HEALTH AND WELLBEING BOARD

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

Date: **Wednesday 24 November 2021**

Time: **9.00 a.m.**

A G E N D A

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

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

3. Apologies for absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Minutes of the previous meeting (Pages 3 - 12)

7. Communications

For Discussion

8. Strategic value of Physical Activity in Tackling Health Inequalities (Pages 13 - 18)
   Sam Keighley, Yorkshire Sport Foundation, to present/discuss the review into the strategic positioning of physical activity in Rotherham

9. Rotherham Surge Plan (Pages 19 - 29)
   Ian Atkinson, Rotherham Clinical Commissioning Group, to discuss Rotherham's Winter Plan

10. Update on Aim 3 of the Health and Wellbeing Strategy
    Sharon Kemp, Chief Executive RMBC, and Michael Wright, The Rotherham Foundation Trust, to provide an update on aim 3 of the Health and Wellbeing Strategy

11. Health and Wellbeing Board Action Plan (Pages 30 - 51)
Ben Anderson, Director of Public Health/Becky Woolley, Policy Officer, to provide an update against the Health and Wellbeing Board action plan

12. Update from the Local Outbreak Engagement Board
Sharon Kemp, Chief Executive RMBC, to give a verbal update

13. Issues escalated from the Place Board
Sharon Kemp, Chief Executive RMBC/Chris Edwards, Chief Operating Officer Rotherham Clinical Commissioning Group, to report

For Information

14. Better Care Fund Plan 2021-22 (Pages 52 - 107)
To endorse the Better Care Fund Plan

15. Rotherham Public ICP Place Board (Pages 108 - 120)
Minutes of meetings of the Rotherham Public ICP Place Board held on 7th July, 8th September and 6th October, 2021

16. Date and time of next meeting
Wednesday, 26th January, 2022, commencing at 9.00 a.m. venue to be confirmed

HEALTH AND WELLBEING BOARD
22nd September, 2021

Present:-

Councillor D. Roche	Cabinet Member, Adult Social Care and Health
Ben Anderson	Director of Public Health
Councillor B. Aveyard	
Dr. Richard Cullen	Strategic Clinical Executive, Rotherham CCG
Councillor V. Cusworth	Cabinet Member, Children and Young People
Chris Edwards	Chief Operating Officer, Rotherham CCG
Sharon Kemp	Chief Executive, RMBC
Dr. Jason Page	Governance Lead, Rotherham CCG
Kathryn Singh	Chief Executive, RDaSH
Paul Woodcock	Strategic Director, Regeneration and Environment
Michael Wright	Deputy Chief Executive, Rotherham Foundation Trust (representing Richard Jenkins)

Report Presenters:-

Ruth Fletcher-Brown	Public Health
Ian Spicer	Adult Care, Housing and Public Health

Also Present:-

Jamie Bland	Rotherham Citizen's Advice Bureau
Gavin Jones	South Yorkshire Fire and Rescue Service
Councillor J. Thompson	Observer
Becky Woolley	Policy Officer, RMBC
Dawn Mitchell	Governance Advisor, RMBC

Apologies for absence were received from Suzanne Joyner (RMBC), Justin Harker-Daniels (RMBC) and Shafiq Hussain (VAR).

14. DECLARATIONS OF INTEREST

There were no Declarations of Interest made at the meeting.

15. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no questions from the member of the press present at the meeting.

16. COMMUNICATIONS

The Chair reported that Becky had successfully secured a position within the Public Health Team.

Board members wished her good luck in her new job.

17. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health and Wellbeing Board were considered.

Resolved:- That the minutes of the previous meeting held on 26th May, 2021, be approved as a correct record.

18. SUICIDE AND SELF-HARM PREVENTION

Ruth Fletcher-Brown, Public Health Specialist, presented the most recent data relating to incidences of suicide.

National real time data collected during the pandemic had not shown the increase in suicides as may have been expected in the United Kingdom. The latest suicide data for Rotherham (November 2020) showed a small decrease in suicides for the period 2018-2020 to 13.3 per 100,000, a decrease by 1.4 from 2017-2019. Rotherham now ranked 6th compared to CIPFA Nearest Neighbour local authorities and still significantly higher than the rate for England at 10.4 per 100,000.

Males still accounted for most deaths in Rotherham, however, it had decreased by 3.3 to 19 per 100,000 for 2018-2020 (22.3 for 2017-2019). Female deaths for Rotherham for the same period had risen by 0.4 to 7.9 per 100,00 and the Yorkshire and Humber and England had seen increases in all person, male and females, during this period.

Attention was drawn to:-

- The Suicide Operational Group had continued to meet during the pandemic to look at all suspected suicides and had updated its action plan in line with emerging risk factors. Specific work had included promoting information on debt management and bereavement support including key messages for frontline staff

- Promotion of the Be the One campaign throughout the pandemic, as part of Safeguarding Awareness Week in November 2020 and would be again in November 2021. A new film launched on 10th September, 2021, targeting women who had been touched by/contemplated suicide and anyone who wanted to be better prepared to help someone else in a crisis. This could be found at https://www.be-the-one.co.uk/

- Zero Tolerance Suicide Prevention training promoted across the Council and partners

- Year 3 of the NHSE Suicide Prevention funding had enabled promotion of the third round of the small grants scheme to community groups who were addressing the underlying causes which could lead to suicide. The funding had now finished

- Promotion of the South Yorkshire Listening Service for those bereaved/affected by suicide throughout the pandemic. Rotherham CCG was leading on procurement of the service on behalf of all South Yorkshire local authorities for 2022/23 but the existing provider would run the service across South Yorkshire until January 2022

- Update of the Care Pathway for Children and Young People Bereaved by Sudden Traumatic Death

- Virtual courses for suicide prevention and mental health first aid offered to all partner organisations with an emphasis on the voluntary sector, Police and Primary Care

- Work with Survivors of Bereavement by Suicide to advertise for volunteers to be trained to run a Rotherham peer support group

- Suicide Prevention symposium to be held on 12th October following which the action plan would be amended and submitted to the Board for approval

Discussion ensued on the report and the video viewed with the following issues raised/highlighted:-

- There were a number of future events that would be used to promote the message including Safeguarding Week
- 3 important steps – talk, listen and care – and was being built into every training session
- Concern with regards to the funding commitment and what happens next; partner organisations had to commit to this initiative. There was additional money from the Zero Suicide Alliance for one year+
- A number of support structures available during the pandemic would cease to exist soon i.e. furlough, the removal of the Universal Credit top up and increased National Insurance contributions, which gave real concern. There was a need to look at what partners could do
- The symposium was an opportunity for partners to challenge themselves around the action plan

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

(2) That future updates on suicide prevention and Public Mental Health activity be submitted to the Board.
Action:- Ruth Fletcher-Brown

(3) That all partners commit to promote training related to this matter, support services, particularly the services for people bereaved, effected or exposed to suicide, and Be the One Campaign.

19. CARERS PROGRAMME AND DRAFT CARERS STRATEGY

Further to Minute No. 86 of the meeting held on 11th March, 2020, Ian Spicer, Assistant Director, Adult Care and Integration, presented an update on the Carers Programme which had been prepared for the July postponed meeting highlighting the following:-

- The programme outlined at Minute No. 86 had had to be reprofiled to take into account the Covid-19 emergency response work of all the partner agencies. In August, 2020, the partners via the Unpaid Carers Group supported a refresh of the Carers programme

- The Unpaid Carers Group had come together during the emergency response work to ensure the network of partnerships was as strong as it could be in the most extreme of circumstances with the aim being that carers were fully supported throughout the pandemic

- The Council had joined forces with Crossroads Care Rotherham to launch a carer grant initiative to help people who had a long term commitment to supporting loved ones. Funding to the value of £50,000 had been accessed by unpaid carers. In April, 2021, a further £25,000 was made available for a second round of carer grant funding

- The draft Carers Strategy would be considered at the next Unpaid Carers Group on 28th September. It focussed on 3 key areas:- making caring visible, improvements that make our lives easier and living in a Borough that cares about carers

- Rotherham was the only authority in the region to deliver a face-to-face event for Carers Week. Members of the Unpaid Carers Group mobilised to ensure the profile of carers and the vital role they played were raised. It had been a well supported event backed by a social media campaign prompting over 30 carers to come forward and make direct contact with the Adult Social Care Service Improvement and Governance Team

- In line with national and local restrictions during the pandemic, the Council-run Carer's Centre had not been open, however, Crossroads had re-opened "The Corner" in All Saints Square. Discussions would take place with the Unpaid Carers Group to look at how this offer could be enhanced as part of the Carers Strategy

- Work was progressing with Young Carers by Barnardos and the Young Carer Council

- Work was continuing on reviewing the Carers Centre looking at the needs assessment to understand how best to support the initiative and the 2 groups going forward

- The Carers Emergency Service was currently under review and looking to align the Strategy principles. Meetings were taking place with the Carers Forum and Adult Social Care Improvement and Governance Team to ensure total understanding of any issues

It was noted that the final Strategy would be submitted to the Board for approval in due course.

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

(2) That the final Strategy be submitted to the Board for approval.
Action:- Jo Hincliffe/Ian Spicer

20. HEALTH AND WELLBEING BOARD PRIORITIES AND DRAFT ACTION PLAN SEPTEMBER 2021-MARCH 2023

Ben Anderson, Director of Public Health, reported on the consultation with Board members and engagement with wider stakeholders, including delivery leads, that had taken place in July, 2021, on the draft refreshed Board priorities. Comments raised during the consultation were set out in the report submitted. The following powerpoint presentation was shown:-

Refresh of Priorities

- As agreed at the last Health and Wellbeing Board meeting, the 4 key aims set out within the Health and Wellbeing Strategy would remain the headline outcomes that the Board was working towards
- The underpinning priorities would now be refreshed. It was proposed that the new priorities ran until March 2023 to align with financial years (with flexibility to refresh priorities sooner if required)
- It was proposed that the Health and Wellbeing Strategy delivery plan would be updated based on these priorities (additional milestones and actions may need to be agreed at appropriate intervals for the latter part of the plan period)

Strategy Principles

- Reduce health inequalities by ensuring that the health of our most vulnerable communities, including those living in poverty and deprivation and those with mental health problems, learning or physical disabilities, was improving the fastest
- Prevent physical and mental ill-health as a primary aim but where there already was an issue, services intervene early to maximise impact
- Promote resilience and independence for all individuals and communities
- Integrate commissioning of services to maximise resources and outcomes
- Ensure pathways were robust particularly at transition points so that no one was left behind

- Provide accessible services to the right people, in the right place, at the right time

Aim 1: All children get the best start in life an go on to achieve their full potential

Previous priorities (November 2020-July, 2021)

- Develop our strategy for a positive first 1001 days
- Support positive mental health for all children and young people
- Support children and young people to achieve their full potential

Proposed priorities (July 2021-March 2023)

- Develop our strategy to give every child the best start in life
- Support children and young people to develop well

Board sponsors – Suzanne Joyner (RMBC) and Dr Jason Page (RCCG)

The new priorities that are being proposed had been consolidated and were broader in focus:

- Best start – this priority will include alignment with first 1001 days work within the Place Plan
- Developing well – this will align with other aspects of the Place Plan including mental health and wellbeing, SEND, LAC and transitions
- This priority will also encompass other key partnership priorities including work to tackle childhood obesity

Aim 2: All Rotherham people enjoy the best possible mental health and wellbeing and have a god quality of life

Previous priorities (November 2020-July, 2021)

- Deliver the Better Mental Health for All Strategy
- Deliver the Rotherham Suicide Prevention and Self-Harm Action Plan
- Promote positive workplace wellbeing for staff across the partnership

Proposed priorities (July 2021-March 2023)

- Deliver the Better Mental Health for All Strategy
- Delivery the Rotherham Suicide Prevention and Self-Harm Action Plan and further enhance crisis support services
- Promote positive workplace wellbeing for staff across the partnership
- Enhance Community Mental Health Services

Board sponsors – Kathryn Singh (RDaSH)

- 2021-23 priorities continued
- Focus on IAPT and crisis support

Aim 3: All Rotherham people live well for longer

Previous priorities (November 2020-July, 2021)

- Build a social movement to support local people to be more physically active
- Ensure support is in place for carers
- Develop a whole-systems approach to tackling obesity in Rotherham with consideration of the impact of Covid-19

Proposed priorities (July 2021-March 2023)

- Ensure support is in place for carers
- Support local people to lead healthy lifestyles including reducing the health burden from tobacco, obesity and drugs and alcohol

Board sponsors – Sharon Kemp (RMBC) and Michael Wright (TRFT)

- Michael Wright will be joining as co-sponsor
- Based on evidence from the JSNA, tobacco had been raised as an important priority. It had also been commented that action around drugs and alcohol was a gap within the previous plan
- Aim 3 would therefore include a focus on lifestyle interventions aimed at tobacco, obesity and drugs and alcohol
- There would still be a close relationship between Aims 3 and 4. Social movement around physical activity would now sit in Aim 4

Aim 4: All Rotherham people live in healthy, safe and resilient communities

Previous priorities (November 2020-July, 2021)

- Delivery of a loneliness plan for Rotherham
- Promote health and wellbeing through arts and cultural initiatives
- Ensure Rotherham people are kept safe from harm

Proposed priorities (July 2021-March 2023)

- Delivery of a loneliness plan for Rotherham
- Promote health and wellbeing through arts and cultural initiatives
- Ensure Rotherham people are kept safe from harm
- Develop a Borough that supports a healthy lifestyle

Board sponsors – Steve Chapman (SYP) and Paul Woodcock (RMBC)

- Maintain focus on the 3 previous priorities around loneliness, arts and culture and keeping Rotherham people safe from harm
- Focus on ensuring that Rotherham was a place that supported healthy lifestyles through
  - Promoting active travel
  - Building on the social movement around physical activity including using the Women's Euros as a focus point of activity
  - Delivering against the Local Authority Declaration on Healthy Weight

Engagement with Board Members

- Maintaining alignment with the Place Plan remained a priority
- Activity to reduce the health burden from tobacco, drugs and alcohol should feature within the plan
- The relationship between the Health and Wellbeing Board's priorities and the priorities of other partnership boards, such as the Safer Rotherham Partnership, should be considered
- Childhood obesity should be captured as part of the Aim 1 section of the plan

- Work around SEND and Youth Offending Provision should also be incorporated within Aim 1
- There was some discussion regarding the overlap between Aims 3 and 4 and where activity should sit. It was emphasised that lifestyle interventions should sit within Aim 3 and developing a Borough that supported healthy lifestyles should sit within Aim 4
- A priority around partners' roles as anchor institutions and promoting social value should be included

Role of Board Sponsors

- Additionally, some feedback was received regarding the current position with Board sponsors. It was noted that:-
  - The role of Board sponsors could be clearer and it would be useful to have a document that set this out in further detail
  - Having a better balance of Board sponsors from all partner organisations would be desirable to ensure that all partners of the Board were able to take a leading role
  - There was currently no Board sponsor for the cross-cutting priorities and Aim 2 was the only Aim with a single Board sponsor

Discussion ensued on the presentation with the following issues raised/highlighted:-

- The need to define the role of a Board sponsor more clearly
- Probability of the need to review after April 2022 once the South Yorkshire ICS was in place and on an annual basis thereafter
- The need for another Board sponsor for Aim 2
- Caution with regard to the use of digital technology and not creating inequalities for service users
- Need to monitor the increase in the use of non-opiate drugs and alcohol in the Borough and ensure that the work plan reflected such

Resolved:- (1) That the refreshed strategic priorities and draft action plan be approved.

(2) That at the next meeting of the Health and Wellbeing Board Executive Group, consideration be given to the draft Terms of Reference for Board sponsors.

(3) That once agreed, a draft memorandum of understanding be produced outlining the role of Health and Wellbeing Board sponsors and emailed out to the Board for comment.

(4) That non-opiate drugs and tobacco be added to Aim 4.

Action:- Ben Anderson/Becky Woolley

21. SMOKEFREE 2030 ROADMAP

This item was deferred until the next meeting due to the absence of the presenting officer.

22. LOCAL OUTBREAK ENGAGEMENT BOARD

Sharon Kemp, Chief Executive, RMBC, gave the following verbal update on behalf of the Local Outbreak Engagement Board:-

- The Government had set out its Covid-19 Response – Autumn and Winter Plan 2021 which included "Plan A" – a comprehensive approach designed to steer the country through Autumn and Winter 2021/22 – and "Plan B" – which would only be enacted if the data suggested further measures were necessary to protect the NHS
- Rotherham's Local Containment Outbreak Plan would be updated once further information and guidance had been received
- The continued focus was on the local infection rate which had seen a decrease since July but was still above the national average. As at 20th September, for all ages, the rate was 381.5 per 100,000 and for the over 60's 226.9 per 100,000. The constant message was to make sure people understood that Covid-19 was still here and the importance of continued undertaking of the behaviours used and to self-isolate/tested if exhibiting symptoms
- The Dinnington testing site had been retained
- The Test and Trace Team continued to work well meeting all the national standards and indicators
- There were a number of challenges during the coming months including the rollout of vaccines for school children in the half term and encouraging everyone to take up the invitation to attend for a vaccination
- The communications message would be revised to ensure members of the public adhered to the national guidance i.e. wear a mask in a close setting, good hand hygiene and maintaining social distances as far as possible
- Some of the behaviours towards staff had not been good

Michael Wright, TRFT, reported that:-

- During recent weeks there had been 76 positive cases which had been above the peak of the first wave. As of 21st September, it had reduced to 45
- There were 3 people in critical care
- A number of staff had been impacted by Covid
- The Hospital had recently been on Level 4, the most severe level in terms of operational pressures
- The Integrated Discharge team was working really well

Discussion ensued with the following issues raised/highlighted:-

- The whole system was facing significant pressure – concern for staff resilience – at the same time as trying to deliver a recovery plan, waiting times for surgery, flu vaccination and a booster programme
- No significant decrease expected
- Priority had to be to get those not vaccinated to take up the offer (approximately 30,000) – importance of Making Every Contact Count encouraging those that had not taken up the offer to do so and signposting to the CCG website for the frequently asked questions

Resolved:- That the update be noted.

