership with South Yorkshire Police.

'Being Safe' – providing information and thinking about how to stay safe and avoid being a victim of scams against older people.

healthwatch Rotherham

Register your attendance for this event by calling 01709 717130 or by email: info@healthwatchrotherham.org.uk or just pop in to our shop at 33 High Street, Rotherham.

Friday 7th October at New York Stadium

Older People Summit

9:30 (Registration) - 10am to 1pm

FREE event—light lunch provided

Health, Social Care, Police Services will be there to listen to you s This is an opportunity for you to tell heads of services your experiences and **expectations**

Rotherham age UK

Register your attendance for this event by calling 01709 386831 or by email: iain.cloke@ageukrotherham.org

Friday 28th October at Rotherham Town Hall

10.30am to 2.45pm

Age Friendly Rotherham

A conversation about a strategy for our ageing society

FREE event—light lunch provided

A meeting for older people with leaders from support agencies to think together about how we can respond locally to tackle issues created by an ageing society, so that Rotherham is a great place to grow older in a world where everyone is able to love later life.

Let's Get Rotherham Talking

Our work in focus: Young Ambassadors

Rotherham Healthwatch developed an innovative programme with young people to promote wellbeing and healthy living. The Rotherham Young Healthwatch Ambassador Programme aims to give young people (aged 12 - 25) a voice in the design and delivery of the health services they receive.

Young ambassadors have attended and now host the Rush House pre-established voice and influence session and in true Voice and Influence spirit this has now been renamed "Hear our Voices" at the request of those who attend. During their involvement they have taken the group in a new direction and are actively engaging the services that the young people want to talk to.

"Our connection with Healthwatch has been established for some time as a service, however, this became a stronger connection when myself and Sharon spoke at an event we were hosting to launch a film we had produced. Sharon (and her young Ambassador Georgia Pell) expressed a real passion and enthusiasm for engaging Rush House young people and so the link was made."

Lisa (Rush House)

Young ambassadors took part in the Recovery Games comimg fourth out of over 30 teams. The Recovery Games celebrates recovery from drug and alcohol dependence, and is a chance for teams of service users, volunteers and staff to work together, competing against other teams from within the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and from services across the region.

The Young Ambassadors visited St Basils in Birmingham to learn about a social action project and to see if the concept could be replicated in Rotherham.

During Christmas, a campaign to help a young Rotherham women return home for Christmas was started and the fundraising target was reached.

For World Aids Day, two Ambassadors gave readings during the awareness event held. The Ambassadors also took park in the first Rotherham Carnival, by taking part in the Carnival and also by decorating the window so people walking past on the Carnial procession could see support.

Our work in focus: Sustainability and Transformation Plan (STP)

Healthwatch Rotherham and Voluntary Action Rotherham (VAR) were commissioned to undertake engagement on the South Yorkshire and Bassetlaw Sustainability and Transformation Plan.

As part of this work we worked together to undertake 10 conversations targeting wherever possible harder to reach groups, 2 focus group discussions and encourage participation in completing the survey.

The Rotherham Integrated Health and Social Care Place Plan, details the joined up approach to delivering five key initiatives that will help achieve the Rotherham Health and Wellbeing Strategic Aims and meet the South Yorkshire and Bassetlaw's Sustainability and Transformation Plan (STP) objectives. A copy of the Place plan can be found on the Rotherham CCG website

The following approach was used:

- To describe the STP briefly as context, but to base the majority of the conversation on the Place plan.
- To be very clear about what could be changed and what not – i.e. some elements could only be information

The aims of the engagement exercise were to

a) Raise awareness with people and communities, especially those less likely to access mainstream information, of the issues facing the NHS and social care in South Yorkshire and Bassetlaw and the thinking so far of the STP partners in addressing these.

b) Gain feedback on the thinking in the STP to shape the future direction of health and care in the region.

c) Increase engagement and motivate people to be involved in shaping health and care in their region.

d) Understand to what extent people and communities are willing and able to get involved in taking more control of their own health.

HWR focussed on seldom heard voices and hosted interactive sessions with the deaf community via Deaf Futures, Rotherham Older Peoples Forum, Rotherham Parents Carers Forum and Rush House residents reaching a total of 106 people and establishing a contact list for NHS England.

Our plans for next year

Future priorities

Our plans for 2017/18 will naturally be determined by the comments we are receiving from the public and we need to be flexible and adaptable to meet those challenges.

We will be working together with Rotherham CCG to improve the engagement and participation of Rotherham residents in improving health and well-being across the Borough.

We will continue to monitor the implementation of the Local CAMHS Transformation Plan and highlight any areas of continuing concern.

Our CEO Tony Clabby has been invited to be a member of the CQC Children and Young People's Mental Health Review Expert Advisory Group. This is a national review to improve access to high-quality mental health services for children and young people and their families across the Country.

We will seek to continue to play a central partner role in Rotherham's Autism All Age Strategy, which was initiated after Healthwatch Rotherham highlighted gaps in services and provision. We also aim to undertake work around Autism, Healthwatch Rotherham applying for an Autism Friendly Award and also possibly Autism accreditation, both awards are through the National Autistic Society.

We will continue to work with the deaf community to understand and assist with the issues they are facing, particularly, around BSL interpreters. To aid with this work, we are putting in a text messaging service for the deaf community - text 07483 987741 and we will text back.

We will continue to provide highly rated advocacy services both for general NHS complaints and targeted CAMHS complaints.

We will undertake research into the issues around the understanding of "power of attorney" as part of our commitment to Rotherham Adult Safeguarding Board.

Our people

Staff

At the end of March 2017, Healthwatch Rotherham employs 6 members of staff.

- Tony Clabby
  CEO
- Nathan Batchelor
  Information & Research Officer
- Anne Lemm
  Advocacy Officer
- Sharon Cope
  Children & Young Peoples Engagement Officer
- Steve Mace
  Advocacy Officer
- Mike Horne
  Children & Young Peoples Advocacy Officer / Advocacy Officer

Sadly, due to budget cuts, we will be losing Sharon's post in June.

During the year, staff have completed the following training:

- Working with People with Learning Disabilities
- Autism Awareness
- End of Life Care
- CSE Awareness
- Safeguarding.

Sharon Cope was highly commended in the ATHENA International Awards. This relates to her work with the Young Ambassador scheme and helping drive and support the young people in the project.

"It will be strange not having contact with the healthwatch crew! You really have been amazing. I know you'll say, you're only doing your job, BUT to me you've been a little lifeline.

I couldn't have achieved what I have, without your help and I'll be forever grateful for that."

Laura (Client)

Decision making

Key decisons and work planning are based on the evidence that Healthwatch Rotherham collects from the citizens of Rotherham. They use the decision support tool to aid them and to prioritise the work.

The escalation of issues is determined by the operational staff using the escalation policy. This is then fed into the Healthwatch Rotherham Board for ratification.

"The governance of Healthwatch Rotherham is well established. How the service is managed is essential to ensure the credibility of the organisation especially when they are challenging providers about their services. How the views from members of the public are gathered and used to determine where changes are required is clear, along with the process to be followed in approaching providers about changes required."

(RMBC Cabinet and Commissioners Decision Making Meeting - 10 October 2016)

Volunteers

The board is made up of volunteers who were selected due to their skills and experiences.

During the year Naveen Judah and Gary Kent both resigned from the Board.

Karen Biddle and Phil Turner both joined the Board. Karen had used the Healthwatch Rotherham advocacy service and was so impressed and wanted to put something back that she opted to join the Board. Phil Turner, is a retired journalist after spending many years working for the Rotherham Advertiser.

The Healthwatch Rotherham board as of 31st March 2017 were:

- Paul May
- Sue Barratt
- Chris Smith
- Catherine Porter
- Karen Biddle
- Phil Turner

The Board make key decisions in our organisation and set the direction of the work we do.

We recognise that volunteers vary in their availablity due to other responsibilities such as work, caring or their own health needs and take this into account.

The volunteers have dedicated a total of 792 hours to Healthwatch ensuring that local people have their say about Rotherham's Health and Social care services.

Wendy Colgrave has volunteered and provided much valuable help and support especially around publishing two resource directories.

Georgia Pell is a Young Ambassador and was awarded the Rotherham Young Volunteer Award presented by Voluntary Action Rotherham in October. The judges said "She shows great compassion and empathy for her peers and has been willing to share her own story to help give insight and hope to others. A

natural leader, charming, charismatic, integral and inspiring are all words attributed to Georgia – it's a pleasure and a privilege to see the journey she has made."

Georgia went to Pakistian as part of the British Youth Council.

Young Ambassadors

Active young ambassadors during the year were:

- Georgia
- Toni
- Lisa
- Deren
- Darren
- Anthony
- Rob
- Nat
- Adele
- Shim
- Jovan
- Pip
- Corry

They have attended:

- Health & Wellbeing Working Groups.
- Rush House Drop In
- Do it for Dylan (Water safety)
- Numerous training sessions
- Reclaim the night
- RotherFed
- Mama Africas Young Mind
- Hate Crime Advocacy (2 young amabassadors qualified)
- Voice and influence partnership
- RotherFed groups
- Rotherham Parents Forum
- Building better futures
- RMBC Young Person complaints steering group
- International women day celebration event
- South Yorkshire Police Hate Crime workshops

One of are young volunteers wrote the following about why the volunteer and what it means to them.

"Time and time again my friends and family question me as to why I do the amount I do completely voluntarily. For some unknown reason they don't understand why I dedicate so much of my free time to causes such as report writing, leafleting, and generally making a fuss over things that are part of our established and structured society. They believe I prioritise wrong, and my A Levels should be more important, or they think I am fighting an endless battle with

people who simply give us an audience to either tick boxes or to silence us from speaking out.

There is more to it than that.

The volunteering I do is in a variety of areas but with a main influence. Voice and empowerment. Simply just listening to a group of young girls talk about and have interest in topics like disability, bullying, and self esteem gives me the sense of achievement as it means their voices can be heard. Alternatively, writing reports on issues that effect young people such as mental health services and transport, gives them a voice to service providers which previously they may not have had. Small things like that make it worth while.

Despite no monetary gain, and sometimes no recognition or immediate action, the fact I'd helped another individual have their voice heard is worth it. The fact that I could have been the only person who had had a conversation with that person that day is worth all the hours and work put in.

At times it is frustrating. Especially when no progress can be seen, or a strategy is put in place with multiple strategies that follow it. It does get to you, and it does mean that sometimes you want to cry, or give up- but it only means you care. It only means that you believe in what you are doing.

Volunteering isn't for everyone and I know that. But for me it's been something that has created second families, and shown me what my real passions are in life. It's given me character, and it's given me invaluable skills. It's helped shape me in to who I am and the courses I've applied for at university and the apprenticeships I've looked at as well. It's something which plays a massive part in my life and is invaluable to me. That's why I dedicate my time to others, no other reason. (Toni)"

Another volunteer, who wants to remain anonymous wrote: "I was a resident of Rush House when I was introduced to the Young Ambassadors as they ran a session there. My friend became a Young Ambassador and I saw in such a small amount of time how much she's changed for the better. She became more happy and achieved amazing goals. This inspired me to start coming to more sessions and eventually I became a Young Ambassador myself. Through becoming a Young Ambassador I was introduced to the project "Who Do I Turn To?". The potential for the project was immense and I am so grateful to be asked to take part. I've always wanted to make a change and help young people and now we have a platform to do it. Sharon, the team and the project has given me so

much motivation, confidence, pride and purpose and I truly believe we can make a change. These people gave me somone to turn to and now its my turn."

Workplace Students

In December, two third year medical students from Sheffield University were on placement with Healthwatch Rotherham for 4 weeks.

Chloe Hobbis and Peter Clarke helped with the creation of a signposting directory for healh and social care services.

"Thank you for making us both welcome during our time with you. Everyone we had contact with was so caring and helpful. It was really interesting in seeing how all the services work with each other."

Dee and Nat who are Young Ambassadors did work placement, though Lifeskills, offering administration support to the Young Ambassador programme.

Our finances

INCOME Year End 31/03/2017	£
Funding received from local authority to deliver local Healthwatch statutory activities	193,500
Additional income	20,000
Total income	213,500
EXPENDITURE Year End 31/03/2017	**£**
Operational costs	32,954
Staffing costs	157,793
Office costs	14,114
Provision for contingent liabilities	7,056
Total expenditure	211,917
Surplus for the year	1,583

Get in touch

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33 High Street
Rotherham

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Website: www.healthwatchrotherham.org.uk

Facebook: www.facebook.com/hwrotherham

Twitter: @HWRotherham

Text: 07483 987741

We will be making this annual report publicly available by 30th June 2017 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group, Health and Wellbeing Board, Overview and Scrutiny Committees, and our local authority Rotherham Metropolitan Borough Council.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

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It's toon time in town

CARTOONIST Tony Husband unveiled an animated depiction of his dad on Rotherham's High Street to help spread dementia awareness.

He revealed a large version of the cover of Take Care, Son, his poignant book charting late father Ron's experience of living with the condition.

The new addition to the streetscene is above the offices of Healthwatch Rotherham.

Chief executive Tony Clabby said: "I got involved with Gallery Town and started thinking about what we could do creatively to link that with health.

"I'd met Tony before and knew he'd done this book about dementia, so I thought it would be good if we could do something with the front cover.

"We're a member of Rotherham Dementia Action Alliance and trying our best to be a dementia-friendly organisation."

He added: "It's a cause close to my heart. My mum suffered from it and Tony's book struck a chord with me.

"So it was great that Tony agreed to it and was able to come to Rotherham to do the unveiling."

Tony, whose strip Yobs has been in Private Eye for 32 years, said cartoons suited discussing dementia because they go straight to the point.

He added: "It's the simplicity of the cartoon that suits this subject. The book is just me talking to my dad. There are funny moments followed by sad moments, just as there were for us.

"There's him going outside in his pyjama bottoms, leaving the tap on but then also him moving from his cottage into a home, where he couldn't take his dog, Lossie."

The success of the book has seen Tony invited to speak on dementia across the country, including to 200 doctors in London.

He added: "I was really honoured and proud to be invited to Rotherham to unveil this sign."

An animated version of Take Care, Son is in the works by Lupus Films — the people behind The Snowman.

Rotherham Advertiser

TAKE CARE, SON: Tony is pictured at the unveiling with guests outside the offices of Healthwatch Rotherham 161082-1

This initiative is part of our commitment to raise dementia awareness

Info@healthwatchrotherham.org.uk
01709 717130
33 High Street, Rotherham, S60 1PT
Twitter: @HWRotherham
Facebook: www.facebook.com/hwrotherham

BRIEFING PAPER FOR H&WBB

1.	**Date of meeting:**	**20th September 2017**
2.	**Title:**	**Equity Audit**
3.	**Directorate:**	**Public Health**

4. Introduction

The World Health Organisation (2017) defines health inequalities as:-

'differences in health status or in the distribution of health determinants between different population groups'.

In the Marmot Review 'Fair Society, Healthy Lives 2010', there are 3 key notes regarding health inequalities:-

1) Reducing health inequalities is a matter of fairness and social justice;
2) There is a social gradient in health – the lower the person's social position, the worse his or her health. Action should focus on reducing the gradient in health;
3) Health inequalities result from social inequalities.

Rotherham is one of the more deprived areas in the country and is ranked 104 out of 150 local authorities for overall premature deaths (deaths before aged 75) per 100,000 for 2013-15 (source:PHE Healthier Lives). Within Rotherham borough itself there are gaps in life expectancy at birth and gaps in healthy life expectancy between the most deprived and least deprived areas of the borough. Rotherham East, Boston Castle, and Wingfield wards have significantly worse life expectancy at birth in years compared to the Rotherham average for both males and females (PHE Local Health Indicators 2010-2014).

Tudor Harts' Inverse Care Law (1971) suggests that those who most need medical care are least likely to receive it, conversely those with least need of health care tend to use health services more (and more effectively). Therefore as part of the action plan for Aim 4 of the Health & Wellbeing Strategy - 'healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing', it was agreed that Public Health would undertake an Equity Audit of its commissioned services. This would review the equity of access of people from some of the most deprived areas of Rotherham and the findings would then be reported back to the Health and Wellbeing Board, with the recommendations that other organisations and departments carry out a similar Equity Audit. 'Equity' refers to fair opportunity for everyone to attain their full health potential regardless of demographic, social, economic or geographic strata (WHO, 2017). Delivering equity may mean giving different levels of service to different people, as people are not all equally able to take advantage of a service offer. 'Equality' can be defined as everyone has 'equal access' to health services regardless of whether their level of need is greater or not. In other words, everyone gets the same service offer.

Commissioned Public Health services in Rotherham were formally contacted to complete an audit of metrics agreed in advance with the services lead commissioning officer. Data was received and analysed from 11 services. 9 services were unable to provide data (the reasons for which are outlined in the Equity Audit report). 3 services included in the audit have since been decommissioned and as service delivery has ceased by the time of publication of this report their results have been omitted.

The data requested and received was from 3 of the most deprived areas of Rotherham (Eastwood, Canklow & Town Centre, and Ferham & Masbrough). The data collected was analysed against available population data for Rotherham to find out whether service accessibility was 'equitable', 'equal' or 'unequal' for the population from these areas. To improve health in the 3 deprived areas (i.e. equitable access) the audit would need to show statistically significantly more of clients from these areas. To test whether this is a significant difference a statistical significance test was undertaken that adds 95% confidence intervals to the data to give us an indication the certainty with which we can interpret the results.

5. Key Issues

- 9 of the services are at the minimum expected level of equality of access in terms of service delivery, with 6 at a sufficiently higher level that is potentially improving the health of 3 of the most deprived areas of Rotherham.

- 2 services are failing to deliver equality of access to 3 of the most deprived areas of Rotherham. These services are likely to be contributing to increasing health inequalities between the 3 areas and Rotherham as a whole. These services have been commissioned by PH Rotherham to reduce inequalities but the audit has shown that this isn't the case which is an unintended consequence. This could also be the case across other services in RMBC.

6. Key actions and relevant timelines

1) Public Health to use the findings to inform our future commissioning, contracting and performance monitoring. PH to pick up the results with these services to ensure they are equitable going forward.
2) Other organisations to undertake similar audits of services especially services that have the potential to reduce or add to inequalities.
3) Commissioning and contracting smarter, to ensure organisations/services put in place commissioning & contracting systems to ensure future services aren't inequitable e.g. appropriate metrics and monitoring and quality premiums around access to services from areas of deprivation.

7. Recommendations to HWBB

- To note the equity audit and its findings, and the actions taken within PH as a result.
- That other organisations/services consider undertaking similar audits to understand the contribution they are making to reducing/increasing deprivation-based inequalities.
- That all partners consider their future service delivery, commissioning and performance monitoring to ensure that they are able to determine whether or not a given service is in fact reducing or contributing to health inequalities.

8. Name and contact details

Giles Ratcliffe (01709) 255866
Tracey Liversidge (01709) 255860

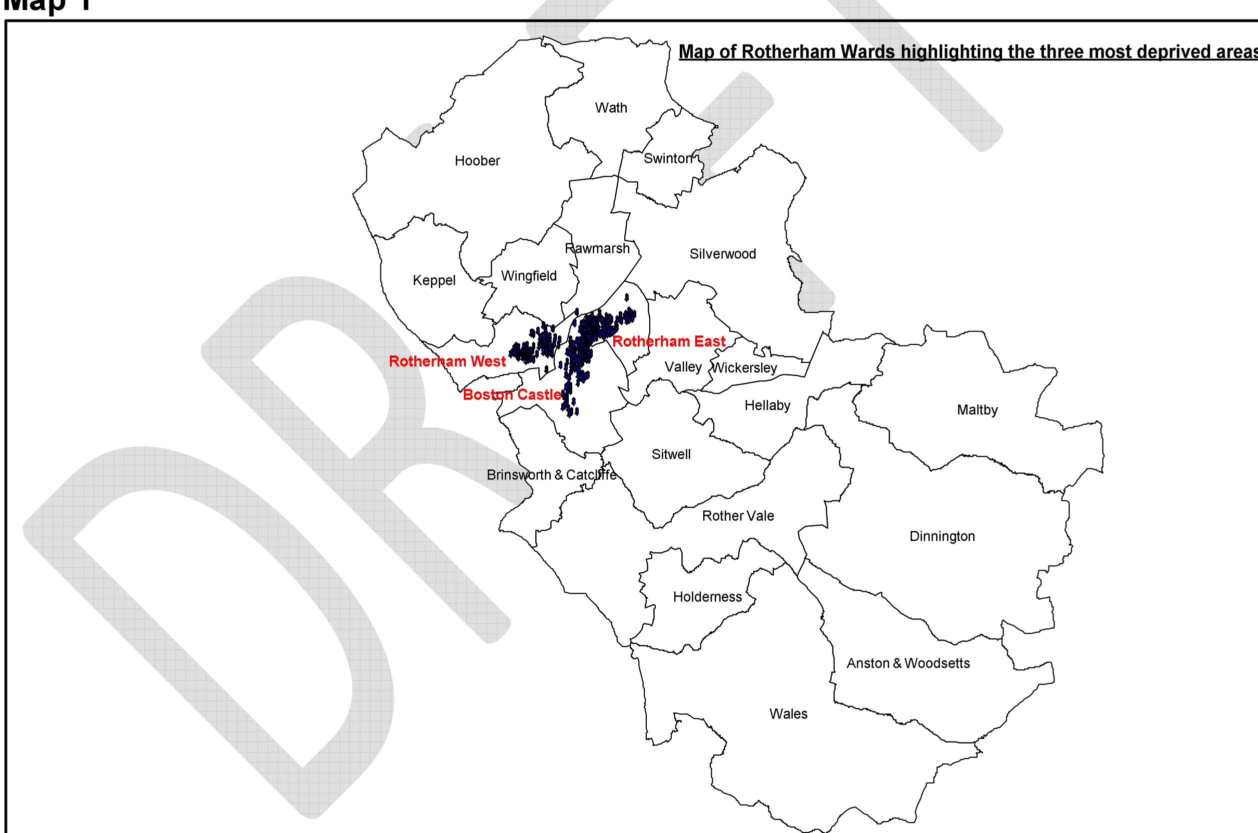
August 2017

Public Health RMBC – Services Equity Audit (EA) 2015-16

1. Introduction

This Equity Audit has been produced as a result of a Rotherham Metropolitan Borough Council Eastwood Tasking Group which was set up to look at equity of access to (Public Health) commissioned services for residents of this deprived area. Also, as part of the Health and Wellbeing Board Strategy for Rotherham, there are currently 5 aims being taken forward. As part of Aim 4 ‘Healthy life expectancy is improved for all Rotherham people and the gap in life expectancy is reducing’ Public Health is reviewing Public Health commissioned services in 3 of the most deprived areas of Rotherham (based on the English Indices of Deprivation 2015 IMD scores). These areas are highlighted on the map below in ‘red’:- **Eastwood** (Rotherham East Ward)**; Canklow and Town Centre** (Boston Castle & Rotherham West Ward)**; Ferham and Masbrough** (Rotherham West Ward)**.** The ‘dots’ on Map 1 below highlight the postcodes in the 3 deprived areas.

Map 1



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The audit looks to demonstrate equity of access to services by reviewing how commissioned services are being accessed by people within Rotherham’s most deprived areas, the results of which will be fed back to the Health and Wellbeing Board and form part of future service contract monitoring discussions.

To improve health in these areas (and reduce the life expectancy gap) we need residents of these areas to use services proportionately more than would be expected based on their population size.

The following definitions will be used in this audit to explain Equality of access versus Equity:

a) ‘Unequal’ - proportionately fewer people from deprived areas than the population size suggests (i.e. neither equality of access or equitable);

b) ‘Equal’ - proportionately similar from deprived areas than the population suggests (i.e. equality of access, but not equitable);

c) ‘Equitable’ - due to higher levels of deprivation and poor health behaviours and mortality, requires proportionately higher from deprived areas to see a reduction in health inequalities (i.e. equitable access).

2. Methods

To demonstrate equity of access to services, Public Health Rotherham formally requested its commissioned service providers to take part in this Equity Audit. The metrics were agreed in advance with the Programme Lead Commissioners for each service and then requested of the provider services. Not all providers could provide post code data either because it wasn’t routinely collected either due to anonymization considerations or confidentiality or because service users may not be required to give this information. The audit includes both adults and children’s services. The data was analysed on receipt.

Where full postcodes have been extracted, data has been used for the three Middle layer Super Output Areas (MSOAs) of Eastwood, Town Centre and Masbrough. Their resident population as at mid-2015 based on Office for National Statistics mid-year population estimates totals 23,360. This equates to 9% of the total Rotherham population. To have equality of access to services we would expect 9% of the service use to be from residents of these areas. To improve health in the 3 deprived areas i.e. Equitable Access, the audit would need to show statistically significantly more than 9% of clients from these areas (determined using 95% confidence intervals*).

Where only partial postcodes have been extracted, the available population data is from the 2011 Census. For S60, S61 and S65 combined this is 108,690 or 42.2% of the total Rotherham population. To have equality of access to services we would expect 42.2% of the service use to be from residents of these areas. To improve health in the 3 deprived areas i.e. Equitable Access, the audit would need to show statistically significantly more than 42.2% of clients from these areas (determined using 95% confidence intervals).

To test whether this is a significant difference we can undertake a statistical significance test that adds 95% confidence intervals around the percentages and checks if these are overlapping or not. These are shown in brackets following the percentage (Lower 95% Confidence interval, Upper 95% Confidence interval).

For a given level of confidence the wider the confidence interval the greater the uncertainty in the estimate. In Public Health the conventional practice is to use 95% confidence. Increasing the level of confidence results in wider limits (Source: PHE).

Unless otherwise indicated, data collected relates to the 2015-16 financial year.

It should be noted that this audit only assesses equity in terms of service access based on deprivation. It does not assess any other form of equity relating to other protected characteristics such as age, gender, ethnicity etc.

**A confidence interval (CI) is a type of interval estimate (of a population parameter) that is computed from the observed data. The confidence level is the frequency (i.e. the proportion) of confidence intervals that contain the true value of their corresponding parameter. (Definition: Wikipedia).*

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3. Commissioned Services

The Public Health Commissioned Services included in the audit are set out in Table 1 below.

Table 1.

Service	Data Received (Y/N)	Explanation of no data
Emergency Hormonal Contraception Services (EHC)	Y	n/a
Know The Score (Young People)	Y	n/a
RDaSH Adult Drug Services (incl. Shared Care)	Y	n/a
GP Alcohol Screening	*Y*	*This service has since been de-commissioned and service delivery has ceased, therefore does not form part of this report.*
Lifeline (Tier 2)	Y	n/a
Places for People WMS (Tier 2) Adults	Y	n/a
Places for People WMS (Tier 2) Children	Y	n/a
RIO WMS (Tier 3) Adults	*Y*	*This service has since been de-commissioned and service delivery has ceased, therefore does not form part of this report.*
MoreLife WMS (Tier 3) Children	Y	n/a
Yorkshire Smoke Free Services	Y	n/a
Active for Health	Y	n/a
DCRS-Health Trainers	Y	n/a
Ministry Of Food	*Y*	*This service has since been de-commissioned and service delivery has ceased, therefore does not form part of this report.*
Action Housing	N	Post code data not routinely collected by provider service
Plus-Me (HIV)	N	Anonymised data due to nature of service and small numbers
Integrated Sexual Health Services (TRFT)	N	Post code data not routinely available to commissioners due to confidential nature of sexual health services.
GP Sexual Health Services	N	Post codes not routinely collected from GP.
Health Visiting	N	Procurement process: - Undergoing re-tender of service and mobilisation.
School Nursing	N	Procurement process:- Undergoing re-tender of service and mobilisation
MoreLife WMS Tier 4 Children Residential Camp	*N*	*This service has since been de-commissioned and service delivery has ceased.*
GP Primary Care Service NHS Health Checks	N	Post codes not routinely collected from GPs.
Peer mentoring (Lifeline)	N	Commissioner provided an Eastwood Project Exit Plan 2014 that was provided by the service and is available to view on request.

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4. Data Analysis

There are several data limitations which are:

- For some providers (e.g. EHC), only partial postcodes were collected or only partial postcodes could be extracted so analysis of this data should be interpreted with caution.
- Some of the data collected contained small numbers (i.e. numbers <5) and so in such cases, data has been amalgamated to protect anonymity.
- The majority of the data is from 2015-16, but where the data is from different time frames, this has been highlighted in the audit.
- Some clients may be included within more than one service dataset and so an overall total of clients using services from the deprived areas is not possible.
- Where the data is not readily available from providers (e.g. Adult Drug Services), other sources of obtaining data has been used. Similarly, data from Know the Score Service (KTS) is only available from the Eastwood area.

An assumption was made that unless stated by the provider, full postcode data had been extracted and the analysis of the results has been done using Middle Layer Super Output Area (MSOA) resident population data as at mid-2015 based on Office for National Statistics mid-year population estimates. Where only parts of postcodes have been extracted and identified as such by the provider, the available population data is from the 2011 Census and based on postcode areas S60, S61 and S65.

4.1 Sexual Health Services

4.1.1 Emergency Hormonal Contraception Services (EHC)

The information was extracted for 2015-16 from the Neo360 system (Needle Exchange and Supervised Consumption) for the number of EHC transactions at pharmacies (unique clients). The data gives an indication of those (female) clients in touch with the service as only the first 3 digits of the postcode are collected. The part postcodes covering the 3 deprived areas in the audit are: S60, S65 and S61. Approximately 41% of clients in touch with pharmacies for EHC services are from these 3 postcode areas.

Service provision is via some Rotherham pharmacies contracted to provide this service.

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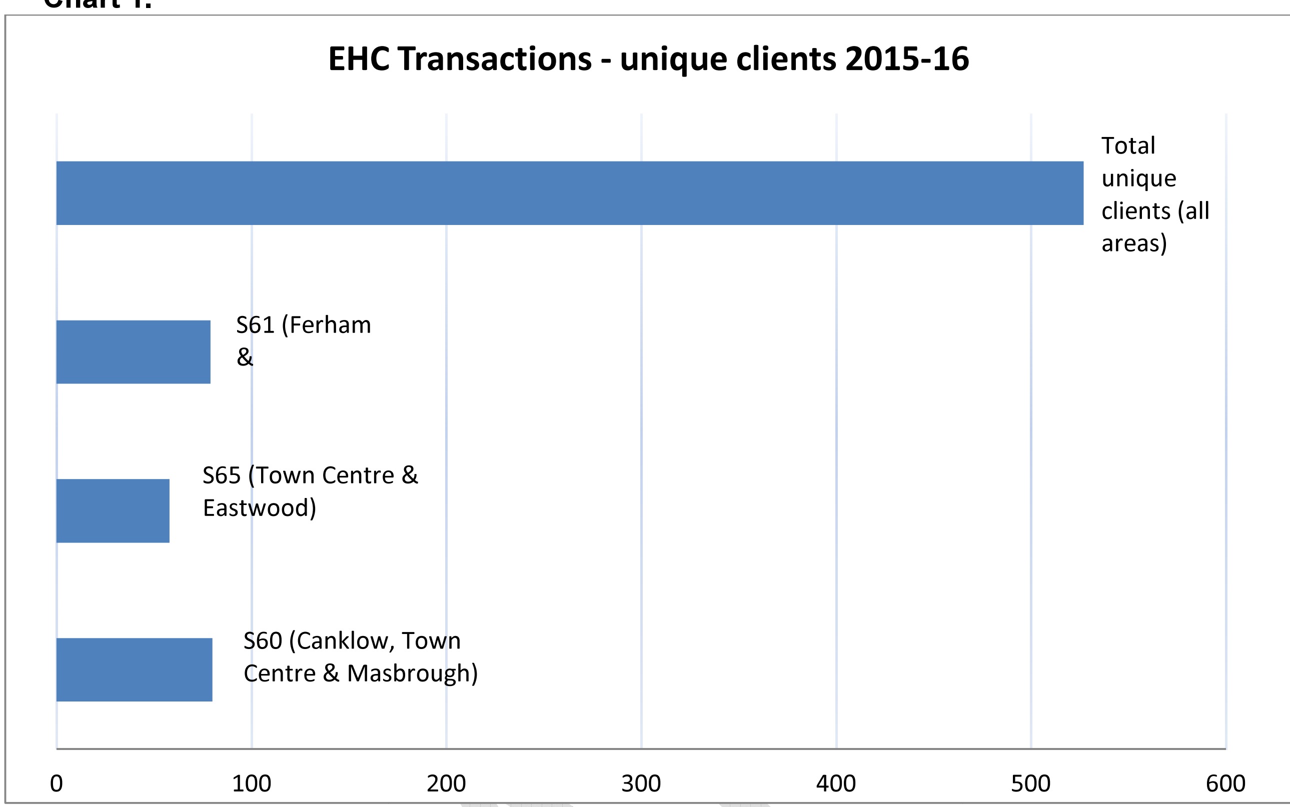
Chart 1.



Source: Neo360 system.

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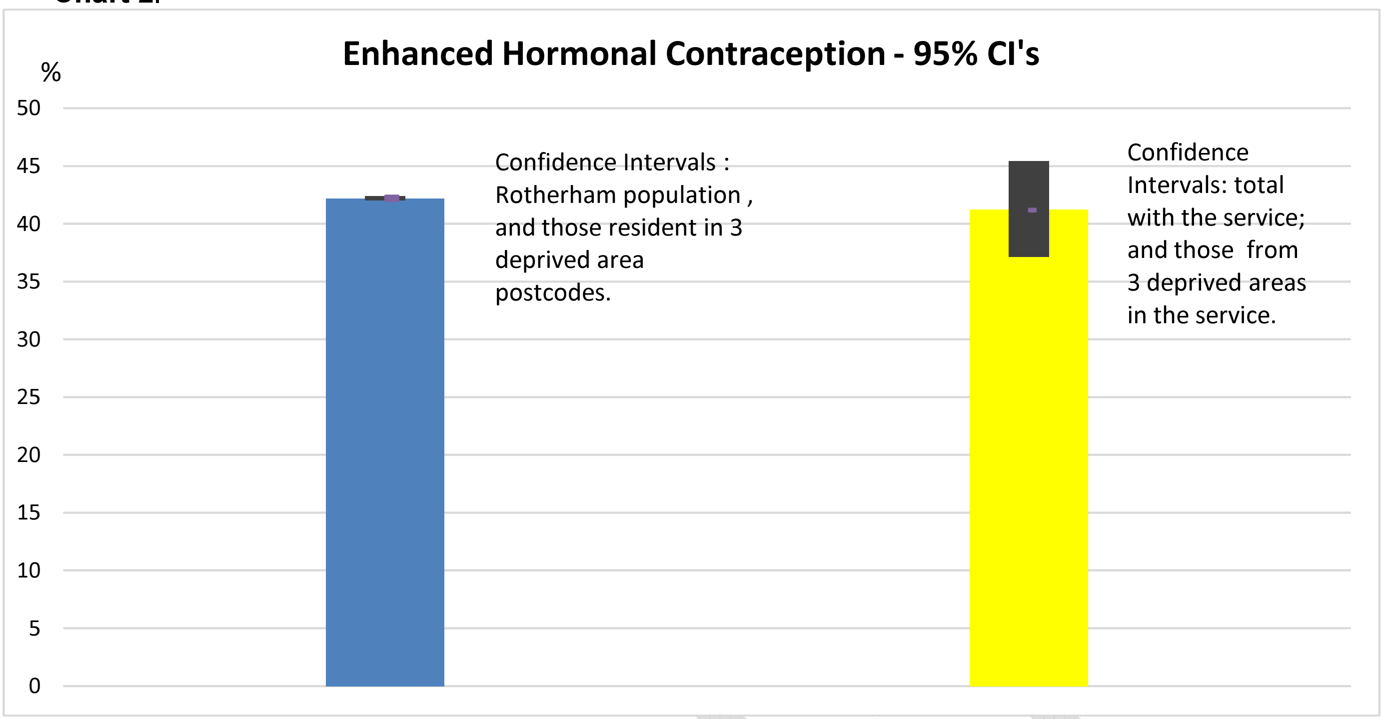
Analysing the results- In terms of postcode areas the available population data is from the 2011 Census. For S60, S61 and S65 combined this is 108,690 or 42.2% of the total Rotherham population. Therefore, we would expect 42.2% (95% CI: 42.0%, 42.4%) of EHC services provided to be to residents of these postcodes. For the Rotherham EHC service, 41.2% (95% CI: 37.1%, 45.4%) of clients in touch with pharmacies for EHC services were from these 3 postcode areas.

Based on these figures the confidence intervals overlap which suggests the results are not significantly different*. This suggests that the service provides equality of access but not equity therefore it is likely not to be contributing to reducing inequalities in the 3 deprived areas.

*Caveat: The above check was based on using the total populations for Persons, all ages due to the available postcode population data not being available split by gender. This in turn looks at a larger population than the 3 areas as the postcodes cross over into other wards that are not part of the audit. This is shown in maps 4, 5 & 6 at the end of the audit.

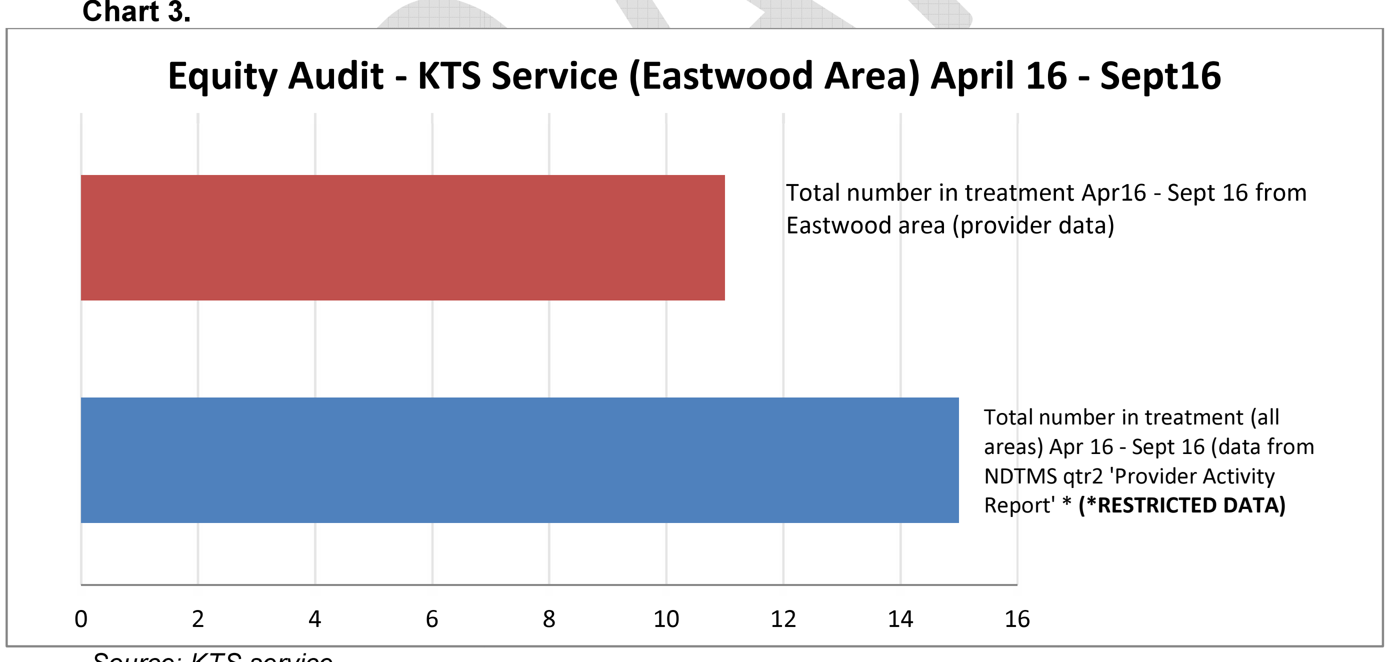
Chart 2.



4.2 Drug and Alcohol Services

4.2.1 Know The Score (KTS)-Young Peoples Service (RDaSH)

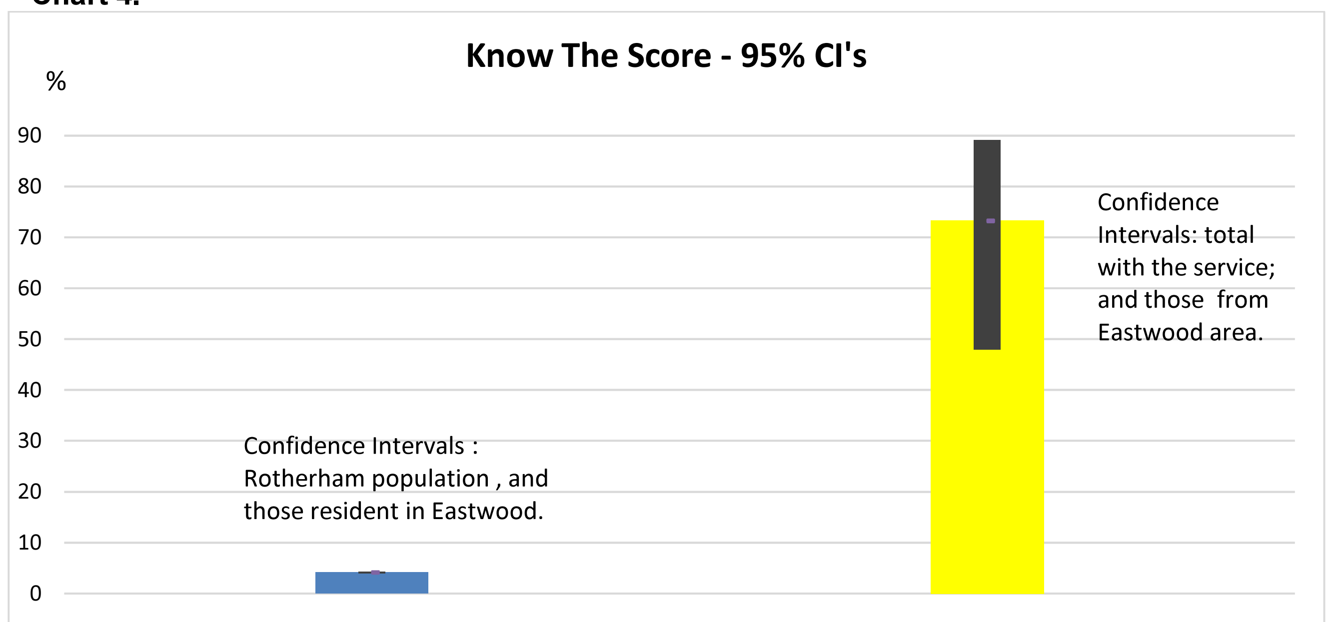
Chart 3.



