HEALTH AND WELLBEING BOARD

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

Date: **Wednesday, 19th September, 2018**

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 Chair 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 (Pages 1 - 8)

7. Communications (Page 9)
   - Question received from a member of the public
   - Peer Support Offer for Local Systems

For Discussion

8. HWb Strategy Aim 4 Update
   - Cultural Strategy– Polly Hamilton, Assistant Director, Culture, Sport and Tourism, to present (Pages 10-37
   - Strategic Housing Strategy consultation – Sarah Watts, Strategic Housing Manager, to present (Pages 38-87)
   - Loneliness (verbal update) - Ruth Fletcher-Brown, Public Health Specialist/Kate Green, Public Health Specialist

9. HWb Strategy Aim 2 Update (Pages 88 - 91)
   Better Mental Health for All - Rotherham's Strategy to promote the mental health and wellbeing of Rotherham people, 2017-2020 - Ruth Fletcher-Brown, Public Health Specialist, to present

10. Final Integrated Care Place Plan (Pages 92 - 154)
Chris Edwards, Rotherham CCG, to present

11. Rotherham Integrated Care Partnership Agreement (Pages 155 - 186)

For Information

12. Healthwatch Rotherham Annual Review 2017-18 (Pages 187 - 214)

13. Adult Social Care Vision for Rotherham (Pages 215 - 234)
Anne Marie Lubanski, Strategic Director, Adult Care, Housing and Public Health, to present

14. Health and Care Select Committee - Review of Integrated Care Systems (Pages 235 - 333)

15. The Local Government Association Green Paper: The Lives We Want to Lead
https://futureofadultsocialcare.co.uk/the-green-paper/

16. Integrated Care Partnership Place Board (Pages 334 - 344)
Notes of meetings held on 6th June, 4th July and 1st August, 2018

17. Date and time of next meeting
Wednesday, 21st November, commencing at 9.00 a.m. venue to be determined

HEALTH AND WELLBEING BOARD
11th July, 2018

Present:-

Councillor David Roche	Cabinet Member, Adult Social Care and Health **(in the Chair)**
Ian Atkinson	Rotherham CCG (representing Chris Edwards)
Tony Clabby	Healthwatch Rotherham
Sharon Kemp	Chief Executive, RMBC
Carole Lavelle	NHS England
Councillor Janette Mallinder	Chair, Improving Places Select Commission
David McWilliams	Assistant Director, Early Help and Family Engagement (representing Mel Meggs)
Chris Morley	Chief Nurse, TRFT (representing Louise Barnett)
Robert O'Dell	District Commander, South Yorkshire Police
Dr. Jason Page	Governance Lead, Rotherham CCG
Terri Roche	Director of Public Health
Janet Wheatley	Chief Executive, Voluntary Action Rotherham

Also Present:-

Steve Adams	South Yorkshire Fire and Rescue Service
Lydia George	RCCG
Kate Green	Policy and Partnership Officer, RMBC
Polly Hamilton	Assistant Director, Culture Sport and Tourism
Janet Spurling	Scrutiny Adviser to Health Select Commission
2 Members of the Public	

Apologies for absence were submitted from Louise Barnett (TRFT), Dr. Richard Cullen (RCCG), Chris Edwards, (RCCG), AnneMarie Lubanski (RMBC), Mel Meggs (Interim Strategic Director Children and Young People's Services), Councillor Short (Vice-Chair, Health Select Commission), Kathryn Singh (RDaSH) and Councillor Gordon Watson (Deputy Leader).

1. KATE GREEN

The Chair reported that, due to Kate taking up a post within Public Health, this was to be her last Board meeting.

On behalf of the Board, he thanked Kate for all the support she had provided to the Board and wished her well in her future position.

2. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

3. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

How could Learning Disability Service users be confident they would have an individual care assessment, before their services were withdrawn, as promised with the Council's track record of conducting assessments so far? How sensible was it to agree the closure of the Centres and Respite Service before the assessments had been done?

In terms of strategic priorities, you talk about how social isolation and the lack of social communication is as a prelevant risk factor for early death as smoking 15 cigarettes a day and well known risk factors such as Obesity and inactivity. When talking about people with Learning Disabilities in terms of their ability to get out and see people in their community they are the most vulnerable so where do they come together for social interaction if you are shutting the day centres?

The Chair stated that the Board had the overall remit of health and wellbeing; the Day Centres came within the Council's responsibility. He had questioned the Services in detail about assessments and was very confident that the resources were in place to ensure that all the assessments took place.

Social isolation was important and why it was one of the new priorities of the Board as well as 3 officers of the Council looking at the overall integration plan for loneliness to present to the Board sometime in the future. There were 3 main ways of moving forward - firstly Shared Lives, secondly Direct Payments and thirdly through a number of organisations that people with Learning Disabilities and their carers could access if they so wished.

In terms of the Health Service Review, I went to 2 meetings one of which was the Scrutiny Panel in Wakefield where the Chair of the Scrutiny Panel questioned the CCG on the consultation process and its depth and gave them a few ideas of how they should widen the consultation. I also attended the Judicial Review in Leeds and the Judge, in her remarks afterwards to the barrister, had made the point that in terms of the consultation process with the Scrutiny Panels it had perhaps fallen short.

In terms of the Hospital Services Review have we done the job in terms of letting people know what is happening? The videos I have seen were quite worrying in that they were rather bland. You would think from it that there were no problems from the Health Service.

The Chair stated that, in terms of the Independent Hospital Review, he had expressed his own concern about the process. He could not answer for the Scrutiny Panel but from looking at what was in the report at this stage it was very bland with not much detail and as such the Council response stated that it would like to see more information and detail about what might be coming down the road and making sure Rotherham got its

fair share of the hubs. We do have concerns about the lack of consultation. We know there have been events but are concerned about the lack of consultation with the Council and Members. We have made that point in our response.

There was a commitment at the moment that all the local hospitals and A&Es would remain as they were.

Janet Spurling, Scrutiny Adviser to the Health Select Commission, stated that the Select Commission had been updated on the key points from the initial report but obviously, as all the local boards were looking at the report now and giving their feedback, there would be time to look again once there was something more concrete going forward. That would be scrutinised in depth where appropriate.

Dr. Jason Page reported that his practice had been approached by a team of people who would be carrying out more public consultation. One of the things they would be doing was attending GP surgeries and talking to patients so there was another layer of public consultation being organised. They would only do that once they had something to discuss.

Ian Atkinson, CCG, reported that it was an independent report into the Health system which partners had been asked to comment on by 12th July in terms of the recommendations. The views of partners had not been sought previously, so this would start to develop potential recommendations in each workstream when a view would be able to be taken as to how it would then impact on local systems. It might impact in different ways so each discrete area may need its own consultation.

I went into some of your documents about what affects people's health and one of the key factors was of course the workplace and stresses from the workplace. I recognise and know the CCG must be putting significant pressure on the hospital to form subsidiaries which is very worrying for the workforce. Campaigners had noted that other authorities were starting to pull away from wholly owned subsidiaries. Is this Board able to pass comment or put some pressure on the stemming of this process?

The Chair agreed that health and the workplace was very important. There was a Healthy Workplace Charter, including Mental Health, which the South Yorkshire authorities had pulled together and was to be piloted in 10 organisations in the near future.

The Place Plan had quite deliberately been included in the remit of the Board in order that the Rotherham Integrated Care Partnership reported into it. There was a Place Board Executive under it which was responsible for the day-to-day work of the Place Board. Currently the Place Board was focussed on positive things to improve the health of Rotherham. In terms of pressure, it would be up to the Board to decide when it affected the health of Rotherham people to start thinking about what our reaction would be but as at the moment there was no talk

whatsoever of anything like a wholly owned subsidiary coming into Rotherham.

Chris Morley, TRFT, confirmed that a wholly owned subsidiary was being considered by TRFT but no decision had been made as yet. It would be a company owned by the NHS so would still report into the TRFT Board.

Ian Atkinson, CCG, clarified that it was not the case that the CCG were putting significant pressure on the TRFT around wholly owned subsidiary.

4. MINUTES OF THE PREVIOUS MEETING

The minutes of the meeting of the previous meeting of the Health and Wellbeing Board held on 16th May, 2018, were considered.

Resolved:- That the minutes of the previous meeting held on 16th May, 2908, be approved as a correct record.

5. COMMUNICATIONS

A. The Chair reported that the Kings Fund had recently published a document, undertaken by researchers from the University of Durham, about health and wellbeing boards and what they had achieved.

A copy of the document would be circulated to Board members.
Action: Kate Green

B. The latest report in a series of reports undertaken on behalf of the Local Government Association was now available and would be circulated to Board members.
Action: Kate Green

6. HEALTH AND WELLBEING STRATEGY: ACTION PLANS AIMS 1-4

Further to Minute No. 75 of the previous meeting, the Board sponsors presented the final versions of 4 action plan aims.

Whilst the plans were submitted as final versions, they would continue to be live documents, being updated as required. Although the Strategy was agreed for a 7 year period, the action plans would be presented as 2 year plans and, therefore, not all activity would be included or completed in each 2 year cycle.

Discussion ensued with the following issues raised/clarified:-

Aim 1

David McWilliams reported on behalf of Mel Meggs

- Acknowledgement that there was more work to be done under all 4 aims including selecting a number of meaningful Key Performance Indicators that could be reported to the Board. A highlight report should then be submitted highlighting the exceptions

- Current performance should include numbers where applicable to enable comparisons to be made

Aim 2

Ian Atkinson reported on behalf of Kathryn Singh

- The roll out of 5 Ways to Wellbeing had been successful to date

- 500K funding from South Yorkshire and Bassetlaw Integrated Care System had been secured to assist with suicide prevention work. Notification was awaited of Rotherham's portion of the funding

- Real improvement on IAPT target which was consistently in the top 25%

- Quarter 3 assessment received for CAMHS which showed real progress had been made, however, the challenges continued

- Rotherham was now the highest in Yorkshire and the Humber for Dementia diagnosis

- Rotherham would receive additional resources this financial year over and above the CCG allocation for CORE 24

- The Autism Strategy was expected shortly

- The disparity of women's life expectancy compared to men's was not included within the action plan

Aim 3

- More work was required in general on this Aim

- It was noted that more GP Practices were needed to volunteer to trial the the clinical pad, which was about encouraging more people to be physically active

- The training for MECC was quite narrow but work was taking place with different groups of professionals to make it more relevant to their work

Aim 4

Rob O'Dell reported supported by Polly Hamilton

- Aim 4 encompassed the environment in its widest sense and, therefore, would take a number of years for things to happen

- There was a cross over with the Safer Rotherham Partnership – not to replace the actions but to look across both Boards and ascertain what contribution could be made

- It was the intention to recruit a Public Health Registrar/student to deliver a piece of work reviewing the Local Plan and how its policies impacted upon health and wellbeing

- Priority 4's wording had been changed to reflect all culture/leisure activity and not just green spaces

- A draft of the Cultural Strategy was to be launched at the Rotherham Show in September 2018

- Active Dearne project – in collaboration with Barnsley and Doncaster Councils and Yorkshire Sports. The proposed pilot would focus on Swinton

- The Selective Licensing Scheme had been very successful in Eastwood and was to be extended into other areas of Rotherham

General

- Evidence showed that Social Prescribing consistently had positive effects on health and wellbeing

- The Government was to announce funding around loneliness. A conversation was required on how bidding to the fund would be tackled in Rotherham and whether there should be one co-ordinated bid rather than multiple bids

- The need to work with the Building Stronger Communities Board

- The Council was about to appoint the company who would be taking forward the Town Centre Master Plan

Resolved:- (1) That the high level activity identified as contributing towards the Strategy aims and priorities be approved.

(2) That the amended wording for Aim 4 Priority 4 be approved to read "increasing opportunities for people of all ages to participate in culture, leisure, sport and green space activity in order to improve their health and wellbeing".

(3) That updates on each individual aim be submitted to future Board meetings.

(4) That work on identifying the reasons for the disparity between males and females' life expectancy be included within aim 3.

ACTION:-

That David McWilliams be the lead for Children and Young People's Services with regard to Aim 1 outcomes

That Board Sponsors to identify 2 -3 Key Performance Indicators to reflect the aim and finalise their action plans.

7. INTEGRATED CARE PARTNERSHIP PLACE PLAN

Ian Atkinson, RCCG, gave a brief verbal update on the Integrated Care Partnership Place Plan.

There had been significant progress with the final Plan being submitted to the Integrated Care Partnership Board in September and then the Health and Wellbeing Board in terms of governance.

There were 4 key changes in the narrative:-

Workforce and organisational development
Enhanced finance aspect
Enhance estate dialogue
Digital agenda

Resolved:- That the update be noted.

8. HOSPITAL REVIEW

The Board considered the slides included within the agenda pack.

The Chair commented that no other organisation other than the RCCG had provided any comments on the Review. It had been agreed at the Integrated Health and Social Care Place Board that all partner organisations would individually provide written comments that would be incorporated into a collective response.

Ian Atkinson, RCCG, reported that the next stage would be, subject to the feedback, production of an outline business case to be considered against the objectives. There would be consultation and further engagement.

It was pointed out that the Review covered the health system and not health and social care. The Council was informed but not part of the consultation.

9. ROTHERHAM INTEGRATED CARE PARTNERSHIP PLACE BOARD

The notes of the minutes of the Rotherham Integrated Care Partnership Place Board held on 4th April and 2nd May, 2018, were noted.

10. DATE AND TIME OF NEXT MEETING

Resolved:- That a further meeting be held on Wednesday, 19th September, 2018, commencing at 9.00 a.m. in the Rotherham Town Hall.

Communication in relation to a question received for the Health and Wellbeing Board

The Health and Wellbeing Board, via Cllr Roche as the chair, received the following question from a member of the public on 29 July 2018.

"The organisation in charge of the Health and Wellbeing Board i.e. the council must take these questions and statements and have them answered by the board under the Public Sector Equality Act. Circumventing any relevant policy that is not a law, that would block these questions or statements, any non-compliance of this request will be subject to a legal challenge by myself [name removed]*and any relevant persons or peoples to whom the issue applies.*

Statement:
JSNA does not provide the full waiting list for primary care and secondary care services for assessment and diagnosis. Given that it is up to the statutory authority to deal with making sure that public sector equality is upheld will they do the following:

Questions 1) Will the chair including all associated bodies that commission local services, now ask or provide waiting lists for each contract in place for assessment and diagnosis, in the NHS and provide the total cost of clearing each waiting list?

Question 2) Will the chair request that the waiting list for all Social Care services are published on a monthly basis for review emergency or otherwise, and the first assessment and provide a cost for each month to clear that waiting list?

Question 3) Will the board then provide the list to the Sectary of State for Health and Social Care, to make sure they are aware of the waiting list and hold them to account on funding the clearing of such waiting list under the health and social care act and the care act?

Please do the above in 3 months of your next board meeting.

Failure to comply could lead to corporate manslaughter charges as this could be deemed a failure of each body, its associated professionals in not meeting the public sector equality duty."

A response was provided via email from Cllr Roche which stated:

"Thank you for your email. Unfortunately the Rotherham Health and Wellbeing Board cannot accept your request as it is not within the remit of the Board to do so.

The Health and Wellbeing Board is a strategic body whose role is to improve the health and wellbeing of the people in its area by encouraging integrated commissioning between health, social care and public health. It does not have a role in monitoring performance or waiting times, which are operational matters. You should therefore direct your request for information on waiting lists and the cost of clearing these lists to each individual provider of commissioned services."

A Draft Cultural Strategy for Rotherham 2018 - 2025

INTRODUCTION

Welcome to this draft Cultural Strategy for Rotherham.

It has been developed by Rotherham's Cultural Partnership Board, an organisation which was formed during 2018 and which brings together people and agencies that care passionately about Rotherham's future – including artists, designers, local businesses, voluntary organisations, regional agencies, and Rotherham Council.

Everyone has come together to create a Cultural Strategy for Rotherham that aims to transform our town and borough into a better place to live, work and visit.

We need your help to make this happen.

We would really like to hear your views on this Draft Strategy and your ideas for making it better:

1. Can you suggest any improvements?
2. Do you think we've left anything out?
3. What do you think are the most important things we should do?
4. Do you agree with our vision for Rotherham?
5. Do you support our key goal – to enable everyone to get active, get creative and get outdoors, more often?
6. What is brilliant about culture in Rotherham and where could it be better?
7. What can you or your organisation do to support the ambitions and actions of the Strategy?
8. What do you think success for the Strategy will look like?

Please email us before the 31st October 2018 at info@likerotherham.org to tell us your thoughts.

Thank you!

Councillor Sarah Allen
Chair, Rotherham Cultural Partnership Board

WHY CULTURE MATTERS

Culture encompasses our natural environment, parks, woodland and countryside, sport, the arts (including performing arts, music, theatre, dance, visual art, craft, literature, circus, film and digital media), tourism attractions, libraries, heritage, museums and archives, events and play.

In the 2016 Views of Rotherham consultation, local people told us that culture matters to Rotherham:

- 82% saw well looked-after parks and public spaces as a priority
- 75% felt that having local places to go, such as museums and parks, is important
- 72% valued a good range of things to do for teenagers
- 67% thought that a bigger range of low cost leisure activities is important

Culture matters to Rotherham, not simply because people want things to do and places to go, but because culture has the power to make a significant impact on wider strategic priorities important to Rotherham's future. It has the power to shape how we think and feel about each other and where we live.

PURPOSE OF THE STRATEGY

The development of a Cultural Strategy is an important next step in shaping Rotherham's future and delivering the vision set out in "The Rotherham Plan: a new perspective 2025".

The Strategy sets out Rotherham's aims for culture, leisure and green spaces. It describes how we will develop our local assets and resources, making the best use of what we have got and building agreement about our priorities for development, supporting the case for external funding and investment.

This Strategy will build understanding about how engagement with the arts, sport and natural environment can improve people's personal growth, health and wellbeing and sense of purpose. It will set out how enabling more people to participate, to get active, get creative and get outdoors, will not only make sure that everyone feels part of and proud of our community but also helps to strengthen our economy.

The Strategy is also an important way for us to build on Rotherham's unique identity, as expressed through our cultural habits and engagement. Rotherham has a wealth of beautiful green space, parks and countryside which are wonderfully accessible from our doorsteps. It has an abundance of places to participate in sport, music and leisure pursuits – many of which sprang from our industrial roots in the form of miners' halls and working men's clubs and pubs, and which still offer a rich mix of entertainment today. There is a year-round programme of events and festivities which bring people together – from Wath Festival, to the Festival of Angels, to Rotherham Show.

The millions of visits a year to Rotherham's cultural, sporting and leisure places, events and activities are just the start - this Strategy underpins our ambitions for the economic development of the borough, strengthening our identity, building pride and helping to transform perceptions of those who live here, those who view us from a distance and those who want to invest in our future.

Rotherham's achievements in culture, creative industries, sport and green spaces are an important way for us to celebrate success, and showcase what makes Rotherham a great place to live, study and do business in. Beyond Rotherham's great location and connectedness to the rest of the UK – it's also what we offer to families, students, businesses and others who may want to make this beautiful borough their home, where they can be confident that their passions and talents will be nurtured.

In recent years, just as our industries and communities have changed, so have our cultural habits and aspirations. Digital technology has both opened up our world and yet reduced our engagement with our own neighbours. Reductions in public sector investment have resulted in fewer opportunities for people to take part. There is less variety of affordable, quality activities and events available to them and fewer people to encourage and enable them to participate. This has significant consequences. It diminishes the talent pool which could mean that there are fewer people from Rotherham who will have the opportunity to turn their passion and talent into a sustainable career or business. It constrains the wider social, civic, health and educational benefits which are attributed to participation in culture, sport and green spaces and increases pressure on health and social care services.

This strategy is a call to action to local people and to local, regional and national partners to come together to make sure that our cultural life is given the opportunity to flourish. Because a flourishing cultural life will grow a flourishing community and a thriving economy.

Because culture matters to Rotherham.

OUR VISION

We believe in Rotherham, our place, whose stories we are proud to tell.

We want to enable our cultural, leisure and tourism sectors to make a brilliant contribution to life in Rotherham – growing us as individuals, helping to create a flourishing community and nurturing a thriving economy.

By 2025, we want to have inspired more people to become more active, more often, to take part regularly in the arts and to enjoy the benefits of our natural landscape, parks, museums and attractions.

Rotherham will be a place where everyone has a story to tell about our astonishing heritage of industry, innovation and the creative and sporting achievements of our people.

OUR KEY PRINCIPLES

In delivering this strategy, partners are committed to the following principles. We will:

- Appreciate, support and celebrate what's already great and unique about Rotherham
- Be imaginative, excited by new ideas and seek to innovate in order to improve the quality of what we do and how we do it
- See Rotherham through the eyes and ambition of our children and young people and create with them a place we're all proud of
- Celebrate our diversity and work hard to make sure everyone can get involved
- Be great partners, recognising the value of collaboration
- Prioritise investment where we can make the most difference

ROTHERHAM'S CULTURAL PARTNERSHIP BOARD

Nobody can deliver transformation alone. The voluntary, independent, public, commercial, professional, educational and private sectors, individual artists, sportspeople, producers, participants and champions all play significant roles. Regional and national sector specific organisations have crucial parts to play as critical friends, sources of expertise, guidance and potential investment.

In 2018, Rotherham's Cultural Partnership Board came together. This new board has developed this draft Strategy and will lead on its delivery, strengthening linkages with the Rotherham Together Partnership and its related boards and plans.

The Cultural Partnership Board is working with a wide range or organisations, including: the Embassy for Reimagining Rotherham, (Rotherham's Cultural Education Partnership), the emerging Rotherham Activity Partnership, the Business Growth Board, the Health and Wellbeing Board, the Youth Cabinet, and the Different But Equal Board, and is keen to further strengthen partnerships across the culture, leisure and tourism sectors.

RESOURCING THE STRATEGY

Organisations, individuals and businesses across the sector, including Rotherham Council, already make significant investment in the cultural growth of Rotherham. In addition a number of external agencies have helped, or are helping, to fund cultural activity, including Arts Council England, Sport England and the Heritage Lottery Fund.

There are likely to be significant changes during the life of the Strategy, not least in the use of new technology, which could impact on the way people access cultural, leisure and sporting activities. We will need to make best and flexible use of resources, reacting positively and swiftly to changing needs and demands.

The Strategy is not about necessarily spending more money. Many of the actions identified can happen without further investment, using no cost or low cost solutions. It is much more about collaboratively making the very best use of the wealth of existing resources, skills and assets and ensuring that the sector becomes increasingly resilient.

The Cultural Partnership Board will work together to build a sustainable and flexible funding model which will make better use of resources, will strengthen Rotherham's position as "investment ready" and present a joined-up approach to securing external support and funding.

TAKING PART

Research shows us that when people participate in sport, physical activity, libraries, the arts, heritage and green spaces, they have better health, better education and better jobs. Participation brings our communities together and helps to grow our economy. However, participation in Rotherham is lower than in most of the rest of the UK. **Therefore our key goal is to enable everyone to get active, get creative and get outdoors, more often.**

We want to make sure that everyone living in, studying in and visiting Rotherham enjoys a healthy, thriving and vibrant cultural life. We want to inspire more people to take part in culture, leisure, green spaces and sport. We want people who do take part to do so more often and to have a great time.

People come across culture at different times of their life and in many different ways. It may be from worry, concern, loneliness or boredom; from interest, curiosity, ambition or passion. Culture for one person could be a life-long interest, for another a different experience every day. No matter, the impact and memories can last a life time – a poem or song learned by heart, laughing until you cry at a pantomime, snuggling up with a good book, playing the guitar to lull a baby to sleep, a family bike ride on the beach, a stroll in the park, winning a race or cheering on a team.

Everybody knows when it happens, that feeling of being in the moment, of being part of something great – but one of the challenges for the sector is to capture that moment and be able to share what it means and the impact it has, in order to fulfil our aim to inspire more people to take part. We need to quantify the buzz.

There are many ways of being involved in culture; for example, as

- a supporter: such as a volunteer, a member of a “Friends” group, or a fundraiser
- a deliverer: such as a lifeguard or a librarian, a museum assistant or an events manager
- an attender: going to a football match, visiting a gallery, walking in the park
- a maker: such as a gardener, artist or choreographer
- a guide: such as a swimming coach, a creative media lecturer, or someone who runs a flower arranging class
- a leader: such as the Arts Council, Sport England, an elite performer or passionate advocate

And taking part; for example, as

- someone who enjoys a directed walk in the local park, completes the Couch to 5k programme, runs a marathon
- someone who learns to ride a bike, joins a cycling club, competes in the Tour de Yorkshire
- someone who reads a book, joins a readers’ group, becomes an author

To inspire and encourage more people to take part, we will:

- Find out more about who is getting involved, who isn't and why
- Find creative solutions to removing barriers to participation
- Work together to signpost people to the right opportunity for them
- Build in accessible ways to encourage and support people to take part more often
- Celebrate what is brilliant and work together to make improvements

NURTURING AND GROWING OUR ASSETS

Culture is life affirming, life enriching and life changing. It's the simple pleasure of entertainment, the joy of inspiration and the challenge of ambition. Taking part helps us to learn more about ourselves and the world around us, tests our preconceptions and gives us new and fresh perspectives. It is clear that culture in its broadest sense underpins the Rotherham Plan's vision for Rotherham in 2025: "a place where people want to live, work, study, invest or visit. We want to develop a competitive, sustainable economy that builds on our strengths in advanced manufacturing, culture and innovation, and we want local people to live healthy, fulfilling lives in a place where local assets are used to their full potential."

For that to happen we need to put a brilliant infrastructure in place which connects our high profile, nationally admired, amazing places with our well-loved, vital, local neighbourhood spaces. We need to celebrate everything from Wentworth Woodhouse and Gulliver's to local libraries, leisure centres and parks. We also need to fill the gaps – develop a culturally rich town centre, take care of and develop our beautiful natural and built heritage, create and deliver a wonderful cultural offer for children, young people and their families.

Rotherham already has some great cultural assets and they are getting better:

- 82% of Rotherham residents see well-looked after parks and public spaces as a priority
- 72% of Rotherham is beautiful green space
- 99% of users love our libraries, situated within 2 miles of 98% of our communities
-
- In the north, Wentworth Woodhouse will become a destination for the nation
- In the south, Gulliver's Valley Resort brings thrills to the region
- In Rotherham centre, we will build a cinema and work together to create new space for the arts

To build and improve our cultural assets, we will:

- Review our cultural, sporting, natural and built heritage assets to understand where investment is needed most
- Do all we can to develop local skills, talents and businesses, bringing in new, additional and sustainable investment
- Listen well to ensure that we take good decisions and make sure we can show what's getting better, prioritising those areas where we can make the most difference
- Work hard together to build vibrant, dynamic, high quality cultural experiences for the place we love
- Use technology to create a Rotherham which is a fun, surprising, place, which will attract new audiences and provide a platform for technology based creative industries to showcase their talents
- Improve support for organisations and businesses across Rotherham who are working hard to deliver sporting and cultural opportunities, events and tourist attractions

STRATEGIC CONTEXT

National

In March 2016, the Department for Culture, Media and Sport published The Culture White Paper, the first white paper for culture in more than 50 years. The paper has four areas of focus:

- Everyone should enjoy the opportunities culture offers no matter where they start in life
- The riches of our culture should benefit communities across the country
- The power of culture can increase our national standing
- Cultural investment, resilience and reform

The White Paper set out the value of culture in terms of:

- The intrinsic value: the enriching value of culture in and of itself
- The social value: improving educational attainment and helping people to be healthier
- The economic value; the contribution culture makes to economic growth and job creation

The White Paper set out Government's commitment to ensuring that culture is an essential part of every child's education, both in and out of school. It also set out that culture is integral to the identity of local areas and has the potential to transform place.

Furthermore, the Government is keen that more partnerships are formed between national and local levels to put culture at the heart of place-making.

“Great art and culture for everyone”, published by Arts Council England in 2010 and updated in 2013, sets out a vision and 10 year strategic framework for the development of arts, museums and libraries.

Sport England’s strategy “Towards an active nation”, published in 2016, aims to make sure everyone can experience the benefits of sport and physical activity, regardless of age, background or ability.

Historic England’s corporate plan 2018-21 sets out actions they will take to support their role of helping people care for, enjoy and celebrate England’s spectacular historic environment

The Department for Environment, Food and Rural Affairs’ “A Green Future: Our 25 Year Plan to Improve the Environment, published in 2018, sets out goals for improving the environment within a generation.

Fields in Trust’s “Revaluing Parks and Green Spaces”, published in 2018, provides a robust economic valuation of parks and green spaces in the UK as well as valuing improvements in health and wellbeing associated with their frequent use.

The Ministry of Housing, Communities and Local Government: National Planning Policy Framework – Draft Revision, published in 2018, (Chapter 8 - Promoting Healthy and Safe Communities), talks about the importance of access to a network of high quality open spaces and opportunities for sport and physical activity make an important contribution to the health and well-being of communities

The Creative Industries Federation’s “Industrial Strategy: a blue print for growth”, published in 2017, demonstrates the role the creative industries play in the modern economy and how a UK industrial strategy can use them to deliver growth.

Regional

The Sheffield City Region is located at the strategic heart of the country. It is comprised of the nine local authority areas of Barnsley, Bassetlaw, Bolsover, Chesterfield, Derbyshire Dales, Doncaster, North East Derbyshire, Rotherham and Sheffield.

There are currently nine sector groups, including two which relate to culture:

- Creative and Digital Industries
- Sport, Leisure and Tourism

The Sheffield City Region's Mayor recognises the importance of culture to the region and, prior to his election in May 2018, outlined plans to put forward a Sheffield City Region of Culture bid to celebrate the best of the region. The development of Rotherham's Cultural Strategy will enable us to build partnerships with the wider city region on projects and issues of shared interest, strengthen Rotherham's role within the City Region and make the case for investment.

Rotherham will be a lead player in Sheffield City Region's bid to be the UK City of Culture in 2025.

Local

The development of a Cultural Strategy is an important next step in shaping Rotherham's future and delivering the vision set out in "The Rotherham Plan: a new perspective 2025", particularly supporting the game-changing activities relating to:

- A place to be proud of: restoring faith and optimism in the borough, transforming perceptions and rebuilding Rotherham's reputation and encouraging ambition
- Skills and employment: building talent, educational achievement and skills; growing creative, leisure industries and the visitor economy
- Town centre: supporting regeneration and place making
- Building stronger communities: growing better neighbourhoods, strengthening community cohesion, building empathy, reducing isolation, improving quality of life and enabling personal growth
- Improving people's health and well-being: encouraging physical activity, strengthening emotional resilience and positive mental health

The four themes for a "child friendly Rotherham" are closely aligned with the cultural planning process:

- A vibrant borough with age-appropriate, fun things to do; supporting their engagement in culture, sport and the outdoors
- Places in Rotherham to be safe, clean and welcoming
- Children and young people have a voice and are listened to
- Opportunities to bring together and celebrate Rotherham's diverse communities

The Cultural Strategy is contributing to the development and delivery of a range of other plans and initiatives, including:

- The Rotherham Story and its key themes of Engineering Excellence, Living Green and Pushing Boundaries
- Rotherham Economic Growth Plan and the town centre masterplan
- Health and Wellbeing Strategy
- Thriving Neighbourhoods Strategy
- Safer Rotherham Partnership Plan 2016-19
- Building Stronger Communities Plan 2017
- Children and Young People's Plan 2016-19

DEVELOPING TALENT, GROWING BUSINESS

We want everyone in Rotherham to have the opportunity to turn their passion into a profession.

Because we want Rotherham residents to contribute to the success of our economy and our nation – on our stages, screens, sports pitches and in industry

By 2025 we will create 500 new volunteers, 50 new apprenticeships and 1500 new jobs in the creative, digital, cultural, leisure and tourism sectors

Rotherham's proud industrial heritage of steel making, coal mining, pottery and glass-making is well known and celebrated. Innovation and engineering excellence is in our DNA – shared with the world in the Rotherham plough, the Bailey bridge and the screw down tap. These historic inventions continue to find expression with the Advanced Manufacturing Park and wider Waverley development in the south west of the borough, aiming to deliver 4,000 new homes and 3,400 jobs over a 20 year period. Despite the decline of our traditional industries, employment has grown in recent years and the number of jobs in Rotherham has increased to a record 117,000. Rotherham is now the fastest growing city-economy in Yorkshire and the eighth fastest growing economy in the UK.

Adult qualification levels are below average, notably higher skills, reflecting Rotherham's industrial legacy. However, most pupils attending Rotherham's schools have good attainment, with GCSE performance above the national average. The University Centre Rotherham, which opened in autumn 2018, will offer degrees and professional training qualifications in a range of subjects, including creative, digital and visual arts, expanding creative horizons for a new generation of students.

Many communities were built up around industry, which shaped leisure and cultural activities and gave us our bands, choirs, amateur dramatic societies and sports clubs which brought people together and shaped our local identity, sense of belonging and civic pride.

Like many places, Rotherham's town centre has experienced particular challenges. However the regeneration of Forge Island, the conservation and redevelopment of our beautiful natural and built heritage and the continued resilience of a number of independent businesses gives reason for optimism. Our historic buildings are finding new life as shops, bars and hotels. Culture, leisure and creative industries have a major role to play in revitalising our town so that Rotherham can compete with its neighbours and once again become a bustling, thriving and attractive place.

In the south of the borough, the development of the brilliant Gulliver's Valley Resort, the introduction of major new camping and caravan facilities, the revitalisation of Rother Valley Country Park and the development of the historic canal network will create new, high quality experiences for residents and visitors alike.

In the north, the astonishing Wentworth Woodhouse, now a charitable trust, provides Rotherham with a nationally-significant new tourism product. This monumental stately home, adjacent to the beautiful Dearne Valley, the historic towns of Elsecar, Wath and Swinton, will create a rival to Chatsworth and a new hub for cultural tourism which will benefit the whole borough.

All of this is set within the lush, verdant landscape that makes up a whopping 70% green space of our borough, making Rotherham one of the most attractive and liveable places to reside, study and do business.

We will:

1. **Develop new products, supporting business growth:**

- Open and promote Gulliver's Valley Resort, a brand new inland resort and theme park designed especially for families
- Open a caravan park at Rother Valley Country Park to encourage more overnight stays
- Develop Wentworth Woodhouse as a heritage attraction, business location and hub for cultural tourism
- Consider ways to develop a rich and diverse cultural offer within Rotherham town, including the redevelopment of Forge Island
- Increase the numbers of Arts Council England National Portfolio Organisations in Rotherham
- Work with Gallerytown, Rotherham Open Arts Renaissance, Clifton Park Museum, Rotherham Planning Service, local developers and other partners to commission high quality new artworks to improve our public realm

2. **Create new employment opportunities**

- Work together to create an additional 1500 jobs in sport, leisure and culture by 2025
- Work with local partners to encourage more commissioning and employment opportunities for local artists, creatives, sports, leisure and environmental organisations and professionals

3. Develop workforce skills

- Work through the local cultural education partnership and the district activity partnership to encourage schools to support engagement in arts, design, physical education and outdoor learning
- Provide opportunities to improve literacy, digital skills and job readiness within our libraries and neighbourhood locations
- Increase the range and numbers of cultural apprenticeships and volunteering opportunities, creating 50 new apprenticeships and 500 new volunteers by 2025
- Encourage take up of sector specific higher level qualifications
- Encourage take up of sector specific customer care training to ensure a warm Rotherham welcome to all our visitors

4. Develop Rotherham Town Centre

- Encourage the development of a new cinema on Forge Island
- Work with partners to create a new cultural hub to increase engagement, provide a home for local creative businesses and increase footfall within the town centre
- Develop new public art to improve the attractiveness of the urban environment
- Improve signage and encourage better navigation of the cultural and leisure offer within Rotherham
- Continue to support the delivery of imaginative events which act as a draw and support the wider retail, food and hospitality sectors

BUILDING PRIDE, CELEBRATING OUR UNIQUE IDENTITY

We want all our residents to really like Rotherham. By 2025, we want other places to want to be like Rotherham.

We will:

- **Develop our events and activities programmes to make them unique to Rotherham, celebrating our heritage and our local stories**
- **Grow tourism to encourage more local people and visitors to enjoy the cultural life of the borough**
- **Work with the media and Rotherham Pioneers to celebrate the achievements and share positive stories about our creative, cultural, sporting and green space sectors**
- **Work with the Local Enterprise Partnership and others to make Sheffield City Region the next UK City of Culture in 2025**

Rotherham's narrative is changing. It undoubtedly has its challenges but despite, or perhaps because of, these challenges, Rotherham people remain staunchly proud of their heritage and culture. From the stunning countryside of the rural south, to the treasures of Clifton Park and Museum, from Rotherham United's magnificent town centre stadium to the grandeur of Wentworth Woodhouse in the north, Rotherham has many new stories to tell.

The identity Rotherham shows to the world has in recent times been challenged in a fundamental way. Those challenges spread loud and clear throughout the borough and people were galvanised to act. There is now a strong and pervasive determination to reclaim a new Rotherham, with a refreshed identity as a vibrant, multicultural, hard-working, fair and harmonious place which promotes equality, challenges intolerance, embraces diversity and celebrates its achievements.

Rotherham has numerous heritage, sporting and cultural attractions, including; the unique Grimm and Co, a famous children's Shakespeare Festival, astonishing heritage landscapes and sites, thriving sports and leisure centres, award winning parks, a well-attended and much loved Civic Theatre, great sports clubs, fantastic days out at Magna and the Butterfly House, a rich and varied music scene and a host of quirky local festivals. We need to make more of and promote our great assets, whilst working hard to seek investment to be better.

Our green spaces, wildflower verges, local and country parks and tree lined streets are rightly much loved by local residents. This view was shared loud and clearly in the Views from Rotherham consultation in 2015. Visitors to Wentworth Woodhouse, Boston Castle, Magna and Clifton Park Museum, with its small wonders and big stories, can explore and experience the wonder and joy of their own and shared heritage. Our award and prize winning sports clubs, champions and professionals give us cause to celebrate and cheer.

As the cultural and leisure offer in the town centre and its surroundings grows and develops and as exciting developments both in the south of the borough, centred around Gulliver's and Rother Valley Country Park, and in the north, where Wentworth Woodhouse finds new life as a creative and cultural hub, all become reality, Rotherham residents will be proud to welcome in regional, national and international visitors.

We will:

1. **Promote our offer**

- Produce a destination management plan and create a new destination management organisation in order to develop the visitor experience and welcome, connecting our cultural offer with the wider food, drink, retail and accommodation offer
- Work with the SCR Tourism Forum and Welcome to Yorkshire on shared promotional opportunities
- Celebrate the achievements of local cultural, leisure and tourism organisations and individuals
- Work with the wider business community to strengthen opportunities for partnership and encourage sponsorship and employee engagement activities

2. **Develop a high quality and innovative culture, sport and green spaces sector**

- Build on the Great Place: Elsecar and Wentworth project and work with Wentworth Woodhouse Preservation Trust to develop a nationally and internationally renowned cultural and creative hub
- Build on the Gulliver's and Rother Valley Country Park developments to create a cohesive, high profile and high quality cultural and leisure offer in the south of the borough
- Deliver a programme of high profile sporting and cultural events, including Yorkshire Day 2020
- Work with the Football Association on a bid to host the Women's UEFA 2021, along with 8 other locations in England
- Develop borough wide programmes to capture local imagination and build local pride, including supporting the ambition for all schools to take part in the Mile a Day Challenge and Arts Mark
- Work with children and young people to deliver their Manifesto for Reimagining Rotherham and supporting their participation in culture, sport and the outdoors

3. Celebrate and develop Rotherham's unique identity

- Work collaboratively with Rotherham Pioneers and the Rotherham Ambition Board to develop and deliver the Rotherham Story and its themes of living green, engineering excellence and pushing boundaries
- Work through the Cultural Partnership Board and its networks to ensure that our events and activities strengthen and celebrate our collective Rotherham identity
- Work with community partners to celebrate our diverse heritage and build our joint identity

BUILDING STRONGER COMMUNITIES

We will continue to build an amazing programme of events to bring people together, making sure that everyone has a fair opportunity to get involved

We will celebrate:

- **The 40th anniversary of Rotherham Show in 2019**
- **Yorkshire Day in 2020**
- **Women's European Football Tournament (UEFA) in 2021**

We will create more opportunities to celebrate our diverse heritage, our collective Rotherham identity and to imagine our shared future.

Rotherham has a vibrant and diverse mix of people, cultures and communities. Its 110 square miles feature a range of small villages, urban towns and rural environments, with 70% being open countryside. Many communities share the challenges of deprivation, particularly those which were most affected by the decline in the traditional coal and steel industries.

Most of the borough's 260,800 residents live in urban areas. Outside of the town centre there are a number of substantial populations and local villages, each with a clear sense of its own heritage, tradition and ambition. People who live there will often describe themselves as from a particular village rather than "from Rotherham". Local neighbourhoods, also, have evolved their unique identities. The warmth and friendliness of local people is commented on both by those who live here and those who visit. Getting on well with your neighbours, enjoying coming together to work on things that are important locally, having local places to go and things to do in safe, clean, green spaces all matter, wherever you live.

The population is increasingly diverse, with around one person in 10 from a minority ethnic group, the largest communities of which are Pakistani/Kashmiri and Slovak/Czech Roma. Our cultural events and activities need to be attractive and accessible to everybody, giving families, neighbours and friends opportunities to come together and enjoy each other's company, challenge preconceptions and tell great stories.

The culture, sport and leisure sectors offer a multitude of ways to enjoy being together, from street parties to carnivals, village fetes to music festivals. Rotherham Pride, International Women's Day, the "Love is Louder" campaign and Armed Forces Day, amongst many others, bring communities together to reflect and to share experiences. Rotherham Show is almost 40 years old and its special mix of entertainment, live music, the Diversity Festival, activities and local flavour has been enjoyed by tens of thousands of local residents and visitors.

Community led projects are making a huge difference across the borough. Passionate and hard working organisations such as Voluntary Action Rotherham and Rotherfed are working with volunteers and communities to build the local sense of belonging and community spirit. The annual Big Volunteer Walk celebrates and says a huge thank you to the huge number of Rotherham people who volunteer their time every day.

Volunteers play a significant role within the cultural sector – coaches, "Friends" groups, litter pickers, musicians, conservationists, reading helpers, fundraisers, befrienders, organisers and deliverers of many, many different activities and events. Volunteering gives you opportunities to hear other people's stories, learn something new, remember what really matters and see that small actions can have an enormous impact.

We will:

1. **Support the delivery of low cost, accessible activities reflecting the diversity, traditions and festivals of our communities**

- Refresh and revitalise Rotherham Show
- Support a year-long programme of activities in the town centre aimed at bringing people together
- Actively promote opportunities to bring communities with different backgrounds together
- Celebrate role models from within the sector and within our different communities
- Bring together and share the stories and heritage of Rotherham's different communities

2. **Create opportunities for volunteering within the sport, leisure and cultural sector**

- Establish community engagement roles across the sector to provide a front door for local individuals and communities
- Enhance the role of libraries as well used neighbourhood hubs
- Work together to develop the infrastructure to support the creation of 500 new volunteering roles within the sector
- Work with local neighbourhoods as they develop their local plans to ensure that we are aware of local needs and can aim to make the biggest impact where it matters most

CHILDREN AND YOUNG PEOPLE

We will work with our children and young people to deliver their Manifesto for Reimagining Rotherham and supporting their participation in culture, sport and the outdoors

We will:

- **Encourage all schools to take part in the Mile a Day Challenge and Arts Mark, reaching 100% by 2025**
- **Work with schools and Rotherham College to increase the numbers of young people progressing to higher level qualifications in culture, leisure and sport-based programmes**
- **Increase the range of outdoor activities for young people through our parks and green spaces**
- **Increase reading for pleasure amongst young people by 25% by 2025**

Rotherham aims to be a place where children are listened to, cared for and given every opportunity to have a full, happy and productive life. Our young people are creating a vision and ambition for Rotherham which sees itself as a place that people want to visit, live, work and study in. Our Cultural Strategy will be led by Rotherham's children and young people – the cultural entrepreneurs, sports people, performers, artists and cultural champions of the future.

Many of Rotherham's children and young people are excited about their future and the future of the borough. The Young Inspectors act as our critical friends, helping us improve what we do. The Youth Cabinet has a strong track record of making a difference and its current manifesto stresses the importance of positive work experiences and volunteering, along with emphasising the support young people need to improve their mental wellbeing. The Different But Equal Board is bringing together and harnessing the energy of a wide and diverse range of voices to ensure that we listen and act. Our schools and colleges are encouraging and supporting young people to enjoy and explore culture, arts and sport.

The passion children and young people have for culture, sports and our green spaces shows itself in their ambitions for Rotherham. The amazing Grimm and Co have worked with young people to co-create a Manifesto for Rotherham's future which puts leisure, green spaces, sport and culture at its heart. The joy and excitement young people show -– whether that be when taking part in Rotherham's brilliant children's Shakespeare Festival, exploring their favourite books in the Summer Reading Challenge, bringing the past to life through magical events at Clifton Park Museum, enjoying the fun of water, grass and the great outdoors in our parks or our young athletes enjoying the challenge of Mega Active – is an inspiration to everyone.

To achieve their full potential, all children and young people, including those who are Looked After, need to be safe, to be healthy and well, to have the knowledge they need to take decisions right for them and the skills and experience to get the most from the world of work. Our safe and welcoming spaces are places to learn, to explore, to be creative and to enjoy making and being with their friends. Our parks, green spaces, sports clubs, leisure centres and play areas provide opportunities to get healthy and enjoy the world around them.

Young people are wonderful advocates and will bring their families, friends and those who care for them to experience all that culture, leisure, green spaces and sport in Rotherham can bring. They encourage and challenge us to see Rotherham through their eyes as a place of great potential, a place where they want to live and work.

We will:

1. **Listen to, learn from and respond to the ambitions of children and young people**

- Work with our children and young people to deliver their Manifesto for Reimagining Rotherham
- Maintain a strong and productive network through the local cultural education partnership (Embassy for Reimagining Rotherham)
- Work with the Youth Cabinet to develop the work experience programme to ensure that it responds to the challenges young people face as they enter work for the first time
- Work with the Different But Equal Board to ensure that all young people feel that there is a culture, leisure or sport offer which is right for them
- Develop a programme of customer based assessment with the Young Inspectors

2. **Work with young people to co-create, co-deliver and co-evaluate our culture, sport and leisure activities, events and programmes, ensuring that they deliver impact where it is needed most**

- Create and deliver an offer which engages children, young people and their families, supporting their participation in culture, sport and the outdoors
- Support the ambition for all Rotherham primary schools to be taking part in the 'run a mile' initiative
- Develop a programme of "first time activity" with children and young people to encourage more to take part
- Co-create a programme of high quality events and activities designed to enable all children and young people to enjoy time together with each other and with the people important to them
- Work collaboratively to increase reading for please amongst young people by 25%

3. Develop, retain and attract young people with talent

- Offer cultural apprenticeships to 10 young people each year
- Provide opportunities for young people to experience work within the sector
- Support schools to achieve sector specific quality marks
- Support young people to obtain sector specific awards
- Encourage young people to progress to higher level qualifications in culture, leisure and sport based programmes

IMPROVING HEALTH AND WELLBEING

Participating in the arts, being physically active, and getting outdoors – particularly in the natural environment – all contribute to making us happier and healthier

We will:

- **Establish a new Activity Partnership to plan, promote and co-ordinate programmes to encourage physical activity**
- **Improve and develop routes for walking, running and cycling – encouraging residents and visitors alike to explore and appreciate our green space, canals and waterways**
- **Increase the involvement of older people, disabled people and other vulnerable sectors in order to reduce the demand on health and social care services**

Good health is the foundation of living a fulfilling life, making the most of our abilities and engaging in the world around us. It is not just about feeling physically fit but feeling good about ourselves and being able to live our lives well. Unfortunately, too many people in Rotherham are not enjoying the best of health.

Being active, spending time outdoors, getting together with friends and neighbours, volunteering, learning something new and taking notice of the world around us can all make a difference to our health and well-being. Encouraging people to be physically active also has wider benefits, developing safer, stronger communities, reducing anti-social behaviour and increasing skills and employment.

Everyday activity, such as gardening and a stroll in the park; active recreation, such as dancing, swimming and active play; structured sport, such as playing hockey or competitive cycling all make enormous contributions to our physical health. From fun runs to 10ks, ballroom dancing to bell-ringing, wheel chair tennis to Zorbing, finding the right activity for you opens up a new world of friendship and shared learning.

A significant proportion of both adults and children leaving primary school are overweight and obese. Ageing healthily starts early in life and, with one in five people in Rotherham under 15 whilst one in four are over 60, there is both a challenge and an opportunity to raise awareness of the benefits which establishing a life time habit of taking part in leisure and sport provide, improving health now and preventing ill health developing in future. More people taking part, more often will help us all live healthy and fulfilling lives, whatever our age.

The benefits of eating well and increasing the amount of time we spend physically active are generally perhaps better known and understood than the impact which taking part can have on our sense of wellbeing and good mental health. We may find out what it feels like to work as a team, think creatively, increase our confidence, concentrate better, make friends and find out we can be better at something than we ever thought we could. On average, mental health problems affect one in four people at some point each year, leaving many of us feeling vulnerable, lonely or depressed. Rotherham's beautiful and inspiring green spaces, its huge network of arts, crafts, sports and social groups, its libraries, and museums, all provide welcoming, safe, accessible opportunities for interaction, creativity, making our own choices and learning more about ourselves and the world – encouraging us to take that first step to a more fulfilling life.

We will:

1. **Address barriers to taking part**

- Promote our joint offer, to increase awareness of what's available, when and where
- Provide a range of no cost or low cost opportunities to take part in culture, leisure and sporting activities
- Develop a wide and varied programme – to give people the widest possible choice
- Encourage people to experience and try out activities for the first time

2. **Encourage participation at all levels**

- Build in opportunities and innovation to improve everyday health within our workplaces, green spaces, cultural buildings and in places people go to the most
- Motivate and support the least active to take the first step to becoming active
- Create opportunities for families and friends to take part in leisure, sport and cultural activities together, particularly during school holidays
- Work together to provide pathways to excellence, inspiring those who are already active to develop their skills and ambition
- Develop walking and cycling as ways to encourage incremental participation and as large scale events

3. **Improve the local sports and physical activity infrastructure**

- Develop a new Active Partnership for Rotherham, promoting and increasing the use of sport, leisure, countryside and green spaces to increase physical activity
- Support clubs providing sports, dance and physical activity to grow membership and sustain provision
- Encourage cycling, walking and running by ensuring good access to green space, canals and riversides and footpaths.

4. Give everyone opportunities to improve and maintain good mental health

- Use the 5 Ways to Wellbeing as a framework for our event programme, encouraging everyone to be active, connect with others, give to others and take notice of the world around them
- Reduce isolation and loneliness by providing safe, welcoming spaces for people to come together and enjoy each other's company

CONSULTATION

Prior to and during the development of this Draft Strategy, a significant amount of consultation has already taken place, including responses gathered during the Views of Rotherham consultation in 2016, the development of the Town Centre Masterplan, the place-shaping work within the Rotherham Story, the 2017 Lifestyle Survey, and the Rotherham Cultural Education Partnership's consultation which culminated in the Embassy for Reimagining Rotherham.

For example, in the Views of Rotherham consultation:

- 82% saw well looked-after parks and public spaces as a priority
- 75% felt that having local places to go, such as museums and parks, is important
- 72% valued a good range of things to do for teenagers
- 67% thought that a bigger range of low cost leisure activities is important

Consistently, during consultation, our children and young people have expressed their passion for Rotherham, their creativity and imagination in proposing a positive, vibrant vision for where they live and their determination and willingness to influence its future. They told us:

- We would like to have a cinema in Rotherham because then we would be able to spend more time with family and friends. Watching films also makes you more imaginative!
- We would like there to be festivities based on other people's religions, cultures and traditions
- We think there should be an arts centre where anyone can go to learn different things, such as singing, acting, dancing, or painting. There would be regular performances at the arts centre and they would be accessible to everybody
- Rotherham should have a communal garden, because gardening teaches people to respect and look after the world, and treat it with greater importance. It is also therapeutic and relaxing
- Everyone should be able to go walking in the woods, because it helps you appreciate nature, become aware of your surroundings, and have fun
- We'd like a café where people can gain work experience

Members of the Cultural Partnership Board have met with individuals, partners, stakeholders, the voluntary sector and businesses to listen to and capture their views. This has included a number of discussions and workshops with community based organisations and young people.

During the coming months, the Board will continue to engage with people and organisations across the borough. The Strategy will be available at www.likerotherham.org and will also be available in print via Council and partner outlets

HOW CAN YOU GET INVOLVED?

Are you interested in working with us to create a new, dynamic, healthy and happy Rotherham?

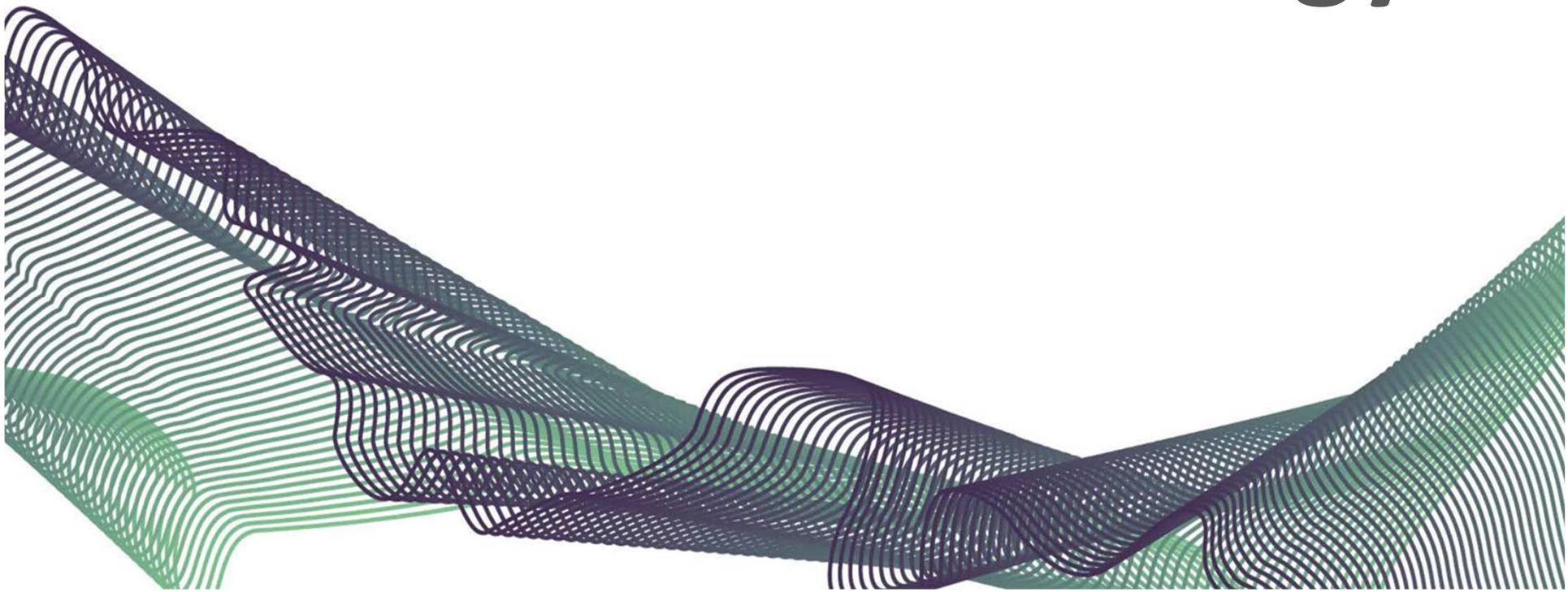
- If you're happy to show your support for Rotherham, promote what we have and celebrate our successes
- If you're already spending some of your time helping out with cultural activities, or you feel this is something you'd like to do
- If you would like to be part of the Cultural Partnership Board and its working groups
- If you enjoy taking part in culture and sport or are working in the sector and would like to work with us to create amazing events, exhibitions and activities
- If you would like to comment on anything in this Strategy or let us have your views about what's important to you

Email us at info@likerotherham.org or contact us via Council and partners outlets

Follow us on Twitter: @LikeRotherham

LIKE ROTHERHAM

A New Cultural Strategy



Stories are the secret reservoirs of values…

Change the stories people and countries tell themselves and you can **change people and countries**

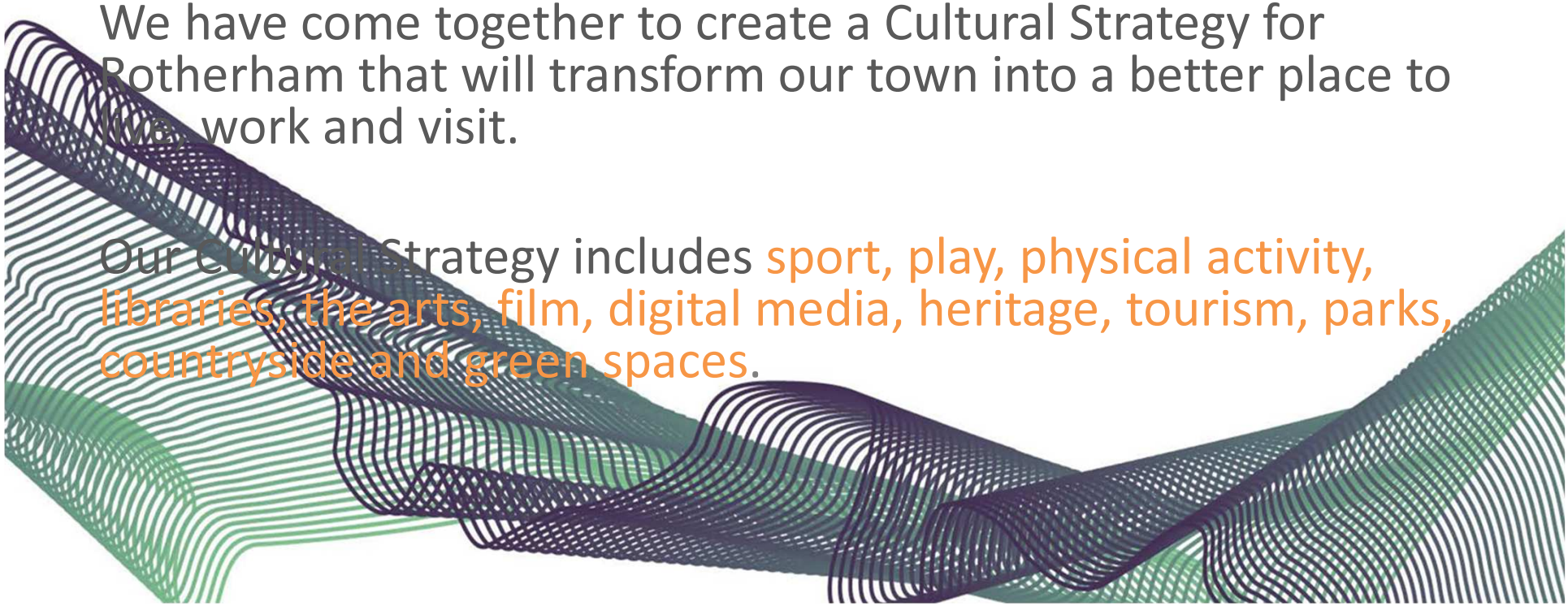
Ben Okri, poet and playwright

Who We Are and What We Do

The **Cultural Partnership Board** brings together people and agencies that care passionately about Rotherham's future – including artists, designers, voluntary organisations, local businesses, regional agencies and Rotherham Council.

We have come together to create a Cultural Strategy for Rotherham that will transform our town into a better place to live, work and visit.

Our Cultural Strategy includes sport, play, physical activity, libraries, the arts, film, digital media, heritage, tourism, parks, countryside and green spaces.



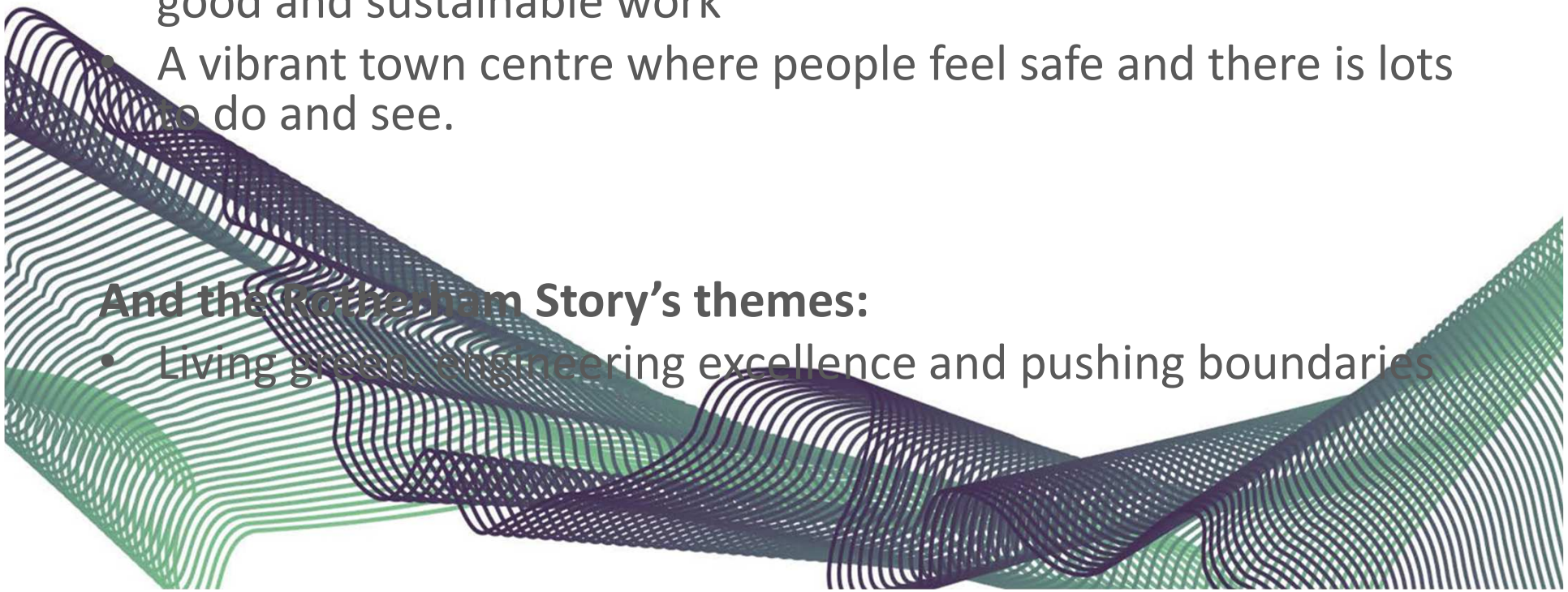
Facts and figures

- Rotherham has one of the fastest growing economies in the UK - £133m of investment in 2017
- Tourism supports 2.6m jobs in the UK, generating £106b a year
- The total UK creative economy accounted for 2.9m jobs, or 1 in 11 of the working population
- Employment in these sectors has increased by 26.9% in Yorkshire and Humber between 2011 and 2015
- Sport England identifies the value of the sports industry to Rotherham as £62m. Almost two-thirds of this relates to participation in sport and physical activity.

Strategic links

Supports the Rotherham Together Partnership ambitions:

- Rotherham is celebrated for its heritage and natural beauty and seen as forward-thinking and ambitious
- A borough with highly-skilled people who have good access to good and sustainable work
- A vibrant town centre where people feel safe and there is lots to do and see.

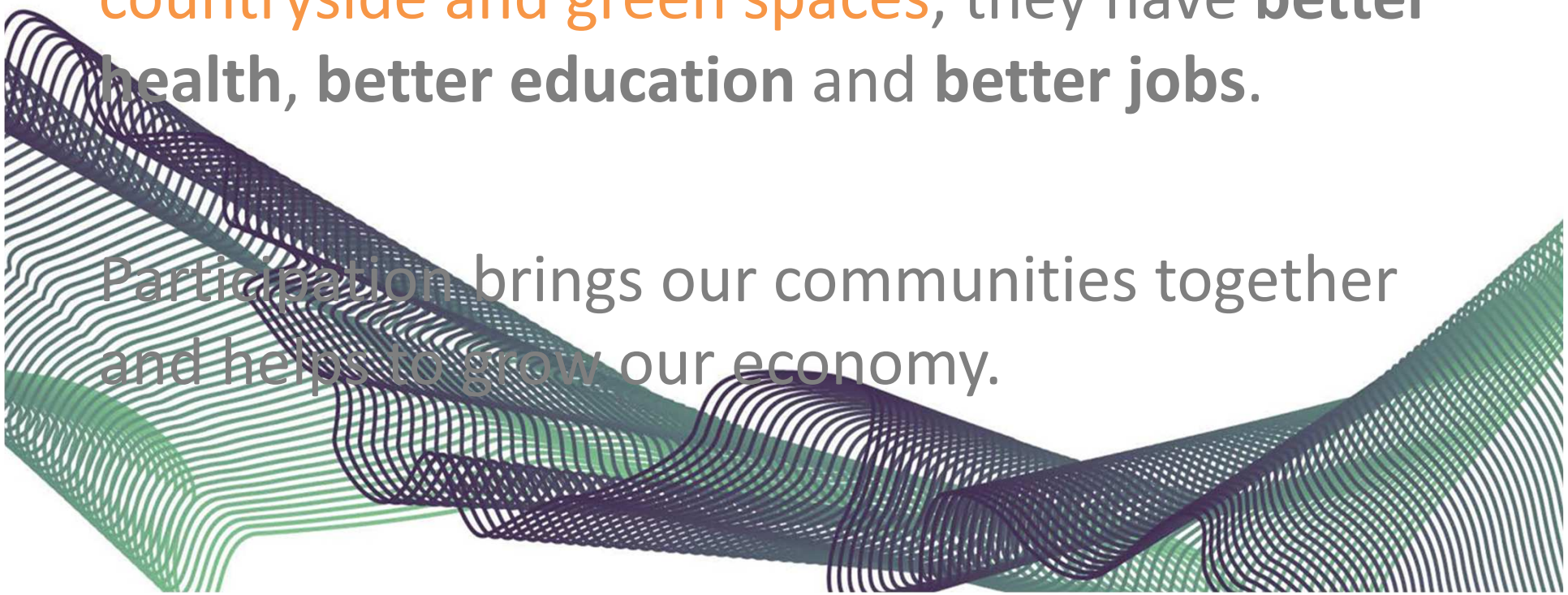


And the Rotherham Story's themes:

- Living green, engineering excellence and pushing boundaries

Increasing Participation

Research shows that **when people participate** in sport, play, physical activity, libraries, the arts, film, digital media, heritage, tourism, parks, countryside and green spaces, they have **better health**, **better education** and **better jobs**.