23. ISSUES ESCALATED FROM THE PLACE BOARD

Chris Edwards, RCCG, presented the updated Rotherham Integrated Care Partnership Agreement.

The updated Agreement was intended to facilitate the further development of an ICP model for Rotherham in line with the policy direction set out in the DHSC White Paper – Integrating Care – and in the Health and Care Bill.

It was noted that Legislation was currently progressing through Parliament and, once the Bill had received Assent and final governance was known, the Agreement would be kept under review and updated further for April, 2022.

The document had been discussed and approved at the 8th September meeting of the Place Board.

Resolved:- (1) That the interim Agreement be noted.

(2) That the Chief Executive be delegated, in consultation with the Chair, authority to finalise and sign the Agreement.
ACTION: Councillor Roche/Sharon Kemp

24. LOCAL GOVERNMENT ASSOCIATION 'MUST KNOW' BRIEFING ABOUT DRUGS AND ALCOHOL TREATMENT

The Board noted the link to the above briefing.

25. DATE AND TIME OF NEXT MEETING

Resolved:- That a further meeting be held on Wednesday, 24th November, 2021, commencing at 9.00 a.m., venue to be confirmed.

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	24th November 2021
	LEAD OFFICER	Ben Anderson
	TITLE:	Strategic value of Physical Activity in Tackling Health Inequalities

Background

1.1 There have been some really positive developments in Rotherham recently in relation to the work around physical activity. The development of 'Moving Rotherham' and its positioning as a 'Game Changer' in the Cultural Strategy alongside the work around the Women's Football Euros, the recent Beat the Street programme and the work on 'Creating Active Schools' is all leading to real momentum being built.

1.2 However, this is against the background that inactivity rates in the District are above national average with almost one in three adults across the Rotherham District classified as inactive. Also, women, people from ethnically diverse groups, people living with long terms conditions, disabled people and people from lower socio-economic groups all have higher rates of inactivity. And the negative effects of intersectionality (when a number of these factors are combined) mean that up to 60% of some groups are likely to be inactive.

1.3 Movement, physical activity and sport have an important role to play in addressing inequalities, and particularly health inequalities; It is estimated that low physical activity levels contribute to 1 in 6 deaths in the UK. Inactivity is associated with poor health at all ages and the benefits of increasing physical activity continue throughout a person's lifetime. People with chronic and multiple health conditions are amongst the least active members of society and have the most to gain from even small increases in physical activity; being physically active reduces risk of heart disease by 35%, hip fractures by 68% type 2 diabetes by 40%, depression by 20%

1.4 The recommended physical activity guidelines for each age are shown in Appendix 1. It is also important to note that, even people who meet the recommended physical activity guidelines, may still be at risk of certain adverse health outcomes if they spend most of their time sedentary.

1.5 The health and socio-economic implications of physical inactivity also have a financial cost. Physical inactivity is estimated to cost the UK £7.4 billion per year, with around £0.9 billion in NHS costs alone.

1.6 To many, being active is fun, and also leads to improved physical and mental health, people living well for longer, people living in healthy, safe and resilient communities and children and young people getting the best start in life.

1.7 In light of the above, Sam Keighley, Strategic Director at Yorkshire Sport Foundation and part of Sport England's Extended Workforce Team, was asked to conduct a series of conversations with members of the Health and Wellbeing Board and others to consider how, if we take a system approach to physical activity, it can help us tackle the health inequalities across Rotherham that have widened further during Covid 19 and

	subsequent lockdowns.
1.8	This report sets out the key messages arising from those conversations. Health and Wellbeing Board members are asked to consider these and commit to collaborative working to achieve at least 2 of the proposals that could make a step change in reducing the number of Rotherham residents who are inactive, particularly the people that could benefit most.
1.9	A full list of people involved in these conversations is attached as Appendix 2
Key Issues	
2.1	Everyone who took part in a conversation agreed that physical activity could add value to their organisation and objectives and, in doing so, help tackle health inequalities.
2.2	Health and Wellbeing Board members also felt physical activity can add value to the Board's 4 shared priorities; improved physical and mental health, people living well for longer, people living in healthy, safe and resilient communities and giving children and young people the best start in life.
2.3	There was general recognition that there isn't a single bullet that will fix the high inactivity rates across Rotherham and achieve the health and social benefits associated with being active. It is complex; some people will be active because they enjoy it and know it is good for their health (motivation, capability & opportunity); some people know it is good for their health but haven't quite got round to doing anything (motivation, capability but no opportunity); and some people might know it would be good for them but don't feel it is for them, don't feel they could manage it and don't think about how it could be part of their lives (no motivation, capability or opportunity)
2.4	Because tackling inactivity is complex, everyone recognised that we can't simply leave the challenge to one or two people who have sport / physical activity/ public health in their job titles. Rather, we need to take a system approach, with everyone owning the challenge and building physical activity into their work. Examples of this included:
2.4.1	• All public sector anchor organisations doing what they can as employers to get and keep their workforces active. Everyone is doing something currently. Sharing and learning between organisations about the best of what everyone is doing - and providing constructive challenge to each other –could really accelerate this. There was mention of having accreditation. Also, asking our key private sector employers to join with us. In effect this could create a social movement across public sector employers. Our emergency service partners have some particularly good models to help keep their staff active to improve and maintain their physical and mental wellbeing
2.4.2	• Creating the conditions where social movements that normalise physical activity can flourish. This should include promoting our open and green spaces and public footpaths; involving people at the earliest stages in our planning, town centre, active travel infrastructure plans, including good lighting and other interventions that improve community safety; developing campaigns that reflect 'people like me' being active, on the basis we can't be what we can't see; co-designed interventions so people can become active with their friends and family (campaigns won't reach everyone)

2.4.3	• Using physical activity as one of the solutions to tackling issues identified through ward and communities of interest plans, particularly loneliness and isolation, improving mental wellbeing and tackling health inequalities
2.4.4	• Training front line workers across multiple organisations (prevention, early intervention and clinical) to be confident to talk about and signpost people to being active. i.e. Making Every Contact Count (MECC). There are some pockets where this is already working well and sharing could help to amplify this across the whole system.
2.4.5	• Create (even more?) diverse workforce teams that reflect the people we want to be working with
2.4.6	• Find the resource to further support VCSE organisations who are working with the people you want to connect with
2.4.7	• Strengthen local social prescribing structures; including building the confidence of G.P.'s and other prescribers to talk about the benefits of physical activity and refer; develop an effective resource that connects with organisations and people that are providing opportunities; develop personal relationships and connections between referrers and VCSE organisations that are providing opportunities
2.4.8	• Work with communities to ensure all physical activity and sport provision is relevant and accessible to all communities; with particular reference to ethnically diverse communities low use of leisure and swimming provision
2.5	Probably more important than the 'what' we need to do, is the 'how' we need to work together. During conversations, people were asked about strategic ambitions that had been successfully translated into action that benefitted communities. Examples were wide ranging and mainly from outside the sport and physical activity world. Whatever examples people gave, everyone talked about the same conditions that had created success. These were:
2.5.1	• Strategic ownership; something that spoke to everyone, individually and organisationally
2.5.2	• Visible leadership across all parts of the system that needed to be involved
2.5.3	• Strong leadership which gives others mandate and cover to make things happen
2.5.4	• A dedicated person to make it happen (not an add on to an existing day job)
2.5.5	• Co-creation and collaboration between everyone who has a stake across the whole system – including the VCSE and communities who have 'lived experience'; identify people who are passionate about this. 'Spark Plug People' who you know make things happen
2.5.6	• Have clear vision and objectives
2.5.7	• Don't make it complicated
2.5.8	• Hold people to account
2.5.9	• Measure success – the right success
2.5.10	• Take a whole person approach i.e. not just that someone is inactive
2.5.11	• Identify and allocate the financial resources required
2.5.12	Taking account of these conditions will help us create transformation in tackling inactivity and helping to address health inequalities

2.6	In addition to these conditions, there were a number of other points raised that, if addressed, will further help our ambition:
2.6.1 **2.6.2** **2.6.3** **2.6.4** **2.6.5**	• Translate short term success into sustainable activity when something proves successful. Work collaboratively to identify the resources required, recognising the negative impact that will be felt in different places if the successful work stops • Invest time to share and learn from pockets of successful work to amplify and spread for increased impact • Invest time in building relationships. Create conditions where, if something is perceived to be a problem, it can be discussed openly and, through collaboration, resolved. • Work as a system, rather than in silos. Always remember that everyone is part of the same team • Don't make assumptions, about communities or each other as partners. Engage with everyone who has a stake in what you are trying to achieve
Key Actions and Relevant Timelines	
3.1 **3.2**	To create a 'coalition of the willing' to work collaboratively on each of the actions selected That the Health and Wellbeing Board ask for an update report in 6 months' time, setting out progress made and the learning from the work that has taken place
Implications for Health Inequalities	
4.1	Tackling inactivity will have a direct impact on tackling health inequalities, including diabetes, falls, healthy years of life, reducing loneliness and isolation, improving physical and mental wellbeing
Recommendations	
5.1	That members of the Health and Wellbeing Board consider the contents of this report
5.2	That the Health and Wellbeing Board prioritise 2 or 3 proposed actions identified in Section 2 of this report. Also, agree to work in the way proposed, including providing the required leadership and resource. (Yorkshire Sport Foundation may be able to provide a financial or in-kind match resource to support the development of any proposed collaborative actions).
5.3	To create a 'coalition of the willing' to work collaboratively on each of the actions selected
5.4	That the Health and Wellbeing Board ask for an update report in 6 months' time, setting out progress made and the learning from the work that has taken place

Appendix 1 – Physical Activity Guidelines

Current Physical Activity Guidelines

Guidance around physical activity varies by age. The Chief Medical Officer's suggested activity for each age group is shown in the table below.

Age Group		Physical Activity Guidance
Child	Birth – 1 year	• At least 30 minutes across the day of tummy time
	1-2 years	• At least 180 minutes across the day, including playing outdoors
	3-4 years	• At least 180 minutes a day, including at least 60 minutes of moderate-to-vigorous intensity physical activity
	5-18 years	• At least 60 minutes of moderate intensity physical activity per day across the week • Should involve aerobic exercise and activities to strengthen muscles and bones
Adult	19-64 years	• At least 150 minutes of moderate intensity exercise per week or at least 75 minutes of vigorous intensity exercise per week, or a combination of the two • Strengthening exercises on at least 2 days a week
Older adult	65 years +	• At least 150 minutes of moderate intensity exercise per week or at least 75 minutes of vigorous intensity exercise per week, or a combination of the two • Strengthening exercises on at least 2 days a week

Moderate physical activity is described as exercise where you can still talk, but not sing. Examples of moderate activity include:

- Brisk walking
- Riding a bike on the flat
- Playground activities
- Dancing
- Hiking

Vigorous physical activity is described as exercise where "you will not be able to say more than a few words without pausing for breath." Examples of vigorous activity include:

- Jogging or running
- Riding a bike fast or on hills
- Aerobics
- Swimming fast
- Singles tennis
- Football
- Martial arts

Examples of muscle strengthening activities include:

- Carrying heavy shopping bags
- Yoga or Pilates
- Tai chi
- Lifting weights or working with resistance bands
- Doing exercises that use your own body weight, such as push-ups and sit-ups
- Heavy gardening, such as digging and shovelling

Appendix 2 – Stakeholder Conversations

Conversations have taken place with the following people:

(in date order)

Sharon Kemp	CEO, Rotherham Council
Ben Anderson	Director of Public Health
Paul Woodcock	Strategic Director Rotherham Council, Regeneration & Environment
Martin Hughes	Head of Neighbourhood Services, Rotherham Council
Jacqui Tufnell	Head of Commissioning, Rotherham CCG
Steve Chapman	District Commander, South Yorkshire Police
Michael Wright	Deputy CEO, Rotherham Hospital Trust
Jason Page	G.P and Rotherham CCG Children's Service Commissioner
Various VCSE stakeholders	Moving Rotherham Partnership
Anne Marie Lubanski	Strategic Director, Rotherham Council, Adult Social Care, Housing & Public Health
Wahid Akhtar and Janice Curren	Communities of Interest Leads, Rotherham Council
Shafiq Hussain	CEO Voluntary Action Rotherham
Julie Anderson	Social Prescribing Lead, Voluntary Action Rotherham
Councillor David Roche	Chair, Rotherham Health and Wellbeing Board and Cabinet Member Adult Social Care and Health, Rotherham Council
Kathryn Singh	CEO RDASH
Azizan Aktar	CEO REMA
Steve Adams	South Yorkshire Fire Service
Various VCSE communities of interest stakeholders	Rotherham Council, Communities of Interest
Councillor Victoria Cusworth	Children and Young People Cabinet Member, Rotherham Council
Chris Siddall	Acting Head of Strategic Projects and Partnerships, Rotherham Council
Kate Green	Public Health Specialist, Rotherham Council
Chris Edwards	CEO Rotherham CCG
Lindsey Taylor-Ward	Operations Manager, Rotherham Council, Adult Social Care, Housing & Public Health

Further Conversations planned:

George Briggs	COO, Rotherham Hospital Trust
Suzanne Joiner & SMT	Strategic Director, Rotherham Council, Children and Young People

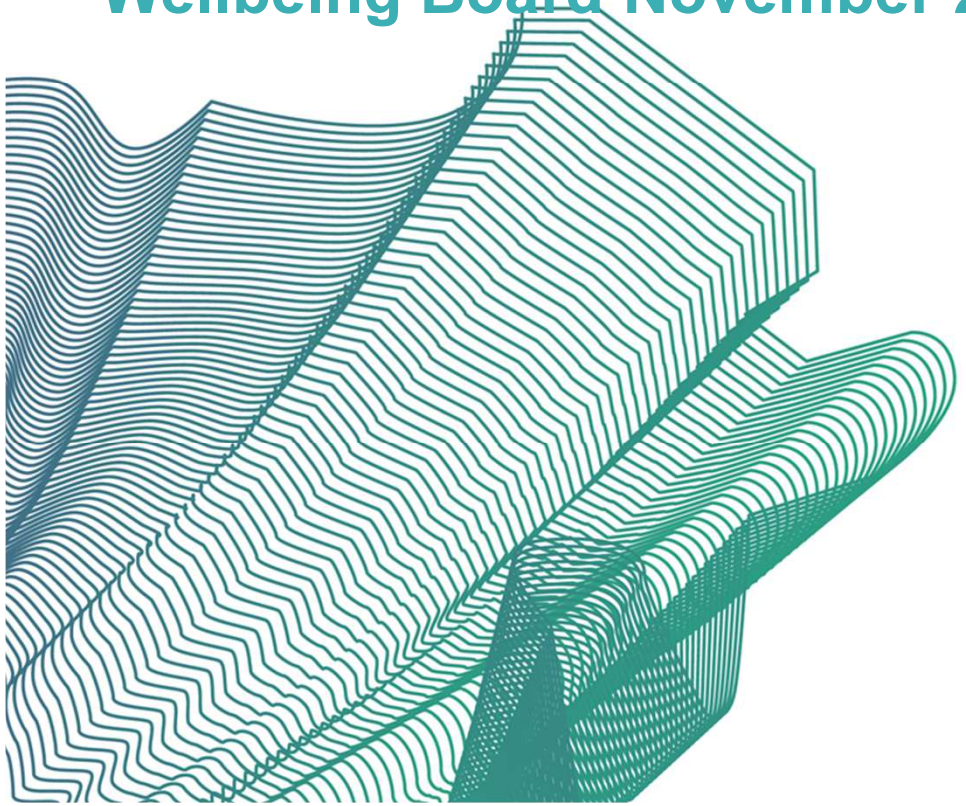
ROTHERHAM

INTEGRATED CARE PARTNERSHIP | HEALTH AND SOCIAL CARE

Demand Management/Surge Plan 2021-22

October 2021

Presentation to Rotherham Health and Wellbeing Board November 2021



NHS
Rotherham
Clinical Commissioning Group

Rotherham, Doncaster and South Humber
NHS Foundation Trust

The Rotherham
NHS Foundation Trust

Rotherham
Metropolitan
Borough Council

VoluntaryAction Rotherham

CONNECT HEALTHCARE
ROTHERHAM CIC

Lessons Learnt 2020-21

Winter 2020-21

Key Lessons Learnt

- Robust Place Based Governance :–
  - Strategic through to operational daily calls
- Mature relationships across the Place:-
  - Early planning of IBCF funding for Winter/Covid19 2020-21
- Jointly funded posts in commissioning and operations
  - Place Capacity Manager
- Housing representatives working in acute to support delays
- HALO in place to support flow through UECC
  - Commenced mid-winter
- Integrated Discharge Team
- Flu vaccinations as early as possible
- Utilising ring fenced elective beds
- Operational Gold management
- Increased on call in acute units
- Escalation Management System

Risks

- Risk of further bed reductions
  - Due to cohorting flu and covid19
- Pressure on social care provision
  - Home care / Reablement resource to meet demand
- Workforce challenges :–
  - Sickness, morale, and mental health
- Unable to recruit to key capacity
  - Acute wards. UECC, Reablement
- Using elective beds for emergency care
- Multiple outbreaks of flu and/or covid-19 in community i.e care homes
- Primary care support for UECC is fragile
- GP hubs need to be provided in a different way
- Ongoing Covid19 issues :–
  - Track and Trace (patients and staff),
  - Access to PPE across the Place partners,
  - Social distancing

COVID-19

Key Lessons Learnt

- Emphasis on 'home first' with significant increase in assessment after discharge.
  - Integrated Discharge Team – Covid-19 changes to ensure same day discharge, working to 3 hour discharges
- Covid19 positive community beds supported flow
- Cross service working & Mobilisation of non clinical staff to front line
  - Can do approach
- Critical care Beds increased from 14 to 50
  - Training of theatre staff to man Critical care
- Operational management Gold Silver command
  - Covid control room
- Reduction in face to face interventions, quick development of hot visiting &hub
- Community Triumvirate given authority to deliver care
- Streaming in UECC at front door
  - Paediatric ED / assessment unit combined
  - Minor injuries transferred to fracture clinic
  - Surgical and medical assessment unit criteria widened
- Staff helpline
  - Staff and patient drive through testing facility

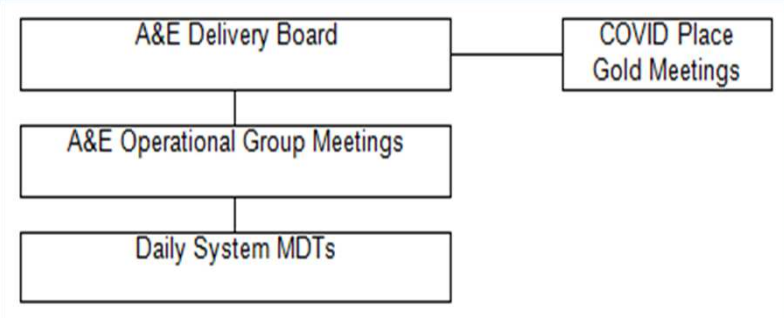
Risks

- Cohorting – reducing beds across the acute
- Critical care staff / Critical care equipment:
  - Ventilators, borrowed 2 but not yet received
- Pressure on social care provision
- Workforce challenges – sickness, morale and mental health,
  - Recruitment
- Multiple outbreaks of flu and/or covid-19 in community
  - Including care homes

Governance – Winter Surge and Covid19

This Surge Plan has been developed as a system wide partnership and as such has been developed in collaboration. The Surge Plan 2021-22 has been signed off by the A&E delivery Board in October 2021 and has been to the Place Gold Covid meeting for information prior to H&WB.