Source: KTS service

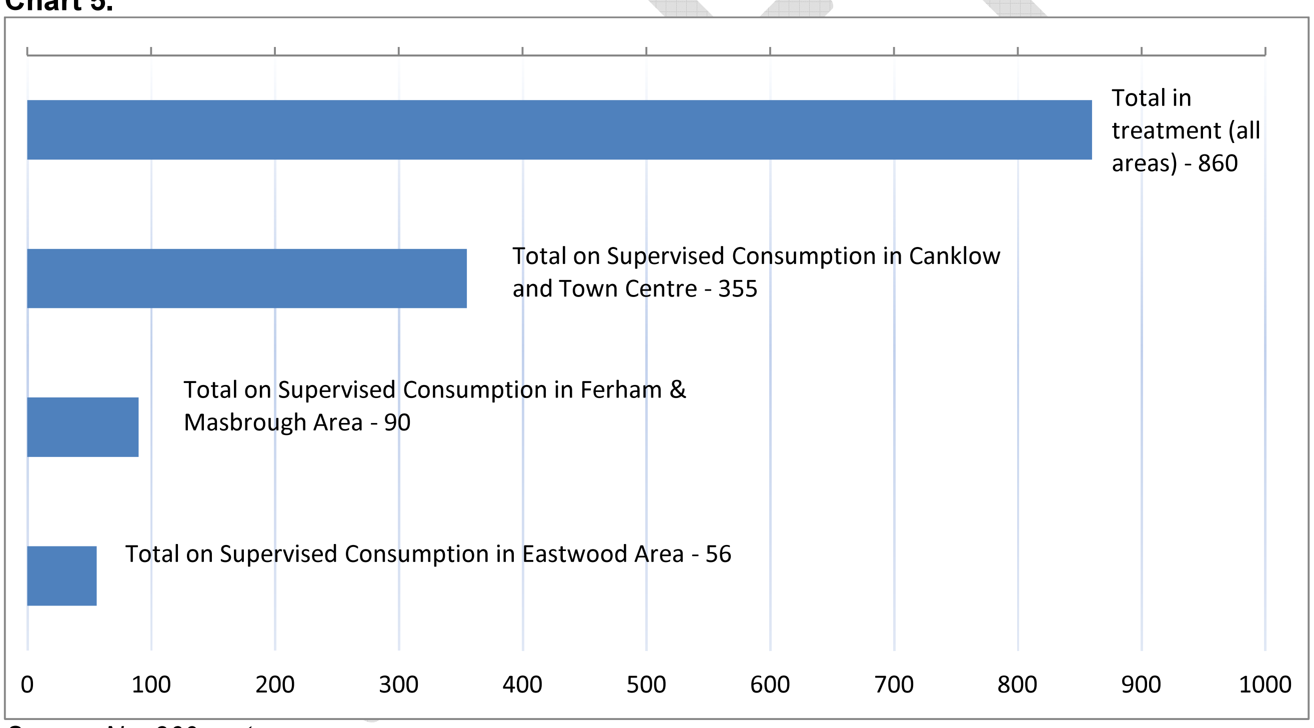
Analysing the results: - The audit shows that 73% of clients in treatment are from one of the most deprived areas of Rotherham –Eastwood area. Of those in treatment from Eastwood area, 64% are male, 36% female. The proportion of service users from the Eastwood area is statistically significantly more than the proportion of children resident in the Eastwood area (the Lower CI of 48.0% is greater than the Upper CI of 4.3%). Therefore, this service provides equitable access and is likely to be making a positive contribution to reducing inequalities in the 3 areas of deprivation.

Chart 4.



4.2.2 RDaSH Drug Services (Adults)

Chart 5.



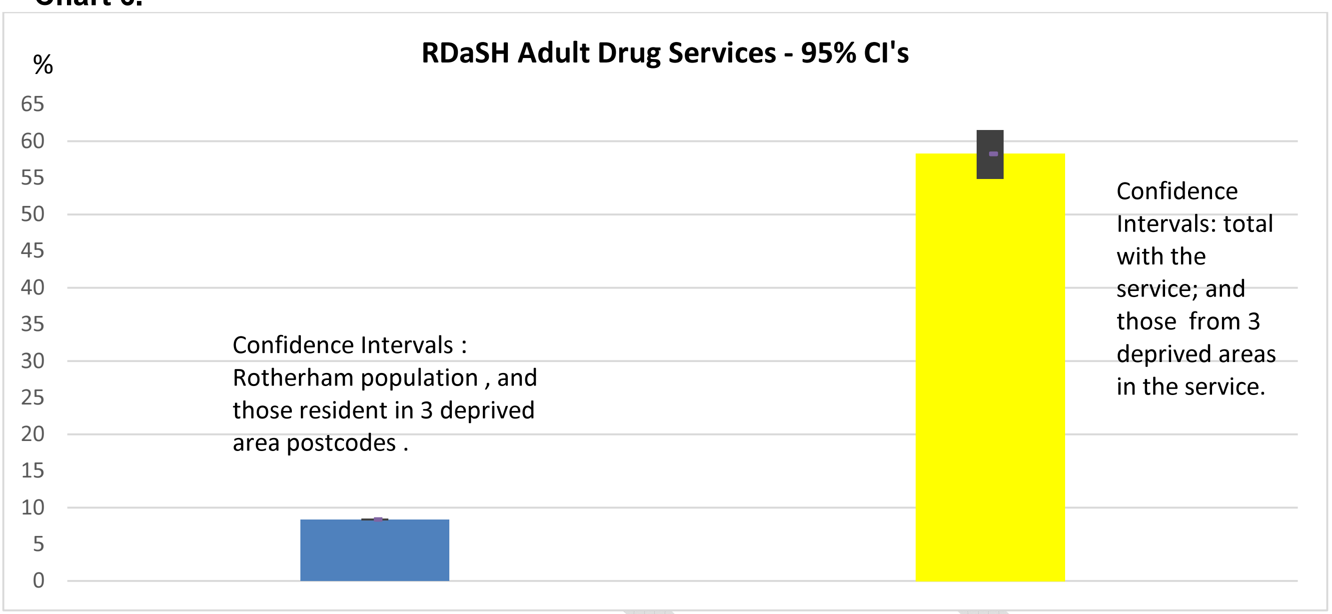
Source: Neo360 system.

These figures have been obtained from the Neo360 system and show numbers of individual clients attending pharmacies in the 3 areas for supervised consumption. Protocol states that clients should be placed with pharmacies nearest to their place of residence. This data gives 'a feel' of service provision to 3 of the most deprived areas of Rotherham. Over half (58%) of those that were in treatment with the Adult Drug services in 2015-16 were from 3 of the most deprived areas.

Analysing the results: - The proportion of service users from the 3 deprived areas is statistically significantly more than the proportion of adults resident in the 3 deprived areas (the Lower CI of 54.9% is greater than the Upper CI of 8.5%). Therefore, this service provides an equitable

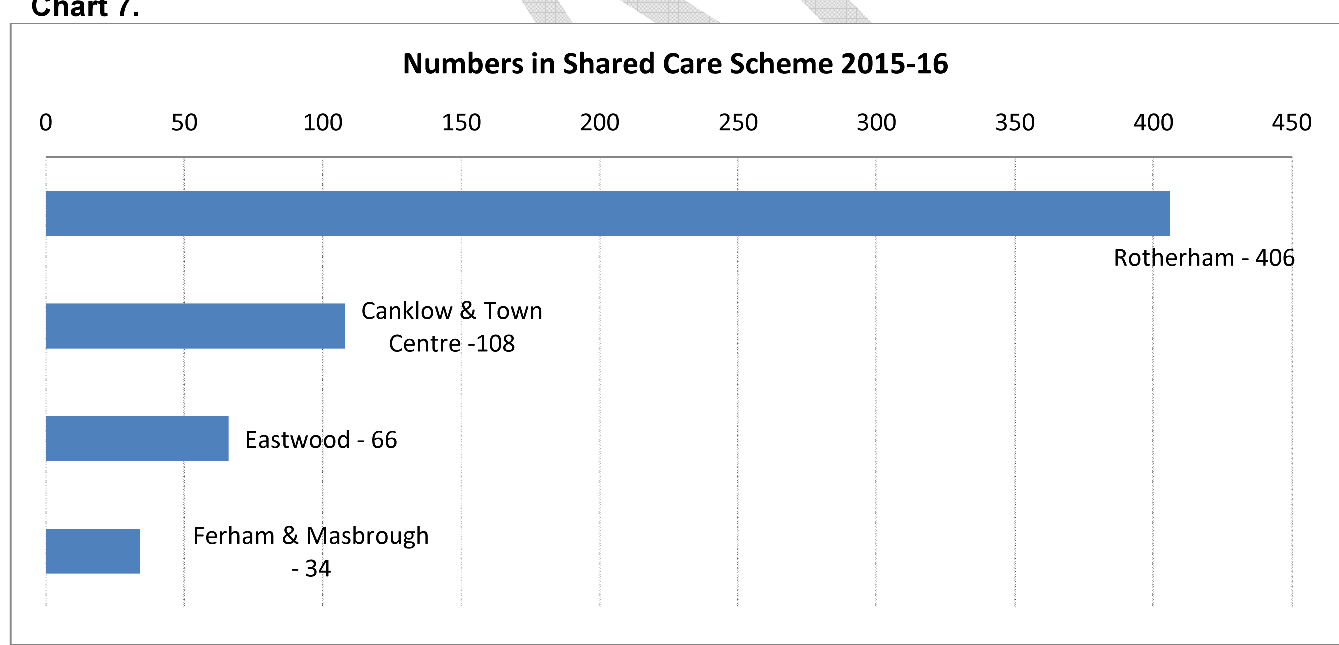
access and is likely to be making a positive contribution to reducing inequalities in the 3 areas of deprivation.

Chart 6.



The below information looks specifically at drug users in the Shared Care Scheme in Primary Care, and of the clients in the Shared Care scheme, 51% were from 3 of the most deprived areas of Rotherham.

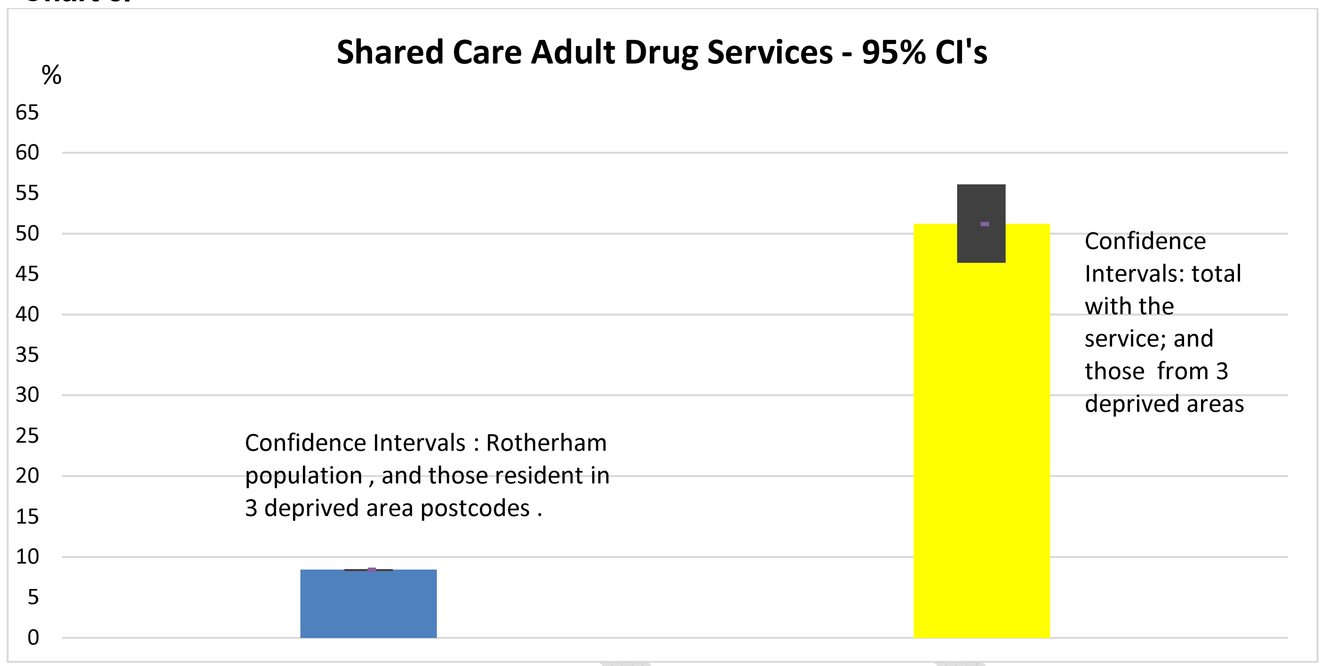
Chart 7.



Source: GP Shared Care Workbooks

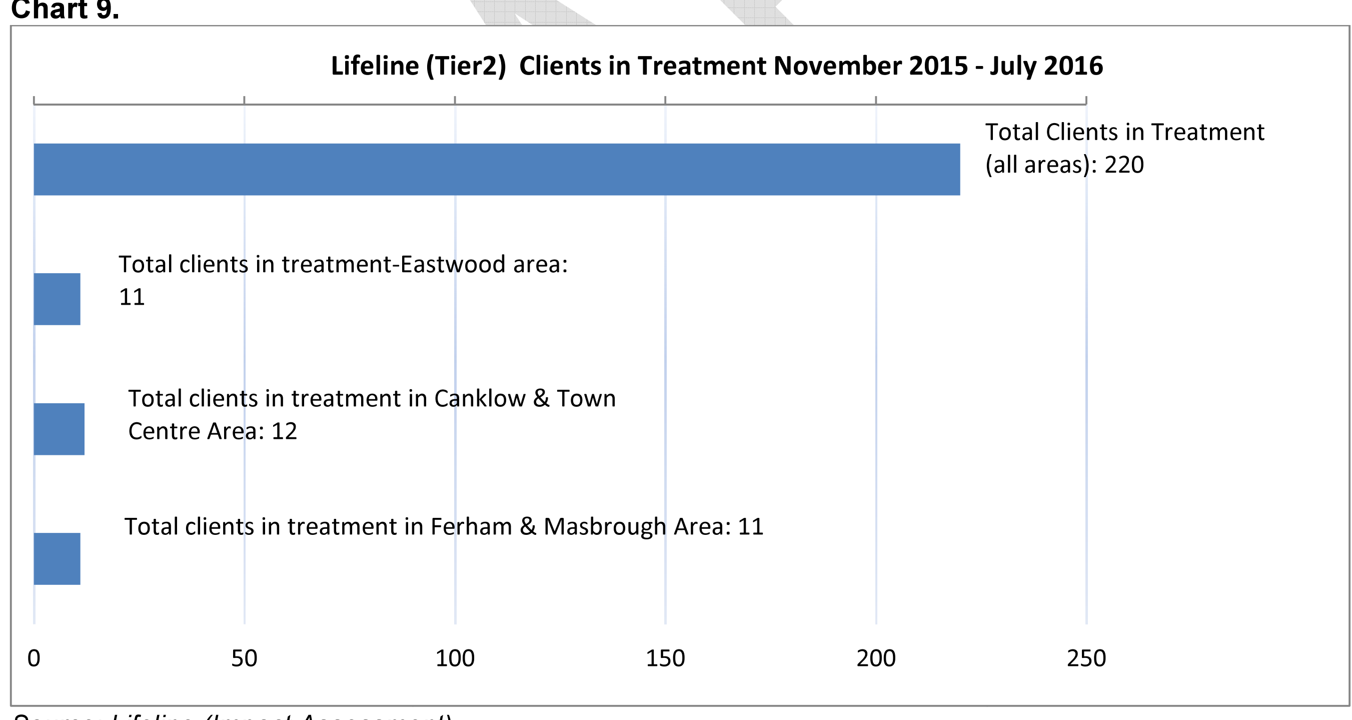
<u>Analysing the results:-</u> The proportion of service users from the 3 deprived areas is statistically significantly more than the proportion of adult's resident in the 3 deprived areas (the Lower CI of 46.4% is greater than the Upper CI of 8.5%). Therefore, this service provides an equitable access and is likely to be making a positive contribution to reducing inequalities in the 3 areas of deprivation.

Chart 8.



4.2.3 Lifeline (Tier2 Alcohol)

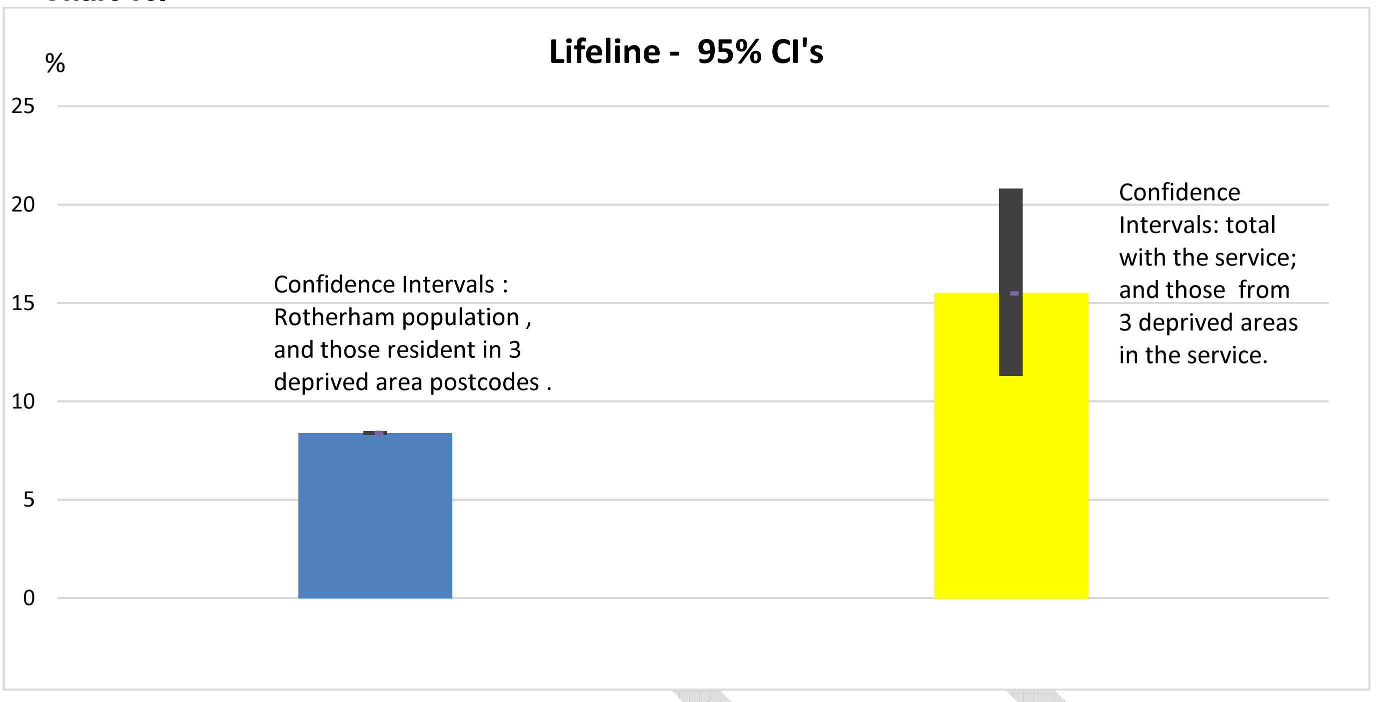
Chart 9.



Source: Lifeline (Impact Assessment)

Analysing the results: - The audit shows that 15% of those in treatment with Lifeline (Nov. 2015 – July 2016) were from 3 of the most deprived areas of Rotherham. The proportion of service users from the 3 deprived areas is statistically significantly more than the proportion of adults' resident in the 3 deprived areas (the Lower CI of 11.3% is greater than the Upper CI of 8.5%). Therefore, this service provides an equitable access and is likely to be making a positive contribution to reducing inequalities in the 3 areas of deprivation.

Chart 10.



4.3 Weight Management Services

4.3.1 Places for People (Tier 2) Adults

Chart 11.

Places for People Leisure (Tier 2) Adults

0 200 400 600 800 1000

Rotherham Adults engaged in service

Eastwood

Canklow & Town Centre

Ferham & Masbrough

Number of adults engaged in the programme

Number who have reduced body weight by 3-5%

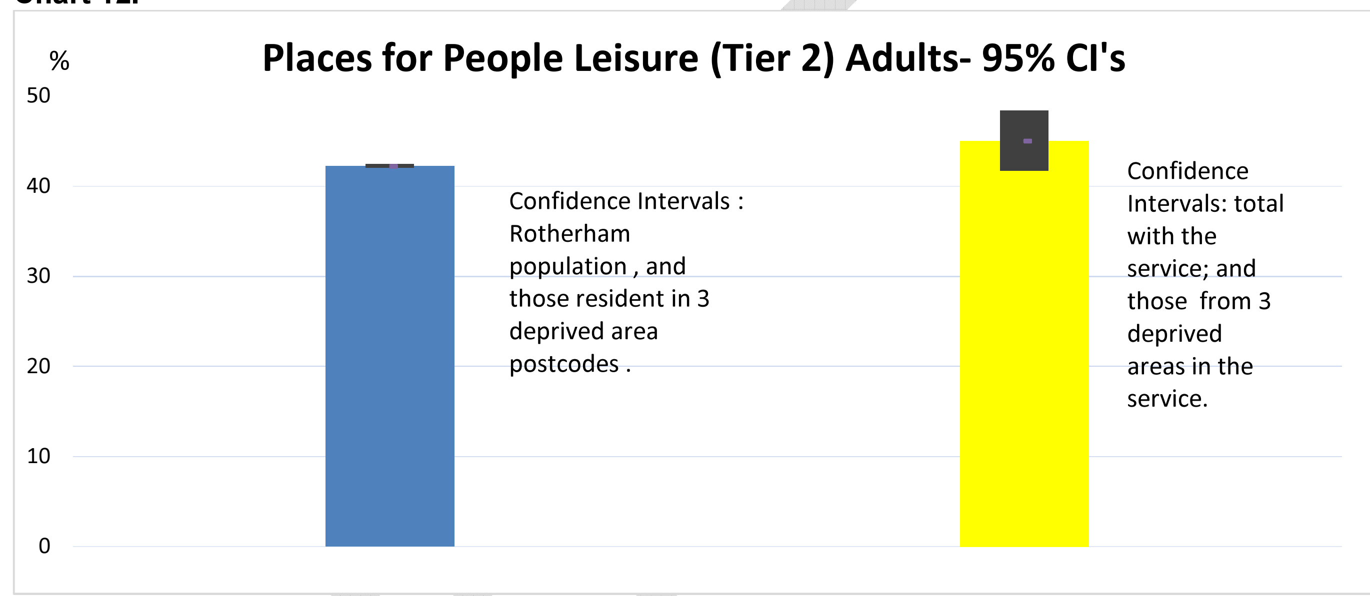
Number who complete the intervention

Source: DCRS (Data Collection & Reporting System).

Analysing the results- The audit shows that of the 855 Rotherham adults engaged in the service, 385 (45%) are from 3 of the most deprived areas of Rotherham. More females are engaged in the service than males. The information 'gives a feel' of clients from 3 of the most deprived areas as the provider stated that they were unable to filter on full postcodes so the available Rotherham population data used is from the 2011 Census*. Based on these figures the confidence intervals overlap which suggests the results are not significantly different. This suggests that the service provides equality access but not equity therefore it is likely not to be contributing to reducing inequalities in the 3 deprived areas.

**Caveat: The above check was based on using total populations for Persons, all ages. The postcode data is not available split by age. This in turn looks at a larger population than the 3 areas as the postcodes cross over into other wards that are not part of the audit. This is shown in maps 4, 5 & 6 at the end of the audit.*

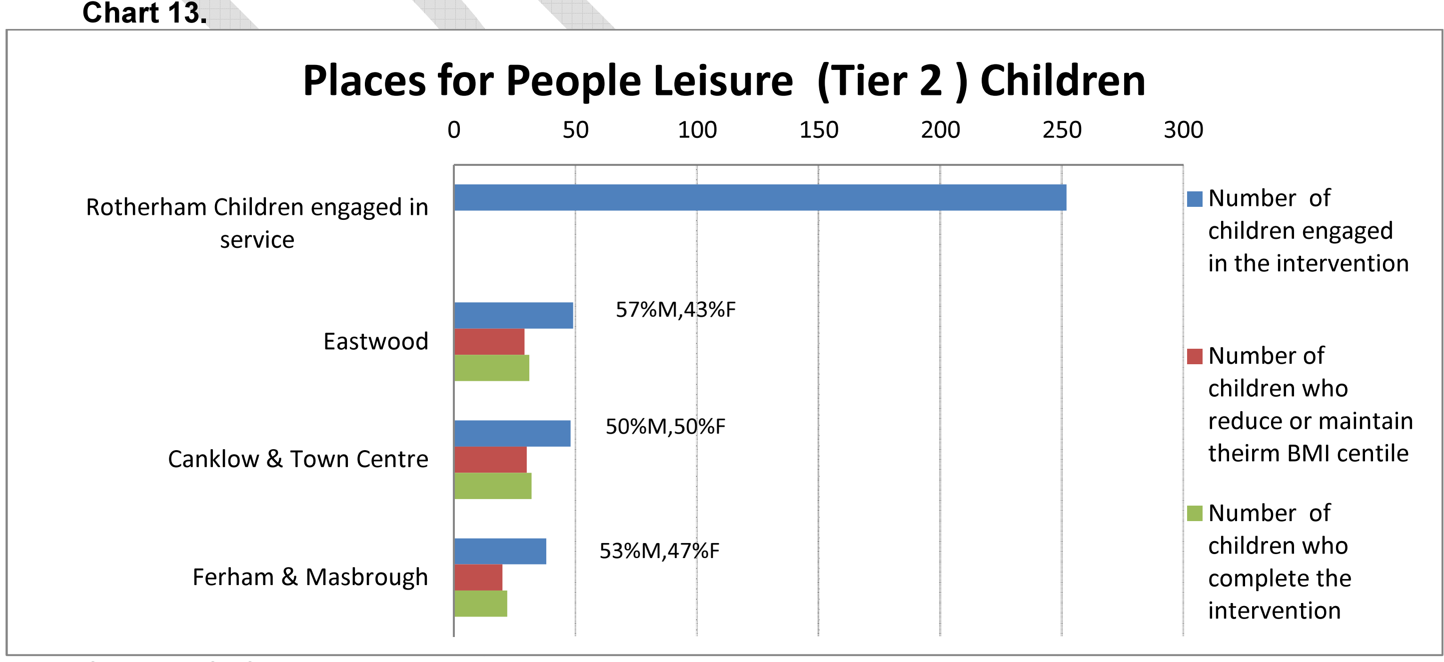
Chart 12.



Source: DCRS

4.3.2 Places for People (Tier 2) Children

Chart 13.

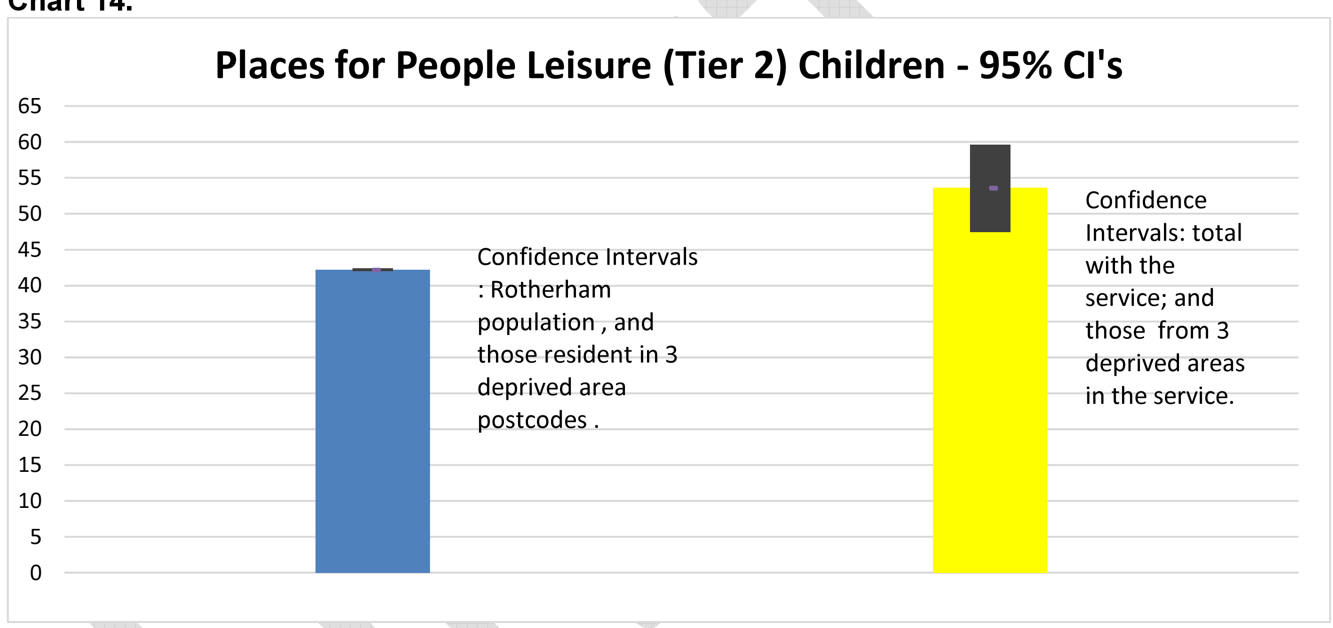


Source: DCRS

Analysing the results: - The audit shows 252 Rotherham Children were engaged with the service, of those 135 came from 3 of the most deprived areas of Rotherham (54%). The information 'only gives a broad indication of clients from 3 of the most deprived areas as the provider stated that they were unable to filter on full postcodes so the available Rotherham population data used is from the 2011 Census*. The proportion of service users from the 3 deprived areas is statistically significantly more than the proportion of children resident in the 3 deprived areas (the Lower CI of 47.4% is greater than the Upper CI of 42.4%). Therefore, this service provides an equitable access and is likely to be making a positive contribution to reducing inequalities in the 3 areas of deprivation.

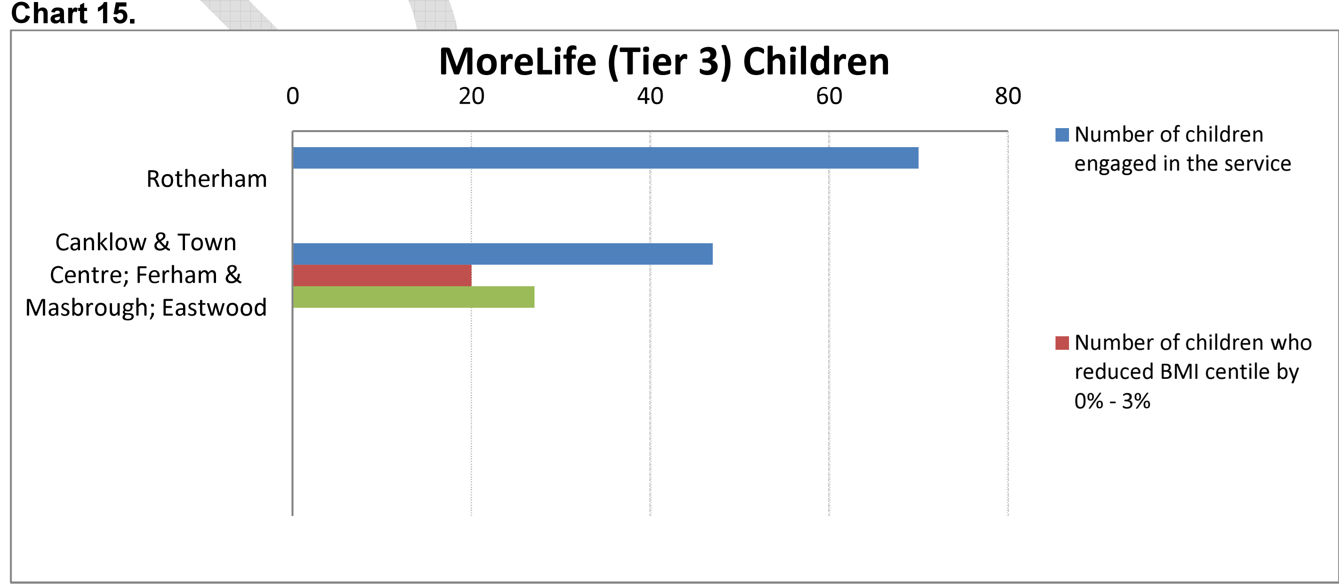
**Caveat: The above check was based on using total populations for Persons, all ages. The postcode data is not available split by age. This in turn looks at a larger population than the 3 areas as the postcodes cross over into other wards that are not part of the audit. This is shown in maps 4, 5 & 6 at the end of the audit.*

Chart 14.



4.3.3 MoreLife WMS Tier 3 Children

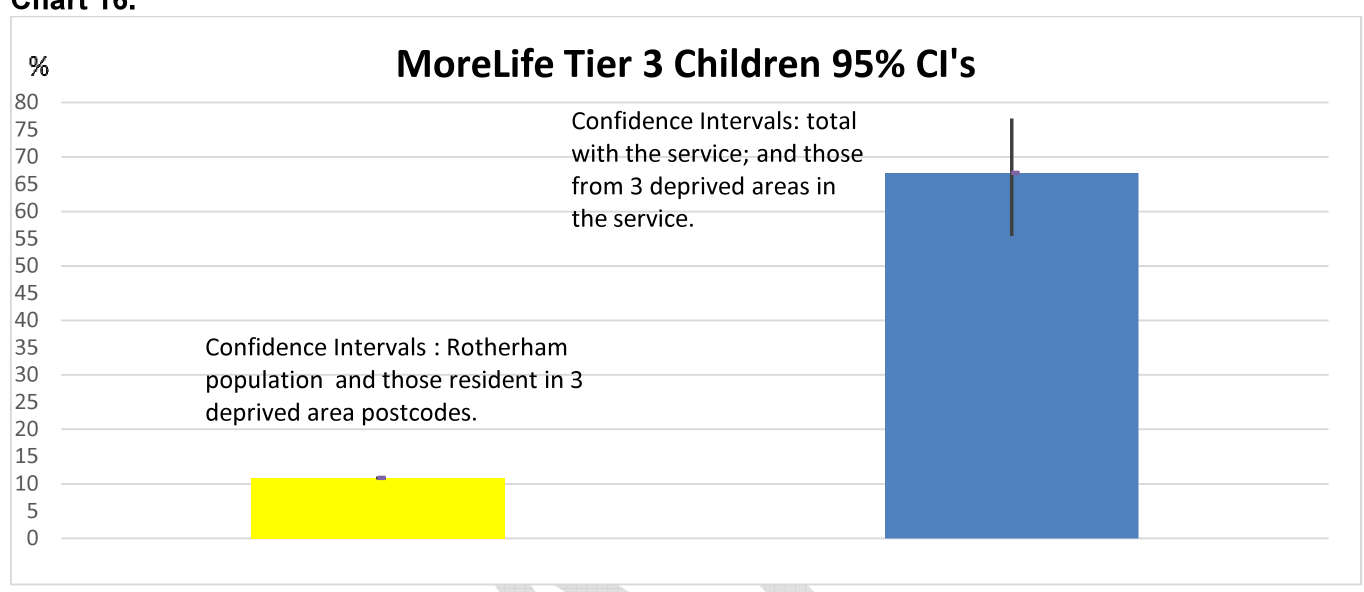
Chart 15.



Source: DCRS

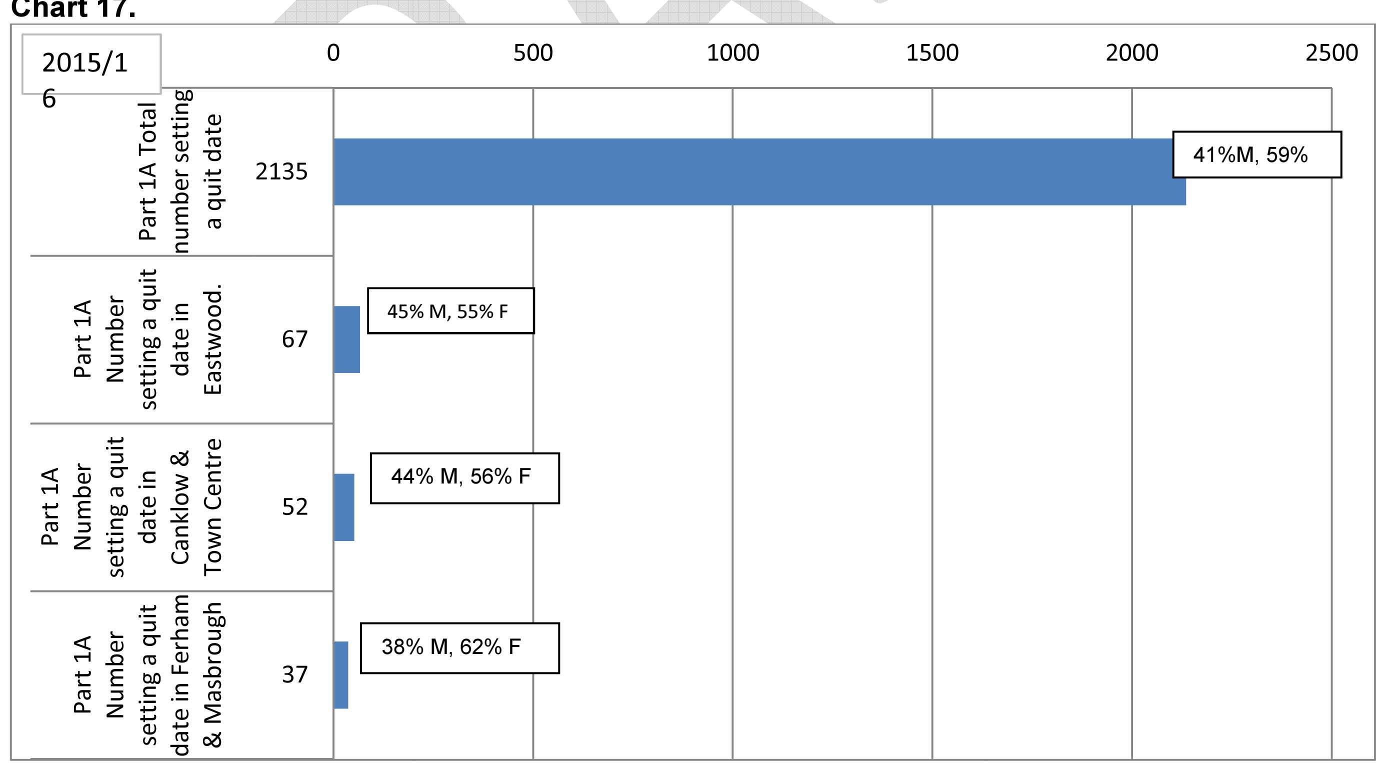
Analysing the results: - The audit shows that of the children engaged in the service, 67% came from the 3 deprived areas (though small numbers were engaged with the service overall*). The proportion of children from the 3 deprived areas is statistically significantly more than the proportion of children resident in the 3 deprived areas (the Lower CI of 55.5% is greater than the Upper CI of 11.3%). Therefore, this service provides an equitable access and is likely to be making a positive contribution to reducing inequalities in the 3 areas of deprivation.*

Chart 16.



4.4 Yorkshire Smoke Free Services (Adults)

Chart 17.



Source: Yorkshire Smoke Free Service.

Analysing the results: - The audit shows that of those setting a quit date with the service, 7% (156) were from the 3 most deprived areas of Rotherham. Based on these figures the confidence intervals overlap which suggests the results are not significantly different. . This

suggests that the service provides equal access to those from the 3 areas of deprivation, but not equitable access.

Chart 18.

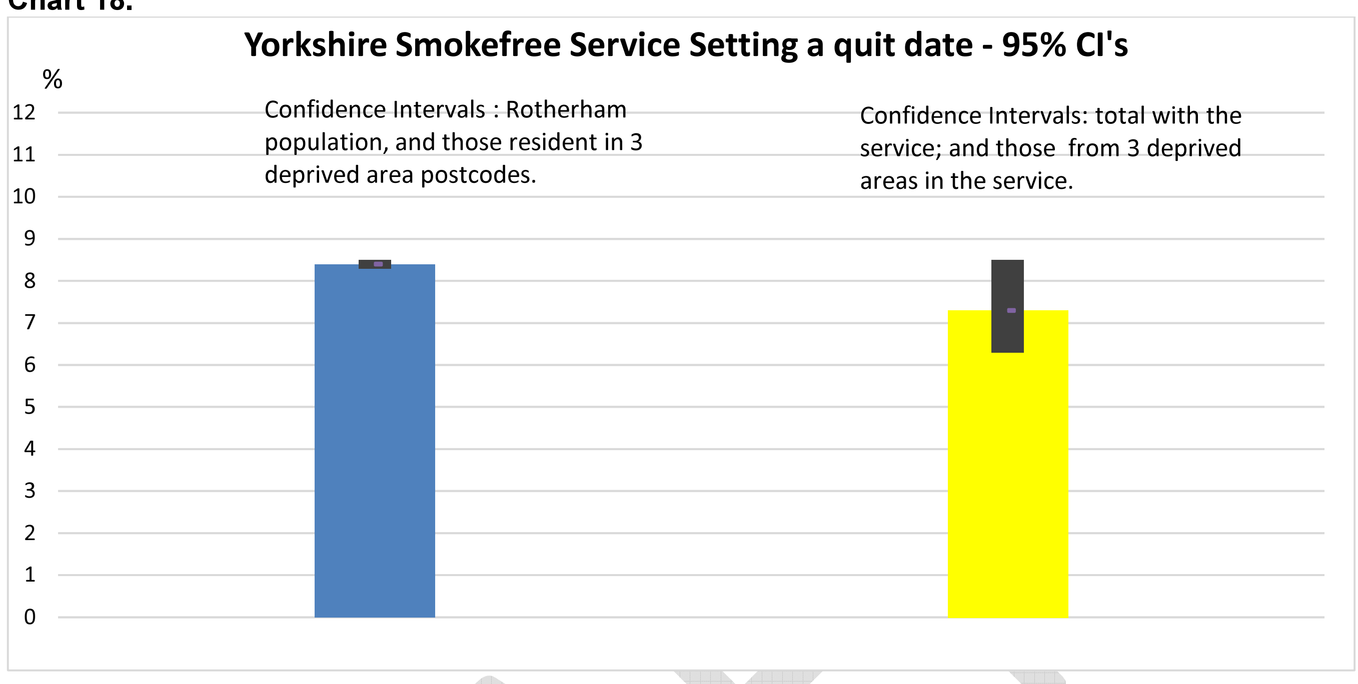


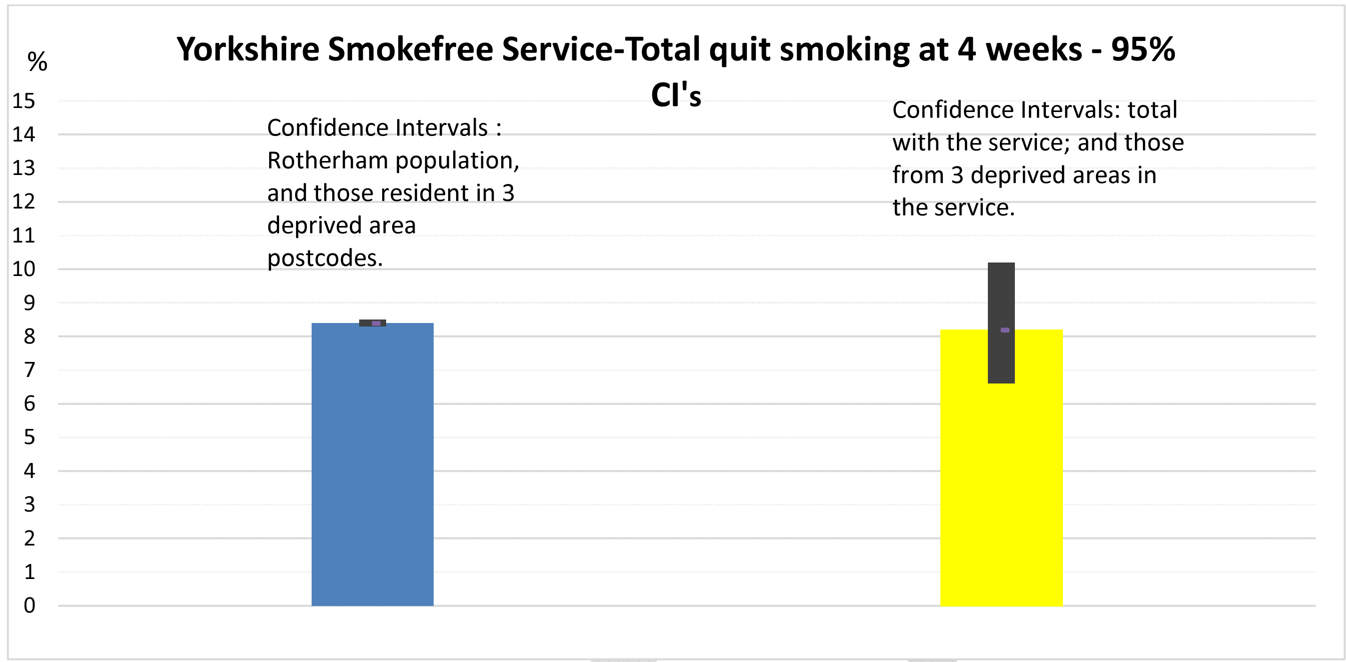
Chart 19.