Participation brings our communities together and helps to grow our economy.

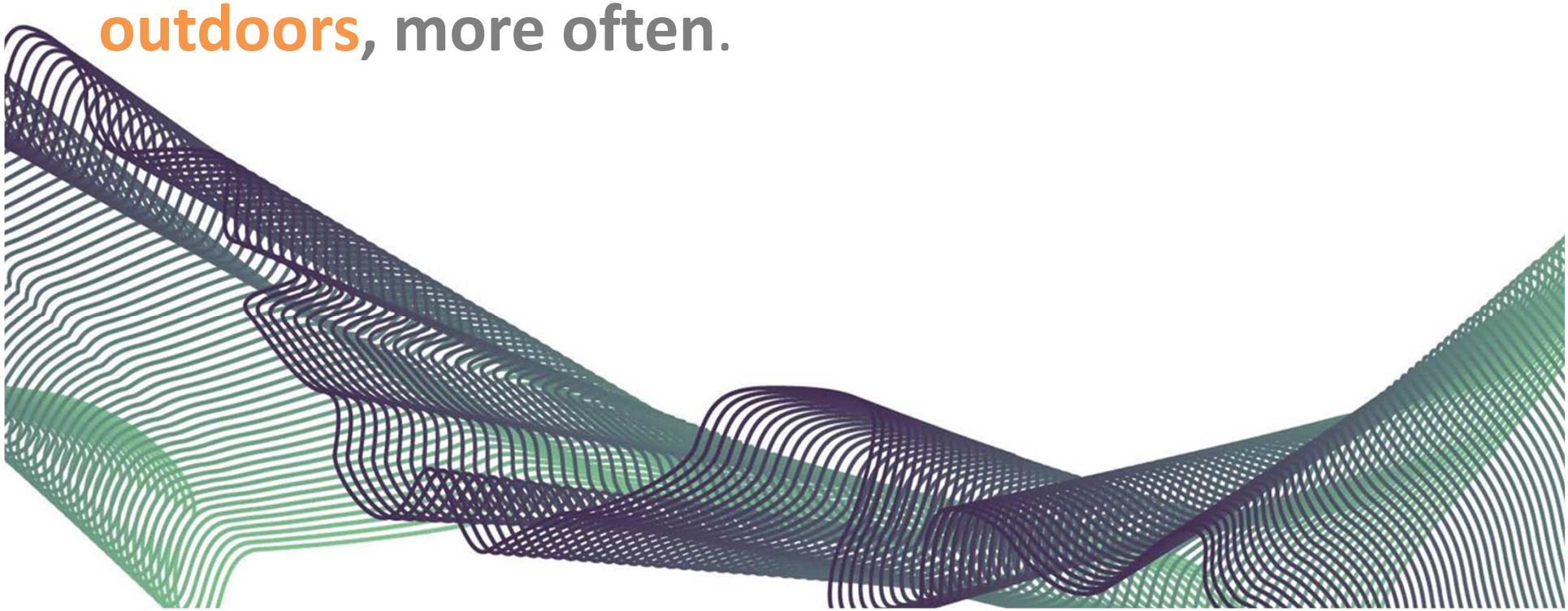
Increasing Participation

However, **participation** in Rotherham is lower than the rest of the UK.

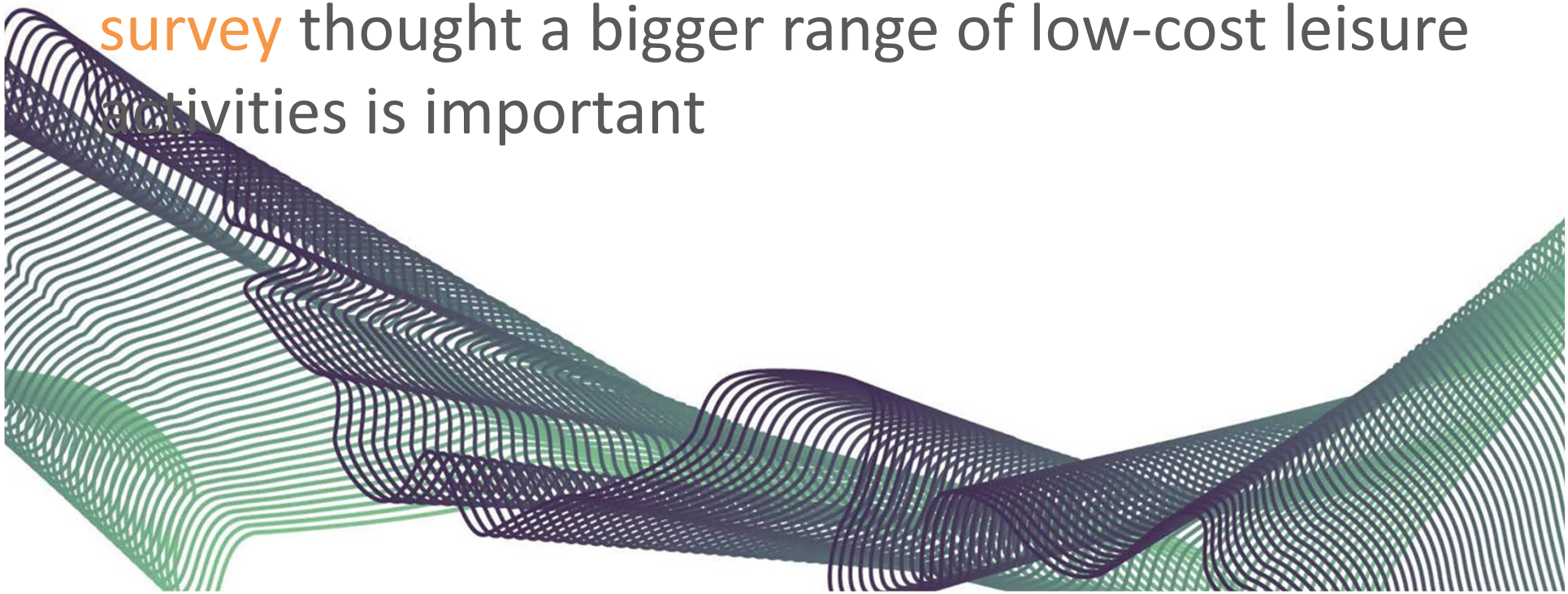
Definition	% Participation rate - national	% Participation rate - Rotherham
Spent time doing a creative, artistic, theatrical or music activity or craft	34.67	27.43
Attended an event, performance or festival involving creative, artistic, dance, theatrical or music activity	52.22	41.44
Used a public library service	35.01	27.49
Attended a museum or gallery	46.5	34.83
Active population (150 minutes+ per week)	61.8	51.3
Fairly active population (30-149 minutes per week)	12.5	11.7
Inactive population (less than 30 minutes per week	25.7	37

Increasing Participation

Therefore, **our key goal is to enable everyone in Rotherham to get active, get creative and get outdoors, more often.**



67% of respondents to the Views of Rotherham survey thought a bigger range of low-cost leisure activities is important



Growing Our Assets

In order to enable everyone in Rotherham to get active, get creative and get outdoors, more often, we need to **grow our assets**.

- Care for our natural environment
- Conserve our built heritage
- Create better space to make, present and experience the arts

Growing Our Assets

If we protect and grow our cultural assets, we can grow our people, our communities, our economy.

- **82%** of Rotherham residents see well looked-after parks and public spaces as a **priority**.
- **75%** feel that having local places to go such as museums & parks is **important**

*Views of Rotherham consultation 2015

Growing Our Assets

If we protect and grow our cultural assets, we can grow our people, our communities, our economy.

We will:

In the **North** - Develop Wentworth Woodhouse

In the **South** – Deliver Gulliver's, Rother Valley Country Park and the canal network

In the **Centre** – Develop Forge Island, cinema, public art and new hub for cultural and creative industries

Developing Talent

If we want to grow our people, our communities, our economy, then we must give people in Rotherham the opportunity to **turn their passion into a profession.**

Because we want all Rotherham residents to contribute to the success of our economy and our nation – on our stages, on our screens, on our sports pitches and in industry.

82% of respondents to the Views of Rotherham survey want **local businesses to grow and create more jobs**

Developing Talent

We want everyone in Rotherham to have the opportunity to turn their passion into a profession.

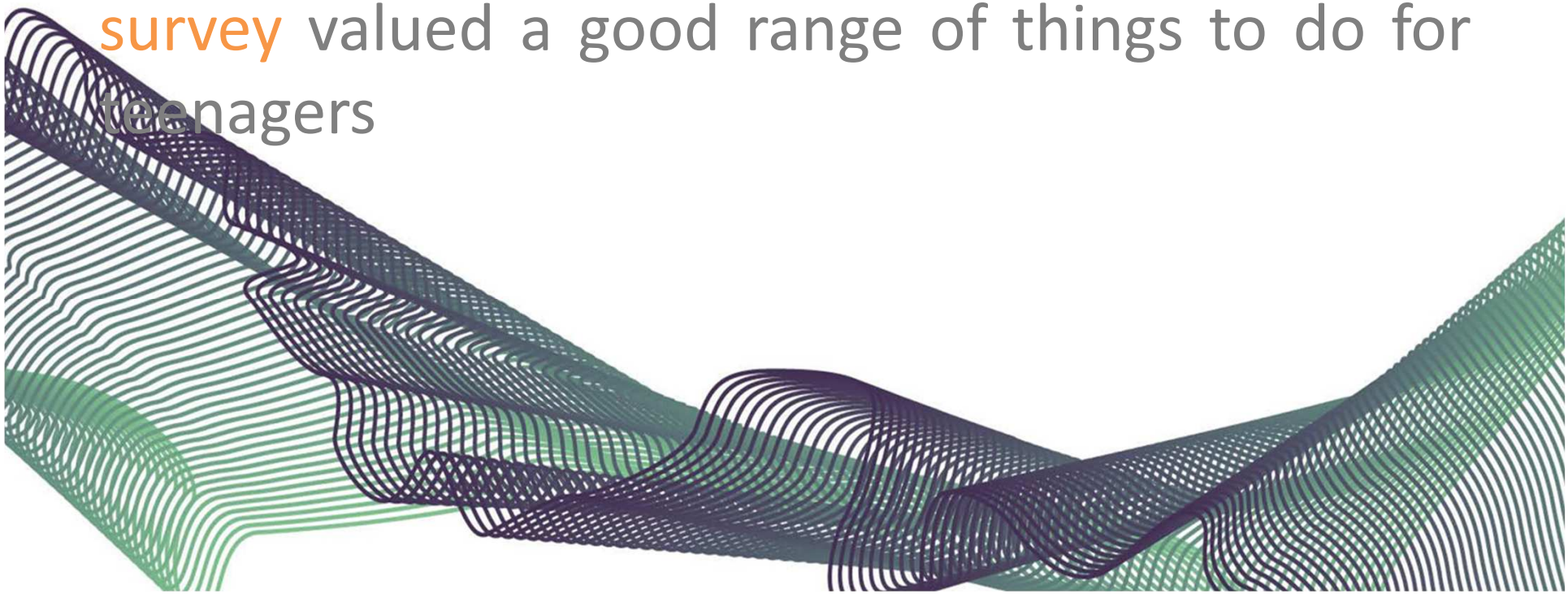
By 2025, we will create **500 new volunteers**, **50 new apprenticeships** and **1500 new jobs** in the creative, digital, cultural, leisure and tourism sectors.

Building stronger communities

We will use our cultural, entertainment and sports programmes to bring people from diverse communities together, building empathy and strengthening networks. We'll celebrate:

- The 40th anniversary of **Rotherham Show** in 2019
- **Yorkshire Day** in 2020
- **Women's European Football** (UEFA) tournament in 2021

72% of respondents to the Views of Rotherham survey valued a good range of things to do for teenagers



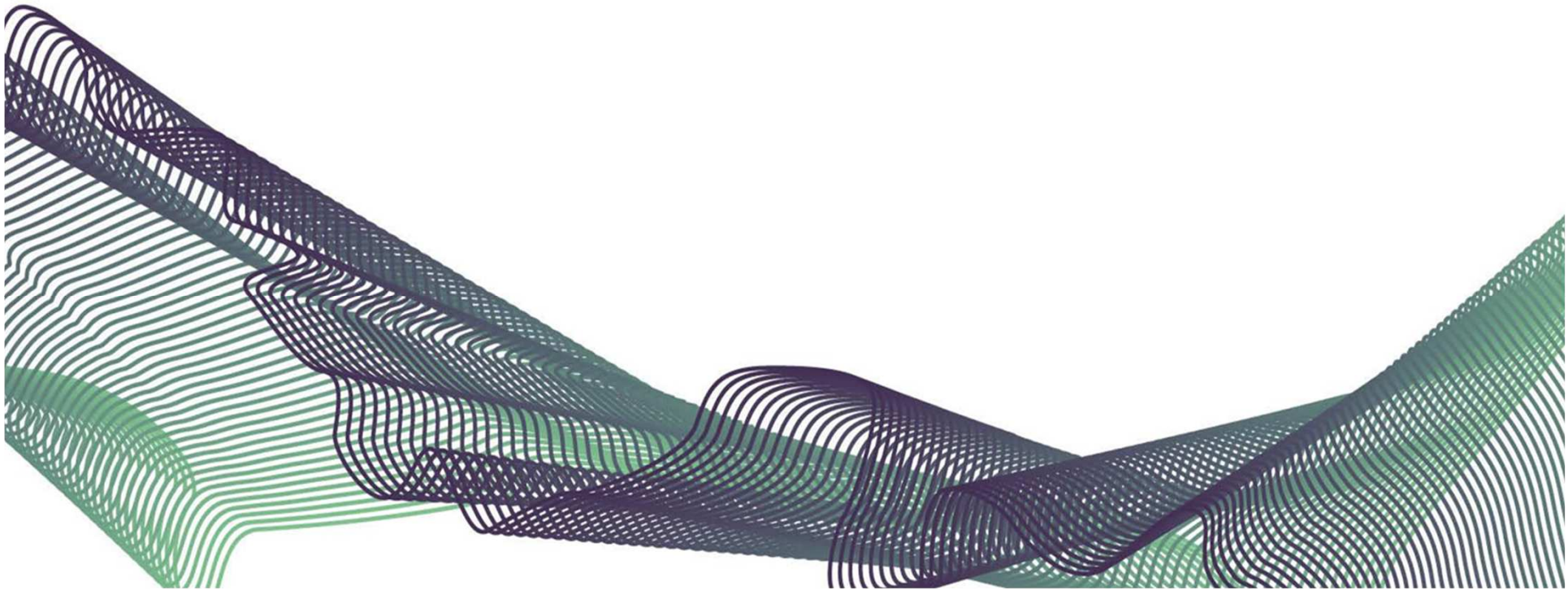
Children and young people

We will work with children and young people to deliver their **Manifesto for Reimagining Rotherham**.

We will:

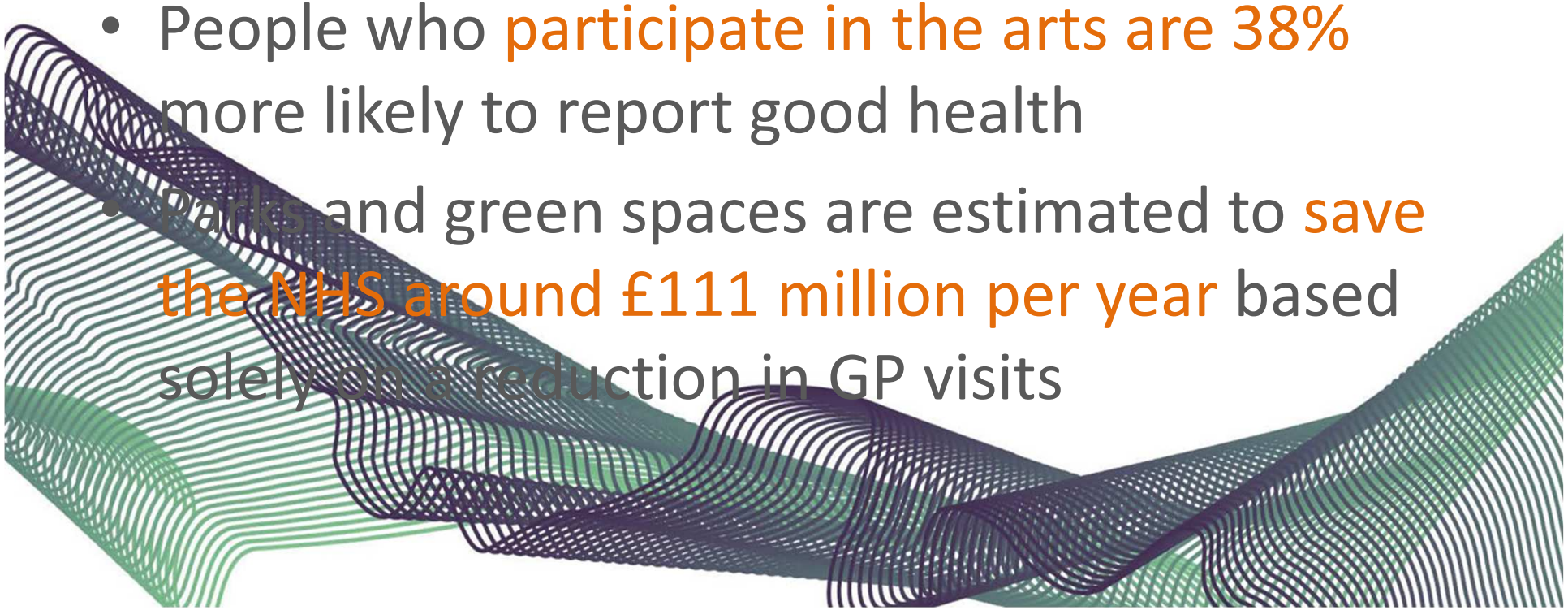
- Encourage all schools to take part in the **Mile a Day Challenge** and **Arts Mark**, reaching 100% by 2025
- Work with schools and Rotherham College to increase the numbers of students progressing to **higher level qualifications** in cultural, leisure and sport programmes.
- Increase the range of **outdoor activities** for young people through our parks and green spaces.
- **Increase reading for pleasure** amongst young people by 25% by 2025.

Improving health and wellbeing



Facts and Figures

- 91% of respondents to the Views of Rotherham survey are keen to make sure that older people stay independent
- People who participate in the arts are 38% more likely to report good health
- Parks and green spaces are estimated to save the NHS around £111 million per year based solely on a reduction in GP visits

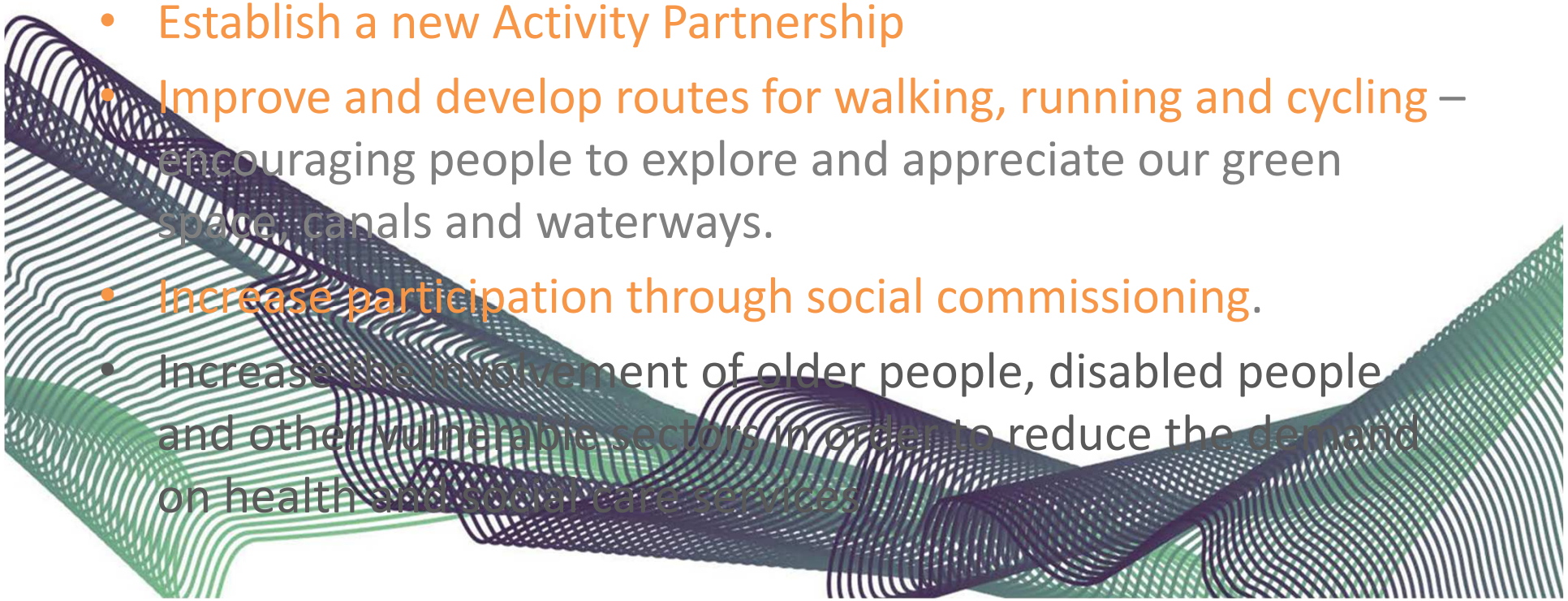


Improving health and wellbeing

Participating in the arts, being physically active, and getting outdoors - particularly in the natural environment - **all contribute to making us happier and healthier**.

We will:

- Establish a new Activity Partnership
- Improve and develop routes for walking, running and cycling – encouraging people to explore and appreciate our green space, canals and waterways.
- Increase participation through social commissioning.
- Increase the involvement of older people, disabled people and other vulnerable sectors in order to reduce the demand on health and social care services.



Strategic links

This theme supports the Rotherham Together Partnership ambition:

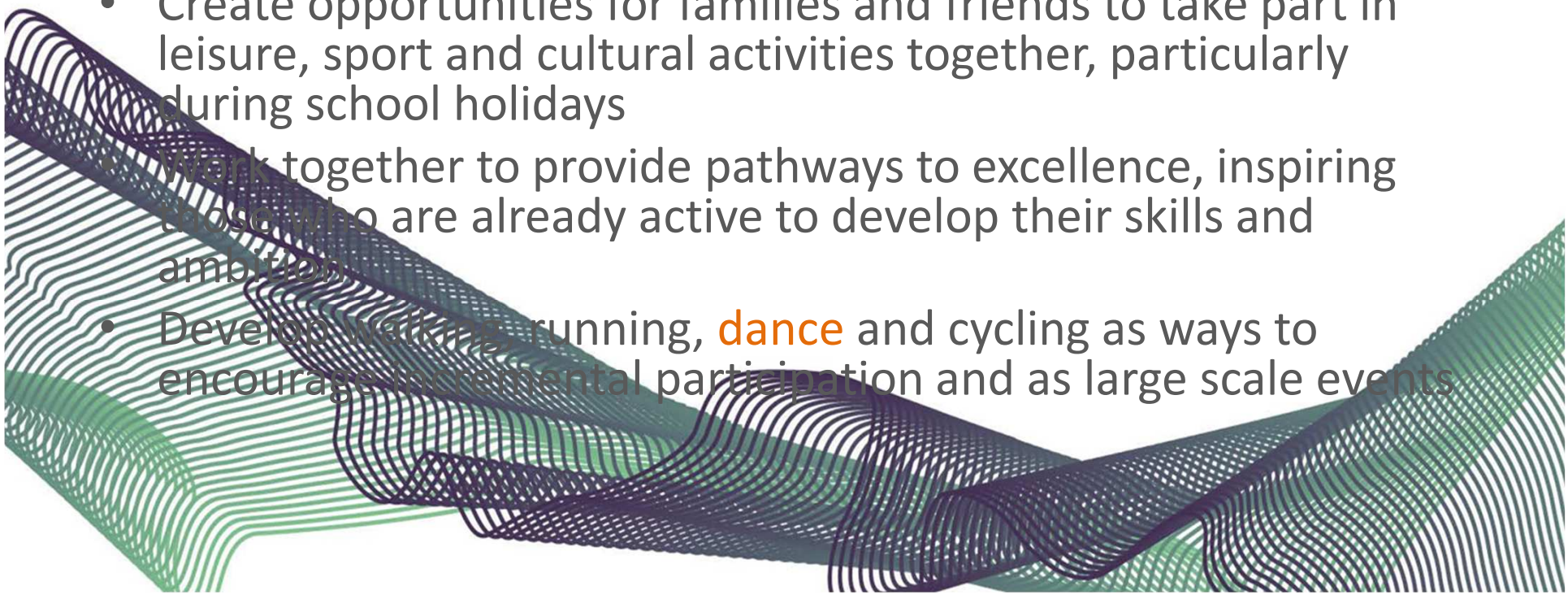
- People enjoy the best possible mental and physical health, enabling them to live happy and fulfilling lives

And the Health and Wellbeing Strategy aims:

- All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
- All people live in healthy, safe and resilient communities

Encourage participation at all levels

- Build in opportunities and innovation to improve everyday health within our workplaces, green spaces, cultural buildings and in places people go to the most
- Motivate and support the least active to take the first step to becoming active
- Create opportunities for families and friends to take part in leisure, sport and cultural activities together, particularly during school holidays
- Work together to provide pathways to excellence, inspiring those who are already active to develop their skills and ambition
- Develop walking, running, dance and cycling as ways to encourage incremental participation and as large scale events



Address barriers to taking part

- Promote our joint offer, to increase awareness of what's available, when and where
- Provide a range of no cost or low cost opportunities to take part in culture, leisure and sporting activities
- Develop a wide and varied programme – to give people the widest possible choice
- Encourage people to experience and try out activities for the first time

Improve the local sports and physical activity infrastructure

- Develop a new Active Partnership for Rotherham, promoting and increasing the use of sport, leisure, countryside and green spaces to increase physical activity

- Support clubs providing sports, dance and physical activity to grow membership and sustain provision

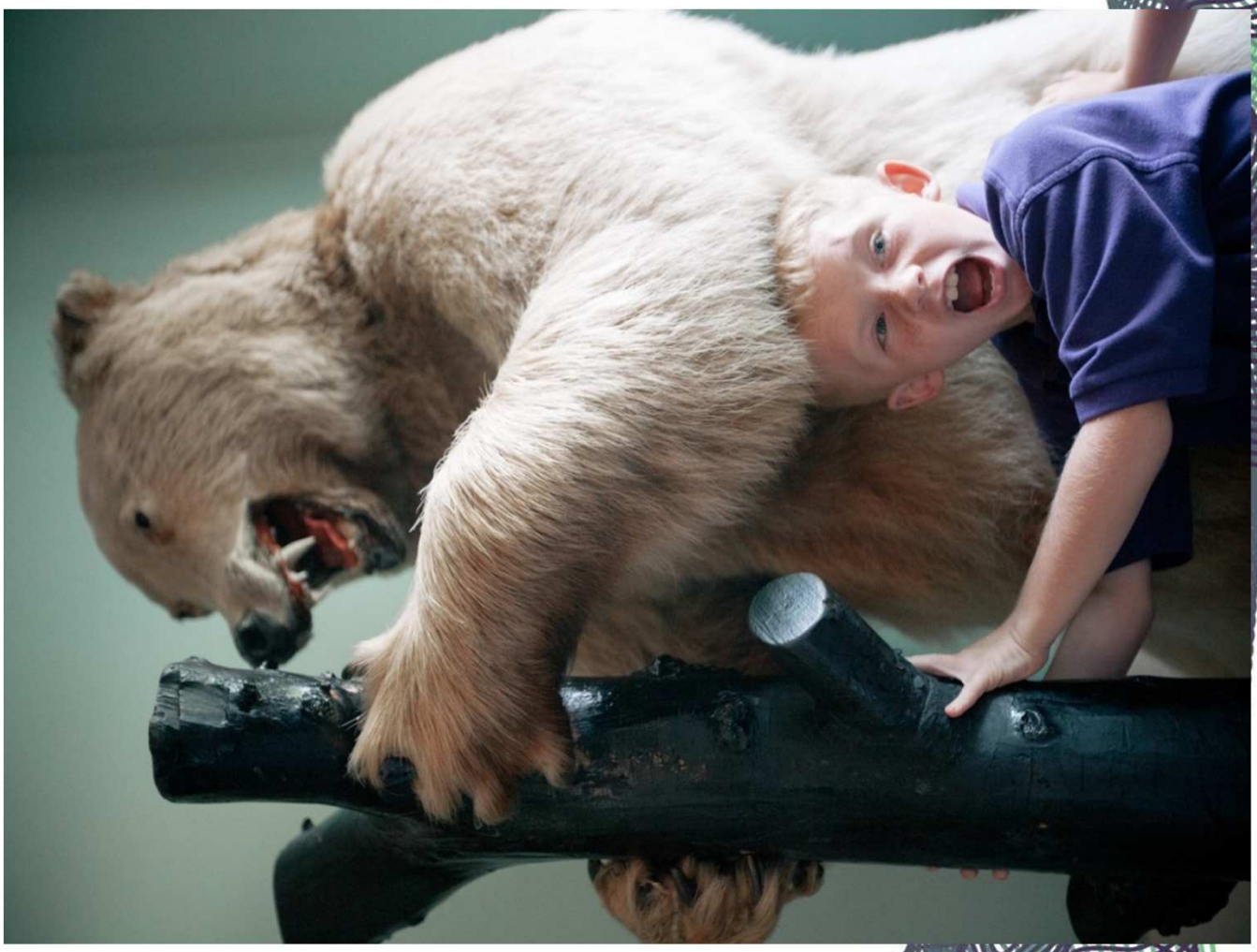
- Encourage cycling, walking and running by ensuring good access to green space, canals and riversides and footpaths.

Give everyone opportunities to improve and maintain good mental health

- Use the 5 Ways to Wellbeing as a framework for our event programme, encouraging everyone to be active, connect with others, give to others and take notice of the world around them
- Reduce isolation and loneliness by providing safe, welcoming spaces for people to come together and enjoy each other's company

Draft measures

- Numbers of participants in activities who said that they felt happier or healthier
- Confidence of residents to take part or join in with cultural activities
- Numbers of participants who said their quality of life had improved
- Numbers of participants who said they felt less lonely or isolated



"We need to get back some **pride** in the town - to hear Rotherham mentioned on national media for good reasons, not bad."

Resident, Views of Rotherham Survey

"When anyone **loves** a place that they are from, it makes you look at it differently."

Rick Stein, chef and writer

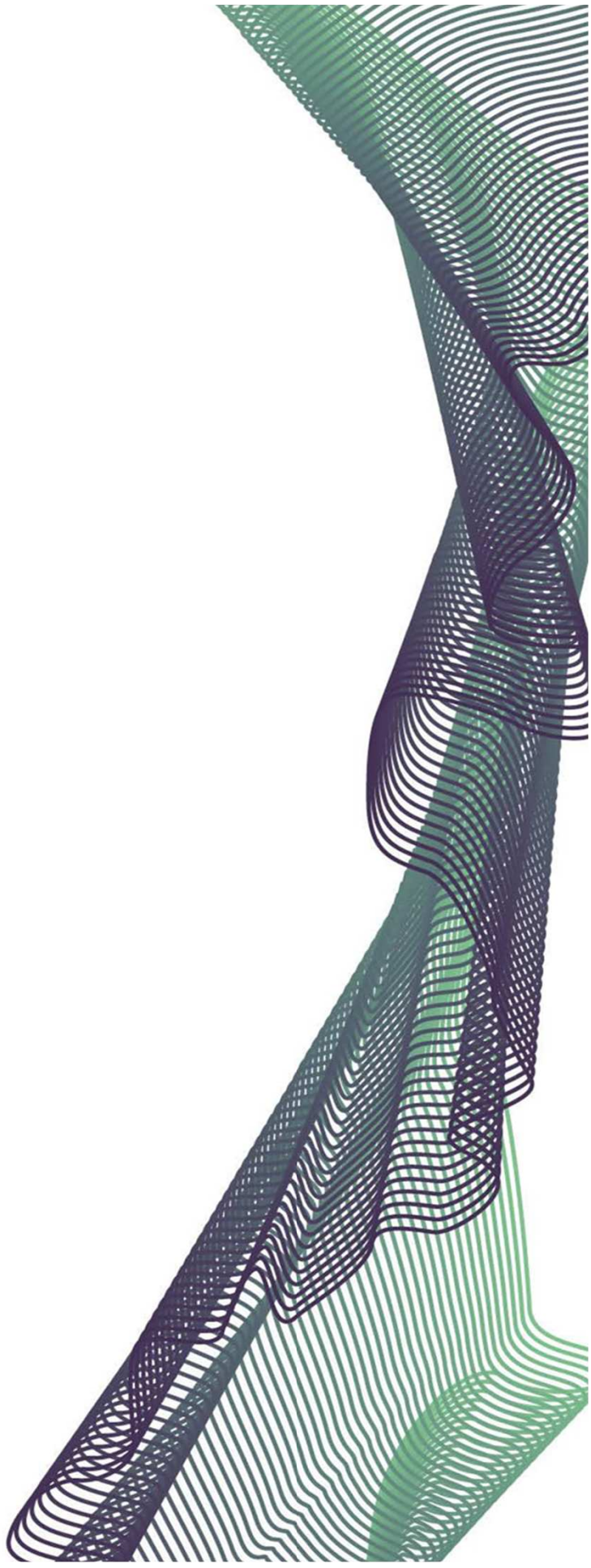
Building Pride, Celebrating our Unique Identity

We want all our residents to really

like Rotherham.

By 2025 we want other places to want to be

like Rotherham.


LIKE
ROTHERHAM

Questions

- Do you support our **key goal** - to enable everyone to get active, get creative and get outdoors, more often?
- Is the argument clear?
- What can you or your organisation do to support the ambitions and actions of the Strategy?
- Volunteers from NHS/CCG to develop action plan?

LIKE ROTHERHAM

Next steps

- 6pm, Wentworth Woodhouse, 26th September – Event with Wayne Hemingway,
- 10am, Carlton Park Hotel - 5th October – Visitor Economy Get-together
- 31st October – Public Consultation Process ends
- Rewrite and produce action plans
- Spring 2019 – Launch of Final Strategy

Have your say

- Use the postcards and download the full draft strategy www.likerotherham.org
- Email us before the 31st October 2018 at info@likerotherham.org to tell us your views
- Follow us on Twitter: @LikeRotherham #likerotherham
- Invite us to talk to your group or network

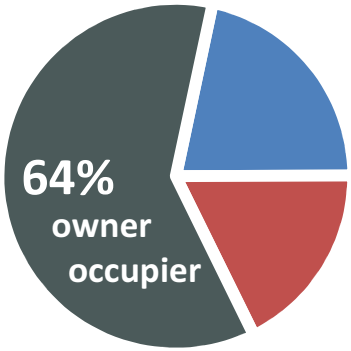
Housing Strategy refresh 2019-2022

Sarah Watts, Strategic Housing Manager

Overview of housing in Rotherham

112k
Households

Largely 3-bed semi-detached houses



22%
social rented

14%
private rented

6,500
Applicants on the housing register

The Council owns and manages…

20,500
tenanted properties

500
leaseholders

900+ Overall target for homes built (SHMA) per annum

600 Average delivery in recent years

202 Sold via Right To Buy last year

Current Strategy: The 5 Themes

- Housing growth
- Social housing
- Private rented housing
- Affordable housing
- Specialist housing

Achievements

- Grant funding for new homes
- Shared Ownership and Affordable Housing
- Clusters Partnership - Wates
- Town centre residential programme
- New council homes
- Home ownership

Achievements

- TPAS Accreditation
- Excellence in tenant engagement award
- Pre-tenancy workshops and tenancy support
- Gas servicing 100%
- Remodelling stock
- Step up step down units
- Selective licensing

Things have changed…

- Housing and Planning Act 2016
- Policy u-turns
- HRA Business Plan refresh
- Increasing resources
- Homelessness Reduction Act
- Social Housing Green paper

The New Strategy

A chance to have your say

Vision

- Meeting housing need through growth
- People living in high quality homes, affordable and energy efficient homes
- Rotherham council being the best housing provider in the country
- Rotherham's people can live independently in safe, healthy and vibrant communities
- A revitalised town centre with a new urban community

Value of new housing

- More than bricks and mortar
- Economic – local jobs and apprenticeships
- Social value – contractors
- Energy efficiency
- Health
- Neighbourhoods
- Community engagement

Structure

- 5 key priorities
  - Providing new homes to meet Rotherham's housing need
  - Investing in Rotherham housing stock
  - Improving health and wellbeing through housing
  - Strengthening Rotherham's economy
  - Working in partnership to deliver this strategy

Timetable for refresh

July 2018 – October 2018
Consultation period

November 2018
First Draft

January 2019
Final Draft

February 2019
Cabinet for approval

March 2019
Publish new strategy

Pipeline Projects

- More new homes
- Housing profiles and land review
- Transformation of adult care
- Modern methods construction
- New repairs and maintenance contract

Any questions?

BRIEFING PAPER FOR HEALTH AND WELLBEING BOARD- PUBLIC

1.	**Date of meeting:**	**19th September 2018**
2.	**Title:**	**Aim 2** **Better Mental Health for All- Rotherham's Strategy to promote the mental health and wellbeing of Rotherham people, 2017-2020** **Suicide Prevention and Self-Harm Action Plan Update 2016/18**
3.	**Directorate:**	**Public Health, RMBC**

1. Background

1.1 This paper is an annual update on the actions detailed in two partnership action plans; the **Rotherham Suicide Prevention and Self Harm Action Plan** for 2016/2018 and the **Better Mental Health for All Action Plan 2017 - 2020**. The Board has recently received an update so this is only a summary of the main actions and the future plans.

1.2 Both action plans evidence the work that all partners are doing to promote the mental health of people living and working in Rotherham and the prevention of suicide.

1.3 The Better Mental Health for All action plan draws upon the evidence of what works promoting the mental health for the whole population, for individuals who are more at risk of developing mental health problems and for people living with a mental health problem.

1.4 The Rotherham Suicide Prevention and Self Harm Action has been written to recognise the role of all partners in addressing the complexity of preventing deaths from suicide.

2. Key Issues

Better Mental Health for All

2.1 Promoting the mental health of Rotherham people and preventing mental ill health is not the responsibility of one organisation. The coordination of the action plan is through a local implementation group with partners of the Health and Wellbeing Board represented.

2.2 The focus of this work is not about developing new services but about linking into community assets (strengths) and connecting people within their local community. The strategy and action plan recognise the skills, knowledge and expertise of individuals and the assets (strengths) that communities and organisations have to improve mental health and wellbeing.

2.3 National research shows that half of all mental health problems have been established by the age of 14 years, rising to 75 per cent by age 24. The prevalence of mental health disorders amongst children and young people in Rotherham is estimated to be 14% above the UK average, this due to higher levels of deprivation in the borough.

2.4 In Rotherham in 2014/15, 10.8% of adults over 18 in the borough had depression; the average for England during this period was 7.3%. For self-reported emotional wellbeing in 2015/16 Rotherham residents reported high levels of; low satisfaction with life, low happiness and high anxiety. These rates were higher than the average for England and for the Yorkshire and Humber region.

2.5 Improved mental wellbeing and reduced mental disorder are associated with: better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and better quality of life. Improving mental wellbeing is also associated with positive outcomes in relation to education, employment, as well as reduced crime and antisocial behaviour. (Joint Commissioning Panel for Mental Health, 2012).

Rotherham Suicide Prevention and Self Harm Group

2.6 Suicides are not inevitable. They are often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This can only be done by working collaboratively across all sectors within Rotherham.

2.7 The All Party Parliamentary Group (APPG) on Suicide and Self-harm published an “Inquiry into Local Suicide Prevention Plans in England” January 2015. The APPG considered that there were three main elements that are essential to the successful local implementation of the national strategy. All Local Authorities must have in place:

a) Suicide audit work in order to understand local suicide risk.
b) A suicide prevention plan in order to identify the initiatives required to address local suicide risk.
c) A multi-agency suicide prevention group to involve all relevant statutory agencies and voluntary organisations in implementing the local plan.

3. Key actions and relevant timelines

Better Mental Health for All

3.1 Film and resources produced to support the Five Ways to Wellbeing campaign completed by April 2018.

3.2 Launch of the Five Ways to Wellbeing Campaign in May 2018.

3.3 Partner organisations signed up to roll out the different topic areas (Be Active, Connect, Give, Keep Learning and Take Notice) from the launch until October/November 2018.

3.4 Work is now ongoing to ensure the Five Ways to Wellbeing principles are embedded in all partners’ commissioning processes and provider services.

3.5 A future focus of the Better Mental Health for All Group will be to look at actions to address loneliness in line with Aim 4 of the Health and Wellbeing Board Strategy. The focus will be partnership working and utilising local assets. The proposal is to utilise the Five Ways to Wellbeing campaign as the public campaign to combat loneliness.

3.6 The group are updating the action plan and reporting back on progress at the November 2018 meeting.

Rotherham Suicide Prevention and Self Harm Action Plan

3.7 Launch of the young people's campaign STILL on World Mental Health Day on the 10th October 2017 at Oakwood School. There was excellent coverage on social media and other local media.

3.8 All Rotherham schools in May 2017 received an updated Critical Incident Prompt sheet from Educational Psychology.

3.9 Six schools piloted a Whole School Approach to mental health and emotional wellbeing embedding this approach throughout their work during the school year 2016-2017. This work has now been shared with other schools across the borough.

3.10 Suicide prevention training was provided in May 2017 by the Public Health Specialist to Crossroads and Rotherham Alzheimer's Society staff. In 2018, Youth Mental Health First Aid training courses were also provided to the Rotherham Parent Carers Forum and a second women's group from BME communities.

3.11 Wentworth Valley Area Assembly identified £8,000 for suicide prevention work in the Maltby, Hellaby and Wickersley wards during 2017. This work included the following courses: ASIST (Applied Suicide Intervention Skills Training), SafeTalk, Adult and Youth Mental Health First Aid. The evaluation and final report were shared with Elected Members at a Members briefing on 30th January 2018.

3.12 Four SafeTalk suicide prevention courses were delivered in March 2017 resulting in 100 frontline staff being trained to identify those at risk, how to ask about suicide and where to signpost for appropriate help.

3.13 The bereavement pathway for children who have experienced a sudden and traumatic death was revised in October 2017 and re issued to all partners. The next revision is due in October 2018.

3.14 Rotherham Samaritans launched their bereavement support project in January 2017. Families are referred to this service after a visit from Police Officers within the Safe Neighbourhood Services. Families are then offered two listening phone calls by Rotherham Samaritans at a time which is suitable for them.

3.15 The action plan is currently being refreshed and will address issues highlighted through Rotherham's real time surveillance work.

3.16 South Yorkshire and Bassetlaw have received funding from NHS England (NHSE) for suicide prevention work for one year. This funding cannot be used to support local plans in their entirety but can be used to support the national themes of:

i. Reducing suicide and self-harm in mental health services
ii. Reducing self-harm in community and acute services
iii. Suicide prevention in men and/or work with primary care

Rotherham Suicide Prevention and Self Harm Group has submitted to NHSE initial proposals for spending the funding in the borough. These proposals have been supported by the Rotherham Mental Health and Learning Disability Transformation Board and are in line with priorities within the local plan.

4. Recommendations to the Health and Wellbeing Board

That members of the Health and Wellbeing Board;

4.1 Continue to support Lead Officers from their organisation to assist with the implementation of the **Better Mental Health for All Action Plan** and the **Rotherham Suicide Prevention and Self Harm Action Plan**.

4.2 Support the proposal for the Better Mental Health for All Group being the place to implement the section on loneliness within Aim 4 of the Health and Wellbeing Board Strategy.

4.3 Receive the revised Rotherham Suicide Prevention and Self Harm Action for approval in December 2018.

4.4 Receive annual updates on progress made with both action plans.

4.5 Receive updates on the NHSE funding for suicide prevention and how this is being implemented locally.

5. Name and contact details

Teresa Roche, Director of Public Health (DPH)

Ruth Fletcher-Brown
Public Health Specialist, Rotherham Public Health, Rotherham MBC,
Ruth.Fletcher-Brown@rotherham.gov.uk

Rotherham Integrated Care Partnership

Rotherham Health and Wellbeing Board – 19 09 2018

Final Draft Rotherham Integrated Health and Social Care Place Plan

Purpose
The Health and Wellbeing Board are receiving the final draft of the Rotherham Integrated Health and Social Care Place Plan for information and endorsement.
Background
Rotherham's first Integrated Health and Social Care Place Plan (Place Plan), was published November 2016, it detailed the joined up approach to delivering key initiatives that will help achieve the health and wellbeing strategic aims. The Place Plan is being refreshed so that it aligns with the revised Health and Wellbeing (H&WB) Strategy which was agreed in April 2018. The H&WB Strategy sets the overall strategic direction for health and social care in Rotherham, the 'Place Plan' is the delivery mechanism for the health and social care elements of the H&WB Strategy. The Place Plan sets out how the following 5 transformational workstreams will be delivered: • Children and Young People • Mental Health • Learning Disabilities • Urgent Care • Community Care The Place Board received a framework for the refreshed Place Plan at their meeting in April and a very first draft of the Place Plan at their meeting in May, a further draft in July and a final draft in September.
Analysis of key issues and of risks
Members are receiving the final draft of the IH&SC Place Plan. This version has addressed all the comments received from partners and all sections are complete with the exception of some minor additions which will be completed over the coming weeks. It should be noted that there is an additional priority within the Children and Young Peoples Transformation Workstream in relation to Maternity and Better Births, this had been identified as a gap. The areas to be completed are: • Completion of milestones and KPIs for the new Maternity and Better Births priority • Addition of a patient story for Children and Young Peoples Transformation Workstream
Patient, Public and Stakeholder Involvement
All 'place' partners have been involved in the development of the IH&SC Place Plan.

Approval history

Date	Meeting	Version of Place Plan	The ask
4 April 2018	ICP Place Board	Draft Framework	For comment
2 May 2018	ICP Place Board (confidential)	Draft Place Plan version 1.0	For comment
4 July 2018	ICP Place Board (confidential)	Draft Place Plan version 1.4	For comment and to agree the version to send out to all partners for final comment
5 July – 17 August	All ICP Partners	Draft Place Plan version 1.4	All partners to circulate as appropriate to get final comments to inform final version of the Place Plan
5 September	ICP Place Board (public)	Final draft Place Plan version 2.0 Incorporating all comments received	ICP Place Board to approve and give recommendation to Place Partners to approve through their respective Governance meetings
19 September	H&WB Board	Final draft Place Plan version 2.0	For information and endorsement
September/ October	All partner Governance Structures	Final draft Place Plan version 2.0	For final approval – this is the version approved by ICP Place Board on 5 September
October / November	ICP Place Board (public)	Final approved version of the Place Plan	For information the final version will be received for sign off / adoption following approval by partners through respective governance structures

Recommendations

The H&WB Board are asked to receive and endorse the final draft of the Integrated Health and Social Care Place Plan.

Rotherham's Integrated Health and Social Care Place Plan

5 September 2018

DRAFT version 2.0

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1 Introduction

1.1 Rotherham Partners' commitment

The Rotherham's Health and Social Care Community has been working in a collaborative way for many years to transform the way it cares for and achieves a positive change for its population of 261,000. Our successful track record in developing and delivering new solutions makes Rotherham the perfect test bed for new innovations. We are passionate about providing the best possible services and outcomes for our population and are committed to a whole system partnership approach. Only through working together can we provide sustainable services over the long term that aim to help all Rotherham people live well for longer.

Rotherham Partners' recognise that to realise our ambition and the necessary scale of transformation, we need to act as one voice with a single vision and a single Plan to deliver the 'Best for Rotherham'. Our shared vision is:

'Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery'

This plan updates our first Rotherham Integrated Health and Social Care (IH&SC) Place Plan, developed in November 2016, and closely aligns to the new Rotherham Health and Wellbeing Strategy. It describes our achievements to date, future strategic intent and how the relationships between the health and social care community have successfully matured to move us forward at pace within the Rotherham place.

The Plan is intended to work as a catalyst to deliver sustainable, effective and efficient health and care support and community services with significant improvements underpinned by collaborative working through the development of the Rotherham Integrated Care Partnership (ICP). Partners are fully committed to working together to make decisions on a best for Rotherham basis to achieve the transformations set out in this Plan. This is underpinned by robust governance arrangements and the 'Rotherham Agreement', a document that captures how we work together, developed and endorsed by all partners.

1.2 Rotherham Culture and leadership

The Rotherham Place strong, experienced and cohesive executive leadership team sets clear expectations and the spirit of collaboration and inclusiveness across the Rotherham ICP with the key aim of driving forward the transformation set out within this plan. It sets a high standard of integrity amongst leaders across all partners, and a culture of empowering and engaging with all staff.

To realise our vision we want everyone who works or lives in Rotherham– patients, people, families – to work together for a better Rotherham, to establish an individual and collective widespread aspiration for improved health and social care.

The Rotherham culture means that staff are confident to challenge and change things that are not right to improve services for people, aligning to the vision and principles within this plan. A key strength in Rotherham is the trust and openness between partners and their shared vision.

"Culture eats strategy for breakfast" is a well- known management phrase – we can create a first class strategy, but the hard part is its implementation and achieving the goals it sets. This can only be done by winning the hearts and minds of our staff and through adapting to diverse approaches and styles and building mutual benefit. This updated Plan therefore focusses, quite rightly, on how we will support and develop the systems workforce.

As well as a shared vision, Rotherham partners have agreed a shared set of principles by which we work to achieve our vision for Rotherham:

1. Focus on people and places rather than organisations, pulling pathways together and integrating them around people's homes and localities; we will adopt a way of working which promotes continuous engagement with and involvement of local people to inform this.
2. Actively encourage prevention, self –management and early intervention to promote independence and support recovery, and be fair to ensure that all the people of Rotherham can have timely access to the support they require to retain independence.
3. Design pathways together and collaborate, agreeing how we do pathways once collectively, to make our current and future services work better.
4. Be innovative, using international evidence and proven best practice to shape our pathways to achieve the best outcomes for people in the most cost effective way.
5. Strive for the best quality services based on the outcomes we want within the resource available.
6. Be financially sustainable and this must be secured through our plans and pathway reform.
7. Align relevant health and social care budgets together so we can buy health, care and support services once for a place in a joined up way.

1.3 Rotherham Success

We are proud that through collaboration, we have had significant success in moving forward the priorities within the 2016 Place Plan, examples include:

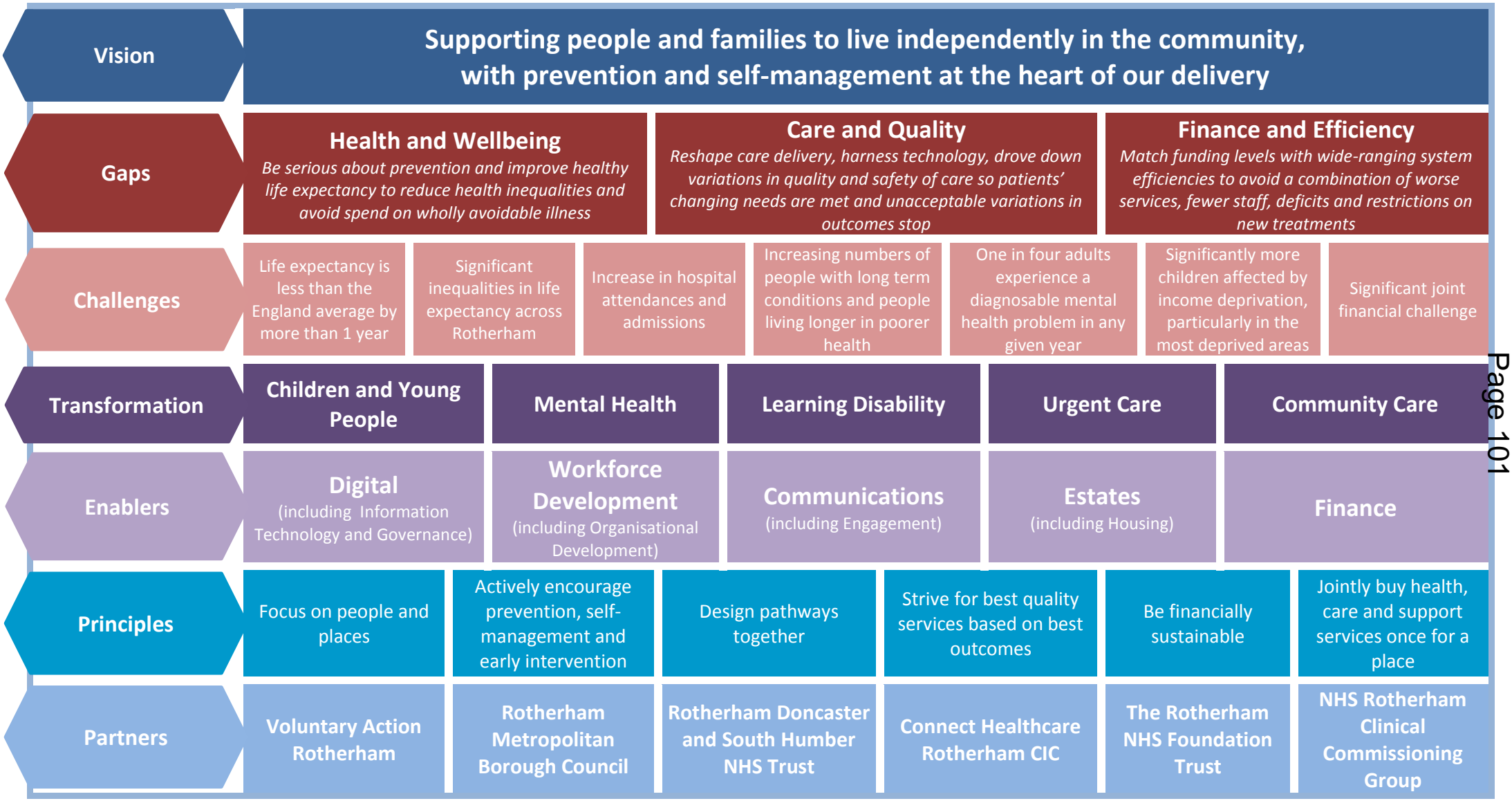
- The new state of the art, £15m, **Urgent and Emergency Care Centre** was successfully opened, delivering an innovative integrated model to improve co-ordination and delivery of urgent care provision.
- The new dementia friendly **Ferns Ward** was piloted, providing integrated specialist mental and physical health care expertise for The Rotherham NHS Foundation Trust (TRFT) patients who are physically well enough to be discharged from the acute setting, but are not yet well enough to be discharged home or to residential care due to a cognitive impairment.
- Implemented the **Rotherham Health Record**, enabling health and care workers to access patient information to make clinical decisions. Already used by TRFT (acute and community), it was rolled out to the Rotherham Hospice and some GP practices. An information sharing agreement has been agreed which will enable Rotherham Doncaster and South Humber NHS Trust (RDaSH) and Rotherham Metropolitan Borough Council (RMBC) social care to come on board during 2018/19.
- Continued success of the award winning **Social Prescribing Service** which helps adults over the age of 18 with long term health conditions to improve their health and wellbeing by helping them to access community activities and services. During 2017 it was extended to **mental health patients** and is now used for autism and social isolation.
- Significant progress with **Child and Adolescent Mental Health Service**, extensive service change leading to substantial improvement in both assessment and treatment: the number of assessments within six weeks rose from 30% in September 2016 to 100% in November 2017; the number of people waiting less than eight weeks for treatment rose from 42% in September 2016 to 84% in November 2017.
- The **Integrated Locality Pilot** has been evaluated to inform the next stage of implementation, it will deliver an integrated commissioning and operating model for community services, with joint leadership and accountability.

- A key enabler for the improvements seen in **Delayed Transfers of Care** (from 6.2% to 2.5%), was the integration and co-location of TRFT Transfer of Care Team and RMBC Hospital Social Work team to form the **Integrated Discharge Team.**
- Successful embedding of an **occupational therapy** offer within the RMBC **Single Point of Access Team,** has been complemented by the piloting of a member of staff from the mental health trust, voluntary sector and input from physical health.

These achievements have been enabled through:

- **Clear leadership and strong relationships -** The Rotherham ICP Weekly Executive meeting, established April 2016, is attended by Chief Executive Officers from all partners within the ICP, along with other senior officers. It has strengthened existing excellent relationships, provided clear leadership and ambition for place transformation and set the spirit and culture by which partners work together to achieve the best for Rotherham.
- **Robust governance and wider partnership engagement** has informed the robust structure to implement the Place Plan. We have:
  - convened the ICP Place Board, which reports to the Rotherham Health and Wellbeing Board.
  - created the Rotherham ICP Delivery Team, which reports to the Place Board and into our transformational workstreams.
  - consolidated our five transformational workstreams into three transformational groups; Children and Young People, Mental Health and Learning Disability; and Urgent and Community.
  - created a compelling and shared case for change for each of the transformational groups, aligned to the Place Plan.
  - identified a number of enablers: Digital, Workforce, Communications, Estates and Finance and have started to deliver programmes of work aligned with them.

1.4 Plan on a page



2 Local Context

2.1 Health and Wellbeing

The Health and Wellbeing (H&WB) Board is a statutory sub-committee of the Council. Locally, it is the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing. It aims to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The third H&WB Strategy for Rotherham was produced in March 2018, it sets the strategic vision for health and social care and improving health and wellbeing outcomes for local people. The role of the H&WB Board is to oversee its implementation and to take action where needed to remove blockages, identify gaps and to hold organisations, worksteams and strategy leads to account for delivery; ensuring opportunities for improving health and wellbeing are maximised.

The H&WB Strategy includes four aims which the H&WB Board have agreed are the most important things to focus on to improve health and wellbeing outcomes for all Rotherham people, and that can be best tackled by a 'whole system' approach:

- **Aim 1:** All children get the best start in life and go on to achieve their potential
- **Aim 2:** All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
- **Aim 3:** All Rotherham people live well for longer
- **Aim 4:** All Rotherham people live in healthy, safe and resilient communities

2.2 Rotherham Place Plan

The second Rotherham IH&SC Place Plan has been refreshed so that it closely aligns to the revised H&WB Strategy and will be the delivery mechanism for the health and social care elements of the H&WB Strategy.

The transformation approach has been to identify five closely interlinked transformational workstreams to maximise the value of our collective action and transform our health and care system so that we can reduce demand for acute services, achieve clinical and financial sustainability and thus close the three gaps. These five transformational workstreams align to the H&WB Strategy and will underpin its delivery:

- Children and Young People
- Mental Health
- Learning Disabilities
- Urgent Care
- Community Care

The transformational workstreams will be taken forward through three transformational groups, and will report through the ICP Delivery Team to the ICP Place Board. Existing mechanisms have been used so as not to duplicate any work within the system, the three transformational groups are; Children and Young People, Mental Health and Learning Disabilities and Urgent and Community Care.

Each of the three transformation groups have agreed a set of priorities that they will take forward over the next two years. These priorities are areas that will make the most impact if addressed collectively across health and social care. The transformational priorities are listed below and section 5 provides detail for each of these.

Children and Young People

1. Implementation of CAMHS Transformation Plan
2. Maternity and Better Birth
3. Oversee delivery of the 0-19 healthy child pathway services
4. Children's Acute and Community Integration
5. Special Educational Needs and Disability (SEND) – Journey to Excellence
6. Implement' Signs of Safety' for Children and Young People across partner organisations.
7. Transitions

Mental Health and Learning Disability

1. Deliver improved outcomes and performance in the Improving Access to Psychological Therapies service
2. Improve dementia diagnosis and support
3. Deliver CORE 24 standards for mental health liaison services
4. Transform the service at Woodlands 'Ferns' Ward
5. Improve Community Crisis Response and intervention for mental health
6. Better Mental Health for All Strategy
7. Oversee Delivery of Learning Disability Transforming Care
8. Support the implementation of the 'My Front Door' Learning Disability Strategy
9. Support the Development and Delivery of Autism Strategy

Urgent and Community

1. Creation of an Integrated Point of Contact for care needs across Rotherham
2. Expansion of the Integrated Rapid Response service
3. Development of an integrated health and social care team to support the discharge of people out of hospital.
4. Implementation of integrated locality model across Rotherham.
5. Develop a reablement and Intermediate Care offer
6. Develop a coordinated approach to care home support.

Our collective approach to Place Plan delivery allows a 'Golden Thread' from our 'Health and Well Being' strategy aims through to the transformational group delivery. We fully acknowledge that each of the transformation groups have identified priorities which cross cut between groups, we manage this through the ICP Delivery Team.

2.3 National Expectations

The NHS Five Year Forward View set out a clear goal that *"the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care".* It places integrated, holistic person-centred support at the heart of health and care systems, breaking down barriers to the traditional divides, further developing out of hospital services and fostering community resilience. With the aim that people and families can be better supported, services provided closer to home and demand for hospital services can be reduced.

The Five Year Forward View identifies three widening gaps; health and wellbeing, care and quality and finance and efficiency. These gaps resonate with the challenges faced at a Rotherham Place level, see section 3.4.

The Care Act 2014 sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support. Under the Care Act 2014, local authorities must:

- carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care
- focus the assessment on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve
- involve the person in the assessment and, where appropriate, their carer or someone else they nominate
- provide access to an independent advocate to support the person's involvement in the assessment if required
- consider other things besides care services that can contribute to the desired outcomes (e.g. preventive services, community support)
- use the new national minimum threshold to judge eligibility for publicly funded care and support.

The Integrated Communities Strategy Green Paper invited views on the government's vision for building strong integrated communities where people – whatever their background – live, work, learn and socialise together, based on shared rights, responsibilities and opportunities.

The green paper sets out an ambitious programme of actions to deliver the vision at a local and national level. The consultation ended 5 June, and feedback is being analysed. The key proposals are to:

1. Strengthening Leadership
2. Supporting New Migrants and Resident Communities
3. Education and Young People
4. Boosting English Language
5. Places and Community
6. Increasing Economic Opportunity
7. Rights and Freedoms

The Place Plan will continue to drive the integration of health and social care in Rotherham.

2.4 South Yorkshire and Bassetlaw (SY&B)

Delivering the Five Year Forward View announced the requirement to develop Sustainability and Transformation Plans, where local leaders were asked to come together to develop a shared vision and plan for the future of health and care services in their area. The next step was for NHS organisations in partnership with local councils to form Sustainability and Transformation Partnerships (STPs) to continue to build on the collaborative work with the aim to improve health and care by looking at the needs of a whole population and not just those of individual organisations. Of the 44 STPS across England, nine were chosen to work towards becoming an Integrated Care System (ICS). An ICS can choose to take on collective responsibility for resources and population health, and in return get far more control and freedom over their health system. SY&B ICS was chosen of one of the nine.

Commissioning will be undertaken in accordance with statutory responsibilities at locality level or when it is most appropriate, by commissioners collaborating at South Yorkshire and Bassetlaw level through joint strategic commissioning arrangements and part of a regional function.

The SY&B ICS is made up of 25 health and care partners from across the region and its plan is based on the five 'places' within SY&B – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. The five place plans are the foundation of what will be delivered in each area. Planning and delivery at an overarching ICS level must be coordinated with planning and delivery at a local Place level, as they represent different elements of the same system.

The SY&B ICS has eight priority areas of focus:

- Healthy lives, living well and prevention
- Primary and community care
- Mental health and learning disabilities
- Urgent and emergency care
- Elective and diagnostic services
- Children and maternity services
- Cancer
- Spreading best practice and collaborating on support office functions

2.5 Primary Care

In 2017/18, general practice provided over 1.5 million appointments in Rotherham. General practice is essential to Place Plan delivery and is undergoing significant change. The key priorities for Rotherham, from the GP Forward View, are:

- **Implemented extended access** – Rotherham already provides 7 day extended access for the whole population and the number of hours available will increase significantly from October 2018 to support accessibility for the working population and also avoid wherever possible primary care attendance at the Urgent and Emergency Care Centre.
- **Implementing a quality contract for general practice** – this consists of 13 standards with key delivery requirements to provide a consistent primary care offer across Rotherham e.g. all GP urgent appointments to be seen within 1 working day and routine appointments within 5 working days.
- **Every practice undertaking productive general practice** – this is a support programme which NHS England are funding to develop practices to undertake LEAN techniques and review elements of practice e.g. front/back office, planning and scheduling.
- **Developing the primary care workforce** – working with practices to consider alternative roles and support the training of new primary care practitioners e.g. clinical pharmacists, newly qualified nurses, student nurses, apprentices, care navigators. Care navigators are now in place across 29 practices ensuring patients are navigated to the most appropriate service or clinician. In August, Physiotherapy First will be rolled out for the 10 pilot practices to all 29 who have care navigators in place and will enable patients with musculo- skeletal issues to be assessed more quickly by an experienced physiotherapist, it is envisaged that this will release GP and nurse capacity in practices by at least 10% improving access for other conditions.
- **Continuing to develop the Federation arrangements in Rotherham to strengthen general practice** – Rotherham now has a Community Interest Company, Connect Healthcare which consists of all 30 practices.
- **Roll-out of telehealth and other IT to support general practice capacity –** Telehealth has been rolled out to 29 practices and evaluated well for releasing capacity, reducing DNA (Did not attends), improving patient experience and reducing administrative costs. Remote consultation equipment has also been provided to all practices to enable both clinicians and patients to connect. Work is also ongoing in relation to a Rotherham Application to enable patients to

book and cancel appointments, receive self-care advice and information from their practices, access extended access appointments directly all from their smart phone or computer. The Rotherham Application has been commissioned on the basis that it can be developed further to incorporate secondary care and the wider place for example single point of access in RMBC.