Governance Structure



There are daily calls with system partners at various levels of authority to monitor the ongoing risk and escalation across winter/surge/covid19. This is supported by the use of an Escalation Management Process including a Dashboard, Escalation Wheel and the daily reporting completed by the Place Capacity Manager.

The Trust have a fully developed and signed off 'Full Capacity Protocol' which clearly demonstrates clinical leadership at all escalation levels. At periods of significant pressure i.e. Level 4 the protocol includes communications at system level via the Trust's Medical Director/Chief Nurse.

What will we do?

Acute

- Develop Additional Critical care capacity
- If demand goes above additional 8 patients i.e. 22 critical care beds
  - TRFT will recreate our 50 bed critical care unit on A floor
- Co-horting Flu and Covid –Amber, Red, Green
- Additional capacity for RSV
- Reduction of elective cases ***Key decision point*** pre planned
- Priortisation of elective – i.e. Cancer and urgent.
- Balance elective and non elective priorities in line with recovery programme
- Continue to utilise local independent sector to sustain elective care
- Halo - YAS relationships
- Review AMU ASU capacity as required
- PPE check stock
  - Source alternatives if a national issue

UECC

- Anticipated levels of referral from NHS 111 First to booked appointments – there are currently 4 slots available per hour for NHS 111 First patients, we do not specify adult or children. These slots will be available over the winter period and we continue to book patients from NHS111 over and above the 4 per hour.
- Ambulance Handover delay improvement plans - TRFT have support from NHSE/I with a piece of work around Ambulance Handover and Streaming. Discussions have taken place with NHSE/I for a series of audits to take place over 2 days in September to specifically look at live handovers, streaming to alternative disposition, patient questionnaire and a retrospective case review of patients conveyed by ambulance and discharged. A report will follow from NHSE/I with the findings and recommendations.

YAS – 999

- Ensure continued Performance against Handover delays – more robust escalation processes between TRFT and YAS.
- £5M additional funding has been made available for YAS to support performance going into Winter 2021-22. Specific aims of the funding have been outlined by NHSE and ICSs have been asked to work with their ambulance Trusts to submit a proposal to NHSE by 23 July.
- Work has been done to establish closer and more collaborative working between YAS ECPs and IRR/CCC as part of the urgent community response

Patient Transport (non-emergency)

- Manage demand in line with discharge guidance.
- Additional PTS provision has been secured for weekdays and weekends – 1 additional 8-hour shift per day.

Manage Flow Successfully

- Continue 3 hour discharge processes:-
  - Including where appropriate/available CHC & brokerage working in IDT, 8am-8pm service, daily MDT with community services including rapid response and reablement. Co-location of H&SC pathways for discharge/hospital avoidance in community
- Continued commissioning of additional community beds ***Key decision point***
- System Capacity Manager:
  - Full Development of Place Dashboard by December 21
- LOS reviews – daily with focused reviews x 2 per week
- Continue Age UK discharge service supporting patient transport

What will we do?

Community Services

- Robust Contingency Plan in place for care homes including action plan links to Outbreak Plan
- Home Care – Dynamic Purchasing System can be used to increase capacity. Further providers already added to framework
- Increase therapy/nursing resource in Integrated Rapid Response linked to Aging Well with Reablement co-located with CCC at Woodside.
- Equipment services available 7 days a week. Age UK staff also being trained as Trusted Assessors for some small pieces of equipment.
- Respiratory exacerbation pathway – respiratory nurses will manage patients with an exacerbation of their respiratory condition in their own home. Patients will receive support via home visits and telephone reviews. On discharge the team will arrange referral into pulmonary rehabilitation and any other appropriate follow up.
- New community respiratory pathway providing early supported discharge, in-reach, admission avoidance, exacerbation management & overall, in conjunction with the GP, community management of respiratory patients

Primary Care

- Hot/Cold home visiting arrangements flex to more 'hot' during periods of demand – increased from June 2021. This will also support primary care presentations for children with RSV. Co-located Hot Paramedics in Woodside with CCC and Rapid Response
- GP LES in care homes
  - Support from Care home liaison service to support people (flu/Covid) to remain at home
- Link Community team to GP services
- Primary Care shift to digital consultations where possible
- Rotherham Primary Care 'hot site' for Covid patients who require face to face services – to be re-established to support increase in demand – the service will run 10am to 6.30pm Monday to Friday until the end of March 2022.
  - Extended Access
- The Extended Access service will continue.
- Same day ANP service to increase capacity for 'cold' patients.
- Flu Vaccinations for patients delivered as a system using PCN/place footprint for delivery to achieve required uptake

Expected capacity of primary care

- Primary care will run at full core capacity, with extended hours provided by PCNs and extended access via a hub model. A hot site for potential covid patients will also be used.

Expected reliance on temporary staffing

- Given the potential for staff sickness this winter, there may be a greater than normal need to use locum staffing. Use of NHSP to support workforce planning. early additional recruitment taking place

Initiatives to maximise and optimise existing workforce

- The PCNs have all recruited ARRs posts, and some have made use of local innovation funding to provide additional staffing to March 2022.

Seasonal recruitment

- Nothing additional is planned.

Potential hotspots for staff sickness/high demand for leave

- As expected for all staffing groups this winter.

What will we do?

Flu Immunisation and Outbreak Plan

- Flu vaccination plans will have been enacted :–
  - Co-ordinated approach to achieve maximum numbers
- Mobile access to cover community primary care
- All PCNs have resilience plans in place to enable patients to be managed from any of their sites/from home

Staff

- Health and well-being across place, impact on staff mental health
- Resilience
- Recruitment and retention
- Review PPE type and availability
- PPE sub group
  - Plan now for what if scenario

Ways of working

- Retaining a collaborative approach
- "Agile Place"
- Keeping our people and services safe
- Making decisions – flexible, proactive rather than reactive
- Innovation and ambition
- Plan
- Use of data and analytics on need, capacity and demand/ population health. Newly established Health Inequalities workstream with dedicated funding via IBCF to support Place priorities.
- Strong communications

Rotherham Plan for Covid Services

- We will work across South Yorkshire and Bassetlaw to develop after care and support services

Social Care

- Continue to provide Brokerage support directly into IDT at peak times
- Continued support of the principles of 8am-8pm working arrangements in IDT (based on assessed demand)
- Daily virtual MDTs with system partners
- Continued support for the principles of discharge to assess in the community
- Increased resource in home care & reablement. More flexibility for providers to review customers of service releasing capacity.
- Robust monitoring and oversight of Care Homes including any Outbreak Incident Management, Training, Communication, Contractual support.
- Staff training in MH Awareness (for all reablement workers and reablement coordinators), MH Positive Risk Taking (all coordinators, to inform their support planning and MH First Aid (coordinators to empower them to confidently manage rising risks/crisis)
- Home care and support services - 9 providers have been identified and are being engaged with to soft market test interest in taking care packages as additional capacity.

Assistive Technology

There is a national drive to better utilise the benefits of technology to provide a cost-effective alternative to formal care and enable someone to remain independent within their home, whether that is a community residence or a care home. The use of AT available through the Rotherham Assistive Technology Service, as well as support available through existing smart technology and for private purchase, could be promoted to support and optimise Winter Planning for 2021/22 and pilot projects could be considered to offer a new approach across the Rotherham Place.

What will we do?

Mental Health

- Staff counselling, breakout facilities
- Mental Health digital consultations where possible.
- Continued promotion of 'Rotherhive' digital approach to delivering mental health support and communication on services are available.
- Uncertainty of demand for services, increase expected, particularly for crisis services.
- RDaSH has funding to support mental health discharge.
- More mental health support for primary care.
- Pilot a link-worker to link between UECC and Rotherham Community Groups.

Care Homes

- Weekly place meetings to continue through winter – focus on areas of concern, data, action plan for older people, LD and MH care homes in the borough.
- Contingency plan developed which provides assessment of risk based on 4 scenarios – covid outbreaks, capacity in the home, staffing levels, financial viability
- Meetings taking place to support care homes
- Incident Management Team – established process for dealing with outbreaks linked to the local Outbreak Plan
- Support via health from GP alignment, care home liaison, community physician and clinical quality officer , hot visiting. Social care contract compliance team within commissioning contacting all homes regularly.
- Virtual multi-agency training package continued to be offered focusing on PEE, IPC and Swabbing (residents and staff).
- Remote monitoring pilot – An App covers basic observations, wound care, under-nutrition and falls.
- ECHO - Training via Zoom, using the ECHO methodology has been implemented in Rotherham. A programme of training sessions has already taken place for care homes as well as Community Nursing staff. Funding has been secured to allow further roll out.

Communications

Throughout winter, we will across the Rotherham health and care partnership to utilise a variety of communications activity, based on local, to encourage a reduction in unnecessary attendances at A&E and an increase in use of community/primary care services and support services such as Extended Access appointments, NHS 111 and pharmacy. Key messages will be developed to be used by all partners, using positive language about services that people can and should use rather than telling them 'not to use services such as A&E'. A local winter communication activity plan will be implemented from October onwards.

What will we do for Children and Young People ?

Children and Young People

Key pressures:

- Increased number of presentations for younger children with RSV or other respiratory viruses. Affects Under 2s.
- Lack of exposure to viruses for children under 5 during Covid – anxious parents needing reassurance – some have not seen children ill before.
- CAMHS – increased presentation of children and young adults with mental health problems. Some being supported in acute beds due to lack of capacity within in-patient mental health facilities.
- Support being provided across South Yorkshire for Doncaster paediatric in-patient services – recent flood and major incident at Doncaster Hospital has reduced its paediatric capacity.
- Staffing – need to ensure staff welfare.

Mitigation:

Communications

- Communications activity has taken place for RSV with more planned. Some of the activity undertaken by Rotherham Health and social care partners includes:

• Websites and social media posts - using national RSV campaign materials and SYB ICS Healthier Together website messages.
• Information shared via partner public and stakeholder bulletins – including primary care.
• Information shared directly with schools and parents during new school term.
• National campaign materials shared with local community and parent groups

TRFT – Acute and Community

- Children's community nursing team (PARROT) – will take referrals from wards and directly from UECC.
- Vulnerable neonatal patients have been identified and referred to Synergis clinic which has commenced 2 months early (August in 21).
- Paediatric acute capacity - ODN surge plan for Yorkshire and Humber has specified that TRFT paediatric inpatient capacity could be increased by 4 beds. This would require additional staff to support and plans are in place to increase as and when required.
- Yorkshire Humber paediatric inpatient DOS provided to allow visibility of both inpatient critical care patients across the region (including staffing).
- Options to use virtual consultations as well as face-to-face when appropriate; consider asking parents views through existing forums.

Primary Care

- Additional capacity for primary care – including hot hub for face-to-face consultations, hot/cold visiting service and additional GP extended hours sessions. This will increase capacity to see under 5s.

What will we do?

RDaSH

- Reduce the length of stay a child or young person requires for care or treatment in the acute hospital, supported by robust risk assessments and community care and treatment plans.
- Ensure children and young people presenting at UECC are seen in an immediate and timely manner receiving a robust risk assessment and are treated at home where appropriate with a care and treatment plan.
- Ensure that at the weekly “at risk of admission "scoping meeting across the RDaSH partnership, children and young people who are known to be at risk of admission for a mental health problem or an eating disorder are identified, risk assessments undertaken and robust care and treatment plans put in place to minimise the risk of admission.
- Self help support and wider public health information will be promoted through the RDaSH social media presence and website
- The Me in Mind Teams will work intensely with schools to support resilience and provide early intervention where children and young people are showing the early sign of emotional distress.

RMBC

Service Delivery Plans for all portfolios within the Council, Borough Emergency Plan, Adverse weather plans, CYPS Emergency Plan, Pandemic Plans.

Business Continuity Plans at Directorate level and service level covering:

- Social Care
- Early Help
- Commissioning, Quality and Performance
- Education and Inclusion

Plans identify priority services that need to be maintained and services that can be reduced temporarily.

School level risk registers with mitigations, School level emergency Plans / Business Continuity Plans / Pandemic Plans / Adverse weather plans (Academies are required by their insurers to have contingency plans in place), Recruitment and retention strategy, Service wide assurance days aligned to service plans and delivery, Internal Communications Strategy, School/Academy Communications Strategy, Development and learning programme, Education places sufficiency strategy, Hybrid working models and Vulnerable children and families oversight and assurance forums.

System-wide

- Cross-Partner Vulnerability meetings are held every 2 weeks.
- All Partners to be responsible for their areas but provide system-wide support during peaks of pressure.

Multi-Agency Covid Booster and Flu Plan

1) Flu Vaccination Programme

A Place-wide flu vaccination programme will be delivered in line with National Guidance. This will include both staff and patient groups and both adults and children. Vaccinations will be delivered by GP practices, pharmacists and NHS Trusts (for staff)

2) Phase 3 Covid Vaccination Programme

A Place-wide plan is in place to deliver Phase 3 of the Covid vaccination programme. PCN sites and TRFT have confirmed participation in the scheme. This will include Covid Booster vaccinations. It also includes the continuation of vaccination for patient groups from Phase 2 including the evergreen offer.

Plans are also in place to deliver the Covid vaccination programme for 12 to 15 year olds.

Assurance against both the above vaccination programmes is provided at the Rotherham Place Vaccination Task and Finish Group meetings.


ANY
QUESTIONS
?

Health and Wellbeing Strategy Action Plan: Update to board, November 2021

Key:

Completed
On track
At risk of not meeting milestone
Off track
Not started

Aim 1: All children get the best start in life and go on to achieve their full potential

Board sponsors: Suzanne Joyner, Strategic Director of Children and Young People's Services, Rotherham Metropolitan Borough Council and Dr Jason Page, Vice Chair, Rotherham Clinical Commissioning Group

Priority	#	Milestones	Timescale	Lead(s)	BRAG rating	Progress update
Cross-cutting	1.1	Work with Health and Wellbeing Board partners to develop a 'Best Start and Beyond' strategy. * *N.B. the strategy will be developed in five stages.	April 2022 – stage one developed April 2023 – complete strategy developed	Alex Hawley, RMBC		Initial stakeholder workshop held in October, with agreement to map pathways. Follow-up meeting planned for December to progress. Pathway-mapping exercise (using tool previously deployed by Early Years) planned for new year.
	1.2	Deliver the 0-19 service with a universal offer to support all children and young people and their families, with an enhanced offer for those that need it, ensuring that there is equality across the service.	Ongoing for the duration of the plan	Alison Cowie, Head of Nursing Children's Services, TRFT		Universal service offer provided to all families – all mandated visits are above defined target – although new birth visits for first time parents is slightly below target – this was impacted by Covid, however recent changes to practice should address this. Maintaining continuity from antenatal contacts can also impact on this however this is seen as beneficial for the families so this will continue to impact on the target. The enhanced targeted offer

						continues to provide support to more vulnerable families though the Young Parents Team, European Migrant Team and Early Attachment Team. Through Evolve young people subject to CSE/CCE are supported and currently developing pathways to support young people within YOT. There is also a Universal Partnership Plus Team supporting significantly vulnerable families or who are Looked After are offered a high-level service to review health and development and offer support.
Develop our approach to give every child the best start in life.	1.3	Develop a local action plan to deliver on the first 1001 days.	September 2021	Alex Hawley, RMBC		Action plan will be developed through Best Start Strategy.
	1.4	Develop a breast-feeding friendly charter and campaign for Health and Wellbeing Board partners to sign up to.	November 2021	Alex Hawley, RMBC		Inclusion of targets for recruitment of premises as unicef Baby Friendly Initiative accredited included within draft 0-19s specification. Exploring further options, e.g. for a local scheme for BF-friendly premises.
	1.5	Work with the LMS with the aim to achieve 35% of women on a continuity of carer pathway by March 2022.* *New wording for action: Work with	March 2022 March 2023	Sarah Petty, Head of Midwifery, TRFT		The national target has now changed, and continuity of carer will now be the default model by March 2023. TRFT

		the LMS to ensure continuity of carer is the default model by March 2023.				are in the process of developing the plan currently, with a focus on targeting the most vulnerable communities in Rotherham, particularly those from deprived communities and ethnic minority groups.
Support children and young people to develop well.	1.6	Review the childhood obesity pathway.	Review of current pathway – March 2022 Review of recommissioned 0-19 pathway – April 2023	Alex Hawley RMBC		Draft Healthier Weight and Physical Activity Health Needs Assessment 2021 for children and adults includes description of 4 Tiers of weight management services. Whilst there are some gaps in current service provision, proposing to broaden this action to one of reviewing the whole strategy/approach - to be a more holistic and prevention-led, and to embed within Best Start and Beyond Strategy.
	1.7	Explore opportunities to increase the number of schools in Rotherham with the Food for Life award.	October 2021	Best Start - Public Health Specialist, RMBC		Public Health have liaised with catering services to explore opportunities and RMBC services have achieved a Food for Life award. Further opportunities to improve food available in schools are being explored.
	1.8	Deliver against PHE funding to develop a team around the school model of working and report learning	July 2022	Nathan Heath, RMBC		Pilot to roll out from November 2021 to March 2022.

		to the Health and Wellbeing Board.				
	1.9	Develop the response to the final COVID survey report, including promoting what young people can do to support their own mental health, delivering actions within schools and developing our partnership response to the findings.	March 2022	Nathan Heath, RMBC		The final response to the COVID survey report has been shared with schools and partners. In response to this, several schools have responded to advise they are implementing new practices, including strategies to support children and young people with how they can support their own mental health. Responses received from partners have included the sharing of NHS Guidance for children and young people's mental health by health colleagues including how parents and carers can access services, and self-care recommendations for young people. In addition, the VAR CYPS Consortium has commenced a 6 month 'Response' project which will include actions to address findings from the surveys.
	1.10	Deliver the SEND development plan.	Ongoing	Nathan Heath, RMBC		SEND Ofsted/CQC written statement of action is in development with all stakeholders. This is to be published January 22, 2022.