Yorkshire Smoke Free Services. Total Quit Smoking at 4 Weeks (2015/16)

		0 500 1000 1500 2000 2500
Part 1B Total Number who successfully quit at four weeks where non smoking-status confirmed 4 week follow up.	903	41% M, 59% F
Part 1B Total Number who successfully quit at four weeks where non smoking-status confirmed by CO validation at 4 week follow up in Eastwood.	26	54% M, 46% F
Part 1B Number who successfully quit at 4 weeks where non smoking-status confirmed by CO validation in Canklow & Town Centre	24	58% M, 42% F
Part 1B Number who successfully quit at 4 weeks where non smoking-status confirmed by CO validation in Ferham & Masbrough	24	37.5 M, 62.5 F

Source: Yorkshire Smoke Free Service.

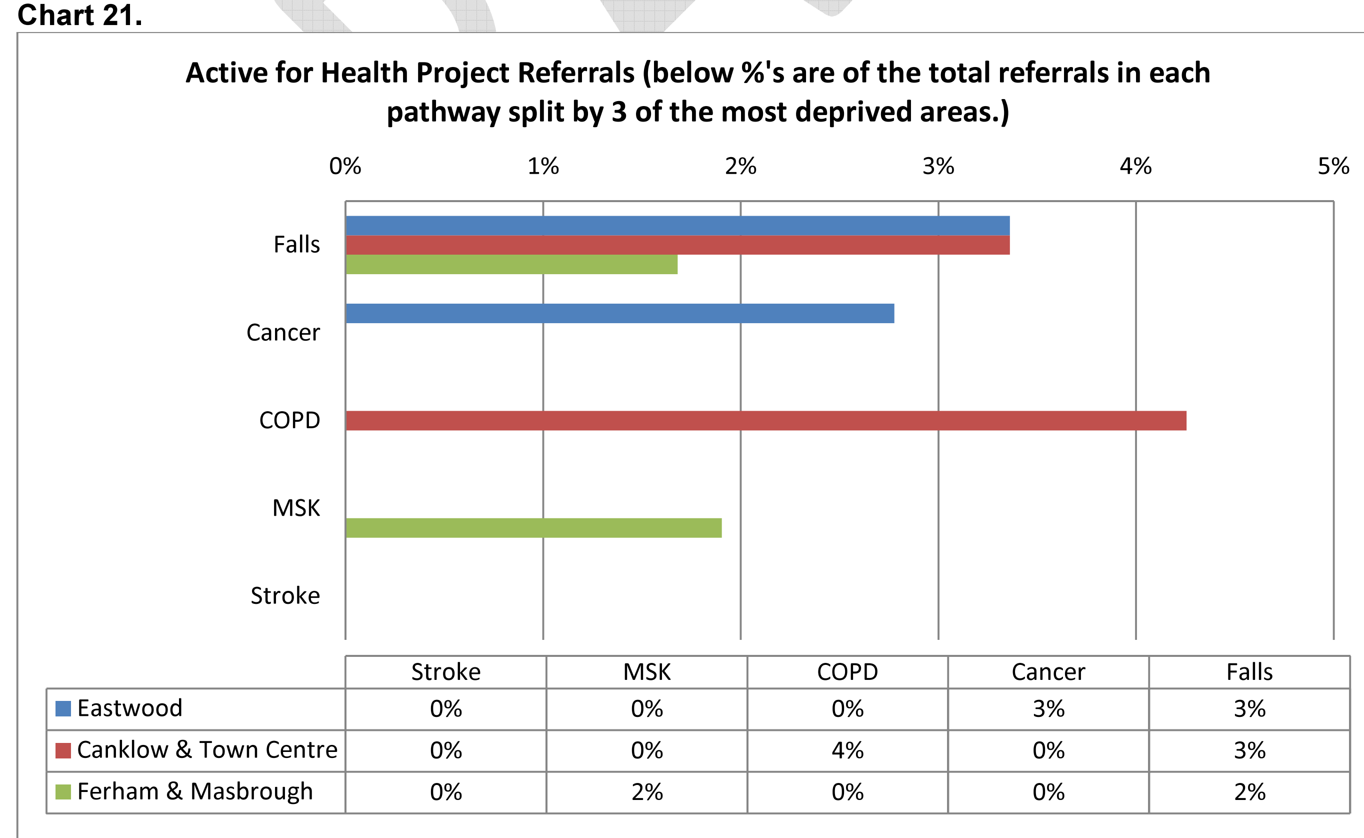
Chart 20.



Analysing the results: The audit shows that of those who quit smoking at 4 weeks (where non-smoking status confirmed by CO validation), 8% were from the most deprived areas of Rotherham.
Based on these figures, the confidence intervals overlap which suggests the results are not significantly different. This suggests that the service provides equal access to those from the 3 areas of deprivation, but not equitable access.

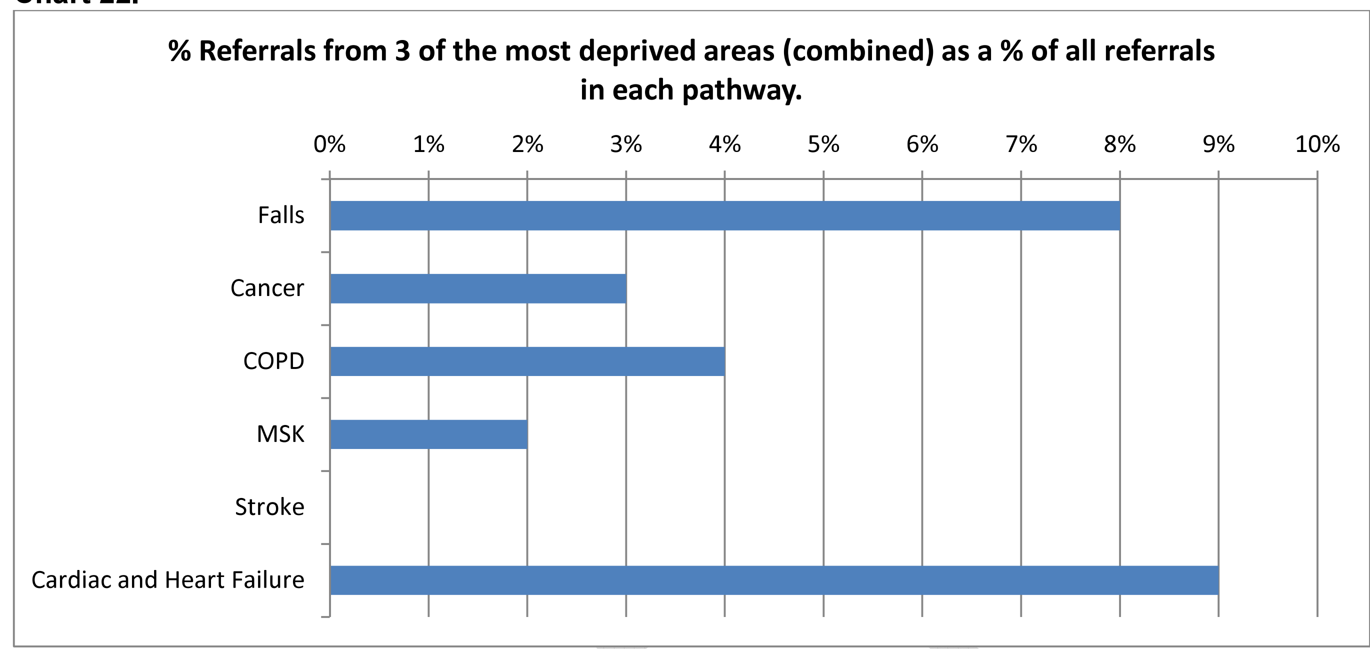
4.5 Active for Health (Adults)

Chart 21.



	Stroke	MSK	COPD	Cancer	Falls
Eastwood	0%	0%	0%	3%	3%
Canklow & Town Centre	0%	0%	4%	0%	3%
Ferham & Masbrough	0%	2%	0%	0%	2%

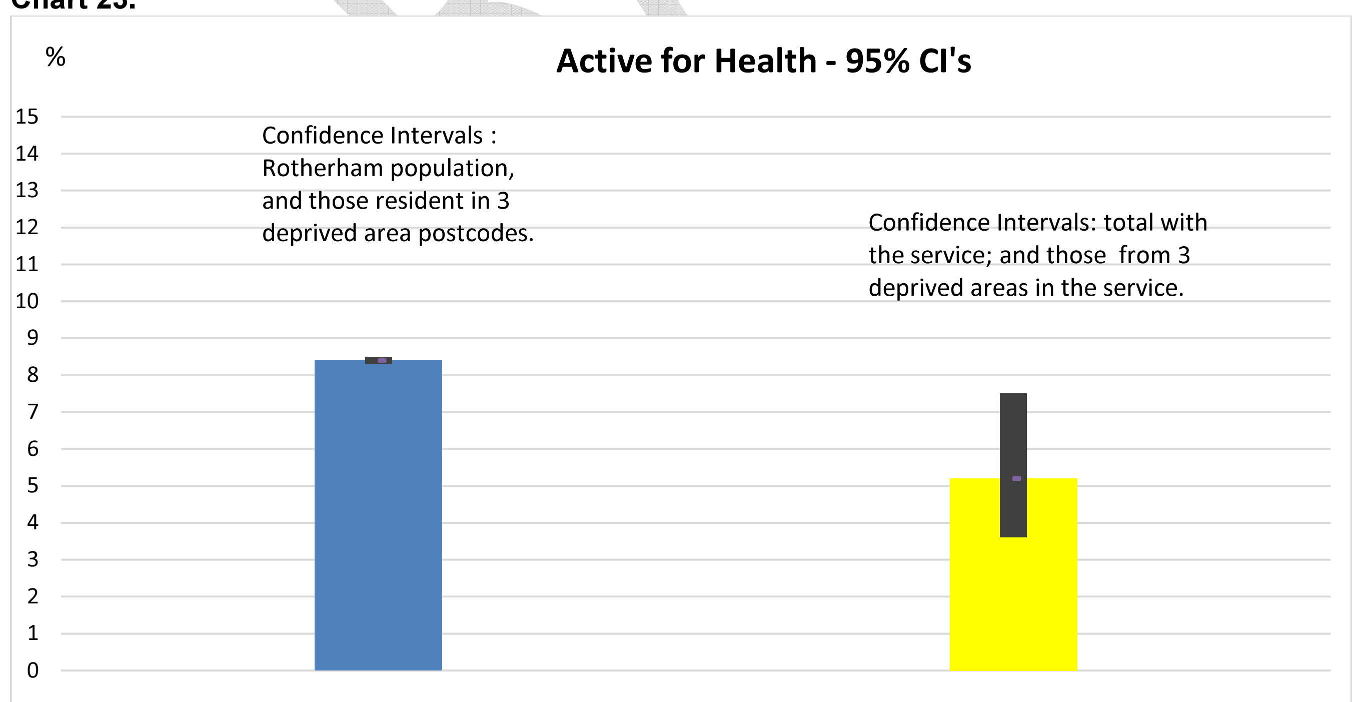
Chart 22.



Analysing the results: - It is worth noting that this service has small numbers of patients. Some of the pathways (Falls, Cardiac and Heart Failure) are not statistically different from the population of adults resident in the 3 deprived areas, and therefore are likely to be delivering equal, but not equitable access. However, overall just 5% of patient referrals into the Active for health service came from 3 of the most deprived areas of Rotherham.

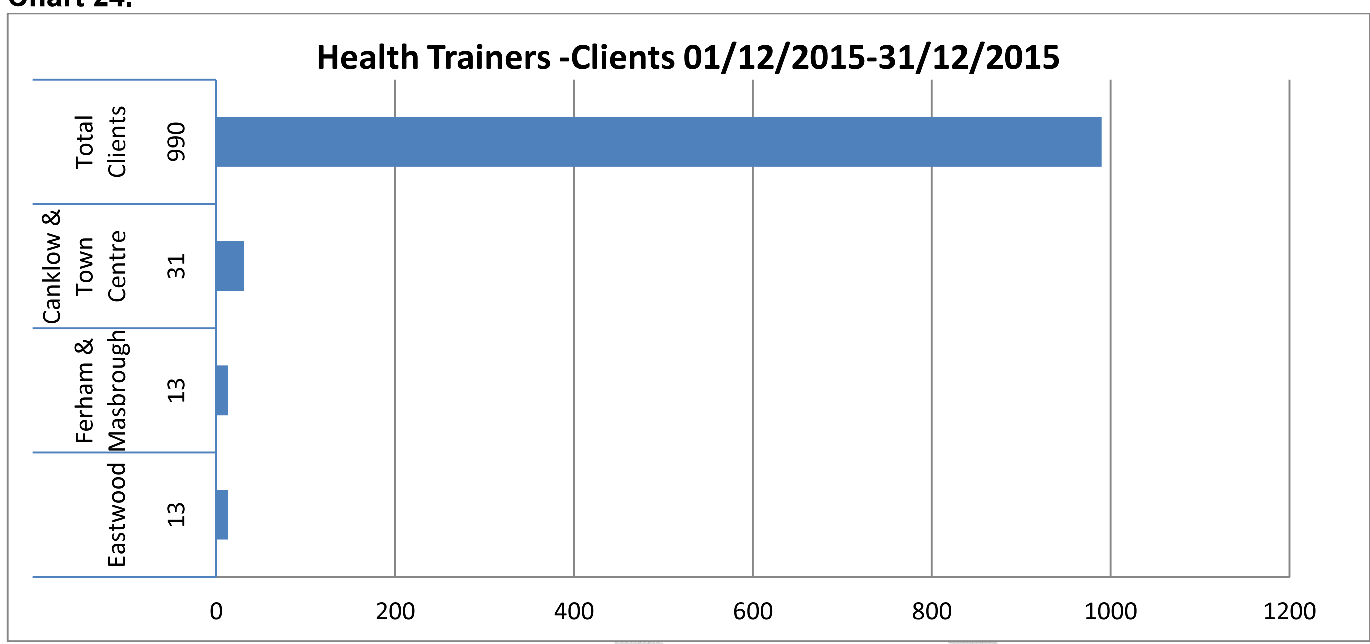
Based on these figures, the proportion of service users across all pathways from the 3 deprived areas is statistically significantly less than the proportion of adult's resident in the 3 deprived areas and therefore delivering inequitable service access.

Chart 23.



4.6 Health Trainer Service (Rotherham Public Health)

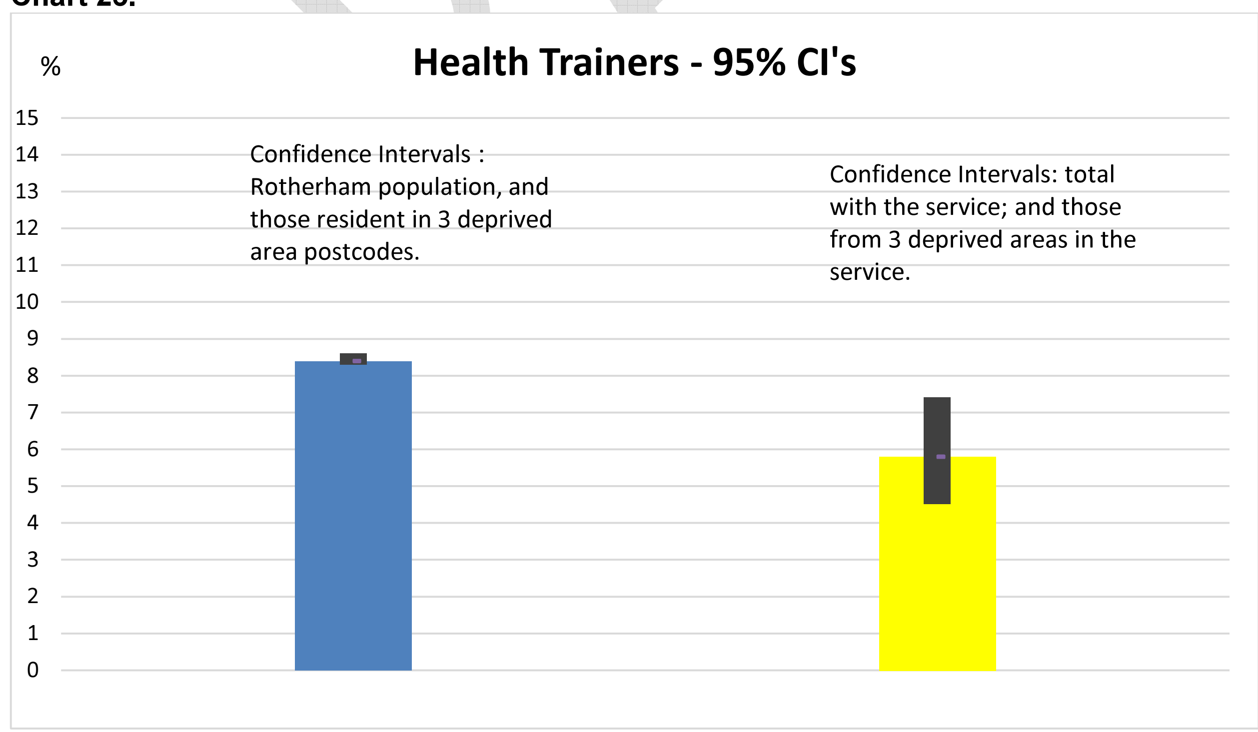
Chart 24.



Source: DCRS

Analysing the results: - Overall, just 5% of clients seen by the Health Trainer service lived in 3 of the most deprived areas of Rotherham and so the proportion of service users from the 3 deprived areas is statistically significantly less than the proportion of adult's resident in the 3 deprived areas (the Lower CI of 4.5% is less than the Upper CI of 8.6%). This suggests that the service is providing inequitable access to people from areas of deprivation. This may contribute to health inequalities between the 3 areas and Rotherham as a whole.

Chart 25.



5. Summary

From the data, out of the 11 services, 9 are at the minimum expected level of equality of access in terms of service delivery with 6 at a sufficiently higher level that is potentially improving the comparative health of the 3 deprived areas in the audit. The data also shows that there are 5 services whose percentage client engagement are below the expected level of equity in relation to the 3 deprived areas of Rotherham, with 2 services being statistically significantly less equitable (at the 95% confidence level).

Therefore out of 11 services, 2 are failing to deliver equality of access to the 3 areas of deprivation. These services are likely to be contributing to increasing health inequalities between the 3 areas and Rotherham as a whole. 3 services are delivering equality of service access to the 3 areas of deprivation. They are not necessarily contributing to a growth of inequalities, but neither are they likely to be reducing the comparative health inequalities between the 3 areas of deprivation and Rotherham as a whole. 6 services are equitable in terms of service uptake in the 3 areas of deprivation. They are attracting more than the expected numbers of people from the 3 areas of deprivation, they are likely to be contributing to a comparative reduction in health inequalities between 3 of the most deprived areas and Rotherham as a whole.

These finding relate only to equity based on an assessment of access from 3 specific areas of deprivation. The service may perform differently in relation to other areas of deprivation within Rotherham. Equally, other aspects of equity of protected characteristics such as age, gender, ethnicity, may have shown different results.

Table 2. Summary

Service	**Population Data Used** (2011 Census postcodes, *or* MSOA as at mid-2015 based on Office for National Statistics mid-year population estimates)	**% Service Level engagement from the 3 deprived areas***	**Expected level (%) for service to be equal in the 3 deprived areas (a)**	**Equitability of service in the 3 areas of deprivation (Equal, unequal, equitable) (b)**	**Expected level for service to improve health in the 3 deprived areas (c)**	**Is service at a level to improve health in the 3 deprived areas? (d)**
EHC (16+)	2011 Census	41.2%	42.2% (d)	Equal**	46.7%	N
Know The Score (Eastwood only) (0-17)	MSOA	73.3%	4.2%	Equitable	20.0%	Y
RDaSH Drugs (18+)	MSOA	58.3%	8.4%	Equitable	10.5%	Y
Shared Care Scheme (18+)	MSOA	51.2%	8.4%	Equitable	11.3%	Y
Lifeline Tier2 (18+)	MSOA	15.5%	8.4%	Equitable	12.3%	Y
Places for People (Tier2) Adults (16+)	2011 Census	45.0%	42.2% (d)	Equal	45.7%	N
Places for People (Tier2) Children (0-15)	2011 Census	53.6%	42.2% (d)	Equitable	48.8%	Y
MoreLife (Tier3) (0-15) Children	MSOA	67.1%	11.1%	Equitable	20.0%	Y
a) Yorkshire Smoke Free (Setting quit date) (18+)	MSOA	7.3%	8.4%	Equal**	9.8%	N
b) Yorkshire Smoke Free (4 week quitters) (18+)		8.2%	8.4%		10.4%	
Active for Health (18+)	MSOA	5.2%	8.4%	Unequal	11.2%	N
Health Trainers (16+)	MSOA	5.8%	8.4%	Unequal	10.3%	N

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Table 3. Summary – detailed (Include percentage and 95% Confidence Interval (lower, upper limits)

Service	**Population Data Used** (2011 Census postcodes, *or* MSOA as at mid-2015 based on Office for National Statistics mid-year population estimates) (e)	**% Service level engagement from the 3 deprived areas***	**Expected level (%) for service to be equal in the 3 deprived areas.** (a)	**Equitability of service in the 3 areas of deprivation (Equal, unequal, equitable)** (b)	**Expected level for service to improve health in the 3 deprived areas** (c)	**Is service at a level to improve health in the 3 deprived areas?** (d)
EHC (16+)	2011 Census	41.2% (37.1%, 45.4%)	42.2% (42.0%, 42.4%) (e)	Equal**	46.7% (42.5%, 50.0%)	N
Know The Score (Eastwood only) (0-17)	MSOA	73.3% (48.0%, 89.1%)	4.16% (4.00%, 4.32%)	Equitable	20.0% (7.1%, 45.2%)	Y
RDaSH Drugs (18+)	MSOA	58.3% (54.9%, 61.5%)	8.4% (8.3%, 8.5%)	Equitable	10.5% (8.6%, 12.7%)	Y
Shared Care Scheme (18+)	MSOA	51.2% (46.40%, 56.10%)	8.4% (8.3%, 8.5%)	Equitable	11.3% (8.6%, 14.8%)	Y
Lifeline Tier2 (18+)	MSOA	15.5% (11.3%, 20.8%)	8.4% (8.3%, 8.5%)	Equitable	12.3% (8.6%, 17.3%)	Y
Places for People (Tier2) Adults (16+)	2011 Census	45.0% (41.7%, 48.4%)	42.2% (42.0%, 42.4%) (e)	Equal	45.7% (42.4%, 49.1%)	N
Places for People (Tier2) Children (0-15)	2011 Census	53.6% (47.4%, 59.6%)	42.2% (42.0%, 42.4%) (e)	Equitable	48.8% (42.7%, 55.0%)	Y
MoreLife (Tier3) (0-17) Children	MSOA	67.1% (55.5%, 77.0%)	11.1% (10.8%, 11.3%)	Equitable	20.0% (12.3%, 30.8%)	Y
a) Yorkshire Smoke Free (Setting quit date) (18+)	MSOA	7.3% (6.3%, 8.5%)	8.4% (8.3%, 8.5%)		9.8% (8.6%, 11.2%)	
b) Yorkshire Smoke Free (4 week quitters) (18+)		8.2% (6.6%, 10.2%)	8.4% (8.3%, 8.5%)	Equal**	10.4% (8.6%, 12.6%)	N
Active for Health (18+)	MSOA	5.2% (3.6%, 7.5%)	8.4% (8.3%, 8.5%)	Unequal	11.2% (8.7%, 14.2%)	N
Health Trainers (16+)	MSOA	5.8% (4.5%, 7.4%)	8.4% (8.3%, 8.5%)	Unequal	10.3% (8.6%, 12.4%)	N

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<u>Notes</u>
* Eastwood, Canklow & Town Centre, Ferham & Masbrough.
** The 95% confidence interval (CI) for Service Level overlaps the 95% CI for Expected Level therefore these are classed as statistically similar so entered as “Y”.
(a) Represents the population of the 3 deprived areas as a percentage of Rotherham total (appropriate to the gender and age group for each service)
(b) Based on the service level percentage to people in the 3 deprived areas being the same or more than the 3 deprived areas percentage population of the Rotherham total.
(c) Calculated based on the current level of service.
(d) Service level statistically significantly higher than deprived population level.
Based on non-overlapping 95% confidence intervals (Service level lower confidence interval is greater than the population base upper confidence interval)
(e) Population data to calculate expected level is only for persons all ages (data by postcode sectors) However, service level data relates to females (EHC), children (PfP) or adults (PfP) therefore the population data can only give a feel for the expected level.

Tracey Liversidge
Information Officer
Public Health
March 2017

Appendix 1. Post codes of the 3 deprived areas and used to work out service level engagement from these areas using MSOA as at mid-2015 based on Office for National Statistics mid-year population estimates).

Post Codes Covered By FERHAM & MASBROUGH Area :			
S61 1AE	S61 1DB	S60 1EG	S60 1JT
S61 1AG	S61 1DE	S60 1EZ	S60 1JU
S61 1AH	S61 1DL	S60 1GD	S60 1JX
S61 1AJ	S61 1DP	S60 1HF	S60 1JY
S61 1AL	S61 1DR	S60 1HG	S60 1JZ
S61 1AN	S61 1DS	S60 1HH	S60 1LA
S61 AW	S61 1DT	S60 1HQ	S60 1LB
S61 1AZ	S61 1DU	S60 1HS	S60 1LH
S61 1BD	S61 1DX	S60 1HW	S60 1LL
S61 1BE	S61 1DY	S60 1HY	S60 1LW
S61 1BG	S61 1DZ	S60 1HZ	S60 1LY
S61 1BH	S61 1EA	S60 1JA	S61 1RD
S61 1BJ	S61 1EB	S60 1JB	S61 1RE
S61 1BL	S61 1HR	S60 1JD	S61 1RF
S61 1BN	S61 1HY	S60 1JE	S61 1RG
S61 1BP	S61 1JE	S60 1JF	S61 1RH
S61 1BQ	S61 1SA	S60 1JG	S61 1RJ
S61 1BS	S61 1TF	S60 1JH	S61 1RY
S61 BW	S61 2LU	S60 1JN	S61 1RZ
S61 1DA	S60 1AB	S60 1JP	S61 1SB
			S61 1TE
			S61 1TR

Post Codes Covered By EASTWOOD Area :			
S65 1LB	S65 2UA	S65 1QU	S65 1PW
S65 1LN	S65 3SP	S65 1QX	S65 1PX
S65 1LP	S65 1LD	S65 1RB	S65 1QJ
S65 1LR	S65 1LE	S65 1RD	S65 1QL
S65 1LS	S65 1LF	S65 1RE	S65 1QN
S65 1LT	S65 1LG	S65 1RF	S65 1QP
S65 1LU	S65 1LH	S65 1RG	S65 1QR
S65 1LW	S65 1LJ	S65 1RW	S65 1QS
S65 1LX	S65 1LL	S65 1SB	S65 1QT
S65 1LY	S65 1LQ	S65 1SD	S65 1QW
S65 1LZ	S65 1NP	S65 1SP	S65 1RJ
S65 1NA	S65 1NU	S65 2BJ	S65 1RL
S65 1NB	S65 1NX	S65 2BL	S65 1RN
S65 1NF	S65 1PA	S65 2BP	S65 1RP
S65 1NG	S65 1PB	S65 2BS	S65 1RR
S65 1NH	S65 1PD	S65 2BW	S65 1RS
S65 1NQ	S65 1PE	S65 1PH	S65 1RT
S65 1QY	S65 1PF	S65 1PJ	S65 1RU
S65 1SH	S65 1PG	S65 1PL	S65 1RX
S65 2BU	S65 1QA	S65 1PN	S65 1RY
S65 2BX	S65 1QB	S65 1PR	S65 1RZ
S65 2DT	S65 1QD	S65 1PS	S65 1SA
S65 2DY	S65 1QE	S65 1PT	

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Post Codes Covered By CANKLOW & TOWN CENTRE Area :			
S60 2JJ	S60 2UY	S60 2EY	S65 1DR
S60 2AB	S60 2UZ	S60 2HE	S65 1DT
S60 2AG	S60 2XA	S60 2HG	S65 1DU
S60 2AJ	S60 2XJ	S60 2JB	S65 1DY
S60 2AP	S60 1AP	S60 2JS	S65 1DZ
S60 2AR	S60 1BD	S60 2LA	S65 1ED
S60 2AU	S60 1BQ	S60 2LH	S65 1EG
S60 2AW	S60 1DA	S60 2LQ	S65 1ET
S60 2BP	S60 1DF	S60 2LR	S65 1EW
S60 2BS	S60 1EX	S60 2LT	S65 1EX
S60 2BY	S60 1FF	S60 2LY	S65 1EY
S60 2DB	S60 1LT	S60 2NA	S65 1EZ
S60 2DD	S60 1NP	S60 2NB	S65 1HA
S60 2DE	S60 1NR	S60 2ND	S65 1HB
S60 2HA	S60 1NU	S60 2NE	S65 1HD
S60 2HZ	S60 1PF	S60 2NF	S65 1HE
S60 2JA	S60 1PL	S60 2NG	S65 1HF
S60 2JF	S60 1PN	S60 2NH	S65 1HG
S60 2JH	S60 1PP	S60 2NJ	S65 1HH
S60 2JL	S60 1PQ	S60 2NN	S65 1HJ
S60 2JN	S60 1PT	S65 1AD	S65 1HL
S60 2JP	S60 1RB	S65 1AH	S65 1HN
S60 2JQ	S60 1RN	S65 1AL	S65 1HP
S60 2JR	S60 1RR	S65 1AY	S65 1HQ
S60 2JT	S60 2DA	S65 1AZ	S65 1HW
S60 2JW	S60 2DR	S65 1BL	S65 1HZ
S60 2PN	S60 2EN	S65 1DE	S65 1JA
S60 2UP	S60 2ER	S65 1DJ	S65 1NJ
S60 2UR	S60 2ES	S65 1DP	S65 1PQ
S60 2UT	S60 2ET	S65 1DQ	S65 2AD
			S65 2AF
			S65 2AG

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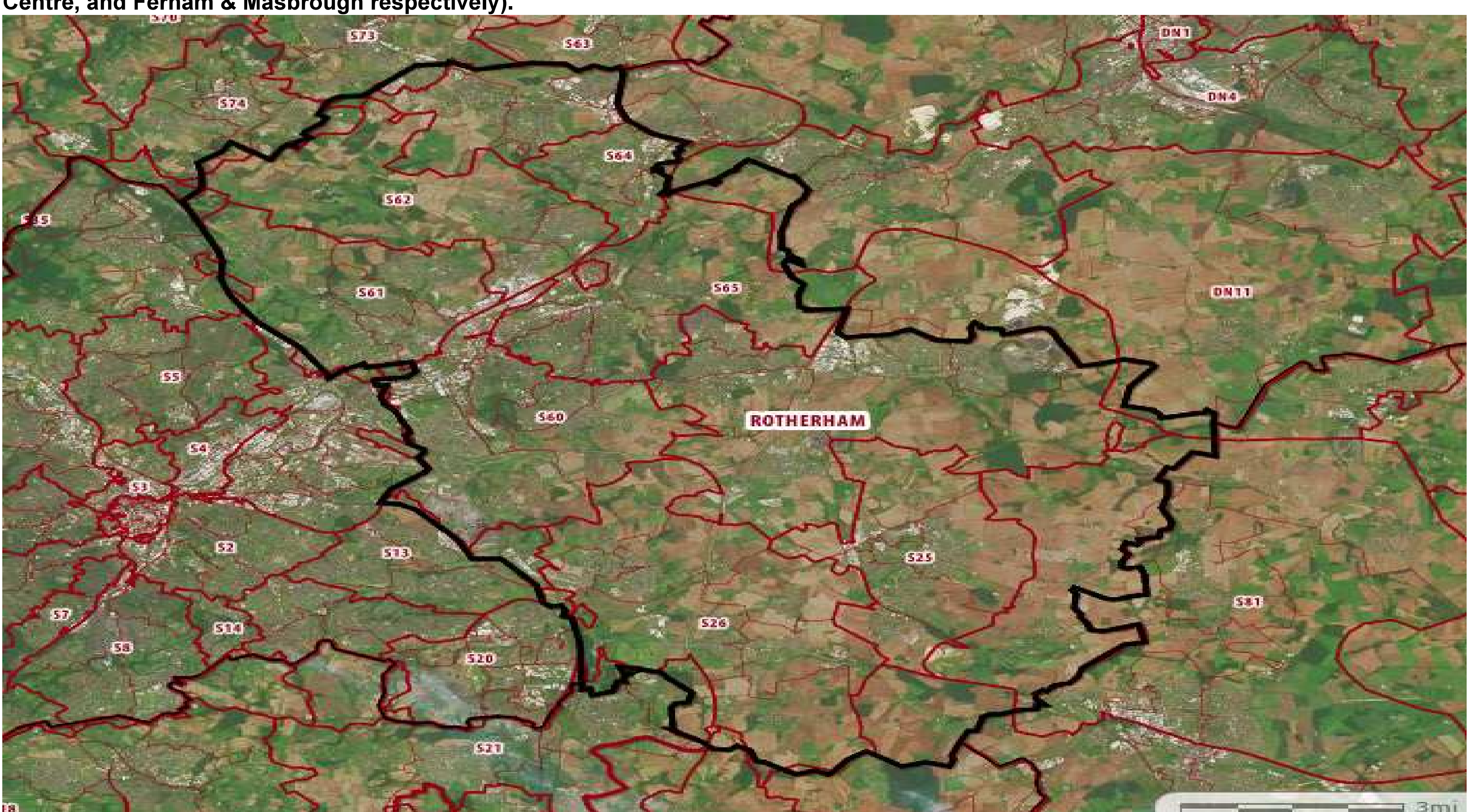
Map 2. Post code areas in Rotherham and in particular S65, S60 & S61 which encompass the 3 deprived areas (Eastwood, Canklow & Town Centre, and Ferham & Masbrough respectively).



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Map 3. Index of Multiple Deprivation for Rotherham (source: PHE SHAPE Tool, population mid 2012: 258,352. English Indices of Deprivation 2015)

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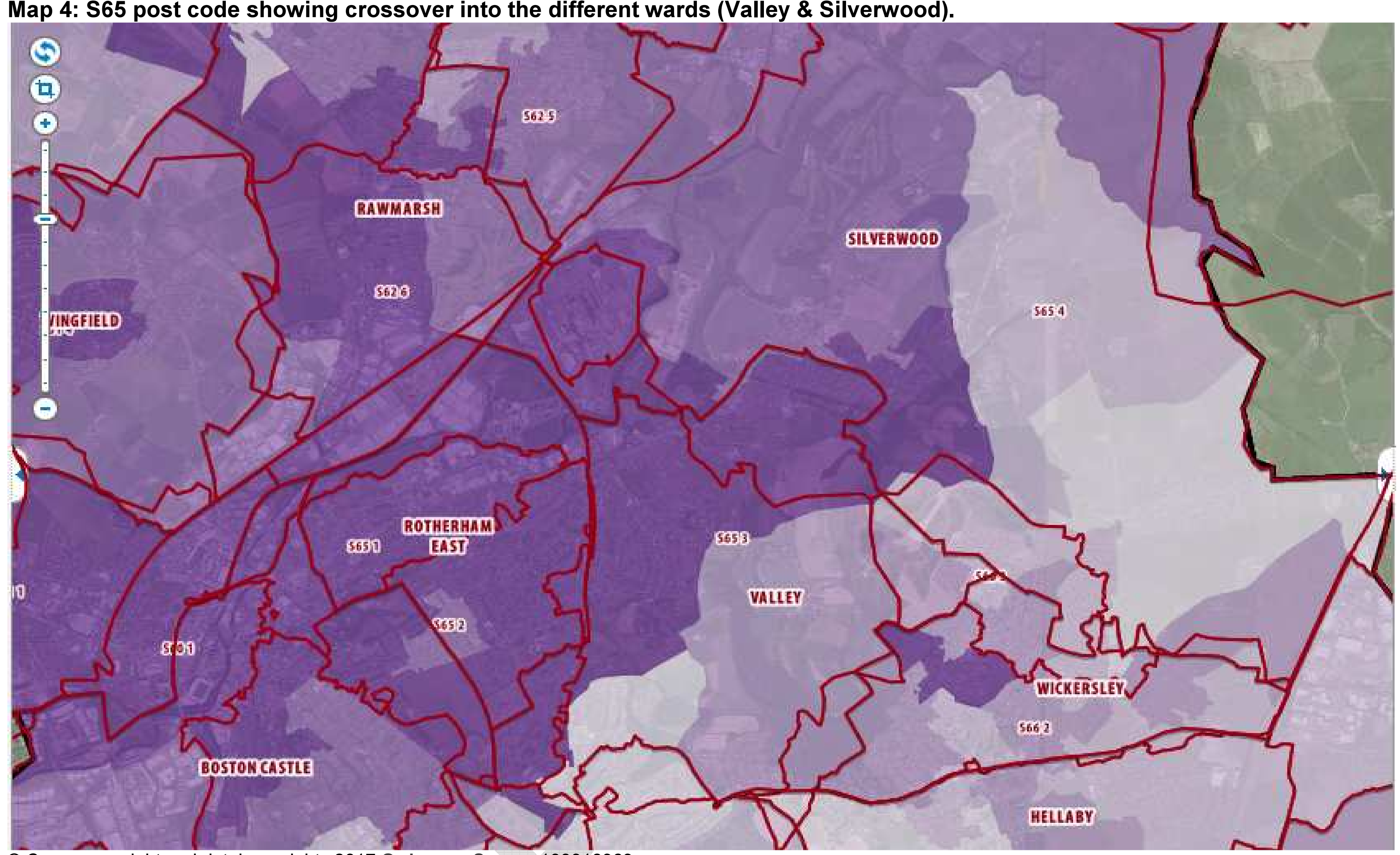
Map 4: S65 post code showing crossover into the different wards (Valley & Silverwood).



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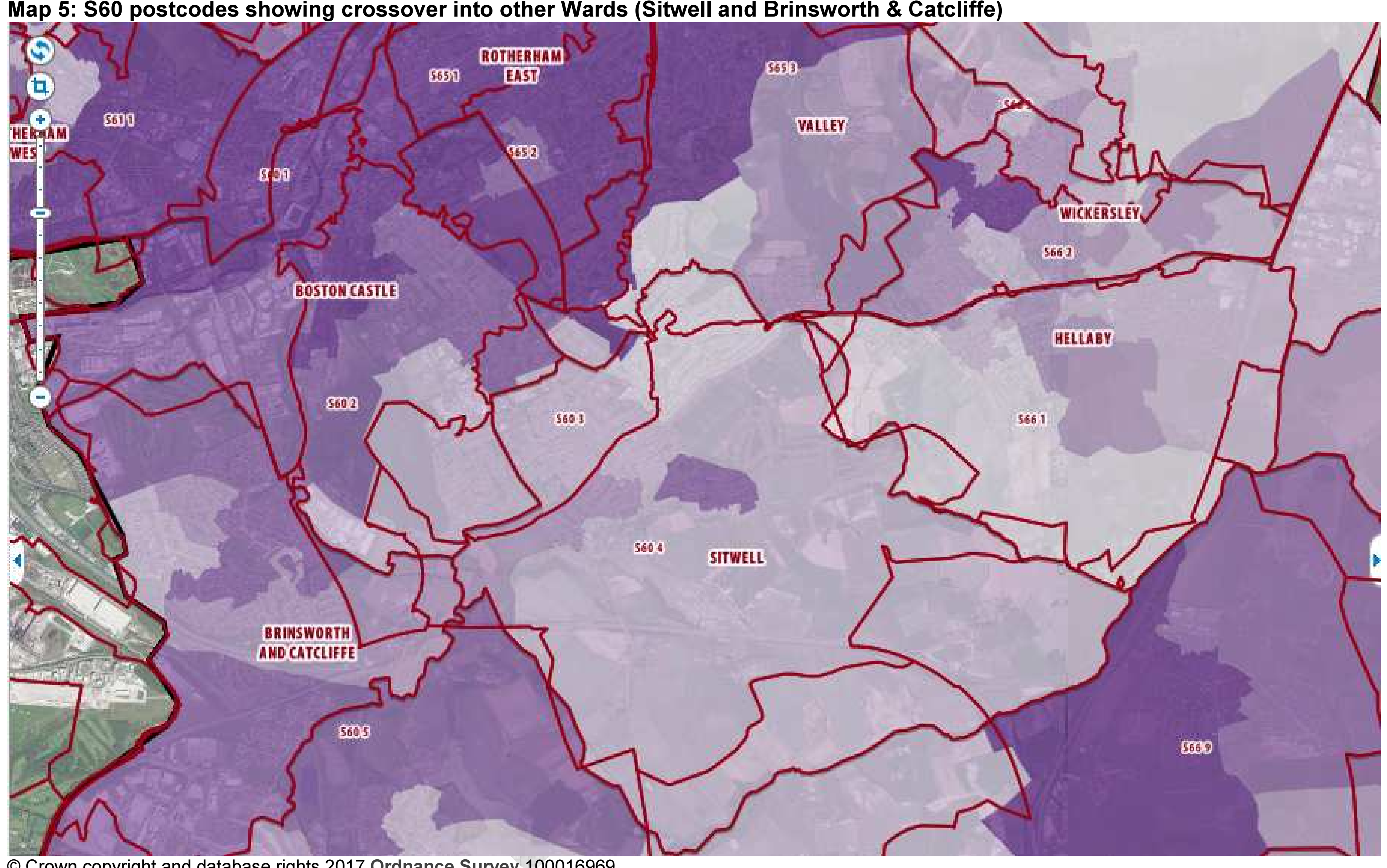
Map 5: S60 postcodes showing crossover into other Wards (Sitwell and Brinsworth & Catcliffe)



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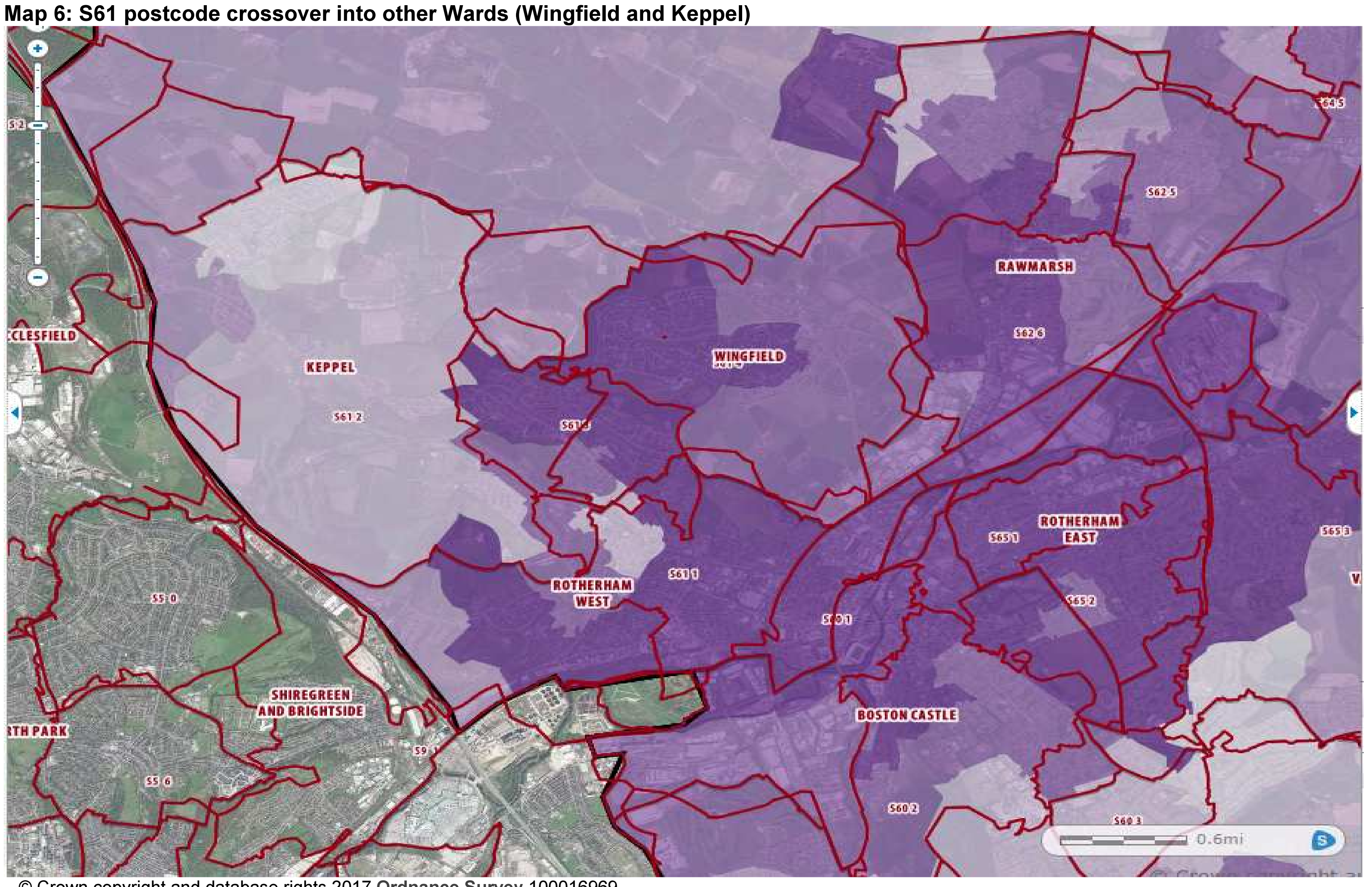
Map 6: S61 postcode crossover into other Wards (Wingfield and Keppel)



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Agenda Item 15

	Meeting:	HEALTH AND WELLBEING BOARD
	Date:	20th September, 2017
	Title:	Better Care Fund (BCF) Plan 2017-19

1. Summary

The purpose of this report is to give the Health and Wellbeing Board an update of the current status of the Better Care Fund Plan for 2017/19.