- ***GP Case Management*** **-** The CCG will continue to expand the GP led, multidisciplinary, case management of patients in Rotherham at highest risk of admission to hospital through the continuation and expansion of the GP Case management programme. This includes maximising the visibility of case management plans to other clinicians. We already target the top 5% of people at risk of hospitalisation using risk stratification and GP judgement and we intend to work with our localities to utilise the tools available to us to ensure we are supporting the right cohort of patients collectively as an integrated system.

2.6 Planned Care

One of the key deliverables to enable Rotherham to transform elective care over the next five is to ensure that clinical pathways are efficient, offer high quality services and provide patients with the best possible experience in line with NICE guidance.

Building on the successful use of clinical referrals management as a vehicle for change, Rotherham partners will continue to develop and share our good practice to support the development of the most appropriate and efficient clinical management of patients whose condition requires elective referral to hospital for planned care.

Keeping within affordable limits requires a step change in the efficiency of elective care particularly where more accessible services avoid the need for hospital attendance and admission; this includes the development of one stop services and the development of new ways of working/pathways.

The work of our Clinical Referral Management Committee will continue to focus on ensuring the evidence base is fully utilised to gain assurance that the appropriate thresholds for treatment are being applied across commissioned services. Where pathways are identified which do not meet the evidence base for clinical threshold or patient outcomes then Rotherham partners will actively work across the wider STP footprint to consider redeveloping existing pathways.

Some elective pathways are already working in a collaborative way across the region e.g. Oral & Maxillofacial Surgery, Ear Nose and Throat, Ophthalmology and we intend to continue working with partners on these services. There are also further opportunities in areas such as elective orthopaedics where work could be consolidated within Rotherham and these opportunities are to be pursued. There are also opportunities to expand the integrated community approach and explore where the provision of services could benefit from more integrated pathways being established and for services to be provided within a community setting.

Overall, Rotherham partners fully accept that in order to deliver high quality, safe and sustainable elective care provision across South Yorkshire in the future that options will need to be considered for the future configuration of the elective system.

2.7 How the Place Plan was developed

Rotherham's Place Plan details our joined up approach to delivering key initiatives that will help achieve the Rotherham Health and Wellbeing Strategy. All services should be provided as close to the patient as possible, the only reason for services being provided outside Rotherham is where there is a compelling reason of clinical safety or improved patient experience. Providing the right care in the right place will mean that more people will receive care closer to their home.

The development of the Place Plan is a joint collaboration with representatives from key stakeholders across Rotherham's health and social care services, as depicted in the diagram.

The H&WB Board sets the strategic vision for health and social care in Rotherham and has refreshed its strategy in 2017/18. The IH&SC Place Plan is the delivery mechanism for the health and social care aims of the H&WB Strategy.

To underpin the delivery of the Place Plan, Rotherham ICP partners have collectively worked towards an agreed governance structure and have agreed a shared vision and set of principles by which the Rotherham ICP partners will work for the best for Rotherham approach. Further information can be found in section 4.5 of this Plan.

The Place Plan does not replace partners' individual plans but rather builds upon them identifying areas where we can do more together. It uses insights from the H&WB Strategy and the JSNA. The Plan also takes account of other key relevant documents:

- The Five Year Forward View
- Delivering the Five Year Forward View
- The Five Year Forward View for Mental Health
- Next Steps on the Five Year Forward View
- General Practice Forward View
- South Yorkshire and Bassetlaw Sustainability and Transformation Plan

3 Achieving our Aspirations

3.1 A snapshot of Rotherham

A Rotherham pen-picture:

- Rotherham is a borough covering 110 square miles.
- It has a population of 260,800 mostly living in urban areas, equating to 108 thousand households.
- It is also made up of many towns, villages and suburbs which form a wide range of geographic communities.
- Of the 260,800 population there are 50,000 children aged 0-15 and 27,300 young people aged 16-24.
- The population is ageing, with 64,600 people aged over 60, 21,800 are aged over 75 and 5,800 over 85 with an additional 1,000 over 85s expected by 2021.
- Rotherham has a diverse community which includes 20,000 people from minority ethnic groups (8.1%). The largest communities are Pakistani/Kashmiri and Slovak/Czech Roma.
- Rotherham has a wealth of green space across the borough, in the form of country and urban parks, nature reserves, woodlands and playing fields. Although used well in some areas, others offer an often untapped resource within communities.
- Rotherham has 94 primary schools, 16 secondary schools and 6 special schools.
- GCSE performance is above the national average, but the performance of children from Rotherhams poorer families compares unfavourably with the national averages on many educational attainment measures.
- The borough benefits from a vibrant voluntary and community sector (VCS), comprising almost 1,400 organisations with 3,600 staff and around 49,000 volunteer roles. It is estimated that the paid VCS workforce contributes £99m to the economy per annum and that volunteers provide approximately 85,000 hours of time per week.
- The average income is below national average and the average house price is six times the average income level, pricing a large proportion of the population out of home ownership and leaving them reliant on social or private rented housing.
- 11.4% of homes are in fuel poverty with localised rates up to 32%
- Rotherham needs to build 900 new homes per year to meet local need, we are currently not meeting this target which results in people living in accommodation that doesn't meet their current needs; which is either overcrowded, unaffordable, unsafe which in turn contributes to poor health.
- 8,214 people in Rotherham are entitled to Carers Allowance with 5,627 receiving the payment due to their role as a carer
- 70 businesses signed up as Rotherham pioneers; McLaren signed a 20 year deal to be based at the Advanced Manufacturing Park
- The Town Centre Masterplan has been agreed which includes; development of Forge Island as a major leisure destination including a new cinema, hotel, food and drink and potentially a new theatre; more than 350 high quality riverside homes; a new higher education development at Doncaster Gate scheduled to open in September 2018 and a refurbished bus interchange and multi-storey car park.

Local health and social care services:

14 nursing/residential homes	**One lead body for voluntary and community sector**	**31 GP practices**
One local authority	**261,000 population**	**One Clinical Commissioning Group**
One hospital (acute and community)		**One GP Federation**
One ambulance provider	**One mental health provider**	**One Hospice**

3.2 A snapshot of our population – Joint Strategic Needs Assessment

The H&WB Board is responsible for producing the JSNA and all members participate in the process. The JSNA is a public repository and summary of information from a wide range of sources relevant to health and wellbeing in Rotherham. It extracts available evidence of need into a series of answers to the following three questions for each issue or subject area covered: Why is this an issue? , What is the local picture? , What is the trend and what can we predict will happen over time? The JSNA is used in the development of commissioning and service planning for health and social care services in Rotherham.

It is good to highlight that whilst we have significant challenges we also have **significant successes**:

- Performance for children achieving a good level of development at the early years foundation stage (up to age 5) is above the national average.
- In the town centre, recent transformation work was recognised with an award in the town centre category of the Great British High Street Awards.
- Pre-recession (2007) workplace jobs in Rotherham reached a high of 104,100 but by 2012 this had fallen to 91,900, a fall of 12,200 (-11.7%). By 2016 job numbers reached 104,000 - a return to pre-recession levels.
- There are 6,810 VAT registered businesses in Rotherham, with the figure increasing by over 6% in 2016.
- Rotherham has a £4.3 billion a year economy and was a top performer in 2017 staying at the top of the UK Powerhouse rankings for gross value added (GVA) growth. GVA is predicted to be 1.3% higher at the end of 2018 compared to the end of 2017 and, looking further ahead to 2028, the researchers put Rotherham's GVA at £4.8 billion.
- From 2013 to 2016, Rotherham children have achieved better than national for a 'good level of development' (GLD), with an upward trajectory each year.
- There are less 16 to 18 year olds in Rotherham who are not in employment, education or training compared to national and statistical neighbours
- GCSE achievement are better than national averages.
- More people are having routine vaccinations and cancer screening in Rotherham than the national average.

- The rate of under 18 conceptions in the borough has more than halved in the last 10 years but is still above the England average.
- The rate of emergency hospital admissions due to injuries from falls in the elderly has decreased by a third in the past 5 years.
- The percentage of alcohol users who successfully complete treatment has increased and is now higher than England average.
- Mortality rates have reduced, in particular infant mortality and premature deaths from cancer.

However, some of our significant challenges, as shown in the JSNA are:

The health of people in Rotherham is generally poorer than the England average	Deprivation in Rotherham is amongst the highest 20% in England, 45% of the population live in one of the 30% most deprived SOAs in England	The gap in life expectancy between the most and least deprived parts of Rotherham for males is 10.9 years and females is 7.1 years - there is a direct correlation between social care needs and deprivation	71.2% of adults in Rotherham were overweight or obese in 2015/16, worse than the 61.3% average for England	22.2% of children leaving primary school are obese, above the national average
Life expectancy in Rotherham is lower compared to the national average by 1.7 years for males and 1.6 years for females and is 9 years lower for men and 7 years lower for women in the most deprived areas of Rotherham compared to the most affluent areas	9.4% of working age people in Rotherham are claiming long term sickness or disability-related benefits	Significantly more Rotherham children are affected by income deprivation 24.3%, compared to 19.9% nationally. This rises to 50% for children living in our ten most deprived areas	Rotherham's breastfeeding initiation rate is amongst the lowest in the region at 56.0%, contributing to levels of childhood obesity and paediatric hospital admissions	922 people aged 15-64 in Rotherham were newly diagnosed with a sexually transmitted infection in 2017, the rate being below the national average
Men in Rotherham will live 18 years of their lives with at least one long term health condition and women will live 26 years with at least one long term health condition	30% of the Rotherham population are estimated to drink at a level that puts their health at risk (14 units per week) and the rate of alcohol-related harm hospital stays is worse than the average for England	Half of people aged 75 years and over live alone and most experience loneliness, especially those who are widowed	Almost 500 smoking related deaths each year in Rotherham – 22% higher than the England average	Early deaths from cancer, heart disease and stroke have fallen, but remain worse than the England average
Mental health problems affect one in four people at some point each year	3.1% of 16-18 year olds in Rotherham are not in employment, education or training, higher than the 2.8% nationally	An estimated 18.3% of Rotherham adults smoke, above the national average of 15.5% and 17.1% of mothers smoke during pregnancy contributing to increased risk of stillbirth, low birth weight and neonatal deaths	There are about 6,550 Potential Years of Life Lost each year in Rotherham through causes considered amenable to healthcare, this is around 1,400 years more than might be expected based on the England average	The number of older people is increasing, especially in the oldest age groups, and people will live longer with poorer health

3.3 The Case for Change

The JSNA clearly tells us that we have significant challenges to address. In the coming years we anticipate growing pressures across a range of services. This will include not only health and social care but also supported housing, informal care and other services. We expect these pressures because of a range of factors, including:

- The health of Rotherham people is generally poorer than the English average
- Life expectancy in Rotherham is poorer compared to the National average and Rotherham has significant inequalities in life expectancy across the borough linked to deprivation
- Significantly more children are affected by income deprivation, particularly in our ten most deprived areas
- Increasingly people are living with multiple long term conditions at an earlier age, this is a significant driver of complex health and social care interventions
- We have a growing population and will see a significant increase in the 85+ population
- Mental health issues are impacting more significantly on people in Rotherham than the nationally recognised issue

These challenges for Rotherham resonate with the three national gaps, described further in section 3.4:

- **Health and Wellbeing** – a major cause of ill health and premature death is due to diseases that could be prevented by living healthier lives. We need to get serious about prevention and improve healthy life expectancy to reduce health inequalities and avoid spend on wholly avoidable illness.
- **Care and Quality** – there are variations in the quality of care received and differences in how services are delivered and the outcomes received. Partners need to work together to reshape care delivery, harness technology, drive down unwarranted variations in quality and safety of care so patients' changing needs are met and unacceptable variations in outcomes stop.
- **Finance and Efficiency** – the forecast is for demand for services to rise. We need to manage demand by supporting people to be healthy, increase productivity and efficiency to maximise available resources and redesign services to develop new ways of delivering joined up care. By matching funding levels with wide-ranging system efficiencies we will avoid a combination of worse services, fewer staff, deficits and restrictions on new treatments

We still, however, all want health and care services that can meet our needs now and in the future. Rotherham Partners aim to offer safe, compassionate and high-quality care, however, the challenges we face mean that we need to change the way we work to improve care and get better value for the money we have available.

As our population grows, and more people live with more long-term conditions, the demands on our services are changing and increasing. Current services are not necessarily designed for todays or future needs, and it is increasingly harder to keep up with rising costs. In the past 10 years, the number of people aged 65 and over in England has increased by 1.4 million, a 17% rise and the number of people reaching their 80th birthday has increased by 17%. These people are more likely to be living with complicated conditions that mean they need support. We need to make the most of opportunities to improve health and wellbeing, prevent illness and support people to manage existing conditions and stay independent.

Rotherham Partners have come together to commission and provide services. By working together can we transform the way we work and improve the health and wellbeing of our population, further and at pace.

Our vision is to put local people at the heart of services, helping people to stay well and independent in their own homes and communities and avoid being admitted to hospital, we want to:

- improve the health and wellbeing of local people
- deliver high-quality, joined-up health and social care
- offer access to the right care and support in the right place, at the right time
- ensure staff are able to continue to deliver the caring ethos of the NHS and social care
- better meet people's needs within existing funding
- build health and care services that are sustainable for years to come

The transformational workstreams - children and young people, mental health, learning disabilities, urgent and emergency care - aim to address both the challenges for Rotherham and close the three gaps - health and wellbeing, care and quality and finance and efficiency. Below is a synopsis of each tranformational workstream and in section 5 we provide further detail. In addition, we have identified a set of enabling workstreams to underpin delivery, these are described in section 4.

3.3.1 Children and Young People

The number of children and young people under 18 in Rotherham is slightly above the English average. The number of Children in Need, Looked After Children and children subject to Child Protection Plans in Rotherham are all above average. The social care needs for children and young people are clearly rising.

Keeping children safe is only possible if we work together effectively across organisational boundaries. Strong partnership working is a way to support children to thrive and achieve positive outcomes in all aspects of their lives. Each of our priorities requires us to take partnership working to the next level, developing integrated pathways, joint commissioning arrangements and a shared view of our performance.

We are also determined that, throughout our work, the voice of the child will be loud, meaningful and embedded in our rationale and activity.

Each priority will focus on a distinct cohort of children whose needs and vulnerabilities require fully integrated pathways to enable them to achieve positive outcomes without the barriers of organisational silos or funding restrictions. Whilst the priorities are not necessarily part of a single integrated pathway, they are sometimes overlapping and interdependent.

Our aspiration is to put prevention and early intervention at the heart of what we do, and reduce the need for acute services that are more intrusive and traumatic for children and families and more costly to deliver. We will be accountable to each other and to children whose voice, individually and collectively, will guide our work.

3.3.2 Mental Health and Learning Disabilities

With advancement in identification, diagnostics and treatment for mental health services, as well as equality legislation and public awareness and understanding; there is a significant increase in demand for services. Mental health problems represent the largest single cause of disability in the UK, and suicide is now the leading cause of death for men aged 15-49. There is an explicit need to bring parity of provision between physical and mental health and to tackle the persisting stigma around mental illness and learning disabilities.

We have a higher rate of people with a learning disability in Rotherham, and the numbers are rising, leading to increased demand for services. We also we have a significant number of older carers who support people with a learning disability.

People with severe and prolonged mental illness are still at risk of dying on average 15 to 20 years earlier than other people. People in marginalised groups are at greater risk of developing mental health issues and receiving poorer outcomes.

We want to provide a better experience and better results. Services must change in order to provide the high quality services the people of Rotherham expect to meet their needs. Co-morbid mental health problems raise total health care costs by at least 45% for each person with an additional long-term condition. Too many people with mental health issues and learning disabilities are still receiving treatment and support in inpatient or residential facilities rather than in their communities, closer to home.

3.3.3 Urgent and Community Care

People are living longer, often with highly complex needs and multiple conditions that require ongoing management from both health and social care services. As the population ages and financial pressures increase, we need to be more proactive and preventative in our approach, providing services in the community that support independence for longer. Services need to work seamlessly together to; deliver better quality care; improve patient experience; improve clinical outcomes; and improve the health and care of local populations.

Only by exploiting the potential of integration and a drive for personalisation, can we create a resilient health and social care economy. Reform needs to happen at different levels – individuals, localities, partnership areas and borough wide.

The aggregation of a host of small scale projects is not enough, pace and large scale reform are the only options. We need a transformational reduction in demand for services across the health and social care system. This can only be achieved at scale through greater personal resilience, independence and well-being.

Our transformational priorities work together as a whole system approach to deliver a step change in how we deliver our services moving from a responsive, paternalistic approach to a proactive preventative integrated health and social care model which supports individuals to live as independently as possible in the community. Where people do need support it will be proportionate and joined up to make best use of limited resources and the emphasis will be on reablement, rehabilitation and recovery.

3.4 Addressing the three national gaps

The Five Year Forward View identifies three widening gaps; health and wellbeing, care and quality and finance and efficiency. These gaps resonate at a local level.

3.4.1 Better Health and Wellbeing

We aim to focus on prevention and improve healthy life expectancy to reduce health inequalities and avoid spend on wholly avoidable illness.

We want health and care to be managed long before someone needs to have hospital treatment or experiences problems in their life. We want to do this in a way that is right for them, whether this is through providing information and advice, or through more active management. We want a culture in Rotherham where people feel empowered to be part of the decisions around their care and support, to maintain dignity and independence and drive their own care.

We will better meet the needs of local people by targeting individuals that can gain most benefit. We will do this through expanding our Social Prescribing service both for those at risk of hospitalisation and for mental health clients and through continued systematic use of Healthy Conversations (brief interventions) and advice by every statutory organisation using Making Every Contact Count (MECC). We will train front-line staff to talk about sensitive issues such as alcohol use, healthy eating habits, increasing physical activity and quitting smoking. We will also ensure quick and easy referral to evidence based lifestyle services (e.g. smoking cessation) to support those that are ready to change and in a way that is right for them.

In section 5 we detail further transformational priorities that will help us to achieve our aspirations for improved health and wellbeing for our population. This includes, such as; delivery of the 0-19 year old healthy child pathway, creation of a single point of contact for care needs across Rotherham and implementing a 24/7 adult mental health hospital liaison service, incorporating alcohol liaison.

These initiatives will allow us to better support individuals to make positive, sustained lifestyle changes by adopting a person-centred and a whole community approach to improving health and well-being.

3.4.2 Better Standards of Care and Quality

We aim to reshape care delivery, harness technology and drive down variations in quality and safety of care so patients' changing needs are met and unacceptable variations in outcomes stop.

We want health and care services that provide people with an alternative to entering services or having a hospital admission. We want to continue to support increased community care to improve patient outcomes, improve flow through the system and provide effective facilitated discharge, with a 'Home is Best' ethos.

We will continue to build on the progress so far , taking a more holistic and integrated approach across physical and mental health, social care and the voluntary and community sector in order to develop and embed an integrated model of care which supports individuals and their carers. We will use new technology to support the delivery of our key priorities.

In section 5 we detail further transformational priorities that will help us to achieve our aspirations for improved standards of care and quality for our population, such as; children's acute and community integration so that we can be responsive to needs, development of an integrated health and social care team to support

the discharge of people out of hospital and to further develop the Ferns facility for dementia patients who are physically well but need further support before they are well enough to go home.

These initiatives will increase quality and standards across the health and social care system, reduce hospital admissions and halt the rise in waiting times. We aim to provide equitable services to meet the needs of our population.

3.4.3 Better use of funds (spending the Rotherham £)

Collectively we spend in the order of £550m on Health and Adult Social Care and Children's Services in Rotherham.

System partners fully acknowledge that they are jointly responsible for ensuring the effective use of the available financial resource within the Rotherham place. Our 'place based' thinking and new ways of working is taking us beyond existing organisational boundaries for both the commissioning and delivery of provision. It is therefore not surprising that as we mature into our place base culture of working, we will increasingly make transparent financial decisions that not only support individual partners to be sustainable, but consider the impact on the wider place position.

Our commitment to working in partnership to best utilise the Rotherham £pound is strong. However we cannot under estimate the on-going significant financial challenge facing individual place partners within our system. The CCG, although in current (April 18) financial balance, has an identified £15m efficiency target in 2018/19, and expects the efficiency requirement to remain challenging beyond 2018/19. RMBC overspent by £11.8m on Adult and Children and Young People's services in 2017/18 and has new savings of £5.6m in 2018/19 identified in those services. In total therefore, RMBC needs to reduce its spend in 2018/19 on Adult Social Care and Children's Services by £17.4m and further significant cost reductions are required beyond 2018/19. In 2018/19 TRFT is operating to a financial plan of deficit £20.3m. RDaSH is operating to a financial plan of surplus £2m.

Given the respective financial positions of partners, we will need to continue to make difficult financial decisions within our Rotherham Place. Of increasing importance is that we do this wherever possible collectively, ensuring that we mitigate any impact on other place partners. Our aspiration is to have in place aligned financial strategy for the place for 2019/20 and beyond.

4 Enabling Workstreams

4.1 Workforce Development

People are key to delivering our vision – the people of Rotherham and our combined workforce. We want to support our workforce to think differently to help create a future system model that will work for them and for Rotherham people.

We know our workforce is our biggest asset, however we also know that alongside finance, workforce is our biggest challenge. Securing the workforce, both home grown and recruited from overseas, to deliver the healthcare services that are required by patients has been earmarked as one of three "major NHS challenges". Pay, staffing shortages and a surge in agency spending is a national issue which needs to be addressed alongside the capacity to deliver of high-quality and safe care, keep a grip on national targets and the added complexity of new commitments to seven-day working and easier access to GPs.

Place partners know that we need to invest in our workforce, not just in terms of changing roles to meet our place plan objectives, but also in organisational development to change behaviours and cultures at all levels. A skilled and experienced workforce, working within the right environment and culture is key to delivery. In our first Place Plan we were maturing as a system and our reference to the need to develop our workforce collectively across the Rotherham Place was understated.

As we move forward in our Place base working, aligning and integrating our system over time, we know there is a stronger need than ever to focus on our workforce, we need to build on the existing excellent work in areas such as Urgent Care, Mental Health and Integrated discharge and Joint Commissioning. We need to be proactive in changing behaviours at all levels across our place , which in turn will change our culture towards one of 'Place first, organisation second'.

4.1.1 Organisational Development

As a system we have spent time reflecting on models of international best practice with regard to organisation development, we acknowledge we need to adopt one framework that all partners will accept, adopt and own within each of their own organisations . The model of organisational development identified therefore is an 8 part model, which utilises concepts from the Burke-Lit win model for organisational development.

As a Place we have identified this model as a starting point in that it places emphasis on environmental factors that can be developed at the 'The Rotherham Place' and cross cuts our organisations. As the identified framework is in 8 parts, we can choose as a system where we put emphasis on our local development/improvement. Suggested opportunities for improvement have been identified below:

Organisation Development area		Areas of Opportunity
1. Mission and Strategy	→	• Build on the collective vision to improve communication to staff and the public • The vision allows a collectively focus on safety, quality and efficiency • We will work together to develop a collective brand for the Rotherham Place
2. Leadership	→	• Agree joint leadership training, designed for certain levels of leadership across Rotherham Place • Commitment to lead change together • Learn from people who have experience of system transition
3. Culture	→	• Changing behavior's to take a Rotherham Place first approach • Develop opportunities to co-produce initiatives such as staff well- being and resilience building
4. Structure	→	• Develop mechanisms that allow across organisational recruitment and retention • Where appropriate create opportunities to introduce across orgainsational posts
5. Management Practice	→	• Develop Rotherham Place 'talent' management opportunities • Develop mechanism to introduce across Rotherham Place apprenticeship / intern opportunities
6. Policies and Procedures	→	• Align induction processes to ensure place and organisation covered • Opportunities to advance the 'working together' passport, co-deliver or optimise training, through sharing of resource
7. Tasks and individual value / behaviours	→	• Agree a set of cross organisation, Place based staff values • Joint approach to identifying good and problematic areas of joint working • Develop an accepted approach to use of language in our Rotherham Place
8. Engagement and motivation	→	• Undertake across organisation engagement events • Engage staff on 'what matters to them'

4.1.2 The changing workforce

We describe in section 5 of our place plan, the many different priorities that we plan to enact across the Rotherham Place in order to transform our system over the coming years. As well as changing organisational approaches to the workforce through organisational development, we fully acknowledge that at a place level we need to develop existing and where appropriate introduce new roles.

In the last two years we have already had great success in changing the way in which our workforce commissions and delivers services in a more integrated way. Examples include; the mix of physical and mental health skills currently being delivered by staff within the Ferns Dementia ward; the adoption of the integrated Hospital and Social Care discharge teams; and also GP colleagues working increasingly within the Urgent and Emergency Care Centre. From a commissioning perspective we have also developed five joint commissioning posts are now in place.

Moving forward we expect a number of changes to our workforce, our agreed approach to locality working will require colleagues from health and social care to not only hold specialist skills, but also play a more generic role in their locality.

Our 'home first model' for Intermediate Care and Reablement will require a different level and skill of workforce working into peoples' own homes as opposed to offering a more traditional bed based care. As a place we fully understand that some of our hospital based specialities would benefit from a networked approach of workforce that would provide greater sustainability.

Rotherham has a diverse and active voluntary and community sector (VCS), underpinned by thousands of volunteers. We recognise that building on a 'community asset' based approach, that the VCS is rooted within our local communities and neighbourhoods. As part of this we recognise that the VCS plays a crucial role in prevention and early intervention, enabling self-help, and supporting community resilience. Our place ambition is to continue to work alongside our VCS partners who will support and enable the delivery of our place plan. As a system we fully recognise that a VCS offer of support delivery does not mean no cost within our place and that appropriate investment will be required, where the system requires support from a VCS partner to support delivery of our plans.

Across the Rotherham Place, partners have developed strong relationships, with local colleges, universities and also Health Education England. We see these relationships developing further and being built upon. These organisations are key to supporting the Rotherham Place to deliver our workforce challenges.

4.2 Communication and Engagement

The communications and engagement strategy describes the approach and direction that focusses on informing, sharing, listening and responding to the people of Rotherham.

Specific communication and engagement has taken place, with a variety of stakeholders, for each of our five transformational workstreams and we will continue to develop meaningful communication, in a simple and easy to understand way, that demonstrates how we will drive transformation. Planning and delivery of our communication and engagement in Rotherham will be co-ordinated with the activity at an overarching ICS level. Our inclusive approach to communication and engagement with key individuals and groups will include:

- proactively and effectively communicating our vision, transformation, priorities and achievements. Being proactive is central to our vision for communication and engagement with local people
- developing two-way communication opportunities where we share news, we listen and respond and are visible to local people
- implementing relevant and effective communication tactics with key audiences and stakeholders

We are committed to the active participation of patients and the public in the development of health and social care services and as partners in their own health and health care. Local people will have an important voice in how services are planned, delivered and reviewed. We need local people in Rotherham to influence change that will improve services, health outcomes and their experience of care.

The success of the place plan and transformation programmes is dependent upon successful collaboration between health, social care and voluntary sector, and to a degree, a level of understanding from a wider set of stakeholders from across Rotherham. The place plan has been jointly developed by health and social care partners in Rotherham and, in doing so, we have engaged views from a range of local partners by presenting the plan at the Health and Wellbeing Board, Rotherham Together Partnership, GP Members Committee, Health Select Committee, and through each partners' governance structure.

4.3 Digital (IT and IG)

In September 2015 NHS England released further guidance on the development of the digital roadmaps titled "Paper-free at the Point of Care - Preparing to Develop Local Digital Roadmaps." The guidance required CCG's to identify the footprint for their local digital roadmap, the digital roadmap partners, and the proposed governance structure by end of October 2015. Rotherham Digital Roadmap was developed across the Rotherham place partner footprint. The rationale for this footprint selection was that the health and social care organisations in Rotherham have long established working relationships, including working together on the delivery of information and technology initiatives over many years.

The Rotherham Local Digital Roadmap is multi-agency IT strategy that was developed in partnership by the Place Plan partners and approved by the Health and Wellbeing Board. The roadmap sets out how locally in Rotherham we will take forward initiatives that support, through technology, collaborative working across services and the improved sharing of information across our organisations. It is comprised of a universal capabilities plan addressing ten 'must do' areas and an aspirational capability development plan covering the period 2016/2020. The Rotherham Health and Social Care Interoperability Group are responsible for managing and monitoring the delivery of the roadmap. Key deliverables of the roadmap over the period 2018/2020.

4.3.1 The Rotherham Health Record

The Rotherham Health Record (RHR) is an integrated web based system that consists of information pulled from a variety of underlying clinical systems, which is linked together and presented in a useful way according to who is accessing it, enabling colleagues from across Rotherham to work together effectively. The system is a bespoke solution developed by TRFT and governed by the Rotherham Health and Care Interoperability Group.

In parallel with on-going activities to develop the RHR system, significant work over the last 2 years has focussed on the development and approval of a robust information governance framework to support use of the system and the establishment of an associated communications programme to ensure that patients and the public are aware of the system and their rights with regard to its use.

The RHR system currently presents information from systems used in TRFT (acute and community services), Rotherham Hospice and some General Practices. Work is underway to link social care information from RMBC into the system, which we aim to conclude over summer 2018. Following on from this, later in 2018/19, it is expected that mental health information from RDASH will also be integrated into the system. The Rotherham Local Medical Committee (LMC) endorsed the RHR Information Sharing Agreement in June 2018, and we are actively working with all Rotherham practices to sign-up for use of the system

The RHR system is used widely in TRFT and in some area of Rotherham Hospice, General Practice and RDaSH. As we work to introduce additional organisations and their data into the system we will seek to increase usage of the system across all partners, including the introduction of social care users.

In addition to the increased scope and usage of the system outlined above, there are specific milestones and plans to:

- Build patient access capabilities, focusing on patients on particular care pathways, e.g. diabetes, stroke, cancer, obstetrics
- Create more tailored views of information for specific pathways
- Extend the document sharing capability to include more partners' information
- Implement subscription-based text messaging alerts for staff triggered by patients being admitted or attending

4.3.2 Rotherham Population Segmentation Model

The Rotherham Place Plan partners wished to expedite their work on sustainable, place-based health and care models for the people of Rotherham with the aim of achieving:

- An aligned vision and outline operating model for integrated, place based, health and care.
- A clear understanding of the baseline budget position for the Health and Social Care economy, its impact on localities and what will happen without change.
- The development of virtual budgeting tool, designed based on local needs that will enable targeted interventions for priority population cohorts and assessment of impact.
- An initial view of the transformation programme required, with priority areas for detailed design and definition.

In order to do so we worked to produce a dynamic and adaptable model to segment the population according to their location, demand for services and historic service usage, demographic profile and likely future service demand (especially where it is likely to increase). The aim was for demand to be profiled by neighbourhood localities and at a citizen-identifiable level where the data is readily available.

During 2017 an online model was developed which brought together and presented baseline data (activity and cost), with the baseline allocated to medical areas, care settings and local care networks. This helped to understand the "do nothing" scenario using annual growth assumptions for activity and cost. Then it allowed evaluation of the impact of modifications to current service use including, but not limited to:

- Activity and cost shifts between existing care settings e.g. from acute to primary care.
- Activity and cost shifts between existing care settings and new care settings defined in the model e.g. preventative measures that may require investment per member of the population, but will decrease activity and cost across the existing care settings.
- Provide flexible reporting that will help determine the preferred option.

This provided an aggregate view of the health economy both in terms of activity and cost and by locality. It additionally provided a segmentation view based on population and a forecast view for the next ten years. Initial population of the model provided a 'current state' view and a forward look based on no change. This work was completed as part of Phase 1 in December 2017.

Phase 2 of the Project is now underway to produce a Super-utiliser Patient Level Analysis Tool . This will allow patient level analysis upon which different personae can be developed to support and inform the various case for change options. To undertake this will require the collation and linking of patient level data into a single view. In order to populate the models we require data inputs from various components that comprise the Health and Social Care Economy in Rotherham, to include: Acute Trusts, Community Services, Mental Health, Primary Care, Ambulance and Transport Service and Social Care. To achieve this we have asked for the support and enablement from partner organisations and their data leads in data collection and provision to support this work.

Activities currently include finalising the Information Governance arrangements and development of the Pseudonymisation tool, building the technical platform and design mock up presentation models that will allow users to query and enquire using factors such as disease, age, location, sex, diagnoses and co-morbidities, care activity, deprivation. The data will then be loaded into the model, documentation and training to be provided. We will confirm and agree resources for on-going model administration and licencing as part of the transition to Business as Usual. This is expected to be complete by September 2018.

4.3.3 Shared Wi-Fi (GovRoam)

In partnership with organisations across the South Yorkshire and Bassetlaw, Rotherham is introducing the GovRoam Wi-Fi solution to support cross working and improve our mobile and agile working capabilities. Partners to the GovRoam solution are able to use it to connect their staff to IT systems and services wherever another partner is broadcasting it. GovRoam is now broadcasting across TRFT, RDaSH and CCG estates. It is currently being implemented in all General Practice sites and plans are being developed for implementation at RMBC sites.

4.4 Housing, Communities and Estates

If we are to have success in the delivery our place ambition, we need to ensure that our available housing and estates support and acts as an enabler to our strategic transformation workstreams. Partners recognise the value of working together and taking a strategic approach to asset management and getting the most from our collective assets. Working within a 'One Public Estate' model, system leaders within the Rotherham place have agreed four key principles for how we will approach our place discussions regarding housing and estates:

1) We collectively value our best assets and will engage in constructive dialogue to maximise the optimisation of these
2) When making decisions we will take into account the impact on partners and not just our own organisations
3) We will work together to produce a Rotherham Estates Strategy
4) Our estate decisions will support the wider Rotherham Economic and Regeneration Strategy, Housing Strategy and the wider Rotherham Together Partnership

Our established Strategic Estates Group continues to work constructively, identifying available estate across the system, ensuring it is fit for purpose and identifying disposals where possible. It will continue to respond to the changing needs of services and the population. Examples of work to date include the successful One Public Estate Phase 6 (OPE6) bid for resources to support transformation including a scheme to create shared storage across the system.

Rotherham place was also successful in 2017 in securing funding to facilitate agile working across providers to enable community teams to work more effectively and reduce the footprint required. Rotherham place is also working with the ICS and Sheffield City Region to ensure estates strategies work beyond the Rotherham boundary. System leaders are clear that our approach to utilising estate needs to be driven by our Place Plan transformation, there are a number of key estate decisions that will need to be made at a Place level during the period of this plan. These will include, but not limited to, the future use of Rotherham Community Health Centre, Joint Service Centre at Rawmarsh and the future use of Badsley Moor Lane.

It is important that people have access to local, well managed services but the type of housing they live in also has a huge impact on health. Good quality, affordable housing provides the basis for people to live healthy, independent and fulfilling lives.

The population continues to age at a rapid pace and pressures on the health services to support individuals is increasing. Therefore it is important that we plan for housing that is care and support ready so that people can live in their home for as long as they wish, whilst reducing reliance on public services and encouraging independence. The Housing Strategy sets out how RMBC and partners can deliver the right homes in the right places so we continue to meet people's needs now and in the future. The role of housing goes beyond bricks and mortar; providing investment in council stock, encouraging improvements in private housing provision, development of new homes, and engagement with tenants and residents all contribute to creating healthy, stronger and more resilient communities. Getting people in the right housing and building community resilience can lead to improved health outcomes, reduce social isolation and financial wellbeing.

4.5 Governance to support delivery

The ICP Place Board is the group responsible for directing and leading the ICP, reporting to the H&WB Board for progress against the Place Plan as well as liaising where appropriate with:

- the South Yorkshire and Bassetlaw ICS to communicate the views of the ICP on ICS level matters; and
- national stakeholders (including NHS England and NHS Improvement) to communicate the views of the ICP on national matters relating to integrated care.

Partners represented at the Place Board have developed and agreed an ICP Agreement for how we will work together. The Agreement is based on a Memorandum of Understanding (MoU) approach to provide an overarching arrangement which governs the development of integrated multi-party solutions for health, care and support across the geographical area of Rotherham. The format is designed to work alongside the NHS Standard Contract and arrangements for the delivery of non-NHS care, support, and community services via RMBC. The Agreement is not intended to be legally binding except for specific elements, but encompasses the spirit by which the ICP partners have and will continue to collaborate in supporting work towards the transformation and better integration of health, care, support and community services for local people.

Collectively the ICP has worked towards an agreed governance structure and have agreed a shared vision and a set of principles by which the Rotherham Place Board, and sub-groups will adhere to. These can be found in section 1.2.

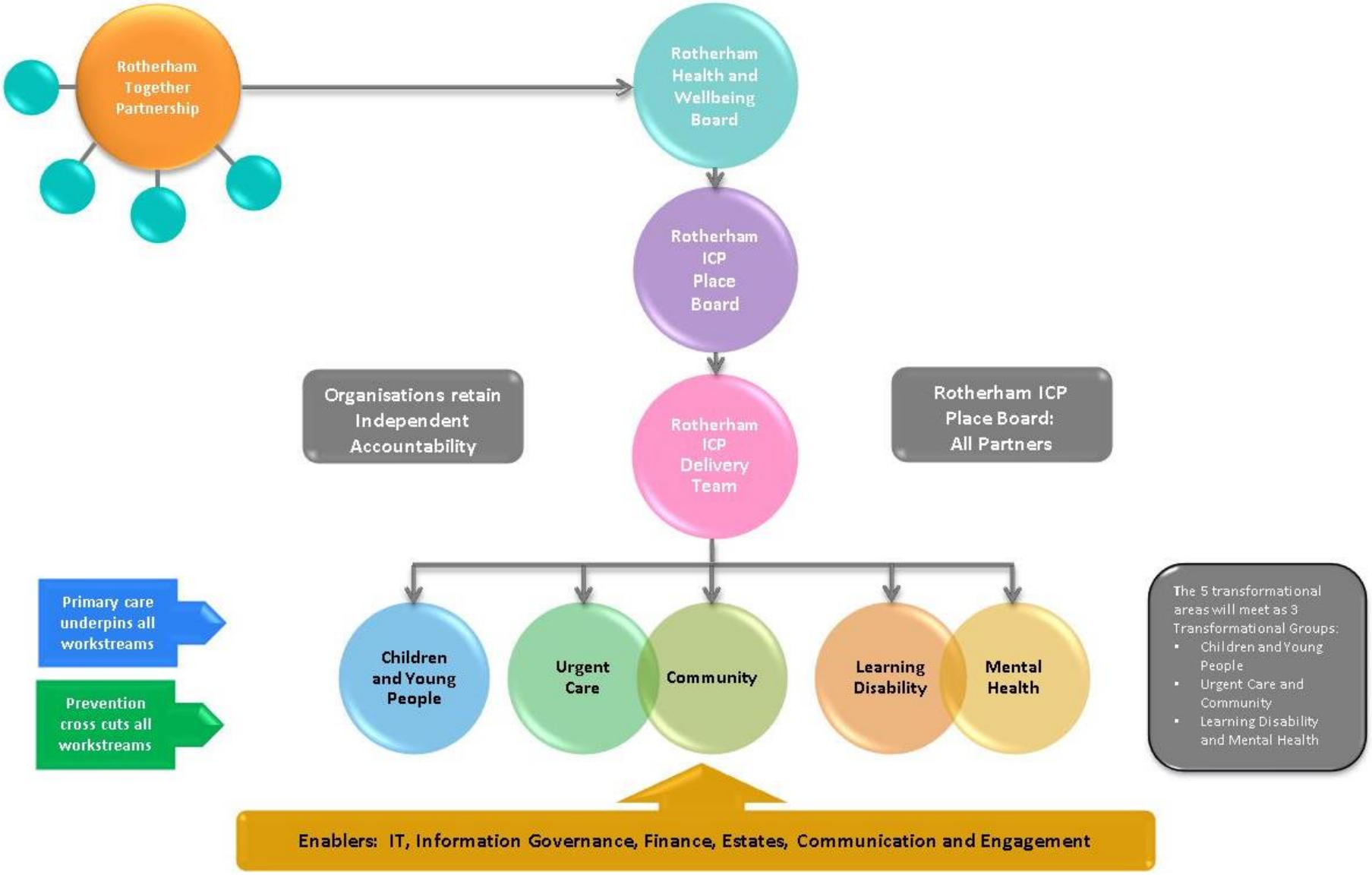
The Place Board will act in accordance with its Terms of Reference and will:

- promote and encourage commitment to the Place Plan and ICP Principles amongst all partners;
- formulate, agree and implement the transformational priorities of the Place Plan;
- ensure alignment of all organisations to facilitate sustainable and better care which is able to meet the needs of the population;
- review performance of partners against the Place Plan and the ICP outcomes and determine strategies to improve performance or rectify poor performance;
- agree policy as required, including values to be adopted and annual and short-term performance outcomes/targets;
- report on progress against the Place Plan to the H&WB Board as required;
- communicate the collective interests and views of the ICP at meetings of, or when liaising with, the ICS and national stakeholders;
- oversee the implementation of the Place Plan in line with the ICP Principles.

The ICP Delivery Team is the group responsible for managing the collaborative operation of partners and the delivery of the Place Plan and will:

- make recommendations to the Place Board for its approval or rejection as to how the services should be delivered in a more integrated and best for Rotherham way so as to deliver the Place Plan; and
- provide clinical and professional leadership with regard to the services.

The diagram bellows shows the governance structure for the Place Board, setting out the relationship to the H&WB Board.



4.6 High level risks

In addition to the robust governance arrangements and structure established to delivery this plan, we have considered the potential risks and mitigations.

Organisational behaviour – potential impact of individual organisations financial and delivery targets on the overall system wide delivery of the Place Plan.	→	• Open and transparent discussions. • Robust governance arrangements. • System wide commitment to joint plan.
Capacity to deliver the Plan – risk of organisations not having the capacity/workforce within existing resources to deliver the plan.	→	• Realistic implementation plans, aligned to partners organisational goals and objectives. • Robust performance monitoring arrangements. • Make best use of joint working arrangements and shared resources. • Joint workforce strategy, aligned to the requirements of the plan. • Joint Organisational Development Plan.
Capability to deliver the Plan - risk of organisations not having sufficient capability / skills within existing workforce to deliver the plan.	→	• Skills gaps analysis/ competency Framework / training plan. • Effective change management / culture change. • Joint Organisational Development Plan.
Impact of national policy / regulations – unknown impact of national policies and changes to business rules.	→	• Robust governance arrangements. • Work with statutory and regulatory bodies to inform development of revised policy / regulations.
Public opinion – risk of not undertaking relevant public consultation on the key initiatives of our plan.	→	• Open and transparent discussions. • Robust governance arrangements. • Use existing consultations and ensure robust consultation is continued to be undertaken on future developments. • Make best use of joint working arrangements and shared resources.
Impact on organisational reputation - risk of adverse publicity in relation to the Place Plan and its objectives.	→	• Open and transparent discussions. • Utilise collective communication and engagement resources to ensure robust approach continues.
Resident Behaviour – risk that current behaviour in terms of access and use of services is not changed as a result of the plan.	→	• Open and transparent discussions. • Effective public education. • Effective communication plan. • Understanding /insight in to local behavior and create environments to make healthy lifestyle choices.
IT Infrastructure – impact of not successfully integrating health and social care systems and not driving forward IT solutions to support self-management.	→	• Joint Interoperability group and partner sign up. • Effective training. • One provider for Health IT.
Wise use of current resources – use of current funding and impact of not being successful in securing additional funding to deliver the place plan at pace and scale.	→	• Development of robust implementation plan, agreed by partners. • Upfront agreement on how potential funding will be prioritised, agreed by partners. • Ability to mobilise plans quickly to attract any potential additional funding announcements.

4.7 Performance Management

A quarterly report will be produced on the delivery of this Place Plan so that the ICP Place Board can be assured on its delivery and can be sighted on any potential opportunities or risks to delivery.

The Performance Report includes key milestones and key performance indicators (KPIs) for each of the priorities beneath the three areas of transformation. The milestones provide a way of measuring that the actions and pace set for each of the priorities is being met. The KPIs have been chosen from existing metrics that are already collected and where there is baseline information and associated targets. For a small number, further work will be undertaken to develop / identify more appropriate metrics.

In section 5 where we have described each of the transformational workstreams and priorities we have also documented the associated milestones and KPIs

5 Transformation Workstreams

5.1 Children and Young People's Transformation

5.1.1 Overview

The imperative to work together to meet the needs of children and young people has been long recognised. Keeping children safe is only possible if we work together effectively across organisational boundaries. As well as the safeguarding imperative, partners are familiar with strong partnership working as a way to support children to thrive and achieve positive outcomes in all aspects of their lives. The Children and Young People's Partnership has been a strong forum to drive forward partnership activity for some time. The Place Plan provides a new impetus to focus on key priorities where we must work together to deliver the services that children and young people need. Each of our priorities requires us to take partnership working to the next level, developing integrated pathways, joint commissioning arrangements and a shared view of our performance.

We are also determined that, throughout the work, the voice of the child will be loud, meaningful and embedded in our rationale and activity.

Each priority will focus on a distinct cohort of children whose needs and vulnerabilities require fully integrated pathways to enable them to achieve positive outcomes without the barriers of organisational silos or funding restrictions. The need for collaborative working has, in some cases, been identified by central government and there are legislative drivers that will inform and drive our transformation. Whilst the priorities are not necessarily part of a single integrated pathway, they are sometimes overlapping and interdependent. Our work together will enable us to identify if these overlaps provide opportunities or challenges and to respond accordingly.

What is consistent across the work of the children's transformation group is an aspiration to put early intervention at the heart of what we do, and reduce the need for acute service that are more intrusive and traumatic for children and families and more costly to deliver. We also recognise that, wherever possible, it is better to take a whole family approach, with a single lead worker and a single integrated plan. As professionals we will work together to develop a shared language to help us understand each other and the children and families we support, we will be strengths-based and outcomes-focused. We will be accountable to each other and to children whose voice, individually and collectively, will guide our work.

5.1.2 Priority 1: Implementation of CAMHS Transformation

Future in Mind is a government initiative aiming to transform the way child and adolescent mental health services (CAMHS) are delivered nationally.

75 per cent of adults with mental health conditions experience symptoms before the age of 18. However, it is reported that as few as one-in-four children and young people in the UK that could be helped are being reached. Future in Mind, published in 2015, is about how each area will set about tackling the problems to create a system that brings together the potential of the web, schools, social care, the NHS, the voluntary sector, parents and of course children and young people.

The Rotherham CAMHS Local Transformation Plan identifies a scheme of work that will ensure that Rotherham responds to the recommendations of 'Future in Mind'. In addition to the policy drivers, the work is informed by a needs assessment conducted in February 2018 for Emotional Wellbeing and Mental Health for Children and Young People. This priority will focus on key milestones including:

- Reducing waiting times
- Embedding positive transitions between children's services and post-18, leveraging where possible links to the social prescribing pilot for mental health services
- Reducing demand pressure on the Looked After Children's Therapeutic Team
- Developing a single commissioning framework for children's mental health
- Working effectively with schools to deliver a graduated response and reduce demand on higher tier services
- Identifying clear evidence of outcomes
- Responding to opportunities from the December 2017 Green Paper – 'Transforming Children and Young People's Mental Health Provision'

Milestones

• Work with all stakeholders to review the RDaSH CAMHS ASD/ADHD diagnosis pathway	Q4 18/19
• Integration of the CAMHS Single Point of Access (SPA) and RMBC Early Help access point	Q4 18/19
• Improved CAMHS Crisis service out of hours	Q4 18/19
• Clarification of the pathways between the CAMHS service and Youth Offending Team (YOT) and 'Liaison & Diversion' service	Q3 18/19
• Scoping out of a Schools 'CAMHS' service in line with the government 'Green Paper' recommendations	Q4 18/19

Key Performance Indicators

- Percentage of referrals assessed within 6 weeks
- Percentage of referrals receiving treatment within 18 weeks
- Percentage of referrals triaged for urgency within 24 hours of receipt of referral
- Percentage of all appropriate urgent referrals assessed within 24 hours of receipt of referral

5.1.3 Priority 2: Maternity and Better Births

We have a strong vision and ambition to ensure that maternity services in Rotherham are safe, personalised and family friendly; where every woman has access to information that allows her to make an informed decision regarding her choice of antenatal care, place of delivery and the type of post natal support.

At the centre of our overall vision, as defined in the 'Better Births Programme', is an aim to introduce 1:1 midwifery-led care right through pregnancy and birth as a choice for all women who are assessed as having 'low risk' pregnancies. This would provide continuity of service throughout the pregnancy and enable a choice of birthing options.

For women who begin on higher risk pathways, there will be consultant-led obstetric care, although there will be named midwife contact throughout and a process of ongoing assessment and monitoring which will enable women to transfer to the lower risk pathway choice and flexibility to all women, with personalised plans throughout enabling an ongoing dialogue around education and prevention.
Supporting the achievement of this vision the SY&B ICS has brought together maternity commissioners from across the region to develop a Local Maternity System. The Local Maternity System will ensure that the recommendations within the national 'Better Births' programme are delivered locally through the Maternity Transformation Programme. The Rotherham place plan reflects the ambition within 'Better Births' aiming to deliver safer, more personalised care for all women and every baby, improve their outcomes, and reduce inequalities. Our aim is to maximise choice and support whilst minimising clinically unnecessary interventions.

Six formal trajectories or Key Lines of Enquiry (KLOEs) will be reported at a national level and in addition, the SY&B Local Maternity System has agreed to focus on reducing smoking in pregnancy as a local aspiration. The seven KLOEs are as follows:

- Stillbirths and neonatal deaths
- Intrapartum brain injuries
- Personalised Care Plans
- Choice of Birth environment
- Continuity of Carer
- Support delivery in Midwifery settings
- Smoking in pregnancy

Each of the above work streams is reflected in the Rotherham Maternity Transformation Plan with a defined improvement trajectory from the current baseline.

Our improvement plan will measure the following key performance indicators:

Milestones
tbc

Key Performance Indicators

- Reduce stillbirths and neonatal deaths
- Reduce Intrapartum brain injuries
- All women to have Personalised Care Plans

- At least three choices for place of birth
- Increase the number of women with Continuity of Carer
- Increase the number of women giving birth in midwifery settings
- Reduce the number of women smoking in pregnancy

5.1.4 Priority 3: Oversee delivery of the 0-19 healthy child pathway services

The development of a 0-19 Integrated Public Health Nursing (IPHN) Service model presents new opportunities for strengthening primary prevention, health promotion, early help and safeguarding by developing a robust approach to improving health outcomes for children, young people and families across Rotherham. The integrated offer means moving away from the traditional health visitor and school nurse roles and the associated focus on 0-5 years and 5-19 years respectively, towards a 0-19 practitioner workforce that incorporates a broad skills mix and works across the age boundaries. This will enable the service to become needs focused, building in flexibility, to better provide a seamless service within a reduced financial envelope. It will require a wholescale workforce reconfiguration which not only looks to increase the skills mix of the workforce but also the location of practitioners to promote multi-functional working alongside the Council workforce in localities. Key to this transformation will be to work in partnership with the Council to ensure that joint models in the borough (such as Signs of Safety and Early Help Assessments) are trained and embedded across the restructured workforce.

The 0-19 IPHN Service is primarily a universal preventative and early help service designed to identify health and social issues at the earliest opportunity and put in place interventions accordingly. However, in response to the rising demand at the more acute end of the needs continuum, the service is at risk of investing increasing resource towards the safeguarding end of the spectrum to the detriment of its early help role. In order to address this, the service must develop a strategy with its partners that enables it to meet its Working Together Agenda duties whilst fulfilling its primary preventative role.

The service has a range of interventions to deploy according to need. Most of these interventions are delivered unilaterally, but a number are delivered in partnership with other agencies – identified as Universal Partnership Plus interventions in the national Healthy Child Programme. As the financial envelope reduces it will be key to review these "touch points" with partners to identify opportunities for streamlining delivery and lean practice. Pathways will be mapped to provide intelligence to inform this review with the aim of developing a broader 0-19 offer which encompasses pathways across a range of services including GPs, Pharmacies, Education, Social Care and the borough's Early Help offer.

Milestones

- To map the 0-19 / RMBC pathways to identify opportunities for efficiencies and highlight any gaps Q4 18/19
- To address the barriers to 0-19 IPHN EHAs and increase the numbers submitted by the service Q4 18/19
- All 0-19 Practitioners will have completed Signs of Safety training by the end of 2018/19 Q4 18/19
- We will work with partners to develop a tool and resources in order to capture the voice of the child Q4 18/19 Q4 18/19

Key Performance Indicators

- Increased Early Help Assessments completed by 0-19 practitioners to a minimum of 10 per month
- Evidence of voice of the child being considered in care planning through audit of individual records

5.1.5 Priority 4: Children's Acute and Community Integration

Agencies who work with Children and Young People are under pressure to meet acute demand. We are committed to identifying need as early as possible and responding appropriately to ensure that children /young people are discharged from hospital in a safe, planned and timely manner which supports the demands on acute hospital services. We also recognise that some children and young people need intensive services and that we must work together to ensure we provide the right care at the right time.

By taking a system-wide approach that responds to families holistically across thresholds of need and clinical need; we will aim to deliver services that are clear and transparent to children and young people and their families in places that are easy to access and close to home wherever possible. At the same time we will evidence and evaluate this approach to demonstrate that it reduces demand on higher tier services.

There is an opportunity to join up children's health and social care transformation work to develop a shared language and understanding across the children's workforce as well as creating clear pathways between services that will enable children, young people and families to experience a holistic response that prevents potential deterioration, and supports children and young people to recover and thrive in the most appropriate environment for them and their condition.

The scheme will focus on:

- Continuing a programme of workshops to develop shared understanding of health and social care (including Early Help) services delivered in community and acute settings
- Developing an integrated multi-agency referral and discharge pathway for children and young people
- Developing a link between the Community Nursing Team / Rapid Response Team and Early Help services

Identifying a dedicated resource from the local authority to support discharge planning

- Developing guidance to ensure that recording systems are well understood and visible to the right professionals
- Developing a shared toolkit to capture the voice of the child

Milestones

• Embed the work of the rapid response team with referral routes established across the system / Work with GPs and test direct referrals from General Practice to the Rapid Response Team	Q4 18/19
• Establish links between Rapid Response Team and Early Help	Q3 18/19
• Pilot a direct link between Children's Ward and Children's Service to support timely discharge plans	Q3 18/19

Key Performance Indicators

- Increase the number of referrals to Early Help from Acute Clinical Services (*Hospital A&E, hospital Children's Ward, maternity ward and other department / ward)*

5.1.6 Priority 5: Special Education Needs and Disability (SEND) – Journey to Excellence

There is an opportunity to improve the SEND offer in Rotherham through a more integrated approach across all agencies and individuals involved in the commissioning, provision and use of the SEND services. A commitment to joint needs assessment and joint working will mean children and young people receive improved identification, their needs are more effectively met, and they experience improved outcomes. A SEND Strategy has been co-produced through joint working and consultation with parents, young people, schools, specialist services, educational providers, health and social care partners and the voluntary and community sector. The strategy will ensure that at a local level Special Educational Needs and Disability statutory duties are delivered in line with the Children and Families Act (2014) and the Special Educational Needs and Disability Code of Practice Statutory Guidance (2015).

The work of the SEND Transformation Programme is wide ranging; there are five priority action areas:

- Shaping provision through co-production and communication; this will impact on the Local Offer; SEND workforce training and the CAMHS parent expert training programme
- Joint commissioning, informed by a shared understanding of business intelligence to enable streamlined decision making through agreed and transparent funding arrangements
- Sufficiency of provision, including the identification of additional placements to meet need providing sufficient volume and choice
- Assuring quality with the provision of a consistent graduated response in mainstream schools and early planning for adulthood
- Value for money, including a sustainable budget model for special schools and identifying the best future delivery model

Milestones

• Develop Voices Action Plan	Q2 18/19

• Undertake the following in respect of Joint Commissioning:
  • Implement the joint financial protocol and service specifications
  • Implement the Special School Funding Model
  • Review of SEMH Support Centres (PRUs)
  • Review of Traded Models
  • Review of service provision within the High Needs Budget
	Q4 18/19

• Create a plan to reduce placements outside Rotherham (including residential provision offer, reduce OOA provision arrangements	Q2 18/19

• Implement Phase 1 of the SEND Sufficiency Plan Complete building work resulting in additional provision at the following locations:
  • SEND Hub (co-location of services) - Complete
  • Cherry Tree / Kelford Schools (Open as SLD provision)
  • Abbey School (20 additional places)
  • 19-25 Provision (15 new college places)
  • Rowan Centre (15 additional places)
	Q3 18/19

• Appoint a lead officer and implement the Joint Preparation for Adulthood Action Plan	Q1 18/19

Key Performance Indicators

- Reduction in the number of young people 16/17 year old who have SEND who are NEET or Not Known
- Reduction in the number of young people 18/19 year old who have SEND who are NEET or Not Known
- Reduction in the number of young people 20-24 year old who are NEET or Not Known
- Reduction in the number of exclusions
- Increased number of Children in Local Provision (reduced OOA)

5.1.7 Priority 6: Implement 'Signs of Safety' for Children and Young People across partner organisations

The implementation of this priority will ensure that all partner organisations who work with children and young people understand the Signs of Safety operating model and Rotherham Family Approach and embed this in their work to identify and respond to risk when working with children, young people and families. Furthermore work will identify how a single operating model (Rotherham Family Approach) might enable all-age models in the future.
The Signs of Safety approach will be the preferred practice approach that all practitioners and managers will use to work directly with children, young people and families across all Early Help, Children's Social Care, Education & Skills and Commissioning, Quality & Performance Services.

The Rotherham Family Approach and Signs of Safety methodology will give practitioners the necessary understanding, skills and confidence to work collaboratively and in partnership with children, young people and their families. The approach will establish a common framework and language for building safety, stability and success by identifying areas that need to change and focussing on strengths, resources and networks that the family can offer.

Milestones

- The RLSCB will be sighted on the roll out to partners and this will include training to all levels of practitioner — Q2 18/19
- Phase 1 of roll out of training — Q3 18/19
- Phase 2 of roll out of training — Q4 18/19
- Evaluation and next steps — Q4 18/19

Key Performance Indicators

- Number of practitioners from across the Multi-agency partnership who have accessed the Rotherham Family Approach and Signs of safety Training (½ days and extended 2 day for safeguarding leads)
- An increase in the conversion rate from contacts to referrals from Partnership agencies highlighting a better shared understanding & assessment of risk and threshold - Evidence of embedding the change & maximising impact

5.1.8 Priority 7: Transitions

Good person centred transition is essential to help young people and their families prepare for adulthood. Government guidance *'Preparing for Adulthood'* will inform this work to ensure that Rotherham has put in place the right support for young people who are transitioning from children's to adult services. It is

important to work together because the legislative drivers of the Children and Families Act (2014) and the Care Act (2014) both outline an entitlement to support for young people aged 18-25.

In order to deliver this Adult Care, Housing and Public Heath Directorate (who lead on Transition) and Children and Young People are proposing to reform the offer made to young people and their families with (Special Educational Needs and Disability SEND) to ensure that they have the right support in their transition from childhood to adulthood. The priority is to prevent gaps forming, particularly for young people with autism. It will also ensure better coordination in response to the 2 year SEND Tier 1 tribunal pilot.

Milestones

- The Transitions team to work jointly with Children Young People Services (CYPS), health and education for all new referrals for young people aged 14 to 18 with an Education, Health and Care Plan (EHCP) / Care Needs Assessment (CAN) who may be in need of a social care assessment using the Preparing for Adulthood model — Q3 18/19
- Develop a transition pathway based on Preparing for Adulthood model — Q3 18/19
- Create a data matrix of the full cohort and risk register — Q2 18/19
- Publish transition pathway on the Council website — Q3 18/19

Key Performance Indicators

- Number of out of Borough residential placements
- Ofsted CQC ratings for services used for transitions
- Numbers of SEND Tier 1 tribunal applications

Add a 'So what' case study……

5.2 Mental Health and Learning Disability Transformation

5.2.1 Overview

In relation to the imperative to improve mental health and learning disability services, the case for change is clear:

Demand for Services – with advancement in identification, diagnostics and treatment for mental health services, as well as equality legislation and public awareness and understanding; there is a significant increase in demand for services. 1 in 4 adults experiences a diagnosable mental health problem in any given year. Mental health problems represent the largest single cause of disability in the UK. Suicide is now the leading cause of death for men aged 15-49.

In Rotherham, there is a higher rate of people with a learning disability per 100,000 population at 371.77. This is compared to a regional rate of 346.06 and our neighbouring authorities - Barnsley with 313.76 and Doncaster with 348.53. Rotherham also has significant cohorts, for example, 204 people aged 18-30 years and 164 people aged 51-64 years. It should also be noted that there are 347 carers aged between 55 and 69 who support a service user with a learning disability. The number of people with a learning disability in Rotherham is increasing and, understandably this leads to increasing demand for services.

Bringing parity with physical health services – the Five Year Forward View for Mental Health has been explicit in the need to bring parity of provision between physical and mental health and to tackle the persisting stigma around mental illness and learning disabilities. There are fundamental requirements such as the need to ensure that people can access mental health care 24 hours a day, 7 days a week in the same way that they are able to access urgent physical healthcare. This sits alongside other central mandates supported by national reporting targets to deliver early intervention in psychosis and access to psychological therapies for a greater number of people. These imperatives have been supported by additional funding allocations. Locally, we need to ensure the people of Rotherham are receiving services to meet their expectations which have been set for the whole country.

Improving Services and Outcomes – People with severe and prolonged mental illness are still at risk of dying on average 15 to 20 years earlier than other people. People in marginalised groups are at greater risk of developing mental health issues and receiving poorer outcomes. Little is known about the outcomes and experiences of service users accessing mental health and learning disability services, yet mental health issues will affect 1 in 4 adults. We want to provide a better experience and better results. Services must change in order to provide the high quality services the people of Rotherham expect to meet their needs. Co-morbid mental health problems raise total health care costs by at least 45% for each person with an additional long-term condition. Too many people with mental health issues and learning disabilities are still receiving treatment and support in inpatient or residential facilities rather than in their communities, closer to home.

In 2017/18 2382 adults in Rotherham were registered with GP's as having a learning disability, and 822 have had their annual health check. We know that:

- Carers of people with a learning disability are often parents and they experience difficulties with increasing age.
- People with learning disability want the right to lead full and inclusive lives.
- Having relationships, a home and employment is very important to a person with a learning disability.
- Currently there are 686 Learning Disability customers aged between 18 and 64 accessing 1154 placements/services.
- The total number of young people with a learning disability aged 14-18 in Rotherham is approximately 45.
- There are 99 people with learning disabilities who also have autism known to the Council.
- Rotherham has 80 older people with a learning disability over the age of 65.
- Rotherham's older (65 plus) learning disabled population is estimated to increase 29% by 2035

The scope of the programme relates to adult services, or where a person under eighteen would be better supported in an adult service. Priorities in relation to mental health and learning disabilities for children and young people will be led by the Children and Young People Transformation Group.

The priority schemes outlined below will deliver a transformation in services for adults with mental health issues and learning disabilities.

5.2.2 Priority 1: Deliver improved outcomes and performance in the IAPT service

Mental health issues are impacting more significantly on people in Rotherham than the nationally recognised issue. The baseline data taken as part of the development of the Rotherham Mental Health and Wellbeing Strategy identified that:

- In 2014/15 10.8% of adults over 18 in Rotherham had depression compared with an England average of 7.3%
- By 2020 4,655 people aged 65 and over are projected to have depression in Rotherham

- For self-reported emotional wellbeing, in 2015/16 Rotherham residents reported high levels of; low satisfaction with life, low happiness and high anxiety. These rates were higher than the average for England and for the Yorkshire and Humber region as a whole
- The number of older people (65+) is projected to rise by 8,800 (18%) between 2015 and 2025 and the number aged 85+ is projected to rise by 2,300 (40%) by 2025. This will mean an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. To optimise the physical health care of patients with long-term conditions, it is essential that their mental health and wellbeing are addressed at the same time.

Set against the local demographic picture is the national mandate to improve access to psychological therapies (IAPT) against the access and recovery targets. The Rotherham IAPT service has experienced a sustained period of improvement following significant challenges and the service is now performing well against these targets. IAPT continues to be a priority in order to meet the trajectories prescribed including to ensure that people with long-term conditions are accessing support from psychological therapies.

Building on improvements to the IAPT service in Rotherham, there is a continued need for focus to meet the national access and recovery targets as well as to reduce DNA rates and increase IAPT take-up in primary care by people with long-term conditions.

Milestones

- Identify and agree workforce development and training requirements (LTC & Core) - IAPT Q1 18/19
- Apply for NHS England LTC training (training commences October-18 & March-19) – IAPT Q1 18/19
- All GP practice review support visits completed - IAPT Q4 18/19
- Delivery of 5 year forward IAPT 18/19 plan - IAPT Q4 18/19

Key Performance Indicators

- Percentage of people referred to IAPT commencing treatment within 6 weeks of referral.
- % Compliance of those who have entered (i.e. received) treatment as a proportion of people entering treatment with anxiety or depression
- % of people who have completed treatment having attended at least 2 treatment contacts and are moving to recovery

5.2.3 Priority 2: Improve dementia diagnosis and support

The Rotherham population is 260,800 (2015) and forecasted to grow to 269,100 by 2025 (3.5%). 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

The number of detected cases of dementia has increased year on year and this trend is predicted to continue. By 2025 it is projected that there will be nearly 4,500 people in Rotherham living with dementia.

Rotherham is the highest performing CCG area within Yorkshire and Humber for dementia diagnosis and has commenced work to enable more diagnosis of dementia in primary care via a Local Enhanced Service (LES). Follow-up support after diagnosis continues to be provided in Memory Clinic rather than in primary care. The Dementia Carers Resilience Service commissioned from Crossroads provides support to carers across Rotherham.