Aim 2: All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life

Board Sponsor: Kathryn Singh, Chief Executive, Rotherham Doncaster and South Humber NHS Foundation Trust

Priority	#	Milestones	Timescale	Lead(s)	BRAG rating	Progress update
Promote better mental health and wellbeing for all Rotherham people.	2.1	Sign up to the Public Health England prevention concordat for better mental health as a Health and Wellbeing Board.	March 2022	Ruth Fletcher-Brown, RMBC		Office of Health Improvement and Disparities (OHID) are holding a workshop for LAs on the revised Concordat on the 11th November. Officers from Rotherham will be in attendance.
	2.2	Develop and deliver a communications campaign centred around various themes to promote 'self-help', early intervention, and prevention.	March 2022	Gordon Laidlaw, CCG & Ben Pindar, RMBC		Communications activity is currently being undertaken to promote awareness around anxiety and the support available for people in Rotherham. A plan has been developed is being implemented the Integrated Care Partnership communications group throughout November and December 2021. A series of mental health self-help guides are being developed and will be available by mid-November via Rotherhive.
Take action to prevent suicide and self-harm.	2.3	Deliver training to 100 people across the partnership on self-harm and suicide prevention awareness.	March 2022	Ruth Fletcher-Brown, RMBC		A virtual suicide prevention training programme is being delivered, targeting Voluntary and Community Sector(VCS), police and primary care as priority groups. Suicide prevention awareness

						sessions are being held for RMBC staff in November and December. Early Help staff are delivering self-harm awareness sessions.
	2.4	Launch the Be the One campaign focussed on women.	September 2021	Ruth Fletcher-Brown & Ben Pindar, RMBC		Campaign launch event was held on the 10th September. Staff from partner organisations attended. Staff were encouraged to use their own social medial to share the campaign. A press release and social media posts were created. The campaign is being promoted across Rotherham. Campaign is being promoted again during Safeguarding Awareness week w/c 15th November. Campaign is referred to on local suicide prevention training.
	2.5	Hold the Suicide Prevention Symposium, develop action plan in light of new priorities and implement.	October 2021	Anne Marie Lubanski & Ruth Fletcher-Brown, RMBC		Symposium held on the 12th October attended by Professor Nav Kapur and partner organisations. Action plan is being developed based on the symposium, real time data and Coroners Audit report.
Promote positive workplace wellbeing for staff across the partnership.	2.6	Ensure Health and Wellbeing Board partners are signed up to the Be Well @ Work award.	Ongoing	Colin Ellis, RMBC		We still need partners to come forward and sign up to the award scheme. No movement on this yet.
	2.7	Deliver the workplace project as part of the better mental health for all fund and identify learning.	March 2022	Colin Ellis and Jacqueline Wiltschinsky,		This project is up and running and we have engaged with 44 SMEs to ask what support is needed around mental health.

				RMBC		We are putting on training, producing a short training video, offering a toolkit and putting on webinars around specific suggested topics.
Enhance access to mental health services.	2.8	Develop an action plan to enhance the access to IAPT for BAME groups, older people, unemployed and those who are post-COVID.	March 2022	Kate Tufnell, CCG		• Action plan development / mobilization underway. • RDaSH IAPT service is part of the Rotherham Long-Covid pathway. • Link established with 'Mental Health at Work Initiative'.
	2.9	Deliver an IAPT provision communications plan.	March 2022	Kate Tufnell and Gordon Laidlaw CCG		• Joint IAPT Communications meeting established (RCCG, DCCG, RDaSH & IESO). • RDaSH, IESO and RCCG all have ongoing communication plans in place to promote this provision via range of different media. • Initial work undertaken to promote the Mental Health offer leaflets across the borough via COVID Vac centres, distribution to key partners, electronic versions of leaflet available on Rother Hive & CCG Internet page.

						Further of promotion recently completed (circulation of leaflets to key partners) Mental Health Offer leaflet web link https://rotherhive.co.uk/wp-content/uploads/2021/04/RCCG-MH-A5-4pp-leaflet-digital-V3.pdf

Aim 3: All Rotherham people live well for longer

Board sponsor: Sharon Kemp, Chief Executive, Rotherham Metropolitan Borough Council and Michael Wright, Deputy Chief Executive, The Rotherham NHS Foundation Trust

Priority	#	Milestones	Timescale	Lead(s)	BRAG rating	Progress update
Ensure support is in place for carers.	3.1	Support the stabilisation of voluntary sector carers groups/services.	March 2022 (as part of delivery of area of focus 1 of the carer's strategy)	Jo Hinchliffe, RMBC		This work is part of the refreshed carers strategy. Regular update meetings are in place. Mini-task groups have also been set up in order to ensure organisations have personalised support. The recovery plan is now being implemented.
	3.2	Strengthen the unpaid carers group meetings.	March 2022 (as part of delivery of area of focus 1 of the carer's strategy)	Jo Hinchliffe, RMBC		As part of the strategy, there is a refreshed approach to the governance framework, which will develop the unpaid carers group forum into 'The borough that cares strategic group'. Work has started to review the membership and Terms of Reference.
	3.3	Establish a voice, influence, and engagement task group with a focus on the health and wellbeing of carers.	March 2022 (as part of delivery of area of focus 1 of the carer's strategy)	Jo Hinchliffe, RMBC		Initial meetings have taken place with Rotherham Carers Forum and Rotherham Parent Carers Forum. This work has reported into the Unpaid Carers Group and this will now become a

						dedicated voice, influence and engagement task group that reports into 'The borough that cares strategic group'. Further to this, once we are in the implementation phase of the refreshed carers strategy, a coproduction programme will be launched.
	3.4	Refresh information, advice and guidance available to carers, including the launch of the carers' newsletter.	March 2022 (as part of delivery of area of focus 1 of the carer's strategy)	Jo Hinchliffe, RMBC		Work is still highly focussed on COVID-19 response and recovery. Plans are in place to develop the newsletter, but comms resources need to be identified.
Support local people to lead healthy lifestyles, including reducing the health burden from tobacco, obesity and drugs and alcohol.	3.5	Review delivery of enhanced tier 2 weight management service, being delivered as part of the PHE Adult WM Grant Programme.	March 2022	Michael Ng / Kate Green, RMBC		The service is now started 01/10/2021; the first data submission for review will be available at the end of December.
	3.6	Undertake health needs assessments for healthy weight and tobacco.	January 2022	Jessica Dunphy and Kate Gray, RMBC		Work is on track to complete the needs assessments before January.
	3.7	Identify and treat inpatient smokers as part of the QUIT programme with: • 30% of inpatient smokers prescribed nicotine replacement therapy within 24 hours of admission • 50% of inpatient smokers referred to Trust Tobacco Treatment Advisors within 24	End of October 2021	Healthy Hospitals Manager, TRFT		There are some reporting issues relating to QUIT data, which are in the process of being resolved. Mandatory reporting will start from December.

		hours of admission				
	3.8	Offer the free smoking cessation service to all hospital staff as part of the QUIT programme.	End of October 2021	Healthy Hospitals Manager, TRFT		There are some reporting issues relating to QUIT data, which are in the process of being resolved. Mandatory reporting will start from December.
	3.9	Increase the number of non-opiate and alcohol treatment completions in line with PHE Average.	September 2021-March 2023	Jacqui Wiltschinsky and Anne Charlesworth. RMBC		A service improvement plan was in place prior to September 2021. All front-line workers have been informed of the new targets and a restructure of staff roles to support people at various stages of treatment more effectively is in progress to support future outcomes. Data is currently unavailable for September and October 2021, however, the previous trends suggest a decline in successful completions. Following the implementation of the improvement plan, the service has experienced problems with staffing levels alongside an increased demand for treatment and recovery services following the pandemic. The service is trying to manage demand by transferring cases into primary care but at present

						this is slow due to the need for face-face appointments before this can happen. Service exits and recovery also depend on community resources which are also not currently back at full capacity. At present, there is a risk of not meeting this milestone. Please note the service is ensuring the quality of delivery and safety of patients is not compromised.
	3.10	Review and establish the drug-related death pathway to identify improvements across the system.	September 2021-March 2023	Sam Barstow and Anne Charlesworth, RMBC		New employee is now in post and has begun engagement with partners and pathway development.
	3.11	Deliver against funding from PHSE to support frequent attenders to ED with complex Alcohol and Mental Health needs through a newly established outreach team.	March 2022	Amanda Marklew, TRFT		The funding is in place and recruitment is commencing in November for the outreach team. This will be a 12-month pilot from recruitment.

Aim 4: All Rotherham people live in healthy, safe, and resilient communities

Board sponsor: Steve Chapman, Chief Superintendent, South Yorkshire Police and Paul Woodcock, Strategic Director of Regeneration and Environment, Rotherham Metropolitan Borough Council

Priority	#	Milestones	Timescale	Lead(s)	BRAG rating	Progress update
Deliver a loneliness plan for Rotherham.	4.1	Launch and deliver MECC training on loneliness, with a target to reach 150 people.	September – March 2022	Phillip Spencer, RMBC		Work is currently on track having delivered the training to 103 people so far.
	4.2	To deliver the Public Health England (PHE) Better Mental Health Fund Befriender project.	July 2021- April 2022	Ruth Fletcher-Brown, RMBC and organisation that is awarded the contract (TBC)		The Rotherham Befriending Network has been commissioned to deliver the "Befriending Project- Addressing loneliness to protect the mental health of vulnerable groups" The contract lead for this project is Rotherham Federation and they have pulled together a partnership of providers who are all currently involved in the delivery of befriending services and/or supporting residents to address loneliness and isolation. The partners involved are: Live Inclusive, Rotherham Ethnic Minorities Alliance (REMA), Rotherham Parent

						and Carers Forum (RPCF), YAWR Services, Age UK Rotherham, and Voluntary Action Rotherham (VAR). A community volunteer campaign called “Be A Good Neighbour” will be created to complement the support, and its aim is to foster/maintain the community spirit that has been evident throughout the pandemic encouraging residents to take part in small acts of kindness within our communities. The partnership has begun to identify those residents they are currently supporting who would benefit from the additional support this programme can offer. Rotherham Federation have also been in contact with a range of services operating across Rotherham who would be effective referral routes into the programme.
	4.3	Develop a communications and engagement plan to address loneliness and deliver this plan working with VCS and wider partnership.	September-March 2022	Ben Pindar, RMBC working with VCS and other partner organisations		Work has started to scope this plan and is on track to be delivered by March.

Promote health and wellbeing through arts and cultural initiatives.	4.4	Deliver Rotherham Show as a three-day festival, including implementing additional COVID secure measures to reassure residents and instil confidence.	September 2021	Leanne Buchan, RMBC		The event was delivered from 3rd to 5th September. Estimated audience of 90,000, of which 75% identified that this was the first event that they had attended since COVID restrictions were relaxed. Infection rates in Rotherham fell during the period of the Rotherham show delivery, indicating that the security measures were effective. The satisfaction rating was 98%, which was a rise from 96% from 2019.
	4.5	Develop a cultural programme using COMF funding targeting over 55s to support physical and mental reconditioning.	Autumn-March 2022	Leanne Buchan, RMBC		The programme is on track and in delivery. The first project within this programme is a care home choir who will be filmed and will be part of the Christmas light switch-on on 26th November. Other projects are due to start in January 2022.
	4.6	Launch a Rotherham Year of Reading event which will target disadvantaged pupils.	January 2022	Zoe Oxley, RMBC		Draft plan in place for Libraries. Meeting arranged for 16th November with PH and RoSIS to agree launch date.
	4.7	Utilise libraries as death positive spaces, where the public can have conversations around loss, grief, end of life planning and legacy.	March 2023	Zoe Oxley, RMBC		Initial plan has been drawn up for Libraries. Next steps are to agree funding through Arts and Health programme.

Ensure Rotherham people are kept safe from harm.	4.8	Embed the Home Safety Partnership Referral Scheme with key partners in Rotherham.	March 2022	Steve Adams and Toni Tranter, South Yorkshire Fire and Rescue		A meeting with relevant stakeholders at RMBC will take place during November 2021 to discuss further development of the referral partnership.
	4.9	Work with other partnership boards on crosscutting issues relating to safety and safeguarding.	Ongoing for the duration of the plan	Board chairs, RTP		Work continues to maintain the partnership relationship between the safeguarding boards, and an update is scheduled for January 2022.
Develop a borough that supports a healthy lifestyle.	4.10	Undertake a review of the strategic positioning of physical activity in Rotherham.	December 2021	Sam Keighley, Yorkshire Sport Foundation (supported by Kate Green, RMBC)		Good progress being made - around 15 conversations have either taken place or planned with strategic leaders across Rotherham place so far. Sam attending HWbB 24th Nov to share reflections and stimulate discussion about the direction of travel and next steps.
	4.11	Deliver a range of programmes to welcome women and girls into football, focussing on under-represented groups.	Ongoing for the duration of the plan (up to July 2023)	Chris Siddall, RMBC		Three sessions are currently in delivery/ development: • Sessions have started with three holiday camps in October Half term with activity then being delivered in local primary schools. This will lead to an afterschool programme in the New Year linking directly to community sessions

						starting in Spring 2022. • The number of primary schools is being increased who work with the Youth Sport Trusts "Girls School Sport Partnerships". Numbers to be confirmed at the end of the academic year. • Work continues with REMA on a project focusing on a variety of women from Rotherham who are engaged in football. One individual is a pub landlady who is to start a pub team. This project is being designed and delivered by an all-female team including photographer and graphic designer.
	4.12	Use football to encourage more women and girls to adopt and maintain a healthier lifestyle.	Ongoing for the duration of the plan (up to July 2023)	Chris Siddall, RMBC		Living a healthy lifestyle is covered in Educational settings across Rotherham. With more schools getting involved in the Girls Football School Partnership this will reach a wider audience.

						Planning for the tournament's Fan Zones is ongoing and will be an opportunity to promote healthy lifestyles. A page will be set up on the Women and Girls Website, hosted by Rotherham United CST, linked to healthier lifestyles.
	4.13	Complete public consultation on the draft Cycling Strategy and present the final draft for approval.	October 2021	Andrew Moss, RMBC		Public consultation has been completed and is being analysed prior to an approval report going to Cabinet in January 2022.

Cross-cutting priorities

Priority	#	Milestones	Timescale	Lead(s)	BRAG rating	Progress update
Work in partnership to maximise social value across the borough.	5.1	Undertake a baselining assessment regarding social value through the Rotherham Anchor Network.	March 2022	Karen Middlebrook, RMBC		Conversations remain ongoing with partners to develop baselining assessment.
Assess and respond to the impact of the COVID-19 pandemic.	5.2	Commission State of the Sector Research to understand the impact of the pandemic on the voluntary and community sector.	Early 2022	Shafiq Hussain, VAR		Due to go out January 2022.
	5.3	Update the GISMO directory, taking into account the impact of the pandemic of voluntary and community sector organisations.	End of September – 50% updated End of December – 75% updated End up of March 2022 – 100% updated	Shafiq Hussain, VAR		80% updated (as of 11th November 2021.)
Develop the Pharmaceutical Needs Assessment.	5.4	Host stakeholder consultation to support needs assessment	January 2022	Gilly Brenner, RMBC		PNA steering group initiated and set to meet in November 2021. Will support agreement of process including consultation.
	5.5	Publish updated Rotherham Pharmaceutical Needs Assessment	September 2022	Gilly Brenner, RMBC		On track to deliver by next autumn.

Work in partnership to further develop the Rotherham Data Hub and assess population health.	5.6	Establish a partnership steering group to prepare the 2021/22 JSNA.	December 2021	Gilly Brenner, RMBC		Partnership steering group meeting for 21/22 held 14/10/21. Agreed refresh and priorities for 21/22 including small area data.
	5.7	Refresh the JSNA for 2021/22.	April 2022	Gilly Brenner, RMBC		On track, agreement across partners to provide refreshed content.

BRIEFING	**TO:**	Health and Wellbeing Board
	DATE:	24th November 2021
	LEAD OFFICER	Karen Smith, Strategic Commissioning Manager, Adults Joint Commissioning (RMBC/RCCG) Karen-nas.smith@rotherham.gov.uk Tel. No. 01709 254870
	TITLE:	Better Care Fund Plan (2021/22)

Background

1.1 The purpose of this report is to provide the Health and Wellbeing Board with an overview of the Better Care Fund (BCF) Planning Template (Appendix 1) and Narrative Plan (Appendix 2) 2021-22 for information and opportunity to provide feedback.

The BCF planning template is in line with the 2021-22:

- BCF Policy Framework,
- BCF Planning Requirements, and
- BCF Metrics Guidance 2021-22.