The final version of the plan has been updated in line with the 2017-19 Integration and Better Care Policy Framework published in July 2017 and Key Lines of Enquiries (KLOE's) released in August 2017 which will support assurance of the planning requirements.

A final version of the BCF Plan 2017/19 (Appendix 1) and planning template (Appendix 2) has now been submitted to NHS England on Monday, 11th September, 2017.

2. Recommendations

That the Health and Wellbeing Board:

(i) Note the contents of the BCF Plan and planning template for 2017/19

3. Introduction/Background

The Integration and BCF Policy Framework and Key Lines of Enquiries has recently been published which has identified areas where the plan needs to be strengthened so that Rotherham can gain full approval of their plan.

The final version of the plan has been updated to include:

3.1 Accountable Care System (ACS) – our new governance arrangements will support us towards becoming an ACS, 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

3.2 Improved Better Care Fund – Rotherham has been allocated the new IBCF grant allocation within the 2015 Spending Review and Spring Budget via a Section 31 Grant from the Department of Communities and Local Government (DCLG). The new funding allocation will meet adult social care needs, reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready, and ensuring that the local social care provider market is supported. This funding will enable Local Authorities to provide stability and extra capacity in local care systems. The grant funding will be pooled within the BCF Section 75 agreement and will be used to meet the National Condition 4 (Managing Transfers of Care).

3.3 High Impact Change Model and Delayed Transfers of Care Plan – Rotherham used this model to self-assess the local position in 2016/17 and developed a Delayed Transfer of Care (DToC) action plan. This self-assessment was completed by the multi-agency effective patient flow group and reported through to our local A&E Delivery Board.

3.4 An updated Summary of Financial Plan and Summary of Investment Profile. Services funded through the BCF which help maintain essential social care services include community based services, residential care, equipment/assistive technology, services for carers and 7 day social work support. 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.

3.5 Confirmation that contribution to social care services has some health benefit by reducing hospital admissions and reducing Delayed Transfers of Care.

3.6 Description of how progress will continue on the former 3 national conditions which are; a joint approach to assessment and care planning, an agreement on the consequential impact of changes on the providers and 7 day working arrangements.

3.7 Case studies included in the plan to provide evidence based impact on local vision and improving outcomes.

3.8 Capturing and sharing learning regionally and nationally around monitoring underperforming schemes.

3.9 BCF metrics – explanation of how these have been reached and data on previous performance.

3.10 DTOC – includes narrative and reference to A&E delivery plan

3.11 Finance – includes narrative in plan to accompany the figures provided in the planning template.

4. Current Progress

Rotherham has updated all aspects of the current plan, including finalising reviews and updating financial and activity information in close collaboration with partners. There are now 4 national conditions to be met as follows:

Condition 1 - Jointly Agreed Plan

Plans are still jointly agreed between the Local Authority and the Clinical Commissioning Group for 2017/19.

Condition 2 - Social Care Maintenance

Rotherham's local plan funding is higher that the contribution required and there is no intention 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.

Condition 3 - 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. These are also supported by the wider initiatives within Rotherham's Integrated Health and Social Care Plan.

Condition 4 - Managing Transfers of Care (New Condition)

Ensuring people's care transfers smoothly between services and settings. An updated action plan is now included in the plan which clearly focusses on how this will be addressed and particular, delayed transfers of care (DTOC).

5. Feedback from BCF Manager for Yorkshire and Humber (NHS England)

The narrative plan has been shared with NHS England who have assessed the plan against the Key Lines of Enquiry (KLOE's) and offered the following feedback:

Rotherham has a really good narrative plan and lots of evidence provided around:

- Engagement with staff, local communities, partner organisations
- Articulating a local vision for integrating health and social care services
- Current issues the BCF plan aims to resolve
- Description of the overarching governance and plan delivery and risk assessment.
- Good examples provided around evidence based impact on local vision.
- Good process for monitoring underperforming schemes

NHS England provided guidance on how the BCF Plan could be further strengthened and this is highlighted within Items 3.1 to 3.11 within this report. This information has now been included with the narrative plan.

6. CQC Local System Reviews

The Health and Wellbeing Board should also note that there are plans for the CQC to carry out Local System Reviews in a number of areas focussing on the interface of health and social care. The reviews will look specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. The reviews will provide a reflection of each of the local areas, highlighting what is working well and where there are opportunities for improving how the system works for people using services. Once all reviews have been completed, a national report will be produced which will identify key themes and recommendations

12 areas in the country have now been notified by CQC that they will part of the review process and this will take place between August 2017 and January 2018. Rotherham has not been selected to be part of the review process at this stage.

7. List of Appendices Included

Appendix 1 Rotherham BCF Plan 2017-19

Appendix 2 Rotherham BCF Planning Template 2017-19

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Rotherham Better Care Fund

Local Authority

Rotherham Metropolitan Borough Council

Clinical Commissioning Group

Rotherham Clinical Commissioning Group

2017/19

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Authorisation and Sign Off

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. Microsoft Word 97 - 2003 Document
Date agreed at Health and Well-Being Board:	30/08/2017
Date submitted:	11/09/2017
Total agreed value of pooled budget: 2017/18 **Total agreed value of pooled budget: 2018/19**	£32.390m £35.523m
Signed on behalf of the Clinical Commissioning Group	
By	Chris Edwards
Position	Chief Officer
Date	11th September, 2017

Signed on behalf of the Council	
By	Sharon Kemp
Position	Chief Executive
Date	11th September, 2017

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor David Roche
Date	11th September, 2017

1. Executive Summary

A copy of the Better Care Fund Executive Summary is attached as Appendix 1

2. Vision for Integrated Health and Care for Adults

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 involves the pooling of budgets and resources to ensure that we have a robust alignment across the health and social care system in Rotherham. This 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).

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
- Developing a Specialist Reablement Centregov

Both these documents identify key integration work to support the ambition of full integration by 2020, which is in line with the intentions set out in 2015 Spending Review and BCF Policy Framework. This 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"
- Reduction in 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

2.1 Better Care Fund (BCF)

The Better Care Fund (BCF) and Integrated Health and Social Care Place Plan provide 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 and Integrated Health and Social Care Place Plan 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, housing, community health services and the voluntary and community sector. We will further 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/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.

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 and the Integrated Health and Social Care Place Plan are consistent with the aims of the NHS Five Year Forward View which 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, 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 and the Integrated Health and Social Care Place 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.

3. Evidence Base

3.1 Health and Wellbeing Strategy

The Rotherham Health and Wellbeing Strategy (2015-18) sets out Rotherham's overarching vision to improve the health and well-being of its population, reablement of people to continue 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

3.2 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 February and April 2017, discussions were held with staff in each of our partner organisations and local communities about the plan. We worked with local Healthwatch and our voluntary sector partners to ensure we have input and views from a wide range of communities. 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

3.3 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 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 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 (See Section 2) that will help us achieve our Health and Wellbeing Strategic aims and meet the region's STP objectives

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 Integrated Health and Social Care 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 system which will be used across the health and social care as a key tool in articulating how our five priorities are closely interlinked to deliver better, more accessible services in the coming years. This can be found at the following website address: http://preview.beach-design.co.uk/nhs rotherham/

As well as the Rotherham Integrated Health and Social Care 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

3.4 Rotherham Carers Strategy 2016-21

Rotherham's Carers' Strategy "Caring Together" 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 make 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

The Carers Strategy "Caring Together" for 2016-21 can be found at the following website address: http://moderngov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=108721

3.5 The Rotherham Plan 2025 (Housing and Community)

The Rotherham Together Partnership (RTP) has been developing a long-term plan setting out partners' shared ambitions for the borough over the next few years. This Rotherham Plan is centred on five "game changers":

- Building stronger communities
- Skills and employment
- Integrated health and social care
- A place to be proud of
- Town centre

This streamlined plan sets out the major areas of joint working and complements ongoing efforts to promote the many positive aspects of Rotherham.

The Rotherham Plan 2025 can be found at the following website address:

http://rotherhamtogetherpartnership.org.uk/downloads/file/7/the_rotherham_plan_a_new_perspective_2025

3.6 The Rotherham Foundation Trust Five Year Strategy

TRFT are currently developing a Five Year Strategy for their organisation the key themes are as follows:

- Patients — Excellence in health care
- Colleagues — Engaged, accountable colleagues
- Governance — Trusted, open governance
- Finance — Sound financial foundations
- Partners — Securing our future together

The overarching vision is intrinsically linked to our STP and Rotherham Integrated Health and Social Care Place Plan priorities. TRFT set their main priorities as follows:

- We will continue as a thriving district general hospital
- We will build a reputation for innovation and quality care
- We will achieve a CQC rating of "good" or better
- We will be a sustainable and financially viable Trust

- We will collaborate with local providers on workforce and delivery
- We will have a strong emergency and urgent care function
- We will develop sub-regional specialist care centres
- We will provide a strong community health service offer
- We will integrate with health and social care partners

3.7 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 aim will be to improve the physical, mental health and well-being and focus on reducing health inequalities for local residents. The two vanguards are:

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

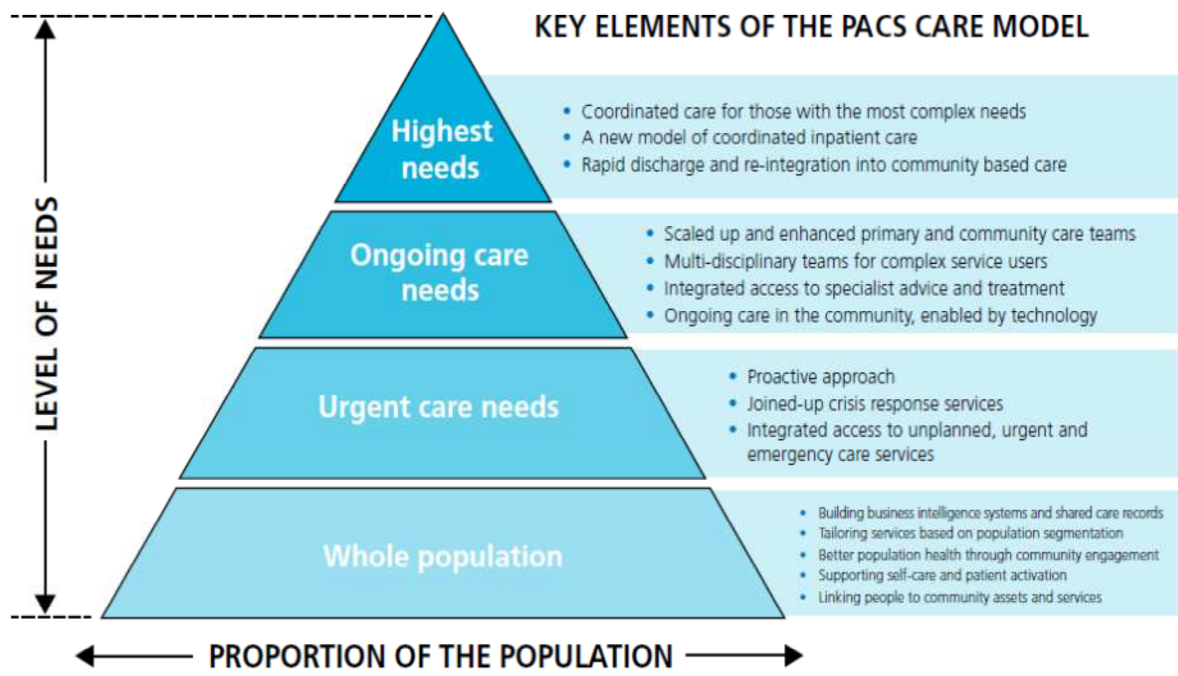
The PACS and the MCPS vanguards now cover 8% of England and nearly all sustainability and a transformational plan (STPs), involve population based accountable care models. Therefore, the national coverage of these models is to grow to 25% next year and to 50% per cent by 2020. Linked to STPs, funding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

3.8 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.



3.9 Accident and Emergency Delivery Plan 2017/18

The A&E Delivery Plan sets out the actions for the Rotherham A&E Delivery Board in relation to the key deliverables for Urgent and Emergency Care set out in NHS England's 'Next Steps on the NHS Five Year Forward View[1]' published in March 2017 (Appendix 2)

Urgent and Emergency Care (UEC) is one of the NHS's main national service improvement priorities and closely ties in with BCF priorities in reducing admissions to hospital and reducing Delayed Transfers of Care.

The key deliverables incorporate:

- Front door clinical streaming in A&E by October 2017.
- Good practice to enable appropriate patient flow.
- Joint work to ensure people are not stuck in hospital while waiting for delayed community health and social care.
- Specialist mental health care in A&E.
- Enhancement of NHS 111.
- Roll out of extended access to GP appointments.
- Strengthening support to care homes.
- Roll out of standardised Urgent Treatment Centres.

Strategic Vision and Key Deliverables

The need to redesign urgent and emergency care services in England and the new models of care which propose to do this are set out in the NHS Five Year Forward View and 'Next Steps on the NHS Five Year Forward View' (March 2017). The Urgent and Emergency Care Review proposes a fundamental shift in the way urgent and emergency care services are provided, improving out of

hospital services so that we deliver more care closer to home and reducing hospital attendances and admissions. We need a system which is safe, sustainable and that provides consistently high quality. The vision of the Review is:

- For those people with urgent care needs we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families.
- For those people with more serious or life threatening emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

3.10 Rotherham System Wide Escalation Plan 2017/18 (including Winter Planning)

The escalation plan sets out winter planning arrangements for health and social care in Rotherham including resources and capacity put in place to manage the impact of winter pressures (Appendix 3). The plan incorporates Rotherham's response to the National Cold Weather Plan which helps prevent the major avoidable effects on health during periods of cold weather in England.

Rotherham CCG, along with other local CCGs, is required to provide assurance to NHS England regarding year-round and winter planning across the Rotherham health and social care community. This plan also links closely with the BCF plan in reducing hospital admissions.

3.11 Joint Strategic Needs Assessment (JSNA)

The JSNA predicts a substantial increase in the number of adults with additional health and social care needs over the next five years.

The Rotherham BCF plan and Integrated Health and Social Care Place Plan are aligned with all of the 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.

The Joint Strategic Needs Assessment can be found at the following website address: http://www.rotherham.gov.uk/jsna/

3.12 Market Sustainability

RMBC has produced a Market Sustainability report which uses the Cordis Bright framework to understand the risks associated with the current diminishing market place for adult social care. This looks at the local, sub-regional and regional market place and carries out benchmarking exercise around Residential, Nursing and EMI beds within the market place. This intelligence enables commissioners to develop a risk matrix with the market and ensure contingency planning is in place to reduce provider failure.

3.13 "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 Integrated Health and Social Care Place Plan have 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 which 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 2019-20.

***Community Occupational Therapy Services* (COT)**

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 was set up to address this issues and this has reduced the numbers from 599 in June 2016 to 126 in September 2017. The agreed rectification actions included:

- 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.
- Support staff to start assessing for level access showers, straight stairlifts and ramps.
- Co-locating Occupational Therapy staff within the Local Authority's Single Point of Access to carry out all moving and handling assessments to reduce home care packages and to provide advice and information and signposting to alternative services.
- The Adult Care Performance and 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. The review also recommended the lead commissioner arrangements be assigned to CCG from the Council due to a slightly larger financial stake and an increased capacity through the joint commissioning function to lead this activity. The Better Care Fund Section 75 agreement with Rotherham CCG allows for the assignment of the Lead Commissioner responsibilities, which has been approved by the Better Care Fund Executive Group.

Extension of the current contracts for a period of up to 12 months will ensure that services can be redesigned, will allow time for the purpose and nature of future preventative services to be agreed in line with the Council's and CCG's Transformation programmes, Corporate Plan, Health and Wellbeing Strategy and the Better Care Fund Plan 2017/19. It will also ensure appropriate commissioning actions are taken to streamline services and ensure funding streams are appropriately placed.

3.14 Directory of Services

The Directory of Services provides clarity on where BCF funding is currently being invested and the strategic relevance of each scheme (Appendix 4). The schemes are 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

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. 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.

Performance and quality is monitored through various formats including individual service Key Performance Indicators, performance and contract meetings with providers, friends and family testing, key stakeholder and service user feedback and quality audits/service reviews.

4. Case for Change

4.1 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 has conducted a review of adult social care 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. This new integrated commissioning structured is the back bone for delivering the aspiration of an integrated health and social care system by 2020. Services that are already subject to joint commissioning and/or pooled budget arrangements include 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.

4.2 Development of New Care Models

The term Accountable Care Organisation is gaining ground in the NHS and describes arrangements where groups of providers come together to jointly deliver new pathways of care in ways that maximise efficiency, reduce cost and improve patient experience and outcomes.

In Rotherham we view ourselves as collectively accountable for the health and wellbeing of our population. The Rotherham Integrated Health and Social Care Plan will be our framework for jointly providing Acute, Community and Emergency Primary Care Services. Our new governance arrangement enables us to work towards an Accountable Care System (ACS). The aim of an ACS is to design and deliver services to meet the needs of the local population and improve health and wellbeing outcomes, within an agreed budget.

The Rotherham Accountable Care System (ACS) model will include commissioners and bring important functions such as needs assessment, identification of priorities, service redesign skills, setting and monitoring outcomes and quality and engaging with public and professional stakeholders.

Workshops have been held (facilitated by Capsticks), to work through what an ACS might look like for Rotherham. The sessions have been attended by Executive Officers and Chairs from TRFT, RMBC, Rotherham CCG, RDaSH, Elected Members and Voluntary Action Rotherham. There is strong support from all partners for the development of an ACS, and work is taking place on the details.

Figure 1: Proposed Accountable Care System Governance

Rotherham Place Plan Board
Rotherham Place Plan Delivery Team
Organisations retain Independent Accountability
Rotherham Place Plan Delivery Team: All Partners
Resource: CCG, RMBC (Adult Social Care & Public Health), TRFT, RDaSH, Voluntary Sector
Children and Young People Transformation
Better Care Fund
Urgent Care Transformation
Community and Locality Transformation
Learning Disability Transformation
Mental Health Transformation
Enablers: IT, Workforce, Finance, Joint Commissioning, Estates, Communication and Engagement
Prevention and Early Intervention

4.3 Community Transformation

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.

The BCF Plan 2017-19 and the Integrated Health and Social Care Place Plan will be instrumental in supporting further initiatives to reduce attendances.

Alongside this, the new Emergency Centre which opened in July 2017, will stream patients at the front door to alternative appropriate provision. This model is reliant on robust community provision that is able to rapidly respond with an integrated approach to care.

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 89.6% in the proportion of adults who received intermediate care and home care reablement services that were discharged without needing any long-term 24 hour care from social care services. In 2016/17 outturn has shown a slight decrease to 87.5% from the 2015/16 outturn of 89.6%. Although, the performance has shown a fall, a positive is that the total number of people using the service increased from 135 to 144.

This demonstrates the total number of people who are benefitting from increased rehabilitation beds capacity is on an upward trend. However, the service is being used for more complex people and this has made the target more challenging to achieve. In addition, the service has been offered to younger people and not all of these are able to be included in this measure, as only those over 65 fall within the definition. We have increased patient utilisation of residential intermediate care from 587 in 2014/15 to 613 2015/16, and this has further increased to 666 in 2016/17. This has been achieved within the same cost envelope.

Day Rehabilitation Figures for 2016-17

Rotherham Intermediate Care Centre Phase 1

169 patients/service users attended Phase 1 sessions in 2016/17.

The average length of intervention/input for Phase 1 in 2016/18 is 12 days (2 weekly sessions x 6 weeks)

Rotherham Intermediate Care Centre Phase 2

141 patients/service users attended Phase 2 in 2016/17.

The average length of intervention/input for Phase 2 in 2016/17 was 19 days

Table 1: Community Transformation KPIs influenced by the BCF Plan

KPI	Performance 16/17	Target 16/17	Perf 16/17 year-end	Target 17/18
People >50 years attending A&E with a fragility fracture	98/month	111/month	127/month (no data for March 17)	97.9/month
No. of people over 55 with a fractured neck of femur	19/month	23.0/month	37.3/month (no data since Nov 16 re transfer to Meditech)	23.3/month
No. of GP referrals to the Medical Assessment Unit	205/month	262.5/month	177/month	262.5/month
No. of unscheduled admissions of patients >65years	839/month	730/month	440.8/month	730/month
No. of long stay patients over 14 days	68/month	212/month	69/month	Not in either Community Perf Framework or Community KPI set for 17/19 contract

	KPI Suite - Community Services and Integrated Pathways 2014/17 Rehabilitation and Reablement Performance Group	Target	Threshold 2016/17	Predicted Out-Turn	Rag Rating	Apr-16	May-16	Jun-16	Jul-1…
1	Bone Health, Falls and Fracture Service								
1.1	Number of patients attending A&E with a fragility fracture (>50 years).	Local	1175	1399	R	59	69	132	157
1.2	Number of patients presenting with a fractured neck of femur.	Local	280	264	G	17	28	18	35

	KPI Suite - Community Services and Integrated Pathways 2014/17 ALOC Performance Group	Target	Threshold 2016/17	Predicted Out-Turn	Rag Rating	Apr-16	May-16	Jun-16	Jul-16	A…
1	Care Coordination Centre									
1.2	Number of GP urgent admissions of MAU	Local	3150	2124	G	216	195	207	203	
4	Integrated Rapid Response									
4.7	No. of emergency admissions for people > 65 years OOH	Local	8760	5289	G	422	459	426	454	

5. Prevention and Early Intervention

5.1 Shaftesbury House/Short Stay Project

We have developed a "Short Stay" Project at Shaftesbury House from November 2016, which provides support through reablement 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.

5.2 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.

5.3 Mental Health

The Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) are:

- Working closely with social prescribing mental health to support people with long term mental health conditions who have remained stable but require support in things like socialisation, vocational opportunities, art and crafts. This has supported people to move away from traditional secondary care services and to become more independent and integrated within their local communities.
- Developing their IAPT (Improving Access to Psychological Therapies) services to work with people with long term conditions, providing CBT focused therapy and working closely with colleagues in primary care to support physical and emotional wellbeing.
- Running physical health clinics for people with long term mental health issues in order to address the health gap in people on long term psychiatric medications. Our staff are providing GP's in primary care with physical health assessments for these patients in order to ensure parity of esteem and early intervention.

- Hospital liaison services, based at the District General Hospital are working closely with general nurses and medical staff to ensure “parity of esteem” for people with co-morbid physical and mental health issues. Mental health staff provides training and advice to the district general hospital in a variety of settings and across all age pathways.
- RDASH and TRFT have opened a hospital ward (12 beds) where RMN’s and RGN’s work together to support people with dementia who also have a physical health condition and would be supported better in a dementia friendly environment and not an acute hospital environment known as ‘Ferns’. This is a real opportunity to provide holistic care to patients that includes caring for their long term conditions in an integrated way.

6. 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. Contribution to social care services has some health benefit in that people are supported to live independently in the community and contributes to reducing hospital admissions/re-admissions and reducing Delayed Transfers of Care.

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 Council are focusing on developing a strength based approach, in partnership with staff, to ensure that community assets are utilised and self-directed support is maximised. They will focus on greater promotion of the use of individual budgets via a direct payment, strength based, focussed assessment of well-being and clear evidence of a person’s needs. Consideration must be taken to eligibility criteria, support planning, completion of Continuing Health Care and Decision Support Tool checklists, alternatives to standard service provision and greater use of assistive technology. The Assistant

Technology offer will be extended to support self-care in the home, as part of the early prevention and personalisation agenda. This will build on the existing profile of telecare solutions available.

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 will 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.

7. 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.

7.1 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. The development of the IRR service includes mental health and learning disability urgent care provision and out of hours approved mental health practitioners.

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 21 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 per week. The RDASH Ferns pilot provides cognitive rehabilitation for people with dementia who are medically fit and can be discharged from the general hospital.

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 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 the 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 per week.

Figure 2 summarises the pathways that Rotherham currently operates for admission prevention and supported discharges

Figure 2: 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.

7.2 Winter Pressure Initatives

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:

7.3 Ackroyd House

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.

7.4 Woodlands known as "Ferns"

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

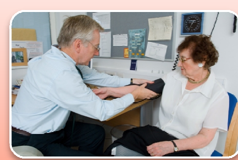
This option could be tested over the winter and, if successful, developed as a pathway modelled on some of the benefits of discharge to assess approaches.

7.5 Care Coordination Centre

The Care Coordination Centre (CCC) has been a key vehicle for delivering BCF outcomes. The expansion of the CCC is to provide a single point of contact for professionals and patients to call for

advice on the most appropriate level of care/appropriate pathways, which includes health, social care and mental health provision. 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 3: Current Functions of the Care Co-ordination 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

7.6 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 which links with BCF commissioned services 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.

8. 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 mind Rotherham's health and social care system will focus on integrated commissioning activities in the following areas:

8.1 Joint Commissioning and Fee Setting of Domiciliary Care/Residential and 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 2017/18 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 reablement 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 blood pressure/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.

8.2 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.

8.3 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.

A co-produced, personalised care and support plan is at the heart of making personal health budgets work well, setting 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.

8.4 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. 'Forward View into Action- Planning for 2015-6' (NHS England) allows local flexibility on which groups will be offered personal health budgets. Information on requesting a PHB and our current plan for extending PHBs beyond continuing

healthcare can be found on the CCG website at http://www.rotherhamccg.nhs.uk/personal-health-budgets.htm

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 to expand health budgets to groups which will benefit. 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.

8.5 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.

8.6 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

9. 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.

9.1 Risk Stratification/Segmentation

Rotherham practices have used risk-stratification tools for the last 5 years to identify the top 3% of the population which 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. The local system is working with KPMG to further expand the current risk stratification/segmentation model to support prevention and early intervention as this is key to promoting self-management and increased independence for longer.

9.2 The Rotherham Long Term Conditions 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's 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.

9.3 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 reablement. 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.

Voluntary Action Rotherham, on behalf of NHS Rotherham CCG, co-ordinates both social care prescribing 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.

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

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

9.4 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 Reablement 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.

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

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 55 attending between April to June 2016. The environment is set out well with an appropriate number of volunteers to support the activity.
- Winthrop in Wickersley has been set up during the summer months of 2017. There are rooms as well as gardens and garden type activities on offer which offers a different approach.

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.

10. 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 (See Section 3.10).

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.

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.

As part of the placed based data modelling being undertaken with KPMG a set of 28,000 children's records have been sent securely (as part of a refreshed data sharing agreement) to colleagues in the TRFT for NHS number matching, once returned this will enhance Liquid Logic and other relevant databases even further.

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 falls rate has improved significantly over the last five years. The most recent data shows that 751 Rotherham people over 65 had an injury that was due to a fall in 2015/16, in comparison to 1,039 in

2011/12. The cost savings to the Rotherham Health and Social Care system for the falls that have been preventing over the last 4 years are close to £15m (using the mean rate), with an average annual saving of £3.6m. This has been calculated using the Kings Fund (August 2013) costings and using the actual number of falls from 2011/12 highest point.

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.

The Association for Public Service Excellence (APSE) have shortlisted Active for Health as a finalist for the 2017 Best Health & Well-being initiative (including social care) Service Awards. This is following a rigorous selection process from 310 submissions. The Service Awards presentation evening will be held at the end of APSE’s annual seminar 2017, which will be held in Oxford on 7 September, 2017. This achievement is another example of how fantastic the project is and a measure of the hard work by all involved.

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.

11. Key Developments for 2017-19

In order to deliver the local priorities the following developments will be focussed upon. 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 reablement 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)

11.1 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 reablement.

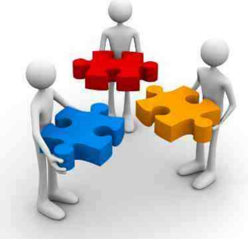
The single point of access cross cuts several Integrated Health and Social Care Place Plan Priorities. It is a key to prevention and self-serves, has strong interdependency with the model of an enhanced care coordination centre, could maximise the benefits of a single reablement hub and provides solutions 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 reablement 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.

11.2 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.

11.3 Development of preventative services that support independence

Rotherham has developed a "Healthy Ageing Framework" 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 the integrated 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 was fully launched in June 2017, and can be found at the following website address: https://www.iagewellrotherham.co.uk/

Promoting physical activity

Public Health and partners have developed an Active for Health programme which provides 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.

11.4 Reconfiguration of the home reablement service

The aim of re-ablement is to help people accommodate illness or disability by learning or re-learning the skills necessary for daily living. Although a focus on regaining physical ability is central, addressing psychological support to build confidence as well as social needs and related activities is also vitally important. People accessing reablement services experience greater improvements in physical functioning and improved quality of life compared with using standard home care (SCIE research). Reablement is usually for a period of up to six weeks and is free to the customer regardless of their means/assets.

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 are in the process of reviewing the Council's Re-ablement service to ensure that it is securing the best and most sustainable outcomes for our customers and that it is being accessed by those who would most benefit from the service. This promotes both best value for the expenditure involved and also contributes to wider health and social work management of need, minimising use of unplanned support in both sectors (including admission avoidance activities). There is a natural alignment with the role of therapists who prioritise function and adopt a clear strengths-based approach to the management of risk.

The overall review of the service is being completed in partnership with wider adult care services, The Rotherham Foundation Trust and their associated network of community provision. This will facilitate a merging with all parallel work-streams, exploring therapies and intermediate care provision, community health 'rapid response' services as well as the peripheral networks that exist in the community.

With a view to creating a customer experience that is more joined-up, efforts are being made to both map and communicate all the teams and services that are in place so that the person concerned is received by the right team, at the right place and is therefore able to achieve the right outcomes. All agencies engaged in working with people who present with social care and health needs are encouraged to consider reablement potential in the first instance to ensure that we are Care Act compliant in respect of preventing, delaying and reducing need. This promotes the independence and wellbeing of the person concerned as well as diverting inappropriate people away from costly and less-effective services. It is anticipated that this approach will incorporate services such as 'social prescribing' and 'early planning' as well as those teams and services that are more traditionally evident in this area.

There is energy and commitment across all organisations involved to ensure that services are efficiently and promptly configured to deliver timely change which accommodates this BCF agenda.

We will implement the outcomes of a recent service review, ensuring that the reablement 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.

11.5 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, reablement of 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 and 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, reabling 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

11.6 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, reabling carers to maintain a balance between their caring responsibilities and a life outside caring, while reabling 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.

11.7 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.

11.8 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 are now on a downward trajectory. To continue this trend 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 staff remains 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 build strong links with care home sector to enhanced health in care homes including trusted assessor, enhanced skills for staff and the role of the Clinical Quality Advisor. 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.

11.9 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.

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

The number of recorded Delayed Transfers of Care (DTOC) from the September 2016 National DTOC report shows that 3.27% of transfers were delayed. This is 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, however it is recognised that our DTOC have been steadily increasing. A trajectory has been agreed to ensure that we reduce our DTOC levels back in line with national requirements which has been included in the DTOC Plan submitted to NHS England on 21st July, 2017.

The national ambition (National Condition 4) is to ensure that all areas reach/maintain a level of more than 3.5% for all DTOCs (health and social care).

In 2017, The Rotherham Foundation Trust reported DTOC as follows:

January 2017	February 2017	March 2017	April 2017	May 2017	June 2017
4.1%	4.2%	6.0%	5.1%	5.9%	5.4%

This is an increasing trend against a relatively stable position prior to 2017, where figures were under the 3.5% target at circa 3%.

In response to the increase in DTOC levels locally, the introduction of the national condition and in order to effectively plan Rotherham's future delivery model, an external evaluation of discharge processes took place in April 2017.

A two day review of current transfers of care was carried out by a senior advisor from the Care and Health Improvement Programme, Local Government Association and a Discharge Planning Manager from the University Hospitals of North Midlands NHS Trust. This has led to the development of a revised DTOC action plan (Appendix 5). Significant progress has already been made to support more effective flow through the system. This includes:

- Project Initiative Plans to integrate the transfer of care team fully with hospital social work and therapy (building on the MoU).
- Appointment of an external consultant two days per week, every two weeks over the winter period (linked to the external review took place in April 2017) to support the Trust and partners in developing Standard Operating Procedures for identification of DTOCs (health and social care) and the review of pathways to ensure consistent and streamlined approaches to discharge.
- Additional £400,000 within the Improved Better Care Fund (IBCF) for winter pressures that will support effective discharges in times of high escalation.

- Appointment to a DTOC lead for two years as part of the IBCF to drive the DTOC action plan forward

Rotherham CCG and its partners will monitor DTOCs through the A&E Delivery Board. The Board endorsed a Memorandum of Understanding (MoU) (Appendix 6) between Rotherham Foundation Trust, Rotherham CCG and the Local Authority on hospital discharge which was signed up to in 2016/17. 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 an integrated discharge function with co-ordinators on each ward (currently being piloted).

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 "multi-agency" weekly meetings which has been successful in supporting complex discharges in 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. This is a key vehicle for achievement of BCF Metrics. An example of success is that we have been able to reconfigure the provision of key safes from the local provider to ensure that complex patients can access a key safe within 24 hours of referral to expedite a discharge.

The DTOC action plan will play a fundamental role in improving flow and is monitored on a continuous basis to ensure achievement of objectives with limited risk of slippage

11.11 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 reablement 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 with long term health and disability needs
	Consideration of the development of a specialist reablement centre incorporating intermediate care	
	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. Key Milestones

Table 3: Key Milestones

Priority	Description	LEAD	MILESTONES	Date
1	A single point of access into health and social care services; including the integration of Integrated Rapid Response	Project Group	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	Project Group	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	30.09.17
		TRFT - with partners	Analysis of demographics and population need across Rotherham and specific to locality area, to inform roll out model.	30.09.17
		External support	Evaluation of pilot	01.07.17 to 01.12.17
		Project Group	Roll out of the integrated locality teams across Rotherham	01.01.18
		Project Group	Care Home transformation timescales to be defined as part of project group	31.01..18

Priority	Description	LEAD	MILESTONES	Date
3	Consideration of a Specialist Reablement Centre incorporating intermediate care beds	Project Group	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	31.12.17
		CCG	Review of acute and community respiratory pathways	31.06.17 **Completed**
		Project Group	Proposals for future development of Reablement Centre	31.3.18
		Project Group	Service reconfiguration begins	30.6.18
4	Preventative services that support independence	RMBC/CCG	OT Review approved by BCF Executive	17.02.17 **Completed**
		RMBC/CCG	New service model agreed by BCF Executive	31.12.17
		RMBC/CCG	Project plan agreed for implementation of new service model	31.12.17
		RMBC/CCG	New service model fully operational	01.04.18
		RMBC/CCG	ICES and Wheelchair Review approved by BCF Executive	31.12.17
		RMBC/CCG	New service model agreed by BCF Executive	31.12.17
		RMBC/CCG	Project plan agreed for implementation of new service model	31.1.18
		RMBC/CCG	New service model fully operational	01.04.18
		RMBC Reablement Team Manager	Complete a review of the in-house assessment and reablement service to determine its current efficiency and	31.8.17

Priority	Description	LEAD	MILESTONES	Date
			effectiveness in relation to the management of demand	
5	Reconfiguration of the home care reablement service	RMBC Reablement Team Manager	Implement an improvement programme linked to the evidence findings of the review	1.9.17
		RMBC Reablement Team Manager	Evaluate the improvement work in relation to the in-house service and produce a report for consideration to the Improvement Group and Improvement Board	31.1.18
		RMBC Reablement Team Manager	The Improvement Programme linked to the in-house reablement team must benchmark against best practice.	1.3.18
7	Single health and social care plan for people with long term condition	Primary Care Team CCG	Scoping exercise completed on integrated care plan	30.09.17
		Primary Care Team CCG	Develop common template for case management	31.11.17
		Primary Care Team CCG	Develop IT solution for sharing care plan across systems	31.12.17
		Primary Care Team CCG	Implement integrated care plan for case management	01.04.17
8	A joint approach to care home support	TRFT Care Home Support Service	Introduction of annual mental health assessments	31.12.17
		TRFT Care Home Support Service	Development of a targeted care home training programme	31.12.17
		TRFT Care Home Support Service	Introduction of protocols for stroke patients in care homes	31.12.17

Priority	Description	LEAD	MILESTONES	Date
9	Shared Approach to Delayed Transfers of Care (DTOC)	Associate Director of Transformation TRFT	Review of implementation of MoU through audit of a ward	01.11.17
		Associate Director of Transformation TRFT	Review findings from pilot of discharge coordinator on one ward to link with Transfer of Care Team and recommendations for future model	30.09.17
		Associate Director of Transformation TRFT	Examine assessment process to streamline and integrate functions of health and social care	30.09.17
		Associate Director of Transformation TRFT	Further work to embed “trusted assessor” role to reduce duplication and improve patient flow	31.10.17

13. National Conditions

13.1 National Conditions

There are 4 national conditions within the BCF plan for 2017/19 as follows:

- **Condition 1- A jointly agreed plan**- A requirement for a jointly agreed plan, approved by the Health and Wellbeing Board. This includes that all minimum funding requirements are met, full involvement from other key stakeholders such as providers, housing authorities and the voluntary and community sector and that the CCG minimum contribution to increase, in line with CCG overall budgets. It also includes agreement on use of the Improved Better Care Fund (IBCF) funding to ensure that local social care provider market is supported and agreement on use of DFG funding.

- **Condition 2- Social Care Maintenance**- Real terms maintenance of transfer of funding from health to support adult social care. This applies to the CCG minimum contribution, uplift of minimum required contribution from 2016/17 baselines in 2017/18 and 2018/19 and local areas can agree higher contributions.

- **Condition 3- NHS Commissioned Out of Hospital Services**- Requirement to ring-fence a portion of the CCG minimum to invest in Out of Hospital services. This applies to the CCG minimum and covers any NHS commissioned service that is not acute care – can include social care. Areas are expected to consider holding funds in a contingency if they agree additional targets for Non-Elective Admissions (NEA) above those in the CCG operational plan.

- **National Condition 4- Managing transfers of care (new national condition**) of the Better Care Fund (BCF) sets out the requirement to ensure people's care transfers smoothly between services and settings. This requires all local areas to implement the high impact change model which is also a condition of the Improved Better Care Fund (IBCF).

13.2 Previous National Conditions

There were 4 previous national conditions in the 2016/17 BCF policy framework which will be continually monitored as follows:

- **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 -** 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.

- **An agreement on the consequential impact of changes on providers that are predicted to be substantially affected by the plans -** 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. We now have an Accountable Care System governance arrangements in place with various sub-groups supporting transformation across the health and social care system, including the Acute and Community Transformation Group and BCF groups.

- **7 day working in hospital and community settings** - 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 are now working towards the development of an Integrated Health and Social Care Discharge Team at the hospital to increase in-patient experience, reduce admissions, delays to discharge, length of stay and to contribute to managing winter pressures.

- **Data sharing between health and social care care** - 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.

  As part of the placed based data modelling being undertaken with KPMG a set of 28,000 children's records have been sent securely (as part of a refreshed data sharing agreement) to colleagues in the TRFT for NHS number matching, once returned this will enhance Liquid Logic and other relevant databases even further.

  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. An information sharing agreement (ISA) relating

to the Rotherham Health Record (RHR) has been drafted and is currently progressing through the Information Governance Boards of the organisations covered by the ISA, these are:

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

The sharing of personal confidential data into the Rotherham Health Record and the viewing of personal confidential data via the Rotherham Health Record are for the purposes of Direct Care only. Accordingly, the patient's consent to such sharing may be implied. Fair processing notices are required and the nature of the sharing will be communicated to patients by a variety of means, and all patients will have the opportunity to opt-out.