The introduction of the Local Enhanced Scheme (LES) to increase diagnosis of dementia in primary care has seen a number of practices take up this LES, overall, diagnostic rates remain high at a positive 82.5%. There are currently 14 practices actively reporting dementia diagnosis to varying degrees and overall the numbers completing the diagnosis pathway in primary care is increasing.

Referrals for diagnosis in Memory Clinic fell in 2017/18 when compared with the previous financial year but has remained static for the last two quarters. Referrals to the Dementia Carers Resilience Service have seen an overall upward trajectory with static performance in Q2 and Q3 of 2017/18 suggesting that current referral rates have reached a steady state.

Current issues are:

- Only 14 of 31 practices are actively undertaking dementia diagnosis with large variation in frequency and volumes of activity.
- All follow-up support (regardless of where the diagnosis is made) is delivered by secondary care services (RDaSH) in the Memory Clinic.
- The Dementia Carers Resilience Service is reporting high caseloads and referrals above expected levels. A further increase in demand may result in waiting lists for the service which could be detrimental to delivery of outcomes.

Rotherham has focused its dementia strategy in the community on increasing the proportion of dementia diagnoses in primary care and is striving to maintain its good performance. In order to address some of the gaps and issues highlighted, the next phase of work for delivery in 2018/19 will be focused on:

- Further increasing the number of dementia diagnoses taking place in the community, enabled by the LES becoming mandatory for practices from April 2018.
- Developing post-diagnostic support in the community including:
    - Increasing follow-up support in primary care to offer the majority of this routine activity in a community setting
    - Re-shaping the Memory Service to provide specialist advice and support
    - Maximising support for carers.

Milestones

- Review dementia diagnosis pathway — Q4 17/18
- Develop new dementia pathway for post diagnostic care — Q4 18/19

Key Performance Indicators

- Dementia diagnosis rates (%)
- % of GP practices achieving 62% of Post diagnostic support plan recorded in last 12 months

5.2.4 Priority 3: Deliver CORE24 standards for liaison mental health services

In its recent review of crisis care, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for

mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police.

Rotherham has invested in both mental health liaison and alcohol liaison services to work into A&E and inpatient wards in TRFT, the impact of the two services have been evaluated. Services currently operate extended twilight hours but at present do not comply with the CORE 24 standards to deliver a 24/7 service and the associated pathways across a 24/7 period.

Rotherham was successful in a bid via the South Yorkshire and Bassetlaw Integrated Care System in obtaining CORE 24 funding from NHS England for 2018/19 (for a 9 month period). The aim of this funding is to pump prime the existing liaison service to meet CORE 24 standards. Recurrent funding and sustainability of the service needs to be locally determined following the ceasing of the time-limited funding.

Building on the investment in mental health liaison services in Rotherham, central funding has been secured to implement CORE 24 national standards and deliver a 24/7 adult mental health liaison service into the acute hospital in Rotherham from April 2018. This is a joint delivery project between RCCG, RDaSH and TRFT.

Phase I will focus on planning for implementation of the model before funding stream commences in April 2018. This planning phase will focus on determining the service model, staff engagement, recruitment and review and redesign of existing pathways where required. NB - Staffing model is interdependent with the community crisis response and intervention model and therefore linked to the CORE fidelity review.

Phase II will focus on implementation of the model. This will be a phased implementation with CORE 24 standards delivered from May 2018. The model must be self-sustaining by 2019-20 and the implementation phase will be used to plan and manage transition to a sustainable model.

Milestones

- Funding received to support expansion of service to CORE 24 compliance — Q2 18/19
- CORE 24 standards delivered in Rotherham. — Q2 18/19
- Core 24 Service self-sustaining. – 19/20 onwards — Q1 19/20

Key Performance Indicators

- Urgent and emergency MH response within 1 hour of receiving an urgent referral (Core 24 liaison)

5.2.5 Priority 4: Transform the service at Woodlands 'Ferns ward'

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. The number of older people (65+) is projected to rise by 8,800 (18%) between 2015 and 2025 and the number aged 85+ is projected to rise by 2,300 (40%) by 2025. This will mean an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer.

The number of detected cases of dementia has increased year on year and this trend is predicted to continue. By 2025 it is projected that there will be nearly 4,500 people in Rotherham living with dementia.

Due to improvements in the management of mental health patients in the community, there has been a recent sustained reduction of inpatient admissions. This has given RDaSH and TRFT the opportunity to utilise the Ferns, one of the three inpatient mental health wards at Woodlands differently. The Ferns, a 12 bedded ward, is being used to meet the needs of patients with diagnosed mental health conditions who are accessing treatment in the acute hospital setting at TRFT. The aim of the pilot is to improve patient outcomes, reduce length of stay and provide care in a holistic caring environment.

Rotherham's acute hospital population is no exception to the national picture. Indeed given the health and social demographics and determinants of the town, there are higher than average levels of incidence and need in Rotherham in relation to patients with dementia and other long term health conditions. Consequently TRFT has a number of workstreams aimed at reducing delays in improving care and outcomes for patients with dementia and in turn, improving system efficiency.

Current intermediate care services have limitations; in particular if the person with dementia has unpredictable or variable abilities, does not easily engage, has communication or capacity issues or there is a level of risk too high for intermediate care settings (such as being unable to summon help, follow safety advice or use call bell systems, is non-compliant or has significant behavioural needs). The most recent National Audit of Intermediate Care (2014) recognised difficulties people with dementia / cognitive impairment have in accessing and benefitting from intermediate care services; advocating further service development in this area.
RDaSH and TRFT have conducted a pilot to develop Ferns as a facility for TRFT patients with who are physically well enough to be discharged from the acute setting, but are not yet well enough to be discharged home or to residential care due to a cognitive impairment. The aim of the pilot has been in place to improve patient outcomes, reduce length of stay and provide care in a holistic caring environment.

The next phase of work will determine the future of the Ferns provision after the pilot ends in March 2018; developing a business case to determine the future model for 2018/19. Evaluation of this will then support the determination of the long-term future model for 2019/20 and beyond.

NB - There is an interdependency with the Community and Urgent Care programme bed review.

Milestones

- Implementation of agreed model of provision at Ferns and continuous evaluation — Q3 18/19
- Agree long-term model and funding source for Ferns. — Q3 18/19

Key Performance Indicators

- Average length of stay (Ferns)

5.2.6 Priority 5: Improve community crisis response and intervention for mental health

Nationally, the number of adult inpatient psychiatric beds reduced by 39 per cent overall in the years between 1998 and 2012. Bed occupancy has risen for the fourth consecutive year to 94 per cent. Many acute wards are not always safe, therapeutic or conducive to recovery. Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances outside of their area.

In its recent review of crisis care, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. The Five Year Forward View for Mental Health was clear that people in a crisis should have access to mental health care 24 hours a day, 7 days a week in the same way that they are able to access urgent physical healthcare.

The CORE fidelity scale was developed in the context of the Crisis Team Optimisation and Relapse Prevention (CORE) study. This is a research study funded by the Department of Health through the National Institute for Health Research and managed by a research team from University College London and Camden and Islington NHS Foundation Trust. The purpose of the study is to identify how Crisis Response Teams (CRTs) can achieve positive practice and function as effectively as possible. *Implementing the Five Year Forward View for Mental Health* required that all areas review their Crisis Resolution and Home Treatment services against CORE standards during 2016/17. Rotherham has not yet undertaken this review.

Crisis response and intervention in Rotherham requires a focus in order to deliver the standards outlined in the Five Year Forward View for Mental Health.

The first phase of this work is to undertake a detailed review of CORE fidelity services (Crisis Response Team and Home Treatment Team) using the CORE fidelity standards and guidance. Following this review, a series of recommendations will be made to support crisis response services in Rotherham to meet CORE standards and detail investment required. **NB** - The staffing model is interdependent with the long-term CORE 24 model and also with the Urgent and Community Transformation's Group priority to create integrated rapid response services.

The second phase of this work will be to undertake redesign and service improvements where required in order to meet the CORE fidelity standards which the review find are not yet met.

Milestones

- Complete CORE Fidelity review, recommendations and action plan for improvement (including investment requirements) Q4 18/19
- SY&B ICS NHS England Suicide-prevention – delivery of Rotherham element of the plan Q4 18/19
- Refresh of the Rotherham suicide prevention and self-harm action plan Q3 18/19

Key Performance Indicators

- To reduce the suicide rate by 10% from the 2013-15 baseline (14.2 per 100,000)
- Referrals who require a Face to Face assessment who were seen within 4 Hours % Compliance (crisis)

5.2.7 Priority 6: Better Mental Health for All

Rotherham place partners have joined together to promote the Five Ways to Wellbeing campaign in Rotherham. This campaign is about getting people of all ages to look after their mental health. It is about accessing things which are around them so it does not need to cost money.

There is a range of resources available, including a toolkit and presentation which are available on the Council's website www.rotherham.gov.uk/health. This includes a film to launch the campaign which can be viewed at www.rotherham.gov.uk/health

We all have mental health, just like we have physical health and it's important that we take steps to look after it. The following steps, known as the 'Five Ways to Wellbeing' are easy and can be incorporated into our daily lives almost straight away.

Be Active: Regular physical activity is associated with lower rates of depression and it doesn't have to be intense to make a difference. Do as much or as little as you can – you could try walking, dancing, running, cycling or gardening.

Connect: People who are connected with family, friends or people living in their community are happier, physically healthier, live longer and generally have fewer problems mental health problems. To connect with others, you could join a group, help a friend, family member or colleague or try volunteering.

Give: It has been proven that people who offer an act of kindness once a week over a six-week period report an improvement in their wellbeing. Giving could be smiling at someone and saying thank you. It could be volunteering within the local community or doing something nice for a colleague or friend.

Keep Learning: People should never stop learning. Learning throughout life enhances self-esteem, increases confidence, encourages social interaction and generally leads to people having a more active life. Why not learn a new skill like cooking, playing an instrument, fixing a bike, photography or painting.

Take Notice: Life can be very busy with little time to stop and reflect. Studies have shown that when people are aware of what is taking place in the present it directly enhances well-being. People worry less about the future and what has happened in the past and can see what really matters, allowing them to make positive choices. Stopping and observing; spending time with friends and family; enjoying nature; and taking a different route home from work or the shops noticing what is different are all ways to take notice.

Milestones

- Launch of Five Ways to Wellbeing campaign — Q1 18/19
- Five Ways communication and marketing plan for 2018/19 - agreed and delivered by partners — Q1 18/19
- Evidence of integration of Five Ways messages within provider and commissioned services — Q4 18/19

Key Performance Indicators

- *TBC*

5.2.8 Priority 7: Oversee delivery of Learning Disability Transforming Care

In October 2015 NHS England, ADASS and the LGA jointly published Building the Right Support- a national plan that outlines how the programme would ensure that more people can live in the community, with the right support, closer to home.

Following on from Building the Right Support a national service model was published called 'supplementary guidance for commissioners' which sets out what good services should look like and should be in place by March 2019 when the national programme closes.

Transforming care will mean that fewer people will need to go into hospital for their care. This will mean a reduction in the number of beds across England and to do this we are making sure that services in the community are much better.

For people who do need to go into hospital the aim is to make sure that they are as close to where they live as possible. This means that in some areas of the country new hospital services need to be developed at the same time as community support.

The South Yorkshire and North Lincolnshire TCP target by 2019 is to have **10-15** people with learning disabilities in CCG commissioned beds, and **20 – 25** people with learning disabilities in NHSE beds. Rotherham CCG has set a local target of having no more than 3 people with a learning disability detained in CCG commissioned beds which is lower than the NHSE / TCP target of 5. The NHSE/ TCP target for NHSE Secure beds is **6.**

We will continue to work with partners across the Transforming Care Partnership (TCP) to ensure delivery of the South Yorkshire and North Lincolnshire TCP Plan.

A Rotherham 'at risk of admissions' process remains in place (including C&YP /Autism), work will continue to review the people who are included this this cohort to understand needs and ensure that community services are fit for purpose to meet the needs of people with behavioural support needs.

We will ensure that STOMP (Stopping the overmedication of people with a learning disability and autism) is implemented by working with partners to ensure that the use of psychotropic medication is always appropriate.

Milestones

- RMBC and CCG to agree process for funding learning disability joint placements — Q2 18/19
- Identify Indicative costs for transforming care cohort (including those on the risk register) — Q2 18/19
- Commissioning solutions to be in place to meet national deadline — Q4 18/19

Key Performance Indicators

- Ensure that patients receive a CETR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: adults.
- Ensure that patients receive a CETR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: children.
- Ensure that patients in an Assessment and Treatment Unit receive a Care and Treatment Review (CTR) every 6 months.
- Reduce the number of people admitted in line with the South Yorkshire and North Lincolnshire LD TCP trajectory – *Local Reporting*

5.2.9 Priority 8: Support the Implementation of the My Front Door – Learning Disability Strategy

The needs of people with a learning disability are continuing to change and are becoming more diverse. People and families have higher expectations of what it means to have an independent life in their community, and want more control over their lives.

People with a learning disability have been telling people who commission and provide services that they want the same quality of life as anyone else; that they have the same dreams and wishes as other people; and that they want the same chance as anyone else of being able to realise these dreams.

People with a learning disability want access to a wider range of services and support which are part of their local community; they want access to employment, jobs, good leisure time, friendships and to travel as independently as possible around the borough.

People with a learning disability in Rotherham are living longer. The challenge is that learning disabled people are more likely to experience chronic health conditions (e.g. obesity, diabetes) much earlier than the general population. It is estimated that people with a learning disability are 58 times more likely to die prematurely. They are more likely to receive poor levels of health treatment as a result of 'diagnostic overshadowing', where people's health needs are overlooked due to focusing on their learning disability.

Good practice and national research tells us that it is possible for people to develop skills and gain greater independence through providing alternatives to services each person with a learning disability has the right to a "Good Day" which will mean different things for different people. For some this means improved access to employment. This is achieved through volunteering projects (such as cafes, volunteering in a community/hospital radio station, a park warden service and other services run by the large statutory organisations) and through real, paid jobs. There are people with high support needs in paid employment in places such as large department stores, supermarkets, and the entertainment sector. There are job share schemes, where jobs are broken down into a number of tasks and the tasks undertaken by a number of people who together complete the whole job. Some people become self-employed and are supported by the development of a number of projects.

There are new ways of developing supported employment by bringing together employers and work with them strategically and supportively to employ people from many different under-represented groups, including people with a learning disability.

Rotherham CCG is participating in the following NHS England programmes: LeDeR (Learning Disability Mortality Review) and STOMP - (Stopping the Over Medication of People with a learning disability).

NHS England's ambition is for 75% of people on GP Learning Disability Registers to have an Annual Health Check (AHC) by March 2020. There is also a commitment to increase the number of people on GP Learning Disability (LD) Registers by 10% year on year. Rotherham has an enhanced service for the delivery of health checks, efforts will be made to increase uptake of annual health checks for people with learning disabilities so that the number of people receiving an annual health check from their GP is 64% higher than in 2016/17. We will ensure that all people with a learning disability aged 14 plus are offered a health check.

Milestones

- Delivery of joint Learning Disability transformation strategy — Q4 19/20

Key Performance Indicators

- Proportion of eligible adults with a learning disability having a GP health check
- Proportion of adults with a learning disability in paid employment
- Proportion of adults with a learning disability who live in their own home or with their family

5.2.10 Priority 9: Support the Development of Autism Strategy

The Autism Act (2009) says people with autism may not always get what they need. This could be because services do not understand what they need or public places are not inclusive. The statutory guidance says each area in the country will have a plan; in Rotherham it was decided to make a new all age plan for everyone with autism.

Autism touches the lives of many people in Rotherham. It is a life-long condition affecting about 1 in every 100 people. It affects how people see, hear and feel the world. Everyone with autism will experience it differently.

Rotherham wishes to be an autism-friendly borough in which people with autism are able to reach their full potential at all stages of their lives. We have developed a strategy for the next five years which includes all ages - children, young people and adults with autism and the needs of families and carers. We have listened to the views of a wide range of people in developing this strategy. A delivery plan has been created which maps out for development of Rotherham's Autism Strategy. The ambition is that all children, young people and adults with autism in Rotherham are able to:

1. Live fulfilling and rewarding lives within a community that accepts and understands them
2. People with autism can get a diagnosis and access support if they need it
3. They can depend on mainstream public and third sector services to treat them fairly as individuals to get the right information and helping them make the most of their talents

Rotherham is committed to improving the lives of adults with autism. This will be done by working with families, local autism groups and partner agencies to address some of the frustrations with existing patterns of services and the difficulties in accessing support.

Milestones

- Complete the development of the Autism Strategy (including Action Plan) — Q3 18/19
- Development of Rotherham based Autism and ADHD diagnostic pathway — Q4 18/19

Key Performance Indicators

- *TBC*

Patient story about Ferns Ward
The Ferns have reopened as a service for dementia patients with physical health needs with both mental health and acute staff.
Below is a copy of an emotive e-mail sent from a daughter of a Ferns patient; demonstrating how important the right care is to patients and families at Rotherham Hospital….

Monday *–dad was sweating, temperature sky high, and violently shaking (looked like he was having little fits) – went home late that night, expecting the worst.*
Tuesday*–dad's temperature sorted, but violent. Hitting and kicking out at nurses, I tried to help as they changed the bedding and finished up punched in the face. He was also shouting out that the nurses and me were 'bitches!' (This is just not my dad!)*
Wednesday*–I couldn't see him as I was preparing for hospital myself the next day.*
Thursday *– popped in to see dad after my procedure, he didn't know who I was.*
Friday *– moved to The Ferns. Friday evening visiting, dad knew me and mum, no violence, no abuse coming out of his mouth, he was calmer.*
Saturday *– calmer again.*
Sunday *– I visited twice, got value for money from his father's day card/pressies, as he couldn't remember he'd got them first time round ...so had the surprise and smile again in the evening when I showed them him again. He was also having physio and walked down the corridor. He was admitted to Rotherham hospital two weeks ago because his legs just wouldn't work.*

The Ferns have already given me a bit of my dad back. (I know he's got dementia – but I got a little piece of him back.) I don't know if it's the different nursing (more attention) or the calm environment, but whatever it is, The Ferns have worked magic. I got something back in my dad that I never expected. ***Giving me a bit of my dad back is priceless! You can't put a budgetary amount on that. And mum, me, and my kids are so grateful.***

5.3 Urgent and community Transformation

5.3.1 Overview

In relation to health and social care integration, the case for change is clear:

Improving Services and Outcomes – service users expect and we want to provide a better experience and better results. We need to make better use of the people and resources we have by working more effectively together. If we do not change, we will not be able to continue the high quality services the people of Rotherham expect to meet their needs because of the growing demand on services.

Demand for Services – with a growing ageing population, more people need our health and social care services and will continue to do so. We cannot afford the future elderly population to be anything other than healthier for longer. Current models of service provision are not fit for the coming financial and quality challenge.

Better Resilience – the rise in demand puts pressure on our limited resources. This is happening at a time of constraint on public sector funding and rising costs of health and social care services. Only by exploiting the potential of integration and a relentless drive for personalisation, can we create a resilient health and social care economy. Reform needs to happen at different spatial levels – the individuals, localities, partnership areas and borough wide.

Need for Scale – Significant individual organisational efficiencies and the aggregation of a host of small scale projects will not be enough to meet the funding gap. A system wide approach to health and social care which engenders personal resilience, independence and wellbeing is the only option to reduce overall demand for services, enabling the right level of care to be targeted where there is a need.

In order to achieve the Place Plan objectives six closely interlinked transformational priorities have been identified, to maximise the value of our collective action and transform our health and care system so that we can reduce demand for acute services, achieve clinical and financial sustainability and thereby close the three gaps. The scope of the programme relates to adult services, or where a person under eighteen would be better supported in an adult service.

The six priority schemes work together as a whole system approach to deliver a step change in how we deliver our services moving from a responsive, paternalistic approach to a proactive preventative integrated health and social care model which supports individuals to live as independently as possible in the community, through a focus on 'home first'/ 'home is best'. Where people do need support it will be proportionate and joined up to make best use of limited resources. The emphasis will be on reablement, rehabilitation and recovery.

5.3.2 Priority 1: Integrated Point of Contact

There are multiple access points for adult health and social care in Rotherham. These will be consolidated around the two main health and social care referral points: the Care Co-ordination Centre (health) and Social Care Single Point of Access (SPA).

RMBC has strengthened the adult social care single point of access (SPA) investing in an MDT approach to develop a preventative model. The service includes social care advisors, social workers and the voluntary sector and is trialling pilots with an occupational therapist and physical and mental health. In June /July 2018 78.7% of customer contacts were resolved at the front door. Contacts to localities which averaged c 350 referrals a week to locality teams before the development are now average c just 39 for North, South and Central.
The CCG commissioned the health Care Co-ordination Centre in 2014 to facilitate sign posting to alternative levels of care; to support patients who are at risk of admission in the community and facilitate discharge. Historically, the Rotherham health community has been an outlier for emergency admissions to hospital, and a more recent challenge for Rotherham has been achieving A&E targets. There is evidence that individual clinicians involved in hospital admissions, such as GPs, ambulance staff and A&E doctors have different thresholds for admission. And whilst hospital admission may seem like the safest and easiest way of dealing with an emergency, for many people high quality care at home or in a community setting is a better, safer option, particularly for those on palliative care and end of life pathways. The service was extended to a 24/7, 365 days a year service in 2015, including referrals to community nursing. The service is now processing c 3,000 contacts a month. As a result the service has become more focussed on managing volume rather than effective co-ordination to the right level of care.

As the health and social care system moves to 'Home First' as an underpinning philosophy and approach promoting independence and care co-ordination becomes increasingly important. Therefore this priority is a lynch pin to effective delivery of the Urgent and Community Place Plan.

The remit of this priority is to develop an integrated front door which promotes independent living at home, admission avoidance and timely discharge through co-ordination of activity to ensure individuals receive the right level of care, at the right time and in the right place. Integration may be achieved either through physical co-location or virtual interconnectivity. The service will:

- Promote a prevent and self-support model
- Resolve up to 80% of contacts at the front door (the percentage will vary according to the specialism), reducing reliance on statutory services and utilising community assets
- Co-ordinate care to ensure the most appropriate level of intervention and support for people to remain at home wherever possible
- Continue to provide a 24/7, 365 day a year urgent service for health with specialist provision provided in core hours, determined according to specific specialist need
- Use a trusted assessor model, sharing information to facilitate decision making, removing the need for repeated questioning

The integrated service will be a blend of co-located MDTs for effective triage and resolution and virtual links facilitated through shared information and trusted assessor protocols. The collective skills set will include admin and clerical staff; non-qualified advisors and qualified physical health, mental health nurses (including nurse prescribers), therapists, social workers and AMHPs, re-ablement, pharmacy and palliative care. A leadership and management structure will be developed with specialist clinical / professional supervision and a tiered support structure including non-qualified advisors and specialist qualified staff.

Milestones

• Transfer mental health referrals to the Care Co-ordination Centre	Q2 18/19
• Agree joint working arrangements between Integrated Rapid Response/Care Co-ordination Centre /Single Point of Access to test the models	Q2 18/19
• Co-locate Care Co-ordination Centre with Integrated Rapid Response	Q3 18/19
• Evaluate joint working arrangements between health and RMBC Single Point of Access	Q3 18/19
• Partners agree integrated service model for Single Point of Access and Care Co-ordination Centre	Q4 18/19
• New service model in place	Q2 19/20

Key Performance Indicators

- Percentage of people provided with information and advice at first point of contact (to prevent service need)
- Number of GP urgent admissions to AMU (including those referred through CCC)
- Percentage of new clients who have had a formal social care assessment completed this year, that went on to receive long term social care support
- Proportion of new clients who receive short term (enablement) service in year with an outcome of no further requests made for support
- New permanent admissions to residential nursing care for adults
- Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduce non elective admissions
- Number of emergency re-admissions within 30 days of hospital discharge (all age)

5.3.3 Priority 2: Integrated Rapid Response

The TRFT Integrated Rapid Response service was established to improve the process for planned hospital discharge and admission prevention. It was recognised that at any one time there were a proportion of patients in an acute bed, whose medical episode was complete, but were awaiting further assessment, care package initiation or decisions on choice of care home. There was also a significant proportion of patients whose care needs could have been met at home, if appropriate services were in place.

The service provides:

- Support to patients who are at immediate risk of hospital admission, co-ordinating health and social care in the community to prevent an avoidable admission
- Assesses patients who are medically stable but need additional support to remain at home. Nursing support is provided for up to 72 hours, or to a maximum of 7 days if required.
- The service is supported by RMBC's Enablement Service, delivering home-based reablement and home care support.
- Out of hours district nursing
- Intensive clinical care and support to older people who live in CQC registered Care Homes

In addition the service triages community referrals from the Care Co-ordination Centre.

The service has recently established a borough wide urgent hub to ring fence resource for unplanned referrals so that planned work is not delayed or cancelled due to high volumes of urgent cases.

Mental health rapid response services are currently provided separately and are made up of the Crisis and Home Treatment teams, including RMBC Adult Mental Health Practitioners, the Mental Health and Alcohol Hospital Liaison Team and the Learning Disabilities Intensive Support team. Their collective remit is to reduce avoidable admissions and facilitate discharge.

The rapid response function is a key component of both the Integrated Point of Contact through providing crisis support, triage and brief interventions and the home first pathway through admission avoidance and facilitating discharge. This priority therefore needs to be aligned with priority 1: Integrated Point of Contact, priority 3: integrated discharge and priority 5: the review and development of the re-ablement and intermediate care offer.

Remit

The aim of the scheme is to incorporate rapid response functions into an integrated multi-disciplinary team to provide time limited brief interventions and wrap around support to enable individuals to remain or return home after an admission. It is therefore a cornerstone of the Home First pathway. The service will provide:

- advice and expert triage to the Integrated Point of Contact for signposting and co-ordinating to the appropriate level of care
- assessment, using trusted assessor protocols where appropriate
- support to people who are at risk of admission to remain at home or who, with additional support, can be discharged home

- provide brief, time limited, interventions of up to 7 days (or an appropriate time period for the specialism eg palliative care) to support individuals to prevent deterioration and reduce the need to enter service
- where further support is required determine what should happen next following a stepped care model
- liaise effectively with services across the care model to enable patients to be cared for at home
- provide out of hours support for unplanned health and social care needs which would otherwise result in an admission or serious deterioration / escalation

This priority provides the bridge between hospital and home in pathway terms and the Initial Point of Contact and Locality Teams in structural terms. It is anticipated that it will include rapid response services (including physical health, Mental Health Crisis and Home Treatment and social care front line services), therapies, integrated discharge, intermediate care and re-ablement and domiciliary care. An initial model will be developed for Winter 2018.

Milestones

- Complete separation of planned/unplanned activity within District Nursing Q2 18/19
- Co-locate the unplanned and Integrated Rapid Response teams Q3 18/19
- Incorporate unplanned specialist community nursing work into the Integrated Rapid Response team Q1 19/20

Key Performance Indicators

- Percentage of new clients who have had a formal social care assessment completed this year, that went on to receive long term social care support
- Proportion of new clients who receive short term (enablement) service in year with an outcome of no further requests made for support
- New permanent admissions to residential nursing care for adults – 65+
- Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduce non elective admissions
- Number of emergency re-admissions within 30 days of hospital discharge (all age)
- Length of stay in hospital (over 64's)
- Reducing long lengths of stay (super stranded patients)
- Number of patients discharged to their usual place of residence (over 64's)
- Intermediate Care - Average length of stay (general rehabilitation)
- Intermediate Care - Average length of stay (specialist rehabilitation)
- Intermediate Care - Late discharge - LOS > 6 weeks (general rehabilitation)

5.3.4 Priority 3: Integrated Discharge Service

Evidence suggests that patients are more likely to make a better recovery at home and regain or retain independence the earlier they return home or to a suitable care home setting.

Delayed discharges are under national scrutiny and whilst Rotherham delays have been comparatively low there has been a drop in performance compared to the national standard. Following an external independent review the following recommendations have been agreed:

1. Development and implementation of an integrated service for discharge planning and assessment
2. Data and Reporting – clear process for the capture, collation and reporting mechanisms for data related to discharge
3. Development of clear pathways to support the principles of Home First, Intermediate Care and Discharge to Assess, consideration of NHS Continuing Healthcare Funding
4. Escalation processes and systems across discharge planning to support effective patient flow and responses in times of pressure
5. Development and implementation of a training programme which can provide on-going sustainable support for all staff involved in discharge planning

The remit is to develop an integrated MDT approach for timely hospital discharge with planning that starts on arrival and is based on a home first ethos. The scheme has been divided into two phases.

Phase 1 (September 2017- January 2018) focussed on targeted activity to reduce delayed discharges - the following has been achieved in phase 1:

- Both Hospital Discharge Teams, Transfer of Care and Supported Discharge Pathways Teams, co-located in a single space
- Single-reporting process and clear sign-off procedures in place for formal reporting of DTOCs both locally and nationally
- Simplified pathways and an improved understanding of how those pathways can work
- Initial stakeholder consultation, training sessions and workshops held across a broad range of multi-disciplinary teams and staff
- Range of documents, such as Standard Operating Procedures, developed to support staff in achieving a sustained approach to recording and reporting accurately
- Overall reduction in the number of patients who remain in hospital for consideration of NHS Continuing Healthcare Funding
- Overall reduction in the numbers of patients delayed in hospital and reported as a DTOC

Phase 2 is to develop an integrated service model which will be a corner stone of the Home First pathway, aligned to the wider Place Plan activity, particularly priority 5, intermediate care and reablement. This will include:

- a costed business case for an integrated discharge team with single line management which operates 7 days a week. The service will be hospital based, though it is envisaged that when the team matures it will move into the community
- Clearly articulate and educate colleagues on the 3 discharge pathways, embedding discharge home as the default pathway
- develop a trusted assessor role with a view to reducing the number of assessments currently undertaken when people are being discharged from hospital

Milestones

• Appointment of Integrated Service Manager	Q2 18/19
• Appointment of Ward Co-ordinator Roles	Q2 18/19
• Partners approve Service Model (incl. team structure and 7/7 working and front door interface)	Q4 18/19
• Implement new model	Q2 19/20

Key Performance Indicators

- Number of patients discharged to their usual place of residence (over 64's)

- Intermediate Care - Average length of stay (general rehabilitation)
- Intermediate Care - Average length of stay (specialist rehabilitation)
- Intermediate Care - Late discharge - LOS > 6 weeks (general rehabilitation)
- Delayed transfer of care from hospital

5.3.5 Priority 4: Integrated Localities

Locally, there continues to be funding and demand challenges. This includes high levels of non-elective hospital admissions, GP attendances/home visits and social care interventions. In order to address these challenges a strong partnership approach is required to create an operating model that works with Rotherham people to take more responsibility for their own wellbeing. Where people do need support it must be proportionate and joined up; making the most of limited resources.

The Integrated Localities priority builds on the learning from development of the RMBC SPA and the Health Village Integrated Locality Pilot. Outcomes from the SPA evidence how timely co-ordination and short term interventions can reduce the volume of people drawing on health and social care services in localities. The Locality Pilot demonstrated the benefits of an MDT approach to support longer term and more complex cases, facilitating independent living, admission avoidance and timely discharge.

This scheme of work will take a case based approach to identify and embed how physical health, mental health, social care and the voluntary sector can work with individuals in a more effective multi-disciplinary way to facilitate independent living for those with longer term and more complex issues. Annual case reviews known to both social care and health services will be taken as a starting point in order to realise early benefits.

Health and social care localities have been mapped into three partnerships: north, south and central. The partnerships will be the vehicles for progressing the work. There will be a common core across each of the partnerships with flexibility to adapt to the local demographic, priorities and maturity of the partnership. Functions will include Social Care, District Nursing & Phlebotomy, Community Matrons, Nurse/AHP Consultants, Therapies & Reablement, Mental Health and the Voluntary and Community Sector including Social Prescribing.

These teams will work together to achieve the required outcomes for their caseloads with a shared responsibility to maximise impact. They will work closely with the urgent, rapid response and discharge functions to facilitate escalation and de-escalation, ensuring that local knowledge of what is the 'norm' for an individual is available and accessible to enable informed decisions of care based on acceptable levels of risk.

Milestones

• Map of current resources in each Partnership area for all organisations complete	Q3 18/19
• Agree outcome framework with partners - identify joint outcomes, agree governance and identify accountable officers for delivery within provider organisations	Q3 18/19
• Hold launch workshops (to agree work plans and targets and working principles)	Q3 18/19
• Partnership leadership teams agreed by partners	Q3 18/19
• Team configuration agreed by partners	Q4 18/19

- Implementation plan for full roll out agreed by partners Q4 18/19
- Agree Long Term Conditions LES to ensure that it links with the localities Q1 19/20

Key Performance Indicators

- Percentage of new clients who have had a formal social care assessment completed this year, that went on to receive long term social care support
- Proportion of new clients who receive short term (enablement) service in year with an outcome of no further requests made for support
- New permanent admissions to residential nursing care for adults – 65+
- Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduce non elective admissions
- Number of emergency re-admissions within 30 days of hospital discharge (all age)
- Length of stay in hospital (over 64's)
- Reducing long lengths of stay

5.3.6 Priority 5: Home First Model; Reablement & Intermediate Care

Local systems interpret Intermediate Care provision differently, it does not define a single service; it is a term that incorporates elements of reablement, rehabilitation and recovery. The Nice Guidelines for Intermediate Care including Reablement provide a clear vision of the model which corresponds with our local aspirations. The guidelines state that local areas should offer all 4 types of intermediate care; Crisis response, Home-based intermediate care, Bed-based intermediate care and Reablement.

The number of people aged 85 and over will increase by a third over the next ten years, and the number of people living with dementia is expected to grow to around 1.3 million in 2025. One estimate suggests that if admission rates continue to increase, the growing and ageing population alone means that the NHS would need approximately 17,000 additional beds by 2022. Responding to these challenges with 'more of the same', acute hospital beds and care home places is not sustainable or the best option for individuals. Commissioners are increasingly investing in reablement services as a means of increasing people's independence and reducing their need for ongoing support.

The majority of Rotherham's provision, both home and bed based, is currently focused on frail elderly with limited reablement/rehabilitation support for those with learning disabilities and physical disabilities to recover their independence. This is not how we see the future model, our vision is for a whole life journey approach for the adult population.

Rotherham has a strong record on joint working across health and social care, there are a number of jointly commissioned services in existence through the Better Care Fund including the Rotherham Intermediate Care Service (residential bed base provision), the Integrated Rapid Response Service and more recently the introduction of an Occupational Therapist into the Reablement service. There is evidence that these services have contributed to positive outcomes for service users and carers.

Rotherham is an outlier in the number of community beds we have. Audits show that there are still a number of hospital admissions that could be redirected to intermediate care and discharges that could be supported by community intermediate care rather than bed based provision. Therefore, a priority of the Rotherham Place Plan is to consider options for the redesign of intermediate care and reablement services. Our aspiration is to create an environment that supports integrated working across these services ensuring a model of recovery for all predicated on 'your bed is the best bed', with a combination of health and social care professionals working as part of a multi-disciplinary team to support clients at home.

We will review the community bed offer to ensure that services are fit for purpose and streamlined to create a reduced dependency on bed based provision. Rationalising the number of community beds in Rotherham will ensure we are in line with our comparators and support the ethos of Home First. To achieve this vision we will divert resources (therapy, nursing and social care) into the reablement and discharge to assess at home.

This ambitious transformation of services will support our joint priorities of promoting independence, prevention of avoidable hospital admission and discharges. Building the right capacity and capability for an integrated intermediate care service is a key element in driving this forward. A fully integrated team of health and social care professionals will provide a mix of community rehabilitation services, residential intermediate care, and the current discharge to assess beds for people living in the community, and for people leaving a hospital setting. This model will allow Rotherham people to remain in their community longer than would otherwise be possible.

Milestones

- Carry out financial modelling of current pathways — Q2 18/19
- Programme lead to develop a comprehensive milestone and action plan for delivery of this priority — Q2 18/19
- Develop draft service model and service specifications for reablement, intermediate Care and Home First — Q4 18/19
- Phase 1 of new service model implemented — Q4 18/19

Key Performance Indicators

- Number of GP urgent admissions to AMU (including those referred through CCC)
- Proportion of new clients who receive short term (enablement) service in year with an outcome of no further requests made for support
- New permanent admissions to residential nursing care for adults – 65+
- Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Number of patients discharged to their usual place of residence (over 64's)
- Intermediate Care - Average length of stay (general rehabilitation)
- Intermediate Care - Average length of stay (specialist rehabilitation)
- Intermediate Care - Late discharge - LOS > 6 weeks (general rehabilitation)

5.3.7 Priority 6: Develop a Coordinated Approach to Care Home Support

The Five Year Forward View *states that 'One in seven people aged 85 or over are living permanently in a care home'.* Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission.

- Around 12% to 15% of all emergency admissions are patients aged 85 or over, including both care home and non-care home resident patients.
- Emergency admissions from care homes make up approximately 11% to 13% of all emergency admissions in patients 65 and over and 25% of all emergency admissions in patients 85 and over.
- Patients admitted as an emergency from care homes spend approximately an extra 2 days in hospital, compared to emergency admissions for all patients, all ages.
- Care home admissions appear to be increasing but the trend is difficult to establish due to recording issues and the general margin of error associated with identifying care home admissions.

An important part of our new integrated locality model of care, is the transformation of our care home sector. The Enhanced Health in Care Homes Framework (NHSE) published in September 2016 lays out a clear vision for working with care homes to provide joined up primary, community and secondary, social care to residents of care and nursing homes, via a range of in reach services. The Rotherham ICP are committed to working collaboratively to improve the quality of life, healthcare and health planning for people living in care homes.

Most people want to be cared for in their own homes and we know that this is best for their wellbeing. Commissioners of health and social care are increasingly investing in reablement services as a means of increasing people's independence and reducing their need for ongoing support. However, there will be some people who need ongoing care in a care home setting, the aim of which will still be to maintain independence. The evidence suggests that many of these people are not having their needs properly assessed and addressed. As a result, they often experience unnecessary, unplanned and avoidable admissions to hospital, and sub-optimal medication. Therefore, we must ensure that the best possible care is provided to those in residential settings.

The Enhanced Health in Care Homes states that the care for people who are living in care homes or who are at risk of losing their independence is being held back by a series of care barriers, financial barriers, and organisational barriers.

Rotherham's self-assessment against the Enhanced Health in Care Homes Framework evidences areas of innovation and best practice. For example multiple teams and resources dedicated to care homes across Rotherham's health and social care economy; a care assessor, a care home support team, GP's aligned to care homes, the hospice at home team, advanced nurse practitioners, rapid response service, clinical quality advisor and social care contract compliance officers . However there still remains a significant opportunity to bring teams together to work in a more joined up way.

We also want to pursue the development of technology to link homes up better, use the initial point of contact as their first point of contact to access the most appropriate professional and support better end of life care planning to improve this service and offer.

A pilot project will run for 18 months through the Hospice service that will address both immediate advice and rapid response in emergency situations and the provision of education and supervision of front line care and residential home staff for End of Life. The project will also look to improve relationships across community teams, the wider health and social care network and care homes themselves.

Milestones

- Local implementation of Red Bag Scheme — Q1 18/19
- Implement and evaluate care home pilots: Trusted Assessor, Telehealth and End of Life — Q1-Q3 18/19
- Review training requirements for Care Home staff to enable effective delivery of service — Q4 18/19
- Continue to ensure the Care Home LES is fit for purpose — Q4 18/19

Key Performance Indicators

- Number of A&E attendances from care home residents (local)
- Percentage of attendances that resulted in hospital admission

CASE STUDY: Trusted Assessor working in the Emergency Department

The following case study illustrates how the different priorities of the place plan join together across the system to improve the outcome for patients. A Trusted Assessor Pilot was established in the Urgent and Emergency Centre in June 2018. The following example is an early case study.

***A**, an 82 year old woman, was assessed by Trusted Assessor in the emergency department. She came in by ambulance via a 999 call with query Cerebrovascular accident (CVA). Her home carer that morning was unable to stand her up and thought she was leaning more to the left side and had left sided facial palsy. **A** was assessed in A&E by a medic and nursing staff with her son present. Her son stated that the left -sided lean is usual due to ataxia relating to previous CVA and that left sided facial palsy is also normal for her. Past medical history includes hypertension and hyperthyroidism and previous falls. There were no FAST symptoms and she scored 0 on MEWS (vital signs) so no CT was required. **A** was deemed medically fit for discharge. She had reduced mobility potentially due to mild dehydration and fatigue due to a bad night's sleep due to hot weather.*

*The Trusted assessor was called to help get the patient back home from the emergency department. Taking details about her home situation from the patient and her son, a mobility and transfers assessment was carried out with the help of nurse. **A** needed assistance of 2 sit to stand, assistance of 2 with toileting and personal ADL's and assistance of 1 and rollator frame when mobilising due to sudden lean to left side and so loosing balance. The trusted assessor organised a rollator frame and contacted the care company to organise assistance for 2. The Care manager stated that they would not be able to resume care that evening as they would need social work input to increase to double handling calls. Usually this would have meant the patient would be unable to return home and would need hospital admission for social reasons.*

*The trusted assessor made contact with a hospital social worker who works alongside the Frailty team. He was able to carry out the necessary work to increase the home care to double handling so that the lady could return home that afternoon. The Trusted Assessor liaised with the urgent therapy team in the community and it was agreed (as in a "discharge to assess" model) that they would assess the lady at home the next day (Saturday) for any extra equipment needs, progress her mobility and give her some exercises to help improve her strength. She was therefore able to return home without needing a hospital admission over the weekend. As the Trusted Assessor also works in the urgent therapy community team she provided continuity by visiting **A** after the weekend to continue therapy.*

6 Glossary

A&E	Accident and Emergency	**KPI**	Key Performance Indicator
BCF	Better Care Fund	**LAC**	Looked After Children
CAMHS	Child and Adolescent Mental Health Services	**LMC**	Local Medical Committee
CCC	Care Co-ordination Centre	**LOS**	Length of Stay
CCG	Clinical Commissioning Group	**MOU**	Memorandum of Understanding
CHR CIC	Connect Healthcare Rotherham CIC	**RDaSH**	Rotherham Doncaster and South Humber NHS Foundation Trust
C&YP	Children and Young People	**RHR**	Rotherham Health Record
DTOC	Delayed Transfers of Care	**RMBC**	Rotherham Metropolitan Borough Council
H&WB	Health and Wellbeing	**SEND**	Special Educational Needs and Disabilities
ICP	Integrated Care Partnership	**SY&B**	South Yorkshire and Bassetlaw
ICS	Integrated Care System	**STP**	Sustainability and Transformation Plan
IH&SC	Integrated Health and Social Care	**TRFT**	The Rotherham NHS Foundation Trust
IRR	Integrated Rapid Response	**VAR**	Voluntary Action Rotherham
IT	Information technology	**VCS**	Voluntary and community sector
JSNA	Joint Strategic Needs Assessment		

REPORT FOR HEALTH AND WELL BEING BOARD

Date of Meeting:	**19 September 2018**
Title:	**Rotherham Integrated Care Partnership Agreement**
Directorate:	**Finance and Customer Services / Adult Care, Housing and Public Health**

1. Summary and Background

At its meeting on 5 September 2018 the Rotherham Integrated Care Partnership Place Board Place Plan Board ("the Place Plan Board") approved the final draft of the Rotherham Integrated Care Partnership Agreement ("the Agreement"). The Agreement, which forms the Appendix to this report, is intended to strengthen the governance arrangements underpinning the Rotherham Integrated Care Partnership Place Plan ("the Place Plan") and to capture the culture of how the Place Plan Board works together.

The Agreement is based on a Memorandum of Understanding approach and aims to provide an overarching arrangement to oversee the development of integrated multi-agency solutions for health, care and support across Rotherham. The Agreement is not intended to be legally binding except for specific elements such as confidentiality or intellectual property. However, if areas such as payment mechanisms and risk sharing/outcomes performance are developed over time, the partner organisations will need to consider moving to a legally binding agreement in the future.

The legally binding elements of the Agreement are:

- Clause 9 (Transparency)
- Clause 16 (Liability)
- Clause 18 (Confidentiality and FOIA)
- Clause 19 (Intellectual Property)
- Clause 20.4 (Counterparts): and
- Clause 20.5 (Governing Law and Jurisdiction)

Clause 21 of the Agreement confirms that the Council does not have the obligations of the other parties to the Agreement in relation to the South Yorkshire & Bassetlaw Integrated Care System.

2. Recommendations to Health and Well Being Board

It is recommended that the Health & Wellbeing Board approve the Agreement and authorise the Chief Executive to sign the Agreement on behalf of the Council.

3. Next Steps

Once the Agreement is approved the governance and working arrangements it contains will apply to the operation of the Place Plan Board and the obligations of the parties set out in the Agreement will apply to the parties. It is intended that this will strengthen the governance of the Place Plan Board.

4. Name and Contact Details

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ROTHERHAM INTEGRATED CARE PARTNERSHIP AGREEMENT

5th September 2018

1. NHS ROTHERHAM CLINICAL COMMISSIONING GROUP

2. CONNECT HEALTHCARE ROTHERHAM CIC

3. ROTHERHAM METROPOLITAN BOROUGH COUNCIL

4. ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST

4. THE ROTHERHAM NHS FOUNDATION TRUST

5. VOLUNTARY ACTION ROTHERHAM LIMITED

OVERARCHING INTEGRATED CARE PARTNERSHIP AGREEMENT FOR THE TRANSFORMATION AND BETTER INTEGRATION OF HEALTH, CARE, SUPPORT AND COMMUNITY SERVICES FOR THE POPULATION OF ROTHERHAM

No	Date	Version Number	Author
2-6	240718	5	EV
2-7	280818	6	RM
2-8	290818	6.1	LG
2-9	050918	7	LG
2-10	060918	7.1	LG Final

ROTHERHAM INTEGRATED CARE PARTNERSHIP AGREEMENT

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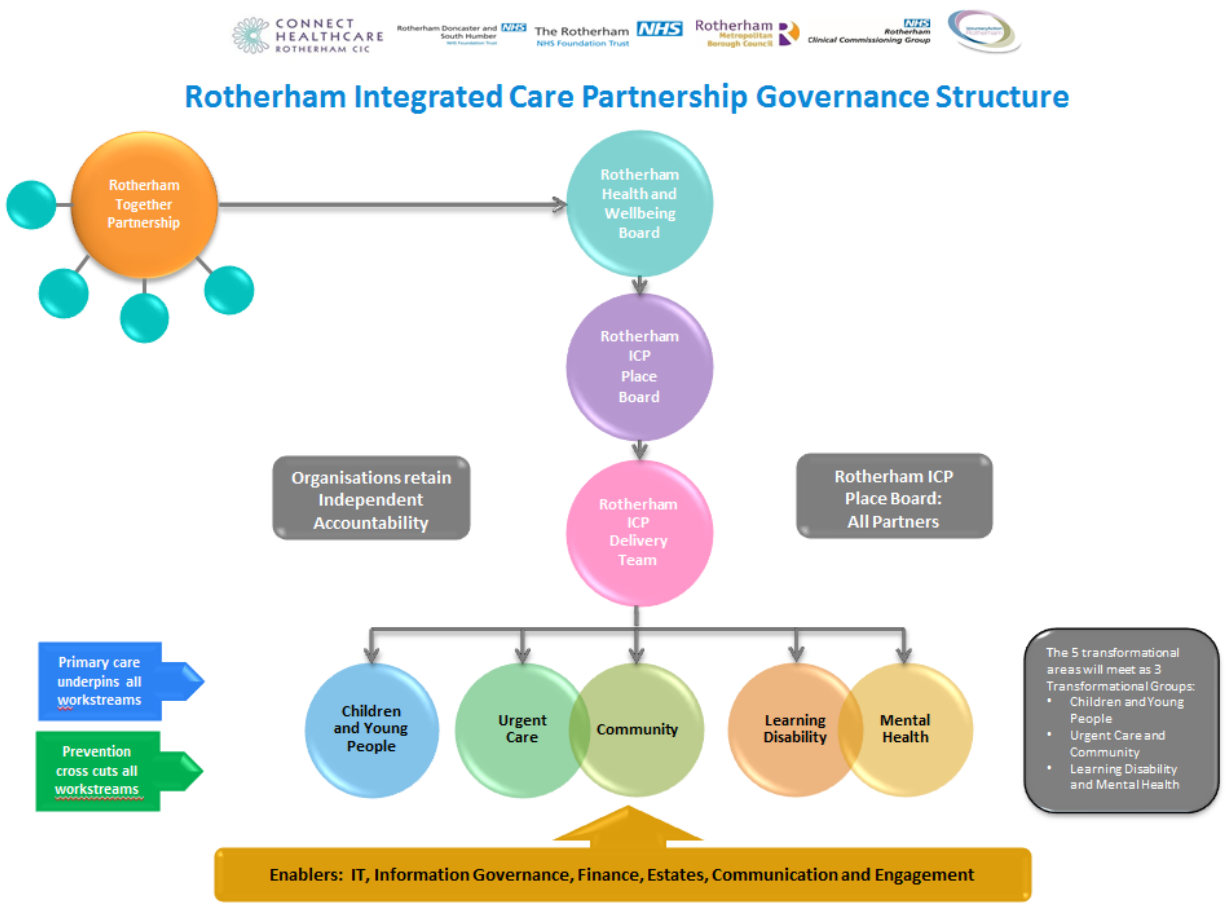
ROTHERHAM INTEGRATED CARE PARTNERSHIP AGREEMENT

Overarching Note – Rotherham Integrated Care Partnership Agreement for the transformation and better integration of Health, Care, Support and Community Services

This Agreement is based on a Memorandum of Understanding (MoU) approach to provide an overarching arrangement which governs the development of integrated multi-party solutions for health, care and support across the geographical area of Rotherham. The format is designed to work alongside the NHS Standard Contract (commonly the Contract) and arrangements for the delivery of non-NHS care, support, and community services via the Council. The overarching arrangements detailed in this Agreement are illustrated in the diagram below.

This Agreement is not intended to be legally binding save for specific elements such as confidentiality or intellectual property. Some areas of drafting will not be relevant for the current non-legally binding approach and will need significant development around the nature and function of the system approach over time, including the payment mechanism and any risk sharing / outcomes performance regime. Where these areas are developed further over time, the Parties will need to consider moving to a (fully) legally-binding agreement.



ROTHERHAM INTEGRATED CARE PARTNERSHIP AGREEMENT

5th September 2018

This Integrated Care Partnership Agreement (the **Agreement**) is made between:

1. **NHS ROTHERHAM CLINICAL COMMISSIONING GROUP** of Oak House, Bramley, Rotherham S66 1YY (the "**CCG**");
2. **CONNECT HEALTHCARE ROTHERHAM CIC** (Company number 10648960) whose registered office is Clifton Medical Centre, Doncaster Gate, Rotherham, S65 1DA ("**Connect**");
3. **ROTHERHAM METROPOLITAN BOROUGH COUNCIL** of Riverside House, Main Street, Rotherham S60 1AE (the "**Council**");
4. **ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST** of Woodfield House, Tickhill Road Site, Weston Rd, Doncaster DN4 8QN ("**RDASH**");
5. **THE ROTHERHAM NHS FOUNDATION TRUST** of Rotherham Hospital, Moorgate Road, Rotherham S60 2UD ("**TRFT**"); and
6. **VOLUNTARY ACTION ROTHERHAM LIMITED** a registered charity (Registered Charity Number 1075995) and a company limited by guarantee (Registered Company number 02222190) whose registered office is The Spectrum, Coke Hill, Rotherham S60 2HX ("**VAR**"),

together referred to in this Agreement as the "**Parties**".

The CCG and the Council (where acting as a commissioner of services) are together referred to in this Agreement as the "**Commissioners**".

Connect, TRFT, RDASH, VAR and the Council (where acting as a provider of services) are together referred to in this Agreement as the "**Providers**".

BACKGROUND

a) The Five Year Forward View set out a clear goal that "the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care".

b) Rotherham's Integrated Health & Social Care Place Plan (the **"Place Plan"**) detailed the Parties' joined up approach to delivering five key initiatives that will help achieve the Health and Wellbeing Strategic Aims.

c) In entering into and performing their obligations under this Agreement, the Parties are working towards the implementation of an integrated care partnership. This Agreement sets out the values, principles and shared ambition of the Parties in supporting work towards the transformation and better integration of health, care, support, and community services for the people who live in Rotherham.

d) Through the development of the Integrated Care Partnership the Parties are looking to see a rapid impact and potential benefit for patients in the population covered by the Commissioners through the collaborative working approach between them.

e) The Commissioners are the statutory bodies responsible for planning, organising and buying social care, NHS-funded healthcare, support and community services for people

who live in Rotherham.

f) The Parties acknowledge that the Council has a dual role within the Rotherham health and care system as both a commissioner of social care services but also as a provider of social care services either through direct delivery or through various contracts. In its role as commissioner of social care services the Council shall act in conjunction with the CCG and in its role as a provider of social care services the Council shall work in conjunction with the other Providers. The Council recognises the need to ensure and will ensure that any potential conflicts of interest arising from its dual role are appropriately identified to the other Parties and managed.

g) The Providers together are providers of social care, NHS funded healthcare services, community and support services to the population of Rotherham.

h) The intention is that the Parties will evolve these Integrated Care Partnership ("**ICP**") arrangements over time. This Agreement sets out the agreed principles for Rotherham place wide conversations and planning for the health and care system whilst the Providers will also look to collaborate (through an organisational form/contract to be agreed between them) to improve the ICP Outcomes and remove duplication.

i) This Agreement is an overarching agreement setting out how the Parties will work together in a collaborative and integrated way for the delivery of the Services from April 2018 to achieve the objectives set out in the Place Plan in accordance with the ICP Principles. As the arrangements develop, the Parties will consider whether further, legally binding, arrangements including section 75 agreements (between the Commissioners) or contracts for integrated service delivery are required to implement the Place Plan.

j) This Agreement is intended to work alongside:

   a. the Place Plan;

   b. the Contracts between the CCG and the Providers and between the Council and the Providers for the delivery of the Services; and

   c. the Section 75 Agreement between the Commissioners under which they commission the services listed in the schedules to that agreement.

IT IS AGREED AS FOLLOWS:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a "person" includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 a reference to a "Provider", the "Council", the "CCG" or the "Commissioner" includes its personal representatives, successors or permitted assigns;

1.2.3 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted; and

1.2.4 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms.

2. STATUS AND PURPOSE OF THIS AGREEMENT

2.1 The Parties have agreed to work together to form an Integrated Care Partnership in order to develop an improved financial, governance and contractual framework for delivering integrated health, support, and community care for the Rotherham population (covered by the CCG and the Council) and to deliver the Place Plan.

2.2 This Agreement sets out the key terms that the Parties have agreed.

2.3 Notwithstanding the good faith consideration that each Party has afforded the terms set out in this Agreement, the Parties agree that save as provided in Clause 2.4 below this Agreement shall not be legally binding. The Parties each enter into this Agreement intending to honour all of their respective obligations.

2.4 Clauses 9 (*Transparency*), 16 (*Liability*), 18 (*Confidentiality and FOIA*), 19 (*Intellectual Property*), 20.4 (*Counterparts*) and 20.5 (*Governing Law and Jurisdiction*) shall come into force from the date hereof and shall give rise to legally binding commitments between the Providers.

2.5 Each of the Providers has one or more individual Contracts (or where appropriate combined Contracts) with the CCG or Council. This Agreement will work alongside these Contracts and any Section 75 Agreement between the CCG and the Council.

2.6 The Parties will work together in a collaborative and integrated way on a Best for Rotherham basis and the Contracts set out how the Providers provide Services to the Population. This Agreement is not intended to conflict with or take precedence over the terms of the Contracts unless expressly agreed by the Parties in writing.

3. ACTIONS TO BE TAKEN ON OR POST THE COMMENCEMENT DATE

Each of the Parties acknowledges and confirms that as at the date of this Agreement it has obtained all necessary authorisations to enter into this Agreement.

4. DURATION

4.1 This Agreement shall commence on the Commencement Date and will continue for the Initial Term, unless and until terminated in accordance with its terms.

4.2 At the expiry of the Initial Term this Agreement will expire automatically without notice unless, no later than six (6) months before the end of the Initial Term, the Parties agree

in writing that the term of the Agreement will be extended for a further term to be agreed between the Parties (the "**Extended Term**").

SECTION A: PLACE PLAN OBJECTIVES AND PRINCIPLES

5. THE PLACE PLAN OBJECTIVES

5.1 The Place Plan agreed by the Parties is intended to deliver sustainable, effective, and efficient health and care, support, and community services with significant improvements underpinned by collaborative working. The Parties have agreed to work together in order to achieve the objectives set out in the Place Plan.

5.2 The Parties acknowledge that they will have to make decisions together in order for the ICP to work effectively. The Parties agree that they will always look to work together and make decisions on a Best for Rotherham basis in order to achieve the objectives in the Place Plan, save for the Reserved Matters listed at Clause 8.2.

6. THE ICP PRINCIPLES

6.1 The ICP Principles underpin the delivery of the Parties' obligations under this Agreement and set out key factors for a successful relationship between the Parties. The Parties acknowledge and confirm that the successful delivery of the Place Plan will depend on the Providers' ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the provision of the Services in conjunction with the Commissioners.

6.2 The principles referred to in Clause 6.1 are that the Parties will work together in good faith and, unless the provisions in this Agreement state otherwise, the Parties will:

6.2.1 focus on people and places through the integration of health and social care services, pulling pathways together around people's homes and localities; adopt a way of working which promotes continuous engagement with, and involvement of, local people to inform this;

6.2.2 actively encourage prevention, self-management, and early intervention to promote independence and support recovery, and be fair to ensure that all Rotherham people can have timely access to the support they require to retain independence;

6.2.3 design pathways in collaboration to reduce duplication and make our current and future services work better, and to reduce health inequalities in Rotherham providing a person-centred approach;

6.2.4 be innovative, using international evidence and proven best practice to shape our pathways to achieve the best outcomes for people in Rotherham in the most cost-effective way;

6.2.5 strive for the best quality services based on the outcomes we want within the resource available;

6.2.6 be financially sustainable and this must be secured through our plans and pathway reform; and

6.2.7 align relevant health and social care budgets together so we can buy health, care, and support services once for a place in a joined up way,

(together these are the "**ICP Principles**").

7. PROBLEM RESOLUTION AND ESCALATION

7.1 The Parties agree to adopt a systematic approach to problem resolution which recognises the objectives in the Place Plan and the ICP Principles.

7.2 If a problem, issue, concern or complaint comes to the attention of a Party which relates to the Place Plan or the ICP Principles or any matter within the scope of this Agreement and is appropriate for resolution between the Commissioners and the Providers such Party shall notify the other Parties and the Parties each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion and/or negotiation within 20 Operational Days of such matter being notified.

7.3 Any Dispute arising between the Parties which is not resolved under Clause 7.2 above will be resolved in accordance with Schedule 3 (*Dispute Resolution Procedure*).

7.4 If any Party receives any formal enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the FOIA in relation to the Services) the receiving Party will liaise with the Delivery Team as to the contents of any response before a response is issued.

SECTION B: OPERATION OF AND ROLES IN THE ICP

8. RESERVED MATTERS

8.1 The Parties acknowledge that each of the CCG and the Council is required to comply with certain statutory duties as statutory commissioners and will be required to act in accordance with their statutory duties in relation to certain matters. Consequently, the CCG and Council reserve the matters set out in Clause 8.2 for their respective determination as they see fit in accordance with Clauses 8.3 and 8.4.

8.2 The CCG and Council shall respectively be free to determine the following Reserved Matters:

8.2.1 making any decision or action where necessary to ensure compliance with their respective statutory duties, including the powers and responsibilities conferred on the CCG and Council respectively by Law, its constitution or the Section 75 Agreement; or

8.2.2 any matter upon which the CCG or Council may be required to submit to public consultation or in relation to which the CCG or Council may be required to respond to or liaise with a Local Healthwatch organisation.

8.3 The Parties agree that:

8.3.1 the Reserved Matters are limited to the express terms of Clause 8.2; and

8.3.2 the Place Board may not make a final recommendation on any of the matters set out in Clause 8.2, which are reserved for determination by the CCG or Council respectively.

8.4 Where determining a Reserved Matter, subject to any need for urgency because to act otherwise would result in the CCG or Council breaching their statutory obligations, the CCG or Council will first look to consult with the Place Board in respect of their proposed determination of a Reserved Matter in line with the objectives of the Place Plan and the ICP Principles.

9. TRANSPARENCY

9.1 The Parties will provide to each other all information that is reasonably required in order to achieve the objectives in the Place Plan.

9.2 The Parties have responsibilities to comply with Law (including Competition Law). The Parties will make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with Competition Law and, accordingly, the Place Board will ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

9.2.1 it is essential;

9.2.2 it is not exchanged more widely than necessary;

9.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of this Agreement; and

9.2.4 it may not be used other than to achieve the aims of this Agreement or the Place Plan in accordance with the ICP Principles.

9.3 Subject to compliance with Clause 9.1 above, the Parties will ensure that they provide the Place Board and Delivery Team with all financial cost resourcing, activity or other information as may be reasonably required so that the Place Board and Delivery Team can be satisfied that the Place Plan objectives are being satisfied.

9.4 The Commissioners will make sure that the Place Board and Delivery Team establish appropriate information barriers between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to

those Providers who need to see it to achieve the Place Plan and for no other purpose whatsoever so that the Parties do not breach Competition Law.

9.5 It is accepted by the Parties that the involvement of the Providers in the Place Board and Delivery Team is likely to give rise to situations where information will be generated and made available to the Providers, which could give the Providers an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a separate Provider). Any Provider will have the opportunity to demonstrate to the reasonable satisfaction of the CCG and the Council (where acting as a commissioner) in relation to any competitive procurements that the information it has acquired as a result of its participation in the ICP, other than as a result of a breach of this Agreement, does not preclude the CCG and the Council (where acting as a commissioner) from running a fair competitive procurement in accordance with their legal obligations.

9.6 Notwithstanding Clause 9.5 above, the Commissioners may take such measures as they consider necessary in relation to such competitive procurements in order to comply with their obligations under Law (for example, the Public Contracts Regulations 2015 and the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013) including excluding any potential bidder from the competitive procurement in accordance with the Law governing that competitive procurement.

10. OBLIGATIONS AND ROLES OF THE PARTIES

CCGs and Council (acting as a commissioner) obligations and role

10.1 The Commissioners will:

10.1.1 help to establish an environment that encourages collaboration between the Providers in order to better achieve the Place Plan where permissible;

10.1.2 provide clear system leadership to the Providers, clearly articulating desired health, care and support outcomes for the Providers, performance standards, scope of services and technical requirements;

10.1.3 support the Providers in developing links to other relevant services;

10.1.4 comply with all of their statutory duties; and

10.1.5 seek to commission the Services in an integrated, effective and streamlined way to meet the Place Plan objectives.

Providers' obligations and role

10.2 The Providers will:

10.2.1 act collaboratively with each other in accordance with the Law and Good Practice to ensure more integrated and effective performance of the Services, having at all times regard to the welfare of the Population;

10.2.2 co-operate fully and liaise appropriately with each other in order to ensure a co-ordinated approach to promoting the quality of patient care across the Services so as to achieve continuity in the provision of the Services that avoids inconvenience to, or risk to the health and safety of, the Population, employees of the Providers or members of the public; and

10.2.3 through high performance, unlock and generate enhanced innovation and better outcomes and value for the Population in line with the Place Plan.

10.3 Each Provider acknowledges and confirms that:

10.3.1 it remains responsible for performing its own obligations and functions for delivery of the Services to the CCG and/or the Council in accordance with its Contracts; and

10.3.2 it will be separately and solely liable to the CCG or the Council (as applicable) for the provision of the elements of the Services under its own Contracts.

10.4 The Providers will each look to:

10.4.1 act in good faith in the best interests of the Population; and

10.4.2 take responsibility for and manage their respective risks where they are performing the Services.

SECTION C: GOVERNANCE ARRANGEMENTS

11. INTEGRATED CARE PARTNERSHIP GOVERNANCE

11.1 The Parties must communicate with each other in a clear, direct, and timely manner. The governance structure for the ICP will consist of:

11.1.1 the Health and Wellbeing Board for Rotherham;

11.1.2 the Place Board; and

11.1.3 the Delivery Team.

11.2 The Place Board is the group responsible for directing and leading the ICP, reporting to the Health and Wellbeing Board for Rotherham progress against the Place Plan as well as liaising where appropriate with:

11.2.1 national stakeholders (including NHS England and NHS Improvement) to communicate the views of the ICP on national matters relating to integrated care.

11.3 The Place Board will act in accordance with the Terms of Reference set out in Schedule 2 (Governance) Part 1 (Place Board) and must:

11.3.1 promote and encourage commitment to the Place Plan and ICP Principles amongst all the Parties;

11.3.2 formulate, agree and implement strategies for implementing the Place Plan;

11.3.3 ensure alignment of all organisations to facilitate sustainable and better care which is able to meet the needs of the Population;

11.3.4 review performance of the Parties against the Place Plan and the ICP Outcomes and determine strategies to improve performance or rectify poor performance;

11.3.5 agree policy as required, including values to be adopted and annual and short-term performance outcomes/targets;

11.3.6 report on progress against the Place Plan to the Health and Wellbeing Board as required;

11.3.7 provide a forum for parties to resolve disagreement relating to the Place Plan;

11.3.8 oversee the implementation of this Agreement and all related Contracts in terms of delivering the Place Plan in line with the ICP Principles; and

11.3.9 in undertaking its role, consider recommendations from the Delivery Team in respect of the operation of the ICP and the delivery of the Services.

11.4 The Delivery Team is the group responsible for managing the collaborative operation of the Parties and the delivery of the Place Plan. The Delivery Team will act in accordance with its Terms of Reference set out in Schedule 2 (*Governance*) Part 2 (*Delivery Team*) and must:

11.4.1 make recommendations to the Place Board for its approval or rejection as to how the Services should be delivered in a more integrated and Best for Rotherham way so as to deliver the Place Plan (subject always to the terms of the Contracts and the consent of the CCG and Council); and

11.4.2 provide clinical and professional leadership with regard to the Services.