The BCF narrative plan is an optional template for local areas to use to submit narrative which complement the agreed spending plans and ambitions for BCF national metrics. This is a national template and editing is restricted with limited capacity to provide additional narrative or to amend the layout of the document. This report provides further details around the key priorities for 2021-22 and the key changes since the last BCF plan.

The BCF will continue to provide a mechanism for personalised, integrated care, with health, social care, housing, and other public services working together to provide joined up care. The BCF supports services to work even more closely together so that people can live healthy, fulfilled, independent and longer lives, so that they continue to remain independent at home or to return to independence after an episode in hospital.

The BCF is a joint plan which uses pooled budget arrangements to support integration, governed by an agreement under Section 75 of the NHS Act (2006).

The BCF planning and reporting has incorporated the utilisation of the IBCF and Disabled Facilities Grants. The narrative plan includes: the local approach with regards to engagement with key stakeholders, key priorities, governance arrangements, supporting discharge and improving outcomes for those discharged from hospital, use of DFG through providing adaptations and priorities for addressing health inequalities.

The narrative plan covers our approach to:

- joint priorities for 2021-22 including supporting discharge from hospital and improving outcomes;
- integrating care around the person, including prevention and self-care, and promoting choice and independence;
- supporting people to remain independent at home, including strengths-based approaches and person-centred care;
- integrating services including joint commissioning arrangements, alignment with primary care services (including Primary Care Networks), alignment of services and the approach to partnership with the voluntary and community sector;
- integration with wider services including Housing, the use of DFG funding to support the

	housing needs of people with disabilities or care needs, including arrangements for strategic planning for the use of adaptations and technologies to support independent living; and • system level alignment, including how the BCF plan and other plans align to the wider integration landscape e.g., ICS/ ICB plans and joint governance arrangements.
Key Issues	
2.1	**Key Priorities for 2021-22** In the refreshed Rotherham Place Reset Plan the following were identified as priority areas for the Urgent and Community Transformation Group (aligned to BCF and Ageing Well funding streams): ***Workstream 1: Prevention and Urgent Response*** 1. Front Door (priority 1). 2. Urgent Response Standards (priority 2). 3. Prevention and anticipatory care in localities: long term conditions and unplanned care (priority 3). ***Workstream 2: Integrating a sustainable Discharge to Assess Model*** (priority 4) to support patient flow from hospital. ***Workstream 3: Enhanced Health in Care Homes*** (priority 5) These priorities include key actions such as: further development of our local Clinical Assessment Service (CAS) working with 111 and 999 to ensure urgent services are effectively managed through the Directory of Services (DOS) to reduce unnecessary conveyances to hospital and avoidable admissions. To pilot an integrated community hub for the triage of complex urgent and intermediate care and reablement, including the co-location of social care reablement staff within Woodside. ***Intermediate Care and Reablement Pathway*** After the implementation of the Integrated Intermediate Care and Reablement pathway, work has now been completed in the development of integrated service specs with KPIs / outcomes across the system. The aim is also to develop further and embed the urgent 2 hour and reablement 2 day urgent standard and mandatory reporting. ***Hospital Discharges*** Although there has been an Integrated Discharge Team in place for a number of years, due to Covid, the guidance has changed to a same day discharge and the aim is to review processes to remove any barriers, developing a business case for a sustainable model with the right workforce to meet demand. ***Enhanced Health Care in Care Homes / High Impact Change Model*** There are a number of key actions across the Enhanced Health in Care Homes and High Impact Change Model which include: Integrating MDTs, review of referral routes and signposting for residents and families, review of physical and mental health care homes team, development of the Rotherham Health Record for Care Homes which provides a care home view of existing information for health and social care practitioners. There is a jointly commissioned Home Care service detailed through the Section 75 and part funded within the BCF. However, a key priority is to align our commissioning of Care Homes across Health and Social Care (joint contracting/ specifications). **Key Changes - since the previous BCF Plan**
2.2	

There are a number of key changes since the previous BCF plan, namely:

- Further integration of community services including enhanced MDT working.
- Training of reablement staff to deliver therapy plans.
- Jointly commissioned home care provision including night visiting services.
- Increase in providers on the framework to support demand.
- Remote monitoring pilot in care homes established.
- ECHO e-learning platform in place for End-of-Life Care and other health related topics.
- New model for Intermediate Care (bed base reconfigured).
- Increased the spend on the COT provision in year to support the demand profile.
- Increased resources across Reablement and Rapid Response to support community services (hospital avoidance/ effective discharge).
- Funded brokerage to provide support over the weekend to facilitate hospital discharges.

2.3 Income and Expenditure

The total BCF for 2021-22 is £45.486m, an increase of £2.796m from 2020-21. This is due to underspends in 2020-21 on the improved BCF and Disabled Facilities Grant, mainly due to covid-19 and these underspends have been carried forward into this years' BCF.

Spending Plans continue to be allocated to the 6 themes and managed within 2 separate pooled funds, with the CCG and RMBC managing one pool fund each. This is in line with previous years and can be summarised in the table below:

BCF Budget 2021/22	2021/22 INVESTMENT			2021/22 SPLIT BY POOL	
BCF Investment	**RCCG SHARE**	**RMBC SHARE**	**Total**	**Pool 1 RMBC Hosted**	**Pool 2 RCCG Hosted**
	£000	**£000**	**£000**	**£000**	**£000**
THEME 1 - Mental Health Services	1,209		1,209		1,209
THEME 2 - Rehabilitation & Reablement	11,253	6,716	17,969	17,969	
THEME 3 - Supporting Social Care	3,624		3,624		3,624
THEME 4 - Care Mgt & Integrated Care Planning	5,111		5,111		5,111
THEME 5 - Supporting Carers	601	50	651		651
THEME 6 - Infrastructure	241		241		241
Risk Pool	500		500		500
Improved Better Care Fund		15,666	15,666	15,666	
Other Health/Grants Funding	500	15	515	515	
TOTAL	**23,039**	**22,447**	**45,486**	**34,150**	**11,336**

2.4 National Conditions

Rotherham is fully meeting the 4 national conditions set within the Government's BCF Policy Framework as follows:

(i) A jointly agreed plan between local health and social care commissioners, signed off by the Health and Wellbeing Board.
(ii) NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.
(iii) Invest in NHS-commissioned out-of-hospital services.
(iv) A plan for improving outcomes for people being discharged from hospital.

2.5 National Metrics

	The BCF Policy Framework for 2021-22 sets national metrics which includes ambitions on how the spending will improve performance. The framework retains two existing metrics from previous years which are: (i) Effectiveness of reablement (proportion of older people still at home 91 days after hospital discharge). (ii) Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population. The previous measure on non-elective admissions will be replaced with a measure of avoidable admissions (unplanned hospitalisation for chronic ambulatory care sensitive conditions). This reflects better the focus of joint health and social care work to support people to live independently in their own home and prevent avoidable stays in hospital. The previous measure relating to delayed transfers of care (DTOC) has been replaced with two measures. One relating to acute hospital lengths of stay over 14 and over 21 days and one relating to patients discharged from acute care back to their usual place of residence. Please note the trajectory on length of stay has been refined since the original papers. The guidance requires that ambitions should reflect a joint local government, CCG and provider agreement, and a co-ordinated approach to discharge. The original trajectory was based on a late September position and sought to achieve the NHS England ambition of 12% or less of patients in hospital over 21 days. The increased pressure seen during October and the early part of November in the system has however led us to a position of holding Q3 performance of 15% of patients in hospital over 21 days. Following feedback from Rotherham FT colleagues the 15% felt more reflective of the joint agreement requested in the guidance.
Key Actions and Relevant Timelines	
3.1	The BCF planning and narrative templates for 2021-22 will go through various stages of the approval process as follows: • Optional draft BCF planning submission to BCM – 19th October 2021. • Review and feedback to areas from BCMs - 2nd November 2021. • BCF Operational Group – 11th November 2021. • BCF Executive Group – 12th and 17th November 2021. • BCF planning submission from local HWB areas - 16th November 2021. • Health and Wellbeing Board – 24th November 2021. • Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation from 16 November to 7th December 2021. • Regionally moderated assurance outcomes sent to BCF team - 7th December 2021. • Cross-regional calibration - 9th December 2021. • Approval letters issued giving formal permission to spend (CCG minimum) - 11th January 2022. • All section 75 agreements to be signed and in place - 31st January 2022.
Implications for Health Inequalities	
4.1	There is a recognition at SYB and Place that Health Inequalities (HI) is integral to everything. Rotherham is working across Place and ICS partners to share knowledge and develop our capabilities in understanding Health Inequalities and Population Health Management (PHM). Work has commenced to develop a Rotherham Office of Data Analytics (RODA) as a Place wide capability in analysing and interpreting PHM and HI data, supporting the Place wide HI and Prevention Group work programme. RODA will generate insight into areas such as the inclusive restoration of services and population segmentation. Rotherham is actively engaged in the SYB PHM work programme to develop insight into SYB communities and share best practice.

	The Prevention and Health Inequality Group provides a multi-agency approach and formulates and leads on actions on tackling health inequalities by looking at the whole population and individual person. It focuses on helping people to get the best start in life, reduce harm from smoking, alcohol, obesity, improving cardio-respiratory health, mental health/well-being and early diagnosis and survival of cancer. BCF funded schemes that aim to tackle health inequalities includes the Social Prescribing programme which provides interventions on tobacco, weight, alcohol, physical activity, obesity reduction, smoking cessation, and diabetes prevention programmes. Breathing Space is also delivering respiratory services within the Right Care pathway. There are projects underway, focused on Frailty and Anticipatory Care including the use of external support to agree a capacity/ demand modelling tool for community services (including urgent response 2 hour and 2 day reablement).
Recommendations	
5.1	**That the Health and Wellbeing Board note the content of the:** **(I) Documentation which was submitted to NHS England (NHSE) on 16th November 2021.**

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net
(please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in ‘yellow’. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.
7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.
For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

HM Government

NHS

Version 1.0

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Rotherham
Completed by:	Karen Smith
E-mail:	karen-nas.smith@rotherham.gov.uk
Contact number:	01709 254870

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chief Executive RMBC/Chief Officer RCCG
Name:	Sharon Kemp / Christopher Edwards

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 24/11/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	David	Roche	david.roche@rotherham.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	Mr	Christopher	Edwards	chris.edwards@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Mr	Ian	Atkinson	ian.atkinson4@nhs.net
	Local Authority Chief Executive	Mrs	Sharon	Kemp	sharon.kemp@rotherham.gov.
	Local Authority Director of Adult Social Services (or equivalent)	Mrs	Anne Marie	Lubanski	annemarie.lubanski@rotherham.gov.uk
	Better Care Fund Lead Official	Mr	Nathan	Atkinson	nathan.atkinson@rotherham.gov.uk
	LA Section 151 Officer	Mrs	Judith	Badger	judith.badger@rotherham.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->	CCG Finance Officer	Mrs	Wendy	Allott	wendy.allott@nhs.net
	CCG Head of Commissioning (Adults - Joint CCG/RMBC)	Miss	Claire	Smith	claire.smith138@nhs.net
	LA Finance Officer	Mr	Mark	Scarrott	mark.scarrott@rotherham.gov.uk

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Rotherham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£3,063,735	£3,063,735	£0
Minimum CCG Contribution	£21,665,926	£21,665,926	£0
iBCF	£14,054,774	£14,054,774	£0
Additional LA Contribution	£5,328,000	£5,328,000	£0
Additional CCG Contribution	£1,374,000	£1,374,000	£0
Total	**£45,486,435**	**£45,486,435**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£6,156,842
Planned spend	£12,583,926

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£7,705,345
Planned spend	£11,759,926

Scheme Types

Assistive Technologies and Equipment	£1,075,907	(2.4%)
Care Act Implementation Related Duties	£1,065,000	(2.3%)
Carers Services	£287,000	(0.6%)
Community Based Schemes	£3,415,000	(7.5%)
DFG Related Schemes	£3,771,828	(8.3%)
Enablers for Integration	£734,000	(1.6%)
High Impact Change Model for Managing Transfer of	£5,461,000	(12.0%)
Home Care or Domiciliary Care	£2,322,000	(5.1%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£2,026,000	(4.5%)
Bed based intermediate Care Services	£4,557,000	(10.0%)
Reablement in a persons own home	£2,808,000	(6.2%)
Personalised Budgeting and Commissioning	£1,983,000	(4.4%)
Personalised Care at Home	£1,005,000	(2.2%)
Prevention / Early Intervention	£2,660,926	(5.8%)
Residential Placements	£11,704,774	(25.7%)
Other	£610,000	(1.3%)
Total	**£45,486,435**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	806.0	1,001.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	25.0%	25.0%
	LOS 21+	15.0%	15.0%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	72.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	433	584

Reablement

	21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (Annual (%))	78.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Rotherham

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Rotherham	£3,063,735
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£3,063,735**

iBCF Contribution	Contribution
Rotherham	£14,054,774
Total iBCF Contribution	**£14,054,774**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Rotherham	£1,723,000	DFG c/fwd from 20/21
Rotherham	£1,994,000	Intermedite Care, OT, Assistive Technology
Rotherham	£1,611,000	ibcf c/fwd 20/21
Total Additional Local Authority Contribution	**£5,328,000**	

CCG Minimum Contribution	Contribution
NHS Rotherham CCG	£21,665,926
Total Minimum CCG Contribution	**£21,665,926**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Rotherham CCG	£1,374,000	Intermedite Care, OT, Assistive Technology
Total Additional CCG Contribution	**£1,374,000**	
Total CCG Contribution	**£23,039,926**	

	2021-22
Total BCF Pooled Budget	**£45,486,435**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Rotherham

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£3,063,735	£3,063,735	£0
Minimum CCG Contribution	£21,665,926	£21,665,926	£0
iBCF	£14,054,774	£14,054,774	£0
Additional LA Contribution	£5,328,000	£5,328,000	£0
Additional CCG Contribution	£1,374,000	£1,374,000	£0
Total	**£45,486,435**	**£45,486,435**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£6,156,842	£12,583,926	£0
Adult Social Care services spend from the minimum CCG allocations	£7,705,345	£11,759,926	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Adult Mental Health Liaison	Adult mental health support in community supporting independence and recovery at home	Integrated Care Planning and Navigation	Care navigation and planning		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£1,209,000	Existing
2	Home Improvement Agency	Handyperson service providing minor works /repairs for people in	Prevention / Early Intervention	Other	Carries out maintenance and repair and	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£30,000	Existing
2	Home Improvement Agency	Handyperson service providing minor works /repairs for people in	Prevention / Early Intervention	Other	Carries out maintenance and repair and	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£8,000	Existing
3	Falls Service	Community service (health) supporting reablement/prevention	High Impact Change Model for Managing Transfer	Early Discharge Planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£470,000	Existing
4	Reablement	LA Reablement Service	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,087,000	Existing
4	Domiciliary Care	Provision of domiciliary care services to help people live in their own	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£758,000	Existing

5	Community Stroke Service	Integrated stoke pathway to support early discharge/rehabilitation	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£527,000	Existing
6	Community Neuro Rehab	Integrated neuro pathway to support early discharge and	High Impact Change Model for Managing Transfer	Early Discharge Planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£162,000	Existing
7	Breathing Space	Community based service for people with Chronic Obstructive	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,820,000	Existing
9	Otago Exercise Programme	Falls prevention exercise programme	Personalised Care at Home	Physical health/wellbeing		Social Care		LA			Local Authority	Minimum CCG Contribution	£20,000	Existing
10	Mediquip (Wheelchairs & Equipment)	Integrated Community Equipment Service	Prevention / Early Intervention	Other	small items of equipment to assist people	Social Care		CCG			Private Sector	Minimum CCG Contribution	£1,612,926	Existing
10	Mediquip (Wheelchairs & Equipment)	Integrated Community Equipment Service	Prevention / Early Intervention	Other	small items of equipment to assist people	Social Care		CCG			Private Sector	Additional LA Contribution	£92,000	Existing
11	Community OT	Occupational Therapy Assessements	Prevention / Early Intervention	Other	OT assessments carried out by community	Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£394,000	Existing
11	Community OT	Occupational Therapy Assessements	Prevention / Early Intervention	Other	OT assessments carried out by community	Social Care		LA			NHS Community Provider	Additional LA Contribution	£394,000	Existing
12	Disabled Facilities Grant	Major property adapatations to enable people to continue to	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£2,048,828	Existing
12	Disabled Facilities Grant	Community alarm and Equipment service to support independent	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	DFG	£1,014,907	Existing
13	Age UK Hospital Discharge	Hospital Discharge supporting flow	Personalised Care at Home	Physical health/wellbeing		Other	Charity/Voluntary Sector	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£158,000	Existing
14	Stroke Association Service	VCS provision to support stroke survivors	Personalised Care at Home	Physical health/wellbeing		Other	Charity/Voluntary Sector	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£50,000	Existing
15	Intermediate Care	Residential Rehabilitation for patients who cannot	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	Additional LA Contribution	£1,435,000	Existing
15	Intermediate Care	Residential Rehabilitation for patients who cannot	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,039,000	Existing
15	Intermediate Care	Residential Rehabilitation for patients who cannot	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		CCG			Private Sector	Minimum CCG Contribution	£1,310,000	Existing
15	Intermediate Care - Home first	Rehabilitation and reablement pathway home	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		CCG			NHS Community Provider	Additional CCG Contribution	£781,000	Existing
15	Intermediate Care - Therapy	Rehabilitation and reablement pathway home	Bed based intermediate Care Services	Other	Therapy Services	Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£517,000	Existing
15	Intermediate Care - Therapy	Rehabilitation and reablement pathway home	Bed based intermediate Care Services	Other	Therapy Services	Social Care		LA			NHS Mental Health Provider	Minimum CCG Contribution	£97,000	Existing
15	Intermediate Care - GP Cover	GP support for bed based intermediate care services	Bed based intermediate Care Services	Other	GP Cover	Primary Care		LA			NHS Community Provider	Minimum CCG Contribution	£36,000	Existing