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

13.2 High Impact Change Model

Rotherham used the High Impact Change Model to self-assess the local position in 2016-17 and developed a Delayed Transfer of Care (DToC) action plan. This self-assessment was completed by the multi-agency effective patient flow group and was reported through to our local A&E Delivery Board prior to winter 2016-17. As a system we have recently commissioned an external review of the discharge processes and pathways by the LGA and NHSE. The outcome of which is as follows;

- Rotherham’s Delayed Transfers of Care are comparatively low. However there is an upward trajectory in recent months
- There is an energy, commitment and enthusiasm from staff to make improvements
- There are some examples of good practice on wards i.e. MDT approaches – but this is not consistent
- IT system Rotherham Care Record is best practice model
- Pathways out of hospital are confusing
- Planning around the individual was strong
- Lack of process for agreeing and signing off DTOCs

We have already developed a Memorandum of Understanding around better integrated discharge planning and have piloted 'Trusted Assessor' models in our services i.e. Ackroyd Care Home. We plan to further develop 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 in 2017-18).

A set of agreed actions have been developed that form part of the DTOC action plan for 2017-19 included in the BCF Plan 2017-1 as follows;

1. Implement an Integrated Discharge Team :
   - Would help with roles, responsibilities, clarity of teams.
   - Would help structure MDT's better, referral processes, working relationships

2. Agree Joint reporting and Data Set
   - System to have standard, single version of the truth
   - Some things get reported, some things unclear (non-acute delays)

3. Simplify Pathways (including Home First and DST's)
   - Too many pathways and need greater clarity
   - DST's need a better pathway and need to get them home where safe to do so

4. Awareness and Training
   - Understanding of DTOC's, Care act needs improving
   - Training for teams and awareness sessions

5. Escalation Process and Response
   - How do teams respond to pressures
   - Who does what, when and how does this get translated into de-escalation

All of these conditions have been included in the plan. There is an expectation that the national conditions are continued, although there will be no formal reporting requirements.

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 2016-17. In summary these are:

- Non-elective admissions (General and Acute)
- Admissions to residential and care homes
- Effectiveness of reablement
- 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
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 hospital admissions* –** The plan illustrated (within the BCF planning template) is the affordable level of non-elective admissions reflected in CCG contracts. The plan is a composite of shares of all the CCG's plans covered by the HWB area. The definitions and shares used for this target are set nationally by the BCF programme.

The Rotherham CCG plan for non-elective admissions is built up from growth assumptions produced by analysing local data on previous trends and from the planned impact of relevant quality improvement and targeted intervention programmes which are all established.

Key schemes for 2017-19 include the opening of the Urgent and Emergency Care Centre - which aims to contain non elective growth through effective streaming of patients to the appropriate level of care - social prescribing, case management, hospice at home and 7 day working.

Non-elective activity and the impact of these schemes are monitored through a number of contractual processes and meetings.

No additional reductions have been planned in as part of BCF as the broader non elective plan already encompasses the key schemes impacting non elective admissions.

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.

This plan is the number of delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+). Delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. The definitions for this target are set nationally by the BCF programme.

There is currently no agreed target for April and May 2017. There are however clear expectations set out by September 2017 for DTOCs, these are:

Not more than 9.4 people in total delayed in hospital per 100,000 adults, which equates to approximately:

- 2.6 people delayed in hospital per 100,000 adults due to social care
- 5.5 people delayed in hospital per 100,000 adults due to the NHS
- 1.2 people delayed in hospital per 100,000 adults jointly attributable

A provisional trajectory from July 2017 has been submitted to meet these expectations. The target figures displayed in the scoreboard are an indicative position between current performance and this trajectory.

The DTOC trajectory has been developed and agreed across all partners (including health and social care providers), underpinned by an action plan, focusing on a universal home first approach and a more integrated discharge model. DTOCs are a key issue for the A&E Delivery Board and a cross partner operational group is in place to work through individual DTOCs.

The gap in delays to meet the national requirement is around 10 patients less delayed a day. The universal home first approach supported throughout the BCF investment themes such as Social Work Support and Home Enabling Services are aimed at addressing this gap.

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

In order to provide customers with greater independence and choice, admission to 24 hour care is provided only for those people who can no longer have their needs met by remaining at home in the community. Final year end admissions data as at end of March 2017 reflected 329 new admissions (or a rate of 663 per 100,000 per population). This was a significant improvement from the 401 admitted in 2015/16. The first quarter of 2017/18 shows 45 new admissions to date, which is below Quarter 1 target of 75. However, there is some ‘recording lag’ regarding current short stay admissions; which may need to transfer to permanent during the year. Planned in-year review of these admissions will enable a projection of total admissions to be included during Quarter 2 reporting onwards. The measure is currently rated ‘on track’ to be below target of 297 admissions by year end which is equivalent to a target rate of 589 admissions per 100,000 population. The target takes account of recent trend analysis and is realistic when considering demographic pressures. A range of the BCF initiatives/projects will contribute positively to this target reduction of 32 fewer admissions in 2017/18

and a further 10 fewer admission in 2018/19 include but especially the Initiative - Supporting the DTOC High Impact Change Action Plan and Initiative - Investment in additional re-ablement capacity.

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

This is an annual measure and collation of data is undertaken during January - March 2018 period to track service users who have been 'offered' (i.e. commenced) the service during October to December 2017, to identify those who were still at home 91 days following discharge from the service.

The 2016/17 outturn reflected a slight decrease to 87.5% from the 2015/16 outturn of 89.6%. Although, the performance has shown a fall, a positive is that the total number of people using the service increased from 135 to 144. This demonstrates the total number of people who are benefiting from increased rehabilitation beds capacity is on an upward trend, but the service is being used for more complex people and this has made the target more challenging to achieve. In addition the service has been offered to younger people and not all of these are able to be included in this measure, as only those over 65 fall within the definition.

A target of 88% has been set for 2017/18 and 89% in 2018/19, data will be collected using the same criteria in 2016/17. However, we anticipate that some planned changes to the service (through additional IBCF funding to increase our reablement service) should enable the performance to stabilise, if not improve, both in terms of 'offered' the service and those still achieving the outcome of being 'still at home' after 91 days after ceasing to use the service. The target takes account of recent trend analysis and is realistic when considering demographic pressures. A range of the BCF initiatives/ projects will contribute positively to this target's improvement over 2017/18 and 2018/19 but especially the initiative – Supporting the DTOC High Impact Change Action Plan and Initiative – Investment in additional reablement capacity..

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
- 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/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, reabling 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 individuals 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 step-up beds	• Non-elective admissions • Admissions to care homes • Effectiveness of reablement • Delayed transfers of care
4	An Integrated	• Better access to benefits,	• Reduced likelihood of	• Non-elective

No.	Project	Patients and Service Users	Providers and Local Health Economy	BCF Metrics
	Carers Support Service	information and advice • Reduction in social isolation for both carer and those being cared for • Improved health and well being	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	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

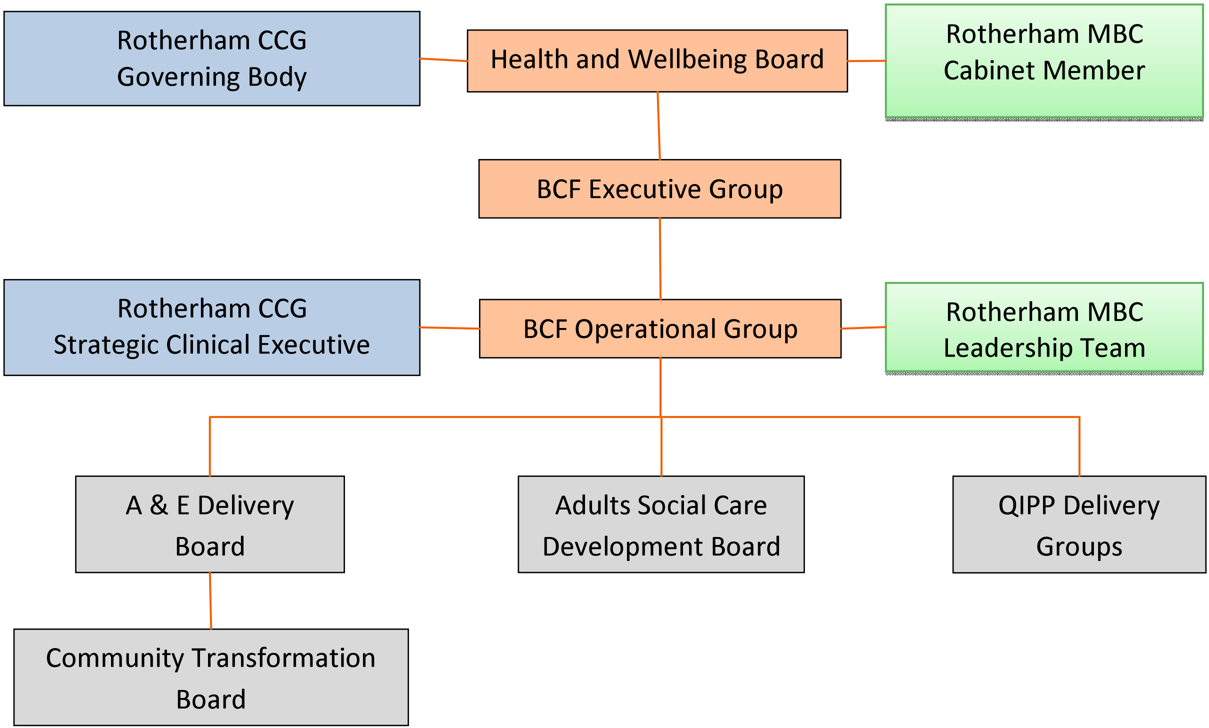
16. Governance Arrangements

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.

The Health and Wellbeing Board and BCF Executive Group have fully endorsed the BCF plan, planning template and narrative plan and all relevant stakeholders support the allocation of BCF and IBCF funding.

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 Executive Group

This group consists 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;

- Agree strategic vision and priorities for the future
- Make decisions relating to the delivery of the plan
- 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 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 current governance arrangements were reviewed and the governance framework shown in figure 4 was agreed.

17. Risk Assessment

Table 6 provides a summary of the risks associated with the development of the Better Care Fund. Risks have been assessed in partnership with key stakeholders and description of how these will be mitigated or managed operationally is detailed below:

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					
	Delay in provision of definitive guidance and confirmation of metrics leads to lack of time for implementation and monitoring	3	3	9	The programme is being monitored closely and the plan is continually updated to take account of changes in the Health and Social Care System.
	Poor alignment between service budgets and actual cost; resulting in overspend	4	3	12	The review process timetabled throughout 2017-18 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.
	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 reconfiguration of service provision in year.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
1	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
1	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.
1	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 of the risks associated with implementation/achievement.
1	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 is 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.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
1	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.
1	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.
1	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.
1	Social care not being adequately protected	3	5	15	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.
Performance Risks					
2	*Non-elective target not met;* BCF Schemes do not deliver the planned	4	5	20	Many of the schemes outlined in the plans from previous years have already been put in place and are

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
	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.				demonstrating outcomes. The focus on out of hospital services will continue in 2017-18.
2	*Residential Care target not met;* BCF Schemes do not deliver a reduction in permanent admissions to residential care increasing costs to the LA.	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.
2	*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.
2	*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	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.

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
	scheme implementation is delayed.				
OPERATIONAL RISKS					
2	*Community Services;* BCF schemes increase demand on community services resulting in increased waits for health and social care assessments/ services	3	4	12	New funding was identified and included in the plan for 2015-6 onwards and this is continually reviewed by the executive group.
2	*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 regularly monitored through performance submissions and meetings with providers.
QUALITY RISKS					
2	*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.
2	*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	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

	Risk	Likelihood	Consequence	Score	Remedial Actions to Reduce Risk
	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 RMBC and CCG				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.

18. 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's plans to dampen down growth of emergency admissions have 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 all of the relevant boards.

19. Patient Engagement

19.1 Integration Locality Engagement

The integrated locality pilot became fully operational in June 2016. There was an initial consultation exercise to ensure patient engagement was central to the integration of community services within one locality and the impact this may have on Rotherham people. Leading on from the consultation there was a focused workshop at the Patient Participation Group in December..

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 December 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.

This was followed by a targeted piece of work with people who had been in receipt 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.

19.2 Case Studies

Case Study 1 – Integrated Locality Team

On 30th May 2017, a letter was sent to the Integrated Locality Team, from a couple, thanking the therapists for the time and effort put in to reabling Mr J to get up and walk again, unaided. Mr J was referred in to the Integrated Team after deterioration following a stroke. He had been isolated to one room in his house due to his inability to move. It required three people to stand Mr J at this point. His deterioration resulted in him being placed in intermediate care, who referred him to the Community Occupational Therapist (COT) attached to the Integrated team, for a hoist to lift him. A multi-

disciplinary review took place to assess Mr J's needs and the case was to be managed by the Physiotherapy and Occupational therapists with input from the Team Social Worker in relation to the care he would require. The team rehabilitated Mr J from December 2016 and, as a result, he is now able to function without aids and reports being so much happier. He is spending time in the garden and has three outings planned for the summer, including to London and Llandudno. The team has reduced Mr John's social isolation, enhanced his mental well-being and overall quality of life. He is now able to attend medical appointments instead of requiring domiciliary visits, the risk of developing sores and District Nursing input has reduced dramatically, and his social care package will be reduced as a result.

Case Study 2 – Rotherham Active for Health – MSK Pathway (Rehabilitation and Reablement)
Client SE was referred to the Active for Health MSK programme after suffering from sciatica on two occasions. His GP referred him to a Physiotherapist who then referred him to the Park Rehabilitation Centre. After completing the NHS 12 week programme at Park Rehab he was recruited into the Active for Health MSK programme in April 2016. SE enjoyed the regular exercise and the opportunity to get out of the house (works from home) and get active along with other people who also suffered from back issues. He wanted to carry on with guided exercises and circuit training and welcomed the opportunity to continue this with Active for Health. Before joining the programme he was living in fear of succumbing to sciatica once again and moving carefully, "not really daring to exercise too hard in case my sciatica was triggered again". SE is now saying that "I am feeling fitter and am now more active than I have been for many years". "I am able to stretch further in all directions and can exert myself more before becoming out of breath. I also recover faster from cardio exercise and feel less aches and pains in my body". "My weekly MSK sessions have inspired me to exercise every single day; in the mornings I go through a stretch and in my lunch breaks I do a small workout and go for a short run. My sciatica has not returned and I am sure this is due to being a part of the Active for Health programme". The extension to the rehabilitation pathways in the NHS has enabled SE to increase his self-care and aid his rehabilitation.

Case Study 3 – Rotherham Active for Health – Stroke Pathway (Rehabilitation and Reablement)
Client JS suffered a stroke in which initially affected all his right side, leaving him with limited movement in his right arm. His wife explains how he was in a bed downstairs as he didn't have the mobility to get upstairs. JS started rehabilitation with the enablement team and Physiotherapy at Park Rehabilitation. JS was then referred to the Active for Health programme and has been attending for the last 10 months. JS has completed step 2 of the programme and has continued into step 3 where he attends on a weekly basis. When JS first started the programme he would attend in his wheelchair, and would exercise in his chair, from this he progressed to being out of the chair assisted by the instructor on a 1 to 1 basis with a walking aid, 10 months into the programme, JS is now talking part in the exercise independently with little instructor support. As a result of the programme, JS is now able to get upstairs to sleep, completes the full session with no walking aid and limited 1 to 1 support, walks independently around his home, his right side had improved greatly and he does not kick his leg out as much, his leg movement is more aligned. This has increased JS's independence, mental wellbeing and built upon the NHS rehabilitation pathway.

Case Study 4 – Rotherham Active for Health – Heat Failure Pathway (Rehabilitation and Reablement)
Client GM suffers with Heart Failure and is also completely visually impaired. Prior to starting Active for

Health he was virtually sedentary and very resistant to starting exercise. GM has been attending the cardiac class once a week at Aston Leisure centre since September 2016, after being referred from the heart failure nursing service. He has completed Active for Health step 2 and has now moved onto step 3 maintenance sessions and is said to be "loving it". He has now increased self-confidence, reduced anxiety, increased his 6 minute walk test by 60m , reduced his Heart Failure symptoms on his health questionnaire, increased physical activity from 40 minutes 90 minutes a week and is now doing regular home programme with his wife as well as attending the follow on cardiac class. He is now that inspired from the team's support that he wants to create his own voice programme to help other visually impaired clients. He has started narrating the home programme and will share with the team once complete. He has improved his confidence and rehabilitation through attending the sessions.

Case Study 5 – Rotherham Active for Health – Cancer Pathway (Rehabilitation and Reablement)
Client MT was diagnosed with cancer, which resulted in some of his thigh muscle being removed. MT was told that he might not be able to walk unaided again. Prior to the diagnosis, MT was active, he was keen to get back to his active lifestyle after following the operation. He picked up on the Active for Health programme at the walk-in centre and took it to his GP, who referred him to the programme. MT has been involved in the programme for over 10 months now and since starting the programme he feels more positive about himself and that he generally feels his wellbeing has improved. MR has said "I am no longer dependant up on his walking during sessions", "I can now complete the full session with no support", he finds it easier to walk, he has more confidence in his walking ability and less fear of falling, he has started gardening again and he enjoys socialising within the group and it has helped increase his confidence. MT has seen great improvements in his independence.

Case Study 6 – Intermediate Care Services
Client admitted to hospital due to TIA, slurred speech and marked weakness in the left upper limb. Client had reduced hip/knee control on the left and weakness of the left shoulder. Client was given an exercise programme to complete independently, and with the support from reablers. This was targeted around improving strength, stability and control around the left shoulder, lower limb strength and control around the left hip. Stairs assessment and practise was completed with 2 rails, client progressing to become independent. Kitchen assessment – completed meal preparation of cutting vegetables and lifting full casserole dish in and out of simulated oven. Support worker continued with the exercise programme given to the client. Client also attended gardening groups – this involved standing to re-plant seedlings using both hands. The support staff also took the client to the local shops where they purchased items for the gardening group from the gardening therapy fund – this aimed to promote community integration. The client was discharge to her own home following 18 days of rehabilitation and no referral to adult care for ongoing support as had gained full independence. On discharge the client was referred to the community stroke team for ongoing therapy. They were also provided with information for ongoing support from Rothercare and Age UK.

Case Study 7 – Intermediate Care Services
Client fell at home, admitted to hospital with hip fracture. Kitchen assessment completed around preparation of drinks and meals, client fatigued quickly. Assessment of washing, dressing and grooming activities assessed, client required assistance with lower half but progressed to becoming fully independent. Client was independent with chair transfers, required minimal assistance to lift legs onto bed, client given a sheet of chair based exercises to complete independently to increase strength and

mobility. Client progressed to being independently mobile with walking frame after 4 days and progressed to step practice with therapy staff as client had internal steps at the property. Support Worker provided ongoing support with standing exercise programmes. Client discharged home after 20 days of rehabilitation with a reablement package to assist with showering and to increase stamina during meal preparation. Client was referred to day rehabilitation to further increase confidence and practice outdoor mobility.

Case study 8 – Active for Health – Falls Pathway (Rehabilitation and Reablement)
The patient suffered a minor stroke, resulting in loss of peripheral vision in left eye and damaging the part of the brain effecting balance and sporadic episodes of dizziness. Following partner bereavement she gradually became withdrawn, disinterested and eventually stopped going out alone, fearing she would fall. The GP initially referred the patient to AFH, following a bad "dizzy spell," leaving her unable to get out of bed for 15 hours. The patient started to attend the sessions and there was a noticeable change immediately. Her daughter stated "Amazing difference, even before the end of the initial 12 weeks". "Even after the very first session, she was totally enthusiastic. There is a significant improvement in her confidence, she's more mentally alert, her concentration has improved and she's generally a much happier person". "I genuinely believe my mum's quality of life has significantly improved, way beyond mine and my sibling's expectations and more importantly, my mum's, due to this programme". "It almost seems impossible such amazing results can be achieved in such a short space of time". The family "feel more confident and less worried about leaving mum alone now, knowing she's happier, having the sessions to look forward to". She is now making her own way to the sessions and gaining independence, she loves the social time as she has made new friends and she is happy to encourage others to follow in her footsteps. The active for health sessions have aided rehabilitation from a fall and supported the patient move from dependence to independence.

20. Engagement with Providers and Stakeholders

20.1 Evidence of Engagement

The Rotherham Health and Wellbeing Board has had consistent and robust representation from Elected Members, Council, CCG, NHS England, General Practitioners, Public Health, main local health providers (TRFT and RDaSH), Police and the voluntary sector (Healthwatch and Voluntary Action Rotherham) which is currently being ratified by the Local Government Association (LGA).. 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.

We now have an Accountable Care System governance arrangements in place with various sub-groups supporting transformation across the health and social care system, including the Acute and Community Transformation Group and BCF groups.

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.

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.

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 is an integral part of all BCF service reviews.

20.2 Engagement with Regional/National Areas

The CCG and Local Authority regularly attends meetings such as South Yorkshire BCF Network meetings, STP Update Meetings, Urgent and Emergency Care Commissioning Steering Boards and Groups and take parts in teleconferences/webinars/seminars to sharing good practice and outcomes

both regionally and nationally. NHS Benchmarking Networks are regularly used to identify improvements in schemes funded by BCF and the commissioning team have recently taken part in the National Audit of Intermediate Care Services in July 2017.

20.3 Provider/Stakeholder Engagement Strategy

This section of the Rotherham Better Care Fund Plan sets out the communication and engagement strategy for 2017-19. 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. This is a continual process designed to ensure that the relevant stakeholder groups are briefed at the right time.

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 forums 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'.

21. Funding Arrangements

21.1 Financial Risk Sharing and Contingencies

There is a risk sharing policy in the Section 75 Partnership Agreement (Appendix 7) 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.

21.2 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. The spend on social care has clear health benefits and supports the overall aim of the BCF plan in reducing hospital admissions, re-admissions, reducing Delayed Transfers of Care, reducing the number of admissions to 24 hour residential care and increasing the proportion of older people living in the community 91 days after hospital discharge.

Total investment in social care from the CCG minimum contribution has increased from £6.5m in 2016/17 to £8.1m in 2017/18, mainly in respect of equipment and adaptations and to meet additional cost pressures arising from the Care Act 2014.

This planned investment remains in 2018/19, with a slight increase of 1.9% in line with the overall increase in BCF funding. 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

	2016/17 Investment	Additional Funding	Total 2017/18	2017/18 Investment by Commissioner			2017/18 SPLIT BY POOL	
BCF Theme				RCCG SHARE	RMBC SHARE	Total	Pool 1 RMBC Hosted	Pool 2 RCCG Hosted
	£000	£000	£000					
THEME 1 - Mental Health Services	790	1	791	791		791		791
THEME 2 - Rehabilitation & Reablement	13,391	779	14,170	10,142	4,028	14,170	14,170	
THEME 3 - Supporting Social Care	3,682		3,682	3,682		3,682		3,682
THEME 4 - Care Mgt & Integrated Care Planning	5,028	11	5,039	5,039		5,039		5,039
THEME 5 - Supporting Carers	690	-40	650	600	50	650		650
THEME 6 - Infrastructure	242	-1	241	241		241		241
Risk Pool	500		500	500		500		500
Improved Better Care Fund	0	7,317	7,317		7,317	7,317	7,317	
TOTAL	24,323	8,067	32,390	20,995	11,395	32,390	21,487	10,903

Table 9: Summary of Investment Profile

BETTER CARE FUND - 2017/18			2017/18
SUMMARY OF INVESTMENTS	**Funding Streams**		**Total**
	RMBC	**RCCG**	
	£'000	**£'000**	**£'000**
THEME 1 - Mental Health Services			
Adult Mental Health Liaison		*791*	**791**
THEME 2 - Rehabilitation & Reablement			
Home Improvement Agency	*15*	*60*	**75**
Falls Service		*444*	**444**
Home Enabling Services		*1,591*	**1,591**
2 SSO reviewing officers to fast track assessments during reablement		*98*	**98**
Community Stroke Service		*181*	**181**
Community Neuro Rehab		*156*	**156**
Breathing Space		*2,346*	**2,346**
Expert Patient Programme		*50*	**50**
Otago Exercise Programme		*20*	**20**
REWS	*92*	*1,293*	**1,385**
Community OT	*372*	*374*	**746**
Disabled Facilities Grant	*2,311*		**2,311**
Age UK Hospital Discharge		*158*	**158**
Stroke Association Service		*50*	**50**
Stroke Social Work Support		*27*	**27**
Intermediate Care Pool	*1,238*	*3,294*	**4,532**
THEME 3 - Supporting Social Care			
Direct Payments		*1,643*	**1,643**
Care Act Implementation		*700*	**700**
Residential Care		*274*	**274**
Learning Disability Services:		*1,065*	**1,065**
THEME 4 - Care Mgt & integrated Care Planning			
GP Case Management		*2,145*	**2,145**
Care Home Support Service		*267*	**267**
Death in Place of Choice		*789*	**789**
Social Prescribing		*760*	**760**
Social Work Support (A&E, Case management, Supported Discharge)		*1,078*	**1,078**
THEME 5 - Supporting Carers			
Day Care Services:		*400*	**400**
Carers Support Service	*50*	*200*	**250**
THEME 6 - Infrastructure			
Joint Commissioning Team		*49*	**49**
IT to support Comm Trans		*192*	**192**
RISK POOL			
Risk pool		*500*	**500**
Improved Better Care Fund			
Sustainability/mitigation of service reduction/transformation	*4,400*		**4,400**
Information Sharing/System Development	*360*		**360**
Leadership capacity for system transformation	*290*		**290**
Discharge Pathways and Patient Flow	*1,250*		**1,250**
Market capacity/sustainability	*955*		**955**
Improved BCF Contingency Fund	*62*		**62**
GRAND TOTAL	***11,395***	***20,995***	***32,390***

21.3 Disabled Facilities Grant (DF)

The DFG is embedded within the 3 year Housing Investment Plan 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 in 2017/19.

The 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 HWB 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

22. Improved Better Care Fund (IBCF)

Rotherham has been allocated a new grant allocation within the 2015 Spending Review and Spring Budget entitled "Improved Better Care Funding" (IBCF) via a Section 31 Grant from the Department of Communities and Local Government (DCLG).

The IBCF funding has not been offset against the contribution from the CCG mimimum contribution, it is a new funding allocation which will meet adult social care needs, reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready, and ensuring that the local social care provider market is supported. This funding will enable Local Authorities to provide stability and extra capacity in local care systems. The grant funding will be pooled within the BCF Section 75 agreement and will be used to meet the National Condition 4 (Managing Transfers of Care).

Rotherham Council's total allocation for the IBCF is £7.318 million in 2017/18 and £10.104 million in 2018/19.

22.1 Grant Conditions of the Improved Better Care Fund

Agreement has been reached between all key stakeholders around the use of the IBCF money that will meet all of the grant conditions set out in the grant determination. These are as follows:

- Meeting adult social care needs
- Reducing pressures on the NHS – including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local care provider market is supported

22.2 Proposals for IBCF and BCF Investment in 2017/18

The proposals for priority areas for investment seek to both meet the grant conditions described above and achieve a balance between off-setting the adult social care budget pressures and strategic investments to achieve greater longer-term financial sustainability, contributing to Rotherham's Better Care Fund Plan.

The proposals for use of the £7.3m BCF funding in 2017/18 are structured as follows:

Investments to ensure the sustainability of adult social care and the local social care provider market

- Reform of care assessment and support planning
- Additional capacity to respond to increasing demand / complexity of care packages
- National Living Wage/Sleep-in Cover

Proposals that support the integrated health and social care priorities within the BCF Plan

- Supporting the DTOC High Impact Change Action Plan
- Investing in the leadership and management capacity to support integrated health/ social care
- Investment in additional reablement capacity
- Developing the Enhanced Care Worker role
- Expanding the Care Home Support Service

Collectively the proposals are designed to reduce the number of permanent admissions to residential and nursing care homes; increase the number of older people still at home 91 days after hospital discharge; reduce the number of delayed transfers of care from hospital; and reduce the total number of emergency admissions/readmissions to hospital. These proposals are expanded below.

22.3 Reform of care, assessment and support planning

Transforming the management, approach and delivery of care assessment and support planning is central to the Council's Medium Term Financial Plan and associated savings targets for adult social care. A detailed Adult Social Care Improvement Plan has been developed (June 2017) which sets out a comprehensive programme of work to strengthen governance; improve the front door to deal with demand better; improve assessment, support planning and review; invest in short term interventions; and re-design the care pathways for long term care and support needs.

The proposed impact of these changes will be stable and capable leadership; continued improvement in the quality and effectiveness of practice; strong and supportive partnerships; robust financial management; a compelling strategy for the workforce; and effective performance information and quality assurance.

Investment in the Improvement Plan will be required in 2017/18 – 2018/19 on an invest-to-save basis. Utilisation of the iBCF grant is appropriate and in line with conditions of use.

22.4 Additional capacity to respond to increasing demand/complexity of care packages

As set out in national policy documents such as the Five Year Forward View, the 2017-19 Integration and Better Care Fund Policy Framework, and Rotherham's Better Care Fund Plan, people are living much longer, often with highly complex needs and multiple conditions. Section 3 above describes the particular set of demand and budget challenges facing adult social care in Rotherham.

The availability of social care is a fundamental element of an effective, integrated health and care system. In the face of growing pressures on social care, additional investment is required to ensure and protect access to packages of care and placements for those who need them.

It is proposed to utilise the iBCF to ensure that those in need continue to receive social care support in the context of increasing volume, complexity and acuity, particularly older people and people with learning disabilities.

22.5 National Minimum Wage/Sleep-in Cover

Many funded packages of care for adults with learning disabilities, in both registered care services and in a person's own home include sleeping in provision. Such packages of care or placements require a member of staff to be present on site overnight to ensure that the person remains safe and has their needs met. However, the member of staff is permitted to sleep and only attend to any needs if required.

Recent case law has established that "sleep-ins" are covered by the National Minimum Wage (NMW) regulations. So even if a worker is allowed to sleep at work, if they are required to stay at their workplace all their hours are covered by NMW regulations.

This means if any worker is paid - on average – less than the National Minimum Wage over their pay reference period they will be entitled to a pay rise. Staff who are paid significantly above the NMW and who do sleep-ins are unlikely to be affected, because their pay will not fall below the NMW on average over the pay reference period.

It is proposed that an additional percentage premium will be added to any inflationary uplift to cover off all NMW changes including the impact of changes to the case law regarding sleep in shifts. New placements will also be made against this premium rate. Whilst this is a recurring cost pressure, this in-year pressure does meet the conditions for iBCF funding and the grant could be used to offset this.

22.6 Supporting the DTOC High Impact Change Action Plan

Rotherham's DTOC performance (all causes) is average at a regional level, masking variations in performance attributable to adult social care and NHS within Rotherham. A jointly agreed High Impact Change Action Plan has been developed (following an independent review of DTOC arrangements) to drive DTOC performance, linked to the third strand of the BCF Plan. The Council proposes to support the action plan using iBCF and BCF funding, including early discharge planning, integrated rapid response, developing the trusted assessor model with social care providers, building capacity of the seven day offer across acute/community services.

22.7 Investing in leadership/management capacity to support integrated health/social care

Together with the CCG, the Council is investing in a series of jointly appointed and funded Assistant Director posts within Children's and Adults services as part of the Joint Commissioning Arrangements strand of the Better Care Fund Plan. This includes a joint commissioning and performance role in Children's Services and three Heads of Commissioning covering Learning Disabilities, Adults and Mental Health.

22.8 Investment in additional reablement capacity

Additional capacity is required in reablement services to reduce delayed transfers of care. It is proposed that the local authority's reablement provision is extended so that it can support the development of integrated localities. The Health Village Pilot is currently developing a reablement service model, which combines the skills and capacity of community therapists and reablement services to reduce reliance on formal care services. By targeting reablement packages at people with social care packages we will be able to drive down the number packages and the unit cost.

22.9 Developing the "Enhanced Care Worker" role

To address the recruitment, retention and quality issues within the social care market, particularly domiciliary care, the Council proposes developing the Enhanced Care Worker role, together with health partners and providers. This will include the administration of medication, supporting community rehabilitation programmes and carrying out baseline health monitoring. As well as potentially widening the scope of support to customers, reducing multiple visits by multiple front line professionals, the role should enable greater integrated working with primary care.

22.10 Expanding the Care Home Support Service

It is proposed that the Care Home Support Service is expanded so that it is able to provide a broader range of support to care home residents. The team can deliver training programmes to care home staff on management of long term conditions, falls prevention, end-of-life care, nutrition/hydration and dementia. They can provide support to care home staff when someone has an urgent care need. These types of interventions will not only improve health outcomes of residents but also support retention of care home staff.

23. Appendices

Ref.	Document	Synopsis and links
Page 5 (embedded document)	**Map of Rotherham**	This map was produced by Rotherham Borough Council to illustrate the 3 locality areas in the North, South and Central area of the borough
Page 7 **(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 8 **(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 8 **(web links provided)**	**Public Health England Fingertip guides**	These guides enables us to track progress and benchmark Rotherham's position against statistically similar areas. https://fingertips.phe.org.uk/profile/older-people-health https://fingertips.phe.org.uk/profile/adultsocialcare
Page 8 **(web links provided)**	**South Yorkshire and Bassetlaw Sustainability and Transformational Plan (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. http://www.smybndccgs.nhs.uk/what-we-do/stp
Page 9 **(web links provided)**	**Rotherham Integrated Health and Social Care Place Plan**	The Integrated Health and Social Care Place Plan details our joined up approach to delivering five key initiatives that will help us achieve our Health and Wellbeing strategic aims and meets the region's STP objectives. http://www.rotherhamccg.nhs.uk/rotherhams-place-plan.htm.
Page 9 **(web links provided)**	**Infographic and Animation System**	This will be used across the health and social care as a key tool in articulating how our five priorities are closely interlinked to deliver better, more accessible services in the coming years. http://preview.beach-design.co.uk/nhs rotherham/
Page 9 **(web links provided)**	**CCG Commissioning Plan 2016-20**	The Commissioning Plan for 2016-20 sets out Rotherham CCG's vision for the next 4 years which includes our purpose, values and priorities and the CCG's contribution to delivering Rotherham's overall Health and Wellbeing Strategy.

Ref.	Document	Synopsis and links
		http://www.rotherhamccg.nhs.uk/our-plan.htm
Page 9 **(web links provided)**	**Rotherham Carers Strategy 2016-21**	The Carers Strategy sets out the intentions and actions necessary to support carers and young carers. http://moderngov.rotherham.gov.uk/mgConvert2PDF.aspx?ID=108721
Page 10 **(web links provided)**	**The Rotherham Plan 2025 (Housing and Community)**	The Rotherham Together Partnership (RTP) has developed a long-term plan setting out partners' shared ambitions for the borough over the next few years. http://rotherhamtogetherpartnership.org.uk/downloads/file/7/the_rotherham_plan_a_new_perspective_2025
Page 13 **(web links provided)**	**Joint Strategic Needs Assessment**	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
Appendix 1 **Page 6**	**BCF Executive Summary**	The BCF Executive Summary gives a brief summary of all strategic priorities contained within the BCF plan.
Appendix 2 **Page 12**	**A&E Delivery Plan**	The Plan sets out the actions for the Rotherham A&E Delivery Board in relation to the key deliverables for Urgent and Emergency Care
Appendix 3 **Page 12**	**Rotherham System Wide Escalation Plan 2017/18 (including winter planning)**	The escalation plan sets out winter planning arrangements for health and social care in Rotherham including resources and capacity put in place to manage the impact of winter pressures
Appendix 4 **Page 15**	**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 5 **Page 47**	**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 **Page 48**	**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 **Page 78**	**Section 75 Partnership Agreement**	The agreement will be signed and agreed by CCG and Local Authority setting out commissioning intentions in the use of the BCF

Planning Template for BCF: due on 11/09/2017

Summary of Health and Well-Being Board 2017-19 Planning Template

Being Board:

Rotherham

Data Submission Period:

2017-19

Summary

<< Link to the Guidance tab

2. HWB Funding Sources

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution exc iBCF	£4,077,793	£4,269,317
Total iBCF Contribution	£7,317,501	£10,103,692
Total Minimum CCG Contribution	£18,592,437	£18,945,693
Total Additional CCG Contribution	£2,402,205	£2,203,949
Total BCF pooled budget	**£32,389,936**	**£35,522,651**

Specific Funding Requirements for 2017-19	2017/18 Response	2018/19 Response
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes
2. In areas with two tiers of local government:		
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?		
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.		
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes

3. HWB Expenditure Plan

Summary of BCF Expenditure (*)	2017/18 Expenditure	2018/19 Expenditure
Acute	£635,000	£500,000
Mental Health	£790,790	£790,790
Community Health	£8,713,916	£8,713,916
Continuing Care	£90,000	£0
Primary Care	£2,145,000	£2,145,000
Social Care	£17,855,431	£22,113,146
Other	£2,159,799	£1,259,799
Total	**£32,389,936**	**£35,522,651**

Summary of BCF Expenditure from Minimum CCG Contribution (***)	2017/18 Expenditure	2018/19 Expenditure
Acute	£0	£0
Mental Health	£790,790	£790,790
Community Health	£7,155,916	£7,155,916
Continuing Care	£0	£0
Primary Care	£2,145,000	£2,145,000
Social Care	£8,123,137	£8,278,137
Other	£1,259,799	£1,259,799
Total	**£19,474,642**	**£19,629,642**

→

Summary of NHS Commissioned Out of Hospital Services Spend from MINIMUM BCF Pool (**)	2017/18 Expenditure	2018/19 Expenditure
Mental Health	£790,790	£790,790
Community Health	£3,738,319	£3,738,319
Continuing Care	£0	£0
Primary Care	£2,145,000	£2,145,000
Social Care	£1,693,231	£1,848,231
Other	£1,259,799	£1,259,799
Total	**£9,627,139**	**£9,782,139**
NHS Commissioned OOH Ringfence	£5,283,443	£5,383,829

Additional NEA Reduction linked Contingency Fund	2017/18 Fund	2018/19 Fund
NEA metric linked contingency fund held from the ringfenced local allocation for NHS OOH spend	£0	£0

BCF Expenditure on Social Care from Minimum CCG Contribution	2016/17	2017/18	2018/19
Minimum Mandated Expenditure on Social Care from the CCG minimum		£6,612,278	£6,737,912
Planned Social Care expenditure from the CCG minimum	£6,496,000	£8,123,137	£8,278,137
Annual % Uplift Planned		**25.0%**	**1.9%**
Minimum mandated uplift % (Based on inflation)		**1.79%**	**1.90%**

4. HWB Metrics

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
Total HWB Planned Non-Elective Admissions	7,395	7,436	7,047	7,016	7,378	7,419	7,029	6,999	**28,893**	**28,824**
HWB Quarterly Additional Reduction Figure	0	0	0	0	0	0	0	0	**0**	**0**
HWB NEA Plan (after reduction)	7,395	7,436	7,047	7,016	7,378	7,419	7,029	6,999	**28,893**	**28,824**
Additional NEA reduction delivered through the BCF									**£0**	**£0**

4.2 Residential Admissions

		Planned 17/18	Planned 18/19
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	**Annual rate**	580	552

4.3 Reablement

		Planned 17/18	Planned 18/19
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**Annual %**	87.8%	89.0%

4.4 Delayed Transfers of Care

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	**Quarterly rate**	1,166	694	694	677	685	692	692	675

5. National Conditions

National Conditions For The BCF 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?
1) Plans to be jointly agreed	Yes	Yes
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes
4) Managing transfers of care	Yes	Yes

Footnotes

* **Summary of BCF Expenditure** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' that have been provided by HWBs in their plans (from the 4. HWB Expenditure Plan tab), where:
Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other

** **Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool** is the sum of the amounts allocated to the 6 individual out of hospital 'areas of spend' that have been provided in tab 4. HWB Expenditure Plan, where;
Area of Spend = Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other (everything other than Acute)
Commissioner = CCG, NHS England or Joint (if joint we use the NHS% of the value)
Source of Funding = CCG Minimum Contribution

***__Summary of BCF Expenditure from Minimum CCG contribution__ is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' form the minimum CCG contribution that have been provided by HWBs in their plans (from the 4. HWB Expenditure Plan tab), where:
Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other
Source of Funding = CCG Minimum Contribution

Planning Template for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: 1. Cover Sheet

<< Link to the Guidance tab

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Health and Well Being Board	**Rotherham**
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Contact Number:	01709 254870
Who signed off the report on behalf of the Health and Well Being Board:	Sharon Kemp and Christopher Edwards

	Role:	**Title and Name:**	**E-mail:**
Area Assurance Contact Details*	Health and Wellbeing Board Chair	Councillor David Roche	david.roche@rotherham.gov.uk
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	Local Authority Director of Adult Social Services (or equivalent)	Anne Marie Lubanski	annemarie.lubanski@rotherham.gov.uk
	Better Care Fund Lead Official	Nathan Aktinson/Claire Smith	nathan.atkinson@rotherham.gov.u
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Please add further area contacts that you would wish to be included in official correspondence -->	CCG Finance Officer	Wendy Allott	wendy.allott@rotherhamccg.nhs.u
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	LA Finance Manager	Mark Scarrott	mark.scarrott@rotherham.gov.uk

***Only those identified will be addressed in official correspondence**

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net **saving the file as 'Name HWB' for example 'County Durham HWB'**

Complete Template

	No. of questions answered
1. Cover	**6**
2. HWB Funding Sources	**31**
3. HWB Expenditure Plan	**16**
4. HWB Metrics	**31**
5. National Conditions	**12**

Planning Template for BCF: due on 11/09/2017

Sheet: 2. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

2017-19

2. HWB Funding Sources

<< Link to the Guidance tab

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Rotherham	£2,310,793	£2,502,317
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Total Minimum LA Contribution exc iBCF	**£2,310,793**	**£2,502,317**

Are any additional LA Contributions being made in 2017/18 or 2018/19? If yes please detail below	Yes	Yes

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
Rotherham	£1,767,000	£1,767,000	
Total Local Authority Contribution	**£4,077,793**	**£4,269,317**	

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Rotherham	£7,317,501	£10,103,692
Total iBCF Contribution	**£7,317,501**	**£10,103,692**

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Rotherham CCG	£18,592,437	£18,945,693
Total Minimum CCG Contribution	**£18,592,437**	**£18,945,693**

Are any additional CCG Contributions being made in 2017/18 or 2018/19? If yes please detail below	Yes	Yes

Additional CCG Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS Rotherham CCG	£2,402,205	£2,203,949	
Total Additional CCG Contribution	**£2,402,205**	**£2,203,949**	

	2017/18	2018/19
Total BCF pooled budget	**£32,389,936**	**£35,522,651**

Funding Contributions Narrative

Specific funding requirements for 2017-19	Response	Response	If the selected response for either year is 'No', please detail in the comments box
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes	
2. In areas with two tiers of local government:			
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?			
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.			
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes	
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes	
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes	
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes	

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend
1	Adult Mental Health Liaison Service	10. Integrated care planning	1. Care planning		Mental Health
2	Home Improvement Agency	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Social Care
3	Home Improvement Agency	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Social Care
4	Care Act Implementation	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Social Care
5	Falls Service	9. High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning		Community Health
6	Home Reablement Services	9. High Impact Change Model for Managing Transfer of Care	3. Multi-Disciplinary/Multi-Agency Discharge Teams		Social Care
7	Reviewing Officers to Fast Track Assessments (LHC)	11. Intermediate care services	4. Reablement/Rehabilitation services		Social Care
8	Community Stroke Service	9. High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning		Community Health
9	Community Neurological Rehabilitation Service	9. High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning		Community Health
10	Breathing Space	9. High Impact Change Model for Managing Transfer of Care	3. Multi-Disciplinary/Multi-Agency Discharge Teams		Community Health
11	Expert Patient Programme	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Other
12	Rotherham Equipment and Wheelchair Service	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Social Care
13	Rotherham Equipment and Wheelchair Service	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Social Care
14	Rotherham Equipment and Wheelchair Service	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Social Care
15	Community Occupational Therapy Services	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Social Care
16	Community Occupational Therapy Services	13. Primary prevention / Early Intervention	3. Other - Physical health/wellbeing		Social Care