11.5 The Parties will communicate with each other clearly, directly and in a timely manner to ensure that the Parties (and their representatives) present at the Place Board and Delivery Team are able to make effective and timely decisions for each respective Party under this Agreement.

11.6 Each Party must ensure that its appointed members of the Place Board and Delivery Teams (or their appointed deputies/alternatives) attend all of the meetings of the Place Board and the Delivery Team respectively and participate fully and exercise their rights

on a Best for Rotherham basis and in accordance with Clause 5 (*Place Plan Objectives*) and Clause 6 (*ICP Principles*).

12. CONFLICTS OF INTEREST

12.1 The Parties will:

12.1.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the performance of the Services or operation of the Place Board or Delivery Team, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Party or any person employed or retained by them for or in connection with the performance of the Services;

12.1.2 not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Parties) before they participate in any decision in respect of that matter; and

12.1.3 use best endeavours to ensure that their Place Board and Delivery Team representatives comply with the requirements of this Clause 12 when acting in connection with this Agreement or the performance of the Services.

SECTION D: FINANCIAL PLANNING

13. PAYMENTS

The Parties will continue to be paid in accordance with the mechanism set out in the Contracts in respect of Services they deliver. To avoid doubt, the Parties have not agreed to share risk or reward in financial year 2018-19 and any future introduction of this will require additional legally binding provisions between the relevant Parties.

SECTION E: GENERAL PROVISIONS

14. EXCLUSION AND TERMINATION

14.1 Parties may be excluded from this Agreement on notice from the Commissioners in the event of:

14.1.1 the termination of their Contract;

14.1.2 an event of Insolvency affecting them.

14.2 A Party may withdraw from this Agreement by giving not less than 3 months' written notice to each of the other Parties representatives on the Place Board.

14.3 A Party may be excluded from this Agreement on written notice from all of the remaining Parties in the event of a material or persistent breach of the terms of this Agreement by the relevant Party which has not been rectified within 30 days of notification issued by the remaining Parties or which is no reasonably capable of

remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Party.

14.4 The Place Board may resolve to terminate this Agreement in whole where:

14.4.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure; or

14.4.2 where the Parties agree for this Agreement to be replaced by a formal legally binding agreement between them.

14.5 Where a Party is excluded from this Agreement, or withdraws from it, the Parties recognise that the associated Contract may be terminated and/or varied to reflect how the impacted Services are to be delivered. In addition to any specific obligations under the relevant Contract and to ensure a smooth transfer of Services the Parties agree to work together in good faith to agree the necessary changes so that the Services continue to be provided for the benefit of the Population. The excluded Party shall procure that all data and other material belonging to any other Party shall be delivered back to the relevant Party or deleted or destroyed (as instructed by the relevant Party) as soon as reasonably practicable.

15. INTRODUCING NEW PROVIDERS

Additional parties may become parties to this Agreement on such terms as the Parties will jointly agree in writing, acting at all times on a Best for Rotherham basis. Any new Party will be required to agree to the terms of this Agreement (including the legally binding elements) before admission.

16. LIABILITY

The Parties' respective responsibilities and liabilities in the event that things go wrong with the Services will be allocated under their respective Contracts and not this Agreement.

17. VARIATION

Any amendment to this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Parties.

18. CONFIDENTIALITY AND FOIA

18.1 Each Party shall keep in strict confidence all Confidential Information it receives from another Party except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Party. Each Party shall use Confidential Information received from another Party solely for the purpose of delivering the Services and complying with its obligations under this Agreement and for no other purpose.

18.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Party or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Party may have in respect of such Confidential Information.

18.3 The Parties agree to procure, as far as is reasonably practicable, that the terms of this Clause 18 (*Confidentiality and FOIA*) are observed by any of their respective successors, assigns, or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

18.4 Nothing in this Clause 18 (*Confidentiality and FOIA*) will affect any of the Parties' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

18.5 The Parties acknowledge that some of them are subject to the requirements of FOIA and will facilitate their compliance with its information disclosure requirements, including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that any Party which is subject to FOIA is able to comply with their statutory obligations.

19. INTELLECTUAL PROPERTY

19.1 In order to deliver the Place Plan in accordance with the ICP Principles each Party grants each of the other Parties a fully paid up, non-exclusive licence to use its existing Intellectual Property insofar as is reasonably required for the sole purpose of the fulfilment of that Party's obligations for the Services under this Agreement.

19.2 If any Party creates any new Intellectual Property through the delivery of the Place Plan and the Services between the Parties, the Party which creates the new Intellectual Property will grant to the other Parties a fully paid up, non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Party's obligations for the Services and the Place Plan under this Agreement.

20. GENERAL

20.1 Any notice or other communication given to a Party under or in connection with this Agreement shall be in writing, addressed to that Party at its principal place of business or such other address as that Party may have specified to the other Party in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

20.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 20.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after

posting; or if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

20.3 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Parties, constitute any Party the agent of another Party, nor authorise any Party to make or enter into any commitments for or on behalf of any other Party except as expressly provided in this Agreement.

20.4 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Party has executed at least one counterpart.

20.5 This Agreement, and any Dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and where applicable, the Parties irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

21. INTEGRATED CARE SYSTEM

21.1 In addition the Parties (with the exception of Rotherham Metropolitan Borough Council) shall have the following obligations in relation to the South Yorkshire & Bassetlaw Integrated Care System;

21.2 The intention is that planning and delivery at an overarching STP (or "Integrated Care System" ("ICS")) level must be coordinated with planning and delivery at a local (Rotherham) level, as they represent different elements of the same system.

21.3 In entering into and performing their obligations under this Agreement, the Parties are working towards the implementation of an integrated care partnership as part of the development of the ICS for South Yorkshire and Bassetlaw

21.4 The Place Board, as the group responsible for directing and leading the ICP reporting to the Health and Wellbeing Board for Rotherham on progress against the Place Plan, will also liaise, where appropriate, with the South Yorkshire and Bassetlaw ICS to communicate the views of the ICP on ICS level matters*;*

ROTHERHAM INTEGRATED CARE PARTNERSHIP AGREEMENT

This Agreement for a Rotherham Integrated Health Care Partnership has been entered into on the date stated at the beginning of it.

Signed by CHRIS EDWARDS

for and on behalf of **NHS ROTHERHAM CLINICAL COMMISSIONING GROUP**

.....

CHIEF OFFICER

Signed by DR GOKUL MUTHOO

for and on behalf of **CONNECT HEALTHCARE ROTHERHAM CIC**

.....

CHAIR

Signed by KATHRYN SINGH

for and on behalf of **ROTHERHAM DONCASTER AND SOUTH HUMBER NHS FOUNDATION TRUST**

.....

CHIEF EXECUTIVE

Signed by LOUISE BARNETT

for and on behalf of **THE ROTHERHAM NHS FOUNDATION TRUST**

.....

CHIEF EXECUTIVE

Signed by SHARON KEMP

for and on behalf of **ROTHERHAM METROPOLITAN BOROUGH COUNCIL**

.....

CHIEF EXECUTIVE

Signed by JANET WHEATLEY

for and on behalf of **VOLUNTARY ACTION ROTHERHAM LIMITED**

.....

CHIEF EXECUTIVE

SCHEDULE 1

Definitions and Interpretation

1 The following words and phrases have the following meanings:

Agreement or ICP Agreement	this agreement incorporating the Schedules
Best for Rotherham	means best for the achievement of the Place Plan for the Rotherham population on the basis of the ICP Principles
Claim	means any claim, action, demand, fine or proceedings
Commencement Date	means the date entered on page one (1) of this Agreement
Competition Law	means the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013 and as applied to the healthcare sector by Monitor in accordance with the Health and Social Care Act 2012
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Providers and which that Provider properly considers is of such a nature that it cannot be exchanged with the other Providers without a breach or potential breach of Competition Law
Confidential Information	means the provisions of this Agreement and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement
Contract	a contract entered into by one of the CCG or the Council and a Provider for the provision of the Services linked to the agreed Workstreams and references to a Contract include all or any one of those contracts as the context requires
Delivery Team	means the Rotherham ICP Delivery Team which oversees the work programmes made up of Provider and Commissioner representatives
Dispute	any dispute arising between two or more of the Parties in connection with this Agreement or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Schedule 3 for the resolution of disputes which are not capable of resolution under Clause 7 (*Problem Resolution and Escalation*)

FOIA	means the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act
Good Practice	Good Clinical Practice and/or Good Health and/or Social Care Practice (each as defined in the Contracts), as appropriate
Guidance	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which a Party has a duty to have regard (whether specifically mentioned in this Agreement or not)
ICP or Integrated Care Partnership	means the Integrated Care Partnership between the Parties as set out in this Agreement
ICP Principles	means the principles set out in Clause 6.2
Initial Term	the period from and including the Commencement Date up to and including 31 March 2020
Insolvency	means (as may be applicable to each Party) a Provider taking any step or action in connection with its entering administration, provisional liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; c) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; d) Guidance;

	e) National Standards; and f) any applicable code.
National Standards	those standards applicable to the Parties under the Law and/or Guidance as amended from time to time
NHS Standard Contract	the current NHS Standard Contract as published by NHS England from time to time
Operational Days	a day other than a Saturday, Sunday or bank holiday in England
Place Board	the Rotherham ICP Place Board
Population	means the geographical population group of Rotherham as covered by the CCG and Council
Reserved Matters	means the matters set out in Clause 8.2
Section 75 Agreement	means the agreement entered into by the CCG and the Council under section 75 of the National Health Service Act 2006 to commission the services listed in the Schedules to that agreement
Services	the services provided, or to be provided, by each Provider to the CCG or the Council pursuant to its respective Contract as set out in the Place Plan
Workstream	the five workstreams set out in the Place Plan, being as at the Commencement Date: Children and Young People; Urgent Care; Community; Learning Disability; and Mental Health.

SCHEDULE 2

Governance

Part 1: Place Board Terms of Reference

Contact Details:	
Joint Chair	**S Kemp –** Chief Executive, Rotherham Metropolitan Borough Council **C Edwards –** Chief Officer, Rotherham Clinical Commissioning Group

Purpose:

The **Scope** of the group:

Rotherham Integrated Care Partnership (ICP) Place Board will focus on the delivery of the Rotherham Place Plan. Strategic direction will be signed off by the Health and Well-Being Board.

The **Rotherham ICP Place Board** is the Integrated Care System Board for Rotherham. It will be the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery. It will work across boundaries to improve patient experience and clinical outcomes, by establishing partnerships and better working relationships between all health and social care organisations in the Rotherham health and social care community.

The **Role** of the **Rotherham ICP Place Board**:

- 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 impact assessments are completed where appropriate to assess any adverse impact in regard to patient safety and experience.

The **principles** the **Rotherham ICP Place Delivery Team** adhere to are:

1. Focus on people and places through the integration of health and social care services, pulling pathways together around people's homes and localities; adopt a way of working which promotes continuous engagement with, and involvement of, local people to inform this;
2. Actively encourage prevention, self-management, and early intervention to promote independence and support recovery, and be fair to ensure that all Rotherham people can have timely access to the support they require to retain independence;
3. Design pathways in collaboration to reduce duplication and make our current and future services

work better, and to reduce health inequalities in Rotherham providing a person-centred approach;

4. Be innovative, using international evidence and proven best practice to shape our pathways to achieve the best outcomes for people in Rotherham in the most cost-effective way;
5. Strive for the best quality services based on the outcomes we want within the resource available;
6. Be financially sustainable and this must be secured through our plans and pathway reform; and
7. Align relevant health and social care budgets together so we can buy health, care, and support services once for a place in a joined up way.

Responsibilities:

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

Members acknowledge that the Board should encompass commissioners and providers who commission or provide health and social care across Rotherham and as such recognise that the membership of the Board may need revising periodically to include additional members.

Rotherham ICP Place Board members should seek to hold each other to account for actions resulting from internal review, with member organisations sharing intelligence and pooling resources where possible, to improve system delivery against agreed key performance indicators. These arrangements do not supersede accountabilities between organisations and their respective regulators.

Chair:

Joint Chair – Chief Officer (RCCG) / Chief Executive (RMBC)

Composition of group:

Each member organisation will have one representative on the group. The Joint Chairs of the Health and Wellbeing Board will attend to ensure the delivery is consistent with the strategic direction.

<u>NHS Rotherham CCG</u>

Chief Officer - Chris Edwards (Joint Chair)

<u>Rotherham Metropolitan Borough Council</u>

Chief Executive – Sharon Kemp (Joint Chair)

<u>The Rotherham Foundation Trust (TRFT)</u>

Chief Executive – Louise Barnett

Voluntary Action Rotherham

Chief Executive – Janet Wheatley

Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)

Chief Executive – Kathryn Singh

Connect Healthcare Rotherham CIC (Rotherham GP Federation)

Rotherham GP Chair - Dr Gokul Muthoo

Participating Observers:

Joint Chair, Health and Wellbeing Board, RMBC - Cllr 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 ICP Place 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 Rotherham ICP Board Manager)

Deputising:
As appropriate.

Quorum:
One member from each of RCCG and RMBC, one provider representative

Accountability:
The chair of the meeting will be accountable to the Health and Wellbeing Board for delivery on the responsibilities set out in the terms of reference.

Frequency of meetings:
Monthly

Agenda deadlines:

Agenda items one week before the meeting, agenda to be circulated Friday prior to the meeting

Minutes:
Health and Wellbeing Board

Review Date:
Reviewed and agreed May 2018 Next review due April 2019

Part 2: Delivery Team Terms of Reference

Contact Details:	
Chair	**Ian Atkinson** – Deputy Chief Officer, Rotherham Clinical Commissioning Group **Anne Marie Lubanski** - Strategic Director of Adult Care & Housing, Rotherham Metropolitan Borough Council

Purpose:

The **Scope** of the group:

Rotherham Integrated Care Partnership (ICP) Place Delivery Team will be the operational group for the delivery of the Rotherham Place Plan, reporting to the **Rotherham ICP Place Board**. Strategic direction will be signed off by the Health and Well-Being Board.

The **Rotherham ICP Place Board** will be the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery and the **Rotherham ICP Place Delivery Team** will be held to account by the **Rotherham ICP Place Board**. It will work across boundaries to improve patient experience and clinical outcomes, by establishing partnerships and better working relationships between all health and social care organisations in the Rotherham health and social care community.

The **Rotherham ICP Place Delivery Team** will be made up of the officers accountable for the workstreams.

The **Role** of the **Rotherham ICP Place Delivery Team** will be:

- Implementation 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 **principles** the **Rotherham ICP Place Delivery Team** adhere to are:

1. Focus on people and places through the integration of health and social care services, pulling pathways together around people's homes and localities; adopt a way of working which promotes continuous engagement with, and involvement of, local people to inform this;
2. Actively encourage prevention, self-management, and early intervention to promote

independence and support recovery, and be fair to ensure that all Rotherham people can have timely access to the support they require to retain independence;

3. Design pathways in collaboration to reduce duplication and make our current and future services work better, and to reduce health inequalities in Rotherham providing a person-centred approach;
4. Be innovative, using international evidence and proven best practice to shape our pathways to achieve the best outcomes for people in Rotherham in the most cost-effective way;
5. Strive for the best quality services based on the outcomes we want within the resource available;
6. Be financially sustainable and this must be secured through our plans and pathway reform; and
7. Align relevant health and social care budgets together so we can buy health, care, and support services once for a place in a joined up way.

Responsibilities:

Recommendations for funding will need to be made by the Board to the relevant statutory bodies, through individuals where responsibility is delegated by relevant statutory bodies.

Rotherham ICP Place Delivery Team members should seek to hold each other to account for actions resulting from internal review, with member organisations sharing intelligence and pooling resources where possible, to improve system delivery against agreed key performance indicators. These arrangements do not supersede accountabilities between organisations and their respective regulators.

Chair:

Joint Chair – Deputy Chief Officer (RCCG)/Strategic Director of Adult Care & Housing (RMBC)

1. Composition of group:

Each member organisation will be represented on the group. Rotherham ICP Place Board officers will be invited and attend as available/appropriate.

NHS Rotherham CCG (CCG)

- Deputy Chief Officer – Ian Atkinson (Joint Chair)

Rotherham Metropolitan Borough Council (RMBC)

- Strategic Director of Adult Care & Housing – Anne-Marie Lubanski (Joint Chair)
- Director of Children's Services – Jon Stonehouse

The Rotherham Foundation Trust (TRFT)

- Director of Strategy and Transformation – Chris Holt

Voluntary Action Rotherham (VAR)

- Deputy Chief Executive – Shafiq Hussain

Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)

- Care Group Director- Rotherham - Dianne Graham

Connect Healthcare Rotherham CIC (Rotherham GP Federation)

- Business Manager – Vicki Linford

In Attendance

- Assistant Director Strategic Commissioning, *RMBC* – Nathan Atkinson
- Children's Care Group Director, *RDaSH* – Christina Harrison
- Director of Public Health, *RMBC* – Terri Roche
- Chair of Partnership Communications Group – Gordon Laidlaw
- Senior Planning and Assurance Manager, *RCCG* – Lydia George

Deputising:
As appropriate

Quorum:
One member from each of RCCG and RMBC, one provider representative

Accountability:
The members of the meeting will be accountable to the Rotherham ICP Place Board for the responsibilities set out in the terms of reference

Frequency of meetings:
Monthly

Agenda deadlines:
Agenda items one week before the meeting, agenda to be circulated Friday prior to the meeting

Minutes:
Rotherham ICP Place Board

Review Date:
Reviewed April 2018 Next review due April 2019

SCHEDULE 3

Dispute Resolution Procedure

1 Avoiding and Solving Disputes

1.1 The Parties commit to working cooperatively to identify and resolve issues to the Parties' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Parties will look to collaborate and resolve differences under Clause 7 (*Problem Resolution and Escalation)* of this Agreement prior to commencing this procedure.

1.2 The Parties believe that by focusing on the delivery of the Place Plan and ICP Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the ICP.

1.3 The Parties shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the ICP (each a "**Dispute**") when it arises.

1.4 In the first instance the Delivery Team shall seek to resolve any Dispute to the mutual satisfaction of the Parties. If the Dispute cannot be resolved by the Delivery Team within 10 Operational Days of the Dispute being referred to it, the Dispute shall be referred to the Place Board for resolution.

1.5 The Place Board shall deal proactively with any Dispute on a Best for Rotherham basis in accordance with this Agreement so as to seek to reach a unanimous decision. If the Place Board reaches a consensus that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice.

1.6 The Parties agree that the Place Board, on a Best for Rotherham basis, may determine whatever action it believes is necessary including the following:

(a) if the Place Board cannot resolve a Dispute within 20 Operational Days of referral, it may select an independent facilitator to assist with resolving the Dispute; and

(b) the independent facilitator shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the Place Board to work towards a consensus decision in respect of the Dispute;

(iii) regulate his or her own procedure and, subject to the terms of this Agreement, the procedure of the Place Board at such discussions;

(iv) determine the number of facilitated discussions, provided that there will be not less than three (3) and not more than six (6) facilitated discussions, which must take place within twenty (20) Operational Days of the independent facilitator being appointed; and

(v) have its costs and disbursements met by the Parties in Dispute equally; and

(c) if the independent facilitator cannot resolve the Dispute within 30 Operational Days of referral of the Dispute by the Place Board, the Dispute must be considered afresh in accordance with this Schedule 3 and only after such further consideration again fails to resolve the Dispute, the Place Board may decide to:

(i) terminate the ICP; or

(ii) agree that the Dispute need not be resolved.

healthwatch

Rotherham

Annual Report 2017/18

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Message from our Chair

Hello, my name is Joanna Saunders and I am currently a Senior Consultant for the Whole Systems Obesity Programme at Leeds Beckett University.

Having joined the Healthwatch Rotherham Board in the summer of 2017, this is my first opportunity to introduce myself as the new Chairperson. I've spent over 30 years working in the NHS and local government, in administration and management, research and public health. In my roles, the engagement of patients, carers and the public has been very important. We all use health and social care services at some points during our lives, and our experiences of services really do matter to the organisations that provide them.

Over the years I have worked closely with voluntary and community organisations in South Yorkshire who represent patients and carers, including the British Heart Foundation and Diabetes UK and smaller local organisations. Healthwatch Rotherham has a different and important role in that it works with both patients/service users/carers and service commissioners/providers – seeking to ensure that services meet the needs of local people and that they are accessible to everyone who needs them.

Our organisation supports people who are having difficulty getting the support they need or find that services are hard to navigate, including services in primary care, RDASH, Rotherham DGH and the Council.

Here in the Annual Report you'll see how our work has helped to change services locally to make them better and more effective. However, there are some services which still need to change – we will continue to champion local autism strategy which has been a long time in gestation – hopefully it will be published soon.

We couldn't achieve such change without our exceptional staff team – they work tirelessly with clients, sometimes for many weeks or months, and receive extremely positive feedback. I would like to take this opportunity to thank them for their work on behalf of you, the patients, carers and people of Rotherham.

Message from our Chief Executive

This report details some of the changes that we have helped bring about over the past year. Despite further reductions to our budget we aspire to achieve maximum impact.

The year saw a few changes to our Board of Directors with the departure of Karen Biddle and the return of Naveen Judah. The Board have continued to provide support whilst steering the work and the strategic direction of Healthwatch Rotherham under the careful eye of our Chair Joanna Saunders. I would personally like to record my thanks to the Board for their contribution.

We have continued to work closely with key stakeholders and service providers to bring about change and also develop a deeper understanding of the influences and prejudices facing our communities, which in turn effects the health and wellbeing of residents and shapes how our services are delivered.

> Mental Health and in particular Autism remains a priority for Healthwatch Rotherham and we will ensure that it stays high on the agenda whilst the Integrated Care Plan is moving to implementation

During the year we published our Lasting Power of Attorney Guide, guiding people through the paperwork and answering lots of common questions on the process. We also updated two highly successful directories which we published the previous year on Mental Health and Health and Social Care.

Our work this year has been heavily focused on the advocacy service, especially on CAMHS cases which has highlighted the need for more work to be done around autism. This has led to us working closely with RMBC and CCG to develop an Autism Partnership Board who are working on an All Age Autism Strategy for Rotherham.

Highlights from our year

This year we've reached 26,859 people on social media

24 volunteers helped us **to deliver our contract**

We have attended **173** meetings

We have **Resolved 101 NHS complaints**

We have made 278 new **contacts this year.**

We've given **over 500** people information and advice

Who we are

Healthwatch Rotherham 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 peoples needs and experiences.

You need services that work for you, your friends and family. That's why we want you to share your experiences of using health and care with us - both good and bad. We use your voice to encourage those who run services to act on what matters to you.

As well as championing your views locally, we also share your views with Healthwatch England who make sure that the government put people at the heart of care nationally.

Health and care that works for you

People want health and social care support that works - helping them to stay well, get the best out of services and manage any conditions they face.

Our purpose

To find out what matters to you and to help make sure your views shape the support you need.

People's views come first - especially those who find it hardest to be heard. We champion what matters to you and work with others to find ideas that work. We are independent and committed to making the biggest difference to you.

your voice counts

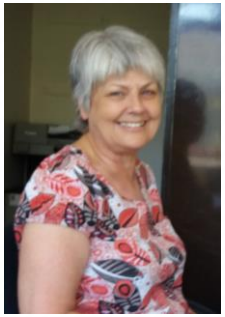
Meet the team

Tony Clabby
Chief Executive Officer

Nathan Batchelor
Information & Research Officer
Left July 2017

Nichola Barnes
Information & Research Officer
Left March 2018

Lesley Cooper
Information & Research Officer
Appointed May 2018



Anne Lemm
Advocacy Officer

Steve Mace
Advocacy Officer

Mike Horne
Children & Young Peoples Advocacy Officer/ Advocacy Officer

Your views on health and care

Listening to people's views

We listen to Rotherham peoples views on the health and social care that they receive by

+ Attending events within the local community to engage with a wide range of residents.
+ Acting upon the Feedback received on services via our website.
+ Performing targeted surveys when needed.
+ Engaging with hard to reach and vulnerable residents in their own environment.
+ Using our social media platforms to gain feedback.

We also work with hard to reach groups by attending outreach sessions at local libraries and GP Surgeries and we have a wide range of advocacy cases encompassing:

- Physical and mental health
- All ages
- A range of disability issues
- All sexes
- Births and Deaths
- A wealth of different backgrounds and religious beliefs

Making sure services work for you

+ Section 186 of the Health and Social Care Act 2012 provides for Healthwatch Rotherham 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 serious concern. Healthwatch Rotherham have not needed to undertake any Enter and View activities in the past year.
+ Our priority would always be to talk to the provider in the first instance as they are not always aware of what peoples views are on their service.

Advocacy Service

Our NHS Advocacy Services help local people to make NHS complaints which can be a daunting task for some people for a variety of reasons. We have seen a 17% increase in our caseload for NHS advocacy during the past 12 months.

As part of the CAMHS Transformational Plan, Rotherham NHS and CCG funded our Child and Adolescent Mental Health Service (CAMHS) Advocate. The service has been welcomed by local people and currently sees 77% of cases being resolved locally to the satisfaction of both parties. We have seen an increase in caseload of 46% in the year 2017/18.

Very respectful, quick response, kept me informed through out the process. Nothing was too much trouble. I would highly recommend to anyone needing an advocate! *T.P (C&YP Advocate case 2017)*

Child & Adolescent Mental Health Service
Survey 2018

During early 2018 Healthwatch Rotherham began a review of the CAMHS Service. This was a repeat of a review which was undertaken in 2014, in order to gauge what, if any, progress has been made by CAMHS…

To enable Healthwatch Rotherham to achieve the above aims, four methodologies were used.

A purpose designed survey

A public two day event gathering views on themed topics

A review of the Healthwatch Rotherham Database

Analysis of the Healthwatch Rotherham Advocacy Service for Children and Young People.

> Was told my son did not have ADHD and when I asked for a second opinion he had in fact got it.

The work is currently on going and information is being pulled together, a report is due in the next few weeks. Early results are showing that 76% of CAMHS complaints are regarding ASD and ADHD which again re-affirms our commitment to drive forward an All Age Autism Strategy for Rotherham.

Older Peoples Summit

Gathering views from our older people during Older Peoples Month October 2017

During the Older Peoples Month, October 2017 we held a conference at Fitzwilliam Arms Hotel in Rotherham where we had a number of guest speakers who were able to inform our older residents of changes to clinical thresholds which could affect their treatment and how they receive it.

Residents were then able to question a representative of the Clinical Commissioning Group and air their views on the changes. Also on the agenda was information about the Lasting Power of Attorney and the guide which Healthwatch Rotherham had published. This was complemented by a presentation on the subject. Afterward there was time for members of the audience to ask general questions regarding their health and wellbeing to a panel including staff from RMBC, Healthwatch and CCG.

At the event we also worked in partnership with Edlington Community Organisation who have recently delivered a series of “Slipper Swap” events in Doncaster and were looking at delivering some in the Rotherham area. The project covers winter wellbeing and fall prevention in the over 50’s by providing them with a brand new pair of slippers in exchange for their old worn ones. They also provide winter wellbeing packs containing thermal gloves, socks and mug along with a fleece blanket and hot water bottle. The event was very well received and further “Slipper Swaps” will be popping up around the borough over the winter months.

There was also time to talk to our older residents about the new plans for Rotherham Town Centre and how we had requested that the views of our aging population were taken into account when it came to the design of street furniture and pathways. The height of the seating, the width of pathways and the placing of street furniture is very important to many people and effects their experience of using local amenities and community venues which again in turn effects the health and wellbeing of our population.

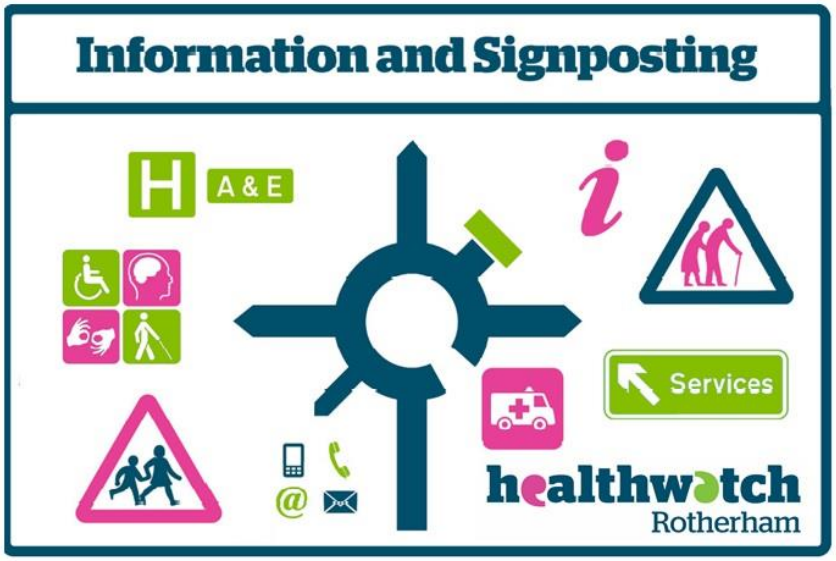
Helping you find the answers

INFORMATION ADVICE & GUIDANCE

How we have helped the community get the information they need

We have excellent links to and knowledge of service providers in the area, this enables us to empower local people to make informed choices about their present and future care:

+ We have staff on hand with a wealth of knowledge on health, social care and wellbeing so many general enquiries are answered instantly.
+ We have a range of leaflets and publications which can be used at community events and support groups.
+ We have an active social media presence with prompt replies to any questions raised via that platform.
+ We have a user friendly website which contains a database of all services in the area – with the opportunity for local people to leave feedback on the service they have received.
+ We will meet anyone who wishes to talk to us either in our new office by appointment or in a convenient central venue.



Seldom heard groups

People in seldom heard groups face multiple barriers when accessing health and social care services, this could be due to their mental health, disability issues or language barriers to name a few.

We will tailor our service to meet the needs of these groups in a variety of ways, for example we meet on a weekly basis with members from our deaf community where we have access to an interpreter.

We will arrange home visits where necessary and we attend sessions in local libraries and GP Surgeries where residents may have mobility issues.

We use venues which are familiar to our clients and helps with any anxiety issues they may have.

Doing for others is such a special art – and deserves a thank you directly from the heart! – To Anne with love and many thanks Judy

Making a difference together

How your experiences are helping to influence change

We share appropriate intelligence with strategic partners to influence the planning of statutory NHS and social care services ensuring the information gathered is used to improve services. Some times the change can appear to be something minor but has a big impact on the service for example;

+ One doctors surgery is now stocking probes as a matter of course, as one of the complaints we were involved in raised this as an issue.
+ Due to a high volume of complaints against a particular ward, the Trust looked at the staff which were managing the ward and made changes. Replacing staff with a more experienced team. The patients are now having a completely different experience.

We work together on larger issues to form working groups to gather information and perform needs assessments.

+ Healthwatch Rotherham identified that there was no (statutory) Autism strategy in place for Rotherham and are now working with RMBC and Rotherham NHS CCG on the Autism All Age Strategy.
+ Healthwatch Rotherham attend regular monthly and quarterly meetings covering a whole range of health matters these include Patient Experience, Engagement and Communications, Contract and Services Improvement, Living with Cancer and Beyond.
+ Healthwatch Rotherham also work to promote health related campaign on social media linking in with local and national campaigns on issues such as Dementia, Mental Health, Oral Hygiene, Diabetes and Learning Disabilities.

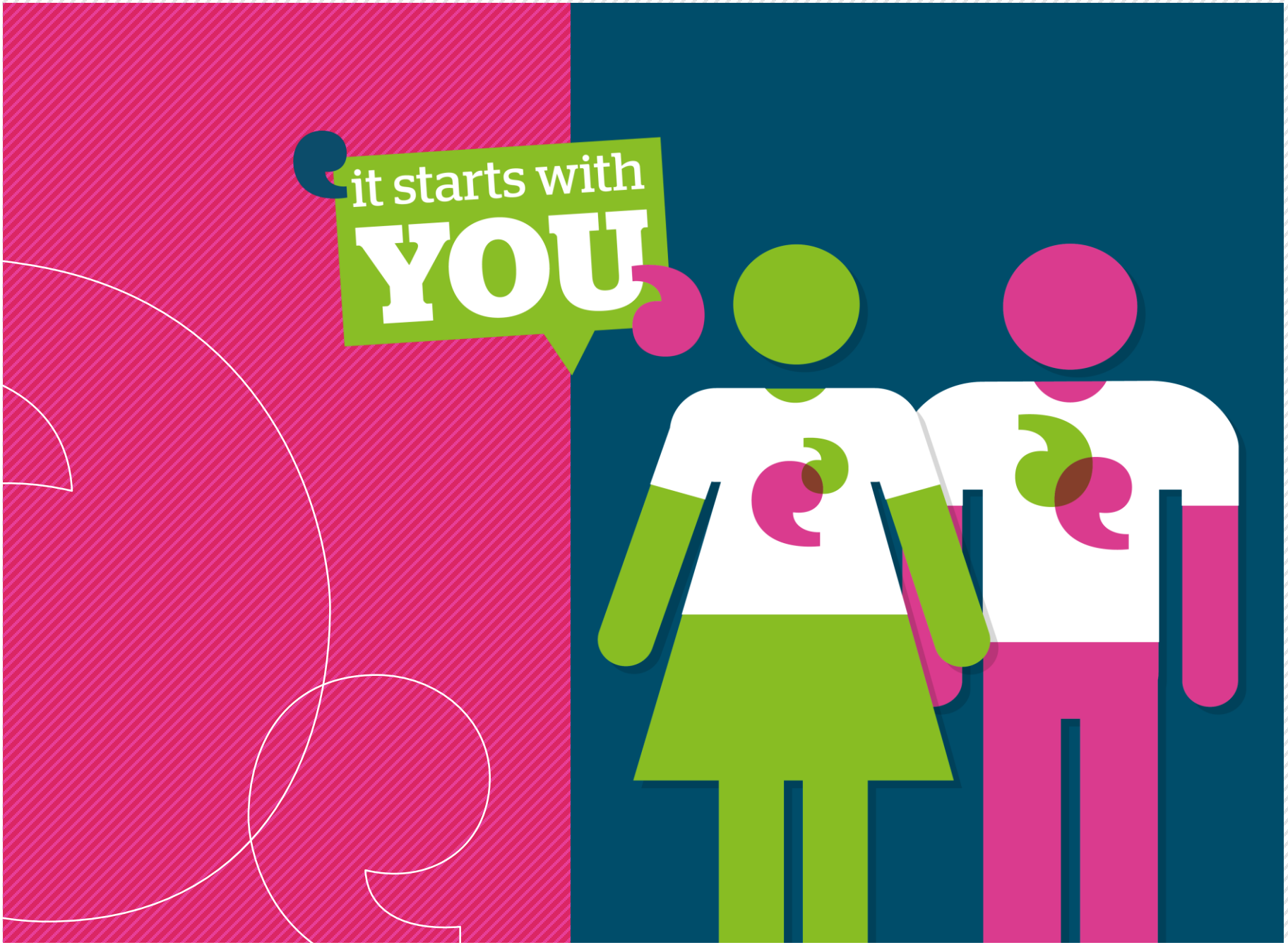
> Knowing that I have been listened to and someone else will not have to have the same experience that I did makes me happy. - Mr W (Adult Advocacy Case)

Working with other organisations

We work with many different organisations in our locality including statutory services and voluntary and community groups – all play a vital role in helping us to gather information and shape the way that future services are delivered whilst ensuring the services which are currently being delivered as good as they possibly can be;

+ We have an active working relationship with the Care Quality Commission (CQC) which has allowed information and evidence to be shared.
+ This relationship has allowed us to provide feedback which supports local CQC monitoring, inspection and regulatory activity.
+ Our work with the CCG enables us to pass on views and experiences of residents which help to shape how services are commissioned and delivered locally.
+ We sit on the Health and Wellbeing Board, where we feedback the health and wellbeing needs of local people.
+ We work with local groups especially the hard to reach including the deaf community and parents forum, taking the time to meet regularly.
+ We work with Rotherham Council, Public Health, The Rotherham Foundation Trust, RDasH and CAMHS on a daily basis covering a variety of matters.

> With the help and support of Healthwatch Rotherham I was able to get a female interpreter to come along to my GP appointment on a sensitive issue - Anna


it starts with
YOU

“Mr Mace became an advocate for our family and we realised that this kind of service is invaluable - we highly recommend this service and cannot thank Mr Mace and Healthwatch Rotherham enough” - Steve & Sue

#ItStartsWithYou

The patient or service user is always at the forefront of any action or meeting that we arrange and it will always be their decision if the reply to any complaint is acceptable and meets their needs.

Case Study - Steve, Sue & their daughter

Hayley is an energetic 9 year old who has Cerebral Palsy, the only way for Hayley to get around is by using a wheelchair. Towards the end of 2016 Hayley was outgrowing her current wheelchair and arrangements were made for a review.

After the assessment Hayley was supplied with a new Invacare wheelchair, which did not meet her needs, it was heavy and cumbersome and did not allow her the freedom her previous Quickie wheelchair had. Hayley's parents were told that there was no budget to provide the more expensive wheelchair which met Hayley's needs and that the NHS only needed to provide a basic chair.

Unhappy with this decision Steve and Sue contacted Healthwatch Rotherham and our advocate took on the case.

A letter of complaint was sent to The Rotherham NHS Foundation Trust (TFRT) explaining the problems, and an unsatisfactory reply was received. From this Steve Mace arranged for Hayley and her parents to meet with representatives from TRFT including Occupational Therapist and Wheelchair Services.

At the meeting it was clear to see the chair with its current set up was not appropriate. A full reassessment of Hayley's needs took place shortly afterwards. The Trust and CCG then agreed to provide Hayley with the correct chair for her needs.

Here is what Steve & Sue said about the service;

“After struggling with accessing a suitable wheelchair for our daughter who is 9 years old, we approached Healthwatch Rotherham. Mr Mace became an advocate for our family and we realised that this kind of service is invaluable. After following the complaints procedure she has now received the essential well fitting wheelchair that she needed. We cannot thank Mr Mace and Healthwatch enough and highly recommend this service”

“Very respectful, quick response, kept me informed, friendly, nothing too much trouble, phoned me when it was convenient and worked with me”

#ItStartsWithYou

To make the biggest difference we need to hear from people.

No matter how big or small the issue is, if it affects your health and social care, we need to know about it.

Case Study – Karen

Karen is a young person who relies on medication for her condition.

Normally when Karen gets low on her medication she will contact her consultant via email who will then issue a prescription which Karen collects. This has been the case and run smoothly until September 2017.

Karen had problems with the pharmacy which was issuing the prescription when she telephoned them to see if the prescription was ready to be collected the pharmacy assistant was very rude and she then received another call from them to say they could only fill part of the prescription. When Karen questioned how the remainder of the prescription would be dealt with and how would they expect payment (i.e. full payment on receipt of the initial part or full payment when the remainder was available) the assistant was very condescending.

Karen contacted Healthwatch Rotherham as she was unhappy with the way that she had been spoken to. She felt the way the assistant had conducted herself was not right and that she deserved better treatment. Karen was also concerned that if this went unrecorded another customer would also get the same experience.

Michael Horne one of our Advocacy Officers took on the case and worked with Karen to draft a complaint letter to the pharmacy concerned.

On receipt of the letter the pharmacy contacted Healthwatch and Karen immediately and apologised for the service which she had received. This was followed by an official written apology from the manager of the pharmacy concerned. Assuring Karen that the correct measures, training and action would be taken to ensure there was no repeat of the situation in future.

Karen accepted the apology and was happy that her complaint had been treated seriously and dealt with in a swift and efficient manner both by the pharmacy concerned and Healthwatch Rotherham.

“I am already partially sighted due to being blind in one eye, so when I had problems with my good eye I expected a quick visit to A&E would get me back on track”

#ItStartsWithYou

By sharing your experiences you can help services hear what works and what doesn’t and how care could be better in the future.

Case Study - Dorothy

Dorothy is part of our aging population and as such requires her senses to be working as well as they possibly can to help her to remain physically and mentally active which in turn helps with her mental well being.

Being partially sighted is something which Dorothy has made adjustments for around her home and in her daily duties. She is blind in one eye, so she heavily relies on her “good eye” to get around.

So when she began having a problem with her “good eye” one Saturday morning, she rang the NHS out of hours service for advice and an appointment was quickly made for her to attend the A&E unit at Rotherham.

Upon arrival at A&E Dorothy was quickly seen by a GP and prescribed medication to clear up the infection. Dorothy left the hospital with the prescription and attended her local pharmacy – who didn’t have the item in stock. As the medication was essential Dorothy decided to get the prescription fulfilled at another pharmacy.

After trying several pharmacies in the area, Dorothy discovered that the medication that she required was only available to order and would be 48 hours before it reached the pharmacy. If the GP in A&E had issued the prescription to the hospital pharmacy it could have been dispensed immediately saving the stress and worry and ensuring immediate relief.

Dorothy contacted Healthwatch Rotherham and an Advocacy Officer took up the case. As a result of the involvement of Healthwatch Rotherham the A&E department have now changed their procedure so prescriptions are now routinely made out for the hospital pharmacy, unless otherwise requested by the patient.

“A referral made to Child and Adolescent Mental Health Services, it was rejected, with no explanation, assessment or consultation”

#ItStartsWithYou

There are always going to be people who are unhappy with the outcome but often if they feel that they are being listened to and the procedure or decision taken was the right one at the time they will accept it.

Case Study – Jane

Jane contacted Healthwatch Rotherham in February 2018 as she felt she had been unfairly treated by the CAMHS service. Despite a referral being made to CAMHS from another service regarding her child, it had been rejected with no explanation.

Jane was left with no support and no idea who to turn to for help and advice, when another parent pointed her in the direction of Healthwatch Rotherham. Jane made the initial contact and our Children and Young Peoples Advocate took up the case.

After an initial meeting with Jane and her partner it was clear to see this was a multi layered case with numerous issues that needed to be looked into.

Several agencies and organisations had been involved with the family in recent times and different conclusions had been drawn regarding the way forward. None of these agencies were communicating effectively with one another and no one was informing the family of action being taken and the next steps. This was adding to the stress and wellbeing of the whole family who were being affected by the childs behaviour.

Our advocate arranged a meeting with CAMHS and raised the issue, a letter was then sent to Jane giving reasons why the referral had been rejected in the first instance. This was raised as in issue with CAMHS that they are not communicating with parents on the reasons why a referral is rejected.

Once Jane had received the letter giving the reasons for the rejection is was immediately obvious that a vital part of information had been missed from the original referral. Following a meeting with Jane, CAMHS and Early Help the case was reviewed and the referral was accepted.

As a result of advocacy and support from Healthwatch Rotherham CAMHS agreed to move forward with an assessment for the child for autism spectrum disorders. They also agreed to review and improve their communication with both parents and other service providers.

Our plans for next year

What next?

Our plans for 2018/19 will see us concentrating on meeting the challenges which we have outlined in our top priorities.

Working with partners we will strive to complete the work on an All Age Autism Strategy for Rotherham which was initiated after Healthwatch Rotherham highlighted gaps in services and provision.

To continue to provide a high standard of advocacy support, for which we are seeing an increasing demand. We successfully dealt with 136 cases this year which is a 17% increase on the previous year.

We will work with the CCG ensuring that the implementation of the Integrated Care System becomes fully operational and "does what it says on the tin" making a positive difference to our residents in the way that they receive health and social care.

We will continue to invest in our staff, providing opportunities for both professional and personal development by identifying training and development needs and establishing individual action plans.

Our top priorities for next year

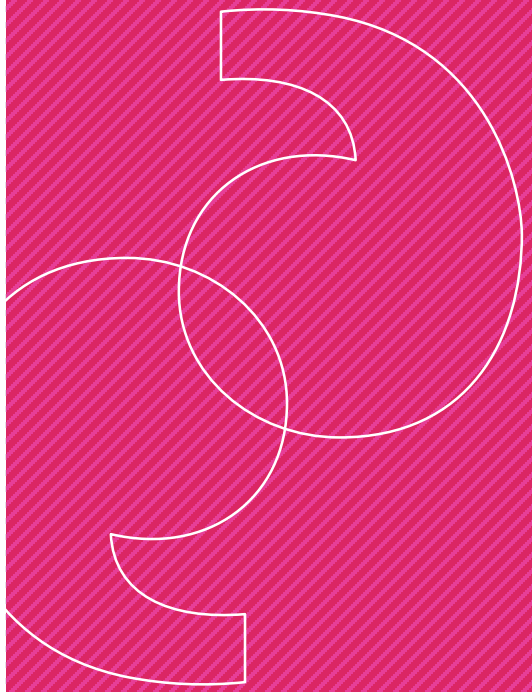
1. To successfully implement an All Age Autism Strategy.

2.Maintain the quality of advocacy support in the face of increasing demand for the service at a time of budget cuts.

3. Stay in touch with the implementation of the Integrated Care System.

4. Staff training and development.

Our people



Volunteer with us

Help make a difference to the health and care your community receives.

healthwatch

Thank You

To all our amazing volunteers who help make a difference to health and care.

healthwatch

Decision making

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

How we involve the public and volunteers

Our board is made up of volunteers who have been selected due to their skills and experiences. Our board for 2017/18 consisted of

+ Joanna Saunders (Chair)
+ Karen Biddle (resigned October 2017)
+ Naveen Judah (joined October 2017)
+ Chris Smith
+ Sue Barratt
+ Catherine Porter
+ Phil Taylor
+ Paul May

We have been supported in our administration tasks for a large part of the year by our champion volunteer Wendy Colgrave who is currently taking a break whilst she recovers from an operation. Thank you Wendy, we miss you and wish you a speedy recovery.

Unfortunately due to budget cuts we lost our Children & Young Peoples Engagement Officer early in the year and we were unable to continue our Young Volunteer/Ambassador Scheme. We still have regular contact with our young volunteers and it is amazing to see how they have grown and how much the scheme helped them to progress.

Our Finances

Income	£
Funding received from local authority to deliver local Healthwatch statutory activities	174,150
Additional income	26,375
Total income	200,525
Expenditure	**£**
Operational costs	29,002
Staffing costs	133,307
Office costs	17,808
Total expenditure	180,117

The views and stories you share with us are helping to make care better for our local community

Mike Smith
Healthwatch Volunteer

Contact us

Get in touch

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Phone number:	01709 717130
Email:	info@healthwatchrotherham.org.uk
Website:	www.healthwatchrotherham.org.uk
Twitter:	@HWRotherham

Our annual report will be publicly available on our website by 30 June 2018. We will also be sharing it with 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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Adult Social Care Vision
2017–2020

Every adult secure, responsible and empowered

Rotherham
Metropolitan
Borough Council

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1 Foreword

As Lead Member for adult social care in Rotherham Council I am pleased to introduce our approach to independent living, which underpins the adult social care Vision for Rotherham. It provides a vision for adult social care based on three key themes:

THEME 1	**Act to help yourself**
THEME 2	**Act when you need it**
THEME 3	**Act to live your life**

By focussing our actions and efforts on these three key themes I believe will allow us over the next three years to strengthen and support the care and support that we provide to residents and their carers in Rotherham.

We believe that the best social care can only become a reality if we further support the residents of Rotherham to have control over how they manage their social care needs, with a strong emphasis on the use of personal and community assets and working in partnership in a way that is financially sustainable in the medium and long term. Strong partnerships will be the best way to deliver support which allows our residents to have full and valued lives.

Our approach demands that we make the best use of our collective resources, as all of our residents expect us to provide fair, safe and affordable care which represents good value for the Rotherham pound. Linked to this vision we will develop an outcomes framework to check out our performance so that we are all confident that both the quality and supply of our support and care is right.

All of this will be secured by a commitment to safeguard anyone who needs specialist support and at all times to show respect and dignity for those we work with.

I hope that you will step up to make our vision and approach a reality so that we can all celebrate and enjoy an independent life in Rotherham.

Councillor David Roche
Cabinet Member for Adult Social Care and Health

2 Our Vision for Active Independence

Our vision for adult social care in Rotherham is:

'We will act together to support the residents of Rotherham to live full active lives; to live independently and to play an active part in their local communities'.

Rotherham Council works closely with partners across health services, including public health, and within the community and voluntary sector to ensure that we deliver the best possible outcomes for our residents. Our vision for adult social care supports the delivery of Council Plan priorities, in particular, 'Every adult secure, responsible and empowered'.

Our Values for 'Active Independence' are:

Focus on the Person	We will encourage people to recognise their strengths in a way that supports choice and control and ensures a personalised approach to safeguarding
Best Value	We will make the best use of our collective resources to get maximum value for the residents of Rotherham at a sustainable cost
Quality	We will make sure that people receive good quality support, which meets their needs in a way that it is timely and safe
Working Together	We will work creatively with partners and communities, empowering them to deliver the best possible outcomes so that people can live well

3 Why we need to change

Adult social care makes a unique and distinctive contribution to society in Rotherham by ensuring that vulnerable adults are protected and those with support needs are able to live full, active and independent lives in their local communities. However, adult social care services across the country face unprecedented challenges caused by a rapidly increasing population, increasing costs and demand, and the requirements of the Care Act, 2014.

In 2016 there were approximately 262,000 people in Rotherham (National Statistics), with 205,300 people aged over 18. The majority of the population (91.9%) in Rotherham were of White British ethnicity (source 2011 Census), with the largest minority ethnic group being Pakistani and Kashmiri. Both male and female life expectancy in Rotherham are below the England average and life expectancy is 9.5 years lower in the most deprived areas compared with those least deprived.

Projections from 2016 to 2020 suggest that the number of people aged 65 and over will increase by 6% to 53,540 and the number of people over 85 will grow by 10.6% to 6,556.

Based on projected population growth, spend will increase by about £2.5 million between 2016 and 2020 if current demand for care stays the same. Adult social care in Rotherham will need to continue to build and strengthen its operating model and offer to reconfirm its commitment to supporting adults and carers in a person-centred way and within a shrinking financial envelope.

A large proportion of the challenge relates to increasing numbers of older people, which means there will be more people developing long term conditions which need more complex support. This increase means there will be a substantial spike in costs and we will need to strengthen how we operate to manage the increased demand. This will continue to be based on a shared responsibility between the Council, the community and the resident. The three themes we have adopted are key to the delivery and measurement of the success of our approach.

In 2016/17 around 6,250 people received care and support provided by Rotherham Council. The Council spent approximately £105 million on adult social care services, with around 1,550 people receiving care in residential accommodation during the year. At national level, social care budgets have reduced by 8% in real terms over the last 4 years. To continue to deliver support and manage demand, we have to strengthen our operating model and our offer in Rotherham.

The Care Act, 2014, represents the single biggest change to social care legislation in decades. Rotherham adult social care is working to promote more responsible choice and control to support a way that enhances active and independent communities.

The purpose of this Vision is to acknowledge the national and local context of shrinking resources and increasing demand, which are some of the factors that have shaped this Vision, and the framing of a strengthened adult social care operating model and offer.

The Vision sets out the Council's three key themes, identifies the improved outcomes we want to see and looks at how we will measure success. It provides the road-map for continued adult social care over the next three years. This will ensure that all residents are encouraged to recognise their strengths, build their independence and identify the support that their family, friends and local community can give them, based on three key themes:

THEME 1	**Act to help yourself**
THEME 2	**Act when you need it**
THEME 3	**Act to live your life**

The Vision fits with the common vision and ambitions in the Rotherham's Health and Social Care Place Plan, which sets out 5 key joint initiatives with partners to champion prevention, independence and place people at the centre of their own care and support. In doing so both visions aim to first improve and then transform the care system, reducing demand and achieving financial sustainability, whilst providing Rotherham people with better services and a better quality of life. Local Government has a place shaping role and we must use this mandate to have new and different conversations with our residents and our communities to ensure that Rotherham can continue to thrive.

4 Our Approach and Offer

Our approach is based on early intervention and self-management, delaying the need for formal care and reducing the demand for adult social care input - and not just waiting for people to reach crisis.

Our offer is based on fundamental principles of:

- **Self-determination:** each person should be in control of their own life
- **Direction:** each person should have their own path and purpose to give their life meaning
- **Money:** each person should have enough money to live an independent life
- **Home:** each person should have their own home, living with people they choose
- **Support:** each person should get the right support that helps them to live their own life
- **Independence:** each person should have the opportunity to learn or regain their skills
- **Community Life:** each person should be able to participate fully in their community
- **Rights:** each person should have their legal and civil rights respected
- **Responsibilities:** each person should take responsibility in their own lives and contribute to their community
- **Assurance:** each person should have confidence in the quality of services the Council commissions or provides itself

Our offer has a number of key commitments which we will make to adults and carers in Rotherham.

We will:

- Listen carefully to understand what makes a good life for you
- Communicate clearly and in a way that is best for you
- Listen to and value what you, family, friends and your community say
- Intervene to facilitate solutions
- Work with you at a pace that is right for you
- Actively engage with our local communities and partners to develop alternative solutions for you
- Work with you to manage risk in a positive way and keep you safe
- Work with you in a fair way with the resources we have.

THEME 1	**Act to help yourself**

We want to promote personal responsibility and for people to have opportunities to become a greater part of their community through increased opportunities for socialising, gaining personal recognition and building relationships, whilst remaining in their own homes and communities for as long as possible.

We will:

- Improve access to information and advice about care and support
- Promote access to 'universal services' which are available to all residents
- Provide support in the community to help people to live active and independent lives, including shaping the quality and capacity of the care market and the voluntary and community sector
- Work with our health partners to identify people most at risk of needing support from adult social care in the future and intervene as early as possible, to help them stay healthy and prevent the need for future support. Our work will strengthen the use of information and advice and technology enabled care.
- Work in partnership to develop interventions that reduce the need for support such as personalised advice, advocacy, peer networks and intergenerational opportunities
- Support carers to maintain their caring role and stay well. We will review our support for carers, especially those providing significant unpaid care or those caring for people with dementia and commission support that is appropriate for their needs

This means:

- I know where to find information about social care services and how to get advice and support when required
- I am helped to remain as independent as possible in my own home for as long as possible
- I am supported as a carer to maintain my caring role and look after my own health.

The delay of the development of long term care needs by targeting support at those who have experienced a recent crisis or acquired an illness or disability is theme 2 of our operating model.

THEME 2	**Act when you need it**

The delay of the development of long term care needs by targeting our support at those who have experienced a recent crisis or acquired an illness or disability is theme 2 of our operating model.

We will:

- Target intensive support through our Assessment and Reablement Service to assist people to recover quickly, regain and retain their independence.
- Work with partners in health and the voluntary and community sector to provide short term support with no assumption of long term support to people who are at risk of losing their independence
- Help people living with health conditions to plan for their future
- Use personal aids such as equipment and assisted technology to regain or maintain a person's independence

This means:

- I will only receive support for the time I need it to regain my independence
- I will recover quickly and regain my social life with family and friends within my own community
- I will be able to plan my future.

THEME 3	Act to live your life

This means looking at what an individual can do for themselves with the support of their existing family networks or community and what they might need help with. This is theme three.

We will:

- Provide a personal budget for those who are eligible for Council support.
- Help people to identify and develop their strengths and increase independence by working with their family and community networks, where possible
- Be responsible with public money and ensure best value when we purchase or commission services
- Support our staff to develop the right skills and knowledge to enable them to be innovative and creative when helping someone
- Develop support plans that build on a person's strengths and the goals they want to achieve rather than creating dependency

This means:

- I manage my own care and support via a personal budget that provides the right amount to meet my needs
- I receive flexible support
- I am helped to remain as independent as possible in my own home for as long as possible.


BREAKFAST

Case Study – **Mandy**	Theme 1 Act to help yourself	Theme 2 Act when you need it	Theme 3 Act to live your life
Mandy is a 23 year old woman with a diagnosis of Autism and Anxiety, who lives at home with her mum and dad. She attends the local college 2 days a week and has just started attending ADPRO Employment Service. Mandy's mum meets all her care and support needs and they are both happy with this arrangement. During the Care Act assessment, Mandy said she wanted more access to the wider community and to 'make new friends' outside of the family home and education. Mandy was also keen to become more independent. **What came out of the different conversation?** Spending time and getting to know Mandy meant a better picture of her skills, capabilities and interests was gained. She was linked in with a local service provision for people with Autism. Mandy is happy with this service and is able to access a wide range of activities and events alongside her peers. Mandy found that some of her friends from college already attended the group and this has given her the confidence and self-esteem to make new friends. Mandy's mum said "they wished they had found this service years ago". Mandy will be able to slowly develop her confidence travelling. She will link in with the travel buddies in time to develop her independence in this area. **Benefits and Savings** o Development of a more varied routine, led by Mandy's interests. o Access to a community asset. o Increased social network with peers. o Increased confidence in accessing new things o Opportunities to develop independence outside of the home environment.	✓		✓

Case Study – **Aazar**	Theme 1 Act to help yourself	Theme 2 Act when you need it	Theme 3 Act to live your life
Aazar is a 52 year old man from Afghanistan, who has been granted Asylum status in the UK. Aazar is disabled, suffers from depression and anxiety, and is going through the emotional trauma of being separated from his wife and children, who are still in Afghanistan. **What came out of the different conversation?** Aazar is a very articulate gentleman who enjoyed talking about his personal interests. Aazar explained he wanted to engage in more activities in order to boost his self-esteem. During the Care Act Assessment, Aazar spoke about wanting to improve his health due to high cholesterol, however, he could not find a reasonably priced or disabled access gym. A search on the Connect to Support website identified Jason at Active Regen, who runs fitness sessions aimed at those with physical disabilities. Jason has since met with Aazar and is providing fitness sessions in his home every week. This is having a positive impact on both Aazar's physical and emotional wellbeing. **Benefits and Savings** With the community support in place for Aazar, he will not require an increase in his service provision. It is hoped that these community assets will give Aazar a greater connection with the local community in Rotherham and therefore have a significant impact on his wellbeing.	✓	✓	✓

Case Study – **John**	Theme 1 Act to help yourself	Theme 2 Act when you need it	Theme 3 Act to live your life
John is an 84 year old man, living in supported housing. John had been a professional footballer and had been very active for his age until, unfortunately, his cognition deteriorated following a diagnosis of dementia. His family requested a social care assessment as they lived away and were concerned about how he was coping at home alone. **What came out of the different conversation?** The Care Act assessment identified that through meals delivery and spending time with his sister, John was able to continue to live an independent life. John shared that he previously enjoyed attending memory clinics in the local community and felt this would be something he would like to do again. Through utilising local community assets, a sporting memories group was found at the local football stadium. John was pleased about this and felt this was something he would like to try as he could share his lived experiences playing professional football. John attended the group and thoroughly enjoyed it. **Benefits and Savings** With the community support in place for John, he will not require an increase in his service provision. It is hoped that these community assets will give John a greater connection with the local community in Rotherham, and therefore have a significant impact on his wellbeing.	✓	✓	✓

5 Making Change Happen

Strengthening the way adult social care operates in Rotherham will require committed and enthusiastic leadership within the Council to strive for the successful delivery of excellent adult social care:

A focus on community, early help and prevention

We are fundamentally changing the way we work across the whole system. This requires a strong partnership approach and significant joint effort in empowering resilient communities to develop and release their resources to support and include vulnerable people in community life. At the core we will be taking a strengths-based approach, helping more people to help each other and themselves.

A focus on the Customer Journey

The Customer Journey will change as a result of the three theme approach to independence. The current Customer Journey is fragmented and involves multiple contact points which can be confusing and can take time to navigate. The strengthened Operating Model will improve the experience for residents and partners. A quick response and reduced contact points means that the Customer Journey will be streamlined and efficient, offering support in the right way.

A focus on innovative commissioning

The Vision requires a different approach to commissioning. An approach that utilises intelligence, works closely with operational adult social care, partners, providers, community and service users to understand demand, to stimulate and co-design the market to provide services that best meet these needs and maximise independence and wellbeing.

Leadership and Governance:

In order to deliver the Vision and the underpinning Operating Model, it will be essential that there is strong political and officer leadership and effective executive and officer support to ensure the operational model becomes a reality in Rotherham. The Adult Social Care Improvement Board will provide strategic leadership and oversight.

The delivery of the Vision will require:

- strong performance management to promote improved outcomes for residents and their carers;
- a clear focus on strengthened commissioning to support improved quality;
- to ensure effective resource management and to develop an effective communication and engagement Vision so that all key partners remain involved and fully contribute.

The Vision and its implementation will be supported through the established project management process. Robust governance, scrutiny and accountability processes are in place. The Health and Wellbeing Board will be key sponsors of this Vision and the Joint Strategic Needs Analysis will be used to refresh and update the Vision on an annual basis.

Local people who access services, based on their experience, working with commissioners will ensure that the key performance indicators measuring success are both reported on and delivered against. These measures will be linked to the adult social care Outcomes Framework.

In addition to this strategic drive we will develop leadership at all levels and especially in the front line where our managers will support staff to deliver the highest quality of support planning and care

Strong partnerships:

Continued and improved joint working between the full range of statutory, voluntary and community sector partners that make a significant contribution to improving the health and wellbeing of residents in Rotherham. Five key joint initiatives in the Health and Social Care Place Plan are championing the change required, promoting prevention, independence and placing people at the centre of their own care and support.

We will work closely with GPs and primary care colleagues, secondary care providers both in community and hospital based settings and specialist providers of health care in areas such as mental health and learning disability. There is a clear requirement for care to be well 'joined up' so that an individual has a clear support plan supported by all the partners working together.

We will include Housing within our collaborative working and develop an Accommodation and Support Vision with commissioners.

This will:

- ensure more people remain at home and within their own community, if that is their choice; and
- enable more people to have an early transfer from hospital through the availability of more flexible specialist housing;
- harness the full potential of assisted technology to enable people with care and support needs to remain living safely in their own homes.

We will make our approach happen by working at 4 levels:

- Individual Practice Level: working in a different way to help individuals and their families to find solutions that build on their strengths and assets
- Solution Level: shaping flexible responsive solutions which empower and are delivered in new and innovative ways
- Community Level: harnessing the strength of resilient individuals, families and communities
- Whole: celebrating that the solution design will be working collaboratively with colleagues in the wider public, voluntary and community and private sectors. We need to harness and lead a win-win solution across health and social care to manage demand and keep people safe and well.

Glossary

Assisted Technology	Is equipment that helps people to do what they need or want to do more easily, independently and better.
Care Act 2014	The Care Act 2014 came into effect in April 2015 and replaced most previous law regarding carers and people being cared for.
Care Market	The Care Act 2014 sets out duties on local authorities to facilitate a diverse, sustainable, high quality market for their whole local population, including those who pay for their own care, and to promote efficient and effective operation of the adult care and support market as a whole.
Census	Is a way to find and record information about every member of a population.
Commissioning	Is when the Council purchases (buys) goods or services from other organisations.
Community/Voluntary Sector	Play an important role in providing services in the community. They are non-profit-making.
Health & Social Care Place Plan	Rotherham's Health and Social Care Community has been working in a collaborative way for the past several years to transform the way it cares for its population, to provide the best possible services and outcomes for our population. The Plan details a joined up approach to delivering five key initiatives that will help us achieve our Health and Wellbeing Strategic Aims and meet the South Yorkshire and Bassetlaw's Integrated Care System (ICS) objectives.
Health & Well Being Board	Established and hosted by local authorities, health and wellbeing boards bring together the NHS, public health, adult social care and children's services, including elected representatives and Local Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health.
Joint Strategic Needs Analysis (JSNA)	Looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, well-being and social care services within a local authority area.

Office for National Statistics	Is the UK's largest independent producer of official statistics and the recognised national statistical institute of the UK. It is responsible for collecting and publishing statistics related to the economy, population and society at national, regional and local levels. It plays a leading role in national and international good practice in the production of official statistics.
Operating Model	Is how an organization delivers value to its customers, as well as how an organisation actually runs itself.
Performance Management	Includes activities which ensure that goals are consistently being met in an effective and efficient manner. Performance management can focus on the performance of an organization, a department, employee, or even the processes to build a product or service, as well as other areas.
Personal Budget	Is money from adult social services to pay for the services people need. This gives better choice and control to people about their care.
Primary Care	Is the first place people go to when they have a health problem and includes a wide range of professionals, eg GPs, dentists, pharmacists and opticians.
Reablement	The active process of regaining skills, confidence and independence after injury or illness
Secondary Care	Means being taken care of by someone who has particular expertise in whatever problem a patient is having. It's where most people go when they have a health problem that can't be dealt with in primary care because it needs more specialised knowledge, skill or equipment than the GP has. It's often provided in a hospital. The GP will decide what kind of specialist the patient needs to see and contact them on the patient's behalf to get them an appointment – this is called a 'referral'.

House of Commons

Health and Social Care Committee

Integrated care: organisations, partnerships and systems

Seventh Report of Session 2017–19

Report, together with formal minutes relating to the report

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Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health & Social Care.

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Committee reports are published on the Committee's website at www.parliament.uk/hsccom and in print by Order of the House.

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Summary

It is one of the greatest triumphs of our age that people are living longer. Many more of us are doing so with complex health and care needs, including multiple long-term conditions. To meet these needs, people rely on a range of health and care services, which are mostly public but also provided by non-statutory services (charities, social enterprises, community services and private providers), as well as dedicated informal support from families and carers. If these services and sources of support don't join up, don't share information, are not coordinated and fail to put the individual front and centre then this can not only result in a poor experience, but risks health problems escalating and an inefficient use of increasingly stretched resources.

Integrated care is about providing a more holistic, joined-up and coordinated experience for patients. Whilst there is not sufficient evidence that integrated care saves money or improves outcomes in the short term, there are other compelling reasons to believe it is worthwhile.

As health spending across the developed world looks set to consume an increasing share of GDP in the years ahead, integrated care provides a way of getting more value out of the resources we put in and a better experience for those who use services. There have been positive early signs from the new care models about the benefits more integrated health and care services can bring to patients.

Our inquiry

Whilst there have long been efforts to join up services at local and national level, our inquiry explored the development of new integrated ways of planning local health and care services (sustainability and transformation partnerships and integrated care systems) and delivering care (integrated care partnerships and accountable care organisations), which have arisen out of the NHS Five Year Forward View.