15	Intermediate Care	Rehabilitation and reablement pathway home	Reablement in a persons own home	Reablement service accepting community and		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£332,000	Existing
16	Direct Payments	Personal budget to support an individual social care plan and	Personalised Budgeting and Commissioning			Social Care		LA			Private Sector	Minimum CCG Contribution	£1,283,000	Existing
16	Supported Living	A range of services to support the independence of people	Residential Placements	Supported living		Social Care		LA			Private Sector	Minimum CCG Contribution	£410,000	Existing
17	Care Act	Deprivation of Liberty Safeguards (Dols) support	Care Act Implementation Related Duties	Independent Mental Health Advocacy		Social Care		LA			Private Sector	Additional CCG Contribution	£40,000	Existing
17	Care Act	Direct Payments and Domiciliary Care provision	Care Act Implementation Related Duties	Other	Direct Payments and Domiciliary Care provision	Social Care		LA			Private Sector	Minimum CCG Contribution	£661,000	Existing
18	Mental Health rehabilitation services	Rehabiltation and support in a bed base provision	Residential Placements	Care home		Mental Health		LA			Private Sector	Minimum CCG Contribution	£209,000	Existing
19	Learning Disabilities independent	Learning disabilities residential placements	Residential Placements	Learning disability		Social Care		LA			Private Sector	Minimum CCG Contribution	£984,000	Existing
19	Learning Disabilities Domiciliary Care	Learning Disabilities Domiciliary Care packages	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum CCG Contribution	£37,000	Existing
20	GP Case Management	Empowering GP's to take full responsibility for all health and social care input	Community Based Schemes	Other	GP support for Long term conditions management	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£1,480,000	Existing
21	Care Home Support Service	Integrated community service to care homes	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£283,000	Existing
22	Death in Place of Choice	EOLC support to ensure needs are meet	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£840,000	Existing
23	Social Prescribing	Links patients in primary care with non medical support within the	Personalised Care at Home	Other	Both Physical and Mental wellbeing	Other	Health and Social Care	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£777,000	Existing
24	Social Work Support (A&E, Case	Includes Fast Reponse and Supported Discharge Pathways	High Impact Change Model for Managing Transfer	Flexible working patterns (including 7 day working)		Social Care		LA			Local Authority	Minimum CCG Contribution	£919,000	Existing
25	Care co-ordination Centre	A single point of contact for health and social care professionals providing	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Acute Provider	Minimum CCG Contribution	£812,000	Existing
26	Carers Support Services	Early Planning support team	Carers Services	Other	Advice and support	Social Care		LA			Local Authority	Minimum CCG Contribution	£237,000	Existing
26	Carers Support Services	Carers Emergency Scheme/Carers Centre	Carers Services	Other	Advice and support	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£50,000	Existing
26	Carers Support Services	Direct Paymenst and domiciliary care provision	Care Act Implementation Related Duties	Other	Advice and support	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£364,000	Existing
27	Joint Commissioning Team	Joint Commissioner team staffing costs	Enablers for Integration	Joint commissioning infrastructure		Other	Commissioning	CCG			Local Authority	Minimum CCG Contribution	£49,000	Existing

28	IT to Support Community Transformation	Digital enablers to support integration of community services	Enablers for Integration	System IT Interoperability		Other	Information sharing	CCG			CCG	Minimum CCG Contribution	£192,000	Existing
29	BCF Risk Pool	Risk pool - contingency for unforeseen cost pressures	Other		Contingency	Other	Health and Social Care	CCG			CCG	Minimum CCG Contribution	£500,000	Existing
30	Adaptation of Liquid Logic to support care	Support IT infrastructure and promote integrated working	Enablers for Integration	System IT Interoperability		Social Care		LA			Local Authority	iBCF	£88,000	Existing
31	Rotherham Place DTOC Project Manager	Strategic Project Manager post to support hospital discharge	High Impact Change Model for Managing Transfer	Early Discharge Planning		Acute		CCG			NHS Acute Provider	iBCF	£80,000	Existing
32	Health Inequalities	Project support to implementation population health	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		Other	Public Health	LA			Local Authority	iBCF	£90,000	New
33	Trusted Assessor	Assessments and care planning to reduce delays in hospital	High Impact Change Model for Managing Transfer	Trusted Assessment		Acute		CCG			NHS Acute Provider	iBCF	£70,000	Existing
34	Social Care Sustainability	Older People Residential placements	Residential Placements	Care home		Social Care		LA			Private Sector	iBCF	£2,779,000	Existing
34	Social Care Sustainability	Older People Domiciliary Care provision	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£1,527,000	Existing
34	Social Care Sustainability	Provision of direct payments to support people within their own	Personalised Budgeting and Commissioning			Social Care		LA			Private Sector	iBCF	£700,000	Existing
34	Social Care Sustainability	Residential placements for younger adults with a Learning Disability.	Residential Placements	Learning disability		Social Care		LA			Private Sector	iBCF	£2,238,000	Existing
35	Care Market Capacity and sustainability	Supporting the increase in provider costs, for example, due to the	Residential Placements	Other	Meet increasing costs of care placements	Social Care		LA			Private Sector	iBCF	£4,224,774	Existing
36	Care Market Capacity and sustainability	Supporting the increase in LD provider costs, including the increase in	Residential Placements	Supported living		Social Care		LA			Private Sector	iBCF	£753,000	Existing
37	Prevention and Early Intervention	Voluntery Sector advice and Support at front of access	Prevention / Early Intervention	Other	Advice and Guidance	Social Care		LA			Charity / Voluntary Sector	iBCF	£50,000	Existing
38	Prevention and Early Intervention	Advocacy support, advice and guidance for people with a learning	Prevention / Early Intervention	Other	Advice and Guidance	Social Care		LA			Charity / Voluntary Sector	iBCF	£50,000	New
39	Additional Legal support costs	Additional legal support to meet increasing demand for legal	Enablers for Integration	New governance arrangements		Social Care		LA			Local Authority	iBCF	£60,000	New
40	Additional Strategic Commissioning	Additional external provision to support the review of commissioning	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Additional LA Contribution	£300,000	New
41	My Front Door	Additional social work capcacity	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Additional LA Contribution	£350,000	New
42	Tactical Brokerage	To broker residential and home care packages of care from commissioned	Other		Brokerage Support	Social Care		LA			Local Authority	iBCF	£110,000	Existing
43	Winter Bed Capacity	Discharge Pathways and Patient Flow	High Impact Change Model for Managing Transfer	Early Discharge Planning		Other	Winter Planning	CCG			Private Sector	iBCF	£500,000	Existing

44	Integrated Discharge Team	Multi-disciplinary teams to support hospital discharges	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	iBCF	£358,000	Existing
45	Targeted Reviewing Team	Social Work support to review and quality assure care packages	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	iBCF	£377,000	New
46	Reablement	LA Reablement Service	Reablement in a persons own home	Reablement service accepting community and		Social Care		LA			Local Authority	Additional LA Contribution	£521,000	New
47	Integrated Discharge Team	Multi-disciplinary teams to support hospital discharges	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Additional LA Contribution	£289,000	New
48	Additional Winter Bed Capacity	Discharge Pathways and Patient Flow	High Impact Change Model for Managing Transfer	Early Discharge Planning		Other	Health and Social Care	CCG			CCG	Additional LA Contribution	£151,000	New
49	Spot purchase Reablement beds	short term provision within the independent sector to support	Residential Placements	Discharge from hospital (with reablement) to		Social Care		LA			Private Sector	Additional CCG Contribution	£107,000	Existing
50	Perform Plus	Coaching Programme to increase capacity and performance of the	Enablers for Integration	Workforce development		Social Care		LA			Local Authority	Additional CCG Contribution	£45,000	Existing
51	Digital Lead Project Manager	Project support to implement AT strategy across Place	Assistive Technologies and Equipment	Other	Project lead for AT strategy across Place	Other	Health and Social Care	CCG			NHS Acute Provider	Additional CCG Contribution	£61,000	Existing
52	Intermediate Care - Double Handling	Intermediate Care beds	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	Additional CCG Contribution	£100,000	New
53	Additional Winter Bed Capacity	Discharge Pathways and Patient Flow	High Impact Change Model for Managing Transfer	Early Discharge Planning		Other	Health and Social Care	CCG			CCG	Additional CCG Contribution	£100,000	New
54	Reablement - Additional staffing	Increase capacity of reablement service	Reablement in a persons own home	Other	Additional staffing resources	Social Care		LA			Local Authority	Additional CCG Contribution	£87,000	New
55	Assessment & Review Co-ordinator	Trusted Assessments for interim short term packages to prevent	High Impact Change Model for Managing Transfer	Trusted Assessment		Acute		CCG			NHS Acute Provider	Additional LA Contribution	£15,000	New
56	Additional Disabled Facilities Grant schemes	Additional major Adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	Additional LA Contribution	£1,723,000	New
11	Additional Occupational Therapy post	Occupational Therapy Assessements	Prevention / Early Intervention	Other	OT assessments carried out by community	Social Care		LA			NHS Acute Provider	Additional CCG Contribution	£30,000	New
15	Intermediate Care Services	Additional investment into Intermediate Care services	Bed based intermediate Care Services	Other	Additional inflation costs	Social Care		CCG			NHS Acute Provider	Additional CCG Contribution	£23,000	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes
5	DFG Related Schemes

6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
17	Other

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
1. Respite services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other
1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other

1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other
1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other
1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other
1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of ‘home ward’ for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.

Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Rotherham

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	806.0	1,001.0	Increase expected in 21/22 due to a change in recording in response to national guidance. Emergency assessment activity which will include some ACS activity is now included in SUS. 20/21 actual is based on local CCG data. 21/22 plan developed based on local CCG data for first 4 months of the year pro rata. The expansion of	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	25.0%	25.0%	Our aspiration is to achieve 12% of inpatients at 21 days or more. However the increased pressure seen during October and the early part of November has led us to a position of holding Q3 performance. Work streams expected to impact this metric include increased resources across Reablement and Rapid Response to support community services (hospital avoidance/effective discharge) and funded brokerage to provide support over the weekend to facilitate hospital	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	15.0%	15.0%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	72.0%	Aspiration to achieve 2019/20 average of 70% then stretch to 72%. Current initiatives including a Discharge Doctor on site to support weekends support this metric. We have also increased capacity within community services to ensure 7 day discharges are facilitated 8am to 8pm including increasing transport availability (week	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	503	562	433	584	The much reduced rate of admisions experienced in 2020/21 is recognised as being due to several unexpected factors. For 2021/22 the service anticipates that a return to similar levels seen in 2019/20 of 294 new admissions but with some additional demand flow from supporting hospital discharges, a plan for 314
	Numerator	264	294	227	314	
	Denominator	52,438	52,299	52,388	53,779	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.0%	72.3%	78.0%	NB. 20/21 was 119/170 = 70%. Aim is to recover performance above 2019/20 levels by further improving the reablement service offer and an aspirational plan of 78% has been set. However, it is also recognised, that the broader cohort supporting hospital discharges may also result in some of the more complex
	Numerator	123	136	156	
	Denominator	143	188	200	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Rotherham

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Narrative plan - page 2. BCF Section 75 agreement HWB/BCF Exec Group members have approved these submissions which includes LA, CCG, ASC, Housing, VCS representatives and providers. Governance	Not applicable	Not applicable
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	Narrative plan- - page 5. Also Page 10 - Health Inequalities.	Not applicable	Not applicable
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Confirmation of DFG included within Expenditure tab and narrative plan - page 8.	Not applicable	Not applicable
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	Ill+H10ustrated within the income and expenditure tab wihtin the planning template.	Not applicable	Not applicable
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes	Confirmation illustrated within the income and expenditure tab.	Not applicable	Not applicable
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes	Confirmation illustrated within narrative plan - page 6 and expeniture tab within the planning template.	Not applicable	Not applicable

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes	Confirmation illustrated within the income and expenditure tab. Also within narrative plan - page 8.	Not applicable	Not applicable
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes	The plan is believed to be stretching given Rotherham's recent trends and having regard to latest national published benchmark data for 2020/21, where Rotherham's admission rate of 431 fell significantly more than regional (550) and national	Not applicable	Not applicable

BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Rotherham Health and Wellbeing Board

Health and Wellbeing Board(s)

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

At a local level Rotherham's Health and Social Care Community has been working in a collaborative way for several years to transform the way it cares for its population of around 267,000. With a mature Integrated Care System (ICS) in Place responsible for the delivery of the Integrated Health and Social Care Place Plan (2020-21).

Our Better Care Fund (including IBCF) provides a substantial funding stream to some of our key priority workstreams within Urgent and Community Transformation.

The governance arrangements through our ICS ensure that all partners across NHS Trust, Social Care, Mental Health, Primary, Independent and the Voluntary and Community Sector are engaged, with several task and finish groups in place under an overarching operational and executive meeting structure.

Outcomes for our population are jointly agreed and we are committed to a whole system partnership approach. The CCG's Commissioning Plan aligns with the Joint Health and Wellbeing Strategy (2018-25) and the Integrated Place Plan and sets out, as a key partner, how we will support their delivery.

The CCG, Council and NHS England work closely together to ensure that all commissioning plans are aligned so that together we deliver the maximum amount for each 'Rotherham pound'. This includes the System Wide Winter Plan developed annually, within an identified Place fund of c600K to spend on winter pressures across partners.

How have you gone about involving these stakeholders?

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

In the refreshed Rotherham Place Reset Plan the following were identified as priority areas for Urgent and Community transformation group (aligned to BCF and Aging Well funding streams): Workstream 1: Prevention and Urgent Response -1. Front Door (priority 1) 2. Urgent Response Standards (priority 2) 3. Prevention and anticipatory care in localities: long term conditions and unplanned (priority 3). Workstream 2: Integrating a sustainable discharge to assess model (priority 4). Workstream 3: Enhanced Health in Care Homes (priority 5). These priorities include key actions such as: further development of our local Clinical Assessment Service (CAS) working with 111 and 999 to ensure urgent services are effectively managed through the Directory of Services (DOS) to reduce unnecessary conveyances to hospital and avoidable admissions. To pilot an integrated community hub for the triage of complex urgent and intermediate care and reablement this includes the co-location of social care reablement staff within Woodside (health building). After the implementation of the Integrated Intermediate care and reablement pathway in 2019-21 we have developed integrated service specs with KPIs/outcomes across the system, which will be signed off in year. We also want to develop further and embed the urgent 2 hour and reablement 2 day urgent standard and mandatory reporting. Although we have had an Integrated Discharge Team in place for a number of years due to Covid the guidance has changed to a same day discharge and we want to review our processes to remove any barriers, developing a business case for a sustainable model with the right workforce to meet demand. We will also seek approval and implementation of a discharge to assess community unit with nursing. Finally we have a number of key actions across the Enhanced Health in Care Homes/High Impact Change Model which include; Integrating MDTs: review of referral routes and signposting for residents and families, review of physical and mental health care homes team, Development of the Rotherham Health Record for Care Homes (following 4 milestones) - Care home view of existing information for health and social care practitioners/Expansion of information for health and social care practitioners/Pilot and roll out of care home view to care homes/Pilot and roll out electronic information capture by care homes to feed the Rotherham Health Record (RHR) care home view. We have a jointly commissioned Home Care service detailed through the Section 75 and part funded within the BCF, however, we want to align our commissioning of Care Homes across Health and Social Care (joint contracting/specifications). The key changes since the last BCF is further integration of community services including enhanced MDT working, training of Reablement staff to deliver Therapy plans, jointly commissioned Home Care provision including night visiting services, increase in providers on the framework to support demand, remote monitoring pilot in care homes established, ECHO e-learning platform in place for End of Life Care and other health related topics, new model for Intermediate Care (bed base reconfigured), increased the spend on the COT provision in year to support the demand profile, increased resources across Reablement, Rapid Response to support community services (hospital avoidance/effective discharge), funded brokerage to provide support over the weekend to facilitate hospital discharges

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

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

The Better Care Fund Section 75 Agreement for 2021/22 will be approved by the Health and Wellbeing Board which consists of Elected Members, Chief Executive, Chief Operating Officer and Directors from CCG and the Council, NHS England, GP's, Voluntary Action Rotherham (VAR), Healthwatch. The key responsibilities of this group include:

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

The BCF Executive Group consisting of Chief Executives, Elected Members, Chief Finance Officers, Directors from both the Local Authority and the Clinical Commissioning Group. Key responsibilities of the Executive include;

• Agree strategic vision and priorities for the future • Make decisions relating to the delivery of the plan• Monitor delivery of the Better Care Plan through quarterly meetings • Ensure performance targets are being met • Ensure schemes are being delivered and additional action is put in place where the plan results in any unintended consequences. • Report directly to the Health and Wellbeing Board on a quarterly basis.

The BCF Executive Group is supported by the BCF Operational Group which meets on a quarterly basis. The Operational group is made up of the identified lead officers for each of the BCF priorities, plus other supporting officers from the council and CCG.

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

A financial governance process is in place and the financial monitoring and performance information is to be provided at monthly operational group meetings and quarterly at Director and Member level. The financial framework will expose those areas of high risk in year and identify areas where slippage may be available to balance the financial pressure in year. The recurrent plans will be modified, where appropriate, as part of the planning cycle for both Health and Social Care in totality, through the 2021-22 Section 75 agreement.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

Please see Executive Summary for detail of our key priorities (joint) for 2021-22 and changes to approach. A new Adult Social Care Pathway was implemented by the Council 2019/20 which takes into account whole system requirements to move to a position where elements of the system collaborate to fully explore the potential of individuals to become as independent as possible.