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend
17	Disabled Facilities Grant	4. DFG - Adaptations			Social Care
18	Age UK Hospital Discharge Service	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Other
19	Stroke Association Service	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Other
20	Stroke Social Work Support Service	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Social Care
21	Intermediate Care Pooled Budget	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health
22	Intermediate Care Pooled Budget	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health
23	Intermediate Care Pooled Budget	11. Intermediate care services	4. Reablement/Rehabilitation services		Community Health
24	Direct Payments	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Social Care
25	Residential Care	8. Healthcare services to Care Homes	2. Other - Physical health/wellbeing		Social Care
26	Learning Disability Services	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Social Care
27	GP Case Management	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Primary Care
28	Care Home Support Service	8. Healthcare services to Care Homes	2. Other - Physical health/wellbeing		Community Health
29	Death in Place of Choice (Hospice at Home)	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Community Health
30	Otago Exercise Programme	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Social Care
31	Social Prescrbing Programme	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Other
32	Social Work Support (A&E, Case Management, Supported Discharge)	9. High Impact Change Model for Managing Transfer of Care	5. Seven-Day Services		Social Care
33	Risk Pool	16. Other		Contingency	Acute
34	Joint Commissioning Team	16. Other		Commissioning	Other
35	IT to Support Community Transformation	16. Other		Information Sharing	Other
36	Day Care Services	16. Other		Day Care	Social Care
37	Day Care Services	16. Other		Day Care	Social Care
38	Carers Support Services	3. Carers services	1. Carer advice and support		Social Care
39	Carers Support Services	3. Carers services	1. Carer advice and support		Social Care
40	Sustainability & mitigation of service reduction to allow transformation	14. Residential placements	4. Care home		Social Care
41	Sustainability & mitigation of service reduction to allow transformation	14. Residential placements	2. Learning disability		Social Care
42	Sustainability & mitigation of service reduction to allow transformation	6. Domiciliary care at home	1. Dom care packages		Social Care

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend
43	Sustainability & mitigation of service reduction to allow transformation	12. Personalised healthcare at home	2. Other - Physical health / wellbeing		Social Care
44	Sustainability & mitigation of service reduction to allow transformation	10. Integrated care planning	1. Care planning		Social Care

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Summary sheet

Running Balances	2017/18	2018/1
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£4,027,793	£4,219,3
CCG Minimum Contribution balance	-£882,205	-£683,94
Additional CCG Contribution balance	£882,205	£683,94
iBCF	£0	£0

<< Link to Guidance tab

Running Totals	2017/18	2018/1
Planned Social Care spend from the CCG minimum	£8,123,137	£8,278,1
Ringfenced NHS Commissioned OOH spend	£9,627,139	£9,782,1

Expenditure

Scheme ID	Scheme Name	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Adult Mental Health Liaison Service		CCG			NHS Mental Health Provider	CCG Minimum Contribution
2	Home Improvement Agency	Private Sector	Local Authority			Private Sector	CCG Minimum Contribution
3	Home Improvement Agency	Private Sector	Local Authority			Private Sector	Local Authority Social Services
4	Care Act Implementation		Local Authority			Private Sector	Additional CCG Contribution
5	Falls Service		Local Authority			NHS Community Provider	CCG Minimum Contribution
6	Home Reablement Services		Local Authority			Local Authority	CCG Minimum Contribution
7	Reviewing Officers to Fast Track Assessments (LHC)		Local Authority			Local Authority	CCG Minimum Contribution
8	Community Stroke Service		CCG			NHS Community Provider	CCG Minimum Contribution
9	Community Neurological Rehabilitation Service		CCG			NHS Community Provider	CCG Minimum Contribution
10	Breathing Space		CCG			NHS Community Provider	CCG Minimum Contribution
11	Expert Patient Programme	Private Sector	CCG			Private Sector	CCG Minimum Contribution
12	Rotherham Equipment and Wheelchair Service		CCG			NHS Community Provider	CCG Minimum Contribution
13	Rotherham Equipment and Wheelchair Service		CCG			NHS Community Provider	CCG Minimum Contribution
14	Rotherham Equipment and Wheelchair Service		CCG			NHS Community Provider	Local Authority Social Services
15	Community Occupational Therapy Services		Local Authority			NHS Acute Provider	CCG Minimum Contribution
16	Community Occupational Therapy Services		Local Authority			NHS Acute Provider	Local Authority Social Services

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[<< Link to Guidance tab]

Summary sheet

Running Balances	**2017/18**	**2018/1**
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£4,027,793	£4,219,3
CCG Minimum Contribution balance	-£882,205	-£683,94
Additional CCG Contribution balance	£882,205	£683,94
iBCF	£0	£0
Running Totals	**2017/18**	**2018/1**
Planned Social Care spend from the CCG minimum	£8,123,137	£8,278,1
Ringfenced NHS Commissioned OOH spend	£9,627,139	£9,782,1

Expenditure

Scheme ID	Scheme Name	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
17	Disabled Facilities Grant		Local Authority			Local Authority	Local Authority Social Services
18	Age UK Hospital Discharge Service	Charity/Voluntary Sector	CCG			Charity/Voluntary Sector	CCG Minimum Contribution
19	Stroke Association Service	Charity/Voluntary Sector	CCG			Charity/Voluntary Sector	CCG Minimum Contribution
20	Stroke Social Work Support Service		Local Authority			Local Authority	CCG Minimum Contribution
21	Intermediate Care Pooled Budget		Local Authority			Local Authority	Local Authority Social Services
22	Intermediate Care Pooled Budget		Local Authority			NHS Community Provider	CCG Minimum Contribution
23	Intermediate Care Pooled Budget		Local Authority			Local Authority	Additional CCG Contribution
24	Direct Payments		Local Authority			Private Sector	CCG Minimum Contribution
25	Residential Care		Local Authority			Private Sector	CCG Minimum Contribution
26	Learning Disability Services		Local Authority			Private Sector	CCG Minimum Contribution
27	GP Case Management		CCG			NHS Community Provider	CCG Minimum Contribution
28	Care Home Support Service		CCG			NHS Community Provider	CCG Minimum Contribution
29	Death in Place of Choice (Hospice at Home)		CCG			Charity/Voluntary Sector	CCG Minimum Contribution
30	Otago Exercise Programme		Local Authority			Local Authority	CCG Minimum Contribution
31	Social Prescrbing Programme	Charity/Voluntary Sector	CCG			Charity/Voluntary Sector	CCG Minimum Contribution
32	Social Work Support (A&E, Case Management, Supported Discharge)		Local Authority			Local Authority	CCG Minimum Contribution
33	Risk Pool		CCG			NHS Acute Provider	Additional CCG Contribution
34	Joint Commissioning Team	Commissioning	CCG			Local Authority	CCG Minimum Contribution
35	IT to Support Community Transformation	Information sharing	CCG			CCG	CCG Minimum Contribution
36	Day Care Services		CCG			Local Authority	CCG Minimum Contribution
37	Day Care Services		Local Authority			Local Authority	Local Authority Contribution
38	Carers Support Services		Local Authority			Charity / Voluntary Sector	CCG Minimum Contribution
39	Carers Support Services		Local Authority			Charity / Voluntary Sector	Local Authority Contribution
40	Sustainability & mitigation of service reduction to allow transformation		Local Authority			Local Authority	Improved Better Care Fund
41	Sustainability & mitigation of service reduction to allow transformation		Local Authority			Private Sector	Improved Better Care Fund
42	Sustainability & mitigation of service reduction to allow transformation		Local Authority			Private Sector	Improved Better Care Fund

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Summary sheet

Running Balances	2017/18	2018/1
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£4,027,793	£4,219,3
CCG Minimum Contribution balance	-£882,205	-£683,94
Additional CCG Contribution balance	£882,205	£683,94
iBCF	£0	£0

<< Link to Guidance tab

Running Totals	2017/18	2018/1
Planned Social Care spend from the CCG minimum	£8,123,137	£8,278,1
Ringfenced NHS Commissioned OOH spend	£9,627,139	£9,782,1

Expenditure

Scheme ID	Scheme Name	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
43	Sustainability & mitigation of service reduction to allow transformation		Local Authority			Private Sector	Improved Better Care Fund
44	Sustainability & mitigation of service reduction to allow transformation		Local Authority			Local Authority	Improved Better Care Fund

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Scheme ID	Scheme Name	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
1	Adult Mental Health Liaison Service	Both 2017/18 and 2018/19	£790,790	£790,790	Existing
2	Home Improvement Agency	Both 2017/18 and 2018/19	£60,000	£60,000	Existing
3	Home Improvement Agency	Both 2017/18 and 2018/19	£15,000	£15,000	Existing
4	Care Act Implementation	Both 2017/18 and 2018/19	£700,000	£700,000	Existing
5	Falls Service	Both 2017/18 and 2018/19	£443,977	£443,977	Existing
6	Home Reablement Services	Both 2017/18 and 2018/19	£1,591,385	£1,591,385	Existing
7	Reviewing Officers to Fast Track Assessments (LHC)	Both 2017/18 and 2018/19	£98,000	£98,000	Existing
8	Community Stroke Service	Both 2017/18 and 2018/19	£180,970	£180,970	Existing
9	Community Neurological Rehabilitation Service	Both 2017/18 and 2018/19	£155,675	£155,675	Existing
10	Breathing Space	Both 2017/18 and 2018/19	£2,345,712	£2,345,712	Existing
11	Expert Patient Programme	Both 2017/18 and 2018/19	£50,000	£50,000	Existing
12	Rotherham Equipment and Wheelchair Service	Both 2017/18 and 2018/19	£1,218,231	£1,373,231	Existing
13	Rotherham Equipment and Wheelchair Service	Both 2017/18 and 2018/19	£75,000	£75,000	Existing
14	Rotherham Equipment and Wheelchair Service	Both 2017/18 and 2018/19	£92,000	£92,000	Existing
15	Community Occupational Therapy Services	Both 2017/18 and 2018/19	£374,130	£374,130	Existing
16	Community Occupational Therapy Services	Both 2017/18 and 2018/19	£372,000	£372,000	Existing

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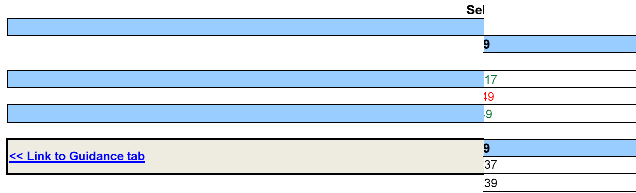

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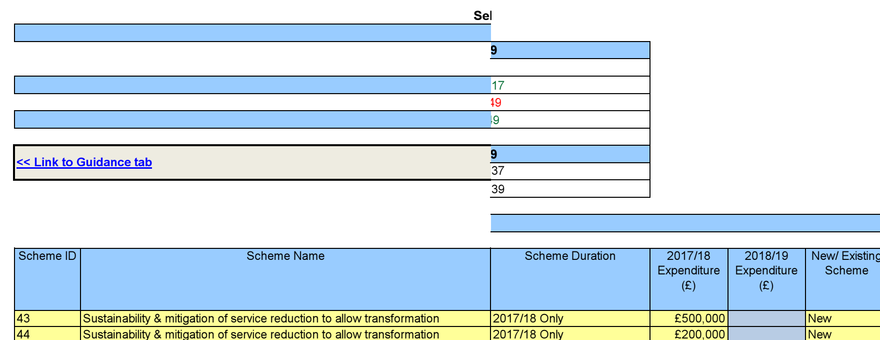
Scheme ID	Scheme Name	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
17	Disabled Facilities Grant	Both 2017/18 and 2018/19	£2,310,793	£2,502,317	Existing
18	Age UK Hospital Discharge Service	Both 2017/18 and 2018/19	£158,321	£158,321	Existing
19	Stroke Association Service	Both 2017/18 and 2018/19	£50,000	£50,000	Existing
20	Stroke Social Work Support Service	Both 2017/18 and 2018/19	£27,000	£27,000	Existing
21	Intermediate Care Pooled Budget	Both 2017/18 and 2018/19	£1,238,000	£1,238,000	Existing
22	Intermediate Care Pooled Budget	Both 2017/18 and 2018/19	£2,973,620	£2,973,620	Existing
23	Intermediate Care Pooled Budget	Both 2017/18 and 2018/19	£320,000	£320,000	Existing
24	Direct Payments	Both 2017/18 and 2018/19	£1,643,000	£1,643,000	Existing
25	Residential Care	Both 2017/18 and 2018/19	£274,000	£274,000	Existing
26	Learning Disability Services	Both 2017/18 and 2018/19	£1,065,000	£1,065,000	Existing
27	GP Case Management	Both 2017/18 and 2018/19	£2,145,000	£2,145,000	Existing
28	Care Home Support Service	Both 2017/18 and 2018/19	£267,174	£267,174	Existing
29	Death in Place of Choice (Hospice at Home)	Both 2017/18 and 2018/19	£788,788	£788,788	Existing
30	Otago Exercise Programme	Both 2017/18 and 2018/19	£20,000	£20,000	Existing
31	Social Prescrbing Programme	Both 2017/18 and 2018/19	£759,996	£759,996	Existing
32	Social Work Support (A&E, Case Management, Supported Discharge)	Both 2017/18 and 2018/19	£1,077,391	£1,077,391	Existing
33	Risk Pool	Both 2017/18 and 2018/19	£500,000	£500,000	Existing
34	Joint Commissioning Team	Both 2017/18 and 2018/19	£49,377	£49,377	Existing
35	IT to Support Community Transformation	Both 2017/18 and 2018/19	£192,105	£192,105	Existing
36	Day Care Services	Both 2017/18 and 2018/19	£400,000	£400,000	Existing
37	Day Care Services	Both 2017/18 and 2018/19	£35,000	£35,000	Existing
38	Carers Support Services	Both 2017/18 and 2018/19	£200,000	£200,000	Existing
39	Carers Support Services	Both 2017/18 and 2018/19	£15,000	£15,000	Existing
40	Sustainability & mitigation of service reduction to allow transformation	2017/18 Only	£2,000,000		New
41	Sustainability & mitigation of service reduction to allow transformation	2017/18 Only	£1,000,000		New
42	Sustainability & mitigation of service reduction to allow transformation	2017/18 Only	£500,000		New



Scheme ID	Scheme Name	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
43	Sustainability & mitigation of service reduction to allow transformation	2017/18 Only	£500,000		New
44	Sustainability & mitigation of service reduction to allow transformation	2017/18 Only	£200,000		New

Planning Template for BCF: due on 11/09/2017

Sheet: 4. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

2017-19

4. HWB Metrics

<< Link to the Guidance tab

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 17/18**	**Total 18/19**
HWB Non-Elective Admission Plan* Totals	**7,395**	**7,436**	**7,047**	**7,016**	**7,378**	**7,419**	**7,029**	**6,999**	**28,893**	**28,824**

Are you planning on any additional quarterly reductions?	No

If yes, please complete HWB Quarterly Additional Reduction Figures

HWB Quarterly Additional Reduction										
HWB NEA Plan (after reduction)										
HWB Quarterly Plan Reduction %										

Are you putting in place a local contingency fund agreement on NEA?	Yes

	2017/18	2018/19
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/contingency fund **	£5,283,443	£5,383,829

Cost of NEA as used during 16/17***	£1,517	Please add the reason, for any adjustments to the cost of NEA for 17/18 or 18/19 in the cells below
Cost of NEA for 17/18 ***	£1,831	£1831 reflects more current price
Cost of NEA for 18/19 ***	£1,831	£1831 reflects more current price

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	**Total 17/18**
Additional NEA reduction delivered through BCF (2017/18)	£0					£0
		Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 18/19**
Additional NEA reduction delivered through BCF (2018/19)	£0					£0
HWB Plan Reduction % (2017/18)	0.00%					
HWB Plan Reduction % (2018/19)	0.00%					

The CCG Total Non-Elective Admission Plans are taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 10/07/2017

* This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

would expect the value of the contingency fund to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: xxxx insert allocation document

*** Please use the following document and amend the cost if necessary: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

4.2 Residential Admissions

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	808.1	771.9	580.2	552.1	In order to provide customers with greater independence and choice, admission to 24 hour care is provided only for those people who can no longer have their needs met by remaining at home in the community. Final year end admissions data as at end of March 2017 reflected 329 new admissions, this was a significant improvement from the 401 admitted in 2015/16. The first quarter of 2017/18 shows 45 new admissions recorded to date, which is within Quarter 1 target
	Numerator	401	390	297	287	
	Denominator	49,625	50,524	51,186	51,982	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-Being Boards.

4.3 Reablement

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	89.6%	91.0%	87.8%	89.0%	The 2016/17 outturn reflected a slight decrease to 87.5% from the 2015/16 outturn of 89.6%. Although, the performance has shown a fall, a positive is that the total number of people using the service (in the sample period) increased from 135 to 144. This demonstrates the total number of people who are benefitting from increased rehabilitation beds capacity is on an upward trend, but the service is being used for more complex people and this has made the
	Numerator	121	132	158	162	
	Denominator	135	145	180	182	

4.4 Delayed Transfers of Care

		16-17 Actuals				17-18 plans				18-19 plans				
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	678.1	671.2	760.0	1103.8	1166.5	694.1	694.1	676.9	684.6	691.9	691.9	675.1	The DTOC trajectory has been set to meet the national requirement for not more than 9.4 people in total delayed in hospital per 100,000 adults. This also incorporates the relevant split between social care, NHS and joint delays. The trajectory represents a decrease on current performance, underpinned by a shared action plan across all partners.
	Numerator (total)	1,390	1,376	1,558	2,271	2,400	1,428	1,428	1,397	1,413	1,428	1,428	1,397	
	Denominator	204,995	204,995	204,995	205,748	205,748	205,748	205,748	206,394	206,394	206,394	206,394	206,937	

Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a DTOC rate for these two Health and Well-Being Boards.

Planning Template for BCF: due on 11/09/2017

Sheet: 5. National Conditions

Selected Health and Well Being Board:

Rotherham

Data Submission Period:

2017-19

5. National Conditions

<< Link to the Guidance tab

National Conditions For The Better Care Fund 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?	If the selected response for either year is 'No', please detail in the comments box issues and/or actions that are being taken to meet the condition.
1) Plans to be jointly agreed	Yes	Yes	
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes	
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes	
4) Managing transfers of care	Yes	Yes	

CCG to Health and Well-Being Board Mapping for 2017-19

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.2%	87.9%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	7.0%	8.5%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.3%	0.5%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.2%	3.0%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.0%	0.1%
E09000003	Barnet	07M	NHS Barnet CCG	91.0%	92.5%
E09000003	Barnet	07P	NHS Brent CCG	1.9%	1.7%
E09000003	Barnet	07R	NHS Camden CCG	0.9%	0.6%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000003	Barnet	07X	NHS Enfield CCG	2.9%	2.4%
E09000003	Barnet	08D	NHS Haringey CCG	2.1%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	08H	NHS Islington CCG	0.2%	0.1%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.5%	98.2%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	93.7%	98.3%
E06000022	Bath and North East Somerset	11H	NHS Bristol CCG	0.3%	0.8%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	12A	NHS South Gloucestershire CCG	0.0%	0.1%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.5%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.6%
E09000004	Bexley	07N	NHS Bexley CCG	93.5%	89.4%
E09000004	Bexley	07Q	NHS Bromley CCG	0.0%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.4%	1.5%
E09000004	Bexley	08A	NHS Greenwich CCG	7.6%	8.8%
E09000004	Bexley	08L	NHS Lewisham CCG	0.1%	0.1%
E08000025	Birmingham	13P	NHS Birmingham Crosscity CCG	91.9%	53.3%
E08000025	Birmingham	04X	NHS Birmingham South and Central CCG	96.8%	24.3%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	3.0%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	40.4%	18.8%
E08000025	Birmingham	05P	NHS Solihull CCG	15.2%	3.0%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	89.0%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.6%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.7%	97.5%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.5%	2.5%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.6%
E08000001	Bolton	00V	NHS Bury CCG	1.4%	0.9%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000028 & E06000029	Bournemouth & Poole	11J	NHS Dorset CCG	45.9%	100.0%
E06000036	Bracknell Forest	10G	NHS Bracknell and Ascot CCG	82.1%	94.6%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.1%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.1%	0.1%
E06000036	Bracknell Forest	11C	NHS Windsor, Ascot and Maidenhead CCG	1.8%	2.3%
E06000036	Bracknell Forest	11D	NHS Wokingham CCG	1.4%	1.9%

E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.4%	18.6%
E08000032	Bradford	02W	NHS Bradford City CCG	99.4%	22.2%
E08000032	Bradford	02R	NHS Bradford Districts CCG	97.9%	57.9%
E08000032	Bradford	02T	NHS Calderdale CCG	0.2%	0.0%
E08000032	Bradford	02V	NHS Leeds North CCG	0.6%	0.2%
E08000032	Bradford	03C	NHS Leeds West CCG	1.7%	1.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.2%	2.4%
E09000005	Brent	07P	NHS Brent CCG	89.9%	86.5%
E09000005	Brent	07R	NHS Camden CCG	4.0%	2.9%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.2%	0.7%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000005	Brent	08E	NHS Harrow CCG	5.8%	4.0%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.5%	2.8%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.1%
E06000023	Bristol, City of	11E	NHS Bath and North East Somerset CCG	0.1%	0.0%
E06000023	Bristol, City of	11H	NHS Bristol CCG	94.4%	97.9%
E06000023	Bristol, City of	12A	NHS South Gloucestershire CCG	3.7%	2.1%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.7%	95.1%
E09000006	Bromley	07V	NHS Croydon CCG	1.1%	1.3%
E09000006	Bromley	08A	NHS Greenwich CCG	1.5%	1.2%
E09000006	Bromley	08K	NHS Lambeth CCG	0.1%	0.1%
E09000006	Bromley	08L	NHS Lewisham CCG	2.0%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Y	NHS Aylesbury Vale CCG	91.3%	35.3%
E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	10H	NHS Chiltern CCG	96.0%	59.7%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.8%	0.4%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.7%
E10000002	Buckinghamshire	10T	NHS Slough CCG	2.8%	0.8%
E10000002	Buckinghamshire	11C	NHS Windsor, Ascot and Maidenhead CCG	1.3%	0.4%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.1%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	14L	NHS Manchester CCG	0.7%	2.1%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.7%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.5%	98.9%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	72.0%	96.7%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.4%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.5%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.2%	0.3%
E09000007	Camden	07P	NHS Brent CCG	1.3%	1.9%
E09000007	Camden	07R	NHS Camden CCG	84.0%	89.2%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.8%	4.8%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.3%	3.1%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.3%	0.2%
E06000056	Central Bedfordshire	10Y	NHS Aylesbury Vale CCG	2.0%	1.5%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.8%	95.2%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.8%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.3%	1.9%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.4%	50.4%
E06000049	Cheshire East	04J	NHS North Derbyshire CCG	0.4%	0.3%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	05N	NHS Shropshire CCG	0.1%	0.0%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.5%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.3%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.7%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	1.9%	1.2%

E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.1%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.3%	29.3%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.9%	69.3%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E09000001	City of London	07R	NHS Camden CCG	0.2%	6.4%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.0%	1.8%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	72.7%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.0%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.9%
E09000001	City of London	08Y	NHS West London (K&C & QPP) CCG	0.0%	0.1%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	99P	NHS North, East, West Devon CCG	0.4%	0.6%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.2%	52.6%
E06000047	County Durham	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.6%	46.1%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.4%	99.9%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.3%	0.1%
E09000008	Croydon	07Q	NHS Bromley CCG	1.6%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.4%	93.3%
E09000008	Croydon	09L	NHS East Surrey CCG	3.0%	1.3%
E09000008	Croydon	08K	NHS Lambeth CCG	2.9%	2.8%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.5%	0.4%
E10000006	Cumbria	01H	NHS Cumbria CCG	97.4%	100.0%
E10000006	Cumbria	01K	NHS Morecambe Bay CCG	0.2%	0.0%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.2%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.1%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.0%	0.1%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.5%
E06000015	Derby	04R	NHS Southern Derbyshire CCG	50.0%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	8.0%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	03X	NHS Erewash CCG	92.4%	11.3%
E10000007	Derbyshire	03Y	NHS Hardwick CCG	94.6%	12.3%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	2.0%	0.5%
E10000007	Derbyshire	04J	NHS North Derbyshire CCG	98.2%	35.9%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.3%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.2%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	04R	NHS Southern Derbyshire CCG	48.2%	33.1%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	14.0%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	99P	NHS North, East, West Devon CCG	70.1%	80.6%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	99Q	NHS South Devon and Torbay CCG	51.1%	18.5%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.4%	0.5%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.7%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%

E10000009	Dorset	11J	NHS Dorset CCG	52.5%	95.9%
E10000009	Dorset	11X	NHS Somerset CCG	0.6%	0.7%
E10000009	Dorset	11A	NHS West Hampshire CCG	2.0%	2.5%
E10000009	Dorset	99N	NHS Wiltshire CCG	0.8%	0.9%
E08000027	Dudley	13P	NHS Birmingham Crosscity CCG	0.3%	0.6%
E08000027	Dudley	05C	NHS Dudley CCG	93.2%	90.8%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	3.9%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.7%	0.2%
E09000009	Ealing	07P	NHS Brent CCG	1.7%	1.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000009	Ealing	07W	NHS Ealing CCG	86.8%	90.7%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.8%	3.0%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.8%	3.6%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.4%	85.0%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.5%	8.1%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.5%	6.6%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.7%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.6%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.8%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.1%	1.3%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.5%
E09000010	Enfield	07X	NHS Enfield CCG	95.4%	90.8%
E09000010	Enfield	08D	NHS Haringey CCG	7.7%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.2%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.3%	11.6%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.7%	0.7%
E10000012	Essex	08F	NHS Havering CCG	0.3%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.6%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.6%
E10000012	Essex	08N	NHS Redbridge CCG	3.0%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.3%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.4%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.1%	19.7%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.9%	97.9%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.1%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	12A	NHS South Gloucestershire CCG	0.3%	0.1%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.5%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.1%	4.2%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	88.7%	89.7%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.2%	4.7%
E09000012	Hackney	07R	NHS Camden CCG	0.8%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.4%	94.4%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.6%
E09000012	Hackney	08H	NHS Islington CCG	4.4%	3.6%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.6%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.2%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.6%	1.0%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.2%

E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.1%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.4%	2.4%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	90.4%	87.7%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.7%
E09000013	Hammersmith and Fulham	08X	NHS Wandsworth CCG	0.1%	0.2%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.4%	7.2%
E10000014	Hampshire	10G	NHS Bracknell and Ascot CCG	0.7%	0.0%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.6%	14.5%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	10M	NHS Newbury and District CCG	5.9%	0.5%
E10000014	Hampshire	10N	NHS North & West Reading CCG	0.9%	0.0%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.4%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	16.0%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.4%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.5%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.3%	1.1%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.8%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.1%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.4%
E10000014	Hampshire	11D	NHS Wokingham CCG	0.6%	0.0%
E09000014	Haringey	07M	NHS Barnet CCG	1.1%	1.5%
E09000014	Haringey	07R	NHS Camden CCG	0.6%	0.5%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08D	NHS Haringey CCG	87.8%	91.5%
E09000014	Haringey	08H	NHS Islington CCG	2.4%	2.0%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.3%
E09000015	Harrow	07P	NHS Brent CCG	3.6%	4.8%
E09000015	Harrow	07W	NHS Ealing CCG	1.2%	1.9%
E09000015	Harrow	08E	NHS Harrow CCG	89.7%	84.4%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	2.0%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.5%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.5%	99.5%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.3%	2.8%
E09000016	Havering	08F	NHS Havering CCG	91.7%	96.4%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.1%
E09000016	Havering	08N	NHS Redbridge CCG	0.6%	0.7%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.1%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	10Y	NHS Aylesbury Vale CCG	0.4%	0.0%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	96.9%	46.6%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.4%	0.1%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.6%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.1%	50.8%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.3%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.8%	0.2%
E09000017	Hillingdon	10H	NHS Chiltern CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.3%	1.9%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	89.9%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.0%	0.9%

E09000018	Hounslow	07W	NHS Ealing CCG	5.7%	7.8%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.0%	0.7%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.2%	86.8%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.6%	3.9%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.6%	5.2%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.5%	0.4%
E09000019	Islington	07T	NHS City and Hackney CCG	3.3%	4.1%
E09000019	Islington	08D	NHS Haringey CCG	1.3%	1.6%
E09000019	Islington	08H	NHS Islington CCG	89.4%	88.7%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.4%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.2%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.0%	1.2%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	63.8%	93.1%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.2%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.9%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.2%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.1%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.0%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	12.9%
E10000016	Kent	10D	NHS Swale CCG	99.9%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.2%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.3%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.5%	98.6%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	87.1%	95.6%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.1%	1.3%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.9%	1.5%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.7%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.7%
E08000034	Kirklees	03C	NHS Leeds West CCG	0.3%	0.2%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.2%
E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.8%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.5%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.8%
E09000022	Lambeth	07R	NHS Camden CCG	0.1%	0.1%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.8%	0.5%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08K	NHS Lambeth CCG	85.9%	92.6%
E09000022	Lambeth	08R	NHS Merton CCG	1.1%	0.6%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.8%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.6%	3.8%

E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.0%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.3%	1.8%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01H	NHS Cumbria CCG	1.4%	0.6%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.5%	11.8%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	17.1%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	99.8%	12.9%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.1%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.0%	8.8%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.8%	0.2%
E08000035	Leeds	02W	NHS Bradford City CCG	0.6%	0.0%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.7%	0.3%
E08000035	Leeds	02V	NHS Leeds North CCG	96.4%	24.2%
E08000035	Leeds	03G	NHS Leeds South and East CCG	98.4%	31.7%
E08000035	Leeds	03C	NHS Leeds West CCG	97.9%	43.0%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.3%	2.0%
E06000016	Leicester	04C	NHS Leicester City CCG	92.5%	95.3%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.7%	2.7%
E10000018	Leicestershire	03V	NHS Corby CCG	0.6%	0.0%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.4%	39.9%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.5%	4.2%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.6%	1.1%
E10000018	Leicestershire	04R	NHS Southern Derbyshire CCG	0.7%	0.5%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	52.9%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.4%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.1%	1.9%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.3%	0.3%
E09000023	Lewisham	08L	NHS Lewisham CCG	91.8%	92.4%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.8%	3.8%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.0%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.0%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.5%	30.5%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	2.6%	0.6%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.8%	19.6%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.3%	16.2%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.7%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.3%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.2%	4.4%
E06000032	Luton	06P	NHS Luton CCG	97.3%	95.6%
E08000003	Manchester	00V	NHS Bury CCG	0.3%	0.1%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	14L	NHS Manchester CCG	90.9%	95.5%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.6%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.1%	1.6%
E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	94.0%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.1%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%

E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.9%
E09000024	Merton	08J	NHS Kingston CCG	3.5%	3.0%
E09000024	Merton	08K	NHS Lambeth CCG	1.0%	1.6%
E09000024	Merton	08R	NHS Merton CCG	87.5%	81.1%
E09000024	Merton	08T	NHS Sutton CCG	3.4%	2.7%
E09000024	Merton	08X	NHS Wandsworth CCG	6.6%	10.8%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.2%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.1%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.3%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.6%	95.1%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	6.0%	4.1%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.5%	0.3%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08M	NHS Newham CCG	96.6%	97.7%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.7%	12.3%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.7%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	23.8%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.9%	25.4%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.5%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.6%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.1%	1.4%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	97.2%	96.8%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.6%	1.5%
E06000024	North Somerset	11H	NHS Bristol CCG	0.3%	0.6%
E06000024	North Somerset	11T	NHS North Somerset CCG	99.1%	97.7%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.0%	96.3%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.4%	8.3%
E10000023	North Yorkshire	01H	NHS Cumbria CCG	1.2%	1.0%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.4%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.5%	22.9%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.9%	26.2%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.0%
E10000023	North Yorkshire	02V	NHS Leeds North CCG	3.0%	1.0%
E10000023	North Yorkshire	03G	NHS Leeds South and East CCG	0.5%	0.2%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.7%	18.7%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%

E10000021	Northamptonshire	10Y	NHS Aylesbury Vale CCG	0.1%	0.0%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.1%	9.7%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	1.9%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.2%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	84.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.2%	1.1%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	01H	NHS Cumbria CCG	0.0%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	1.0%	0.7%
E06000057	Northumberland	00L	NHS Northumberland CCG	98.0%	98.6%
E06000018	Nottingham	04K	NHS Nottingham City CCG	89.7%	95.3%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.7%	2.0%
E06000018	Nottingham	04M	NHS Nottingham West CCG	4.3%	1.2%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.3%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.3%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	03X	NHS Erewash CCG	7.6%	0.9%
E10000024	Nottinghamshire	03Y	NHS Hardwick CCG	5.0%	0.6%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	98.0%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.6%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.3%	4.6%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.0%	17.3%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	90.5%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.4%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04R	NHS Southern Derbyshire CCG	0.6%	0.4%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.6%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	10Y	NHS Aylesbury Vale CCG	6.1%	1.8%
E10000025	Oxfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10M	NHS Newbury and District CCG	0.1%	0.0%
E10000025	Oxfordshire	10N	NHS North & West Reading CCG	2.0%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.3%	96.6%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.6%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	22.8%	96.3%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.1%	3.7%
E06000026	Plymouth	99P	NHS North, East, West Devon CCG	29.2%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.4%	1.3%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.6%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.3%	0.3%
E06000038	Reading	10N	NHS North & West Reading CCG	61.6%	36.2%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E06000038	Reading	10W	NHS South Reading CCG	79.8%	60.6%
E06000038	Reading	11D	NHS Wokingham CCG	3.1%	2.7%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	5.6%	3.8%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.5%	1.8%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.6%	88.7%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.4%	3.2%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.0%	1.0%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.4%	99.0%

E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.4%	0.4%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.9%	7.0%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.5%	1.4%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	91.7%	90.5%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000005	Rochdale	00V	NHS Bury CCG	0.6%	0.6%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.5%	96.6%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.4%	3.2%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	1.0%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.3%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.4%
E06000017	Rutland	03V	NHS Corby CCG	0.3%	0.6%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.8%	85.7%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.7%	11.9%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.5%
E08000006	Salford	00T	NHS Bolton CCG	0.3%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.9%	1.4%
E08000006	Salford	14L	NHS Manchester CCG	0.9%	2.2%
E08000006	Salford	01G	NHS Salford CCG	94.0%	94.8%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000028	Sandwell	13P	NHS Birmingham Crosscity CCG	3.0%	6.2%
E08000028	Sandwell	04X	NHS Birmingham South and Central CCG	0.2%	0.2%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	54.0%	89.2%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.3%
E08000014	Sefton	01T	NHS South Sefton CCG	96.1%	51.8%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.9%	41.8%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	03Y	NHS Hardwick CCG	0.4%	0.0%
E08000019	Sheffield	04J	NHS North Derbyshire CCG	0.7%	0.3%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.3%	0.1%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.6%	99.2%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.4%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.4%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.6%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.5%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.3%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.1%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.8%	0.3%
E06000039	Slough	10H	NHS Chiltern CCG	3.1%	6.5%
E06000039	Slough	09Y	NHS North West Surrey CCG	0.0%	0.1%
E06000039	Slough	10T	NHS Slough CCG	96.6%	93.1%
E06000039	Slough	11C	NHS Windsor, Ascot and Maidenhead CCG	0.4%	0.4%
E08000029	Solihull	13P	NHS Birmingham Crosscity CCG	1.9%	6.2%
E08000029	Solihull	04X	NHS Birmingham South and Central CCG	0.4%	0.6%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05L	NHS Sandwell and West Birmingham CCG	0.0%	0.1%
E08000029	Solihull	05P	NHS Solihull CCG	83.6%	92.1%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.3%	0.4%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11T	NHS North Somerset CCG	0.9%	0.3%
E10000027	Somerset	99P	NHS North, East, West Devon CCG	0.3%	0.5%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.0%

E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.6%	0.5%
E06000025	South Gloucestershire	11H	NHS Bristol CCG	5.0%	8.9%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	12A	NHS South Gloucestershire CCG	95.1%	88.7%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.7%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.7%	4.6%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.7%	95.4%
E09000028	Southwark	07R	NHS Camden CCG	0.4%	0.3%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.2%	1.4%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.7%
E09000028	Southwark	08L	NHS Lewisham CCG	2.0%	1.8%
E09000028	Southwark	08Q	NHS Southwark CCG	94.4%	88.7%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.1%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.1%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.0%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	13P	NHS Birmingham Crosscity CCG	0.5%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.0%	14.6%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	04J	NHS North Derbyshire CCG	0.7%	0.2%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.5%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.0%	0.4%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.1%	23.7%
E10000028	Staffordshire	04R	NHS Southern Derbyshire CCG	0.5%	0.3%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.6%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.9%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.3%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.7%	0.9%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	14L	NHS Manchester CCG	1.1%	2.2%
E08000007	Stockport	01W	NHS Stockport CCG	95.0%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.3%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.4%	0.5%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.9%	98.6%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.4%	0.6%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.1%	97.0%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.3%	16.4%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.8%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.1%	0.4%
E10000029	Suffolk	07H	NHS West Essex CCG	0.1%	0.0%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.1%	29.7%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.9%	0.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.8%
E08000024	Sunderland	00J	NHS North Durham CCG	2.2%	2.0%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.4%	0.2%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.1%

E10000030	Surrey	10G	NHS Bracknell and Ascot CCG	1.7%	0.2%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.2%	0.4%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	17.0%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.5%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.6%	0.2%
E10000030	Surrey	08J	NHS Kingston CCG	4.4%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.3%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.4%	29.4%
E10000030	Surrey	08P	NHS Richmond CCG	0.6%	0.1%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.1%	23.8%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.9%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E10000030	Surrey	11C	NHS Windsor, Ascot and Maidenhead CCG	8.5%	1.1%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.4%	3.3%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.4%	6.7%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.4%	2.0%
E09000029	Sutton	08T	NHS Sutton CCG	94.5%	85.6%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.2%	0.3%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.2%	98.3%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.7%	1.4%
E08000008	Tameside	14L	NHS Manchester CCG	2.3%	5.9%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.8%
E08000008	Tameside	01W	NHS Stockport CCG	1.7%	2.2%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.1%	88.1%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.7%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.1%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.2%	0.2%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000034	Thurrock	08F	NHS Havering CCG	0.2%	0.3%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	99.2%
E06000027	Torbay	99Q	NHS South Devon and Torbay CCG	48.9%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.4%	0.3%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.9%	0.9%
E09000030	Tower Hamlets	08H	NHS Islington CCG	0.1%	0.1%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	97.5%
E08000009	Trafford	14L	NHS Manchester CCG	2.7%	6.9%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	02A	NHS Trafford CCG	95.6%	92.8%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.9%	0.6%
E08000036	Wakefield	03G	NHS Leeds South and East CCG	1.0%	0.8%
E08000036	Wakefield	03C	NHS Leeds West CCG	0.1%	0.2%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.1%
E08000030	Walsall	13P	NHS Birmingham Crosscity CCG	1.8%	4.6%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.2%
E08000030	Walsall	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.1%	0.0%
E08000030	Walsall	05Y	NHS Walsall CCG	92.7%	90.6%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.4%	1.3%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.3%	0.3%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.2%	1.6%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.6%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.9%	0.5%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	3.0%	3.2%
E09000032	Wandsworth	08R	NHS Merton CCG	2.9%	1.7%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.8%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.3%	93.1%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.6%	0.4%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.3%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.8%	96.9%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.3%
E10000031	Warwickshire	13P	NHS Birmingham Crosscity CCG	0.2%	0.2%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.2%	21.5%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.8%	0.2%
E10000031	Warwickshire	05P	NHS Solihull CCG	0.6%	0.3%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.2%	45.5%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.7%	30.9%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	10M	NHS Newbury and District CCG	93.2%	66.4%
E06000037	West Berkshire	10N	NHS North & West Reading CCG	35.3%	23.5%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	10W	NHS South Reading CCG	8.7%	7.5%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E06000037	West Berkshire	11D	NHS Wokingham CCG	0.1%	0.1%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.2%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.7%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	13.9%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.0%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.7%	25.8%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.1%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.6%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	1.9%
E09000033	Westminster	07R	NHS Camden CCG	3.0%	3.4%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	80.4%	71.2%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000033	Westminster	08K	NHS Lambeth CCG	0.1%	0.2%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.4%	23.2%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.2%
E08000010	Wigan	01G	NHS Salford CCG	0.9%	0.7%
E08000010	Wigan	01X	NHS St Helens CCG	3.8%	2.3%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.7%	0.9%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.6%

E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.8%	0.3%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	10M	NHS Newbury and District CCG	0.8%	0.2%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12A	NHS South Gloucestershire CCG	0.9%	0.5%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.2%	0.6%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	96.8%
E06000040	Windsor and Maidenhead	10G	NHS Bracknell and Ascot CCG	12.3%	10.8%
E06000040	Windsor and Maidenhead	10H	NHS Chiltern CCG	0.6%	1.2%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.1%
E06000040	Windsor and Maidenhead	10T	NHS Slough CCG	0.6%	0.6%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E06000040	Windsor and Maidenhead	11C	NHS Windsor, Ascot and Maidenhead CCG	88.1%	85.5%
E06000040	Windsor and Maidenhead	11D	NHS Wokingham CCG	1.3%	1.3%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	10G	NHS Bracknell and Ascot CCG	3.2%	2.6%
E06000041	Wokingham	10N	NHS North & West Reading CCG	0.2%	0.1%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E06000041	Wokingham	10W	NHS South Reading CCG	11.5%	9.5%
E06000041	Wokingham	11D	NHS Wokingham CCG	93.5%	87.4%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.4%	1.6%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.7%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.5%	3.6%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.8%	93.2%
E10000034	Worcestershire	13P	NHS Birmingham Crosscity CCG	0.4%	0.5%
E10000034	Worcestershire	04X	NHS Birmingham South and Central CCG	2.5%	1.3%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.8%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	1.0%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.9%	27.9%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05P	NHS Solihull CCG	0.5%	0.2%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.1%	49.0%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.4%	18.7%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.1%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.2%	99.9%

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Rotherham Health & Wellbeing Board

Meeting:	Health & Wellbeing Board
Date:	20 September 2017
Title:	Rotherham Improved Better Care Fund 2017-19
Report of:	Rotherham Metropolitan Borough Council
Author:	Nathan Atkinson, Assistant Director Strategic Commissioning, Adult Care and Housing

1.0 Purpose of this report

1.1 The purpose of this report is to update the Rotherham Health and Wellbeing Board on the key content of the submission of the Rotherham Improved Better Care Fund Plan for 2017-19. This was submitted to NHS England on 11 September 2017 by Rotherham Metropolitan Borough Council with agreement from Rotherham Clinical Commissioning Group as to the content.

2.0 Background information

2.1 The Department of Health (DH) and the Department for Communities and Local Government (DCLG) published a detailed policy framework for the implementation of the Better Care Fund (BCF) in 2017-18 and 2018-19. This was developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England.

2.2 The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF). The Spring Budget 2017 announced an additional £2 billion to support adult social care in England. This money is included in the IBCF grant to local authorities and has to be included in local BCF pooled funding and plans.