We support the move away from a competitive landscape of autonomous providers towards more integrated, collaborative and placed-based care. However, understanding of these changes has been hampered by poor communication and a confusing acronym spaghetti of changing titles and terminology, poorly understood even by those working within the system. This has fuelled a climate of suspicion about the underlying purpose of the proposals and missed opportunities to build goodwill for the co-design of local systems that work more effectively in the best interests of those who depend on services.

Sustainability and transformation partnerships and plans

Sustainability and transformation partnerships (STPs) got off to a difficult start, with limited time to forge relationships, develop plans and make difficult decisions about changes to local health and care services. National media coverage of "secret plans", "developed behind closed doors", reflected the poor communication between local bodies and their communities. This, along with accusations that STPs were a smokescreen for cuts, tainted the STP brand.

The STP process has moved on since the original plans were published in December 2016, with the emphasis now firmly on the performance of the partnerships, rather than the delivery of their plans. The 44 partnerships are now at different stages in their journey towards further integration as integrated care systems (ICSs). Systemic funding and workforce pressures affect almost every area. Some areas have made considerable progress in light of these pressures, but those furthest behind are struggling with rising day-to-day pressures let alone transforming care.

Integrated care systems

ICSs are more autonomous systems in which local bodies take collective responsibility for the health and social care of their populations within a defined budget. A cohort of 10 ICSs, made up of the leading STPs, is currently paving the way for other systems. While these areas have made good progress in difficult circumstances, they are still nascent and fragile.

Accountable care organisations and integrated care partnerships

Integrated care partnerships (ICPs), alliances in which providers collaborate rather than compete, are becoming increasingly prevalent across the NHS, often building on the new care models programme and pre-existing collaborations between services. Two areas have expressed an interest in using an Accountable Care Contract to formalise their partnership into single organisations known as accountable care organisations (ACOs).

Public debate about the introduction of ACOs into the English NHS has been confused by concerns, mostly stemming from organisations with origins in the US which are different but also called ACOs. The main concern is the possibility that these new contracts might extend the scope of private sector involvement in the NHS. Based on our assessment of the evidence, this looks unlikely in practice but steps could and should be taken to reassure the public on this point.

There have also been misleading statements seeking to link ACOs, as proposed in England, with people having to pay for healthcare as in the US. There is no evidence that ACOs will lead to a dismantling of the fundamental principle that the NHS is free at the point of delivery.

The ACO model will entail a single organisation holding a 10–15 year contract for the health and care of a large population. Given the risks that would follow any collapse of a private organisation holding such a contract and the public's preference for the principle of a public ownership model of the NHS, we recommend that ACOs, if introduced, should be NHS bodies and established in primary legislation.

Before this can happen, there are critical questions remaining, particularly whether using an ACO contract to merge services into a single organisation accelerates integration and improves outcomes for patients. Therefore we recommend that ACOs should be subject to careful evaluation.

Removing barriers to integrated care

The legal barriers and fragmentation that arose out the Health and Social Care Act 2012 will need to be addressed. A hung Parliament can make more comprehensive review and revision of legislation difficult, but all sides should work together to try to find agreement which allows for the joining up of services on which people depend.

Simon Stevens, head of the NHS and architect of the Forward View, has described these changes as the greatest move to integrated care of any western country. However, as yet, the scale of this ambition has not been matched by the time and resources required to deliver it. Countries that have made the move to more collaborative, integrated care have done so over 10–15 years and with dedicated upfront investment.

Transformation remains key to sustainability. We have seen and heard of examples of local areas which have made excellent strides forward in difficult circumstances. What is now required is the dedicated national financial and leadership support to enable the NHS to transform at pace. Too often plans are constrained by the upfront funding needed to make them effective.

The NHS is currently in survival mode, with NHS providers struggling to recruit, train and retain staff and balance their books, while maintaining standards in the face of relentlessly rising demand. A long-term funding settlement and effective workforce strategy are essential not only to alleviate immediate pressures on services, but to facilitate the transition to more integrated models of care.

Priorities for change

The Government's announcement of a long-term funding settlement is welcome. As the NHS turns 70, we recommend the Government and national leaders use this opportunity to improve the delivery of joined-up services. The Government and national leaders should:

a) Develop a national transformation strategy backed by secure long-term funding to support local areas to accelerate progress towards more collaborative, place-based and integrated care;

b) Commit to a dedicated, ring-fenced transformation fund;

c) Explain the case for change clearly and persuasively, including why it matters to join up services for the benefit of patients and the public.

d) Alongside these changes, the Government should facilitate national bodies to work with representatives from across the health and care community, who should lead in bringing forward legislative proposals to overcome the current fragmentation and legal barriers arising out of the Health and Social Care Act 2012. These proposals should be laid before the House in draft and presented to us for pre-legislative scrutiny.

Our report sets out several areas where we feel legislative change may need to be considered, including:

- a statutory basis for system-wide partnerships between local organisations;
- potential to designate ACOs as NHS bodies, if they are introduced more widely;
- changes to legislation covering procurement and competition;
- merger of NHS England and NHS Improvement; and
- Care Quality Commisssion's regulatory powers.

It must however be kept central to all the plans to create and develop new regional and local structures, partnerships and contracts that these are a means to achieve more coordinated, person-centred and holistic care for patients, particularly patients with long-term conditions.

1 Integrating care for patients

1. The term "integrated care" means nothing to most people. It is also poorly defined. National Voices, a coalition of charities focused on giving people greater control over their health and care, told us that a review of the evidence on integrated care found 170 definitions.[1] Patients and the public, Don Redding, Director of Policy at National Voices, explained:

> […] want to feel that their care is co-ordinated, that the professionals and services they meet join up around them, that they are known where they go, that they do not have to explain themselves every single time, and, therefore, that their records are available and visible.[2]

2. Patients and the public not only expect care to be integrated, but they believe this is already the case and are surprised when they encounter problems. Kate Duxbury, Research Director at Ipsos MORI, a polling company, told us:

> If you say to a person that a hospital might not have access to their GP records and vice versa, they are very surprised about that and will assume it is already happening.[3]

3. The public are often unaware of the divides between health and social care services, whether that be primary and acute care or NHS and social care. For example, a patient receiving homecare from their local authority is just as likely to think that the service is provided by the NHS.[4]

4. A shared commitment signed by the Department of Health, its arms-length bodies, the Association of Directors of Adult Social Services and the Local Government Association included the following definition which expresses the essence of integrated care from a patient's point of view:

> I can plan my care, with people who understand me and my carers, allow me control and bring together services to help me achieve the outcomes that are important to me.[5]

5. As Simon Stevens, Chief Executive of NHS England, explained, integration occurs along a spectrum, across which services can be more or less integrated. Integration is not necessarily as important for every patient, but is of particular significance to people living with chronic conditions and complex health and care needs.[6]

6. Patients living with complex health and care needs and long-term conditions, together with their families and carers, may draw on a range of public and non-statutory services (charities, social enterprises, community services and private providers) , including digital services. This personalised network may be opaque to health and care services and professionals within it. This has important implications for how policymakers and

1 Q133
2 Q133
3 Q138
4 Ipsos MORI(0104) p4
5 Q151
6 Q268

local services think about integration. Dr Charlotte Augst from The Richmond Group of Charities, a collaboration of 14 leading health and care charities, told us how integration is often thought about from the perspective of the services involved, rather than patients:

> Often, I think it is only the patient and their carer who understand who is on the team. Therefore, if you do not start by asking that question, you do not understand which pharmacy, which GP, which hospital consultant and which charity are on the team and therefore what we are co-ordinating. From the patient perspective—the care perspective—it is really important to understand what it is we are trying to co-ordinate so that you are rolling it out from that end rather than from the integration end, which always starts with structures.[7]

7. From a patient's perspective, integrated care is about how patients experience the health and care services they use. Healthcare has historically been delivered in a paternalistic, siloed fashion. However, patients' interactions with healthcare services account for only a fraction of their lives. The ability of patients to manage chronic conditions themselves is therefore critical to their health and wellbeing. Adopting a more person-centred approach, in which patients are supported to manage their conditions more independently, requires a radical shift in how health and care is delivered. This would entail, as Don Redding described, services in which:

> We (health and care professionals) find out what their (patients) priorities and goals are, we work to support those, and we judge outcomes by the extent to which people can achieve good outcomes.[8]

8. Integrated health and social care has been a longstanding ambition of health policy pursued by successive governments over decades. There are three levels at which care can be integrated: patient level, service level and organisational level. The National Audit Office provide the following examples of each:

a) Integration at a patient level may consist of joint assessments of a patient's needs by multiple professionals and services.

b) An example of integration at a service level is when multiple services are brought together in one place for patients with a particular condition (e.g. diabetes).

c) Examples of integration at an organisational level include jointly commissioning services or pooling budgets.[9]

Need to define outcomes for patients

9. The remainder of this report focuses on organisational and service level integration, particularly the emerging ways in which local health and care services are being planned (sustainability and transformation partnerships and integrated care systems) and delivered (integrated care partnerships and accountable care organisations).

7 Q136
8 Q135
9 National Audit Office, Health and social care integration, HC 1011 Session 2016–17 8 February 2017, page5

10. For people relying on health and social care, 'integration' is about joining up the services they use and putting them as individuals at the centre, sharing information, working collaboratively, supporting them to manage their own health and focusing on what matters to them: their priorities, goals and aspirations.

11. It is absolutely essential not to lose sight of the patient and their families in any debate about NHS and care reform. Organisational and structural changes are merely a means to an end: the litmus test to determine whether these reforms succeed will depend on how effectively these new structures and organisations deliver better integrated care at the patient level.

12. **The Department of Health and Social Care, NHS England and NHS Improvement should clearly define the outcomes the current moves towards integrated care are seeking to achieve for patients, from the patient's perspective, and the criteria they will use to measure whether those objectives have been achieved.**

Our inquiry

Background

13. Our predecessors launched an inquiry on Sustainability and Transformation Partnerships, which was cancelled when Parliament dissolved for the General Election. We decided to resume this inquiry and launched our call for evidence in November 2017.

Focus of the inquiry

14. Before starting our oral evidence, we decided to focus our attention on the recent debates about the new forms of integrated care emerging in the NHS (particularly Integrated Care Systems, Integrated Care Partnerships and Accountable Care Organisations). Along with STPs, we have sought during this inquiry to judge the desirability of ICSs, ICPs and ACOs in policy terms, seeking to assess whether, and to what extent, they will improve health and care services for patients.

Visit to South Yorkshire and Bassetlaw

15. On Tuesday 20 February 2018 we visited South Yorkshire and Bassetlaw STP, one of the leading integrated care systems, at which we held a focus group with national and local leaders from the NHS and local government (see Annex 1 for more information about the visit).

Oral evidence sessions

16. We held three oral evidence sessions, during which we heard from stakeholders across the health and care community, including campaign groups, professional bodies and trade unions, representatives of small, medium and large charities, pollsters, think-tanks and academics, representatives of NHS providers, commissioners, and local government, along with ministers and senior officials.

17. We are very grateful to all those who gave evidence to us, both written and oral. We are also grateful to our specialist advisers, Professor Chris Ham and Dr Anna Charles of the King's Fund, and Professor Pauline Allen of London School of Hygiene and Tropical Medicine, for their advice and guidance throughout our inquiry.[10]

Legal challenges

18. During our inquiry accountable care organisations have been the subject of two judicial reviews. The first, by 999 Call for the NHS, contends that the ACO contract breaches sections 115 and 116 of the Health and Social Care Act 2012, which includes provisions for the price a commissioner pays for NHS services and the regulations around the national tariff.[11]

19. The second, by a group known as JR4NHS, disputes whether the consultation process involving the draft ACO contract was legal. JR4NHS argue that the decision to introduce regulations in February 2018 before the ACO contract itself had been consulted on effectively prejudged the lawfulness of the future contract.[12]

20. We have not during this inquiry sought to make any judgement about the legality of ACOs, or any of the other emerging forms of integrated care. These matters are for the courts to decide. Instead, as mentioned earlier, we have sought to judge the suitability of these mechanisms in policy terms: will they help local services to integrate care, maximise the use of resources and, mostly importantly, improve patient outcomes and experience.

10 Professor Pauline Allen declared the following interests: I hold a series of research grants from the Policy Research Programme of the National Institute for Health Research. The following research concerns issues of relevance to the inquiry: 1)Diverse Healthcare Providers: Behaviour in response to commissioners, patients and innovations; Professor Rod Sheaff, Plymouth University is the Principal Investigator and I am a co-investigator.

2) Understanding the new commissioning system in England: contexts, mechanisms and outcomes; Professor Katherine Checkland, Manchester University is the Principal Investigator and I am a co-investigator. 3). National Policy Research Unit in Commissioning and System Management in the NHS; Professor Stephen Peckham of Kent University is director and I am co director with Professor Kath Checkland.

Professor Chris Ham declared the following interests: The King's Fund is working to support accountable care systems in England and some of the funding for this work has been provided by NHS England. Our work on STPs was funded entirely by The King's Fund.

Anna Charles declared the following interests: The King's Fund is providing support to accountable care systems in England. This work has been partly funded by NHS England. Our work on STPs was funded by The King's Fund.

11 Accountable care organisations, Briefing paper: Number CBP 8190, 5 March 2018, page 12

12 Accountable care organisations, Briefing paper: Number CBP 8190, 5 March 2018, page 12–13

Section 1: Background on integrated care reforms

2 Progress towards more integrated care

21. Integrated care has been a longstanding ambition pursued by successive governments. As far back as 1972, a National Health Service Reorganisation white paper described the need for more coordinated care outside hospitals:

> There is a need for far more … services that support people outside hospital. Often what there is could achieve more if it were better co-ordinated with other services in and out of hospital.'[13]

22. Progress towards achieving integrated health and social care across England has been slow. Personal health budgets, integrated care pilots, integrated care pioneers, the Better Care Fund, joint strategic needs assessments and joint health and wellbeing strategies, as well as legal duties on NHS clinical commissioning groups and health and wellbeing boards to promote integration, have all been intended to bring about more integrated care.

23. The House of Lords report on the Long-term Sustainability of the NHS and Adult Social Care, published in April 2017 stated:

> system-wide integrated services were still very far from being a reality. Integration policy has been discussed for decades but it was clear from the evidence that there was a degree of frustration at the lack of progress on the integration of either funding or service delivery.[14]

24. This point was echoed by the NAO, who concluded that 20 years of initiatives to join up health and care has not resulted in integrated services across the system. Instead, "progress with integration of health and social care has, to date, been slower and less successful than envisaged and has not delivered all of the expected benefits for patients, the NHS or local authorities."[15]

25. Integrated care remains the Government's ambition. The 2015 Spending Review set a target for health and care to be integrated across England by 2020. Local areas were required as part of the Spending Review to develop plans by April 2017, setting out how they plan to achieve this objective. This work was then rolled into sustainability and transformation plans.[16]

26. The Government's mandate to NHS England in 2015/16 also set a target for 20% of the country to be covered by new care models by the end of 2017/18, rising to 50% by 2020. This objective has been rolled into successive versions of the mandate.[17]

27. Integrated care has been pursued with the triple aim of improving outcomes, improving patient experience and delivering financial savings. However, as the NAO has highlighted, there is currently insufficient evidence to demonstrate that integrated care

13 Department for Health and Social Security (1972) *National Health Service Reorganisation*: England. HMSO:London

14 House of Lords Select Committee on Long-term Sustainability of the NHS, Long-term Sustainability of the NHS and Adult Social Care, April 2017, para 90.

15 National Audit Office, Health and social care integration, HC 1011 Session 2016–17 8 February 2017, page 12

16 National Audit Office, Health and social care integration, HC 1011 Session 2016–17 8 February 2017, page 6

17 Department of Health, The Government's mandate to NHS England for 2016/17, March 2017

leads to better outcomes, financial savings or reduced hospital activity.[18] The observable benefits of integration for patient experience at an individual level have not yet translated into robust evidence that integrated care leads to better outcomes or saves money.[19] In addition, rather than saving money, more integrated care may also identify currently unmet needs, thereby adding costs in the short term.[20]

Complexities of integrating health and social care

28. The NAO concluded that slow progress over the last 20 years casts doubt on the Government's plan to deliver integrated health and social care services across England by 2020. The NAO made the following observations of the performance of government departments and national bodies in delivering integrated care:

a) The bodies are still developing their understanding of how to measure progress on integrating care.

b) The oversight and governance of initiatives to deliver integrated care is poor.

c) The main barriers to integrated care are not being systematically addressed.[21]

29. The practicalities of integrating services are complex. Simon Stevens described how structural divides imposed when the NHS was originally founded no longer make sense today: for example, the distinction between an NHS that is free at the point of use and a means-tested social care system, or the contractual separation of general practice from other NHS services.[22]

30. Integration depends on building new ways of working and developing relationships between professionals in different services. These health and care services often have different cultural practices, legal accountabilities, payment systems and terms and conditions for staff, all of which create obstacles to integrated care.

31. Nigel Edwards, Chief Executive of the Nuffield Trust, emphasised the significant optimism bias inherent in the ambition of the Department and national bodies, which does not adequately appreciate the scale and nature of the changes required. As Mr Edwards explained:

> These models take a long time to develop. They are based largely on changing the way people practise medicine and how complex organisations interrelate, and indeed how individual relationships between different clinicians and organisations change and morph over time. There is very little way of accelerating that process; it has to be learned and developed.[23]

Integration, patient choice and competition

32. Alongside efforts to integrate health and social care over the last 20 years, policymakers have also sought to introduce greater choice and competition within health

18 National Audit Office, Health and social care integration, HC 1011 Session 2016–17 8 February 2017, page 7
19 Q233
20 The Nuffield Trust, Shifting the balance of care: Great expectations, March 2017, page 5
21 The Nuffield Trust, Shifting the balance of care: Great expectations, March 2017, pages 9–10
22 Q325 [Simon Stevens]
23 Q228

and care system in England. The NHS Health Service and Community Act 1990 created an internal NHS market, introducing a spilt between the provision and commissioning of healthcare with the creation of self-governing trusts and GP fund-holders.

33. The NHS internal market continued throughout the 1990s, but accelerated at the turn of the century with a series of reforms, including the introduction of payment by results (PbR) in 2002, the establishment of foundation trusts in 2003 and the introduction of primary care trusts. This period also saw an extended role for the private sector in the NHS, under successive governments.

34. The Health and Social Care Act 2012 was the culmination of the shift towards choice and competition within the NHS. The Act saw the creation of NHS clinical commissioning groups responsible for commissioning services for their local populations. This was supported by reforms designed to support a diverse and competitive landscape of public and non-statutory provision, with an extended role for Monitor as the economic regulator.

35. Rt. Hon Andrew Lansley MP, then Secretary of State for Health, told our predecessor Committee in 2011:

> What we are doing, through amendments to the legislation, is to make it absolutely clear that integration around the needs of patients trumps other issues, including the application of competition rules.[24]

However, despite that reassurance, reforms to extend the NHS internal market, including the role of competition, have impeded rather than supported services to integrate. The NAO concluded that:

> shifts in policy emphasis and reorganisations which promote competition within the NHS, such as the move from primary care trusts to clinical commissioning groups in 2013 and the Health and Social Care Act 2012, have complicated the path to integration.[25]

36. Mr Stevens described how at the heart of the Forward View is the aim to not only work around, at least in the short-term, aspects of the Health and Social Care Act that promote competition over collaboration, but also to lower unhelpful boundaries between services that were imposed from the creation of the NHS.[26]

37. Competition, and the fragmented provision that arises as a consequence, erects barriers to integrated care. However, patient choice is where these two competing agendas converge. Our view is that a diverse local health and care economy, with a mix of mostly public, but also non-statutory services (private providers, social enterprises, charities, and community and voluntary services), can be arranged so as to enable rather than detract from integrated care. From a patient's perspective, what matters is that these providers, whether public or non-statutory, create coherent and comprehensive services, share information, work together and put patients' needs, priorities and goals at the centre. From the NHS's perspective, non-statutory services must enhance and not undermine the ability of the NHS to serve local populations.

24 The House of Commons Health Committee, Impact of the Spending Review on health and social care, 19 July 2016 HC 139, para 116, footnote 146

25 National Audit Office, Health and social care integration, HC 1011 Session 2016–17 8 February 2017, page 7

26 Q325

38. Patients' ability to choose and access a range of different services and sources of support, from which they may find therapeutic benefit, should be preserved. Public and non-statutory services both have a role to play in a diverse local health and care economy, which favours collaboration and quality over competition.

39. Not only do non-statutory services provide support when statutory services are stretched, but they can in some circumstances be more adept at meeting unmet demands in ways that statutory services may struggle to do. Competition can also be a useful tool but this should be on quality, not a race to the bottom on price. New entrants to the market can provide an incentive for incumbent providers to improve.

40. Having a "free choice system playing in", as Julie Wood, Chief Executive of the representative body NHS Clinical Commissioners, described, does create a challenge for NHS bodies seeking to maximise the value of the NHS pound, as they have to pay for NHS staff and then again for another intervention.[27] We appreciate this concern. However, one of the warnings against removing choice and competition is that "there is a danger of creating airless rooms in which you simply have one provider who is there for a huge amount of time."[28]

Conclusions and recommendations

41. **More joined-up, coordinated and person-centred care can provide a better experience for patients, particularly those with multiple long-term conditions. However, progress to achieving these benefits has been slow. There is no hard evidence that integrated care, at least in the short term, saves money, since it may help to identify unmet need, although there is emerging evidence from new care models that it may help to reduce the relentless increase in long-term demand for hospital services.**

42. **More integrated care will improve patients' experience of health and care services, particularly for those with long-term conditions. However, the process of integrating care can be complex and time consuming. It is important not to over-extrapolate the benefits or the time and resources required to transition towards more integrated care.**

43. **The Government should confirm whether it is able to meet the current target to achieve integrated health and care across the country by 2020, as well as plans for 50% of the country to be covered by new care models. These targets should be supplemented by more detailed commitments about the level of integrated care patients will experience as a result.**

44. **We support the move towards integrated, collaborative, place-based care. To help deliver more integrated care for patients we advocate the cultivation of diverse local health and economies, comprised of mostly public, but also some non-statutory provision, in which the organising principle is centred on collaboration and quality rather than financial competition. We consider that this diversity is important for protecting patient choice and with proper oversight and collaborative working may facilitate, rather than impede, joined-up, patient-centred and co-ordinated care.**

27 Q209 [Julie Wood]

28 Q209 [Niall Dickson]

3 NHS Five Year Forward View

45. Sustainability and transformation plans and partnerships, integrated care systems, new models of care, integrated care partnerships and accountable care organisations are all mechanisms designed to achieve the aims of the NHS Five Year Forward View. This chapter describes the aims of the NHS Five Year Forward View and introduces these new ways of planning and delivering local health and social care services.

46. The NHS Five Year Forward View set a collective vision for how the NHS needed to change between 2015/16 and 2020/21. The vision sought to address persistent variations in health inequalities and the quality of care as well as address the growing gap between resources and patient demand.

47. The NHS Five Year Forward View set out three financial scenarios for closing the NHS's £30 billion funding gap (between patient need and the available resources) by 2020/21. The third of these scenarios suggested that £22 billion of efficiencies could be delivered by 2020/21, meaning that the health service would be required to improve productivity by an average of 2–3% over the period. This is significantly higher than the average rate of productivity growth the NHS has delivered in the past but it also depended on adequate funding of social care and public health.[29]

48. As well as transforming care, sustainability and transformation partnerships, including integrated care systems, and new models of care are also intended to address the funding gap by managing and redistributing limited resources and improving efficiency by slowing the rate of activity growth in acute services. The Government set out an ambition to deliver £900million in savings from new care models by 2020/21.[30]

49. The delivery of the NHS Five Year Forward View is based on the following principles:

- Distinguishing ends from means–so the focus remains keeping people healthier for longer than reorganisation for its own sake.
- Evolution not big bang.
- Not a one size fits all approach.
- Co-production with patients and other local stakeholders.
- Support for the energy and leadership from wherever it exists.[31]

50. The new forms of planning local health and social care services (sustainability and transformation partnerships and integrated care systems—see Chapter 4) and delivering care (new care models, integrated care partnerships and accountable care organisations—see Chapter 5) can be seen a manifestation of these principles, although there are examples where these principles have not been adhered to.

51. Unlike previous efforts to reform the NHS, the national bodies have opted to make evolutionary changes within the existing legislative framework rather than introduce changes through primary legislation. As Simon Stevens described:

29 NHS England, Five Year Forward View, October 2014
30 National Audit Office, Health and social care integration, HC 1011 Session 2016–17 8 February 2017, page 9
31 NHS England, Next Steps on the NHS Five Year Forward View, March 2017, page 29

> Our whole process of change through the Five Year Forward View has not been just about issuing a single administrative blueprint and then a reshuffling of the administrative deckchairs. It has been entirely grounded in the question of what care should look like and how patients should be looked after, and then everything else, be it funding flows, organisational structures or governance, is the means to the end of trying to get that right. That is what distinguishes this set of changes from just about every other reorganisation the health service has been the victim of since 1948.[32]

32 Q325

Section 2: Changes to local planning and delivery of care

4 Sustainability and transformation partnerships and integrated care systems

52. This chapter summarises key changes to the local planning of health and care services across England, including the development, and current status, of sustainability and transformation plans, as well as key issues concerning sustainability and transformation partnerships and integrated care systems, including the geographical boundaries of these areas.

Development and status of sustainability and transformation plans

Development of sustainability and transformation plans

53. The NHS planning guidance in December 2015 set a requirement for local areas to come together and develop blueprints setting out how they planned to deliver the NHS Five Year Forward View. As part of the plans, local areas were required to estimate the funding gap in their area and set out how they planned to fill this gap.[33] This meant local bodies, often without a history of collaborative working, had to come together and make very difficult decisions about changes to health and care services locally. The process was made more challenging by the very tight timeline national bodies set for these plans to be developed.[34]

54. Local areas had until the end of January 2016 to develop partnerships and submit proposed boundaries, known as footprints. The original deadline for the final plans was in June 2016. However, this was moved back to October 2016 following an initial assessment of the plans by national bodies. Areas with a history of collaborative working and a clearer, meaningful and more practical geographical boundary started with an advantage.[35]

55. The tight timeframe placed significant strain on the resources of local NHS leaders and senior management. In many cases, management consultants were used to fill gaps in the capacity and capability of local organisations to develop these plans.[36]

56. There was also limited time and capacity to involve all the key local partners. From the outset, representatives from local government expressed concerns that the process was inherently NHS-centric; many local councils and MPs had limited or no input into the original versions. Representatives from primary care providers also reported similar experiences and wider engagement with staff and local communities, including voluntary

33 NHS England, Delivering the Five Year Forward View: NHS planning guidance 2016–17 to 2020/21, December 2015, pages 4–7

34 The King's Fund, Sustainability and Transformation Plans in the NHS: How they are being developed in practice?, November 2016, pages 67–79

35 The King's Fund, Sustainability and Transformation Plans in the NHS: How they are being developed in practice?, November 2016, page 5

36 The King's Fund, Sustainability and Transformation Plans in the NHS: How they are being developed in practice?, November 2016, page 43

groups and members of the public, was also minimal in many places.[37] Public engagement was also limited by instructions from national NHS bodies to "STP leaders to keep details of draft STPs out of the public domain."[38]

57. Sustainability and transformation plans for each of the 44 local areas were published by December 2016. These plans contained a series of proposals to redesign the shape of local health and social care provision, including controversial plans to reconfigure acute services and reduce bed capacity.[39]

58. In many cases, proposals contained within the plans were not supported by robust evidence. An analysis of the 44 sustainability and transformation plans by London Southbank University found that very few of the proposals were based on a robust assessment of population need. Similarly, no detailed workforce plans were evident in two thirds of the original STPs, in which local areas set out how they planned to ensure they have enough staff to deliver the new policies and services proposed in the plans.[40]

59. Over the course of 2016 the media portrayal of the STP process moved from relatively benign reports of progress locally within regional and trade outlets in the early part of the year, through to widespread negative portrayals of the plans in national media in July and August 2016. This reached a peak in late August, with reports of an investigation by 38 Degrees, a campaign group. The King's Fund's analysis of media coverage over the period in which STPs developed noted that:

> On 26 August, the campaigning group 38 Degrees published an investigation into STPs that was covered by all major newspaper and broadcast outlets. News items focused on the 'secrecy' and lack of public consultation on the plans, as well as making frequent links to potential 'cuts', ward closures and the downgrading of A&E services.[41]

60. In the run up to the final deadline, coverage about the secrecy of plans continued and was accompanied by reports of plans leaked to the press, in which the focus of the coverage was on proposals to close services, reduce bed capacity and reconfigure hospitals.[42] The STP brand as a consequence was politicised and became seen as a smokescreen for cuts to services. As Professor Chris Ham described:

> They were asked to produce a plan by whenever it was—October 2016—that showed how they would balance their collective budgets within the envelope that they knew they had available. That was behind the realistic concern

37 The King's Fund, Sustainability and Transformation Plans in the NHS: How they are being developed in practice?, November 2016, pages 31–38

38 The King's Fund, Sustainability and Transformation Plans in the NHS: How they are being developed in practice?, November 2016, page 23

39 The King's Fund, Delivering Sustainability and Transformation Plans: from ambitious proposals to credible plans, February 2017

40 London Southbank University, Sustainability and Transformation Plan, How serious are the proposals? A critical review, May 2017

41 The King's Fund, Sustainability and Transformation Plans in the NHS: How they are being developed in practice?, November 2016, page

42 The King's Fund, Sustainability and Transformation Plans in the NHS: How they are being developed in practice?, November 2016, pages 14–15

> that this was about a cost-cutting exercise rather than about transformation of care. Sadly, STPs got off to a very bad start, a very difficult start, because of that.[43]

Current status

61. Professor Chris Ham described how "most STPs got to the finishing line of October 2016, submitted their plans and breathed a huge sigh of relief. No further work has been done on those STPs. The governance and leadership they brought together remains very weak by comparison with what is happening at the organisational level in most parts of the country."[44] The prominence given to the plans has diminished since the Next Steps to the NHS Five Year Forward View was published. The focus has now shifted from "plans" to "partnerships".[45] NHS England and NHS Improvement's written evidence to our inquiry stated that:

> it is partnerships–not plans–that matter most. Every local partnership is at a different stage of its integration journey, normally predicated on the strength of local relationships. The most mature partnerships are evolving further to become 'integrated care systems.[46]

62. Simon Stevens described the original plans as a "conversation starter". He confirmed that NHS England is not expecting most of 44 areas to deliver on those plans, although NHS England is backing some of the local areas to make progress. Mr Stevens told us:

> In some places, such as Dorset, they had a clear plan, and I think they are able to push on with that. We have backed it with capital and they are progressing well.[47]

63. In other local areas we heard that the thinking has evolved since the plans were published,[48] as the financial position in 2018/19 is, according to Mr Stevens, "more benign than it was when the plans were drawn up a couple of years ago."[49] Consequently, local areas may be revisiting their original proposals, especially given recent commitments of extra funding made by the Prime Minister at the Liaison Committee on 27 March 2018.[50] However, while the NHS' overall financial position has improved, it is still far from stable (see Chapter 8).

Conclusions and recommendations

64. **STPs got off to a poor start. The short timeframe to produce plans limited opportunities for meaningful public and staff engagement and the ability of local areas to collect robust evidence to support their proposals. Poor consultation, communication and financial constraints have fuelled concerns that STPs were secret plans and a vehicle for cuts. These negative perceptions tarnished the reputation**

43 Q274 Professor Chris Ham
44 Q261 Professor Chris Ham
45 NHS England, Next Steps on the NHS Five Year Forward View, March 2017, page 31
46 NHS England STP0107, page 1–2
47 Q314
48 Q312
49 Q312
50 Oral evidence taken before the Liaison Committee on 27 March 2018, HC 905 (2017–19), Q76 [Prime Minister]

of STPs and continue to impede progress on the ground. National bodies' initial mismanagement of the process, including misguided instructions not to be sharing plans, made it very difficult for local areas to explain the case for change.

65. NHS England has rightly decided not to expect every area to deliver against the original sustainability and transformation plans published in December 2016. This is a pragmatic approach given the controversy surrounding the proposals contained within the original plans, and the constraints imposed on areas against engaging key voices locally. However, NHS England needs to learn from the mistakes of the initial roll out of STPs.

Status of STP boundaries

66. The STP footprints, or boundaries between services, were developed in a short space of time. Creating geographical boundaries is extremely difficult since, as Nigel Edwards from the Nuffield Trust described, "there is no real right organisational level for things as complex as healthcare."[51] Boundary issues are pervasive across many STP areas. Professor Chris Ham provided an example, saying that "Epsom and St Helier is part of the Surrey Heartlands integrated care system, but it is really part of south-west London and the STP there."[52]

67. A clear message from our inquiry is that the practical issues arising from STP boundaries have significantly affected progress so far. STPs are in a better position when their geographical boundaries, including sub-sections of the STP, make sense to local people, professionals and services. Unsurprisingly, STP footprints with a smaller population, a smaller number of partners, boundaries that align with patient flows between services and coterminous organisational boundaries between partners tend to be further ahead.[53] Boundaries in the more advanced areas tend to align with pre-existing relationships, often built around a geographical area that is clear, practical and recognised locally. Julie Wood, Chief Executive of NHS Clinical Commissioners, told us:

> The starting point in history and relationships is very important, also the geography. Some of the geographies the STPs were built on were the same as the places people were working in—for example, Nottinghamshire or Dorset. We heard from Greater Manchester that they have been working in that way for some time. Some of the other geographies did not feel as natural, so it has taken time to get to first base.[54]

68. Councillor Jonathon McShane from Hackney Council, representing the Local Government Association, also argued that areas which are focused on patient flows around acute services, rather than wider community services and assets, including local authority boundaries, have struggled to make progress.[55]

69. Despite the pervasiveness of boundary problems, the evidence we were strongly advised against any national intervention to reconstruct more cohesive geographies, even if, from the perspective of national bodies, this leads to a complicated patchwork

51 Q256 Nigel Edwards
52 Q260 Professor Chris Ham
53 NHS Providers STP0050
54 Q203 Julie Wood
55 Q203 Cllr McShane

of accountabilities.[56] Instead, encouraging each local area to focus on developing clear, meaningful and practical boundaries, either at the STP level or in sub-sections of the STP, is considered to be the key.

70. It is not essential that the STP footprint as a whole corresponds to an area that might be recognised by local people, professionals and services. Instead, the clear, practical and meaningful boundaries to which we refer above could be set around a sub-section of an STP, where, as Professor Chris Ham described, "it makes sense to focus on the place, the population and how services in this area join up."[57] Ian Williamson from Manchester Health and Care Commissioning emphasised this point, saying "if there is one lesson I have taken from the last three or so years, it is place-based focus rather than organisational focus."[58]

71. Within South Yorkshire and Bassetlaw STP, for example, five separate sub-sections of the footprint (Sheffield, Doncaster, Barnsley, Bassetlaw and Rotherham) had been identified and alliances between providers were being built at this level. In South Yorkshire and Bassetlaw, the governance of the STP was built upon these five sub-sections, as local leaders operated on the principle that decisions would only be taken at an STP level where it made sense to do so.

72. NHS England, in the Next Steps on the NHS Five Year Forward View, made clear that boundaries, while initially imposed in some cases, are not set in stone, but can be adjusted, with national approval, where local areas present a clear benefit to doing so.[59] In other words there has been an understanding that changes should be initiated at local level rather than imposed from above.

Conclusions and recommendations

73. **An STP area, or areas within it, work more effectively where they are meaningful to partners, local health professionals and most importantly the public. STPs, particularly those with more complex geographical boundaries, should be encouraged and supported to allow local areas to identify, define and develop meaningful boundaries within their patch in which local services can work together around the needs of the population.**

74. **STPs should be encouraged to adopt a principle of subsidiarity in which decisions are made at the most appropriate local level. NHS England and NHS Improvement should set out in their planning guidance for 2019/20 advice and support to achieve these recommendations.**

56 Q256 Nigel Edwards
57 Q256 Professor Chris Ham
58 Q194 Ian Williamson
59 NHS England, Next Steps on the NHS Five Year Forward View, March 2017, page 34

Status of Sustainability and Transformation Partnerships

75. The Next Steps in the NHS Five Year Forward View shifted the focus and the name of STPs from sustainability and transformation plans to sustainability and transformation partnerships.[60] These partnerships were described by Simon Stevens as being on an "evolutionary and developmental journey."

76. Despite getting off to a difficult start, many local leaders conveyed the benefits they have already seen and the potential of more place-based working. This potential extends beyond the NHS's traditional role in healthcare. For example, partnerships have facilitated conversations that may not have taken place in the same way before.[61] Ian Williamson from Manchester Health and Care Commissioning explained:

> from my background largely as an NHS person, this has given us the opportunity to have conversations about, for example, how we try to reduce childhood obesity, or how we work on emissions in our atmosphere in a way that we have not previously been able to do. Those are real things that impact on people's health and wellbeing, and it has given us a way to address them.[62]

77. Many local leaders also spoke with enthusiasm at our visit to South Yorkshire and Bassetlaw about the positive contribution the NHS can make to wider social issues and local economic growth. Rob Webster from West Yorkshire STP described how, with a strong life science sector in his patch, the NHS locally has a potential role to play as a catalyst for innovation and growth. Senior leaders in South Yorkshire also told us how the NHS, as a large employer, could play a critical role in providing career opportunities for young people locally.

Role of sustainability and transformation partnerships

78. Increasingly STPs have become the vehicle for delivering national priorities and targets, improving financial management across the system and managing demands, particularly on acute care, despite the governance and infrastructure being fragile and in development.[63] NHS Providers argue:

> There needs to be far greater clarity and discipline over what STPs are intended to deliver. There is an increasing tendency for STPs to become the default footprint for delivering national policy initiatives, but they do not currently have the mandate, statutory authority, or infrastructure to deliver these.[64]

60 The NHS planning guidance in December 2015 required local areas to come together to develop sustainability and transformation plans: blueprints for delivering the NHS Five Year Forward View. These plans were originally intended to contribute to filling the gap between patient demand and resources between 2015/16 to 2020/21. 44 plans, one for each local area, were published in December 2016. The Next Steps to the NHS Five Year Forward View shifted the emphasis of from the original plans to partnerships, focusing on driving efficiency and improvements through more collaborative working locally than rather making progress with the proposals described in the original STPs.

61 See Annex

62 Q194 Ian Williamson

63 NHS Providers STP0050, Q261 Professor Chris Ham

64 NHS Providers STP0050

79. National leaders should not lose sight of the fact that local leaders, as well as the wider workforce are rightly far more enthused and motivated by what can be achieved for patients through joint working than by the prospect of how this delivers national policy objectives.

Assessing the progress of sustainability and transformation partnerships

80. NHS England and NHS Improvement have published an STP dashboard which rates the progress in each of the 44 sustainability and transformation partnerships. Each area is rated on the following 4-point scale: Outstanding, Advanced, Making progress and Needs most improvement. The written evidence we received identified a series of concerns about the utility of the dashboard and the indicators chosen. In particular, the indicators selected in the dashboard add further weight to concerns that the national bodies have narrowed their focus away from the original aims of the Five Year Forward View: the indicators chosen to measure the progress of STPs focus on their ability to reduce demand on hospitals, manage financial resources and deliver national priorities in the short term. In future there needs to be greater emphasis on what these deliver in improving the experience and outcomes for patients.

Integration, transformation and prevention

81. Sustainability and transformation partnerships are mechanisms for delivering the NHS Five Year Forward View, which in part, was a vision for making the transition to more integrated models of care. However, the STP Dashboard has no indicators to measure integration or the progress local areas have made in transforming care, such as progress made against their STP plans.[65]

82. Integrated care is difficult to measure and, as noted in Chapter 2, national bodies are still developing their understanding of how to do so.[66] However, it seems surprising that there are no indicators to measure integration or transformation in the dashboard, particularly given statements characterising STPs as part of the greatest move towards integrated care in the western world.

83. A central part of the NHS Five Year Forward View is the shift to more proactive and preventative delivery of health and healthcare. However, we heard that the indicators chosen to measure prevention narrowly define prevention in terms of reducing demands on acute services.[67] This is unlikely to help to build the case for change with the public.

Local engagement

84. There is also no measure of how local areas have engaged with key partners and local communities. Engagement with local groups, who are understandably active and vocal about local service changes, is critical for STPs as they begin to transform services.

65 NHS Providers STP0050, Local Government Association STP0027, NHS Clinical Commissioners STP0064
66 National Audit Office, Health and social care integration, HC 1011 Session 2016–17 8 February 2017.
67 Local Government Association STP0027

85. The public and voluntary groups are not only important constituents to engage, but play a critical role in the delivery of the NHS Five Year Forward View. Ian Williamson from Manchester Health and Care Commissioning referred to the importance of situating these partnerships in their wider communities. Mr Williamson stressed:

> it cannot stop at just the statutory sector or public-sector bodies; it has to reach out to neighbourhoods, community groups, be they communities of interest or geographical communities, and the voluntary and community sector. It is crucial that this is a journey we go on together, so to speak.[68]

86. Chapter 2 of the Forward View emphasises the need to empower people and communities. However, the prominence given to the role of people and communities has not been carried through to the STP Dashboard. Simon Stevens, in response to a question from Anne-Marie Morris MP at a meeting of the Committee of Public Accounts about whether NHS England should have a target to assess engagement with local voluntary groups, stated that:

> we have been discussing, as recently as this morning, the extent to which we should try to build some of that into the processes we use to assess and check how well the STPs are working.[69]

87. We heard that engagement with local voluntary groups was very limited in the development of sustainability and transformation plans, although it has improved in some areas.[70] Cuts to voluntary sector funding have meant that many charities have struggled to engage with STPs, particularly smaller charities that do not have the same infrastructure as the larger national charities.[71]

88. Involvement and engagement of local communities, representatives and voluntary groups are pivotal to realising the changes described in the NHS Five Year Forward View. Progress of STPs, as one of the key mechanisms for delivering the Forward View, should include an assessment of how effectively local communities are involved and engaged.

Local relationships

89. For most local systems, the focus has been on building trust and relationships between local leaders and services. National support and funding for transformation has been directed predominately towards the 10 integrated care systems which are further ahead (discussed in more detail in Chapter 8). These areas, in contrast to those further behind, often drew on a history of collaborative working locally. NHS Providers' written evidence identified the following factors that have affected progress of sustainability and transformation partnerships:

- 'The quality of relationships between all key players in the local system.
- The quality and capacity of local leaders and their ability to engage and mobilise the wider workforce.

68 Q194 Ian Williamson

69 Oral evidence taken before the Public Accounts Committee on 21 March 2018, HC (2017–19) 793, Q118 [Simon Stevens]

70 Q143 [Don Redding]

71 Q144 [Don Redding]

- A collective commitment to prioritise the needs of patients and the system at the expense of the individual institution.
- A focus on a small number of practical priorities and a drive for practical improvements on the ground in chosen priority areas, rather than just trying to build a grand plan.
- A culture of pragmatism meets continuous improvement."[72]

90. The strength of local relationships is pivotal to the process. According to NHS Providers, where the factors outlined above are less evident, more time is necessary for local areas to form relationships, build trust and agree local aims and objectives.[73] Rob Webster, STP lead in West Yorkshire, characterised the importance of relationships in saying that "change happens at the speed of trust."[74] This message was expressed by Simon Whitehouse, STP Director for Staffordshire and Stoke-on-Trent, one of the more challenged local areas:

> There is also recognition that as we sit here now STPs in their widest sense are not statutory bodies; they do not exist in an organisational form. It is literally the strength of the relationship and the collaboration that sits underneath it that drives it. We have to keep coming back to why we are here and what we are trying to deliver for the population we serve. For me, you can change the three letters as many times as you want, but we need to serve the local population, improve health outcomes, bring a real focus to rigorous continuous quality improvement at local level and get partners to work collaboratively to drive that change.[75]

Conclusions and recommendations

91. **Sustainability and transformation partnerships provide a useful forum through which local bodies can come together in difficult circumstances to manage finite resources. However, they are not on their own the solution to the funding and workforce pressures on the system. We are concerned that these pressures, if not adequately addressed, may threaten the ability of local leaders to meet their statutory obligations let alone transform services. Overwhelming and unrealistic financial pressure drives them to retreat back to organisational silos. This would seriously undermine the progress local leaders have made in already difficult circumstances.**

92. Sustainability and transformation partnerships have no legal basis, and so depend on the willingness of local leaders to participate. These relationships are fragile: national bodies must be careful not to overburden these partnerships by increasingly making them the default footprint for the delivery of national policies, especially while their relationships, governance and infrastructure are relatively weak in comparison to other parts of the system.

93. **We recommend that the national bodies, including the Department, NHS England, NHS Improvement, Health Education England, Public Health England and CQC,**

72 NHS Providers STP0050
73 NHS Providers STP0050
74 Note on SY&B visit
75 Q194 Simon Whitehouse

develop a joint national transformation strategy. This strategy should set out clearly how national bodies will support sustainability and transformation partnerships, at different stages of development, to progress to achieve integrated care system status. This strategy must not lose sight of patients. National bodies in this strategy should:

a) **set out how national bodies plan to support local areas to cultivate strong relationships;**

b) **strengthen the programme infrastructure of STPs;**

c) **consider whether, and if so how, support, resources and flexibilities currently available to integrated care systems could be rolled out to other areas to help them manage pressures facing their local areas;**

d) **develop a more sophisticated approach to assess the performance of STPs and their readiness to progress to integrated care status. This should include an assessment of local community engagement, the strength of local relationships and the progress towards preventative and integrated care. An assessment of prevention should encompass a broader definition than preventing demands on hospitals and integration should focus on how to improve patients' experience of and outcomes from services.**

Integrated care systems

94. Integrated care systems are advanced forms of sustainability and transformation partnerships, in which "commissioners and NHS providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they operate their collective resources for the benefit of local populations."[76]

95. The benefits of ICS status for STPs include greater autonomy over funding, such as resources earmarked for transformation, and for services currently commissioned nationally (e.g. primary care and specialised services). However, to qualify for ICS status local areas must demonstrate that they have robust mechanisms for collective governance and decision-making, deliver horizontal and vertical integration across services, have robust measures to continue to provide choice to local residents and are capable of managing population health.[77]

96. The recent NHS planning guidance published by NHS England and NHS Improvement introduced a series of changes which seek to foster greater system-wide management. These changes include a requirement for each ICS to produce a system-wide plan to deliver the system's control total, in other words the limit on its spending,[78] more streamlined oversight from national bodies, and a series of financial incentives to support

76 NHS England and NHS Improvement, Refreshing NHS Plans for 2018/19, February 2018, page 12, para 5.2

77 NHS England, Next Steps on the NHS Five Year Forward View, March 2017, page 36

78 System control totals are overall financial targets for an STP. Each NHS body within an STP also has an individual control. ICS areas, unlike STPs, are able to move resources between partners as long as the system control total is met.

system-wide management of funding. NHS England and NHS Improvement will only assure system-level plans, leaving ICSs to review plans of individual organisations within their area.[79]

97. The first wave of integrated care systems are expected to pave the way for the remaining local systems by developing a pathway to full ICS status, leading on the implementation of specific system-wide efficiencies (e.g. consolidation of back-office functions), and providing lessons, and possibly support, for future cohorts moving to ICS status.[80]

98. Since the Next Steps to the NHS Five Year Forward View announced the creation of accountable care systems (the former title of ICSs), the focus in the first cohort has been on building the capacity of these systems to take collective responsibility for their local system. In doing so, these areas are grappling with complex changes, such as how to align the work of CCGs with wider system plans. The landscape within these areas is also changing rapidly, with the emergence of integrated care partnerships and changes to local commissioning (mergers of CCGs, joint executive teams between CCGs and integrated commissioning between CCGs and local authorities).[81]

99. Like STPs, ICSs vary significantly. Greater Manchester covers a population of 2.7 million, whereas Blackpool and Fylde Coast has around 300,000. The number of bodies also varies widely between these areas. The 10 integrated care systems face similar problems to the rest of country, but have been able to demonstrate positive progress in the changes they have made and some of the outcomes they have already achieved.[82]

100. Despite examples of progress, organisational roles and accountabilities within these areas still cause tensions and difficulties. Local bodies in these areas have competed for many years and, in some cases, may not have worked together for long. Partners within integrated care systems in 2018/19 have flexibility to move funds between organisations to balance the system control totals. However, organisations are having to reconcile system control totals with their own individual controls and use of the provider and commissioner sustainability funds (see Chapter 8).[83] The King's Fund has warned that:

> if control totals are not realistic, they could create significant financial disincentives to partnership working and bring into question the commitment of NHS organisations to continue working in this way.[84]

101. Even in the more advanced areas, local leaders were worried about how to maintain the cooperation between all the relevant players. Pressures on even the most advanced areas are far from sustainable. South Yorkshire and Bassetlaw had made excellent progress and the areas' financial position was more benign than other local systems, yet the area is not immune from some of the pressures. Primary care in the area, notwithstanding excellent examples such as Larwood Practice, faces significant workforce challenges.

102. While very supportive of the principle and potential of integrated care systems, Professor Chris Ham from The King's Fund, who has been working with NHS England and the first wave of integrated care systems, provided a word of caution, saying:

79 NHS England and NHS Improvement, Refreshing NHS Plans for 2018/19, February 2018, pages 13–14
80 Exclusive: Accountable care systems will make pathway for stps to follow, Health Service Journal10 July 2017
81 The King's Fund, A progress report on integrated care systems, March 2018
82 The King's Fund, A progress report on integrated care systems, March 2018
83 The King's Fund, A progress report on integrated care systems, March 2018
84 The King's Fund, A progress report on integrated care systems, March 2018

> the 10 integrated care systems are beginning to show what is possible through place-based working that goes beyond STPs. Let's not underestimate how nascent and fragile those systems are. They depend on the willingness of organisations to come together in the same room and collaborate, in a system that was not designed to make that the easy thing to do.[85]

Professor Ham went on to say that:

> There is clearly a risk that some of them will not be able to build on the progress they have made so far because, with the growing pressures, the focus will be on organisations dealing with their deficits, which may get in the way of systems playing a bigger part in supporting organisations to do that collaboration. I do not want to exaggerate, but I do not want to adopt an overly optimistic view either.[86]

103. A lot of pressure is being put on these frontrunners. The King's Fund argue that they are "writing the manual for system working rather than being readers expected to implement a blueprint written by others."[87] National bodies need to pay careful attention to how they support these fragile and nascent systems to maintain the progress they have made so far, as well as pave the way for future cohorts.

104. Another dilemma facing national bodies is how they approach areas in which the concept of integrated care systems, as currently envisaged, does not work or is unlikely to work.[88] A lesson from the foundation trust pipeline is that it is quite possible that the eligibility criteria local areas need to meet to attain ICS status will be outside their reach. While this is entirely possible, an even more likely scenario is that some local areas which manage to achieve ICS status may struggle to maintain their performance, resulting in a scenario where the ICS badge becomes tokenistic. Such a scenario would see a similar pattern to the one that emerged between NHS trusts and foundation trusts, which Simon Stevens described as a "distinction without a difference."[89]

Conclusions and recommendations

105. **We support the development of integrated care systems, including plans to give greater autonomy to local areas as part of their ICS status. We are encouraged by the positive progress the first 10 integrated care systems have made in the face of challenges on the systems. However, like STPs more generally, we are concerned that funding and workforce pressures on these local areas may exacerbate tensions between their members and undermine the prospect of them achieving their aims for patients.**

106. **NHS England and NHS Improvement should systematically capture and share learning from areas that are furthest ahead, including their governance arrangements and service models, to accelerate progress in other areas and also to provide clarity about what is permissible within the current legal framework.**

85 Q253 Professor Chris Ham
86 Q253 Professor Chris Ham
87 The King's Fund, A progress report on integrated care systems, March 2018
88 Q226 [Saffron Cordery]
89 NHS Chief backs Monitor and TDA merger, *Health Service Journal*, 10 February 2015

107. **We recommend, as part of a joint national transformation strategy, that national bodies clarify:**

a) **how they will judge whether an area is ready to be an ICS;**

b) **how they will support STP areas to become ICSs;**

c) **what they will do in areas that fail to meet the criteria;**

d) **how they will monitor the performance of existing ICS areas and provide support including the necessary funding to ensure they continue to make progress; and**

e) **how they will address serious performance problems in ICS areas.**

5 Integrated care partnerships and accountable care organisations

Background

108. This chapter explains the changes in the delivery of integrated care that have emerged since the NHS Five Year Forward View was published in October 2014, particularly new care models, integrated care partnerships and ACOs.

109. While ACOs have attracted more attention, there are currently no ACOs in the NHS. The main expression of change to the delivery of care in the NHS has been the emergence of integrated care partnerships. This chapter describes the development of integrated care partnerships and also some of the key issues surrounding the inclusion of ACOs in the English NHS.

New models of care

110. The NHS Five Year Forward View led to the development of new models of care. These models of care blur traditional boundaries between existing health and care services. 50 vanguard sites across the country have piloted these models through, for example, partnerships between hospitals, primary care providers, clinical commissioning groups and care homes.

111. Two of these models, primary and acute hospital systems (PACS) and multispecialty community providers (MCPs), have a greater focus on integration and prevention. NHS England's written evidence to our inquiry set out a series of positive early signs that these new models are improving patient care and reducing demands on the system. However, the evidence for this improvement is not yet statistically robust.[90]

112. The Government's ambition for health and social care to be integrated across the country by 2020 depends on the scale-up and spread of new models of care across the country. As yet, there is no clear plan describing how NHS England plans to fulfil this objective. NHS England is required by the mandate to:

> Assess progress of the vanguards and identify models consistent with the multispecialty community providers, integrated primary and acute care systems and enhanced health in care homes vanguard frameworks that can be replicated across the country.[91]

Integrated care partnerships

113. The new models of care programme built on pre-existing partnerships between local services in some parts of the country and encouraged the development of partnerships in others. These partnerships were recently defined by The King's Fund as:

90 Q234 [Professor Checkland]

91 Department of Health and Social Care, The Government's mandate to NHS England for 2018–19, March 2018, page 20

> alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.[92]

114. Some of these partnerships have emerged out of the new care models programme, although many predated the new care models initiative. These integrated care partnerships are delivering integrated care without the need to form a single organisation. We heard during our inquiry that by using flexibilities within the current legislation to form alliances, services within the partnerships can agree to collaborate rather than compete.

115. Contractual tools, namely alliance and prime provider contracts, aim to facilitate these arrangements by enabling partners to share financial risks. These contracts can be costly and time-consuming to set up, but initial evidence suggests that where these contracts have been used successfully parties report greater inter-organisational working. However, it is too early to provide empirical evidence of the effectiveness of these contracts in the NHS.[93]

Accountable care organisations

116. Accountable care organisations do not yet exist in the NHS. Within the English NHS, The King's Fund explain that ACOs are likely to be:

> a more formal version of an ICP that may result when NHS providers agree to merge to create a single organisation or when commissioners use competitive procurement to invite bids from organisations capable of taking on a contract to deliver services to a defined population.[94]

117. Two areas, Dudley and the City of Manchester, have expressed an interest in formalising their existing integrated care partnerships into a single organisation if, and when, NHS England makes an accountable care contract available.

118. Organisations called ACOs currently exist in the US: a legacy that has sparked concern that organisations of the same name proposed for England could follow the same formula.

119. ACOs in the US were established by the US Affordable Care Act 2010, but built on models such as Kaiser Permanente in the US and Ribero Salud Grupo in Spain. According to an article in the British Medical Journal there are approximately 1000 ACOs serving over 30 million people in US.[95]

120. The context in the US is very different. The fragmentation of funding and delivery is far more pronounced within the US. For example, the US does not have a nationally funded and centrally controlled national health service and eligibility criteria for access to

92 The King's Fund, Making sense of accountable care, January 2018

93 Sanderson, M., Allen, P., Osipovic, D., Moran, V. (2017) New Models of Contracting in the NHS: Interim Report Policy Research Unit on Commissioning and the Healthcare System; London School of Hygiene & Tropical Medicine

94 The King's Fund, Making sense of accountable care, January 2018

95 Can accountable care organisations really improve the English NHS? Lessons from the United States, British Medical Journal, 2 March 2018

services are wholly different to those of the NHS. Therefore ACOs in the English NHS are likely to be very different from those in the US and other countries.[96] However, the choice of this terminology was mistaken and has contributed to widespread misunderstanding.

Current status of proposals to introduce ACOs in the English NHS

121. The Department of Health and Social Care has consulted on changes to existing regulations to enable an Accountable Care Contract to be introduced. The outcome of the Department's consultation on the regulations was published in April 2018. NHS England also plans to consult on a draft contract, which will outline "how the contract fits within the NHS, how NHS commissioners and providers party to an ACO contract will perform their existing statutory duties and the arrangements that will be in place to ensure public accountability and patient choice".[97]

122. NHS England has delayed its consultation pending the outcome of our inquiry and two judicial reviews on the legality of the changes it proposes. The Department of Health and Social Care signalled in its consultation response its intentions to consult again on legal directions to ensure "criteria for an ACO delivering primary medical services (GP services) are consistent with the criteria for existing providers of primary medical services."[98] Once NHS England has implemented a contract, these legal directions will be limited to Dudley and the City of Manchester initially, although other areas may apply to use the contract.[99]

123. We heard concerns that national bodies have an expectation that STPs will develop into integrated care systems which will then lead to the roll-out of accountable care organisations across the NHS. On the contrary, rather than national bodies having a pre-determined expectation that each area will form accountable care organisations, we heard from NHS England that an Accountable Care Contract, if and when it becomes available, will be just one option for local systems. Simon Stevens, Chief Executive of NHS England, told us that:

> I doubt that the whole of England, or anything like the majority of it, will be using this particular contractual vehicle, but those who want to integrate funding may do so.[100]

124. Dudley and the City of Manchester, while they have both expressed an interest in using an ACO contract, differ in the extent to which this is integral to their plans. Paul Maubech, Chief Executive of Dudley Clinical Commissioning Group, described several reasons why an ACO contract is critical to Dudley's plan. The City of Manchester, in

96 British Medical Journal, Can accountable care organisations really improve the English NHS? Lessons from the United States, March 2018

97 Department of Health and Social Care, Accountable care organisations: Government response on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable care models), April 2018

98 Department of Health and Social Care, Accountable care organisations: Government response on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable care models), April 2018

99 Department of Health and Social Care, Accountable care organisations: Government response on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable care models), April 2018

100 Q280 Simon Stevens

contrast, see the ACO contract as a potential enabler, although there are issues, including different regulations covering VAT exemptions between NHS and local government, which may have significant financial implications for the partners involved.[101]

125. Stephen Barclay, Minister of State for Health, referred to plans to "pilot" ACOs in Dudley and the City of Manchester.[102] The Government's response to the proposed regulatory changes to enable an ACO contract stated that legal directions, once consulted on, would be limited to Dudley and the City of Manchester.[103] However, as yet we have not seen any detailed proposals setting out the parameters of these pilots: the time period, the outcomes they seek to measure, or how the pilot will be evaluated. The Minister also said that pilots of ACOs are in part being carried out to assess the budget that is needed to transform care across the wider NHS:

> Of course, there needs to be transformation and that requires a budget, and there is a question as to what that should be. The ACOs involve two areas at the moment. It is very difficult to make an assessment ahead of that. Part of the reason for having pilots is to understand what is involved, and to take that forward.[104]

126. We are unclear about Government and national bodies' plans to pilot ACOs in Dudley and the City of Manchester, and it is not certain that the City of Manchester will go down this route if and when the contract becomes available.

127. The Minister's evidence also implies that these pilots will be used to assess the level of transformation funding that is required across the NHS. The need for transformation funding in our view is urgent and should not wait for the results of a small pilot of ACOs. Also, the Minister's comments appear to contradict Simon Stevens's statement that the ACO contract will be an option for local areas (including those other than Dudley and the City of Manchester).[105]

Arguments for and against ACOs

Benefits of a single organisation and aligned financial incentives

128. The purported benefits of using an ACO contract are that it enables an integrated care partnership to merge into a single organisation, streamline decision making and align financial incentives. National and local leaders made the case that merging services into a one single legal entity would reduce complexity, particularly the complexity of internal decision-making processes, and bring health professionals together into one organisation, with the same objectives and incentives.[106]

129. As explained in Chapter 2, there are some substantial and persistent obstacles which make the task of integrating health and social care hard to achieve. The case was made

101 Q161 Ian Williamson
102 Q414 Stephen Barclay
103 Department of Health and Social Care, Accountable care organisations: Government response on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable care models), April 2018
104 Q414 Stephen Barclay
105 Q280 Simon Stevens
106 Q394 Jonathon Marron, Q184 Paul Maubach

to us that merging partnerships into a single organisation would enable change to occur at a faster pace, as it would help to overcome some of these obstacles (organisational boundaries, cultural practices, terms and conditions, legal accountabilities and payment systems).

130. Paul Maubach from Dudley CCG made the case that, unlike acute hospitals, primary, community and social care services are provided by a more disparate array of services. The NHS Five Year Forward View argues that these traditional divides are no longer fit for purpose. Mr Maubach argued that the proposition of splitting hospital services into separate organisations, with separate management teams, and then asking them to form an alliance to collaborate to provide an acute contract would be undesirable, so why approach services outside hospitals in this fashion? He stated: "we have multiple organisations, but actually the public want one joined-up service."[107]

131. One of the persistent barriers to integrated care, according to the NAO, are misaligned financial incentives.[108] Paul Maubach described how Dudley CCG commission long-term diabetic care from GPs and diabetologists. Those funding the service, clinicians and patients, all want stable management of a patient's diabetes, yet GPs and diabetologists are paid in different ways. GPs are paid based on their practice population, with incentives to reward the stable management of a patient's condition, whereas the diabetologists are paid for activity, specifically how often a patient visits, with no link to outcomes.[109]

132. Stephen Barclay, Minister of State for Health, described how having a single organisation responsible for the health and care provision of a defined population within a capitated budget over a 10–15 year contract presents an opportunity to frontload investment and focus on outcomes, so services have "more skin in the game."[110]

133. The purported benefits of organisational integration, while they appear convincing at a common-sense level, are not supported by studies from organisational or economic literature.[111] Organisational integration and alignment of financial incentives, through changes to payment systems, remove barriers to integrated care. An analysis of ACOs, particularly in the US, suggests that the benefits of removing such barriers are unlikely to be sufficient to drive improvements in patient care. Instead, evidence presented in the British Medical Journal, which looked at factors contributing to the performance of ACOs in Colorado and Oregon, suggests leadership, culture and management, particularly enhancing the capability of professionals to redesign services, are better explanations of ACO performance.[112] Professor Katharine Checkland, from the University of Manchester, who leads the national evaluation of the new care models programme, echoed this view:

107 Q185 Paul Maubach

108 National Audit Office, Health and social care integration, HC 1011 Session 2016–17 8 February 2017, page 10, para 20

109 Q169 Paul Maubach

110 Q393 Stephen Barclay

111 Q236 Professor Katharine Checkland

112 Department of Health and Social Care, Accountable care organisations: Government response on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable care models), April 2018

> creating an integrated organisation does not necessarily make it easier to do integration work. It is about relationships and communication, and knowing where people are and who to speak to. It is the day-to-day work of integration.[113]

Strengthening primary care and community services

134. There has been a longstanding effort to provide more care outside of hospitals. However, hospital services continue to consume the lion's share of healthcare resources compared to the rest of the sector. Problems in the acute sector also consume the attention and resources of policymakers. As Paul Maubach described the centre of gravity in the NHS is towards the acute sector. The Sustainability and Transformation Fund has largely been used to improve the financial position of NHS providers, particularly acute providers.

135. Primary care and community services are currently much smaller, more disparate, organisations, although there has been an increase in GP federations over recent years. According to Paul Maubech from Dudley CCG:

> A major challenge at the moment is how to shift that gravity towards integrated care to support people, managing and supporting them to live with the complexity of the conditions they have, in their own homes.[114]

136. Paul Maubech argued that bringing the disparate array of primary and community health services into a single, much larger, ACO provider would help to shift the balance within the system.[115] While this may be the case, the challenge of allocating resources, which are currently limited, within a single organisation does not of itself resolve the problem of moving funding towards out-of-hospital services when demand for acute care is rising. It is possible such an arrangement could also favour secondary care if other sectors are not sufficiently represented and protected within one provider.

137. Another critical reason for using an ACO contract is to improve the resilience of primary care services. Paul Maubech told us how five years ago Dudley had 52 GP practices, but is now losing branch surgeries and practices at the rate of one every six months.[116] There are two interrelated reasons for this development. One is that there are not enough doctors coming into general practice. The other that there is rising demand for primary care. Patients are increasingly presenting with complex multi-morbidities, which according to Mr Maubach are better served by a multi-disciplinary approach.[117] A key advantage of an ACO contract is the ability to incorporate primary care. Mr Maubach explained that an ACO contract:

> offers the opportunity fully to integrate primary care with the rest of the system. There is no other contractual mechanism available to do that. Without the ACO contract, you cannot formally integrate primary care with community mental health and other services.[118]

113 Q264 Professor Katharine Checkland
114 Q196 Paul Maubach
115 Q171 Paul Maubach
116 Q172 Paul Maubach
117 Q172 Paul Maubach
118 Q172 Paul Maubach

138. The ability of the accountable care organisations to improve the resilience of primary care is largely at the discretion of GPs themselves. Simon Stevens told us that GPs have to "feel that this is a sensible approach and they want to do it, in parts of the country where the health service wants to do it. That is why it should be an option, but it is not a requirement."[119] Most of the GPs in Dudley have opted for partial integration rather than full integration with the ACO contract if and when this becomes available.[120]

Conclusions and recommendations

139. There are questions about whether using an Accountable Care Contract to create a single organisation will accelerate integration. However, there is a strong case for using these contracts to streamline decision making rather than require decisions to be referred back to individual statutory partners. Evidence to date suggest that the most important factor is effective joint working to shift incentives towards preventing ill-health, improve the management of long-term conditionss and strengthen services outside hospitals.