The community support offer within the new model will be based on people being supported via their social, community and neighbourhood assets, through joint working with partners across Rotherham to allow people to access the support they need through a variety of more sustainable support networks. We fully recognise that individuals need to be at the centre of the new care pathway, who need to self-manage their care, unless their requirements exceed the threshold. This means that people who have a care package will be re-enabled so that their needs are decreased, resulting in either a reduced or no care package, an increased level of independence and enhanced quality of life, that is healthier and more fulfilling for the individual. This will also result in a stronger understanding of what care is currently being provided and whether or not it is the most appropriate, with increased reviews and oversight, specifically with a recovery model that requires close working with the provider and individuals. The aim of care and support should be for people to live the best life that they can, meaning living independently, in their own home when possible, utilising the assets and the people around them to do the things that make them happy and leading a fulfilled life. This has required a strengthening of partnerships and collaboration with a wide range of key stakeholders including Public Health, Housing, CCG, Foundation Trusts and Mental Health Trusts, voluntary, community and independent sector to create more options for how care can be delivered through, for example, natural forms of support, universal services and community assets, as well as formal health and social care services. The four key themes of the new operating model are as follows:

1. Prevention 2 Integration 3. Care co-ordination 4. Maximising independence and reablement.

The Council along with partners are focusing on a strength based approach, in partnership with staff, to ensure that community assets are utilised and self-directed support is maximised, thus increasing choice and control. With a focus on greater promotion of the use of individual budgets via a direct payment, strength based, focussed assessment of well-being and clear evidence of a person's needs. Consideration must be taken to eligibility criteria, support planning, completion of Continuing Health Care and Decision Support Tool checklists,

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

BCF funding contributes to our Integrated Discharge Team (IDT) – funding posts such as the joint manager across health and social care and the capacity manager in The Rotherham Foundation Trust (TRFT) who provides our daily oversight across Place and escalation levels (Opel). Our discharge home is consistently higher than the national target at c.95% and our Length of Stay (LOS) has been one of the best in South Yorkshire and Bassetlaw (SYB) consistently for many months, although recent challenges due to continuing Covid pressures has increased our LOS slightly. We were asked this summer to present to NHSE Regional colleagues our integrated approach to discharges due to the recognition of our performance including weekend discharge rates. We have a joint approach to discharge planning. From a strategic perspective it is one of the 3 portfolio projects within our integrated Place Urgent and Community Transformation Programme. The Place Discharge Executive lead is the TRFT Head of Operations and TRFT Deputy Chief Operating Officer (COO). Discharge plans are co-developed with all Place partners and assured via the Place governance structure including an Executive Lead group comprising the Trust's Deputy Chief Executive, Deputy CCO and Community Division General Manager. Cross system working is well embedded in IDT, with at least twice daily MDT (including community/reablement), twice weekly LOS MDT and reviews of stranded patients based on the ECIST model. We have increased our capacity within IDT and ensure cover over weekends with an 8am-8pm approach in place. There is a Discharge Doctor on site to support weekends. We have also increased capacity within community services to ensure 7 day discharges are facilitated 8am to 8pm including increasing transport availability (week days/weekends to meet peak times in demand) and 7 day equipment access. However, there is some performance variation and seasonal spikes through the year. In order to embed the changes made and to meet the new national discharge guidance we have, in collaboration with Attain, reviewed the discharge processes and pathways including our community bed base facilities, culminating in a Discharge Action Plan that is currently being implemented. Our new model of an integrated intermediate care, reablement/recovery pathway is well established which supports effective patient flow. Our processes start with early discharge planning and management of patient transfers, through to community beds with additional discharge co-ordinators appointed across acute/community beds. We want to ensure patients receive right level of care and that processes are streamlined to speed up transfers and reduce duplication and gaps resulting from previous siloed working. Our community unit with nursing/therapy has recently been retendered to better meet the changing complex needs of our population. The BCF funds a number of community services across health and social care including Reablement/Urgent Response. These services have seen an increase in resources in 2021-22 to provide sufficient capacity to meet the demand (increasing no. of complex cases requiring additional support). We have also increased the number of providers on our jointly commissioned home care framework to support the demands on the care sector and are looking to employ a locum therapist to work in COT service to support the review of care packages, freeing capacity to provide better flow from the Acute Trust. Additional reablement co-ordinator/support workers in ASC will increase capacity to deliver both discharge/admission avoidance. The brokerage function has also been increased to cover weekends

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

The Strategic Director for Adult Social Care, Housing and Public Health is fully engaged in the planning and approval process for the BCF 2021-22 and is a member of the Health and Wellbeing Board and BCF Executive Group. Both the Boards and group includes representatives from the CCG including the Chief Officer and Chief Finance Officer. This ensures there is a joined up approach in improving outcomes across the health, social care and housing sector

The Disabled Facilities Grant (DFG) provides funding for the provision of aids and adaptations to disabled people's homes to enable them to live independently and to improve their quality of life. Social Care and Housing Services work collaboratively together in responding to the Care Act (2014) requirements in order to prevent, reduce or delay care and support needs.

The DFG has provided funding for aids and adaptations for older people, people with physical disabilities and care needs, children and those living in owner occupied, private and social tenancies in 2020/21. Grant approvals range from a minimum of £1,000 and a maximum of £32,552.

The Housing Strategy (2019-21) aligns to the Integrated Place Plan and BCF Plan by supporting people to live at home for longer and has benefits for the individual's health as well as a positive impact on health and social care budgets. Instead of providing everyone with the same service regardless of need, housing support or adaptations are tailored to the individual and used to empower people to make choices for themselves. Council owned stock is also ageing and it is essential that investment continues so that the Council is able to continue to provide good quality, safe and affordable homes in sustainable neighbourhoods that meet the needs of local people. As people's needs evolve, the Council will seek opportunities to make better use of its stock and consider conversions and adaptations to provide more suitable homes where appropriate. The Council's Adaptations Policy aims to assist people in living independently through either the provision of equipment and/or adaptations in their current home or re-housing to a suitable property that meets their needs. The IBCF currently funds a project lead for Assistive Technology and Community Occupational Therapy (COT). This post is currently working with Adult Social Care (ASC) colleagues to embed the COT provision (we are funding a further 1fte COT to support the increasing caseload of the service) within ASC to support the prevent, reduce and delay agenda. The post is also supporting ASC to better utilise care technology. There is a wide range of Technology Enabled Care equipment in use including exit sensors, GPS trackers and pre-set reminders enabling people with memory difficulties to remain safe and live their lives well, as well as several falls detection options. Robotic pets are also proving successful in reducing anxiety, purposeful walking and challenging behaviours. There is also a Remote Monitoring Pilot in operation to March 2022 with Care Homes around vital signs. The aim is to keep people out of hospital and reduce the length of stay in hospital if a person was to be admitted.

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

There is a recognition at SYB and Place that Health Inequalities (HI) is integral to everything. Rotherham is working across Place and ICS partners to share knowledge and develop our capabilities in understanding HI and Population Health Management (PHM). We are working to develop a Rotherham Office of Data Analytics (RODA) as a Place wide capability in analysing and interpreting PHM and HI data, supporting the Place wide HI and Prevention Group work programme. We are anticipating that RODA will generate insight into areas such as the inclusive restoration of services and population segmentation. Rotherham is actively engaged in the SYB PHM work programme to develop insight into SYB communities and share best practice. Our Prevention and HI Group provides a multi-agency approach and formulates/leads on actions on tackling health inequalities by looking at the whole population and individual person. It focuses on helping people to get the best start in life, reduce harm from smoking, alcohol, obesity, improving cardio-respiratory health, mental health/well-being and early diagnosis and survival of cancer. The group includes the Director of Public Health, Commissioning, Public Health, CCG, GP Federation, Medicine Management, Intelligence, TRFT, Mental Health Trusts and Voluntary Action Rotherham (VAR). BCF funded schemes includes the Social Prescribing programme which provides interventions on tobacco, weight, alcohol, physical activity, obesity reduction, smoking cessation and diabetes prevention programmes. Breathing Space is also delivering respiratory services within the Right Care pathway. There are projects underway, focused on Frailty and Anticipatory Care including the use of external support to agree a capacity/demand modelling tool for community services (including urgent response 2 hour and 2 day reablement). We have also started to focus on the impact of the pandemic and taking a population approach to meeting those needs and preventing further demand. This includes our resource funded through BCF and working with partners to review/audit access to acute care for those with long Covid. As we are seeing both physical and mental health need rising, it is deemed timely to deliver a focused piece of work. This will include looking at risk factor prevalence, with a focus on cardio-vascular disease, diabetes, mental health. There will be a long stay audit taking place that looks at factors effecting long length of stay, establishing the facts about population, analysis of pre and post pandemic and targeted population including co-morbidities. We are also working on our Anticipatory Care model, the national ask is for systems to provide proactive health and care interventions for all ages. To be targeted at frailty, multiple morbidity and/or complex needs for people living in their own homes. The focus is on what is important to individuals and it is delivered and co-ordinated through cross system MDT working. We have allocated funding in year to scope the development, which will use population health and local data to identify those at risk by PCN/Offer, carry out a proactive needs assessment with individuals, provide personalised care and support planning based on a 'what matters to me conversation' and establish a digital MDT to agree what interventions the person needs

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 7 July 2021
Venue:	Via MS Teams
Chair:	Chris Edwards
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@nhs.net

Apologies:	R Jenkins, TRFT S Kemp, RMBC K Singh, RDaSH I Atkinson, Rotherham CCG
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services.

Members Present:
Chris Edwards (**CE**) Chair, Chief Officer, Rotherham Clinical Commissioning Group
Shafiq Hussain, (**SHu**) Chief Executive Voluntary Action Rotherham
Annemarie Lubanski (**AML**) Deputising, Strategic Director, Rotherham Council
Matthew Pollard (**MP**) Deputising, Care Group Director, Rotherham, Doncaster & South Humber Foundation Trust
Michael Wright (**MW**) Deputising, Deputy Chief Executive, The Rotherham NHS Foundation Trust

Participating Observers
Dr Richard Cullen (**RC**) Chair & Joint H&WB Board Chair, Rotherham CCG
Cllr David Roche (**DR**) Joint Chair of H&WB Board, Rotherham MBC

In Attendance:
Andrew Clayton (**ACl**) Head of IT for Rotherham CCG/ICP
Lydia George (**LG**) Strategy & Delivery Lead, Rotherham CCG
Gordon Laidlaw (**GL**) Head of Communications, Rotherham CCG/ICP
David McWilliams (**DM**) Assistant Director, Rotherham MBC
Wendy Commons (**WC**) ICP Support, Rotherham CCG

Item Number	Business Items
1	**Public & Patient Questions**
There were no questions raised.	
2	**South Yorkshire & Bassetlaw ICS Digital Transformation Strategy & Overview Update**
Dr Richard Cullen presented the strategy which has been consulted upon across all organisations. He highlighted that it fits with the national framework, national agenda and with the approach being taken in Rotherham. The strategy will be key to addressing health inequalities, keeping it at the forefront and giving all staff the same access to digital capabilities. Once consultation and engagement has been completed across the South	

Yorkshire & Bassetlaw which is anticipated to be by the end of August 2021, it will be signed off by the SYB ICS Head of IT.

3	**Rotherham Place Digital Update**

Andrew Clayton gave an overview of the programme of work progressing in Rotherham and outlined how this aligned with the SYB ICS Digital Strategy.

He highlighted that a new Digital Programme Management Office (PMO) has been formed to co-ordinate around 69 projects underway across all ICP member organisations. For assurance, the PMO reports monthly into the ICS Digital Group giving a good oversight of progress across Place.

ACl reminded colleagues that a comprehensive piece of work had been completed across Rotherham culminating in the production of Rotherham Place Digital strategy which had been approved by the ICP Place Board in November 2019. It was encouraging to see how closely the Rotherham Strategy which was now in year 3 aligned with the SYB ICS strategy, received by Members today, providing assurance for Place Board.

ACl went on to update on some of the key projects Key projects, including:

- the Rotherham Health Record that had been particularly helpful during the pandemic for sharing records with GPs when working with non-registered care home patients. We are the only area in South Yorkshire that has met the standards set out in the Operating Plan for the shared care record specification and are seen as an exemplar.
- Rotherham Health App is widely used however, we will look to align to SYB Place wide digital platform as it becomes available.
- Development of Population Health Management is focused on supporting the health inequalities agenda. The ICS is looking at the 'Radar' system as a way of providing population health management dashboards and has chosen Rotherham as the place to pilot this.
- With digital literacy and inclusion there are 3 live projects running currently, an ICS-led digital inclusion project with Age UK supporting citizens, work with RMBC-led place wide digital inclusion programme and, as SRO for digital in SY&B, RCu is working with Sheffield Hallam University reviewing the digital needs of nursing services and allied health professionals.

ACl also gave an update on the digital aspirant programme noting that Rotherham successfully obtained £12m investment through this just as the pandemic commenced. The programme is now in year 3. The money can normally only flow to Trusts (ie TRFT & RDaSH), but Rotherham has taken a unique approach and through working with NHSX and NHSE some of the monies have been able to flow through other partner organisations to support their digital ambitions, reinforced by strong governance processes.

Members noted the risks associated with the programmes and how they were being managed and mitigated.

Lastly, ACl outlined a number of next steps including a review of place-wide IT services which will report in August. Place Board will receive an update including any recommendations in September.

SHu echoed how the partnership approach to using digital aspirant programme funds has been transformational and allowed VAR to connect digitally with partners and work on the frontline which would not have been possible previously. SHu conveyed thanks on behalf of VCS and VAR.

The Place Board thanked ACl for the update and noted the impressive amount of work undertaken.

4	Transformation Group Updates

3i Children & Young People
Due to the CQC SEND inspection taking place an update will be provided at the next Place Board.

3ii Mental Health & Neurodevelopmental
As above, although full details of all projects underway were detailed in the Place Priorities earlier in the meeting which Members were referred to.

3iii Urgent & Community Care
Work continues around the reset of priorities with a number of initiatives around integrated care and care homes starting to gain traction.

5	Rotherham Place Achievements

Members received a draft document summarising the work undertaken in Place since 2016 to date. The draft will be enhanced and refined so that it can be used as evidence as Rotherham starts to go through the assurance processes to take on full delegation from the SYB Integrated Care System as a Place Partnership. These achievements will demonstrate Rotherham's excellent record to date of working together. Once finalised, Members will share within their own organisations and with their Boards to provide assurance and confirm of good practice.

Action LG/All

6	NHS System Oversight Framework & Metrics for 2021/22

Members noted the System Oversight Framework that had been published outlining the approach being taken by NHS England/Improvement to monitoring performance. It marks another step towards system-led delivery of integrated care and clarifies accountability arrangements throughout the transition year.

Standard Items

7	Draft Minutes from Public ICP Place Board – 4 March 2020

For the record it was noted that Public Place Board meetings had not taken place since March 2020 due to the Covid pandemic. Place members had been meeting as 'Gold' command during that time to ensure Partner response was timely and appropriate.

The minutes from Place Board held on 4 March 2020 were formally accepted as a true and accurate record.

8	Communication to Partners

It was agreed that Place Board Members should share the following items from the agenda within their own organisations:

- SYB ICS Digital Transformation Strategy
- Rotherham Place Digital Update
- Rotherham Place Achievements
- NHS System Oversight Framework & Metrics for 2021/22

9	Risks and Items for Escalation

None.

10	Future Agenda Items
Forward Items for Place Board (Sept) • *Rotherham Place Development Plan* • *Rotherham ICP Place Agreement – sept draft for formal sign off in Mar 2022* • *Revised H&WBB Plan Update to ensure fully aligned* • Review of Place Wide IT Services Report (Sept)	
10	**Date of Next Meeting**
No meeting will be held in August. The next meeting is scheduled for ***Wednesday 8 September 2021 at 8-9am***	

Place Board 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 – Richard Jenkins
Voluntary Action Rotherham, Chief Executive – Shafiq Hussain
Rotherham Doncaster and South Humber NHS Trust (RDaSH), Chief Executive – Kathryn Singh
Connect Healthcare Rotherham Ltd (Rotherham GP Federation) – Dr G Muthoo

Participating Observers:
Joint Chair, Health and Wellbeing Board, Rotherham MBC - Cllr David Roche
Joint Chair, Health and Wellbeing Board, Rotherham CCG - Dr Richard Cullen

In Attendance:
Deputy Chief Officer, Rotherham CCG – Ian Atkinson (as ICP Delivery Team Chair)
Director of Public Health, Rotherham MBC – Ben Anderson
Head of Communications, Rotherham CCG – Gordon Laidlaw
Strategy & Delivery Lead, Rotherham CCG – Lydia George

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 8 September 2021
Venue:	Via Zoom
Chair:	Chris Edwards
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@nhs.net

Apologies:	R Cullen, Chairman, Rotherham CCG R Jenkins, Chief Executive, TRFT A Lubanski, Strategic Director, RMBC Cllr Roche, Chair of Health & Wellbeing Board, RMBC K Singh, Chief Executive, RDaSH
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services.

Members Present:
Sharon Kemp (**SK**) Chair, Chief Executive, Rotherham MBC
Chris Edwards (**CE**) Chief Officer, Rotherham Clinical Commissioning Group
Shafiq Hussain, (**SHu**) Chief Executive Voluntary Action Rotherham
Gok Muthoo (**GM**) Clinical Director, Rotherham GP Federation
Ben Anderson (**BA**) Director of Public Health, Rotherham MBC
Ian Atkinson (**IA**) Executive Place Director/Delivery Team Chair, Rotherham CCG
Matthew Pollard (**MP**) Deputising, Care Group Director, Rotherham, Doncaster & South Humber Foundation Trust
Michael Wright (**MW**) Deputising, Deputy Chief Executive, The Rotherham NHS Foundation Trust

In Attendance:
Lydia George (**LG**) Strategy & Delivery Lead, Rotherham CCG
Gordon Laidlaw (**GL**) Head of Communications, Rotherham CCG/ICP
Suzy Joyner (**SJ**) Director of Children & Young Peoples Services, Rotherham MBC
Wendy Commons (**WC**) ICP Support, Rotherham CCG

Item Number	Business Items
1	**Public & Patient Questions**
No questions had been received from members of the public.	
2	**Rotherham Integrated Care Partnership Agreement**
Following the publication of the White Paper around Integrating care and the Health and Care Bill going through Parliament, our current ICP agreement had been reviewed and refreshed in preparation for the transition to the new arrangements under the South Yorkshire & Bassetlaw Integrated Care System from April 2022. The agreement had been updated to set out: • Updated principles that Partners will comply with in working together to achieve the common vision and objectives • Updated terms of reference for the Rotherham Place Board and Delivery Team • The updated Rotherham Place Plan • The development of the Plan	

- Provision to enable provider collaboration as a key part of Place arrangements.