2.3 The 2015 Spending Review set out the Government’s intention that, by 2020, health and social care will be more fully integrated across England. BCF plans must set out how CCGs and local authorities are working towards fuller integration and better co-ordinated care, both within the BCF and in wider services. Narrative plans should set out the joint vision and approach for integration, including how the work in the BCF plan complements the direction set in the Next Steps on the NHS Five Year Forward View, the development of Sustainability and Transformation Partnerships (STPs), the requirements of the Care Act (2014) and wider local government transformation in the area covered by the plan.

3.0 Policy requirements

3.1 The grant conditions for the IBCF require that a grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more

people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

3.2 Under the IBCF a recipient local authority must:

- pool the grant funding into the local Better Care Fund, unless an area has written Ministerial exemption;
- work with the relevant Clinical Commissioning Group and providers to meet national condition four (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and
- Provide quarterly reports as required by the Secretary of State.

3.3 The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans for spending the grant have been locally agreed with Clinical Commissioning Groups involved in agreeing the Better Care Fund plan.

4.0 Timetable

4.1 The submission and assurance process will follow the timetable below:

Milestone	Date
BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local authorities). All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net .	11 September 2017
Scrutiny of BCF plans by regional assurers	12 – 25 September 2017
Regional moderation	25 September 2017
Cross regional calibration	2 October 2017
Approval letters issued giving formal permission to spend (CCG minimum)	6 October 2017
Escalation panels for plans rated as not approved	10 October 2017
Deadline for areas with plans rated approved with conditions to submit updated plans.	31 October 2017
All Section 75 agreements to be signed and in place	30 November 2017
Government will consider a review of 2018-19 allocations of the IBCF grant provided at Spring Budget 2017 for areas that are performing poorly. This funding will all remain with local government, to be used for adult social care.	30 November 2017

5.0 The IBCF allocations of the additional funding for adult social care

5.1 The allocation of additional funding for adult social care in Rotherham under the IBCF is highlighted in the table below. This is tapered funding and therefore investments must be sustainable within the budget allocation for the three year period.

Local authority	2017-18 Additional funding for adult social care announced at Budget 2017	2018-19 Additional funding for adult social care announced at Budget 2017	2019-20 Additional funding for adult social care announced at Budget 2017
Rotherham	6,227,348	3,844,207	1,902,941

5.2 In addition to the IBCF, a further allocation of £1.09m was made available through the Better Care Fund for 2017/18. This has also formed part of the wider IBCF plan.

6.0 Rotherham IBCF Plan Overview

6.1 Rotherham has been allocated the new IBCF grant allocation within the 2015 Spending Review and Spring Budget via a Section 31 Grant from the Department of Communities and Local Government (DCLG). The new funding allocation will meet adult social care needs, reduce pressures on the NHS, including supporting more people to be discharged from hospital when they are ready, and ensuring that the local social care provider market is supported. This funding will enable Local Authorities to provide stability and extra capacity in local care systems. The grant funding will be pooled within the BCF Section 75 agreement and will be used to meet the National Condition 4 (Managing Transfers of Care).

6.2 The Rotherham IBCF Plan has five themed areas:

1) Sustainability and mitigation of service reduction, to allow transformation
2) Information Sharing / system development
3) Leadership capacity for system transformation
4) Discharge pathways and patient flow
5) Market capacity / sustainability

6.3 The first Quarterly monitoring returns on use of IBCF funding from Rotherham was submitted to DCLG on 21 July 2017. This was a high level submission, outlining challenges to meeting the national condition of a 3.5% improvement in DTOC metrics.

7.0 Rotherham IBCF Plan – Narrative and Budget Allocation

7.1 The full submission of the Rotherham IBCF, including detailed action plans within the themes and a financial break down of each formed the basis of the 11 September 2017 return to NHS England. £6.2m is allocated for 2017/18 and this is detailed below.

7.2 The first theme of the plan centres on ***Sustainability and mitigation of service reduction, to allow transformation***. This has four elements:

7.2.1 Adult Care within Rotherham is facing considerable budget pressures and also projected savings for further budget reductions over the next two years. There is a significant projected overspend for 2017/18 (circa £5.3m) and scoping work has indicated that a number of planned Adult Care savings plans may not be realised in full. In order to support the wider health system, it is imperative the frontline functions of Adult Care are sustainable. It is therefore proposed to utilise £4m from the IBCF to mitigate against adverse impacts across all cohorts supported by Adult Care.

7.2.2 Social work assessments drive the social care system. It has been identified that there is a need for a temporary increase in capacity within the locality social work teams in response to demand pressures and increased case complexity. It is therefore proposed to recruit three temporary social workers to provide additional capacity during 2017/18 for complex high cost cases at a total cost of £200,000.

7.2.3 Adult Care within Rotherham is undergoing an improvement journey to further refine and develop assessment processes and the wider customer journey pathways. In order to support this critical activity, it is proposed to invest £100,000 in short term, time limited consultancy to inform social care transformation. The consultants will devise an operating model that embeds the principles of the Care Act 2014, with prevention and self-management at the core, whilst ensuring that the model supports health integration, complimenting initiatives within the established Better Care Fund.

7.2.4 Rotherham has an excellent national reputation for embracing the wholescale use of social prescribing by GPs to support people with long term conditions and mental ill-health. The service is run by Voluntary Action Rotherham (VAR) and it is proposed to invest a further £100,000 in the model. This investment will increase the social prescribing offer to support low level mental health and social isolation for adults within the Borough. This investment will also enable alternative referral routes to be trailed alongside the traditional GP pathway.

7.3 ***Information Sharing / system development*** forms a crucial part of the plan and is fundamental in terms of improving communication, removing duplication and providing the basis for informed decision making.

7.3.1 The Rotherham Accountable Care System partners have been working with consultants to develop an initial tool to provide population segmentation based on actual data from across the partners to forecast future demand and costs. The first phase has been concluded with the tool being produced. However, this requires further refinement and development to inform systems planning under the Rotherham Integrated Health and Social Care Plan. It is proposed to invest a further £100,000 on the tool and further support to inform a Target Operating Model for the whole Accountable Care System.

7.3.2 The Council implemented the initial phase of the Liquid Logic case management system for children and adult social care in late 2016. The system provides excellent reporting capabilities and has the potential to deliver increased functionality. It is proposed that £90,000 is invested to further develop officer skills to provide tactical / operational performance management reporting from within the Liquid Logic case management system.

7.3.3 Rotherham was an early adopter of the system wide escalation management tool known as EMS. This has proved effective in alerting relevant

professionals to escalation issues across the Health and Social Care System. The local health economy (TRFT Community and Acute, RDaSH, Social Care, Out of Hours, Yorkshire Ambulance Service) each has an agreed set of EMS triggers which correspond to a series of actions proportionate to the degree of pressure in the system. The online tool has the capability to produce reports which analyse trends in escalation (i.e. days, weeks months of the year), it can also highlight particular triggers that are continually causing concern and provides a teleconference facility including the ability to disseminate actions agreed on the escalation calls to all partners. The intention is to further develop and enhance the system with an investment of £70,000

7.3.4 The 2016 HSJ award winning initiative SEPIA portal enables professionals to see patient demographics, including live views of Accident and Emergency attendees, lab results, admissions to hospital and discharge dates for patients across the community. The system is currently limited to NHS employees for access. The intention is to invest £100,000 to enhance the SEPIA portal to incorporate social care data enabling access for social workers and other frontline professionals based at the hospital and also within integrated community settings.

7.4 ***Leadership capacity for system transformation*** will be crucial in order to oversee the necessary strategic programmes of work to support

7.4.1 In order to increase the pace and scale of health and social care integration, it is proposed to create the time limited (two year) role of Deputy Director for Adult Care, Integration and Transformation with £100,000 set aside for this. The role holder will be responsible for aligning the operational/tactical aspects of adult care with the wider health system, particularly the Rotherham Foundation Trust and RDaSH, with the role covering all aspects of the Rotherham Integrated Health and Social Care Plan.

7.4.2 It is proposed to invest £100,000 in the development of a place based finance approach and model utilising the expertise of a specialist consultant in this area. This supports the wider ambitions of the Accountable Care System to take a whole system approach to finance and to ensure that investment and disinvestment decisions are considered not just from a single organisational perspective. Further, investment will be predicated on an established evidence base of return on investment in terms of improved patient outcomes and system savings.

7.4.3 The integrated locality pilot - ‘The village’ is in Rotherham’s town centre. The pilot was established in July 2016 and covers 31,000 patients in one of the existing seven localities. It showcases multi-disciplinary working between primary care, social care, secondary care, social care, mental health, community services and the voluntary sector, reducing the reliance on the acute sector. The aim is to provide seamless care to the designated GP practice cluster population, ensuring the individual receives coordinated care from a single case management plan and lead professional. It is proposed to invest £30,000 in the evaluation of the effectiveness of the pilot to inform further roll out.

7.4.4 It is proposed to invest £60,000 in the creation of two year time limited joint partnership provider post between the Council and the Rotherham Foundation Trust to support integration initiatives. The role holder would focus on community service transformation and further development of the locality roll out.

7.5 The Plan focuses on a series of initiatives to support ***Discharge pathways and patient flow:***

7.5.1 An investment of £60,000 is proposed to create a Rotherham Place Delayed Transfers of Care (DTOC) Project Manager role. The aim of the role holder will be to design an integrated approach to discharge pathways and to facilitate further multidisciplinary working with a whole system ethos.

7.5.2 The Council and the Rotherham Foundation Trust commissioned an external review via the Local Government Association/NHS England in April 2017 to explore effective discharge pathways and patient flow. The review identified good practice, but highlighted a number of areas for further review. This resulted in a DTOC action plan being produced and agreed by all parties. It is proposed to invest £25,000 in additional external support to guide implementation of the agreed DTOC action plan

7.5.3 Colleagues in Sheffield have benefited greatly from external support to strengthen discharge pathways and improve DTOC performance. This was in two phases; the first involved an extensive external review, followed by a second phase which focused on organisational development of DTOC staff across organisations. This has led to significant service and performance improvements. It is proposed to replicate the phase two Sheffield approach regarding organisational development of DTOC staff (the review phase has already been carried out in Rotherham as highlighted above). It is envisaged that up to £50,000 will be required for this activity to be provided by an external organisation.

7.5.4 £200,000 will be invested in additional reablement capacity from the independent sector to support winter pressures. Reablement is a crucial part of front end of social care and is critical in terms of rehabilitating people to prevent a decline in independence and a reliance on more comprehensive care packages. Currently, the in-house service has limited capacity and this can inadvertently cause delays or lead people to access permanent packages prematurely. The additional capacity will enable a faster discharge process and a greater volume of people benefiting from the intensive support. This has benefits across the whole system. The proposed provision also has a built in trusted assessor model, which will help contribute to longer term ambitions to develop more blended roles and utilise a wide range of professionals to conduct assessments. The effectiveness of the independent sector model will be evaluated, with consideration of future commissioning intentions predicated on an evidence base.

7.5.5 A number of hospital delays are attributed to a perceived lack of night support provision for people in their own homes. The current model is predicated on a domiciliary care model with limited capacity from an independent sector care provider. It is proposed to invest £100,000 in alternative models of support that will provide a menu of choice for hospital social work teams and facilitate improved discharge performance, including investment into the hospital's Rapid Response service.

7.5.6 £400,000 has been assigned to resource winter pressures bed capacity. This will act as a contingency fund to respond to bed pressures following the anticipated winter demand surge. The specific investment has not yet been defined as the aim is that this budget can be used by system partners to

respond flexibly to where it is required. In previous years this has funded independent sector provision.

7.5.7 Rotherham has an ambition to put in place an enhanced domiciliary care model which will loosely be based on the successful Buurtzorg model from the Netherlands, blending aspects of the district nursing and domiciliary care worker roles. This approach is now being trailed in parts of the UK. The intention in Rotherham is to prepare for a new delivery model through the development of an enhanced competency framework with the existing domiciliary care providers. An investment of £100,000 will enable independent sector workers to be trained to carry out low level health tasks and deliver reablement interventions as part of an ongoing package of care in readiness for a new service offer in 2019.

7.5.8 The Rotherham branch of Age UK successfully delivers the ‘Back to Home’ service for hospital patients who require short-term, low level support when they are discharged. The service is very popular, but it only has capacity to support patients in the Wards. It is proposed to invest £90,000 to extend this offer to patients in the Urgent Care unit and in the Assessment Units. This will facilitate effective discharges and prevent delays in the system which may not be efficiently and expediently met by other professionals.

7.6 In order for adult social care to be viable and effective there must be a focus on ***Market capacity / sustainability***

7.6.1 As highlighted in the discharge pathways section above, there is an intention to develop alternative models for night provision that are not solely based on domiciliary care. £30,000 has been allocated to develop a new delivery model and implement a wider strategy for night provision that embraces the use of assistive technology such as Just Checking and communication tools such as Skype for Business.

7.6.2 There is a need to ensure that there is sufficient capacity within the domiciliary care market within the existing service model. There is a wider ambition articulated above for a new delivery model, though this will not go live until 2019. However, the development of a joint strategy for domiciliary care should mitigate unintended competition within the borough and explore pricing strategies to incentivise increased capacity within the market. £30,000 has been set aside for any potential uplifts needed.

7.6.3 Facilitated engagement with the care home sector will need to take place to actively encourage development of more nursing beds within the borough and specialist services such as for bariatrics where there is extremely limited provision. £30,000 has been proposed to fund any pilot schemes or pump prime a provider to develop a new service offer where there is a pressing service demand.

7.7 A further allocation of **£1.09m** was made available through the **Better Care Fund for 2017/18**. This has also formed part of the wider IBCF plan, with the focus on the themes pertaining to discharge pathways and patient flow, aligned to market capacity/sustainability.

7.7.1 A further investment of £225,000 in additional external reablement capacity from the independent sector. This extends the pot for the commissioned service referenced in 7.5.4 above, thereby enabling a wider cohort to benefit from the provision during the winter period.

7.7.2 The independent sector, primarily care homes and domiciliary providers are experiencing financial pressures with front line staff costs due to further increases in the National Living Wage from April 2017. It is therefore intended to provide funding to support fee increases where there is demonstrable evidence of financial hardship across all adult cohorts. A budget of £456,000 has been set aside for this purpose.

7.7.3 Following recent legal precedents and changes to Her Majesty's Revenue & Customs (HMRC) rules in relation to sleep in arrangements, providers can no longer charge a flat rate for sleep in services when supporting people with Learning Disabilities or Mental ill-health. Support workers must now be paid an hourly rate for the full sleep in period at National Minimum Wage or above. Consequently, the Council has been approached by the majority of providers for increases to honour these commitments. This equates to £400,000 and monies will be used to ensure that provision is sustainable.

8.0 Recommendations

8.1 That the Health and Wellbeing Board notes the content of this report.

Rotherham CAMHS Local Transformation Plan (LTP) Update Reports for Quarter 4 (2016/17) and Quarter 1 (2017/18).

In October of 2015, the CCG was required to produce a CAMHS LTP, in conjunction key partners, which would outline how the ambitions of the 'Future in Mind' document would be taken forward in Rotherham.

This was produced and submitted in October of 2015 and signed off by NHS England. A CAMHS LTP Action Plan was also produced, reflecting the 'Local Priority Schemes' outlined in the LTP, and detailing how these schemes would be implemented. This is updated on a regular basis to ensure that the individual schemes are being progressed.

Each quarter, the CCG is required to produce an update for NHS England, outlining progress with the LTP. This comprises 3 documents:-

- **The update report** – which goes through each 'Local Priority Scheme' and provides a general overview of progress.
- **An Issues & Risks to Delivery report** – which outlines key risk areas relating to the LTP and any mitigating actions.
- **A Financial Assurance Document** – which clarifies the areas of expenditure in the LTP and whether this is on track.

The attached papers are the updates for Quarter 4 of 2016/17 and Quarter 1 of 2017/18.

In addition, the CCG is required to 'refresh' the LTP every October. For 2017/18 there is no requirement to produce a Quarter 2 update as this will coincide with the 'refresh' in October.

The 'refresh' will be taken to the Health & Wellbeing Board for sign-off, before being submitted to NHS England.

Nigel Parkes
4th September, 2017

CCG NAME: Rotherham				Planned Spend 16/17 **				Actual Spend 16/17 **				
	Local Priority Scheme (LPS) Reference / number *	Local Priority Scheme (LPS) Description *	Funding Source/Stream (use drop down menu)	Planned Spend Q1 16/17	Planned Spend Q2 16/17	Planned Spend Q3 16/17	Planned Spend Q4 16/17	Actual Spend Q1 16/17	Actual Spend Q2 16/17	Actual Spend Q3 16/17	Actual Spend Q4 16/17	Commentary (including details of any slippages against plan
1	1	Intensive Community Support Service	LTP Funding	42500	42500	42500	42500	42500	42500	42500	42500	Includes the funding for LPS 2
2	2	Crisis response	LTP Funding	0	0	0	0	0	0	0	0	Funding for this is included in LPS 1
3	3	Autism Spectrum Disorder (ASD) Post diagnosis Support	LTP Funding	13500	13500	13500	13500	13500	13500	13500	13500	
4	4	Prevention/Early Intervention	LTP Funding	0	0	0	0	0	0	0	0	Original LPS from 2015/16. Now picked up in other areas.
5	5	Family Support Service	LTP Funding	17500	17500	17500	17500	17500	17500	17500	17500	
6	6	Workforce Development	LTP Funding	0	0	0	0	0	0	0	0	Original LPS from 2015/16. Now picked up in other areas.
7	7	Hard to reach Groups	LTP Funding	0	0	0	0	0	0	0	0	Original LPS from 2015/16. Now picked up in other areas.
8	8	Looked After Children (LAC)	LTP Funding	0	0	0	0	0	0	0	0	Original LPS from 2015/16. Now picked up in other areas.
9	9	Provision of Advocacy Services	LTP Funding	5000	5000	5000	5000	5000	5000	5000	5000	
10	10	Child Sexual Exploitation (CSE)	LTP Funding	12500	12500	12500	12500	12500	12500	12500	12500	
11	11	Increased General Capacity	LTP Funding	20000	20000	20000	20000	20000	20000	20000	20000	
12	12	Increased Funding for Out of Hours services	LTP Funding	7500	7500	7500	7500	7500	7500	7500	7500	
13	13	Single Point of Access	LTP Funding	8750	8750	8750	8750	8750	8750	8750	8750	
14	14	Interface & Liaison Post	LTP Funding	13750	13750	13750	13750	13750	13750	13750	13750	
15	15	24/7 Liaison Mental Health		0	0	0	0	0	0	0	0	Capital funding only in 2015/16
16	16	CYPIAPT	CYP - IAPT Funding	18500	18500	0	0	18500	18500	18500	18500	
17	17	Eating Disorder Service	ED Funding	34750	34750	34750	34750	34750	34750	34750	34750	
18	18	Transition	LTP Funding	0	0	0	0	0	0	0	0	
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30												

* Please ensure the LPS refererence/number and description entered above matches the details in the latest version of your LTP Plan

** Please note cells for planned and actual spend have been restricted to a maximum £500,000.

Funding Source/Stream	Spend
ED Funding	Minimum: 0
LTP Funding	Maximum: 500,000
CYP - IAPT Funding	
New Investment (NHS)	
New Investment (Local Authority)	
New Investment (Criminal Justice)	
New Investment (Schools)	
New Investment (Voluntary Sector)	
New Investment (Other)	

CAMHS Transformation Plans – Issues and risks to delivery Q4 2016/17

Please complete for any issues or risks that prevented or delayed the delivery of your 2016/17 Local Priority Schemes (LPS) in Q4 2016/17

CCG Name: Rotherham

LPS Number	Description of local priority scheme	Description of issue of risk to delivery of 2016/17 plan	Mitigating Actions	*Date expected to deliver
1	CAMHS Intensive Community Support	That the service is not able to be provided 7 days per week.	Further work is ongoing to ensure that the service is fully developed alongside the Crisis service. The service is working closely with Children & Young People to determine appropriate hours of service delivery.	31st March, 2018
2	Enhanced Crisis Response (Including Liaison)	That the 8pm to 8am all age Crisis service will not be able to be provided, particularly in respect of the contribution required from the Adult Crisis service.	Discussions are continuing between the CAMHS and Adult services to ensure that an all age service is developed.	30th June, 2017
6	Workforce Development	A Workforce Development Strategy is not developed and a screening tool is not rolled out.	Other work is ongoing across Yorkshire & Humberside to develop a workforce development plan and 'best practice' will be adopted.	30th September, 2017
13	Single Point of Access (SPA)	The SPA is not properly established.	Discussions are continuing with the Local Authority.	30th September, 2017
18	Transition from CAMHS to Adult	A Transition specification and robust process is	A CAMHS Transition specification has	30th September,

	services	not agreed and implemented in 2016/17.	not been agreed but a group has been formed to take forward the whole area of Transition. A national CQUIN is also in place for this area.	2017
Please insert more lines as needed				

*Please highlight in red any areas not delivered by 30th June 2016 that were planned for delivery or spending during Q1 2016/17.

NHS Rotherham CCG - CAMHS Local Transformation Plan - Update Report Quarter 4, 2016/17

1. Progress to date –

a. General progress made in respect of implementation of the plan.

Progress with the Rotherham LTP continues to be closely monitored through the LTP Action Plan, which is updated on a bi-monthly basis and 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 33 during January and February of Quarter 4. Of these, 22 required urgent assessments and there was 1 admission to an Inpatient facility. In February there were 4 referrals for looked After Children.

RDaSH CAMHS is continuing to develop the monitoring information relating to the Intensive Community Support service and this will be more qualitative in future.

The numbers of Rotherham children & young people in inpatient facilities remained at a low level during Quarter 4. This was 2 at the end of February 2017.

The CCG is continuing to work with other CCGs in the Yorkshire & Humberside region and NHS England to develop a framework for collaborative commissioning.

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 January & February of Quarter 4, there were 3 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 it is still planned that this will be phased out and replaced with an all-age Crisis service from June 2017. It will also link to the Intensive Community Support service and be provided from 8pm to 8am. In January & February of Quarter 4, there were 2 face to face assessments out of hours and 2 telephone assessments by RDaSH CAMHS.

Local Priority Scheme 3 – Autism Spectrum Disorder (ASD) Support

From 1st January 2017, all the team were in post and systems have been established. Clinical supervision arrangements between RDaSH CAMHS and RMBC have been finalised, and monthly supervision sessions for the two Autism Family Practitioners have been ongoing from February 2017.

New diagnosis referrals are being made to the team by RDaSH CAMHS and the Child Development Centre (CDC). Alongside the contact and support offered to families with a new diagnosis, the service offers a number of advice sessions for families with previous diagnosis, has taken over the organisation of parent workshops - 'The Basics' - and facilitated the delivery of the spring term 2017 workshop. Analysis of the feedback from course attendees has been carried out by the team, and will be used to inform future course content. The team are also looking at delivering further, more in depth, courses around Teenagers with autism and 'Foundations for Communication' for Parents.

The Family Practitioners have attended a 4 day course in Sensory Integration and Behaviour, with a view to offering further support to families around the sensory needs of children with autism. This will be complimented by the training being delivering to educational settings and the workshops being delivered by the Children's Disability Team Family Service (aimed at families of children with any disability – 2 x 6 week workshops over 2016/17).

Four further sensory training workshops were offered this quarter, and sensory kits have been distributed to the majority of parent and school attendees. The impact of this work is being monitored. A further 6 workshops will be offered in 2017-18.

The 32 sensory assessments carried out in the scoping project and their impact on families and education is currently being evaluated with a report to be produced by the end of May 2017.

A booklet for families (green book) 'Basic strategies to support children with Autism and other social communication difficulties (for families) has been produced to sit alongside the Autism Communication Team book for schools (blue book) 'Basic strategies to support children with Autism and other social communication difficulties (for educational settings). The green book is shared at the appointment after diagnosis on an individual basis, focussing on the areas identified as greatest need. Cases will remain open with the service until the age of 25 so that families can return as their children change. Young people from 18 upwards may contact the service themselves for advice.

Alongside RDaSH CAMHS, the team are developing links and working closely with a range of other services such as the Autism Communication Team, Schools, RMBC Early Help, RMBC Childrens Disability Social Care team, RMBC locality social work teams, Young Women's Christian Association (YWCA) and Rotherham Parents Forum Ltd.

The team have also had contact with practitioners working in Adult Mental Health teams regarding support for adults with autism. A practitioner also attended a meeting relating to the All Age Autism Partnership Strategy in Rotherham, and has contributed to the development of a local strategy to support people of all ages who have a diagnosis of autism.

Local Priority Scheme 4 – Prevention/Early Intervention

Six schools in Rotherham signed up to a 'Whole School Approach' pilot in 2015/16. Action Plans' continued to be rolled out in 2016/17 and full reviews will be undertaken in July 2017.

Schools are making good progress to deliver on their action plans. Officers from RMBC meet with all six schools on a one to one basis each term to hear about progress and offer support to further develop the whole school approach. All schools attend a Steering Group meeting once a term which enables them to learn from each other and share good practice.

Each school has chosen their priority areas based on local need. Their action plans reflect two or three areas within the whole school model. See link below for further information;

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf.

Examples of schools activity include:

- Student Voice- creation of Student Ambassadors who attend Academy SLT
- Targeted work with vulnerable groups
- Initiatives to promote staff wellbeing
- Working with families of vulnerable individuals
- Workforce development initiatives

Some schools are working closely with their primary schools to roll out the whole school approach, involving them in partnership meetings.

The schools will all be participating in a good practice learning event involving all Rotherham schools which will be held in the autumn term of 2017/18. All schools are looking at sustaining this work beyond the pilot scheme and evaluation of the scheme within each school is ongoing.

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. An additional Peer Support Worker has been recruited to the service (and plans are in place to recruit more) and 4 volunteers have been identified and have attended induction training. Subject to DBS checks they will start volunteering. These volunteers have all benefited from the service themselves.

37 families were supported in Quarter 4, (giving a total for the year of 69) with a total of 51 children (giving a total for the year of 86). Most families had 1 child supported and the majority were aged 5 to 11 as was seen in previous Quarters, although in Quarter 4 there were more children in the 8 to 11 age group. Of the children supported, 35 were male & 16 female. This gender split is similar to that seem for previous quarters. A very high proportion of the cases supported related to ASD (31).

The Parents Forum continues to work closely with a wide range of providers and other stakeholders across Rotherham and one of the co-ordinators also works with the Autism Post Diagnostic support Team (Local Priority Scheme 3).

The service has successfully worked through initial challenges with other services concerning trust and in quarter 4 there were cases where other services referred families to the Rotherham Parents Forum service.

Local Priority Scheme 6 – Workforce Development

Rotherham is represented on the Early Years/Schools and Colleges Task and Finish Group (NHS England CYP Mental Health & Emotional Wellbeing Clinical Network Group) which is looking at producing a competency framework for staff working in all these settings. Once complete this Y&H work will inform a wider framework for anyone working with (paid or voluntary) or caring for children and young people in Rotherham (e.g. foster carers).

Local Priority Scheme 7 – Hard to reach groups – Completed.

Local Priority Scheme 8 – Looked After Children

The pilot, which prioritised the treatment of LAC in the CAMHS service, finished at the end of quarter 4. An evaluation paper will be prepared during quarter 1 of 2017/18.

During quarter 4 there was only 1 LAC referred to the CAMHS service and their assessment was 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 in supporting LAC in Rotherham and to avoid duplication of effort.

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 continue to benchmark themselves against the recommendation which came out of the scoping work and have prepared an action plan to take forward work on the gaps identified.

Funding is continuing in 2016/17 for the Healthwatch Rotherham advocacy service for children & young people. As at the end of quarter 4, the service had 11 active cases, 6 for children & young people between 0 and 9 years old and 5 for those between 9 and 18 years old. The advocacy work covered a range of services including; CAMHS, the Child Development Centre (CDC), The Rotherham Foundation Trust and children's continuing care services.

Local Priority Scheme 10 – Increased funding for working with children & young people and adults affected by Child Sexual Exploitation.

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 4 to date (January & February), the CSE pathway had 3 first appointments and 38 follow-up contacts with CAMHS patients and 2 first appointments and 10 follow-up contacts with Adult patients.

The service also had 62 consultations in Quarter 4 to date (January & February) with other services about CAMHS patients and 30 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 is also (by its nature) closely linked to the 'hard to reach' and 'vulnerable' groups in priority scheme 7 and there are challenges relating to engagement with these groups.

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 is still delayed.

A meeting is being organised to revisit the proposed change. The delay has mainly been due to changes in personnel or absence from work of key people who were driving the change.

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.

The CCG has committed to fund two Psychological Wellbeing Practitioners (PWPs) from 2018/19. These PWPs have been identified and will commence training in April 2017, funded by Health Education England. It is expected that these posts will be able to provide some direct patient support/interventions later in 2017/18.

Local Priority Scheme 17 – Eating Disorders Service

The ‘Hub & Spoke’ Eating Disorder Service, established jointly with Doncaster CCG and North Lincolnshire CCG, is now in place and all staff have been recruited.

The South Yorkshire Eating Disorder Association (SYEDA) is jointly providing services alongside RDaSH.

Numbers being referred to the RDaSH service remain relatively low, although they are in line with expectations for the first year, and total 30 for the year (6 urgent and 24 non-urgent). RDaSH have promoted the service widely and hosted an official service launch at the Kimberworth place facility on the 25th January, 2017.

SYEDA have undertaken a number of ‘awareness raising sessions’ throughout the year which have been attended by participants from Social care (7), GP Practices (212), Health Professionals (61), Education (9) and ‘Other’ (10). Participants totalled 299.

It is not believed that the low referral numbers are due to access problems and the CCG is working with the providers involved to revisit the care pathway to ensure that it is ‘fit for purpose’.

Local Priority Scheme 18 – Transition from CAMHS to Adult services

A Transition ‘Task & Finish’ group has been established to oversee work in this area, including representation from the Local Authority, statutory and voluntary mental health services and the commissioners. This is using the Yorkshire and Humber transitions toolkit as a basis for taking forward this area.

The CCG is also proposing to fund, from 2017/18, 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. Some non-recurrent funding was used to fund a scoping exercise for this piece of work. See section 7.c below.

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.

A new service is to be developed from 2017/18 providing education and support around anxiety. This is seen as a significant contributor to self-harm in children & young people.

2. Key outcomes and achievements delivered by the LTP in 2016/17.

- **Intensive Community Support Pathway (Local Priority Scheme 1) –** The establishment of an intensive community support pathway, with an ongoing maintained caseload to provide support to children & young people in the community. Rotherham had the lowest level of Inpatient admissions in South Yorkshire and Bassetlaw for 2016, with 8.4 per 100,000 population. This is compared to other CCGs as follows; Sheffield – 29.19, Bassetlaw – 33.01, Doncaster - 42.15 and Barnsley - 20.92.
- **ASD Post diagnosis support service (Local Priority Scheme 3)** – The implementation of the ASD post diagnosis support service. This was highlighted as a significant gap in provision and the service is now supporting newly diagnosed children and young people and their families, in the family environment. The service links well with the Autism Communication Team (ACT) which supports children & young people whilst at school. The service also interfaces well with the RDaSH CAMHS service and the Rotherham Parents Forum, which deals with a high percentage of families with children with Autism pre and post diagnosis.
- **Family Support Service (Local Priority Scheme 5)** – Further development of the family support service and an increasing number of families being supported, some of which are then going on to support other families in turn. The work of the Rotherham Parents Forum is seen as ground-breaking in this area and an example of national good practice.
- **Referrals of Looked After Children (LAC) to the RDaSH CAMHGS service. (Local Priority Scheme 8)** - The pilot for processing all referrals of LAC to the CAMHS service as urgent has enabled both the CAMHS service and Looked After and Adopted Childrens Therapeutic Team (LAACTT) to gain a better understanding of the numbers of LAC In the system and what support is being provided. This has been particularly important in terms of ensuring that there is no duplication of effort and that LAC are receiving the appropriate level of interventions. The two teams have now forged much closer links. It has also allowed the LAACTT to recognise a need for increased capacity, which is now being put in place.
- **Future commitment by the CCG to increased capacity in prevention and early intervention work –** Through its commitment to support the recruitment and training (funded by Health Education England) of two Psychological Wellbeing Practitioners (PWPs), the CCG is making a real commitment to increasing the capacity of the RDaSH CAMHS service to tackle lower level mental health issues and provide early intervention support. The continued development of the RDaSH CAMHS Locality Workers and their 'Advice and Consultation' work with schools in particular is also supporting this area of work.

- **Waiting Times –** The CCG has worked hard with RDaSH CAMHS to reduce the numbers of Children & Young People without an assessment appointment booked. This was a significant number in April 2016, as outlined in Section 3 above, but has been systematically reduced and is now at a manageable level. There has also been a significant reduction in 'long waiters' over the last year.

3. Areas of most challenge in implementation.

- **Staff Recruitment & Retention** continues to be less of an issue than in the past and the RDaSH CAMHS service is generally only affected by the normal turnover/sickness of staff, although a general reconfiguration across the whole trust (see below) has impacted recently with changes in the roles of the senior CAMHS Managers. However, the CCG continues to have regular (bi-weekly) update meetings to monitor progress in the CAMHS service.

- **Mental Health Provider overall reconfiguration** – The main mental health provider in Rotherham is still undertaking a major reconfiguration of its services. The CCG is working closely with the provider to ensure that this does not affect the further development of the CAMHS service.

- **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, and at the end of Quarter 4 this was only 30. 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 4, the average waiting time for an assessment was 3.6 weeks and for treatment 7.0 weeks.

- **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. The CCG requested that the CAMHS service complete an exercise to outline thresholds it applies and how these relate to other service provision. This piece of work has been delayed due to change of CAMHS service managers, but remains a priority for the CCG.

- **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.

4. Finance and activity review.

All of the Rotherham 2015/16 and 2016/17 LTP allocations were spent on improving services.

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 4 to date (January & February) the CAMHS service received 362 referrals, of which 11 were inappropriate and returned to the referrer and 183 were signposted to other services.

Local Priority Scheme 14 – CAMHS Interface & Liaison post

In Quarter 4 to date (January & February), 12 referrals were made from the acute hospital to the Liaison nurse. All of these had a joint TRFT/RDaSH Discharge plan.

5. 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. The last meeting was on the 26th April, but minutes are not yet available to be included in this report. A copy of the minutes from the meeting on the 18th January, 2017 was included in the Quarter 3 report.

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.

6. Eating Disorders –

See Local Priority Scheme 17 above for a general update on this area.

7. Children and Young Peoples Mental Health Additional Allocation

a. Distribution of the 'Basic Strategies to Support Children with Autism and Other Social Communication Difficulties' support documentation (£5,000)

How the money has been used? - The extra funding was used to print a further 3,000 'green' and 'blue' books, with inserts containing further reading/websites, to support newly diagnosed families and those with a previous diagnosis.

What outcomes have been delivered? – The booklets are being used as a focus for discussion and handed out to families during advice/consultation appointments by the family practitioners. Those for education settings are being shared as a 'First Wave' resource by the Learning Support Service and Autism Communication Team as well as being handed out as part of Understanding Autism training.

What evidence there is to support the delivery of the outcomes? - Numbers are being collated, verbal and informal feedback is very positive and formal evaluations are to be completed.

b. Purchase of Sensory Kits for children with Autism. Training Packages for support staff and volunteers. (£6,500)

How the money has been used? – 150 sensory kits were purchased.

What outcomes have been delivered? – The kits will be used by families who have attended sensory workshops and will help with proprioception dysfunction. The kits will support families work at home.

What evidence there is to support the delivery of the outcomes? – This will follow once the workshops have been delivered.

c. Scoping Exercise by the Children, Young People and Families Consortium (CYP & F C) for the Social Prescribing Service for CYP (£10,000)

How the money has been used? - The funds were used to pay for dedicated personnel time and associated costs to undertake the scoping work required. This involved undertaking desk research, literature reviews, the setting up and carrying out a number of interviews and conversations: 1:1, focus group and stakeholder input / consultation.

What outcomes have been delivered? – The outcome has been a clear, well researched and informed report that makes a number of recommendations for a social prescribing service for young people transitioning CAMHS, for whom a 'social prescription' may be an appropriate route. Some conclusions from the report are detailed below:

> "Young people, parents, practitioners and managers raised concerns about the overall availability and the variable quality of mental health provision including CAMHS. Key examples cited included inadequate transition arrangements and a lack of services post CAMHS. However, examples were also given of CAMHS staff who had provided excellent support.

There is consensus that preparation for leaving CAMHS needs to begin early, and that there is a lack of provision for young people if they do not meet the threshold to access adult services. It should also be noted that there are a number of young people who receive mental health support through their school, but who will at some point leave and receive no further support.

Transition from CAMHS needs to include an assessment of social and non- medical needs and a well planned and agreed transition/discharge process which involves young people, parents, and other practitioners working with the young person.

All those who took part in the consultation agreed support/social prescribing services are needed for young people who are leaving CAMHS. Social prescribing includes providing support to individuals on a 1:1 basis and through group based services such as community engagement groups/activities, befriending and therapeutic activities provided by local voluntary and community sector organisations. It is now widely understood the that provision of a range of social prescribing services, which are tailored to individual needs provide a number of positive impacts on the well-being of people with mental health conditions.

Evidence suggests that many young people would require 1:1 support to access wider services. This support from a key/support worker during transition and when leaving CAMHS would provide these young people with on-going support, tailored to their needs.

The role of the support worker is to help with motivation, confidence building and providing to access activities and support in the community. The support worker is also important in ensuring a joined up approach between services and helping to move the young person to independence.

There is clear evidence that support sessions/social prescribing activities based on a young person's needs and delivered in accessible venues where young people feel safe, supports good mental health. Young people, parents and practitioners suggested a range of activities – arts/crafts, sport, peer mentoring/buddying, cookery, managing money etc. "

What evidence there is to support the delivery of the outcomes? - See above extracts from the report.

d. Further development of the children & young people's 'My Mind Matters' website. (£2,500)

How the money has been used? - This local website was developed with young people in Rotherham. The website has been developed in response to consultation with young people and parents/carers and practitioners in Rotherham who wanted information which was safe, reliable and appropriate. New promotional materials (posters, cards, pens and pencils) have been purchased and will be distributed across the borough. This promotion will particularly encourage parents/carers to use the website as a source of information in addition to young people.

What outcomes have been delivered? – It is too early to see any immediate impacts of the work, but we expect to see the following:-

- Higher usage of the My mind Matters website.
- A reduction in the stigma of mental health problems amongst young people in Rotherham by helping young people feel that they are not alone.
- Young people and families accessing help at an early opportunity thereby improving recovery for the young person.
- Demystifying mental health problems and helping young people talk about their mental health.
- Improved mental health literacy amongst Rotherham young people.
- The promotion of a strong recovery message to Rotherham young people and their families.

We regularly monitor the usage of the website and will be looking to see an increase in young people accessing the website along with parents and carers.

We work with groups like the Youth Cabinet to regularly review the website and encourage them to share their ideas of how it can be improved upon.

What evidence there is to support the delivery of the outcomes? – As mentioned above, it is too early to show evidence of the outcomes.

e. Development of the 'Council for Disabled Children - Expert Parent Programme' for delivery at CAMHS workshops by the RP Forum (£5,000)

How the money has been used? – 17 parents have received initial training on the CAMHS expert programme. This supports a better understanding of CAMHS services and how they are commissioned.

What outcomes have been delivered? – The initial training has taken place and these 17 parents are now experts, who are able to roll out the training to other parents.

What evidence there is to support the delivery of the outcomes? – This will be available once the training is rolled out to other parents.

f. Suicide Prevention Training – Rotherham Metropolitan Borough Council (RMBC). (£2,900)

How the money has been used? - Four 'Safe Talk' courses were delivered to people who work with/care for young people in March.

What outcomes have been delivered? – This suicide prevention training equips people to be able to:-

- Recognise those who may be at risk of suicide
- Ask individuals clearly and openly about their thoughts of suicide
- Connect individuals at risk to local sources of help

What evidence there is to support the delivery of the outcomes? – A number of very positive feedback questionnaires were received following the delivery of the 'Safe Talk' courses.

- 'Did not realise the high rates of suicide in the area'
- 'It was excellent training'
- 'Respectful, well prepared.'
- 'Good material to take away'
- 'Kept the course interesting with practical scenario based'

g. Maltby Academy Therapeutic Resource Hub. (£5,500)

Maltby Academy serves a local community which statistically represents a diverse social demographic and which in some areas falls within the most 2- 4% most deprived nationally. The school provides differentiated interventions for all students but is working innovatively to provide therapeutic interventions for those students who have special education needs and disabilities (SEND), social, emotional and mental health needs (SEMH) and/or specific medical conditions. This includes intervention from Rotherham Multi Agency Support Team (MAST), an in-house specialist mental health resource.

The aim of the funding provided was:

- To provide alternative and high quality resources for the cohort of children with SEMH/SEND needs currently struggling to access mainstream education, and to assist them in overcoming adversity to enable better engagement with learning in the classroom.
- To provide a safe, therapeutic and quality resourced environment within which SEMH/SEND children are able to explore feelings and express emotion, and to feel valued.
- To equip staff with resources and tools to implement this.
- To create a programme of intervention which supports an extended transition from primary to secondary school for those children who are not 'secondary ready.'
- To enable a planned and sustainable programme of classroom re-integration.

How the money has been used? -

The funding was used as follows:

- Creation of a sensory room: high quality resources e.g. play mats, sensory cushions, fibre optic light system.
- Sensory integration programmes: high quality resources e.g. balance boards and aerobic bouncers, lap pad weights and shoulder weights.
- Attachment group: Rotherham MAST commissioned to produce 'train the trainers' attachment group programme.
- Therapeutic resources: High quality resources to assist in therapy eg sand trays, puppets and games.
- Learning resources for staff: Specific books relating to alternative approaches to therapy.
- Resources for students: Mood diaries and fidget materials.

What outcomes have been delivered? – The above resources are being used to achieve the following outcomes:-

- Overcome difficulties associated with poor attachment experiences.
- Develop personal confidence, emotional resilience and improved self esteem.
- Develop the ability to form meaningful relationships with peers and significant adults.
- Develop concentration and the ability to focus.

Longer term, it is expected that the above outcomes will result in:

- Less behaviour incidents.
- Positive social interaction with others.
- Increased self-esteem and emotional resilience.
- Focused engagement with learning.

What evidence there is to support the delivery of the outcomes? –

Comments from students using this resource:

- 'I am in REACH and in the morning we do sensory circuits. I think this helps me to get ready to go to my lesson. I like the balance board best and the maze. I couldn't do the maze but now I can.'
- 'On Friday we have SEAL lessons. I love this because we talk about how we feel. We use the parachute and do lots of different games together as a team. This is my favourite time because I don't feel worried about stuff.'
- 'In the morning we do sensory circuits. I like doing this because it calms me down and I can concentrate better. My favourite is the balance boards. I'm getting good at it and can do it longer.'
- I use my sensory weight in class. I put it on my knee and it does help me. I used to fidget but now I can listen.'
- 'In REACH I do sensory circuits in the morning. We do different things each time and we have new stuff. I like the trampoline time because it makes me ready to go to class.'
- 'I really like it when I can go in the sensory room. I feel safe in there and when I am in there I like to look at all the bubbles and colours. It relaxes me if I feel stressed and can't go to lesson.'
- 'When I am stressed I go to the new time out room to calm down and to help relax.'

h. Mental Health First Aid (MHFA) Youth and Adult courses – Rotherham Metropolitan Borough Council (RMBC). (£3,000)

How the money has been used? – Materials were purchased to be able to deliver 4 Youth MHFA courses and 4 Adult MHFA courses by December 2017.