140. **Given the controversy surrounding the introduction of accountable care organisations in the English NHS, we believe piloting these models before roll-out is advisable. There should be an incremental approach to the introduction of ACOs in the English NHS, with any areas choosing to go down this route being carefully evaluated.**

141. **The evaluation of ACOs should seek to assess:**

a) **the benefits and any unintended consequences of these structures compared with improving joint working through integrated care partnerships.**

b) **the implications of the scope of the ACO contract, particularly whether hospital services, GP practices and social care should be incorporated, either in a partially integrated or fully integrated capacity.**

c) **the impact of ACOs on decision-making processes, objectives and incentives for staff and the resilience of services outside of hospitals.**

d) **the impact on patient choice.**

We do not believe it is in the best interests of patients to return to a system devoid of choice.

Concerns about ACOs

142. There is no doubt that contracting a single organisation to deliver health and care for an entire local population over a 10–15 year period brings with it risks that will need to be managed. In this respect, accountable care organisations represent a significant shift in health policy. In acknowledgement, the Next Steps to the NHS Five Year Forward View, referring to the introduction of ACOs, stated clearly that:

> The complexity of the procurement process needed, and the requirements for systematic evaluation and management of risk, means they will not be the focus of activity in most areas over the next few years.[121]

119 Q271 Simon Stevens

120 *Aspiring ACO will not fully integrate vast majority of its GPs*, Health Service Journal, 22 March 2018

121 NHS England, Next Steps on the NHS Five Year Forward View, March 2017, page 37

143. Given the risks involved, it is not surprising that many responses to our inquiry expressed significant concerns about the introduction of accountable care organisations in the English NHS. The worries people have cover not only the concept of ACOs and the initial proposals over how they will operate, but also how these contracts will be introduced.

144. The main concerns expressed to us are that accountable care organisations extend the scope for privatisation of the NHS, will worsen terms and conditions for staff or will lead to increased charges and care being rationed.

Privatisation

145. The Government has not ruled out the prospect of private providers bidding or holding an ACO contract because they point out that Clinical commissioning groups are prevented from favouring bidders based on their ownership (e.g. whether they are public or non-statutory services), by the Public Contracts Regulations 2015.[122]

146. Privatisation of the NHS remains a concern for many people (see Chapter 6). Keep Our NHS Public, on its website, suggest that accountable care organisations, "increase the potential scope of NHS privatisation."[123] According to this website, the introduction of ACOs means:

> multiple procurements will be replaced by a single, major, long-term contract to provide health and social care services for an entire area. The draft model contract for ACOs published by NHSE allows for, and is likely to attract, bids from multinational corporations.[124]

147. The main concerns about the prospect of private companies taking responsibility for an ACO contract include:

a) The type of private provider, including the potential for ACOs to be special purpose vehicles.

b) The length of the contractual term (a 10–15 year contract).

c) The ability of private providers to exit the market in the event of failure.

148. Stephen Barclay assured us that there are a "number of checks and balances in the system". He told us that they include:

- local requirements for CCGs to consult health and wellbeing boards, and oversight and scrutiny committees as well as their local populations; and
- national checks of CCGs through the integrated support and assurance process.[125]

122 Correspondence from Rt. Hon Jeremy Hunt MP, Secretary of State for Health and Social Care to Dr Sarah Wollaston MP, Chair of the Health and Social Care Committee, 22 January 2018, POC_1115906

123 Keep Our NHS Public, Accountable care: Accountable care organisations, accountable care systems in England, accessed on 18 May 2018.

124 Keep Our NHS Public, Accountable care: Accountable care organisations, accountable care systems in England, accessed on 18 May 2018.

125 Q375 Stephen Barclay

149. There are several reasons why the prospect of a private provider holding an ACO contract is unlikely. Most significantly, while commissioners cannot discriminate based on a bidder's organisational form, CCGs can decide not to tender services if there is only one credible provider.[126] Using an ACO contract to merge existing services, acute, community, primary, mental health and social care, into one complex contract would effectively narrow the scope of eligible bidders. Integrated care partnerships between NHS bodies looking to use the contract to form a large integrated care provider would have an advantage over non-statutory providers that are less likely to have experience of managing the same scope of services: NHS bodies, therefore, are far more likely to be "credible providers" than non-statutory bodies.

150. Jonathon Marron from the Department of Health and Social Care described this process, saying that the regulations as they currently stand mean, for example, that a competition is not run every year for the "Guy's and St Thomas's contract" as there is no alternative provider.[127] Rather than increasing private sector involvement, we heard that creating large integrated legal entities through an ACO would enable more services (e.g. community nursing, sexual health) to be incorporated into the organisation, thereby reducing the eligibility of smaller providers to bid for separate contracts and the necessity for commissioners to go out to tender.

151. It was also pointed out that there is little room to extract profits given the available budgets and so these contracts are unlikely to appeal to the private sector in the way that some fear.[128]

152. The two areas considering using the ACO contract, Dudley and the City of Manchester, are looking to work through NHS bodies, rather than with the private sector. Paul Maubach from Dudley CCG explained that an ACO contract becomes a useful vehicle once you have effective partnerships between services in place. Mr Maubach's view was that the concerns surrounding privatisation are a "red herring", as the existence of effective partnerships means it is harder for independent providers outside a partnership to demonstrate that they could provide greater value than existing, NHS, providers.[129]

153. There is also little appetite from within the private sector itself to be the sole provider of these contracts. NHS Partners Network, a representative of independent sector providers, told us that in the current environment it does not expect private providers to take on an ACO contract for a whole system. NHSPN states that in addition to the political sensitivities involved, it would be a significant financial risk and independent providers would not expect to be 'bailed out'.[130] Nigel Edwards, Chief Executive of the Nuffield Trust, explained that transferring staff and assets to a private provider, while theoretically possible, may require primary legislation.[131]

Staff terms and conditions

154. There is currently no prescribed organisational form for ACOs. Theoretically they can be public or non-statutory organisations. For many staff, there is a worry that their

126 Q389 Jonathon Marron
127 Q390 Jonathon Marron
128 Q240 Professor Chris Ham
129 Q164 Paul Maubach
130 NHS Partners Network STP0120
131 Q238 Nigel Edwards

employer could end up being outside the NHS, thereby posing a threat to their existing terms and conditions. Such fears have been amplified by a recent increase in the practice of foundation trusts establishing subsidiary companies to make efficiencies. Simon Stevens confirmed that NHS England:

> will be making it absolutely clear in our public consultation on the draft contract that subcontracting of that nature would not be permitted without the authorisation of the CCG as exists at the moment, so that there were no new risks arising.[132]

Conclusions and recommendations

155. **We recognise the concern expressed by those who worry that ACOs could be taken over by private companies managing a very large budget, but we heard a clear message that this is unlikely to happen in practice. Rather than leading to increasing privatisation and charges for healthcare, we heard that using an ACO contract to form large integrated care organisations would be more likely to lead to less competition and a diminution of the internal market and private sector involvement.**

156. **We recommend that ACOs, if a decision is made to introduce them more widely, should be established in primary legislation as NHS bodies. This will require a fundamental revisiting of the Health and Social Care Act 2012 and other legislation. Whilst we see ACOs as a mechanism to strengthen integration and to roll back the internal market, these organisations should have the freedom to involve, and contract with, non-statutory bodies where that is in the best interests of patients.**

132 Q278 Simon Stevens

6 Concerns about the direction of travel

157. There are five key concerns arising out of the NHS Five Year Forward View process. We describe, and respond to, each in this chapter. Some of these concerns reflect genuine obstacles to transformation and risks to the sustainability and cohesion of the health and care system. Others, however, such as assertions that the NHS is being 'Americanised' in a way that will lead to people having to pay for care, are creating a climate that risks blocking the joining up of services in the interests of patients.

158. We know from polling that the British public are worried about the future of the national health service.[133] The way national bodies communicate has often exacerbated public concerns. For example, the language of the NHS, and the wider health and social care system, is full of unhelpful jargon (See Chapter 7).

159. The positive underlying intention of the NHS Five Year Forward View process is clouded by unhelpful acronym spaghetti. Jargon, we heard from Dr Charlotte Augst from the Richmond Group, is not only ineffective, it raises suspicion. The public do not understand these acronyms, which leads some to think there is a story they are not being told.[134] Niall Dickson, Chief Executive of the NHS Confederation, made this point:

> I suspect that Mr and Mrs Smith walking down the road probably do not know what STP stands for and do not understand a lot of this process. That is part of the problem, but the way it was launched and people's genuine fears about what might happen have become attached to both the letters and the process, and we have to move on from that.[135]

160. The Government and national bodies must take responsibility for finding effective solutions to address the key funding and workforce pressures on the system. However, we frequently see and receive messages from campaign groups that are inaccurate, misleading and play on the public's genuine concerns. These messages make it harder for local organisations to make progress. For example, as Niall Dickson described, negative labels attached to the STP brand have tainted the process.[136]

Top-down reorganisation of the NHS without public consultation and parliamentary scrutiny

161. Current changes to regional structures and local organisations, such as STPs, ICSs and ACOs, focus on integration at the organisational level. We have heard concerns that these reforms constitute another top-down reorganisation of the NHS, which is taking place without adequate public consultation or parliamentary scrutiny. This focus, it is argued, is a distraction from the task for integrating care for patients.[137]

162. Dr Graham Winyard, a former National Medical Director for the NHS in England, argued that the NHS has had 35 years of changes to the organisational superstructure.

133 Ipsos MORI (STP0104)
134 Q155 Dr Augst
135 Q206 Niall Dickson
136 Q206 Niall Dickson
137 Q18 Dr Graham Winyard, Q8 Dr Tony O'Sullivan

He told us that integrated care depends on relationships between professionals; the NHS superstructure can either impede or support inter-professional working.[138] Dr Tony O'Sullivan from Keep our NHS Public echoed this view, saying:

> It is top-down. The integration is integration of management systems, of financial purses and of organisations, and, to me, it is at the expense of the integration of true delivery of co-ordinated care that has been going on and did not need Simon Stevens or Jeremy Hunt to tell us to do it.[139]

163. The current suite of NHS reforms is seeking to remove barriers and blur obstructive boundaries between services (see Chapter 2). Examples include the opportunity to use an ACO contract to bring primary care, community services and social care into one organisation to allow more streamlined decision making. Integrated care systems for example, can align incentives (e.g. through the use of capitated budgets) for better preventative care, thereby moving away from tariff arrangements which drive hospital activity.

164. Removing barriers at an organisational level is one part of improving integrated care. However, these changes alone are not the solution. Integrating care at the frontline is also about the workforce challenge, dependent primarily on building relationships between professionals. Simply removing external obstacles will not be sufficient to address the wider cultural and relational challenges of integrating care. So far scarce attention has been paid to the role of national bodies in building and supporting the intrinsic capability and capacity of frontline staff to improve, integrate and transform care.

Inadequate response to system pressures

165. We heard concerns from Keep Our NHS Public (KONP), a national campaigning body, that integrated care is often asserted as a solution to the NHS's problems. KONP argue that the narrative described in the NHS Five Year Forward View is an inadequate response to fundamental problems facing the NHS: staff shortages, funding levels and the separation of health and social care.[140]

166. There is widespread recognition that the moves to more integrated care are not a solution to systemic funding and workforce pressures facing health and social care services. These pressures represent significant barriers to the transformation of care, which if not adequately addressed, will compromise the NHS's ability to maintain the quality of existing services, let alone enable staff to find the time to transform care. The extent and implications of these barriers are described in more detail in Chapter 7.

167. Sustainability and transformation partnerships, and the more advanced integrated care systems, provide a mechanism to move away from the autonomous competitive arrangements imposed by the Health and Social Care Act 2012, towards a collaborative, placed-based approach to care. **These mechanisms are no substitute for effective solutions to funding and workforce pressures, but if well designed and implemented they can represent a better way to manage resources in the short-term, including using the skills of staff more effectively on behalf of patients.**

138 Q18 Dr Graham Winyard
139 Q8 Dr Tony O'Sullivan
140 Keep Our NHS Public (STP0093)

Smokescreen for cuts

168. A specific requirement of the sustainability and transformation plans was to quantify the funding gap in each footprint, along with proposals to fill this gap. Difficult decisions facing local areas, and the short timeframe in which they had to develop their plans, led to STPs being labelled as a "smokescreen for cuts".[141]

169. Helga Pile, Deputy Head of Health at UNISON, argued that the STP initiative is "being seen as a means of delivering cuts to spending, and that means that many of the aims that they have that would benefit patients are not being identified and recognised."[142] This point was echoed by Dr Chaand Nagpaul from the British Medical Association. Based on information obtained from the BMA's regional offices, Dr Nagpaul pointed to reports from BMA members that the boards of STPs are "talking about how we make cuts", rather than how to transform care.[143]

170. STPs originated in a time of financial constraint. These challenging circumstances meant partnerships were faced with difficult decisions from their inception. As Ian Williamson from Manchester Health and Care Commissioning explained:

> You asked about cost-cutting. Frankly, we all live in a world where we have budgets that we must stay within, and it is our role to do so. I do not think there is a part of the NHS in the country that is not struggling to manage a set of very competing pressures.[144]

171. The main criticism that STPs are a smokescreen for cuts conflates the principle of bringing local leaders together to plan services and manage finite resources with the difficult decisions the current funding envelope imposes on these partnerships. Conflation of these two separate points has unfortunately contributed to the negative, and tainted, perception of STPs.[145]

Privatisation

172. Fears that the NHS is being privatised have been projected onto various changes in health policy since 1990. The World Health Organisation in 1995 defined privatisation as "a process in which non-government actors become increasingly involved in the financing and/or provision of healthcare services."[146] Privatisation encompasses the transfer of government or state assets, organisations and operations to the non-government actors.[147]

173. Private sector involvement in the NHS is very different to the private insurance based systems found in other countries (e.g. the US). Private companies have played a role in the NHS throughout its 70-year history; most GP practices are profit-making independent contractors to the NHS and community pharmacies are private businesses for example.[148]

141 Keep Our NHS Public (STP0093) UNISON (STP0057) Unite the Union (STP0070)
142 Q84 Helga Pile
143 Q86 Dr Nagpaul.
144 Q160 Ian Williamson
145 Q206 Niall Dickson,NHS Clinical Commissioners (STP0064)
146 Full Fact, Ask Full Fact: Does the World Health Organisation think the UK no longer has an NHS? 21 March 2016
147 OECD, Glossary of statistical terms: Privatisation, accessed on 2 June 2018
148 The King's Fund, Is the NHS being privatised? 22 August 2017

174. The vast majority of the British public support the founding principles of the national health service.[149] No mainstream political party supports shifting the NHS from a tax-funded system to a private insurance model. When given a choice, most people would prefer their NHS-funded care to be provided by the NHS, rather than non-statutory providers (up from 39% in 2015 to 55% in 2017). However, 30% of the population have no preference whether their NHS-funded care is delivered by the public, private or voluntary sector.[150]

175. There has been an expansion in the role of the private sector since the early 2000s: for example, the use of private sector investment to fund new hospitals (e.g. private finance initiative) and independent treatment centres to reduce waiting times for elective care. More recently, there has been an increase in non-NHS providers of NHS-funded care, with the most significant increase being in community health services. Community health service contracts have gone to a range of providers including charities, social enterprises and community interest companies as well as private companies.[151]

176. Keep Our NHS Public have argued that the underlying motive of national bodies is to transfer large parts of local health and care provision into the private sector through the use of an accountable care contract. Dr Tony O'Sullivan, Co-Chair of Keep Our NHS Public, told us that:

> these things have been put in place because of the top-down plan to go on a journey, which includes, I am afraid—we have not really discussed this—the assumption of a growing degree of privatisation, to an end form of ACOs that are independent bodies outside the NHS, so you have fragmented the NHS.[152]

177. We heard repeatedly, however, from a series of both local and national leaders, that the direction of travel is more likely to reduce private sector involvement rather than increase it. This is explained in more detail in Chapter 5. However, fears about privatisation have been projected onto the NHS Five Year Forward View process, making the challenge of integrating care more difficult. Niall Dickson from the NHS Confederation argued:

> A lot of the comment is misinformed. The idea that this is a secret plot in Jeremy Hunt's desk to privatise the NHS is palpable nonsense. Everybody involved in the process knows that that privatisation argument is nonsense, but it has certainly tainted the (STP) brand.[153]

Paying for healthcare

178. Doctors for the NHS expressed a concern that blurring boundaries between health and social care could result in charges being introduced for services currently classified as healthcare. For example, Dr Colin Hutchinson, Chair of Doctors for the NHS, explained:

> At my local authority health and wellbeing board, the medical side of the collaborative agrees that there are situations where the definition of what

149 Ipsos MORI (STP0104)
150 Ipsos MORI (STP0104)
151 The Health Foundation, Briefing: Provision of community care: who, what, how much? April 2017
152 Q41 Dr Tony O'Sullivan
153 Q206 Niall Dickson

> is classified as healthcare and what is classified as social care could become very important, such as the use of intermediate care beds, including the care B&B type of model that has been suggested. Are those health or are they social care? The use of rehabilitation services, particularly if they are delivered in patients' homes, raises the possibility of hotel charges for non-direct medical care for patients staying in hospital. If you are dissolving those boundaries, it does need to be defined, otherwise people will receive unexpected bills.[154]

179. Simon Stevens, Chief Executive of NHS England, provided assurance that it is crucial that NHS care remains free and based on patients' need rather than ability to pay. He said that this is "a founding and enduring principle in the NHS, and nothing that is proposed will change it."[155]

180. With pooled budgets and alignment of incentives to reduce hospital stays, it is likely that the blurring of boundaries could advantage rather than disadvantage patients by seeing more personal care directly funded by the NHS for limited periods after discharge. For example, the Discharge to Assess model in Sheffield entails patients being discharged when they are medically fit and having their support needs assessed at home by an immediate care or social care team. The model has reduced length of stay and helps to ensure patients receive the right support at the right time.[156]

Conclusions and recommendations

181. **STPs, ICSs and ICPs currently have to work within the constraints of existing legislation and manage rising pressures with limited resources. This context limits progress towards integrating care for patients.**

182. **Some campaigns against privatisation confuse issues around integration. Concerns expressed about the 'Americanisation' of the NHS are misleading. This has not been helped by poor communication of the STP process and the language of accountable care, neither of which have been adequately or meaningfully co-designed or consulted on with the public or their local representatives.**

183. **We recommend that the efforts to engage and communicate with the public on integrated care which we refer to above should tackle head-on the concerns about privatisation, including a clear explanation to the public that moves towards integrated care will not result in them paying for services.**

184. **We recommend that national bodies take proactive steps to dispel misleading assertions about the privatisation and Americanisation of NHS. The Department should publish an annual assessment of the extent of private sector in the NHS, including the value, number and percentage of contracts awarded to NHS, private providers, charities, social enterprises and community interest companies. This should include an analysis of historic trends in the extent of private sector involvement over a 5–10-year period.**

154 Q28 Dr Colin Hutchinson

155 Q271 Simon Stevens

156 The Health Foundation, 'Discharge to assess' at Sheffield Frailty Unit, accessed on 2 June 2018

Integrated care: positive examples of progress across the NHS in England

We have seen and heard of excellent examples of progress local areas have made to deliver more integrated care for patients across the country. Below are some examples from a selection of the integrated care systems, although similar examples are evident in many other parts of the country.

Frimley Health

Frimley is one of the leading integrated care systems and one of the areas involved in the new care models programme. As part of service changes made through the vanguard programme, Frimley has achieved a decrease in hospital activity in 2017/18, despite a growth in emergency admissions in previous years.[157] Frimley is a good example of an area that has implemented changes to bring care out of hospitals and closer to communities. For example, the area has developed urgent care hubs, run by GP practices and other services in the area, to offer same-day appointments. Patients in need of urgent medical care are seen by members of an interdisciplinary team consisting of GPs, nurse practitioners, paramedics and other relevant healthcare professionals.[158]

Nottinghamshire

Nottinghamshire provides a good example of how more integrated working between GPs, community services and care homes has helped to improve care and reduce hospital activity. Principia is one of the multispecialty community providers, consisting of a partnership between 12 local practices. which operates within the Nottingham and Nottinghamshire integrated care system. The partnership runs an enhanced GP support service in 22 care homes—including the provision of a named GP for each home—in the Rushcliffe area, which has led to a 29% reduction in A&E attendances and a 23% fall in admissions.[159]

Buckinghamshire

Buckinghamshire is an example of where local councils are working closely with the NHS to improve the health and wellbeing of the local population. There are a series of initiatives across a range of issues—such as the promotion of physical activity and health checks, prevention and early diagnosis of diabetes, falls prevention and cancer prevention—that have demonstrated significant progress, including:

- a 57% reduction in falls causing severe harm;
- a 9% increase in the uptake of NHS health checks; and

157 NHS England (STP0107)
158 NHS England (STP0107)
159 Health Foundation, The impact of providing enhanced support for care home residents in Rushcliffe, March 2017; http://www.health.org.uk/publication/impact-enhanced-support-rushcliffe

- a 17% reduction in inactivity levels and 20% increase in people achieving recommended levels of activity.[160]

Dorset

Dorset is an example of an area which is planning to make changes to its acute hospitals in order to address variations in quality and improve the financial sustainability of the system. The main hospitals in Dorset currently provide many of the same services. However, Dorset has made progress in making more efficient use of hospitals with plans to ensure each hospital specialises in a particular area. Dorset is also planning to introduce community hubs in which GPs, specialist doctors, nurses, physiotherapists and social care workers work in one place and provide more timely and effective support to rural communities within the county.

Dorset has also been using technology to help patients manage their long-term conditions. For example, patients with diabetes, chronic obstructive pulmonary disease and heart disease use mobile phone apps to manage these conditions.[161]

160 NHS England (STP0107)
161 NHS England (STP0107)

Section 3: The case for change

7 Making the case for change

Narrative for change

185. The NHS's history has been one of repeated reorganisations. In contrast to previous reforms, we heard that the NHS Five Year Forward process, rather than spending time redrawing the map of the NHS, is supposed to focus on improving the relationships and behaviours between local services.[162] This is a pragmatic approach, particularly given there is little appetite within the service for another set of legislative reforms in the wake of the Health and Social Care Act 2012.

186. National bodies have attempted to harness local support and energy across the health and care community, at a time of rising pressures and limited resources. However, a key message from our inquiry is that there needs to be a clearer narrative to explain the direction of travel: what are these reforms trying to achieve; what does the end state look like; what are the risks and what the benefits for patients and taxpayers.

187. There has been great variation in the extent to which local communities and their representatives have been informed and involved. Nigel Edwards, Chief Executive of the Nuffield Trust, explained:

> perhaps the biggest weakness, not just with the STP process but arguably with the "Five Year Forward View", is the lack of a very strong story about what we are trying to achieve, where we think we are going, what the advantages of that are and what the risks might be. That has been largely absent.[163]

188. Based on the evidence we have heard, a compelling narrative should:

a) **articulate what high-quality integrated care looks like, its benefits and the litmus test for success from the patient perspective**. A compelling narrative would describe integrated care from a patient perspective. The NHS Five Year Forward View was a vision for how the system needed to change. It articulated the benefits of change primarily from a system perspective.[164] However, when it comes to communicating the case for change locally, describing the benefits for the system as a whole is not the best starting point.

   The public want to know how proposed changes will improve care for them, their families and their local communities.[165] Despite this, many of the original sustainability and transformation plans used the Forward View as the starting point for the local service changes proposed within these documents. London Southbank University's analysis of the South Yorkshire and Bassetlaw STP highlighted that it was one of the few plans that did not use the NHS Five Year Forward View as driver behind the plan.[166]

162 Oral evidence taken before the Public Accounts Committee on 5 March 2018, HC (2017–18) 793, Q133 [Sir Chris Wormald]
163 Q262 Nigel Edwards
164 Q150 Dr Augst
165 Ipsos MORI (STP0104), Richmond Group of Charities (STP0102)
166 London Southbank University, STP analysis South Yorkshire and Bassetlaw STP, June 2017

b) **focus on reform from the bottom up by supporting frontline staff and removing barriers to integrated care.** There is widespread support for integrating care at patient and local level across the health and care community. The benefits of delivering holistic, joined up care for patients are recognised by staff. Dr Nagpaul from the British Medical Association made clear that "the workforce does not go into a hospital or a GP's surgery thinking "STP." People look at their lives in terms of looking after patients within the setting they are in."[167]

There is widespread support for changes that support health and social care staff to integrate care from the bottom up and to remove barriers to joined up working and information sharing. We heard that many frontline staff have spent large parts of their professional careers trying to integrate care for patients, often working around policies that construct rather than remove barriers to integrated care at local level.

c) **provide clarity on what the shape of the health and care system will look like.** One of the problems arising from the lack of a clear narrative, according to Dr Charlotte Augst from the Richmond Group, is that the " ill-defined nature of the STP endeavour means that people can project on to it whatever anxieties or hopes they have about it."[168]

NHS providers, clinical commissioning groups and local government have called for greater clarity over the future shape of health and social care, particularly the role some of the current functions, such as commissioning, should play within a more collaborative, placed-based structure.[169]

d) **be based on a realistic, open and honest dialogue with the public.** Nigel Edwards from the Nuffield Trust cautioned that it is important not to over-extrapolate the benefits of integrated care and the time and money required for transformation.[170] Professor Katherine Checkland from Manchester University, who leads the evaluation of the new care models programme, told us "at the micro-level, as Nigel said, there is good evidence that integration is good for patients, but it is not at all clear that it will reduce overall activity or costs. There is a lot of fairly clear evidence that that is not the case."[171]

Communicating the case for change to patients and the public

189. The vast majority of the British public continue to support the principles of a national health service that is tax-funded, comprehensive and free at the point of delivery.[172] Most people agree that the NHS is crucial to British society and that everything must be done to maintain it. According to Ipsos MORI this has been a popular and stable belief for almost two decades. From 2000 to 2017 the percentage of people agreeing with this statement has ranged from a low of 73% to a high of 79%.[173]

167 Q93 Dr Nagpaul
168 Q143
169 NHS Providers STP0050, NHS Clinical Commissioners STP0064, Local Government Association STP0027
170 Q230 [Nigel Edwards]
171 Q233 [Professor Checkland]
172 Ipsos MORI (STP0104)
173 Ipsos MORI (STP0104)

190. Compared to other countries, British people are more worried about the future of the health system. For example, 47% of British respondents to an Ipsos MORI survey expect the quality of care to get worse over the coming years - higher than all the other countries surveyed.[174] The public increasingly recognise that the NHS is struggling with funding and workforce pressures.[175]

191. Health reforms in western countries are often controversial. However, pressures on the health and social care system, and the public's perception of these pressures and their causes, make the challenge of transforming care even more difficult.

192. Trust in Government, politicians and system leaders has long been low and despite doctors and nurses enjoying high levels of public trust compared to other professions,[176] mistrust among the public plays into local changes to services. Ipsos MORI are regularly commissioned by NHS organisations to support consultations involving local changes to healthcare services. Kate Duxbury from Ipsos MORI told us that the company is finding higher levels of mistrust among the public in this work.[177]

193. The campaign groups we heard from during this inquiry described how trust in national leaders, including NHS leaders, has eroded following a series of reforms to extend the role of choice and competition within the NHS.

194. Public distrust is also fuelled by the way national and local bodies communicate. The use of jargon heightens suspicions among the public, thereby making the challenge of implementing changes even more difficult.[178]

195. Communicating the case for change is not a simple task. Kate Duxbury from Ipsos MORI described how within an STP there are so many "different issues that matter to many different people in different ways that actually it is very difficult to engage with the public and represent everything they are saying."[179] National bodies are aware of the need for greater public and community engagement and are taking steps to support it.[180]

196. Despite overwhelming support for a national health service, making the case for change based on the benefits for the system does not resonate with the public. Depicting the health service as being in crisis and therefore in need of radical reform does not in many cases chime with people's actual experience.[181] The Richmond Group in 2014 and 2016 commissioned Britain Thinks, an insight and strategy consultancy, to research the most effective messages and communications approaches for engaging the public in service changes. Britain Thinks found that people are reluctant to label the system as in crisis as they feel it is disloyal. However, recognition that funding and staff shortages are growing creates more openness to change.[182]

197. Britain Thinks found that saving money is not regarded by the public as a justifiable basis for health service reform. Patients and the public need to know how changes will

174 Ipsos MORI (STP0104)
175 The Richmond Group of Charities STP0102
176 Ipsos MORI STP0104
177 Q153 [Kate Duxbury]
178 Q155 [Dr Augst], Q206 [Niall Dickson]
179 Q154 [Kate Duxbury]
180 NHS England (STP0132)
181 Richmond Group of Charities (STP0102)
182 Richmond Group of Charities (STP0102)

benefit them, their families and friends and their local communities. Focusing on tangible changes to treatment processes or problems that are recognised locally works better. Imelda Redmond, National Director of Healthwatch England, described a good example:

> I saw some very nice work done by Suffolk and North East Essex STP. They did all their deliberative events with the public and they could interpret what people were saying. They could understand the difference in life expectancy between Southwold and Jaywick, which are both in their patch—I cannot remember how many years it is—so they could quickly get to, "The public think that is not fair." Then they can relay back to people in very tangible ways, "We will improve the life expectancy," "We will reduce that gap," or, "We will have a zero tolerance on suicides in our patch." These are tangible things that people get, which is quite a different language to, "We will improve the pathway for people who need tertiary care on blah."[183]

198. The public also have a strong emotional attachment to local services, particularly hospitals.[184] Hospitals signify safety, somewhere people can go in emergencies and receive expert treatment.[185] For many people hospitals and GP practices are the two access points they rely on.[186] From the public's point of view any changes to these services are much more "radical" than any of the changes the health community considers radical (e.g. risk stratifying patients).[187] Therefore, it is important the public continue to recognise the services they depend on (hospitals, GP surgeries etc) in whatever changes are proposed.

199. Ipsos MORI explained that there is strong support for ensuring the public is engaged in decisions about local service changes. For example, 44% of the public said that they wanted to have a say on their local STP. Similarly, even though 39% did not want to be personally involved, they believed the public should have a voice.[188]

200. Often the NHS has consulted with the public in a manner which can feel very tokenistic for those involved. As Niall Dickson from the NHS Confederation described:

> The history of the health service has, frankly, long struggled with public engagement. The traditional means by which you consulted the public was to have a very firm plan. You took that plan out, you went through a period of time and you either got it through or you did not. The way STPs started was probably not terribly helpful; they were seen as secretive.[189]

201. We heard that the NHS can improve the way it engages by initiating an early dialogue with the public and local groups about the direction of travel rather than waiting until they have a concrete plan. As Niall Dickson described, that could take the form of a conversation which begins with saying "this is the direction we want to go in; these are the trade-offs." The evidence we received is that the public recognise the need to make trade-offs and are willing to engage in a constructive dialogue. Niall Dickson told us that:

183 Q147 [Imelda Redmond]
184 Ipsos MORI (STP0104) Richmond Group of Charities (STP0102)
185 Richmond Group of Charities (STP0102)
186 Q152 [Dr Augst]
187 Q152 [Dr Augst]
188 Ipsos MORI (STP0104)
189 Q205 [Niall Dickson]

> Going forward, there is a real prospect that we can go out and have very grown-up conversations, hopefully supported by local and national politicians, because there are some difficult conversations, as well as ones that explain how the new models of care will work.[190]

Conclusions and recommendations

202. **There has not been a sufficiently clear and compelling explanation of the direction of travel and the benefits of integration to patients and the public. National and local leaders need to do better in making the case for change and how these new reforms are relevant to those who rely on services. The language of integrated care is like acronym soup: full of jargon, unintelligible acronyms and poorly explained.**

203. **The Department of Health and Social Care and national bodies should clearly and persuasively explain the direction of travel and the benefits of these reforms to patients and the public. We recommend the Department and national bodies develop a narrative in collaboration with representatives of communities, NHS bodies, local government, national charities and patient groups. The messaging should be tested with a representative sample of the public. A clear patient-centred explanation, including more accessible, jargon-free, language, is an essential resource for local health and social care bodies in making the case for change to their patients and wider communities.**

204. **Making the transition to more integrated care is a complex communications challenge covering a range of different services and patient populations. The case for change must be made in a way that is meaningful to patients and local communities. In addition to providing a clear narrative, in accessible language at a national level, the Department of Health and Social Care, NHS England and NHS Improvement should explain how they plan to support efforts to engage and communicate with the public.**

205. **NHS England and NHS Improvement should make clear that they actively support local areas in communicating and co-designing service changes with local communities and elected representatives.**

190 Q205 [Niall Dickson]

Section 4: Barriers to change

8 Funding and workforce pressures

Funding

206. The NHS is over halfway through the most austere decade in its history. Simon Stevens told us that over the last five years constraints on NHS funding have contributed £27billion to the country's deficit reduction. If health spending had kept pace with historic trends then the NHS would be expected to receive an extra £8.8billion next year than is currently planned.[191]

207. **Bringing local health and social care services together through STPs and ICSs to plan and organise care within their footprints is a much better way to manage constrained resources than the siloed, autonomous and competitive arrangements imposed by the Health and Social Care Act 2012. Our view is that STPs and ICSs are a pragmatic response to the current pressures on the system, rather than a smokescreen for cuts, but that these mechanisms are not a substitute for adequate funding of the system. Funding them properly, including access to ring-fenced transformation money, is necessary and would allow a far better assessment of their potential.**

Financial problems

208. The systemic pressure on the finances of the NHS and social care has shaped the context in which local organisations have come together. In some cases, where financial problems are looming, yet less serious, the circumstances facing local areas have acted as a catalyst for constructive conversations. However, there are local areas with deeply entrenched financial problems. Areas in greater financial distress can be consumed by maintaining day-to-day levels of performance and find it very difficult to find the capacity to engage in longer-term transformation. Nigel Edwards, Chief Executive of the Nuffield Trust, told us that:

> A significant number of systems are under such financial distress that even the task that they have been set to try to agree shared control totals is causing problems. One of the reasons why many change programmes fail at the system level is that people stop working in a system way and go back to managing the financial objectives of their organisations. There is a significant number of systems where the level of financial distress is such that the time and space to be able to deal with some of the bigger transformational changes that we all know need to be made is being diverted by the search for financial balance.[192]

Capital funding

209. Since 2014/15 the Department of Health and Social Care has relied on transfers from its capital budget to finance day-to-day running costs.[193] The Department, in evidence to the Committee of Public Accounts, confirmed that capital to revenue transfers are set to

191 Q304 Simon Stevens

192 Q246 Nigel Edwards

193 National Audit Office, Sustainability and transformation of the NHS, January 2018 Session 2017–19 HC 719, para 118

continue during this Parliament.[194] Using capital resources to fund day-to-day running and maintenance means there is less within the existing budget to transform care. Sir Robert Naylor's report on the NHS estate set an ambition for capital investment of £10billion in the NHS, with half going on transformation and the other half on addressing the backlog of maintenance within the system.[195]

210. In March 2017, the Chancellor announced £325million in capital funding for the most advanced STPs. An extra £3.5billion over the next four years was subsequently announced in the Autumn Budget in November 2017. Most of this funding, £2.6billion, has been earmarked to help STPs deliver their plans.[196]

211. The Government's intention is for this funding to be supplemented by £3.3billion from the sale of surplus land and buildings and "private finance investment in the health estate where this provides good value for money."[197] In addition, NHS England is investing £1billion in primary care infrastructure and £808million for national priorities.[198]

212. The capital resources provided so far fall short of Sir Robert Naylor's estimate and the amount of capital resource local areas are calling for. London South Bank University's analysis of all the 44 sustainability and transformation plans calculated the capital requirement to be over £14billion.[199] Nigel Edwards from the Nuffield Trust echoes the concern that the capital resources available to local areas are going to be significantly less than what they are calling for. Mr Edwards told us:

> We also know that, where they have made capital requirement estimates, they are significantly in excess of what is likely to be available, even if there are substantial land sales. The London STPs alone would account for an entire year's capital allocation, and more.[200]

Sustainability and Transformation Fund

213. The Department of Health's original intention was for the Sustainability and Transformation Fund (STF) to restore the NHS to financial balance and support the transformation of care. However, the use of the STF to date has predominately been to address NHS deficits, rather than fund transformation.[201] The Fund, and the way it is allocated, has helped NHS organisations to improve their financial discipline.[202]However, according to the NAO, the remaining deficit continues to create problems for future years and leaves less funding available for transformation.[203]

194 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC 793 Q41 [Sir Chris Wormald]
195 Department of Health and Social Care, NHS Property and Estates: Why the estate matters for patients. An independent report by Sir Robert Naylor for the Secretary of State for Health, March 2017
196 HM Treasury, Autumn Budget 2017, November 2017 (Session 2017–19) HC587, page66 para 6.8
197 HM Treasury, Autumn Budget 2017, November 2017 (Session 2017–19) HC587, page66 para 6.9
198 National Audit Office, Sustainability and transformation in the NHS, January 2018 Session 2017–19 HC719
199 London Southbank University, Sustainability and transformation plans: How serious are the proposals? A critical review, June 2017
200 Q247 [Nigel Edwards]
201 National Audit Office, Sustainability and transformation in the NHS, January 2018 Session 2017–19 HC719
202 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC793 Q55 [Sir Chris Wormald]
203 National Audit Office, Sustainability and transformation in the NHS, January 2018 Session 2017–19 HC719

214. The NHS planning guidance recently spilt the Sustainability and Transformation Fund in two: the Provider Sustainability Fund and the Commissioner Sustainability Fund.[204] Simon Stevens told the Committee of Public Accounts that "I think the "T" was probably a misnomer and that's why we dropped it."[205] The Government and national bodies have committed to the two Sustainability Funds for the next financial year, at which point they can choose to use this resource differently.[206]

Funding transformation

215. A clear message from our inquiry is that transformation is key to sustainability. Ian Dalton, Chief Executive of NHS Improvement, described the difficult dilemma facing national and local leaders, saying that:

> if we do not make the changes to care, we will be committing to dealing with potentially an ageing population, and the consequent rising demand, with care models that were designed for a different era, and we know that that is not the way forward either.[207]

216. The OECD's analysis of health systems across Europe acknowledges that making the transition to more efficient ways of delivering acute and chronic care is likely to require upfront investment.[208] We heard how many health systems that have undergone a similar journey to more integrated models of care have done so over 10–15 years, with dedicated upfront investment reserved for transformation.[209] As health spending looks set to consume an increasing proportion of GDP in western countries over the coming decades, investing in more integrated care is a way of getting better value for patients and taxpayers.

217. The NHS is "still very much in survival mode", according to the Public Accounts Committee.[210] Simon Stevens confirmed this view, stating that within the "aggregate funding available" national bodies decided to focus on supporting services in the "here and now," which left less resources available "for pump-priming and extending wider changes."[211]

218. The King's Fund and the Health Foundation in 2015 identified the following key components for funding transformation in health services: physical infrastructure, programme infrastructure, staff time and double running of services, in which new services are run alongside incumbent services before the latter can be safely decommissioned.[212]

204 NHS England and NHS Improvement, Refreshing NHS plans for 2018–19, February 2018
205 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC793 Q67 [Simon Stevens]
206 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC793 Q55 [Sir Chris Wormald]
207 Q359 [Ian Dalton]
208 OECD, *Health at a Glance: Europe 2016. State of Health in the EU Cycle*, November 2016
209 NHS Providers (STP0050)
210 House of Commons Committee of Public Accounts, Sustainability and transformation in the NHS, March 2018 Session 2017–19 HC793
211 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC793 Q85 [Simon Stevens]
212 The King's Fund and the Health Foundation, Making change possible: a transformation fund for the NHS, July 2015, page 6

219. Rather than changing administrative structures, the sort of change required to design and implement integrated care is often at a micro-level and concerns how frontline staff work together. Staffing is not the only component, but a clear message from our inquiry is that investment in staff capacity is critical for service transformation.

220. Quantifying the amount of funding required to deliver new and more integrated models of care across the NHS is very difficult, given both the scale of the transformation and the length of time needed to deliver the changes. We are disappointed that neither the Department of Health, NHS England nor NHS Improvement were able to provide an estimate of the scale of funding needed to deliver new models of care at scale or the approach they would take to make such an assessment. Greater Manchester had a £450million transformation fund over 5 years. Multiplying the level of transformation funding provided to Greater Manchester for the whole population of England comes to a figure of £9billion over 5 years.

Workforce challenges

Workforce shortfalls

221. Integrated care at the patient, service or organisational level is dependent on relationships between people working in health and social care. Whether patients experience holistic, coordinated and person-centred care depends on staff working together across acute, community, primary care, mental health, social care services and the voluntary sector.

222. The capacity, capability and motivation of staff to engage in transformation is also critical. Moving to new models of more integrated care requires:

a) the capacity and capability of staff to participate in complex service redesign;

b) engagement in dialogue with healthcare professionals and unions;

c) time to train staff with new skills; and

d) funding the staffing costs associated with double-running.[213]

It should also include time for meaningful local engagement with those who rely on services both now and in the future.

223. National bodies are endeavouring to transform care during a period in which NHS and adult social care services are struggling to recruit, train and retain sufficient numbers of staff to cope with rising, and increasingly complex, demands. We have heard throughout this inquiry and our recent inquiry into the nursing workforce that professionals often worry about their ability to maintain professional standards when confronted with relentless, complex or unmanageable caseloads.

224. Moving care out of hospitals is only acceptable if there is adequate provision already in place within community and primary care settings to meet changes in demand. This depends on having sufficient numbers of suitably qualified staff within these settings.

213 The King's Fund and the Health Foundation, Making change possible: a transformation fund for the NHS, July 2015

However, recent workforce trends run counter to this objective. The acute workforce has grown at a faster rate than primary, community and mental health services, some of which have seen numbers of staff drop considerably in recent years.[214] Where communities see highly valued resources, such as community hospitals, closed down before the promised new services to replace them are up and running, it seriously undermines trust in future service changes.

225. More collaborative, place-based ways of working, through sustainability and transformation partnerships and integrated care systems, provide an opportunity for local areas to deploy and retain limited pools of existing health professionals in the short term. However, without effective delivery of Health Education England's workforce strategy, collaborative working may be put at risk as staffing pressures encourage organisations to compete rather than look to share limited pools of staff.

Workforce engagement

226. NHS and social care professionals are likely to be the best advocates for more integrated care. Effectively communicating service change to the public depends on who presents the message as well as the message itself.[215] Public trust in nurses (93%) and doctors (91%) is significantly higher than politicians (17%), Government ministers (19%) and journalists (27%).[216] Alongside the NHS's strong brand, Ipsos MORI argue public trust in these health professions is a key advantage in making the case for change to the public, although Ipsos acknowledge:

> ...while this can be a benefit to be harnessed, it can also work in the opposite direction: a reform or message without NHS staff backing is unlikely to be popular with the public where staff are vocal, and the impact of this should not be underestimated.[217]

227. The NHS Constitution, the Royal College of Nursing told us, includes a requirement for NHS-funded organisations to "engage staff in decisions that affect them and the services they provide."[218] Staff engagement was limited in the development of the original plans. Professional bodies, including royal colleges and trade unions, continue to perceive staff engagement in sustainability and transformation partnerships as insufficient, poor and patchy.[219]

228. Local GPs appointed by the Royal College of General Practitioners to act as regional ambassadors in the development and implementation of STPs have "struggled to find a voice or influence on key STP boards."[220] Similarly, allied health professionals (e.g. physiotherapists, occupational therapists, paramedics, speech and language therapists), we heard, have also struggled to find a voice in the leadership of STPs. None of the clinical leads on STP boards come from the ranks of allied health professionals.[221]

214 Q110 [Lara Carmona] Q105 [Dr Nagpaul].
215 Ipsos MORI (STP0104)
216 Ipsos MORI (STP0104)
217 Ipsos MORI (STP0104)
218 Royal College of Nursing (STP0048)
219 British Medical Association (BMA) (STP0063) Royal College of Emergency Medicine (STP0015)Royal College of General Practitioners (STP0043)Royal College of Nursing (STP0048)
220 Royal College of General Practitioners (STP0043)
221 The Royal College of Speech and Language Therapists (STP0049)

229. We also heard reports of limited clinical engagement in proposals that clearly affect specific professional groups. For example, despite plans to reconfigure acute hospitals within many of the plans, the Royal College of Emergency Medicine reported that clinical engagement of its members was widely considered to be poor or patchy.[222]

Conclusions and recommendations

230. Funding and workforce pressures on NHS, social care and public health services present significant risks to the ability of the NHS even to maintain standards of care, let alone to transform. Funding and workforce pressures, if not adequately addressed, risk compromising these fragile local relationships which are pivotal to transforming care. We are concerned about workforce and funding shortfalls in community services, primary care and mental health, which are seriously limiting the capacity to shift more services closer to individuals within their communities.

231. **The NHS and local government have not been given adequate investment, support and time to embark on the scale of transformation envisaged. Transformation depends not only on having sufficient staff to maintain day-to-day running of services, but in the capacity and capability of staff to redesign services, engage in dialogue and consultation and develop new skills. Transformation also requires funding the staff costs associated with double-running new services, while old models are safely decommissioned.**

232. **The Government's long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention. We recommend that the Government commit to providing dedicated transformation funding when it announces its long-term funding settlement this summer.**

233. **The task of determining the scale of funding and the most appropriate ways to allocate and manage such resources is a complex challenge. To inform this work we recommend:**

- **Building on experience from the new care models programme and Greater Manchester, national and local bodies should form an estimate of the transformation funding they require to transition to new models of care at scale. This should include an estimate of funding required in each area to provide staff with the capacity to engage in transformation, develop new skills and facilitate the double running of services.**
- **Government and national bodies should develop clear proposals on how to allocate and manage this resource to ensure the best value for money.**

222 Royal College of Emergency Medicine (STP0015)

9 Oversight and regulation by national bodies

234. The health and social care landscape includes a complex national system of executive agencies, non-departmental public bodies and regulators, as well as the Department of Health and Social Care. The roles, responsibilities, legal powers and functions of these national bodies in many cases were introduced in statute by the Health and Social Care Act 2012.

235. These bodies are responsible for a complex range of interrelated and interdependent functions. The extent to which these bodies collaborate has a significant bearing on the operating landscape NHS and social care providers work within. This chapter describes the key concerns we heard about the role of national bodies in the development of sustainability and transformation plans.

Incoherent approach by national bodies

236. There is a widespread perception, particularly from health and social care providers and commissioners, including their representative bodies, of competing priorities between the key national bodies, particularly the Department of Health and Social Care, NHS England, NHS Improvement and the Care Quality Commission. This incoherence is manifested not only through conflicting policies, but also through the mixed messages local organisations receive from these national bodies.

237. Incoherent messages and priorities between NHS England and NHS Improvement have been evident since the beginning of the STP process in December 2015.[223] The King's Fund's report on the development of the original sustainability and transformation plans concluded that there was a need for closer alignment, and clearer messages, between NHS England and NHS Improvement as well as from regional teams within these organisations.[224] These inconsistencies between NHS England and NHS Improvement have persisted.

238. Local organisations, according to the National Audit Office, have continued to receive inconsistent messages from NHS England and NHS Improvement. For example, NHS England has encouraged local areas to explore the use of new payment systems that incentivise better ways of managing demands, whereas NHS Improvement has advised NHS providers to use payment by results to maximise their income, thereby improving the financial position of their individual organisations rather than that of the system.[225]

239. Simon Stevens, Chief Executive of NHS England, and Ian Dalton, Chief Executive of NHS Improvement, both acknowledged that their organisations need to do more to provide consistent messages to those on the frontline. Ian Dalton said that:

223 The King's Fund, Sustainability and Transformation Plans in the NHS: How they are being developed in practice?, November 2016, para 3.17

224 The King's Fund, Sustainability and Transformation Plans in the NHS: How they are being developed in practice?, November 2016

225 National Audit Office, Sustainability and transformation in the NHS, January 2018 Session 2017–19 HC719

> if we expect the NHS to integrate and to work together across different bits of the NHS, then we, as the local superstructure that supports the front-line, even if we do not deliver care directly to patients, must give consistent and clear messages.[226]

240. Since our oral evidence session, NHS England and NHS Improvement have published commitments setting out how they intend to work more collaboratively. From September 2018, the seven regional teams of NHS England and NHS Improvement will be led by one regional director working for both organisations. Also, where possible, the two bodies will integrate and align national programmes and activities. These changes are intended to ensure both organisations provide coherent messages, reduce duplication, use resources more effectively and, most importantly, are better equipped to work with commissioners and providers in breaking down barriers between health and care services.[227]

241. We welcome these commitments, although we are aware that sometimes the rhetoric of national leaders can be at odds with local bodies' experience of their regional arms. Professor Chris Ham, Chief Executive of The King's Fund, told us:

> They are becoming more aligned, and they are making efforts to do that by having a single regional director across the two regulators to relate to places like Cornwall, but the lived experience of leaders in the NHS is that it often does not feel like that. There may be alignments at the top between Simon Stevens and Ian Dalton, or indeed at a regional level, but when it comes to the day-to-day interactions of places like Cornwall you get very mixed messages.[228]

242. **To assess whether the commitments by NHS England and NHS Improvement to align priorities and incentives at national level have made a tangible difference to those on the frontline, we encourage those organisations to conduct a joint survey one year after their announcement on 27 March 2018. The real test will be whether this makes a positive difference at local level.**

243. More joint working, clear priorities and consistent messages are positive steps forward. However, it is not clear how the suite of national bodies, particularly the Department of Health and Social Care, NHS England, NHS Improvement, Health Education England, Public Health England and CQC, and their respective roles, functions, policies and powers, interact to provide an effective approach to driving the move towards more integrated care.[229]

Focus on individual organisations rather than placed-based care

244. Structurally, the main problem with the existing national bodies is that they were originally created, in some cases, to drive improvement through choice and competition between a diverse and autonomous landscape of providers. Since the NHS Five Year Forward View was published national bodies have taken positive steps, within the scope of their existing legal structures, to promote more placed-based care. Ian Dalton, Chief

226 Q361 [Ian Dalton]

227 NHS England, NHS England and NHS Improvement: working closer together, 27 March 2018 accessed on 2 June 2018

228 Q243 Professor Chris Ham

229 The Health Foundation (STP0116)

Executive of NHS Improvement, argued that the Single Operating Framework for NHS trusts and foundation trusts makes clear that NHS providers should "work together to join up care for their populations, and to be part of that strategic move locally." Ian Dalton argued that:

> We have moved a long way from the caricature of a hospital being able clinically to stand on its own. That is not the model that necessarily exists going forward. We will play our part.[230]

245. This is encouraging, although the widespread perception, particularly from NHS providers and commissioners, is that the operation of the national system, whether fully intended or not, continues to perpetuate behaviours that act against the needs of local systems. NHS Clinical Commissioners described how even more recent policy changes present barriers to placed-based care:

> The development of different control totals for providers and commissioners, the focus of the inspection and regulatory regime on individual organisations, and the supportive interventions that are undertaken, often with a lack of cross-organisational communication, all undermine the development of a coherent local approach to service development and delivery and encourage a retreat into organisational silos. Our members' view is that top-down intervention and performance measurement may be the greatest barrier to local relationship building.[231]

246. To introduce a national structure that is more conducive to place-based care would in many instances require primary legislation.

Support directed at those furthest ahead

247. We heard repeatedly during our inquiry how the allocation of support and resources by national bodies have been targeted towards those local areas that are furthest ahead, leading to the likelihood of perpetuating "success to the successful", with the risk of leaving less advanced local health economies further behind.[232]

248. As well as preferential receipt of funding, particularly capital funding, the more advanced local areas, particularly integrated care systems, have benefited from more autonomy and support, which are described in more detail in Chapter 4. Describing the factors that have contributed to differences in the progress of local areas so far, Saffron Cordery from NHS Providers told us that:

> One of the factors that underpins the diversity is that those right at the front, the top five—I do not want to rank them necessarily—that have been making real progress have been fully supported by the national system, so there is a full support programme in place.[233]

230 Q360 Ian Dalton
231 NHS Clinical Commissioners (STP0064)
232 Q248 [Nigel Edwards]
233 Q203 [Saffron Cordery]

249. Niall Dickson described how STPs in the middle of the performance curve often feel neglected by national bodies, while often those at the bottom find that the approach adopted centrally exacerbates, rather than alleviates, the difficulties they experience.[234] Speaking about those at the bottom of the performance curve Niall Dickson said that:

> There is a sense in which some organisations find themselves in a really difficult position. Just taking their STF money away from them is like somebody digging a hole. Instead of the regulator helping them to get out of the hole, they jump in with a larger spade and dig even faster. I think the regulators have started to do some of those things, but the whole system of how we performance-manage the process needs to be looked at.[235]

250. Instead of targeting resources at those furthest ahead, we heard that national bodies should describe how they plan to offer "differential support to different STPs depending on where they are on their journey."[236] Professor Chris Ham from The King's Fund told us how NHS England and NHS Improvement have begun to provide this sort of development and support at a small scale.[237]

251. One option is to extend some of the benefits given to integrated care systems to other areas. For example, Simon Whitehouse from Staffordshire and Stoke-on-Trent STP argued the case for greater autonomy, funding and resources to be targeted towards areas that are less advanced:

> With Staffordshire and Stoke-on-Trent being one of the more challenged areas in terms of both performance and financial viability, we have a real challenge. We need some of the flexibilities that are being offered and talked about in the more successful parts of the patch to enable us to make the scale of changes we need to make, but the resource, effort and focus is going to areas that are doing really well; they are advanced and probably had strong and robust relationships in place previously to enable some of that to happen. I would make the case, and articulate really strongly, that while we understand that and we need to learn from those areas, if all of that resource and effort goes into the ones that are at the leading or cutting edge, we are creating an even greater gap in terms of what that looks like.[238]

Role in accelerating improvement and new care models across the system.

252. There is a widespread concern that the pace of transformation is too slow. A survey of NHS trusts and foundation trusts by NHS Providers in April 2017 found that 62% of local leaders were concerned that their local area was not transforming fast enough.[239] Nevertheless, during our inquiry we have seen and heard of encouraging examples where local efforts to pilot new, more integrated, ways of delivering care, such as the vanguard

234 Q226 [Niall Dickson]
235 Q226 [Niall Dickson]
236 Q203 [Saffron Cordery]
237 Q252 [Professor Chris Ham]
238 Q181 [Simon Whitehouse]
239 NHS Providers (STP0050)

programme or local initiatives such as the Primary Care Home Model, have resulted in benefits to patient care. However, it is unclear how these positive examples will be scaled up and spread at pace across the system.

253. The Department of Health and Social Care and the other national bodies recognise the widespread variation in performance and progress across the system. The Minister of State for Health, Stephen Barclay MP, said:

> The NHS is very good at pilots and innovation, partly because it has brilliant people who will innovate. Where I think its performance needs to improve is in how it industrialises that innovation across the system.[240]

254. National bodies are clear that a critical task will be to accelerate progress in local areas that are less well advanced. NHS England's National Medical Director, Professor Steve Powis, told us:

> I agree that that is the challenge, to focus on how those systems that are further back in their development can be brought up to the levels of the systems that we have been describing.[241]

255. The 10-point efficiency plan described in the Next Steps to the NHS Five Year Forward View mandated a series of efficiency opportunities to be pursued across the NHS to contain rising cost pressures on the system. Within the list of mandated efficiencies, there are several recommendations which relate to improving patient care and experience through prevention, better self-management of existing conditions and more joined-up working between services.[242]

256. What is not clear from the evidence we have received during this inquiry, including from national bodies themselves, is how the arms-length bodies, particularly NHS Improvement and NHS England, are seeking to accelerate the scale-up and spread of transformative changes to the delivery of care, such as the new models of care.

257. Three main ways national bodies described their role in accelerating transformation were clinical leadership, intelligent transparency and opportunities to learn from those furthest ahead, either through direct support or the sharing of best practice. However, there was no clearly articulated approach which explained the role of national bodies.

258. Efforts by national bodies to facilitate learning and share best practice have included "speed-dating" sessions for local leaders in different health systems to learn from those furthest ahead, such as South Yorkshire.[243] NHS England is also planning to publish learning reports to share best practice from the vanguard programme.[244] Similarly, with regard to intelligent transparency (the use data to highlight variations in performance), Simon Stevens informed the Committee of Public Accounts that initiatives such as NHS Right Care are programmes that are "now being layered across the country."[245]

240 Q396 Stephen Barclay
241 Q311[Professor Powis]
242 NHS England, Next Steps on the NHS Five Year Forward View, March 2017, pages 38–54
243 Q311 [Steve Powis]
244 Q397 Jonathon Marron
245 Oral evidence to the Committee of Public Accounts 5 March 2018, Session 2017–19, HC 793 Q103 [Simon Stevens]

259. We support all of these approaches. Holding up a mirror to local organisations so that stark variations in the quality and efficiency of patient care are clear is undoubtedly a useful tool to drive improvement, especially where such programmes are led by those with clinical expertise, as is the case with NHS Right Care and the Getting it Right First Time initiative.

260. Opportunities to share best practice between local areas, particularly from vanguards and integrated care systems, also have their place. For example, Professor Chris Ham described how the experience of integrated care system leaders could be utilised to accelerate progress:

> Part of it is drawing on the experience of those already in the advance guard, if you like, of STPs and, now, integrated care systems, and using their experience and expertise to help those coming along behind. If we have 10, hopefully, in a year's time we will have 20, and the people leading this work in Manchester, Nottingham, Bedfordshire, Luton, Milton Keynes and elsewhere will be able to free up some of their time to work with the second wave and perhaps the third wave coming along behind.[246]

261. There are challenges and trade-offs for national bodies in the approach they decide to take to capture and share lessons from the first wave of integrated care systems. For example, introducing buddying arrangements to enable those furthest ahead to support the less well-advanced areas could arguably slow the progress of the frontrunners.[247] This is not a valid reason not to capture and share lessons, but rather a risk that should be considered and mitigated. However, the greatest risks to accelerating progress are the lack of proper finance and the workforce capacity to design and implement change.

262. We also support NHS England and NHS Improvement's intention to explore the role clinical leadership can play in accelerating changes across the system. There is ubiquitous support and enthusiasm for integrated care across health and social care, including clinical leaders and senior managers. A clear message from this inquiry is that many have spent large parts of their careers trying to integrate care for patients.

263. Simon Stevens has acknowledged that frontline staff and local leaders across the health and social care sector "are busy people and they are not out touring the country on fact-finding missions."[248] Many are overwhelmed by the task of maintaining quality standards and making efficiencies in the face of significant shortfalls in staff.

264. National bodies' answer to the question of how they drive improvement fails to acknowledge the importance of ensuring staff have the capacity to engage in transformation by finding time outside of the day job to build relationships and think through the complexities of how different services and professionals collaborate. In such a scenario, Professor Chris Ham argued that:

> Part of what the national bodies can do is no harm, and to get out of the way, facilitate and support people at a local level to do more of the good things already happening, and extend that to more areas. I want to be

246 Q251 [Professor Chris Ham]

247 Q253 [Professor Chris Ham]

248 Oral evidence to the Committee of Public Accounts 5 March 2018, Session 2017–19, HC 793 Q106 [Simon Stevens]

> realistic, being a natural optimist: given the huge financial pressures on the system, and that there is absolutely a focus on sustainability as well as transformation, this will take time.[249]

Conclusions and recommendations

265. **Local bodies' experience of their national counterparts is one of competing priorities that perpetuate existing divides between services and encourage organisations to retreat into individual silos. While this appears to be improving, we have not heard clear and compelling evidence that the interventions of national bodies reinforce and enable more integrated, place-based care. Incoherence in the approach of national bodies is a key factor holding back progress.**

266. **We heard, and saw, outstanding examples of great care that frontline services have been able to build, implement and maintain even in periods of constrained resources. We also heard of promising results from the new care models programme. However, how national bodies plan to scale up and spread best practice and accelerate transformation across the system remains unclear.**

267. **We recommend that the Department of Health and Social Care and national bodies, particularly NHS England, NHS Improvement, Health Education England and the Care Quality Commission, clearly describe as part of a national transformation strategy how each of the bodies will work together to support transformation.**

268. **We request a joint response from the Department of Health and Social Care, NHS England, NHS Improvement, Health Education England and CQC setting out, against each of the following headings, how their roles, responsibilities, functions and policies support the following factors that are critical to transformation and integrated care.**

- **Skills and capacity of frontline staff;**
- **NHS leadership;**
- **Financial incentives;**
- **Infrastructure, particularly digital infrastructure; and**
- **Coherent oversight and regulation.**

The response should include details of plans the national bodies have over the next year to make progress on each of these areas.

269. **NHS England and NHS Improvement should systematically capture, distil and disseminate key lessons from the local areas that are furthest ahead, including the governance arrangements and service models used in these areas. Careful attention should be played to striking a balance between learning from the frontrunners and not overburdening these areas. We recommend that NHS England and NHS Improvement undertake a review of the first cohort of integrated care systems starting in April 2019, and make the key findings available to all STP areas. That should include the level of financial support underpinning transformation.**

249 Q251 [Professor Chris Ham]

10 Governance and legislation

270. The current legislation does not prohibit collaborative working or integrated care, but neither was it designed to enable it.[250] Rather, the legislation was intended for a different purpose: to facilitate choice and competition within the NHS. As described in Chapter 2, reforms by successive governments from the 1990s through to the Health and Social Care Act 2012 extended the role of market forces in the NHS. These reforms, and structural divides imposed since the NHS's creation, in some instances present obstacles to collaborative working.

271. Procurement regulations covering the tendering of NHS contracts and criteria for mergers between NHS organisations, as well as the autonomy and flexibilities provided to foundation trusts (e.g. their ability to generate income from private work) were designed to facilitate choice and competition. Chapter 8 describes how the legal duties and powers of national bodies in many instances were set up to oversee, protect and incentivise diverse local health and care economies in which autonomous organisations compete.

272. Sustainability and transformation partnerships, integrated care systems, integrated care partnerships and an Accountable Care Contract, if and when it is introduced, are all pragmatic responses to constraints imposed by the current legal framework in which health and social care services operate.

273. Some witnesses told us that introducing STPs, integrated care systems and accountable care organisations into legislation would be a significant undertaking. However, there are trade-offs to make. As we describe in this chapter, working within the existing legislation means health and social care services are operating with significant governance risks, and this has potential implications for patients and local communities.

274. This chapter sets out the main problems and challenges posed by the current legislation and views on legislative reform, particularly the timing of primary legislation and the Government's approach to legislative reform.

Governance and accountability arrangements

275. Remaining within the existing legislation carries significant risks for local bodies. Sustainability and transformation partnerships and integrated care systems bring together clinical commissioning groups, NHS trusts and foundation trusts and local councils. The governance arrangements of these organisations are complex for the following reasons:

a) The legal decision-making powers rest with the organisations involved rather than the STPs or ICSs. These constituent NHS and local government bodies have different legal duties and powers. For example, local councils are democratic institutions in their own right, and are unable to run a deficit, unlike NHS bodies.

b) STPs and ICSs often have a large number of bodies. The smallest partnership is made up of six organisations, whereas the largest has 42.

250 Q209 Saffron Cordery

c) The size of the population covered by these partnerships also varies considerably, from 312,000 to 2.8million patients.

d) All partnerships were formed in a short space of time and the boundaries of some areas were imposed. These boundaries do not always align with organisational boundaries or patient flows.

e) For many local leaders, the relationships in these partnerships are still relatively new. Many do not have the same history of collaborative working, which is evident in the leading integrated care systems.

276. In the Next Steps on the NHS Five Year Forward View, NHS England and NHS Improvement announced a basic governance structure to support sustainability and transformation partnerships. The document prescribed that from April 2017 each local sustainability and transformation partnerships must form an STP board from existing partners, including local government and primary care where possible, and establish "formal CCG Committees in Common or other appropriate decision-making mechanisms where needed for strategic decisions between NHS organisations."[251]

277. Despite the fact that STPs and ICSs are not legal entities, national bodies in their oral evidence sought to assure us of the strength and clarity of the legal accountabilities of the local bodies. Ian Dalton, Chief Executive of NHS Improvement, stated:

> Certainly when I was a hospital chief executive, before I came to NHSI, I was very interested in joining up care, but I also felt that both in law and in my own personal aspirations for patients that the quality of care was on my shoulders, as the person running the health services provided by those five hospitals. None of the arrangements that we have been talking about today in any way alters that.[252]

278. The concern that was expressed to us was that the local health and social care providers and commissioners are operating with significant risks to their governance and decision-making, as these arrangements increase the distance of decision-makers from the decisions they are taking.[253] For example, Saffron Cordery, Deputy Chief Executive of NHS Providers, explained that STPs and ICSs "impact on the level of risk, and on governance, accountability and lines of sight over what we are doing."[254]

279. Operating in this way is also time consuming. Proposals agreed at an STP level must be taken back and approved by the boards of the partner organisations.[255] Local leaders we have heard from during this inquiry described the concerns they have about ensuring all the bodies continue to collaborate. As Rob Webster, Chair of the West Yorkshire STP, told us, "change proceeds at the speed of trust."[256]

251 NHS England, Next Steps on the NHS Five Year Forward View, March 2017, page 33
252 Q351 [Ian Dalton]
253 Q209 Saffron Cordery
254 Q209 Saffron Cordery
255 Q222 Julie Wood
256 See Annex 1

280. Julie Wood, Chief Executive of NHS Clinical Commissioners, explained that "what the systems are trying to do locally is make sure that their governance and accountability, where they are working across a bigger geography, is clear, so that there is clear accountability for the decisions they are taking."[257]

Procurement

281. The most limiting aspect of the existing framework are requirements covering clinical commissioning groups' procurement of NHS services. Julie Wood explained that procurement regulations pose immediate obstacles to collaborative working:

> It is where our current systems are running close to where the legislation ends. Our new system of working together in an integrated way depends much more on collaboration between organisations, and at one point that pushes up against the procurement and competition elements you talked about earlier.[258]

282. NHS commissioners through these arrangements are unable to discriminate between bidders based on the type of ownership (e.g. whether they are public, private or voluntary). Unless the scope of services contracted means there is only one credible bidder, NHS providers compete with each other, as well as non-statutory providers, for NHS contracts. As well as the consequent fragmentation of service delivery, this process is widely described as time-consuming and costly. For example, Paul Maubach from Dudley CCG explained:

> It would be quite helpful if we were not legally required to go through a procurement process, because it is very time-consuming. If we have a system that is working well, to be able to switch from the current NHS standard contract to an ACO contract without the need for procurement would be extremely helpful because it would speed up the process significantly.[259]

Views on legislative reform

283. The legal requirements imposed by the Health and Social Care Act 2012, and its ethos around competition, are widely considered to be a barrier to integrating care. During our inquiry we heard that the law will need to change if we are to best realise the transition to more integrated, place-based care. However, demands on parliamentary time and civil services resources posed by Brexit create an extremely challenging background for introducing primary legislation. The arithmetic of a hung parliament may be a disincentive to bring forward health reforms, but also presents an opportunity if there is goodwill for cross-party collaboration.