It was acknowledged that this framework is flexible to allow for development throughout the transition period and so that future governance arrangements can be developed as guidance is issued. However, it is anticipated that the Rotherham Health & Wellbeing Board will continue to play a central role in the ICP approach.

Place Board members had received a copy of the refreshed agreement in July and were happy to approve this latest iteration and support it going through partner governance processes.

It is intended to incorporate any comments/feedback from Partners into the version that Place Board will be asked to sign off at the October meeting, noting that it will be an interim agreement up to April 2022 and still subject to development and review in line with new policy and legislation issued.

Action: All Partners

3	**Integrated Care Development Plan and Highlight Report**

The development plan has been produced in response to the integrated care development matrix, a process that Rotherham Place had undertaken to assess our readiness for taking on delegated arrangements following the implementation of 'Integrating Care'. An IC (Integrating Care) Design Team and Engine Room have been formed across Place to undertake this work and oversee the assessment process. At Quarter 1 there were no exceptions to report, work is on track. As further guidance has recently been published the two forums will be meeting again in September and revisiting the plan to ensure it aligns. Any significant changes will be brought to the next Place Board with quarterly updates given on progress thereafter.

Action: IA/LG

Acknowledging that population health management is an approach and a tool supported by digital solutions, however it was agreed that broader involvement across all Place Partners will be required. As Chair of the Prevention & Health Inequalities Group, BA will ensure links are in place with the Health & Wellbeing Board.

Action: BA

MW advised that the plan is going to the Trust's Board later in the week. Any feedback will be forwarded to LG.

Members agreed the Plan and the direction of travel, and noting it as a 'live' document, acknowledged the importance of receiving regular quarterly updates.

Action: LG (for future agendas)

4	**Transformation Group Updates**

3i Children & Young People

SJ advised that the Lead Officer Group has been re-established and has recently reviewed all its priorities and refreshed them. Work is still being undertaken to confirm the milestones, particularly around special educational needs and disabilities and preparation for adulthood in life which will ensure they reflect the actions from the recent inspection findings and that they are firmly located in multi-agency activities.

3ii Mental Health & Neurodevelopmental

IA advised that the group had continued to meet throughout the pandemic and had reviewed and refreshed all priorities. IA highlighted three key areas to note:

- Neuro development – the diagnostics and post diagnostic pathways have been agreed for adults and children
- Suicide Prevention – the 'Be the One' campaign will be re-launched this week priorities
- IAPT- pathway work is underway to manage increasing demand can continue to be

met.

3iii Urgent & Community Care

This group has also updated and refreshed priorities. The key areas being focussed on are enhanced health in care homes, urgent response, prevention and discharge and 'front door'. There are numerous community development projects that are being worked on collectively and good progress has been made throughout the pandemic.

Members recognised that despite Rotherham having stubbornly high rates of Covid transmission creating pressures in the system, progress has been made with the transformation challenge set out in our plan and asked that thanks be passed on to frontline staff.

5	**Social Prescribing Update**

SHu explained that the social prescribing scheme been in place since 2012. The scheme initially covered long term conditions and mental health. More recently the national scheme was expanded to resource and support link workers to work with GPs and across the Primary Care Network to identify those patients that will benefit from a social prescription to give the best possible outcomes from the scheme. Broader work has included supporting long covid questionnaires with patients throughout the set-up of the TRFT long covid clinic and assessing patient needs. A social prescribing advisor will be linked to the clinic model supporting those patients who have non-medical need. The long covid clinic went live last week and there is a communications plan in place as part of the implementation to raise awareness and outline the pathway.

As part of SY&B ICS, Voluntary Action Rotherham is involved in supporting green and blue social prescribing initiatives. One is working with around wildlife, gardening, horticulture, focussing on BAME groups and those with mental health support needs. Another is supporting the Council's Public Health Team with a bid to the Department of Transport around cycling and walking intervention schemes. Although initially a pilot, the intention is to submit an expression of interest to gain access to longer term funding to develop the cycling infrastructure and make available cycles, training, access to cycling groups and peer support. Green prescribing is about to 'go live'. Practices will be informed of the details via the Link Worker newsletter.

Throughout the pandemic, mental health has been exacerbated for many individuals, working with RDaSH and with additional monies VAR has been able to increase frontline services, including access to counselling.

Working with NHS Property Services an unused building at Rawmarsh customer service centre has been brought to life, equipped as a community centre specifically linked to VCS organisations and activities around social prescribing.

It was noted that Rotherham is unique in its approach to supporting social prescriptions and importantly in sustaining VCS organisations to provide services.

Members welcomed the progress made and thanked SHu for the update.

6	**Integrated Care Guidance**

Various documents had been issued on 19 August all relating to the integrated care transition. A list had been compiled signposting Members to the online guidance. CE briefly appraised the documents for Members which fitted with the expected direction of travel. It was noted that some of the guidance related to the Integrated Care Board and will be implemented by the CCG prior to transition whilst that relevant to Place will be reviewed and progressed by the Rotherham Design Team and Engine Room in line with local governance arrangements.

The list will continue to be maintained to provide a library log that can be added to as additional guidance is published. The guidance is all subject to legislation currently going

through Parliament with the committee stage expected in Autumn and final assent in February 2022.	
Standard Items	
7	**Draft Minutes from Public ICP Place Board – 7 July 2020**
The minutes from the Public Place Board held on 7 July were noted as a true and accurate record.	
8	**Communication to Partners**
Detail on the long covid pathway will be shared with partners for information. ***Action: GL*** Given our infection rates remain high in Rotherham and try to keep everyone safe to reduce transmission rates, Members agreed to work collectively to continue to encourage and promote vaccination to all Rotherham residents and to reinforce the national guidance around safe working with masks and safe distancing key messages. ***Action: All partners***	
9	**Risks and Items for Escalation**
None.	
10	**Future Agenda Items**
Forward Items for Place Board • Rotherham Place Development Plan Update (Oct) then quarterly updates thereafter • Rotherham ICP Agreement – Formal Sign Off (Oct) • Review of Place Wide IT Services Report (Dec)	
11	**Date of Next Meeting**
The next meeting is scheduled for ***Wednesday 6 October 2021 at 9am***	

Place Board 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 – Richard Jenkins
Voluntary Action Rotherham, Chief Executive – Shafiq Hussain
Rotherham Doncaster and South Humber NHS Trust (RDaSH), Chief Executive – Kathryn Singh
Connect Healthcare Rotherham Ltd (Rotherham GP Federation) – Dr G Muthoo

Participating Observers:
Joint Chair, Health and Wellbeing Board, Rotherham MBC - Cllr David Roche
Joint Chair, Health and Wellbeing Board, Rotherham CCG - Dr Richard Cullen

In Attendance:
Deputy Chief Officer, Rotherham CCG – Ian Atkinson (as ICP Delivery Team Chair)
Director of Public Health, Rotherham MBC – Ben Anderson
Head of Communications, Rotherham CCG – Gordon Laidlaw
Strategy & Delivery Lead, Rotherham CCG – Lydia George

Minutes	
Title of Meeting:	**PUBLIC Rotherham ICP Place Board**
Time of Meeting:	9:00am – 10:00am
Date of Meeting:	Wednesday 6 October 2021
Venue:	Via Zoom (and broadcast live on You Tube Channel)
Chair:	Chris Edwards
Contact for Meeting:	Lydia George 01709 302116 or Lydia.george@nhs.net

Apologies:	R Jenkins, Chief Executive, TRFT S Kemp, Chief Executive, RMBC
Conflicts of Interest:	General declarations were acknowledged for Members as providers/commissioners of services.

Members Present:
Chris Edwards (**CE**) Chair, Chief Officer, Rotherham Clinical Commissioning Group
Kathryn Singh, (**KS**), Chief Executive, Rotherham, Doncaster & South Humber Foundation Trust
Shafiq Hussain, (**SHu**) Chief Executive Voluntary Action Rotherham
Gok Muthoo (**GM**) Clinical Director, Rotherham GP Federation
Annemarie Lubanski (**AML**), Strategic Director, Rotherham MBC
Ian Atkinson (**IA**), Executive Place Director/Delivery Team Chair, Rotherham CCG
Michael Wright (**MW**), Deputy Chief Executive, The Rotherham NHS Foundation Trust

Participating Observers
Cllr David Roche (**DR**), Joint Chair, Health and Wellbeing Board, Rotherham MBC
Dr Richard Cullen (**RCu**), Joint Chair, Health and Wellbeing Board, Rotherham CCG

In Attendance:
Lydia George (**LG**) Strategy & Delivery Lead, Rotherham CCG
Gordon Laidlaw (**GL**) Head of Communications, Rotherham CCG/ICP
Ben Anderson (**BA**) Director of Public Health, Rotherham MBC
Suzy Joyner (**SJ**) Director of Children & Young Peoples Services, Rotherham MBC
Alex Hawley, (**AH**), Consultant in Public Health, Rotherham MBC
Rebecca Woolley, (**RW**), Policy & Partnerships Officer, Rotherham MBC
Sue Hillyard (**SHi**), ICP Development Support, Attain
Wendy Commons (**WC**) ICP Support, Rotherham CCG

Item Number	Business Items
1	**Public & Patient Questions**
No questions had been received from members of the public.	
2	**Rotherham Integrated Care Partnership Agreement**
Following the publication of the White Paper proposing changes around integrating care and the Health & Care Bill currently progressing through Parliament, the current ICP agreement had been reviewed and refreshed to prepare for the transition to new arrangements under South Yorkshire Integrated Care System that are planned to come into effect from April 2022. The changes include:	

- Updated principles that partners will comply with in working together to achieve the common vision and objectives
- Updated terms of reference for Rotherham Place Board and Delivery Team
- An updated Rotherham Place Plan
- The development of the Plan
- Provision to enable provider collaboration as a key part of Place arrangements

Members approved the latest version of the Agreement, acknowledging that it will be kept under review and may be subject to further revision with the issue of policy and legislation to ensure that Rotherham Place meets the requirements for the new future architecture.

3	**Rotherham Integrated Care Development Plan Update**

Members noted the Quarter 2 report which highlights the process being undertaken against several actions in relation to integrating care to provide due diligence and ensure Rotherham Place is in a position to take on delegation from the ICS by April 2022. Progress is on track and there were no concerns of note. A further progress update will be received at the end of Quarter 3.

Action: IA/LG

4	**Provider Alliance Update**

Kathryn Singh reported that, following the publication of further guidance on Provider Collaboratives, Place partners are already working multi-sectorally to engage on whole pathways of transformation and collaboration and are considering how mental health, primary care, acute and social care sectors all work together in a single collaborative format. Work is in progress, supported by Hill Dickinson and with dedicated project management support, to look at real benefits to reduce variation and improve health for Rotherham residents. Sector provider collaboratives are also being established with, an acute federation of provider trusts across South Yorkshire, as well as an emerging mental health alliance of providers and additionally, provider alliances forming around primary care and general children's services. It is therefore important for Rotherham Place to be cognisant of how we will operate in the new infrastructure with ICS partnerships and boards as well as single sector federations.

Acknowledging these complex changes, Place Members noted the importance of ensuring Rotherham Place is represented at all forums whilst continuing to ensure the best possible outcomes is achieved for our population. Members will be kept updated on further discussions and developments.

5	**Transformation Group Updates**

5i Children & Young People

On behalf of the group Alex Hawley updated members on the First 1001 days priority. He highlighted four aspects:

- 0-19s had performed well despite the disruption of the pandemic using a skill mix staffing model approach
- There has been good partner engagement in the re-commissioning process for the new 0-19s service which will commence in 2023
- The Trust has developed the 'grow your own' local model to address filling vacancies for specialist nurses which is a national issue
- realigning of public health consultant portfolios with the four aims of the Health & Wellbeing Board has improved focus, strengthened relationships with partners and provides a more co-ordinated approach.

Concerns highlighted included the impacts of the pandemic, particularly for those born within the crisis, sustained breastfeeding had not been measured and could show an impact on outcomes e.g., healthy weight. However, the system upheaval and effects of the pandemic and local service changes are being taken into account.

In response the Group will be:

- creating a strategy framework for best start and beyond, with a workshop planned with partners to begin the process.
- continuing work to complete the 0-19s commissioning process by April 2022 with new guidance expected to inform the specification for the new contract from 2023.
- Reviewing the current oral health service against new guidance and completing the South Yorkshire feasibility study for a potential sub-regional water fluoridation scheme
- Adopting the new healthy child programme guidance into the new contract
- Undertaking a pilot to provide a model for broadening continuity of care to address concerns of smoking at time of delivery.

Place Board thanked the Children & Young People's Transformation Group for continuing the work throughout the difficult pandemic period.

5ii Mental Health & Neurodevelopmental

Ian Atkinson gave an update on Priority 10 – Development of the Autism Strategy & Neurodevelopmental pathway which focusses predominantly on the adult element of the pathway and highlighted the following areas as working well:

- the development of the diagnostic service which had been expanded and launched in September 2020. Further expansion will 'go live' from December 2021
- post diagnostic service provision has also been introduced and is being expanded towards the end of the year
- Positive partnership working has facilitated the establishment of a neurodevelopment group, a neurodiversity support service and an autism diagnostic service
- The post diagnostic pathway has been reconfigured to enhance post diagnostic provision
- A gap analysis review has been conducted on the autism strategy

In terms of concerns, further work is required to understand capacity and demand for the adult ASD pathway. A gap analysis has identified unmet need around post diagnostic support for those with a recent diagnosis or those who may not have been able to access support at the time of their diagnosis, pre and post diagnostic support is required to bridge the gap for transitioning from children and young people to adult services and finally Rotherham's Autism Strategy should consider how accessible public transport is for the autistic population.

Next steps for the group will be to focus on:

- the mobilisation of the expansion of the diagnostic and specialist and wider post diagnostic offer
- analysing demand to avoid reactive commissioning and provide more stability
- enhance and develop the ADHD pathway
- pilot solutions (in partnership with the ICS/TCP) for unmet pre and post diagnostic needs
- Work with SYPTE and City Region to make public transport more accessible for autistic people

Members thanked the MH, LD and ND Transformation Group and teams for the comprehensive update and the good progress made.

5iii Urgent & Community Care

Michael Wright gave an update on Enhanced Health in Care Homes highlighting a number of areas that are working well including:

- supporting care homes through the pandemic with training in PPE use, infection protection and control, Covid testing etc
- Targeted holistic support including multi-disciplinary teams, development of a dashboard to identify homes requiring intensive support, specialist resources eg hydration video
- Providing digital improvements for families to connect with residents, Wi-fi provision, remote monitoring of falls, wound care and nutrition, introduction of Rotherham Health Record
- Supporting the development of the health record and Echo on-line training (using Aging Well monies)
- 98% of residents and staff in homes for older people and learning disabilities received first dose of Covid vaccination

Concerns with this priority area include increased complexity including challenging behaviour that has led to some people moving home, recruitment and retention of nursing and care staff, heavy reliance on agency staff which compromises quality and cost, low bed occupancy rates are being seen and there is fragility in the market that could result in home closures.

A clear plan was outlined in terms of what needs to happen next including:

- A review of current practice to standardise the offer and share good practice
- Review and mapping of activities to streamline physical and mental health care homes to simplify access and support
- Continue to roll out Rotherham Health Record to care homes
- Implement a holistic approach to hydration in care homes to reduce hospital admission
- Commence joint commissioning across health and social care

Place Board noted the update and asked that thanks are conveyed to the Transition Group and teams for the continued hard work throughout the challenges of the pandemic.

6	**Rotherham Revised Health & Wellbeing Plan Priorities**

Cllr Roche explained that during the pandemic the Health & Wellbeing Board had agreed a one-year plan which had concluded in the Summer. Engagement sessions had been held with Health & Wellbeing Board Members to refresh priorities based on the key principles that H&WB priorities should fit closely with the Rotherham Place Plan and should take account of the Health & Social Care Bill and future working arrangements within SY Integrated Care System. Members reviewed the four aims and the twelve strategic priorities that had been agreed by the Health & Wellbeing Board which had consolidated the focus and improved alignment with Place Board as well as clarifying alignment between the H&WBB and Place Board.

Members noted the strong governance link between the two Boards and the strong relationship and alignment with the priorities and thanked Rebecca Woolley for the update.

7	**Draft Minutes from Public ICP Place Board – 8 September 2020**

The minutes from the Public Place Board held on 8 September were noted as a true and accurate record. There were no issues outstanding on the action log.	
8 & 9	**Communication to Partners/Risks and Items for Escalation**
There were no issues to be escalated or communicated but as we move towards transition it will be important to plan communication and engagement with all stakeholders.	
10	**Future Agenda Items**
Forward Items for Place Board • Rotherham IC Development Plan Updates - Quarterly • Review of Place Wide IT Services Report (Dec) • Provider Collaborative Updates • Transformation Group Updates (monthly)	
11	**Date of Next Meeting**
The next meeting is scheduled for ***Wednesday 3 November 2021 at 9-10am***	

Place Board 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 – Richard Jenkins
Voluntary Action Rotherham, Chief Executive – Shafiq Hussain
Rotherham Doncaster and South Humber NHS Trust (RDaSH), Chief Executive – Kathryn Singh
Connect Healthcare Rotherham Ltd (Rotherham GP Federation) – Dr G Muthoo

Participating Observers:
Joint Chair, Health and Wellbeing Board, Rotherham MBC - Cllr David Roche
Joint Chair, Health and Wellbeing Board, Rotherham CCG - Dr Richard Cullen

In Attendance:
Deputy Chief Officer, Rotherham CCG – Ian Atkinson (as ICP Delivery Team Chair)
Director of Public Health, Rotherham MBC – Ben Anderson
Head of Communications, Rotherham CCG – Gordon Laidlaw
Strategy & Delivery Lead, Rotherham CCG – Lydia George