The Youth MHFA and Adult courses are internationally recognised courses. The Youth MHFA course is designed specifically for those people that teach, work, live with or care for young people aged 8 to 18 years.

What outcomes have been delivered? – The Youth MHFA course will provide participants with information, tools and techniques to promote a young person's mental and emotional wellbeing The Youth MHFA course helps participants to support a young person who might be experiencing mental and emotional distress.

What evidence there is to support the delivery of the outcomes? – Each course will be evaluated and a follow-up with participants will take place a few months after attendance.

i. Young people's mental health campaign – Rotherham Metropolitan Borough Council (RMBC). (£4,000)

How the money has been used? - Activities the project will deliver.
We have consulted with young people in Rotherham to look at ideas for a young people's mental health campaign. Their ideas have shaped the development of a Z card and supporting resources. The message of this campaign is to encourage young people in Rotherham to look out for each other. We know that young people can delay getting help when they are worried about their mental health for a variety of reasons including fear of being judged and not knowing what will happen when they ask for help. This campaign focuses on the message that we all have mental health which varies over time and can be affected by a number of factors. It will encourage young people to look out for each other, talk about mental health and then encourage each other to get appropriate support.

We held focus groups with young people across the borough (Youth Cabinet, Looked After Children's Council and young people in schools) to discuss their thoughts on the campaign, it's messages and how best to reach young people.

We are planning on launching the campaign in May with some of our local schools it will be supported by the new resources.

What outcomes have been delivered? –

- An improvement in the knowledge, attitudes & behaviour of young people around mental health
- Young people seeking help at an earlier opportunity
- A reduction in the stigma which young people with mental health problems experience
- Greater support for young people with mental ill health within communities (schools/ geographical communities/communities of interest)

What evidence there is to support the delivery of the outcomes? – This will follow the roll-out of the campaign.

j. EMDR training (Eye Movement Desensitisation and Reprocessing), 3 day course delivered in February 2017 (£2000)

How the money has been used? - Supporting clinician undertaking EMDR (eye movement desensitization and reprocessing) training- levels 1-3

What outcomes have been delivered? - Specialist CSE worker will be able to use EMDR for treatment of trauma; EMDR has been used effectively in the treatment of children who have

experienced trauma and complex trauma. EMDR is often cited as a component in the treatment of complex post-traumatic stress disorder.

What evidence there is to support the delivery of the outcomes? - Clinician attending and concluding training and use of EMDR with young people accessing services in RDaSH CAMHS

k. Clinical diagnostic testing for over 16's and improved self-help materials (£10,000)

How the money has been used? - Purchase of specialist neurodevelopmental standardised assessment packs which are up-to-date and relevant.

What outcomes have been delivered? - Use of new assessment tools has commenced.

What evidence there is to support the delivery of the outcomes? - Evidence based assessment process for ASD and ADHD assessment and more efficient use of time with information gathering, etc.

l. Perinatal pre and postnatal support – Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH). (£4,000)

How the money has been used? – Establish 'support groups' which will support the emotional wellbeing and mental health of mothers and their families in Rotherham during and after pregnancy.

What outcomes have been delivered? – Further information not available due to sickness leave of key contact.

What evidence there is to support the delivery of the outcomes? – This will be available once the outcomes have been delivered.

CCG NAME: Rotherham				Planned Spend 16/17 **				Actual Spend 16/17 **				Actual Spend 17/18 **				
	Local Priority Scheme (LPS) Reference / number *	Local Priority Scheme (LPS) Description *	Funding Source/Stream (use drop down menu)	Planned Spend Q1 16/17	Planned Spend Q2 16/17	Planned Spend Q3 16/17	Planned Spend Q4 16/17	Actual Spend Q1 16/17	Actual Spend Q2 16/17	Actual Spend Q3 16/17	Actual Spend Q4 16/17	Actual Spend Q1 17/18	Actual Spend Q2 17/18	Actual Spend Q3 17/18	Actual Spend Q4 17/18	Commentary (including details of any slippages against plan
1	1	Intensive Community Support Service	LTP Funding	42500	42500	42500	42500	42500	42500	42500	42500	42500				Includes the funding for LPS 2
2	2	Crisis response	LTP Funding	0	0	0	0	0	0	0	0	0				Funding for this is included in LPS 1
3	3	Autism Spectrum Disorder (ASD) Post diagnosis Support	LTP Funding	13500	13500	13500	13500	13500	13500	13500	13500	13500				
4	4	Prevention/Early Intervention	LTP Funding	0	0	0	0	0	0	0	0	0				Original LPS from 2015/16. Now picked up in other areas.
5	5	Family Support Service	LTP Funding	17500	17500	17500	17500	17500	17500	17500	17500	21250				
6	6	Workforce Development	LTP Funding	0	0	0	0	0	0	0	0	0				Original LPS from 2015/16. Now picked up in other areas.
7	7	Hard to reach Groups	LTP Funding	0	0	0	0	0	0	0	0	0				Original LPS from 2015/16. Now picked up in other areas.
8	8	Looked After Children (LAC)	LTP Funding	0	0	0	0	0	0	0	0	2500				Original LPS from 2015/16. Now picked up in other areas.
9	9	Provision of Advocacy Services	LTP Funding	5000	5000	5000	5000	5000	5000	5000	5000	5000				
10	10	Child Sexual Exploitation (CSE)	LTP Funding	12500	12500	12500	12500	12500	12500	12500	12500	12500				
11	11	Increased General Capacity	LTP Funding	20000	20000	20000	20000	20000	20000	20000	20000	20000				
12	12	Increased Funding for Out of Hours services	LTP Funding	7500	7500	7500	7500	7500	7500	7500	7500	7500				
13	13	Single Point of Access	LTP Funding	8750	8750	8750	8750	8750	8750	8750	8750	8750				
14	14	Interface & Liaison Post	LTP Funding	13750	13750	13750	13750	13750	13750	13750	13750	13750				
15	15	24/7 Liaison Mental Health		0	0	0	0	0	0	0	0	0				Capital funding only in 2015/16
16	16	CYPIAPT	CYP - IAPT Funding	18500	18500	0	0	18500	18500	18500	18500	2250				
17	17	Eating Disorder Service	ED Funding	34750	34750	34750	34750	34750	34750	34750	34750	34750				
18	18	Transition	LTP Funding	0	0	0	0	0	0	0	0	5000				
19	19	Perinatal Mental Health	New Investment (NHS)									0				
20	20	Anxiety/Self Harm	LTP Funding									10000				
21																
22																
23																
24																
25																
26																
27																
28																
29																
30																

* Please ensure the LPS refererence/number and description entered above matches the details in the latest version of your LTP Plan

** Please note cells for planned and actual spend have been restricted to a maximum £500,000.

Funding Source/Stream	Spend
ED Funding	Minimum: 0
LTP Funding	Maximum: 500,000
CYP - IAPT Funding	
New Investment (NHS)	
New Investment (Local Authority)	
New Investment (Criminal Justice)	
New Investment (Schools)	
New Investment (Voluntary Sector)	
New Investment (Other)	

CAMHS Transformation Plans – Issues and risks to delivery Q1 2017/18

Please complete for any issues or risks that prevented or delayed the delivery of your 2017/18 Local Priority Schemes (LPS) in Q1 2017/18

CCG Name: Rotherham

LPS Number	Description of local priority scheme	Description of issue of risk to delivery of 2017/18 plan	Mitigating Actions	*Date expected to deliver
1	CAMHS Intensive Community Support	That the service is not able to be provided 7 days per week.	Further work is ongoing to ensure that the service is fully developed alongside the Crisis service. The service is working closely with Children & Young People to determine appropriate hours of service delivery.	31st March, 2018
2	Enhanced Crisis Response (Including Liaison)	That the 8pm to 8am all age Crisis service will not be able to be provided, particularly in respect of the contribution required from the Adult Crisis service.	As at July, 2017, this development is out for consultation with staff. The existing arrangement using the 'out of hours' on-call service is still operating.	30th October, 2017
6	Workforce Development	A Workforce Development Strategy is not developed and a screening tool is not rolled out.	Other work is ongoing across Yorkshire & Humberside to develop a workforce development plan and 'best practice' will be adopted.	30th September, 2017
13	Single Point of Access (SPA)	The SPA is not properly established.	Discussions are continuing with the Local Authority.	31st December, 2017

18	Transition from CAMHS to Adult services	A Transition specification and robust process is not agreed and implemented in 2016/17.	A CAMHS Transition specification has not been agreed but a group has been formed to take forward the whole area of Transition. A national CQUIN is also in place for this area.	30th September, 2017
Please insert more lines as needed				

*Please highlight in red any areas not delivered by 30th June 2016 that were planned for delivery or spending during Q1 2016/17.

NHS Rotherham CCG - CAMHS Local Transformation Plan - Update Report Quarter 1, 2017/18

1. Progress to date –

a. General progress made in respect of implementation of the plan.

Progress with the Rotherham LTP continues to be closely monitored through the LTP Action Plan, which is updated on a bi-monthly basis and 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. The format of the action plan is being improved to ensure that appropriate governance is in place.

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).

As at the end of May, 2017, the pathway was dealing with a caseload of 30 patients and 15 urgent assessments were carried out in April and May. There were no Inpatient admissions during this period and 4 of the referrals into the service were for looked after children.

RDaSH CAMHS is continuing to develop the monitoring information relating to the Intensive Community Support service and in future it is expected there will be a good balance of qualitative and quantitative information available to give a detailed understanding of the delivery and outcomes of the service.

The numbers of Rotherham children & young people in inpatient facilities remained at a low level during Quarter 1 and in fact at the end of May, there were no Rotherham inpatients.

The CCG is continuing to work with other CCGs in the Yorkshire & Humberside region and NHS England to develop a framework for collaborative commissioning.

The objectives of this scheme have been achieved, evidenced by the continuing low levels of inpatient admissions.

What outcomes have been delivered? –

- Better support for children & young people who need more intensive treatment.
- More timely urgent assessment of patients referred in to the service.
- Continuing low level of inpatient placements for Rotherham children & young people.

Evidence to support the delivery of the outcomes –

- Continuing low numbers of Rotherham inpatients.

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 April and May of Quarter 1, there was only 1 patient referred to CAMHS services via A & E and they were assessed within 24 hours.

The 'out of hours' on-call service continues to be provided and it is still planned that this will be phased out and replaced with an all-age Crisis service. This was planned to be from June 2017 but has been delayed until October 2017 due to the level of consultation required with staff and the need to ensure that a robust training programme is implemented. It will also link to the Intensive Community Support service and be provided from 8pm to 8am. The CAMHS service is actively reviewing feedback from service users in supporting the delivery of revised opening hours within 8am-8pm to ensure that the needs of Children, Young People and Families can be met. In April & May of Quarter 1, there were 3 face to face assessments out of hours and no telephone assessments by RDaSH CAMHS.

The CAMHS Interface and Liaison post is fully established and has developed successful working relationships with both A&E and Ward staff. The role has been integrated within the Intensive Community Support Team, this ensures that the role is not isolated and ensures smooth handover of cases where intensive home treatment may be required.

A successful training programme has been delivered to the acute hospital staff and this has been well received and evaluated. The role will continue to work with acute staff to support their understanding of children's mental health issues.

The Crisis response service is now well established, but not all the objectives have been achieved due to the delays in moving to the all age service.

What outcomes have been delivered? –

- Children & young people in crisis are supported on a 24/7 basis.
- Children & young people who are admitted to the Acute hospital with mental health issues are discharged as soon as possible in a safe way.

Evidence to support the delivery of the outcomes –

- Patients do not have to be picked up through alternative routes such as section 136 admissions.
- Low levels of Rotherham inpatients.
- Patients admitted to the acute hospital with mental health issues are assessed within 24 hours and have joint RDaSH TRFT discharge plans in place.

Local Priority Scheme 3 – Autism Spectrum Disorder (ASD) Support

27 referrals in total were received during the quarter. These were newly diagnosed patients from the CAMHS service. 100 additional contacts were made, through email and other referral sources.

The service is co-ordinating 'The Basics' workshops for parents with delivery being undertaken by the Autism Communication Team, the RMBC Educational Psychology Service and RDaSH CAMHS.

It is planned to offer more in-depth sessions in September including; 'Foundations for Communication', 'Teen Life' and also individual workshops from NAS Rotherham around managing anger, understanding autism and sensory differences.

Leaflets and posters to promote the service are available both in electronic and printed format and copies of the 'Green booklets' (to support families at home) have now been printed in Urdu, Punjabi, polish and Slovak languages.

The service continues to provide a number of courses including 'Sensory Workshops'. Feedback from the 4 sensory workshops delivered between January – March has been very positive. 6 more workshops are planned from June 2017 to March 2018 and two of the dates will be pilots aimed at parent carers of particular age groups but the rest will be for any age group. The family practitioners are taking an active role in presenting the sensory workshops. Representatives from Rotherham Parents Forum are involved, and a young person will be making a presentation about their experiences. Some places will also be available to staff from other agencies, such as Early Help, Child Development Centre (CDC) and CAMHS.

Sensory equipment continues to be distributed to schools.

The family practitioners will also complete training in the 'Teen Life programme' by the end of July, and the aim will be to deliver this course in January/February 2018 as an alternative for parents of older children to attend rather than the 2 day Basics course.

The service has also commissioned a 'Foundations for Communication' course, focused upon communication and emotional regulation. There will be 16 modules of 2hrs on various topics with the aim of giving parents a better understanding of various topics and use this to write a communication passport about their child.

Additional staff from the Autism Communication Team (ACT), CAMHS learning disability team, SENDIASS (including young people's advocates) and Rotherham Parents Forum Parent peer support scheme are also training as facilitators, to enable a wider audience to be reached.

Finally, the service is completing a sensory report outlining the results of the pilot sensory assessments and workshop training to establish the value of Sensory Assessments.

The objectives of establishing the service have all been achieved and the gap that was identified in services for newly diagnosed children & young people has been filled.

What outcomes have been delivered? –

- Better understanding and awareness by families of children & young people diagnosed with ASD and development of their coping skills.
- Better contact with hard to reach groups.

Evidence to support the delivery of the outcomes –

- Attendance of families on ASD courses
- Distribution of support literature to families.
- Translation of key documentation into other languages.

Local Priority Scheme 4 – Prevention/Early Intervention

Six schools in Rotherham signed up to a 'Whole School Approach' pilot in 2015/16. The CCG had applied for funding for the NHSE schools pilot, but had been unsuccessful. It was therefore decided to use some of the funding in 2015/16 to take a similar approach but with a small number of schools. The intention being that best practice could be rolled out to other schools.

Each school chose their priority areas based on local need. Their action plans reflected two or three areas within the whole school model. See link below for further information;

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414908/Final_EHWB_draft_20_03_15.pdf.

The schools implemented their action plans from September 2016 through to July 2017.

Regular 'one to one' meetings have been held with all six schools to offer support in the implementation and check progress. In addition all six schools met as a whole group once a term to share good practice and learn from each other's experiences.

Schools have made good progress delivering on their action plans. Examples of activity include:

- Targeted work with vulnerable children and young people.
- Identifying areas of concern with vulnerable children and young people and delivering themed workshops (for example managing stress and anxiety) and resilience programmes.
- Working with hard to reach parents and carers and helping engage them in school life and supporting the needs of their child.
- Initiatives to improve and maintain staff health and wellbeing.
- Workforce development for staff (attachment and mental health awareness training).
- Two out of the six schools have worked closely with their primary schools on supporting young people around transition and pastoral staff supervision and support.
- Five schools out of the six schools are either signed up to or are in the process of signing up to the National Workplace Wellbeing Charter.

Schools are currently working on finalising their case studies evidencing the outcomes of this work. This information will form part of a written report to be circulated in early autumn. All six schools will be presenting their work in October. This event will provide other schools with an opportunity to hear about the work they have done. Some of the six schools have produced resources which will be available for others to adopt.

At the last meet meeting held with all six schools they expressed an intention to continue to meet, extending the invite to other schools who wanted to learn and support each other with developing whole school approaches to mental health and wellbeing. All six schools have indicated that the work they began in the school year 2016/17 will be continuing beyond the life of the project.

The CAMHS service is continuing to develop their model of consultation and advice for schools to support early intervention. It is expected that the new model will be established for implementation with schools by the Locality Workers in the new term in September. The current RDaSH SPA has developed and implemented its own model of consultation and advice at the point of contact to ensure that agencies are supported in ensuring children and young people access the most appropriate services for their needs and to prevent delays or unnecessary referrals.

Despite the initial disappointment of not being successful in the School Pilot bidding round, the initiative in Rotherham has been very successful and many of the objectives of establishing a 'Whole School Approach' have been met, albeit on a small (pilot) scale.

What outcomes have been delivered? –

- Vulnerable and hard to reach children & young people are better able to cope with their school life.
- School staff are better able to support children & young people.
- Children & young people and staff in other schools are being supported.

Evidence to support the delivery of the outcomes –

- Delivery of targeted support to children & young people.
- Staff health & wellbeing is being supported.
- The 'Whole School approach' is benefitting schools not part of the original pilot.

Local Priority Scheme 5 – Family Support Service

The service continues to support families with children & young people with disabilities, the highest proportion of which have ASD or ASD traits..

28 families were supported in Quarter 1 and 12 of these were new to the service. A number of families which were supported in the past have not required support in Q1, but are still registered with the service and can access support in the future if required.

A total of 37 children were supported, of which 26 were male and the majority were aged between 5 and 11.

Advice is provided by a number of different methods, split fairly evenly between telephone, face to face, email and Facebook. The service has also built up good links with other services, including SENDIASS and Healthwatch, and now actively signposts families as appropriate as well as receiving referrals back.

The team now comprises;

- Peer Support Co-ordinators (3 posts) – 1.5wte
- Peer Support Workers (1 post) – 0.2wte
- Peer Support Volunteers x 4

The Parents Forum also has 4 volunteer counsellors.

The development of the service has been very successful, not least because it has responded directly to the needs of families and remained very flexible in it's delivery.

What outcomes have been delivered? –

- Families are empowered to interact more effectively with services.
- Families better understand their child's issues and are better able to cope with them.

Evidence to support the delivery of the outcomes –

- 100% of families surveyed said that:-
  - The information/support they received helped them feel better about interacting with services.
  - Accessing the services has had a positive impact on the family.
  - If they hadn't accessed the service they would not know where else to access information/support.

Local Priority Scheme 6 – Workforce Development

Rotherham is represented on the Early Years/Schools and Colleges Task and Finish Group (NHS England CYP Mental Health & Emotional Wellbeing Clinical Network Group) which is looking at producing a competency framework for staff working in all these settings. One Rotherham school has agreed to pilot the Y&H Schools Competency Framework during the next academic year. This regional work will inform a wider framework for anyone working with (paid or voluntary) or caring for children and young people in Rotherham (e.g. foster carers).

RMBC Children and Young People's Service have a workforce development group. They are currently conducting needs analysis work with teams of staff. The theme of mental health and emotional wellbeing is included in this work of this group.

The aims & objectives of this scheme have not yet been achieved, but it was felt appropriate to take account of the regional development work rather than to try to 'reinvent the wheel'.

What outcomes have been delivered? –

- None so far as the work is still in progress.

Evidence to support the delivery of the outcomes –

- None so far.

Local Priority Scheme 7 – Hard to reach groups – Completed.

Local Priority Scheme 8 – Looked After Children

An evaluation report has now been prepared, following the completion of the pilot, which prioritised the treatment of LAC in the CAMHS service,

During the period of the pilot (1st November 2016 to 31st March 2017) 18 referrals were received by the RDaSH CAMHS service. Of these, 8 were either already receiving support from the local authority Looked After and Adopted Childrens Therapeutic Team (LAACTT), or were waiting to receive support. Only in one case did a LAC require a specialist mental health intervention.

Throughout the pilot, the RDaSH CAMHS service and LAACTT worked hard to improve the relationship between the two organisations and ensure that patients were supported in the appropriate manner.

The report made the following recommendations:-

- Implement a new pathway for routine referrals to RDaSH CAMHS via the LAACTT.
- Commence regular consultation meetings between RDaSH CAMHS and the LAACTT.
- Urgent referrals to continue to be seen as per RDaSH protocol.
- Neurodevelopmental assessments to be supported by the LAACTT by providing life history and developmental history.
- Develop clear information sharing agreements and documentation of consultation and advice sessions.

The CCG, RMBC and RDaSH will discuss the recommendations and agree an appropriate way forward.

For some time, the CCG has approved the support of local CAMHS services for LAC placed outside of Rotherham. The CCG is now formulating pro-forma paperwork to help improve the governance around this process. £10,000 of extra funding has also been identified for 2017/18, from the LTP, to support the access to these services.

The priority scheme was very successful in terms of the initial non-recurrent funding providing an excellent 'boost' for the LAC team and providing a platform for further investment by the Local Authority and the development of a true multi-agency pathway.

What outcomes have been delivered? –

- LAC are receiving appropriate care from the appropriate organisation.

Evidence to support the delivery of the outcomes –

- Close working between the RMBC LAACTT and RDaSH CAMHS.

Local Priority Scheme 9 – Development of services through input from Children & Young People and parents/carers.

RDaSH are continuing to take forward the recommendations which came out of the scoping work around engagement. They are now working closely with the Children, Young People and Families Consortium, which is part of Voluntary Action Rotherham (VAR).

RDaSH has started a piece of work with the Voice and Influence Partnership, which is a sub group of the Children, Young People and Families Consortium and whose purpose is to strengthen the voice of children, young people and families and involve them in the decisions that affect them.

RDaSH are regularly engaging with the Rotherham Young Inspectors and the 'Different But Equal' Young People's group. The Young Inspectors recently completed an inspection within the Kimberworth base and the CAMHS team are working closely with them to implement their recommendations.

Similarly the service regularly reviews the feedback shared by children, young people and parents/carers through the Experience of Service questionnaire, making improvements to service delivery and practice as a direct result of the feedback.

Funding is continuing in 2017/18 for the Healthwatch Rotherham advocacy service for children & young people. As at the end of quarter 1, the service had 12 active cases and during the quarter supported 15 children, young people and families. The advocacy work continues to relate to a number of difference service, although predominantly CAMHS.

There have been delays with the priority scheme but, with the help of the VAR initiative, and also the work of the Rotherham Parents Forum and Healthwatch, through other priority schemes there is a renewed focus in this area.

What outcomes have been delivered? –

- Services are more designed around children & young people and their families.

Evidence to support the delivery of the outcomes –

- Locality workers see patients in schools, GP practices and children's centres.

Local Priority Scheme 10 – Increased funding for working with children & young people and adults affected by Child Sexual Exploitation.

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 1 to date (April & May), the CSE pathway had 7 first appointments and 30 follow-up contacts with CAMHS patients and 2 first appointments and 11 follow-up contacts with Adult patients.

The service also had 31 consultations in Quarter 1 to date (April & May) with other services about CAMHS patients and 20 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 is also (by its nature) 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 pathway was already well established, prior to the extra investment from the LTP funding, and this has further strengthened the work in this important area.

What outcomes have been delivered? –

- Patients affected by CSE receive direct support from a dedicated pathway.
- Staff from other agencies who deal with patients affected by CSE feel more able to deal directly with these patients.

Evidence to support the delivery of the outcomes –

- Numbers of contacts and consultations by the pathway.

Local Priority Scheme 11 – Increased general CAMHS capacity

This funding is continuing in 2017/18 and is now fully integrated into the overall RDaSH CAMHS service.

The RDaSH CAMHS service has now completed its reconfiguration; all staff have been appropriately aligned to clinical pathways. The service is well staffed, carrying only one vacancy, at the end of June. Following a long term sickness, this post is now out for recruitment.

Local Priority Scheme 12 – Increased funding for the CAMHS 'Out Of Hours' service.

This funding is continuing in 201718 and links to Local Priority Scheme 2.

Local Priority Scheme 13 – Single Point of Access (SPA)

This funding is continuing in 2017/18 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 is still delayed.

Due to the continued developments and changes made to both RDaSH CAMHS and RMBC Early Help, the joint SPA work was delayed. Initial meetings between the agencies have been held to revitalise the previous discussions and identify appropriate steps to move this work forward. There is clear commitment from both agencies to deliver a joint SPA, and whilst it recognised that there needs to be some pace to this work, both agencies want to ensure that what is delivered is meaningful for children, young people and their families as well as referrers. Both agencies are mindful of the need to ensure appropriate consideration is given to all aspects of this work. Regular project meetings are planned throughout July and August.

The objectives of this priority scheme have been achieved in terms of establishing the SPA within the CAMNHS service, but not in respect of joining with the Early Help hub.

What outcomes have been delivered? –

- Children & young people are being signposted to the appropriate services, at an early stage rather than being 'bounced around' the system.

Evidence to support the delivery of the outcomes –

- Low level of inappropriate referrals – 2.8% at the end of May, 2017.

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 2017/18.

Local Priority Scheme 16 – Children & Young Peoples IAPT (CYPIAPT)

A specification has been signed between the CCG and NHS England and training is ongoing with two members of staff from RDaSH CAMHS. They are undertaking training relating to Enhanced Evidence Based Practice (EEBP) for children & young people.

The CCG has committed to fund two Psychological Wellbeing Practitioners (PWPs) from 2018/19. These PWPs have been identified and commenced in post in April 2017. Their posts are funded by Health Education England during 2017/18. It is expected that these posts will be able to provide some direct patient support/interventions later in 2017/18.

What outcomes have been delivered? –

- Staff are benefiting from improved training and an increased enthusiasm as a result of the new PWP roles.

Evidence to support the delivery of the outcomes -

- Better staff morale.

Local Priority Scheme 17 – Eating Disorders Service

RDaSH, in conjunction with the South Yorkshire Eating Disorder Association (SYEDA), continue to provide the new community Eating Disorder service. The SYEDA focus is on delivering training and awareness raising to professionals and Young People.

Numbers being referred to the RDaSH service remain relatively low, although they are in line with those seen in the first year, and are 4 for the first 2 months of the year.

It is not believed that the low referral numbers are due to access problems and the CCG is working with the providers involved to revisit the care pathway to ensure that it is ‘fit for purpose’.

Following the launch of the service in January, the service team have engaged and networked with other agencies in Rotherham. SYEDA continue to engage with a wide range of the Children’s Workforce in Rotherham to provide training and awareness raising, with a significant number of activities undertaken in Rotherham in Q1.

Work has been undertaken to ensure that the care pathway is appropriate and meets the relevant NICE Guidelines. A recent audit against NICE Guidance highlighted full compliance with the majority of the standards, with the exception of Binge Eating, where partial compliance was identified. The team have implemented an action plan to address this.

The full team has attended the National ED Team.

The aims and objectives have been delivered in terms of establishing the community ED service. Clearly further work is ongoing to understand the referral numbers and establish if there is unmet need.

What outcomes have been delivered? –

- Children & Young People in Rotherham are benefitting from a ‘Hub & Spoke’ community Eating Disorder service which meets NICE guidelines.

Evidence to support the delivery of the outcomes -

- Community Eating Disorder service in place.

Local Priority Scheme 18 – Transition from CAMHS to Adult services

A Transition 'Task & Finish' group has been established to oversee work in this area, including representation from the Local Authority, statutory and voluntary mental health services and the commissioners. This is using the Yorkshire and Humber transitions toolkit as a basis for taking forward this area.

RDaSH CAMHS have completed the Transition Toolkit benchmarking and are actively working with adult mental health colleagues to improve the areas identified for development. This continues to be supported through the CQUIN work.

RDaSH CAMHS are actively engaged in the Yorkshire and Humber Clinical Network Transition Group work which has included the development of relevant questionnaires for young people on their pre and post transition experience.

The CCG is also funding 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. Some non-recurrent funding was used to fund a scoping exercise for this piece of work at the end of 2016/17

Whilst this work has been delayed, and the objectives have not yet been achieved, it is still expected that a service will be in place from the autumn.

What outcomes have been delivered? –

- Children & Young People (C&YP) continue to leave the service in a planned way.

Evidence to support the delivery of the outcomes -

- The service continues to meet the target of 95% of patients who have completed treatment being discharged in a care planned way

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. Target March 2018.
- Undertaking a scoping exercise to understand how 'One-stop-shops' could be developed in Rotherham. Target March 2018.

A new service is to be developed from 2017/18 providing education and support around anxiety. This is seen as a significant contributor to self-harm in children & young people.

2. Key outcomes and achievements delivered by the LTP in Q1 2017/18.

- **Intensive Community Support Pathway (Local Priority Scheme 1) –** Further development of the intensive community support pathway, which is having a direct impact on reducing the numbers of inpatient admissions for Rotherham patients. Rotherham had the lowest level of Inpatient admissions in South

Yorkshire and Bassetlaw for 2016, with 8.4 per 100,000 population. This is compared to other CCGs as follows; Sheffield – 29.19, Bassetlaw – 33.01, Doncaster - 42.15 and Barnsley - 20.92.

- **ASD Post diagnosis support service (Local Priority Scheme 3)** – The service is now fully established and takes referrals directly from CAMHS following diagnosis. It links well with other agencies and is successfully filling a gap that was highlighted by patients and families.
- **Family Support Service (Local Priority Scheme 5)** – The service has been further expanded through some additional funding and continues to have excellent feedback from families, some of which then start to work with the Parents Forum and themselves provide support to families, in the same way they were helped.
- **Referrals of Looked After Children (LAC) to the RDaSH CAMHGS service. (Local Priority Scheme 8)** - The two LAC services, provided by RMBC and RDaSH CAMHS are forging even closer links to provide what will effectively be a single LAC pathway. This work is being helped by the development of a 'Section 75' agreement between the CCG and Local Authority..
- **Future commitment by the CCG to increased capacity in prevention and early intervention work –** The two Children's Psychological Wellbeing Practitioners (CPWPs), are now in place and have embarked on their training. They are embedded in the CAMHS team and will start to work with caseloads as their training progresses. The continued development of the RDaSH CAMHS Locality Workers and their 'Advice and Consultation' work with schools in particular is also supporting this area of work.

3. Areas of most challenge in implementation.

- **Thresholds for referrals into the CAMHS service** – There is still 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. The CCG has asked the CAMHS service to undertake a 3 month review of signposted referrals to understand the background. There is also an ongoing dialogue to better understand thresholds for referrals.

- **Project Management time** – There are still significant challenges in terms of managing all the LTP priority areas, although other agencies are picking up specific areas and some are now well established and are essentially running themselves. The pressures are due to new and existing initiatives & areas of work such as Care Education and Treatment Reviews (CETRs), the Crisis Care Concordant, Transforming Care Partnerships (TCPs) and general contract management responsibilities.

- **Overall Funding Issues** – The CCG is continuing to increase CAMHS funding in line with the expected levels, but there are increasing pressures due to developing areas such as CETRs and the TCP initiative. There are also some growing pressures resulting from changes in funding elsewhere in the system such as in schools and the Local Authority.

4. Finance and activity review.

The following table shows expenditure by local priority scheme.

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 1 (April & May), the CAMHS service received 335 referrals, of which 7 were inappropriate and returned to the referrer and 115 were signposted to other services.

Local Priority Scheme 14 – CAMHS Interface & Liaison post

In Quarter 1 (April & May), 11 referrals were made from the acute hospital to the Liaison nurse. All of these had a joint TRFT/RDaSH Discharge plan.

5. 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 being updated and transferred to a new format. Part of the rationale for this is to enable better governance and it will be very clear which individuals are responsible for specific action areas.

The LTP is overseen by 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. The last meeting was on the 12th July, 2017 and the minutes of this meeting are 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.

6. Eating Disorders –

See Local Priority Scheme 17 above for a general update on this area.

7. Children and Young Peoples Mental Health Additional Allocation

The following update was not possible for the Q4 update due to sickness leave.

l. Perinatal pre and postnatal support – Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH). (£4,000)

How the money has been used? – to purchase:-

- Projector & Speakers.
- Compassion focused therapy resource for perinatal illness.
- Copies of a Perinatal loss book.
- Medications and lactation flipchart paper and flip chart and pens.
- Eye Movement Desensitisation and Reprocessing (EMDR) equipment, including tappers and light bar for use in therapy.

The equipment/resources will then be used by 'support groups' which will support the emotional wellbeing and mental health of mothers and their families in Rotherham during and after pregnancy.

What outcomes have been delivered? – Equipment has been purchased but the support groups are yet to be established.

What evidence there is to support the delivery of the outcomes? – See above.

8. Children and Young People's Mental Health Waiting Times

Quarter 1 (As at end of May) –

- Total number of CYP waiting for treatment - 193
- Average waiting times from referral to treatment – 7.1 weeks
- Actions being taken to improve waiting lists and average waiting times –

The following actions are being undertaken during the remainder of 2017/18:-

- Review of the ADHD/ASD pathways to examine how the diagnosis processes can be further speeded up (a significant reduction has already been made over the last year)
- Close tracking of three key measures; number on pathway who have not started an assessment, number who have started an assessment and how long assessments are taking.
- Full review of CAMHS capacity across all pathways.
- Development of two new Childrens Psychological Wellbeing Practitioner (CPWP) roles, which have now started training and should be having some impact on reducing waiting lists later in the year.
- Co-locating the CAMHS Single Point of Access (SPA) with the Local Authority Early Help service to provide a more co-ordinated service and reduce the number of signposted referrals.
- Further development of the CAMHS Locality Workers to ensure that referrals are more focussed and contain all the required information. This will include 'Advice & Consultation' sessions which will also help to reduce inappropriate or signposted referrals.
- The provider moving to a new electronic data system which will speed up internal monitoring and recording.

Quarter 2

Quarter 3

Quarter 4

Appendix 1

	Title of Meeting:	CAMHS Strategy & Partnership meeting
	Time:	9am – 11am
	Date:	Wednesday 12th July- 2017
	Venue:	Willow Room, Oak House
	Chairman:	Jason Page

Present		
Melanie Robinson	MR	Project Support, RCCG
Nigel Parkes	NP	Senior Contracts Manager, RCCG
Jason Page	JPA	
Ruth Fletcher-Brown	RFB	Public Health Specialist
Juliette Penney	JP	Matron IPHNS, TRFT
Teresa Brocklehurst	TB	Strategic Co-ordinator, Children & Young People & Families Consortium
Jo Smith	JS	Head of Commissioning CYPS, RMBC
Sally Dodson	SD	Commissioning Officer, RMBC
Paul Theaker	PT	Commissioning Officer, RMBC
Paula Williams	PW	Head of Inclusion, RMBC
Karla Capstick	KC	Head of Services, Early Help
Debra West	DW	CAMHS Peer Support Scheme, Co-ordinator
Sara Graham	SG	Multi Agency Support Team (MAST), Maltby Academy.
J Fitzgerald	JF	Rotherham Parents Forum Limited
Sara Whittaker	SW	LAACTT, RMBC
Katie Simpson	KS	CAMHS Project Manager

		Actions
1.	**Apologies:** Laura Whixton, Lianne Morewood, Lisa Morris, Mel Meggs, Pepi DiLasio, Carol Taylor, Anders Cox, Linda Harper, Tony Clabby, HealthWatch, Rita Thomas, Nanette Mallinder, Chris Hood, Barbara Murray, Christine Harrison, Frankie Hibberd, Lisa Morris, Nanette Mallinder.	
2.	**Declarations of conflicts of Interest** None declared.	

3.	**Minutes of CAMHS Strategy & Partnership Meeting – 26 April 2017** The minutes were approved as an accurate record with the amendment to item 4 – Single Point of Access should be Susan Claydon not KC. Item 10 - PW informed the meeting that the number of children on the Children and Young People at risk of admission list has decreased. Item 16 – RDaSH Self Assessment Tool - KS to discuss with BM. BM to submit for August Meeting.	**KS/BM**
4.	**School Partnerships for Social Emotional and Mental Health Needs.** PW updated the meeting on the work been undertaken around School Partnerships for Social Emotional and Mental Health Needs (SEMH). PW informed the meeting that the work is being undertaken with around 120 schools to provide provision for children. There is a large amount of exclusions due to home circumstances and schools are working individually and as a partnership to adapt the curriculum and resources to incorporate the graduated response document. PW explained to the meeting that children do not have to be excluded to attend ASPIRE and the work being undertaken with primary schools to keep children in schools and the need to improve provision for Social Emotional and Mental Health Needs. PT informed the meeting that the Aspire leadership has changed and conversations are due to take place in the summer. The meeting discussed the primary partnerships and the model for primary schools been different to the model for secondary schools KC explained to the meeting who attends the partnership meetings and the needs required by primary schools. TB informed the meeting of the conference held in June to promote primary school – stay in schools and reported that requests had been received to have an annual conference. PT informed the meeting that CAMHS is working closely with Early Help and looking at ways of obtaining information from agencies already working with children. PW asked to be involved with the work CAMHS are undertaking around primary schools. NP informed the meeting about Amber Lodge, The Becton Centre, Sheffield and how the lodge supports children of primary school age. Funding for this service was previously held by NHS England and is now being held by the commissioner who would like to make more use of this facility. JPa informed the meeting that RCCG are keen on partnership working and regular meetings to share updates and information.	

	PW to circulate presentation slides to members.	**PW**
5.	**Rotherham CAMHS Local Transformation Plan (LTP)** **LTP Update –** NP informed the members that for 2017/18, new recurrent funding of £60,000 will be used for 2 new work streams around social prescribing and anxiety/self-harm. Feedback from NHS England on the Q4 report has been received and NHS England is 'fully confident' in the CCG. This had changed from 'partially confident'. NHS England has given positive feedback for the post ASD diagnosis, family support work and transition work. NP informed the meeting that the Q1 report was due to be submitted to NHS England on the 28 July. NP informed the meeting that in the feedback from the last update NHSE are asking the following to be included in the Q1 update:- • More specific information on the impact and outcomes of the work and whether aims and objectives were delivered. Specific updates on the SPA and 'all-age' Crisis service. • The specific impact of the sensory training workshops, kits and sensory assessments. • Actions taken to increase referrals to the Eating Disorder service. • Perinatal & postnatal support groups. The meeting discussed the work in schools been undertaken by SYEDA and the launch of the eating disorder service. **LTP Action Plan (V27)** NP informed the meeting that the Action plan was undergoing an update and being transferred to an excel format. The new format will emphasise those individuals responsible for specific actions and action areas.	
6.	**Service Capacity Issues – Statutory & Voluntary** Education Health and Care (EHC) Plans PW informed the meeting that target statements were required to be converted to EHC Plans by 31 March 2018 and asked colleagues to be mindful that staff are working to tight deadlines. Education Health Care teams are under an extreme amount of pressure nationally to meet the deadline. Work is being undertaken with partners to enable an understanding of what is required from services. PW to circulate the dates of the course being provided by the Inclusion team. Work around earlier intervention in schools will help to decrease the number of Education Health and Care plans received. Templates are being developed with education services.	PW

	Early Health are attending meetings and offering support The meeting discussed the average waiting times for CAMHS and noted a decrease in some areas, though there has been a noted rise in attachment referrals to Early Help. School partnerships are looking at funding mental health workers and councillors within schools due to the reduction in school counselling services	
7.	**Crisis Care Concordat – for information** NP informed the meeting that the Crisis Care Concordat had been circulated for information. NP reported to the meeting that a further meeting was being arranged to update the concordat. New dates to be circulated to hold the meeting in September.	
8.	**Looked after and adopted Children's Therapeutic Team (LAACTT)** SW informed the meeting that additional funding has been received and half the new team members are now in post and the remainder will be in post by August. SW provided an insight into how the team will work with the child, carer and schools. SW informed the meeting of the Post Special Guardianship Order post. The role will include work around help and support for guardians.	
9.	**RDaSH CAMHS Reconfiguration** KS informed the meeting that the RDaSH CAMHS Reconfiguration has been completed. The meeting agreed to change the agenda item to RDaSH CAMHS update. KS informed the meeting of the current vacancies within CAMHS and these included a replacement vacancy in the Intensive Support team and a Family Therapist post which has been appointed to. RFB enquired about the CAMHS bulletin and specifically the need for guidance following the recent events in London and Manchester. KS will discuss with Michelle?	MR
10.	**Tier 4/Complex Cases feedback** NP informed the meeting that the Care Treatment Reviews have been renamed to the Care Education and Treatment Reviews (CETR). NP outlined that he had attended a CETR in Doncaster to shadow the process and updated the meeting. NP informed the meeting there was an urgent need for a CETR process to be established and that these may need to be undertaken every 3 months for children & young people identified at risk of admission.. There are 8-9 children in residential care who have ASD and or LD and may require reviews. NP will be leading the process.	NP

11.	**Directory of Services & 'Top Tips'** NP to discuss with Tracy in JP's absence. The Top Tips will need updating to take account of the 0-19 service changes. Any changes would also need to be reflected in the RMBC Top Tips. The meeting discussed the service directory produced by Healthwatch and the CCG. The latter supported the Top Tips used by GPs so were for a different purpose and more focussed that the Healthwatch document.	NP RFB
12.	**Voice of the Child** TB informed the meeting that Anders Cox was attending the monthly Voice of Young Persons In CAMHS meetings. TB reported to the meeting that the 'Different but Equal' Board are holding an event in July at the Carlton Park Hotel. CAMHS are having a market stall at the event and discussion are being held with the 'Different but Equal' Board to discuss the stall. The meeting was informed of the draft CAMHS passport and how the passport will enable people to relate their story without giving a repeated verbal account. SW informed the meeting that the LACTT are producing a passport, which will consist of a hand held file. JPA raised a concern around GPs having to update the passports and it was agreed that the passports are for the young person not GPs. PT informed the meeting that the Health and Wellbeing Board would need to be aware of the draft passport. PT to make them aware. The meeting was informed that a passport is used in Barnsley for people with learning disabilities and provides useful information on how to communicate with the person.	PT
13.	**Commissioner updates** **RMBC –** PT informed the meeting that the new quality of care framework was being circulated to schools. **SEND** – PT reported to the meeting that service requirements relating to SEND were being included in service specifications. **Section 75** - An agreement is being developed between RCCG and RMBC to manage parts of the RDaSH contract. There is to be a shared budget for LAC teams. This will not include Rise and Barnardos. NP informed the meeting of the joint posts with RCCG and RMBC.	
14.	**Rotherham Eating Disorders Service** The meeting discussed the structured intervention work being undertaken by SYEDA within Rotherham schools. The role of Rotherham Eating Disorders with schools was also discussed.	

	DW informed the meeting of the problems experienced by young people with Learning Disabilities experiencing feeding disorders rather than eating disorders. NP outlined that this had been discussed at a recent meeting regarding the Eating Disorder Service and had been flagged up as an issue in Doncaster. As a result, NP had put the Eating Disorder service in contact with the TRFT dieticians. KS informed the meeting that the service developed by SYEDA for primary schools was due to be evaluated.	
15.	**CAHMS Articles** Articles circulated for information. The meeting agreed the articles were a good source of information.	
16.	**Actions Log of the meeting held on April 2017** The meeting agreed that this agenda item was to be removed from the agenda as the actions are covered as part of the minutes.	
17.	**Any Other Business:** RFB **-** Pathway re Sudden Bereavement (Children) to be shared with partners. SG – Informed the meeting of the need for schools counselling following NSPCC no longer providing funding. Agenda item for October meeting. Pathway Leads - Jenny Nicholson to attend the October meeting.	RFB SG MR
18.	**Date and time of Next Meeting:** 11th October 2017, 9am - 11am, Larch Room, Oak House	