Rotherham's Integrated Health and Social Care Place Plan

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

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

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

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

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

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

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

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

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

We also intend to further develop new funding and risk sharing models across health and social care.

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

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

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

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

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

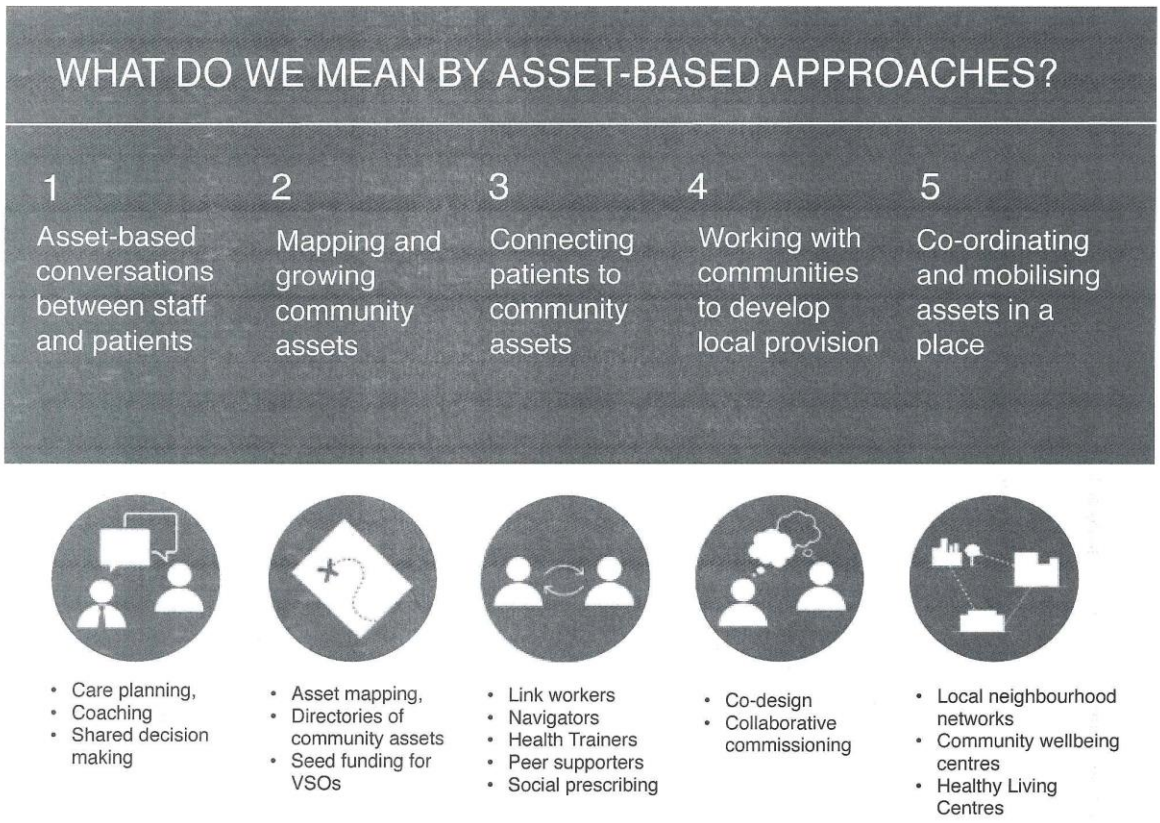
- **Further Development of our social prescribing service to cover mental health clients and facilitate earlier hospital discharge.** We already target the top 5% of patients at risk of hospitalisation using risk stratification and GP judgement. We have identified non-medical interventions for over 5000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

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

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

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

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



We will work with communities to have a different conversation to understand what matters to them, with a focus on their strengths and values. These conversations will inform commissioners about requirements outside of traditional service models. People can be linked to mapped assets readily available in their local community or the wider borough. Where there are gaps in provision e.g. for people with learning disabilities, we will support, and where necessary, seed fund organisations to develop local services. This

approach embeds an owned culture of wellbeing and prevention across communities as well as within statutory services in addition to demand shift with clear fiscal benefits.

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

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

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

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

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

Evaluation

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

What STP transformation funding do we need?

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

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

  Additional one – off funding of **£1.5m** would support the borough wide roll out of MCP working facilitating relevant one off initial infrastructure / set up costs within our system. We would also like to invest **£1.25m per annum** to trial new staffing models in primary care to ensure patients receive services in the right place, first time. This development should reduce non elective bed days

by 20,000 and allow the Trust to reduce the bed stock by 31 beds recurrently saving £1.5m per annum. This will also support our strategy for sustainable primary care services.

- **A 24/7 Rotherham wide Care Coordination Centre (CCC)** which manages system capacity and advises on the most appropriate level of care for patients to avoid hospital admission wherever possible. Our aspiration is to enhance our CCC beyond Acute Hospital provision and co-ordinate care across Social Care, Acute and Mental Health services, improving access for patients through a comprehensive directory of services, driving efficiency and cutting down waste. The solution will also support the sharing of information among all health and social care professionals to quickly identify individuals at risk and where a needs assessment can be made and to identify the most appropriate pathway and correct deployment of resources. The CCC will also act as a single point of access for patients by giving them access to health and social care professionals on a 24/7 basis through which initial assessments can be undertaken and teams deployed to provide support and avoid potential hospital presentation or admission. The non-recurrent infrastructure cost for this work is estimated at **£0.46m per annum** and is expected to deliver at least £0.86m additional system wide efficiencies and also improve the efficiency, and further integrate health and social care services.

- **One Public Estate approach for Rotherham** – we are currently assessing the scale of the transformation required to inform the 30 June submission.

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

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

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

- **Further Development of our social prescribing service to cover mental health clients and facilitate earlier hospital discharge.** Our national award winning Social Prescribing service was highlighted in the Five year forward View as exceptional practice and we have aspirations to expand the service to support hospital discharge and mental health service. We expect to increase referrals to 2000 per year we expect the cost to be an additional **£0.55m per annum**. Our evaluation shows we should expect further system benefits of £0.55m in savings and significantly improved outcomes.

Further develop the prevention offer to better meet the needs of local people by targeting communities and individuals that can gain most benefit. The development of a comprehensive health improvement model presents new opportunities to increase capacity across the health and social care system, supporting individuals to make positive, sustained lifestyle changes by adopting a person-centred and a whole community approach to improving health and well-being. Initial funding would be to industrialise the approach, building on the evidence from the national NHS diabetes and CVD prevention programme, and moving forward using the Making Every Contact Count (MECC) model. We would use transformation funding to fast-track these schemes in partnership with the other communities in South Yorkshire and Bassetlaw. Further work will be undertaken to develop a strategy for transformation, using self- care and including telemedicine, for the 30 June submission.

- **Urgent and Emergency Care Centre Development with innovative 'next available clinician staffing model'** which integrates GPs, A&E consultants, highly trained nurses and is not reliant on middle grade medical staff and significantly reduces waiting times. The centre will offer alternative services to 120,000 patients a year. The project requires a new capital build and transformation investment of **£5.5m capital funding** would enable to us to go further, faster in developing the model and would help us to realise system savings of £30m over 10 years. 2017 will see increased provision at the hospital site with the opening of the new integrated centre. The Walk in Centre will no longer be commissioned.