284. This scenario has left national and local leaders with an imperative to move towards more collaborative working, but with little room for manoeuvre in which to do so. The current position of national bodies is that the changes that are being made are legal (although the legality of an ACO contract is subject to a judicial review) and that:

257 Q223 Julie Wood
258 Q209 [Julie Wood]
259 Q197 [Paul Maubach]

> What we are not doing, as the NHS, is sitting back and projecting on to you guys as Parliament, and saying, "Until you do something, we are just going to sit here and let things fizzle on." We are getting on with doing what we can to improve care for patients.[260]

285. We heard that repeated top-down reorganisations of the health service, including the changes made by the Health and Social Care Act 2012, mean there is little appetite from local leaders of health and social care services for major legislative reform, even if it would make the changes local leaders are making easier.

286. The existing legal context does not necessarily enable the collaborative relationships local leaders are building, and in places adds significant complexities for them to grapple with. However, the absence of prescriptive legislative proposals has meant local leaders can focus on developing their relationships and how local bodies work together. Imposing legislative reforms while local systems are still evolving was regarded as a potential distraction from transforming care.[261]

287. This argument is echoed by national leaders. Noting that the history of the NHS "has not been short of reorganisations", Sir Chris Wormald, Permanent Secretary at the Department of Health and Social Care, told the Committee of Public Accounts that the Department and national bodies had taken the decision not to spend "another several years redrawing the map of the NHS," but instead to focus on relationships between professionals. According to Sir Chris:

> Most of the things we are describing as transformation come down to how clinicians and others relate to each other, not the organisations that they sit within.[262]

288. Proponents of introducing more immediate changes to primary legislation made the case that working around the existing legal framework bypasses the important role Parliament plays in providing public accountability and scrutiny. Dr Graham Winyard, former National Medical Director for the NHS and an advocate of integrated care, expressed grave concerns about the way integrated care is being implemented. The crux of Dr Winyard's argument is that:

> In normal times, there would be absolutely no doubt that changes of this magnitude would be brought about by primary legislation following public consultation and proper Parliamentary scrutiny. Instead Parliament is perceived as paralysed, not least by Brexit, and incapable of addressing serious NHS issues. The resultant work-arounds being adopted by NHS England, with commercial contracts introduced to enable ACOs to function, themselves introduce a whole range of real dangers to the NHS.[263]

289. Professor Allyson Pollock and Dr Graham Winyard argued that it is possible to introduce primary legislation that allows changes to be worked out from the bottom up

260 Q319 [Simon Stevens]
261 SY&B note
262 Oral evidence to the Committee of Public Accounts on 5 March 2018 Session 2017–19 HC793 Q113 [Sir Chris Wormald]
263 Dr Graham Winyard (STP0069)

and without any need to impose these changes on local bodies until they are ready, but with the advantage of providing clear public accountability when they do. According to Professor Pollock:

> I think this is a false binary. It is perfectly possible to have legislation that allows for proposals to be worked out on the ground, and indeed Scotland did it over health and social care. They passed an Act of Parliament and it was worked out bottom up from the ground.[264]

290. There are strong arguments for wider changes to primary legislation. In the meantime, we support the current evolutionary approach to the development of STPs, integrated care systems, integrated care partnerships and accountable care organisations. However, lines of accountability for changes to local services must be clear and robust and decisions must be taken in a transparent way.

291. There are also immediate legal obstacles that the Government and national bodies should seek to address to enable local areas to progress before primary legislation can be introduced. One example of an immediate obstacle was presented to us by Ian Williamson, Chief Accounting Officer for Manchester Health and Care Commissioning, who described how differences in VAT exemptions covering NHS and local government pose significant financial implications for the local area's plans to introduce accountable care.[265]

292. Simon Stevens did not suggest any aspects of the current legal framework that need to change imminently, although he committed to keeping us informed of any frictions that arise as the NHS proceeds towards more integrated care. We welcome NHS England's commitment to keep us informed and we will be following this matter closely.

293. Niall Dickson, Chief Executive of the NHS Confederation, presented a view which was echoed by many stakeholders, in saying:

> There will come a time when Parliament will have to intervene and set out a new form of legislation. I hope it is approached in a very different and much more consultative way, which allows for greater flexibility at local level, but nevertheless gives ordinary users of the service guarantees about what they can find in their local area, because it is still a national service and still needs to be. It needs visible governance and accountability.[266]

294. There is widespread support for a bottom-up and evolutionary approach to change, but we also heard calls, often from the same organisations, for more clarity about what the future health and social care landscape will look like, including the roles and functions of bodies within it.[267] For example, clarity is needed on the role of commissioners within the system and which of the new structures are likely to be a permanent fixture and which are temporary solutions.

264 Q48 [Professor Pollock]
265 Q161 [Ian Williamson]
266 Q209 [Niall Dickson]
267 See Chapter 6.

Conclusions and recommendations

295. **Positive progress has been made within the constraints of the current legislative framework but sometimes requiring cumbersome workarounds. Our view is that national and local leaders have had little room for manoeuvre in which to transform care. We are concerned that many local areas are operating with significant risks in terms of their governance and decision-making.**

296. The law will need to change to fully realise the move to more integrated, collaborative, place-based care. There is an opportunity for the Government and the NHS to rebuild the trust previous reforms have eroded by developing legislative proposals. These proposals should be led by the health and care community to shape the future health and social care landscape. In the meantime, Government and national bodies should do more to provide clarity and guidance on what is possible within the current legal framework.

297. **The law will need to change. We recommend that Parliamentarians across the political spectrum work together to support the legislative changes to facilitate evolutionary change in the best interests of those who rely on services.**

298. **The Department and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The Department and NHS England should establish an advisory group, or groups, comprised of local leaders from across the country, including areas that are more advanced and those further behind, and representatives from the health and care community, to lead on and formulate legislative proposals to remove barriers to integrated care. The proposals should be laid before the House in draft and presented to us to carry-out pre-legislative scrutiny.**

299. **The purpose of legislative change should be to address problems which have been identified at a local level which act as barriers to integration in the best interest of patients. We wish to stress again that proposals should be led by the health and care community.**

300. **Evidence we have heard from representatives from NHS and local government has identified the following legislative areas that may need to be considered:**

a) **A statutory basis for system-wide partnerships between local organisations;**

b) **Potential to designate ACOs as NHS bodies, if they are introduced more widely;**

c) **Changes to legislation covering procurement and competition;**

d) **Merger of NHS England and NHS Improvement; and**

e) **CQC's regulatory powers.**

Where barriers are identified and can be removed with secondary legislation, this may represent a less complex way forward.

301. **Until legislation is introduced, national bodies should support local areas to develop transparent and effective governance arrangements that allow them to make**

progress within the current framework. National bodies should also provide greater clarity over what is permissible within current procurement law and develop support for local areas in working through these issues. National bodies should set out the steps they plan to take to provide clarity, guidance and support to local areas on these matters in response to this report.

11 Conclusion: A call to action

302. Integrating care leads to clear benefits to patients' experience of care, particularly those living with long-term conditions. Support for integration of care at local level is widespread across the health and care community. Local leaders spoke with energy and enthusiasm about the potential of more integrated, placed-based care not only to improve the delivery of health and care services, but to address wider social problems and contribute to the growth and prosperity of local areas.

303. For these reasons, we support the move towards integrated care, in which collaboration, rather than competition, is the organising principle of the health and social care system in England.

304. Historically, progress towards integrated care has been slow. Serious pressures facing the system have led national bodies to narrow their focus away from transformation and towards achieving financial balance. The Government and national bodies must act quickly to take the health and social care system out of survival mode and onto a more sustainable long-term footing. The current financial and workforce shortfalls present the greatest threat to successful transformation as organisations under extreme pressure have no space for reform.

305. Transformation is key to sustainability. To accelerate the progress towards integrated care, we recommend that the Government, together with the national bodies, develop over the next year a national transformation strategy, supported by:

a) a dedicated transformation fund; and

b) a clear narrative which describes the benefits of integrated care from the patient's perspective.

306. Whilst we recognise the need to make evolutionary progress within the current legal framework, there are strong arguments for wider changes to primary legislation. The purpose of legislative change should be to address problems which have been identified at a local level which act as barriers to integration in the best interest of patients. We wish to stress that proposals should be led by the health and care community. We recommend that Parliamentarians across the political spectrum work together to support the legislative changes that will facilitate evolutionary change in the best interests of those who rely on services.

307. Patient care must remain the focus. Delivering better care for patients at the front line is what motivates and unites health and care professionals and the wider sector. Integration depends on services putting patients at the centre, joining up around them, sharing information and working with them to meet their needs, priorities and goals. The recommendations of this report are intended to assist the Department of Health and Social Care, national bodies, local NHS organisations and local government to achieve those aims. The most important test of all, however, is whether this translates into better care for patients.

Integrated care: glossary of terms

Integrated care

There are numerous definitions of integrated care. There are also different levels at which care can be integrated: patient-level, service-level and organisational-level (see Chapter 2). NHS England's current definition of integrated care is care that is "person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family. It means moving away from episodic care to a more holistic approach to health, care and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered."[268]

Placed-based care

Place-based care involves local service providers collaborating and sharing the resources available to them to improve health and care for the populations they serve. This concept has been extended to planning and commissioning of services through examples such as sustainability and transformation partnerships and integrated care systems.

Accountable care

Accountable care refers to an organisation or organisations taking responsibility for the health and care of a defined population within a set budget. Accountable care, according to The King's Fund, is a synonym for integrated care, as it is built on organisations working together to meet the needs of their local population.[269] Another benefit of accountable care is that holding a set budget for the health and care of a local population incentivises providers to improve population health. ICSs, ICPs and ACOs are all expressions of accountable care.

Sustainability and transformation partnerships

Sustainability and transformation partnerships are made up of NHS organisations, including clinical commissioning groups (CCGs), NHS trusts and foundation trusts and primary care services, as well as local authorities. They were originally established to produce a plan setting out how they planned to deliver the NHS Five Year Forward View, but have since become a mechanism for delivering other national priorities. There are 44 partnerships across England. The number of bodies involved in these partnerships and the size of the STP population varies considerably. They are a mechanism in which local bodies can plan changes to the shape of health and social care services locally. However, the partnerships are not legal entities and do not have authority to take forward decisions themselves. Decisions must be agreed separately by the organisations involved.

The forty-four footprints cover the whole of England, but vary considerably in the size of the area they cover and the populations they serve.

268 NHS England, Integrated care and support, accessed on 2 June 2018

269 The King's Fund, Making sense of accountable care, January 2018

Sustainability and transformation plans

NHS organisations were asked to come together, with local government and primary care where possible, to create local blueprints for delivering the NHS Five Year Forward View, known as sustainability and transformation plans (STPs). These plans were published in December 2016 (see Chapter 4).

Sustainability and transformation footprints

Sustainability and transformation footprints refer to the geographical boundaries of STPs (see Chapter 4).

Integrated care systems (ICSs)

According to The King's Fund, integrated care systems in an area are taking more collective responsibility for "planning and commissioning care for their populations and providing system leadership" (see Chapter 4). ICSs have evolved from STPs, but are not legal entities. There are 10 ICSs which are setting a path for the remaining areas to progress to this status.[270]

New care models

The NHS Five Year Forward View announced the creation of new ways of delivering care which blurred the traditional boundaries between services. These have been piloted across 50 sites in England. For example, integrated primary and acute systems, is a new model of care which joins up hospitals with community and mental health services as well as primary care.

Integrated care partnerships (ICPs)

ICPs are alliances between hospitals, community services, mental health services and GPs, but may also include social care and third sector providers. Providers in these alliances collaborate rather than compete to deliver health and care services for their local populations.

Accountable care organisations (ACOs)

ACOs in the US were established by the US Affordable Care Act 2010. ACOs vary widely. This is important as they are likely to take a very different form when introduced to the NHS in England. The King's Fund argue ACOs are likely to be:

> a more formal version of an ACP that may result when NHS providers agree to merge to create a single organisation or when commissioners use competitive procurement to invite bids from organisations capable of taking on a contract to deliver services to a defined population.[271]

270 The King's Fund, Making sense of accountable care, January 2018
271 The King's Fund, Making sense of accountable care, January 2018

Conclusions and recommendations

Integrating care for patients

1. The Department of Health and Social Care, NHS England and NHS Improvement should clearly define the outcomes the current moves towards integrated care are seeking to achieve for patients, from the patient's perspective, and the criteria they will use to measure whether those objectives have been achieved. (Paragraph 12)

Progress towards more integrated care

2. More joined-up, coordinated and person-centred care can provide a better experience for patients, particularly those with multiple long-term conditions. However, progress to achieving these benefits has been slow. There is no hard evidence that integrated care, at least in the short term, saves money, since it may help to identify unmet need, although there is emerging evidence from new care models that it may help to reduce the relentless increase in long-term demand for hospital services. (Paragraph 41)

3. More integrated care will improve patients' experience of health and care services, particularly for those with long-term conditions. However, the process of integrating care can be complex and time consuming. It is important not to over-extrapolate the benefits or the time and resources required to transition towards more integrated care. (Paragraph 42)

4. The Government should confirm whether it is able to meet the current target to achieve integrated health and care across the country by 2020, as well as plans for 50% of the country to be covered by new care models. These targets should be supplemented by more detailed commitments about the level of integrated care patients will experience as a result. (Paragraph 43)

5. We support the move towards integrated, collaborative, place-based care. To help deliver more integrated care for patients we advocate the cultivation of diverse local health and economies, comprised of mostly public, but also some non-statutory provision, in which the organising principle is centred on collaboration and quality rather than financial competition. We consider that this diversity is important for protecting patient choice and with proper oversight and collaborative working may facilitate, rather than impede, joined-up, patient-centred and co-ordinated care. (Paragraph 44)

Sustainability and transformation boundaries, plans, partnerships and integrated care systems

6. STPs got off to a poor start. The short timeframe to produce plans limited opportunities for meaningful public and staff engagement and the ability of local areas to collect robust evidence to support their proposals. Poor consultation, communication and financial constraints have fuelled concerns that STPs were secret plans and a vehicle for cuts. These negative perceptions tarnished the reputation of STPs and continue

to impede progress on the ground. National bodies' initial mismanagement of the process, including misguided instructions not to be sharing plans, made it very difficult for local areas to explain the case for change. (Paragraph 64)

Sustainability and transformation boundaries

7. An STP area, or areas within it, work more effectively where they are meaningful to partners, local health professionals and most importantly the public. STPs, particularly those with more complex geographical boundaries, should be encouraged and supported to allow local areas to identify, define and develop meaningful boundaries within their patch in which local services can work together around the needs of the population. (Paragraph 73)

8. STPs should be encouraged to adopt a principle of subsidiarity in which decisions are made at the most appropriate local level. NHS England and NHS Improvement should set out in their planning guidance for 2019/20 advice and support to achieve these recommendations. (Paragraph 74)

Sustainability and transformation partnerships

9. Sustainability and transformation partnerships provide a useful forum through which local bodies can come together in difficult circumstances to manage finite resources. However, they are not on their own the solution to the funding and workforce pressures on the system. We are concerned that these pressures, if not adequately addressed, may threaten the ability of local leaders to meet their statutory obligations let alone transform services. Overwhelming and unrealistic financial pressure drives them to retreat back to organisational silos. This would seriously undermine the progress local leaders have made in already difficult circumstances. (Paragraph 91)

10. We recommend that the national bodies, including the Department, NHS England, NHS Improvement, Health Education England, Public Health England and CQC, develop a joint national transformation strategy. This strategy should set out clearly how national bodies will support sustainability and transformation partnerships, at different stages of development, to progress to achieve integrated care system status. This strategy must not lose sight of patients. National bodies in this strategy should:

    - set out how national bodies plan to support local areas to cultivate strong relationships;
    - strengthen the programme infrastructure of STPs;
    - consider whether, and if so how, support, resources and flexibilities currently available to integrated care systems could be rolled out to other areas to help them manage pressures facing their local areas;
    - develop a more sophisticated approach to assess the performance of STPs and their readiness to progress to integrated care status. This should include an assessment of local community engagement, the strength of local relationships and the progress towards preventative and integrated care.

An assessment of prevention should encompass a broader definition than preventing demands on hospitals and integration should focus on how to improve patients' experience of and outcomes from services. (Paragraph 93)

Integrated care systems

11. We support the development of integrated care systems, including plans to give greater autonomy to local areas as part of their ICS status. We are encouraged by the positive progress the first 10 integrated care systems have made in the face of challenges on the systems. However, like STPs more generally, we are concerned that funding and workforce pressures on these local areas may exacerbate tensions between their members and undermine the prospect of them achieving their aims for patients. (Paragraph 105)

12. NHS England and NHS Improvement should systematically capture and share learning from areas that are furthest ahead, including their governance arrangements and service models, to accelerate progress in other areas and also to provide clarity about what is permissible within the current legal framework. (Paragraph 106)

13. We recommend, as part of a joint national transformation strategy, that national bodies clarify:

    a) how they will judge whether an area is ready to be an ICS;

    b) how they will support STP areas to become ICSs;

    c) what they will do in areas that fail to meet the criteria;

    d) how they will monitor the performance of existing ICS areas and provide support including the necessary funding to ensure they continue to make progress; and

    e) how they will address serious performance problems in ICS areas. (Paragraph 107)

14. Given the controversy surrounding the introduction of accountable care organisations in the English NHS, we believe piloting these models before roll-out is advisable. There should be an incremental approach to the introduction of ACOs in the English NHS, with any areas choosing to go down this route being carefully evaluated. (Pargraph 140)

15. The evaluation of ACOs should seek to assess:

    - the benefits and any unintended consequences of these structures compared with improving joint working through integrated care partnerships.

    - The implications of the scope of the ACO contract, particularly whether hospital services, GP practices and social care should be incorporated, either in a partially integrated or fully integrated capacity.

    - the impact of ACOs on decision-making processes, objectives and incentives for staff and the resilience of services outside of hospitals.

- the impact on patient choice.

We do not believe it is in the best interests of patients to return to a system devoid of choice. (Paragraph 141)

Accountable care organisations

16. We recognise the concern expressed by those who worry that ACOs could be taken over by private companies managing a very large budget, but we heard a clear message that this is unlikely to happen in practice. Rather than leading to increasing privatisation and charges for healthcare, we heard that using an ACO contract to form large integrated care organisations would be more likely to lead to less competition and a diminution of the internal market and private sector involvement. (Paragraph 155)

17. We recommend that ACOs, if a decision is made to introduce them more widely, should be established in primary legislation as NHS bodies. This will require a fundamental revisiting of the Health and Social Care Act 2012 and other legislation. Whilst we see ACOs as a mechanism to strengthen integration and to roll back the internal market, these organisations should have the freedom to involve, and contract with, non-statutory bodies where that is in the best interests of patients. (Paragraph 156)

18. These mechanisms are no substitute for effective solutions to funding and workforce pressures, but if well designed and implemented they can represent a better way to manage resources in the short-term, including using the skills of staff more effectively on behalf of patients. (Paragraph 167)

Making the case for change to the public

19. STPs, ICSs and ICPs currently have to work within the constraints of existing legislation and manage rising pressures with limited resources. This context limits progress towards integrating care for patients. (Paragraph 181)

20. Some campaigns against privatisation confuse issues around integration. Concerns expressed about the 'Americanisation' of the NHS are misleading. This has not been helped by poor communication of the STP process and the language of accountable care, neither of which have been adequately or meaningfully co-designed or consulted on with the public or their local representatives. (Paragraph 182)

21. We recommend that the efforts to engage and communicate with the public on integrated care which we refer to above should tackle head-on the concerns about privatisation, including a clear explanation to the public that moves towards integrated care will not result in them paying for services. (Paragraph 183)

22. We recommend that national bodies take proactive steps to dispel misleading assertions about the privatisation and Americanisation of NHS. The Department should publish an annual assessment of the extent of private sector in the NHS, including the value, number and percentage of contracts awarded to NHS, private

providers, charities, social enterprises and community interest companies. This should include an analysis of historic trends in the extent of private sector involvement over a 5–10-year period. (Paragraph 184)

23. There has not been a sufficiently clear and compelling explanation of the direction of travel and the benefits of integration to patients and the public. National and local leaders need to do better in making the case for change and how these new reforms are relevant to those who rely on services. The language of integrated care is like acronym soup: full of jargon, unintelligible acronyms and poorly explained. (Paragraph 202)

24. The Department of Health and Social Care and national bodies should clearly and persuasively explain the direction of travel and the benefits of these reforms to patients and the public. We recommend the Department and national bodies develop a narrative in collaboration with representatives of communities, NHS bodies, local government, national charities and patient groups. The messaging should be tested with a representative sample of the public. A clear patient-centred explanation, including more accessible, jargon-free, language, is an essential resource for local health and social care bodies in making the case for change to their patients and wider communities. (Paragraph 203)

25. Making the transition to more integrated care is a complex communications challenge covering a range of different services and patient populations. The case for change must be made in a way that is meaningful to patients and local communities. In addition to providing a clear narrative, in accessible language at a national level, the Department of Health and Social Care, NHS England and NHS Improvement should explain how they plan to support efforts to engage and communicate with the public. (Paragraph 204)

26. NHS England and NHS Improvement should make clear that they actively support local areas in communicating and co-designing service changes with local communities and elected representatives. (Paragraph 205)

27. Bringing local health and social care services together through STPs and ICSs to plan and organise care within their footprints is a much better way to manage constrained resources than the siloed, autonomous and competitive arrangements imposed by the Health and Social Care Act 2012. Our view is that STPs and ICSs are a pragmatic response to the current pressures on the system, rather than a smokescreen for cuts, but that these mechanisms are not a substitute for adequate funding of the system. Funding them properly, including access to ring-fenced transformation money, is necessary and would allow a far better assessment of their potential. (Paragraph 207)

Funding and workforce challenges

28. The NHS and local government have not been given adequate investment, support and time to embark on the scale of transformation envisaged. Transformation depends not only on having sufficient staff to maintain day-to-day running of services, but in the capacity and capability of staff to redesign services, engage in

dialogue and consultation and develop new skills. Transformation also requires funding the staff costs associated with double-running new services, while old models are safely decommissioned. (Paragraph 231)

29. The Government's long-term funding settlement should include dedicated, ring-fenced funding for service transformation and prevention. We recommend that the Government commit to providing dedicated transformation funding when it announces its long-term funding settlement this summer. (Paragraph 232)

30. The task of determining the scale of funding and the most appropriate ways to allocate and manage such resources is a complex challenge. To inform this work we recommend:

    - Building on experience from the new care models programme and Greater Manchester, national and local bodies should form an estimate of the transformation funding they require to transition to new models of care at scale. This should include an estimate of funding required in each area to provide staff with the capacity to engage in transformation, develop new skills and facilitate the double running of services.

    - Government and national bodies should develop clear proposals on how to allocate and manage this resource to ensure the best value for money. (Paragraph 233)

National oversight and regulation

31. To assess whether the commitments by NHS England and NHS Improvement to align priorities and incentives at national level have made a tangible difference to those on the frontline, we encourage those organisations to conduct a joint survey one year after their announcement on 27 March 2018. The real test will be whether this makes a positive difference at local level. (Paragraph 242)

32. Local bodies' experience of their national counterparts is one of competing priorities that perpetuate existing divides between services and encourage organisations to retreat into individual silos. While this appears to be improving, we have not heard clear and compelling evidence that the interventions of national bodies reinforce and enable more integrated, place-based care. Incoherence in the approach of national bodies is a key factor holding back progress. (Paragraph 265)

33. We heard, and saw, outstanding examples of great care that frontline services have been able to build, implement and maintain even in periods of constrained resources. We also heard of promising results from the new care models programme. However, how national bodies plan to scale up and spread best practice and accelerate transformation across the system remains unclear. (Paragraph 266)

34. We recommend that the Department of Health and Social Care and national bodies, particularly NHS England, NHS Improvement, Health Education England and the Care Quality Commission, clearly describe as part of a national transformation strategy how each of the bodies will work together to support transformation. (Paragraph 267)

35. We request a joint response from the Department of Health and Social Care, NHS England, NHS Improvement, Health Education England and CQC setting out, against each of the following headings, how their roles, responsibilities, functions and policies support the following factors that are critical to transformation and integrated care.

    - Skills and capacity of frontline staff
    - NHS leadership
    - Financial incentives
    - Infrastructure, particularly digital infrastructure, and
    - Coherent oversight and regulation.

    The response should include details of plans the national bodies have over the next year to make progress on each of these areas. (Paragraph 268)

36. NHS England and NHS Improvement should systematically capture, distil and disseminate key lessons from the local areas that are furthest ahead, including the governance arrangements and service models used in these areas. Careful attention should be played to striking a balance between learning from the frontrunners and not overburdening these areas. We recommend that NHS England and NHS Improvement undertake a review of the first cohort of integrated care systems starting in April 2019, and make the key findings available to all STP areas. That should include the level of financial support underpinning transformation. (Paragraph 269)

Governance and legislation

37. Positive progress has been made within the constraints of the current legislative framework but sometimes requiring cumbersome workarounds. Our view is that national and local leaders have had little room for manoeuvre in which to transform care. We are concerned that many local areas are operating with significant risks in terms of their governance and decision-making. (Paragraph 295)

38. The law will need to change. We recommend that Parliamentarians across the political spectrum work together to support the legislative changes to facilitate evolutionary change in the best interests of those who rely on services. (Paragraph 297)

39. The Department and national bodies should adopt an evolutionary, transparent and consultative approach to determining the future shape of health and care. The Department and NHS England should establish an advisory group, or groups, comprised of local leaders from across the country, including areas that are more advanced and those further behind, and representatives from the health and care community, to lead on and formulate legislative proposals to remove barriers to integrated care. The proposals should be laid before the House in draft and presented to us to carry-out pre-legislative scrutiny. (Paragraph 298)

40. The purpose of legislative change should be to address problems which have been identified at a local level which act as barriers to integration in the best interest of patients. We wish to stress again that proposals should be led by the health and care community. (Paragraph 299)

41. Evidence we have heard from representatives from NHS and local government has identified the following legislative areas that may need to be considered:

    a) A statutory basis for system-wide partnerships between local organisations;

    b) Potential to designate ACOs as NHS bodies, if they are introduced more widely;

    c) Changes to legislation covering procurement and competition;

    d) Merger of NHS England and NHS Improvement; and

    e) CQC's regulatory powers.

    Where barriers are identified and can be removed with secondary legislation, this may represent a less complex way forward. (Paragraph 300)

42. Until legislation is introduced, national bodies should support local areas to develop transparent and effective governance arrangements that allow them to make progress within the current framework. National bodies should also provide greater clarity over what is permissible within current procurement law and develop support for local areas in working through these issues. National bodies should set out the steps they plan to take to provide clarity, guidance and support to local areas on these matters in response to this report. (Paragraph 301)

Annex: Visit to South Yorkshire and Bassetlaw STP

On Tuesday 20 February 2018 five members of the Health and Social Care Committee visited South Yorkshire and Bassetlaw STP, at which we held a focus group with national and local leaders from NHS and local government.

South Yorkshire and Bassetlaw (SY&B), led by the Chief Executive of Sheffield University Hospitals NHS Foundation Trust, Sir Andrew Cash, is part of the first wave of integrated care systems announced in March 2017. As well as being one of the leading local areas, SY&B was an example of a large, politically diverse area with some challenging population health needs. For example, governance in SY&B is very complex, with 20 local bodies involved in the STP, including a mix of both Labour and Conservative councils.

SY&B is an excellent example of an STP in which integrated care partnerships–alliances between local providers–have formed around subsections of the STP population. Within SY&B, five integrated care partnerships have formed in the five main towns, cities and areas covered by the STP: Sheffield, Doncaster, Rotherham, Barnsley and Bassetlaw. These partnerships are working to integrate services in these five sub-sections of the population. The area decided to opt for an alliance between organisations (an integrated care partnership model), rather than adopt an accountable care contract.

The following Committee members attended the visit:

- Dr Sarah Wollaston MP
- Dr Paul Williams MP
- Diana Johnson MP
- Ben Bradshaw MP
- Andrew Selous MP.

This note provides an outline of the visit and a summary of the key points heard.

Visit to Doncaster Royal Infirmary

The Committee visited Doncaster Royal Infirmary to hear from frontline staff about two local initiatives, Consultant Connect and the Integrated Discharge Team. Consultant Connect is an initiative that enables GPs at the borough's 43 practices to ring hospital specialists at Doncaster Royal Infirmary for immediate advice about how to manage a patient's condition, often while the patient is still in the consulting room.

The Integrated Discharge Team is a partnership between Doncaster and Bassetlaw Hospitals, Nottinghamshire County Council and Nottinghamshire Healthcare NHS Foundation Trust, where services work together to plan the safe discharge of patients from hospital.

Visit to Larwood Practice

Larwood Practice is one of several practices in the area involved in the Primary Care at Home initiative–a way of working that connects primary care, secondary care, social care and the voluntary sector.

Focus group in Sheffield

The Committee held a focus group in Sheffield with senior representatives from the NHS, including STP leads and national leaders, and local government, including councillors and chief executives. The group represented STPs at different stages of development, including representatives from integrated care systems. The discussion was facilitated by Professor Chris Ham, Chief Executive of The King's Fund and specialist advisor to the Committee's inquiry. The discussion covered the following five themes:

- Governance arrangements
- Regulatory and legislative framework
- Local relationships
- Management of the process so far
- Communication and engagement.

Summary of discussion

The following section provides a summary of the key points that were raised in discussion.

Governance arrangements

The governance arrangements vary between STPs and some are extremely complex, because of the number of organisations involved. The group opened with a discussion of the governance arrangements in Greater Manchester from one of the local councillors. The Committee heard the number of partners involved brought significant gains, but also challenges.

More generally leaders spoke about the fragility of the system. The governance arrangements are largely considered to be workarounds of the existing legal framework. However, local leaders were clear that they retained responsibility for their individual organisations. The point was made that local leaders do not cede responsibility unless they agree to do so through a joint board.

As in many other leading areas, there was a strong focus on sub-sections of the STP population, often at a neighbourhood level. For example, local representatives mentioned how Greater Manchester had concentrated on the formation of neighbourhood units covering 30,000–50,000 people.

Regulatory and legislative framework

Despite the fragility of the arrangements in place in many areas, there was little appetite for imposing top-down legislative and regulatory requirements on the system as it is evolving. However, it was acknowledged that there needs to be "some bite somewhere." For example, one participant mentioned that a lot of the changes are built on a consensus between the partners involved. Therefore, if one organisation says no then there is "an immovable object in the system."

While there are aspects of the legislation, particularly competition and procurement regulations, that local bodies are working around, there are also aspects of the law that require collaboration, for example, Joint Strategic Needs Assessments by Health and Wellbeing Boards.

There was an acceptance that changes to primary legislation would be needed eventually. One of the senior local leaders described the need to "dock in" with a legislative superstructure at some point. Matthew Swindells from NHS England mentioned that he expects "two to three flowers to bloom" out of the models that are evolving locally. There was wide support for an evolutionary approach in which successful arrangements locally inform future changes to primary legislation.

There was also brief discussion about how the regulatory structure would need to change. In particular, there was a sense that regulators need to embrace a genuine acceptance of local decision-making. Similarly, regulators perception of failure is needs to be carefully considered, given the risks involved in transformation.

Local relationships

Local relationships were widely perceived as pivotal to the process. There was a strong sense that it is not possible to mandate the sort of changes that are happening locally, but rather that these changes need to be created by local leaders. A critical aspect of this is building relationships locally and identifying a shared purpose. Working to achieve consensus was also considered to be very important. Leaders spoke about a need to broker deals between parts of the system and to be aware and mitigate risks to the different partners involved, particularly in relation to their accountabilities. Rob Webster from West Yorkshire STP described the importance of local relationships saying that "change proceeds at the speed of trust."

Relationships between the NHS and local government was another theme of the discussion. One representative from local government spoke about the challenge for councils in joining STPs and the importance of focusing on how these partnerships can help councils with their problems not just the NHS's, such as housing. There were areas of shared interest such as IT, workforce and public health. For example, the point was made that local government can borrow money cheaper than NHS. This is an advantage for local areas if the focus is not on hospitals, but on the wider community, health and jobs.

Participants spoke with enthusiasm about the prospect of contributing not just to health and care, but to the wider local economy. The NHS was seen as a critical part of the local infrastructure. Therefore, links between STPs and local enterprise partnerships

was another area for potential development. Rob Webster, STP Lead in West Yorkshire, described the potential role the NHS could play in supporting the life science industry in his patch, thereby contributing to local economic growth.

Management of the process so far

There was an appreciation that realistically the NHS is 5 years into a 15-year transformation. There are significant challenges in the short-term. Funding and workforce pressures were mentioned as significant problems that limit the ability of the system to transform. There is a recognition that different local areas are at different stages. As such it is important to move a piece at a time.

Community engagement

There was concern that the prominence given to communities in the NHS Five Year Forward View has been diluted. However, participants spoke about the importance of realising the value of community assets and the value people can bring to changing their own lives. Participants spoke about the need to co-produce plans with stakeholders, including staff and local communities. This involves sitting down and understanding their perspectives.

One participant described how locally the NHS and local councils through the STP went out to hard-to-reach groups with low levels of engagement (e.g. commuters). The council helped NHS colleagues to target these groups, which was then used to develop a public panel with 2000 people to go out too.

Formal minutes

Wednesday 23 May 2018

Members present:

Dr Sarah Wollaston, in the Chair

Luciana Berger	Johnny Mercer
Mr Ben Bradshaw	Dr Paul Williams
Dr Lisa Cameron	

Draft Report (*Integrated care: organisations, partnerships and systems*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 307 read and agreed to.

Annexes agreed to.

Summary agreed to.

Resolved, That the Report be the Seventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 5 June at 2pm.

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 27 February 2018

Dr Colin Hutchinson, Chair, Doctors for the NHS, **Dr Tony O'Sullivan**, Co-Chair, Keep Our NHS Public, **Professor Allyson Pollock**, Professor of Public Health and Director of the Institute of Health and Society, Newcastle University, and **Dr Graham Winyard CBE**, Former Chief Medical Officer for NHS in England — Q1–80

Lara Carmona, Assistant Director of Policy, Public Affairs UK and International, Royal College of Nursing, **Dr Chaand Nagpaul**, Chair, British Medical Association, and **Helga Pile**, Deputy Head of Health, UNISON — Q81–131

Imelda Redmond, National Director, Healthwatch England, **Dr Charlotte Augst**, Partnerships Director, The Richmond Group, **Don Redding**, Director of Policy, National Voices, and **Kate Duxbury**, Research Director, Ipsos MORI — Q132–156

Tuesday 6 March 2018

Ian Williamson, Chief Accountable Officer, NHS Manchester Clinical Commissioning Group, **Paul Maubach**, Chief Executive Officer, Dudley Clinical Commissioning Group, and **Simon Whitehouse**, STP Director, Staffordshire and Stoke-on-Trent STP — Q157–201

Councillor Jonathan McShane, Local Government Association, **Niall Dickson**, Chief Executive, NHS Confederation, **Saffron Cordery**, Deputy Chief Executive and Director of Policy and Strategy, NHS Providers, and **Julie Wood**, Chief Executive, NHS Clinical Commissioners — Q202–226

Professor Chris Ham, Chief Executive, The King's Fund, **Professor Katherine Checkland**, Professor of Health Policy and Primary Care, University of Manchester, and **Nigel Edwards**, Chief Executive, The Nuffield Trust — Q227–264

Tuesday 20 March 2018

Professor Steve Powis, National Medical Director, NHS England, **Professor Jane Cummings**, Chief Nursing Officer and Executive Director, NHS England, and **Simon Stevens**, Chief Executive, NHS in England — Q265–345

Ian Dalton, Chief Executive, NHS Improvement, and **Ben Dyson**, Executive Director, Strategy, NHS Improvement — Q346–370

Jonathan Marron, Interim Director General, Community and Social Care, Department of Health and Social Care, and **Stephen Barclay**, Minister of State for Health, Department of Health and Social Care — Q371–417

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

STP numbers are generated by the evidence processing system and so may not be complete.

1 ADASS (STP0024)
2 Age UK (STP0084)
3 Allied Health Professions Federation (STP0061)
4 All-Party Parliamentary Group on Obesity (STP0062)
5 All-Party Pharmacy Group (STP0123)
6 Alzheimer's Society (STP0076)
7 Association of Directors of Public Health (STP0014)
8 Assura (STP0056)
9 Bliss (STP0011)
10 British Medical Association (BMA) (STP0063)
11 British Red Cross (STP0081)
12 Cancer Research UK (STP0065)
13 Care Provider Alliance (STP0032)
14 Chartered Society of Physiotherapy (STP0075)
15 CIPFA (STP0023)
16 Cllr Martin Shaw (STP0085)
17 Councillor Mike Allen (STP0006)
18 Department of Health and Social Care (STP0117)
19 Devon STP (STP0044)
20 Diabetes UK (STP0013)
21 Doctors for the NHS (STP0092)
22 Doctors for the NHS (STP0105)
23 Doctors for the NHS (STP0122)
24 Dr David Kirby (STP0003)
25 Dr Graham Winyard (STP0069)
26 Dr Gurjinder Sandhu (STP0087)
27 Dr Sally Ruane (STP0079)
28 Dudley CCG (STP0118)
29 Ealing save Our NHS (STP0037)
30 East London Health & Care Partnership (STP0040)
31 Epilepsy Action (STP0077)
32 Faculty of Public Health (STP0059)
33 Good Governance Institute (STP0106)
34 HCSA (STP0018)
35 Healthcare Audit Consultants Ltd (STP0008)

36 Healthcare Financial Management Association (STP0041)
37 Healthwatch Birmingham (STP0071)
38 Healthwatch Cornwall (STP0038)
39 Healthwatch County Durham (STP0020)
40 Healthwatch England (STP0066)
41 Healthwatch Northumberland (STP0039)
42 Healthwatch Stockport (STP0129)
43 Healthwatch Worcestershire and Healthwatch Herefordshire (STP0054)
44 Ipsos MORI (STP0104)
45 Keep Our national Health Service Public Sunderland & District (STP0036)
46 Keep Our NHS Public (STP0093)
47 Keep Our NHS Public (STP0127)
48 Keep Our NHS Public - Cornwall (STP0022)
49 Kevin Donovan (STP0028)
50 Leicester Mercury Patients' Panel (STP0009)
51 Lifeways (STP0019)
52 London Borough of Hammersmith & Fulham (STP0097)
53 Macmillan Cancer Support (STP0030)
54 Manchester Health and Care Commissioning (STP0119)
55 medConfidential (STP0099)
56 Medical Technology Group (STP0025)
57 Mind (STP0100)
58 Mr Colin Standfield (STP0026)
59 Mr James Guest (STP0088)
60 Mr John Popham (STP0002)
61 Mr Michael Vidal (STP0098)
62 Mr Mike Llywelyn Cox (STP0017)
63 Mr Mike Scott (STP0005)
64 Ms Barbara Martin (STP0078)
65 Ms Carol Ackroyd (STP0112)
66 Ms Celia Minoughan (STP0010)
67 Ms Elizabeth Lloyd (STP0091)
68 National Voices (STP0101)
69 NHS Clinical Commissioners (STP0064)
70 NHS Clinical Commissioners (STP0124)
71 NHS Confederation (STP0115)
72 NHS England and NHS Improvement (STP0108)
73 NHS Partners Network (STP0042)
74 NHS Partners Network (STP0120)
75 NHS Partners Network (STP0121)

76 NHS Providers (STP0050)
77 NHS Support Federation (STP0060)
78 Norfolk & Waveney STP Stakeholder Board (STP0109)
79 North East London Save Our NHS (STP0031)
80 Nuffield Trust (STP0080)
81 Optical Confederation and LOCSU (STP0046)
82 Otford Medical Practice Patient Group (STP0016)
83 Paediatric Continence Forum (STP0068)
84 Parkinson's UK (STP0045)
85 Paul Bunting (STP0114)
86 Pharmaceutical Services Negotiating Committee (STP0074)
87 Professor Allyson Pollock (STP0126)
88 Professor Allyson Pollock and Mr Peter Roderick (STP0094)
89 Professor Kath Checkland (STP0103)
90 Reform (STP0047)
91 Richard Taylor (STP0086)
92 Richmond Group of Charities (STP0102)
93 Royal College of Anaesthetists (STP0096)
94 Royal College of Emergency Medicine (STP0015)
95 Royal College of General Practitioners (STP0043)
96 Royal College of Nursing (STP0048)
97 Royal College of Nursing (STP0125)
98 Royal College of Physicians (STP0095)
99 Royal College of Psychiatrists (STP0082)
100 Royal College of Radiologists (STP0058)
101 Royal Pharmaceutical Society (STP0110)
102 Save Our Hospitals (STP0089)
103 ST@P Campaign Group Lutterworth (STP0083)
104 The Health Foundation (STP0116)
105 The Local Government Association (STP0027)
106 The Royal College of Speech and Language Therapists (STP0049)
107 The Shelford Group (STP0052)
108 Together for Short Lives (STP0067)
109 Totnes Mansion Art (STP0035)
110 UNISON (STP0057)
111 Unite the Union (STP0070)
112 West Sussex County Council (STP0073)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Appointment of the Chair of NHS Improvement	HC 479
Second Report	The nursing workforce	HC 353
Third Report	Improving air quality	HC 433
Fourth Report	Brexit: medicines,medical devices and substances of human origin	HC 392
Fifth Report	Memorandum of understanding on data-sharing between NHS Digital and the Home Office	HC 677
Sixth Report	The Government's Green Paper on mental health: failing a generation: First Joint Report of the Education and Health and Social Care Committees of Session 2017–19	HC 642
Eighth Report	Childhood obesity: Time for action	HC 882
First Joint Special Report	Children and young people's mental health—the role of education: Government Response to the First Joint Report of the Education and Health Committees of Session 2016–17	HC 451

Rotherham Integrated Care Partnership

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 6th June 2018
Venue:	Elm Room (G.04), Oak House
Chair:	Sharon Kemp
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@rotherhamccg.nhs.uk

Apologies:	Chris Edwards, Rotherham CCG Louise Barnett, The Rotherham Foundation Trust Dr Richard Cullen, Rotherham CCG Connect Healthcare, GP Federation Representative
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services. However, no specific direct conflicts/declarations were made relating to any items on today's agenda.

Members present:
Sharon Kemp (**SK**), CHAIR, Chief Executive, Rotherham Metropolitan Borough Council (RMBC)
Kathryn Singh (**KS**), Chief Executive, Rotherham Doncaster and South Humber Foundation Trust (RDaSH)
Janet Wheatley (**JW**), Chief Executive, Voluntary Action Rotherham (VAR)

Participating Observers
Cllr David Roche (**DR**), Joint Chair, Heath & Wellbeing Board, RMBC

In Attendance:
Ian Atkinson (**IA**), Chair, Rotherham ICP Delivery Team
Lydia George (**LG**), Rotherham ICP Place Board Manager, RCCG
Kate Green (**KG**), H&WB Board Manager, RMBC
Dermot Pearson (**DP**), Director of Legal Services, RMBC
Gordon Laidlaw (**GL**), Head of Communications, RCCG
Chris Holt (**CHo**), Director of Strategy & Transformation, TRFT
Jenny Lingrell (**JL**), Acting Head of Service – Transformation Lead, RMBC
Wendy Commons, Minute Taker

No members of the public were present.

Item Number	Discussion Items
1	**Revised Terms of Reference**
Following comments and feedback received at the May Board, the Terms of Reference had been updated. Place Board members formally approved and adopted the final updated version which will be kept under regular review going forward.	
2	**Transformation Group Updates**
Place Board took assurance by way of presentations from the three transformation groups: ***Children & Young People's – Acute & Community - Jenny Lingrell*** Given the limited resources available, Place Board asked this transformation group to consider and advise where to target resources in order for services to be sustainable. ***Action: JL*** ***Urgent & Community Care – Integrated Care & Re-ablement – Chris Holt*** Members received an update on integrated care and re-ablement, one of this transformation group's six priorities. In implementing the 'Home First' approach, the Place Board were keen to ensure that loneliness and isolation issues were not created for people and asked CHo to reflect whether the transformation group has sufficient expertise, representation and adequate and appropriate on-going support available to address these aspects, particularly in communicating the benefits of Home First' and putting the patient first to the public. GL assured Members that the communications team will ensure consistent and appropriate messages to the public and these will be conveyed across all workstreams. The Place Board noted on-going dialogue and progress being made in approach to Integrated Care & Re-ablement from a partner perspective. ***Mental Health & Learning Disability – Dementia – Ian Atkinson*** IA gave an update on work taking place over the past 18 months in particular and the next steps. The presentation showed a positive position but significant work is still required for ongoing support and to meet increasing numbers. IA assured Members that the group has a clear plan in place and work taking place to meet the targets within the performance plan.	
3	**Place Plan Update**
IA reported that a clear framework is now in place for the production of the Rotherham ICP Place Plan. Work is continuing through the Place Delivery Team in order to populate the sections. A draft will be available for review at the July Place Board. ***Action: IA***	
4	**Hospital Services Review Summary**
IA advised that the review of acute hospital services in South Yorkshire and Bassetlaw, Mid Yorkshire and North Derbyshire (SYB (MYND)) had concluded and the CCG has received a full report by the Independent Review Director, Chris Welsh which is currently being considered. Members noted the short presentation of the report's recommendations. Next steps will be for the ICP Place Board to form a collective view of what the recommendations will mean for Rotherham's health system and draft a shared response to the report. The response will be placed on July's ICP Place Board. ***Action: SK***	
5	**Rotherham Integrated Health & Social Care Achievements**
LG presented a list that had been compiled outlining achievements across the Rotherham Integrated Care Partnership. Members welcomed the summary that showed the work	

undertaken across the health system so far and agreed to continue to populate it in order to share with other partnership forums and as part of organisation's annual reporting processes. ***Action: LG***	
6	**Draft Minutes from Public ICP Place Board – 2nd May 2018**
The minutes from the May meeting were accepted as a true and accurate record and approved as the final version.	
7	**Communications to Partners**
GL advised that the Hospital Services Review report is currently being taken through CCG Governing Body Meeting for feedback.	
8	**Risk/Items for Escalation**
None	
6	**Future Agenda Items**
	Future Agenda Items • Refreshed ICP Place Plan • Rotherham Health Care Record Update Standard Agenda Items • Delivery Dashboard • Transformation Groups Update. The Place Board asked IA to request that the Delivery Team prepares a forward plan of spotlight presentation for the next three months. Chairs of Transformation Groups will also be asked to provide presentations in advance of Place Board so that Members can better prepare with questions. ***Action: IA/LG***
7	**Date of Next Meeting**
Wednesday 4th July 2018, *at 9am at New York Stadium* *Apologies were noted in advance from Sharon Kemp*	

Membership
NHS Rotherham CCG - Chief Officer - Chris Edwards (Joint Chair)
Rotherham Metropolitan Borough Council - Chief Executive – Sharon Kemp (Joint Chair)
The Rotherham Foundation Trust (TRFT) - 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

Participating Observers:
Joint Chair, Health and Wellbeing Board, RMBC - Cllr David Roche
Joint Chair, Health and Wellbeing Board, RCCG - Dr Richard Cullen

In Attendance:
Director of Legal Services, RMBC – Dermot Pearson
Head of Communications, RCCG – 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)
Deputy Chief Officer, RCCG – Ian Atkinson (as Delivery Team Place)

Rotherham Integrated Care Partnership

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 4th July 2018
Venue:	Elm Room (G.04), Oak House
Chair:	Chris Edwards
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@rotherhamccg.nhs.uk

Apologies:	Sharon Kemp, Chief Executive, RMBC Louise Barnett, The Rotherham Foundation Trust Connect Healthcare, GP Federation Representative Gordon Laidlaw, Head of Communications, RCCG
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services. However, no specific direct conflicts/declarations were made relating to any items on today's agenda.

Members Present:
Chris Edwards (**CE**), Chair, Chief Officer, Rotherham CCG
Kathryn Singh (**KS**), Chief Executive, Rotherham Doncaster & South Humber Foundation Trust, RDaSH
Janet Wheatley (**JW**), Chief Executive, Voluntary Action Rotherham (VAR)
Dominic Blaydon (**DB**), Associate Director of Transformation, TRFT (Deputising for Louise Barnett)

Participating Observers
Dr Richard Cullen (**RCu**), Joint Chair, Health & Wellbeing Board, Rotherham CCG,
Cllr David Roche (**DR**), Joint Chair, Heath & Wellbeing Board, RMBC

In Attendance:
Ian Atkinson (**IA**), Chair, Rotherham ICP Delivery Team
Lydia George (**LG**), Rotherham ICP Place Board Manager, RCCG
Kate Green (**KG**), Health & Wellbeing Board Manager, RMBC
Dermot Pearson (**DP**), Director of Legal Services, RMBC
Nathan Atkinson (**NA**), Asst Director of Strategic Commissioning, RMBC
Mark Chambers (**MC**), Head of Commissioning, RMBC
James Rawlinson (**JR**), Director of Health Informatics, TRFT
Andrew Clayton (**ACl**), Head of IT, Rotherham CCG
Wendy Commons, Minute Taker

Six observers/members of the public were present.

Item Number	Discussion Items
1	**Rotherham Health Record**

James Rawlinson, Director of Health Informatics from TRFT and Andrew Clayton, Head of IT, Rotherham CCG attended to give a presentation updating on the work undertaken to develop the Rotherham integrated health record. James advised that this system is unique developed to aid locality teams to share and manage care. Frontline staff have been very supportive of the approach and the level of visibility it provides.

Members watched a short video clips showing clinicians using the system and the benefits its introduction has made to their role. The video can be found at: https://www.youtube.com/watch?v=FVxhBbkZYeE

Discussion followed about the issues and challenges overcome with information sharing particularly around consent and how these have been overcome. James gave assurance that robust system controls are in place to protect and restrict access to patient information appropriately.

Cllr Roche welcomed this development and confirmed that the Council is supportive of the next steps to expand the number of users to include social care. Rotherham should celebrate its achievement and the benefits of using this unique system to support the integration agenda.

Mr Edwards thanked James and Andrew for attending the Place Board and asked if they could return in 6 months' time give a further update on the expansion of the system with Council Partners.

Action: JR/ACl/LG for agenda

2	**Transformation Group Updates:**

Mr Atkinson explained that each Transformation Group has key delivery areas as part of the ICP strategy. Place Board takes updates on these transformation areas on a rolling programme to check on progress.

Children & Young People's Transformation Group
Subject - Signs of Safety (SoS)
Presented by Mark Chambers, Head of Commissioning, RMBC

Mr Chambers explained how SoS is being implemented across C&YP to assess risk. It uses three measures ie 'what's working well', 'what are we worried about' and 'what needs to happen next'. He outlined progress with the roll-out so far.

Mrs Singh enquired about the timeline for all partners to be using SoS. Mr Chambers explained that the implementation plan is still being developed.

Members noted that the presentation and the Chair requested that a timeline for implementation of SoS across Rotherham partners was included when Place Board receives its next update on SoS.

Action: MC/LG for agenda

Urgent & Community Care Transformation Group
Subject - Home First
Presented by Dominic Blaydon, Associate Director of Transformation, TRFT

Mr Blaydon explained that the concept of 'Home First' is to support people at home, where possible. This approach has been agreed as a priority and all partners are committed to changing the mindset of staff to enable its successful implementation.

Mrs Wheatley explained that although the voluntary sector is supportive of 'Home First' approach, people's ability to cope in their own home can vary significantly post discharge. The Transformation Group should bear in mind the non-clinical elements and practicalities that will make the difference to a person's discharge. Mr Blaydon explained how the voluntary sector is involved in the implementation and the discharge team is totally committed to a holistic approach and recognising individual needs.

Mental Health & Learning Disability Transformation Group
Subject - Promoting the Mental Health Wellbeing Strategy
Presented by Ian Atkinson, Deputy Chief Officer, Rotherham CCG

Mr Atkinson updated on the work being carried out around the suicide prevention and self-harm plan including a successful ICS bid for funding across SY&B. Discussions are taking place with NHS England about the delivery of the programme. In the bid submission three self-harm key priority areas had been identified ie improving access to mental health services, working with middle aged men and links into primary care, specifically aimed at reaching out to those at risk who are not currently in contact with services.

The group reviewed a video on the recently launched Rotherham Five Ways to Wellbeing which can be found at: https://www.youtube.com/watch?v=jb5NqV2bqGI&feature=youtu.be

Members thanked Mr Atkinson for the presentation and asked to see that the MH & LD Transformation Group shares the implementation plan as part of their next update to Place Board.

Action: IA

3	**Draft Minutes from Public ICP Place Board – 6th June 2018**

The minutes from the June meeting were accepted as a true and accurate record.

It was noted that a representative from the SY&B Shadow Integrated Care System Team (who wrote the Hospital Services Review report) would be attending the CCG's Governing Body later in the day to give a presentation on the review and answer questions.

7	**Communications to Partners**

None to note.

8	**Risk/Items for Escalation**

None.

6	**Future Agenda Items**
	Future Agenda Items • Forward plan - rolling programme for Transformation Group Updates • Joint Partnership Agreement/MOU Standard Agenda Items • Delivery Dashboard/performance framework • Transformation Groups Update
7	**Date of Next Meeting**

Wednesday 1st August 2018, *at 9am at Elm Room, Oak House*

Membership

NHS Rotherham CCG - Chief Officer - Chris Edwards (Joint Chair)
Rotherham Metropolitan Borough Council - Chief Executive – Sharon Kemp (Joint Chair)
The Rotherham Foundation Trust (TRFT) - 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

Participating Observers:
Joint Chair, Health and Wellbeing Board, RMBC - Cllr David Roche
Joint Chair, Health and Wellbeing Board, RCCG - Dr Richard Cullen

In Attendance:
Director of Legal Services, RMBC – Dermot Pearson
Head of Communications, RCCG – 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)
Deputy Chief Officer, RCCG – Ian Atkinson (as Delivery Team Place)

Rotherham Integrated Care Partnership

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 1st August 2018
Venue:	Elm Room (G.04), Oak House
Chair:	Chris Edwards
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@rotherhamccg.nhs.uk

Apologies:	Sharon Kemp, Chief Executive, RMBC Kathryn Singh, Chief Executive, RDaSH Ian Atkinson, Chair, Rotherham ICP Delivery Team
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services. However, no specific direct conflicts/declarations were made relating to any items on today's agenda.

Members Present:
Chris Edwards (**CE**), Chair, Chief Officer, Rotherham CCG
Louise Barnett (**LB**), Chief Executive, The Rotherham NHS Foundation Trust
Janet Wheatley (**JW**), Chief Executive, Voluntary Action Rotherham (VAR)
Dr Muthoo (**GM**), Medical Director, Connect Healthcare Rotherham

Participating Observers
Dr Richard Cullen (**RCu**), Joint Chair, Health & Wellbeing Board, Rotherham CCG,
Cllr David Roche (**DR**), Joint Chair, Heath & Wellbeing Board, RMBC

In Attendance:
Lydia George (**LG**), Rotherham ICP Place Board Manager, RCCG
Gordon Laidlaw (**GL**), Head of Communications, RCCG
Dermot Pearson (**DP**), Director of Legal Services, RMBC
Nathan Atkinson (**NA**), Assistant Director of Strategic Commissioning, RMBC
Anne Marie Lubanski (**AML**), Joint Chair of ICP Delivery Team
Mel Meggs, Acting Strategic Director, C&YP Services, RMBC
Wendy Commons, Minute Taker

There were no observers/members of the public present.

Item Number	Discussion Items
1	**Public & Patient Questions**

None

2	**Integrated Care Partnership Agreement**

Members received the Rotherham Integrated Care Partnership Agreement for approval. Mr Edwards explained that a small amendment had been requested on Page 3, section H which will be updated accordingly.

Action: Mrs George

Mr Edwards welcomed Dr Muthoo, as the newly appointed Medical Director at Connect Healthcare Rotherham (the GP Federation) and asked Dr Muthoo to review the agreement with and on behalf of the Federation and forward any feedback for incorporating from a primary care perspective.

Action: Dr Muthoo

The agreement will be updated to reflect any further feedback and comments. The ICP Place Board will be asked to formally accept and sign off the final version of the agreement in September.

Action: All/Mrs George

3	**Transformation Group Updates:**

Place Board received progress updates on the transformation areas below:

Mental Health & Learning Disability Transformation Group
Transforming Care, Autism and Learning Disability Strategy
Presented by Nathan Atkinson

Nathan Atkinson updated Place Board on three key areas on behalf of the MH & LD Transformation Group. Beginning with transforming care, he highlighted that the number of patients in Rotherham remain relatively small. There is now good information available about NHSE cases which enable much better planning and a risk register has been put in place which is working well. The National Transforming Care programme is due to end in March 2019. This will present a challenge for Rotherham in moving people with very complex needs out of long stays into more community based placements recognising these must be the right solution and give as much independence as possible.

The second update related to the Autism strategy which Rotherham has committed to produce. Positive engagement has been undertaken with Stakeholders to produce the all age Autism Strategy linking all aspects of public services to ensure partners work to the plan. An issue with Rotherham diagnostic waits was highlighted. These are currently undertaken by a Sheffield Consultant however a local pathway is being discussed as a solution. It was acknowledged that although diagnosis helps some parents with better parenting, post diagnosis pathways and support also need to be available when required.

Discussion followed with feedback given for the MH & LD transformation group to focus on adult autism as well as children's. Mrs Barnett offered support from TRFT to community services from the general workforce perspective including around communication and education for the wider workforce.

Place Board supported the Group in developing the autism strategy with a timeline of November 2018 and requested an update on progress to the February Place Board in line with the rolling schedule of Transformation Group spotlight update. Place Board would also like a post diagnosis pathway and information on progress with the development of a Rotherham consultant led diagnostic pathway to be included in the update.

Action: Mr N Atkinson/Mrs George (for agenda)

The final update from the MH & LD Transformation Group was on the implementation of 'My Front Door' Learning Disability Strategy which is about providing a more person-centred approach and

solutions for individuals to maximise their independence.

The principles and ethos of 'My Front Door' with stakeholders and providers who are keen to work in partnership with RMBC to offer new solutions. Place Board noted that the transformation plan is to be delivered by March 2020 with an increase of 64% in GP health checks for people with a learning disability by April 2019.

Place Board thanked Mr Atkinson for the updates.

Children & Young People's Transformation Group
Subject – Special Educational Needs & Disability Transitions
Presented by Nathan Atkinson

Mr N Atkinson gave an update on behalf of the Children & Young People's Transformation Group relating to Special Educational Needs and Disability (SEND). Rotherham is looking to adopt effective best practice to assist with the transition from children to adult services and their progression to independence.

Activity is currently being undertaken to build up a detailed cohort profile on the volume of people in transition to ensure better and more effective planning of transition cases. Further work is also required to understand the legacy implications of placements made outside the approved national framework prior to children's services transformation.

Place Board thanked the Children & Young People's transformation group for the update on SEND transitions and noted two key milestones of creating a risk register by August 2019 once detailed profile information on the cohort has been compiled and the intention to publish a transition pathway on RMBC's website by October 2018. For completeness the Place Board will receive details of the transition pathway in December 2018.

Action: Mr N Atkinson/Mrs George

Urgent & Community Transformation Group
Subject – Integrated Rapid Response – Unplanned Hub
Presented by Anne Marie Lubanski

Mrs Lubanski updated Place Board on developments with the Integrated Rapid Response unplanned hub which will build social care elements into the single point of access to provide a more joined up approach to managing increases in activity volume for community health teams.

This has proved to be an effective nurse led initiative with improvements seen including effective triage and patients remaining at home thereby avoiding acute admissions and GP visits.

It was acknowledged that there has been an increased demand since the introduction of the Home First model, but this is not unusual following the implementation of a new system. The expected co-location of the Care Co-ordination Centre with the unplanned hub and integrated rapid response team in October 2018 will embed Home First and bring improvements. This will be dependent on suitable space being found.

Dr Muthoo asked if reductions have been seen in GP visits. Mrs Lubanski explained that each of the transformation groups is in the process of developing a performance framework of key performance indicators and milestones that can be used to measure integration implementation. Place Board is expected to receive a final version of this framework for agreement in September after which it will be used as a reporting mechanism for Board Members.

Mrs Barnett announced that TRFT have planned an Unplanned Care Open day at Woodside, TRFT on Thursday 9th August 2018. Place Board Members are welcome to attend. Details will be forwarded by Mrs Barnett for circulation to Members.

Action: Mrs Barnett/Mrs George

Place Board members thanked the Urgent & Community Transformation Group for the update and noted the good progress made so far with the integrated rapid response unplanned hub element. The next update will be in six months.

4	**Update on the Hospital Services Review Process**

Mr Edwards explained the next steps will be for each organisation's Governing Body to receive a strategic outline case in December for feedback with a view to the final outline business case being presented in Mar/Apr.

It was agreed that Mr Edwards will write to SYB ICS Hospital Review Team on behalf of the Place Board to request clarification in relation to the governance arrangements for partner organisations. Mr Edwards will update Members at September Place Board.

Action: Mr Edwards

5	**Update on Provider Alliance**

Mr Edwards reported that some areas in South Yorkshire have drafted provider alliance agreements which formalise an agreed understanding of how and when providers will work together in a collaborative and integrated way to deliver services.

Mrs Barnett explained that Rotherham Providers have had a couple of initial meetings to discuss forming a Provider Alliance and had expressed commitment in principle to work together. Mr Edwards advised that the CCG as commissioners were supportive of Rotherham Providers taking the Alliance approach. Following discussion it was agreed that Mr Edwards will arrange a session in September to share and discuss experiences with other South Yorkshire partners who have already developed a Provider Alliance to assist Rotherham Providers in determining their requirements.

Action: Mr Edwards

6	**House of Commons Health & Social Care Committee Report – Review of Integrated Care**

Mr Edwards presented the report undertaken on integrated care: organisations, partnerships and systems. He drew Members' attention to Page 91, an Annex to the report that outlined details of the visit to the SYB ICS earlier this year. In short, the national team are supportive of the direction of travel in that integrating health and care is the right approach and recognised STPs/ICS's as enablers rather than solutions acknowledging that workforce and funding issues still need to be addressed. It was however perceived that local relationships are pivotal to the process.

Place Board noted the report which will go to the next Health & Wellbeing Board.

7	**Draft Minutes from Public ICP Place Board – 4th July 2018**

The minutes from the July meeting were accepted as a true and accurate record.

All actions for updates have now been scheduled on Place Board's forward plan to ensure Members are updated accordingly.

8	**Communications to Partners**

Mr Laidlaw had no specific issues for Partners to note.

Mrs Wheatley advised that SYB ICS are looking to develop a social prescribing strategy. Voluntary Action Rotherham (VAR) has offered to submit a partnership proposal on Rotherham's behalf. Members were very supportive of VAR developing the strategy and all Partners offered to support Mrs Wheatley and VAR colleagues as required.

Mrs Barnett referred to recent inaccurate local press coverage from the the Hospital Services Review report reporting that the Children's ward at TRFT was in jeopardy. Meetings have taken place with the staff concerned to give reassurance. Mr Edwards also attended the staff meetings with Mrs Barnett to give assurance from a commissioner's perspective. In future, it has been agreed that SYB ICS communications team and Rotherham ICP communications will liaise more closely to ensure 'One Voice' communication responses across the partnership can be prepared to reflect appropriate and robust comments on local issues.

Cllr Roche advised that the Government has recently announced a delay in the publication of the green paper on adult social care until the autumn. However the Local Government Association has published its own version and is seeking views. The paper entitled 'The Lives we want to Lead' will be circulated to Place Board Members for information.

	Action: Mr Laidlaw
9	**Risk/Items for Escalation**
None.	
10	**Future Agenda Items**
	Future Agenda Items • Communications & Engagement Strategy • Performance Framework – September 2018 • SEND Transitions Update – October 2018 (as per rolling schedule) • Autism Strategy Update – November 2018 (as per rolling schedule) • Hospital Services Review Outline Business Case – September 2018 • Social Prescribing Strategy Update – provisionally November 2018 Standard Agenda Items • Delivery Dashboard/performance framework • Transformation Groups Update (as per rolling schedule) ie for Sept 2018 o C&YP – 0-19 Healthy Child Pathway o U&CC - Support to Care Homes o Community Crisis & Home Treatment/IAPT
11	**Date of Next Meeting**
Wednesday 5th September 2018, *at 9am at Elm Room, Oak House*	

Membership

NHS Rotherham CCG (RCCG) - Chief Officer - Chris Edwards (Joint Chair)
Rotherham Metropolitan Borough Council - Chief Executive – Sharon Kemp (Joint Chair)
The Rotherham Foundation Trust (TRFT) - Chief Executive – Louise Barnett
Voluntary Action Rotherham (VAR) - Chief Executive – Janet Wheatley
Rotherham Doncaster and South Humber NHS Trust (RDaSH) - Chief Executive – Kathryn Singh
Connect Healthcare Rotherham Ltd (Rotherham GP Federation) – Dr G Muthoo

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Joint Chair, Health and Wellbeing Board, RCCG - Dr Richard Cullen

In Attendance:
Director of Legal Services, RMBC – Dermot Pearson
Head of Communications, RCCG – Gordon Laidlaw
Senior Planning and Assurance Manager, RCCG – Lydia George (as Place Plan Board Manager)
Policy and Partnership Officer, RMBC – Vacancy
Deputy Chief Officer, RCCG – Ian Atkinson (as Delivery Team Place Joint Chair)