NHS Rotherham Clinical Commissioning Group

Health & Wellbeing Board – Weds 13 July 2016

South Yorkshire & Bassetlaw Sustainable & Transformation Plan (STP)

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Purpose:

To update the Health and Wellbeing Board on the South Yorkshire and Bassetlaw STP process.

Background:

The NHS Shared Planning Guidance asked every local health and care system in England to come together to create its own ambitious local plan for accelerating implementation of the Five Year Forward View (5YFV). These blueprints, called Sustainability and Transformation Plans (STPs), will be place-based, multi-year plans built around the needs of local populations.

To deliver STPs, local health and care systems have come together to form 44 footprints, which collectively cover the whole of England. These geographic footprints are of a scale which should enable transformative change and the implementation of the Five Year Forward View vision of better health and wellbeing; improved quality of care, and stronger NHS finance and efficiency by 2020/21.

Rotherham sits within the South Yorkshire and Bassetlaw footprint which is led by Sir Andrew Cash (Chief Executive of Sheffield Teaching Hospitals).

The Rotherham place based plan is a draft document which is currently being developed and summarises local ambitions for the STP and is jointly produced by the Rotherham Clinical Commissioning Group (RCCG), Rotherham Metropolitan Borough Council (RMBC), The Rotherham NHS Foundation Trust, (TRFT), Rotherham, Doncaster & South Humber NHS Foundation Trust, (RDASH) and Voluntary Action Rotherham (VAR).

Financial Implications:

NHSE has indicated that transformation funding will be made available plans which meet their criteria.

Recommendations:

- The Health and Well Being Board are asked to note progress and delegate responsibility to individual organisations to sign off the September submission.
- Note that it is proposed to bring the September submission to a future meeting.

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.

Our ambition would be to establish these initiatives on a Rotherham footprint to prove the concept and then 'industrialise' on a South Yorkshire and Bassetlaw footprint.

On our journey we are already delivering in the following areas:

What is Rotherham's ambition for doing more on prevention?

- **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 admission risk stratification and GP judgement. We have identified non-medical interventions for over 5000 patients with significant 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. We intend to target the top 10% at risk patients as our patient level evaluation has shown this cohort of patients will benefit from the service.

- **Prevention and Self Care.** More systematic primary prevention is critical in order to reduce the overall burden of disease in the population and maintain the financial sustainability of the NHS. While prevention in childhood provides the greatest benefits, it is valuable at any point in life. It is estimated that 80 per cent of cases of heart disease, stroke and type 2 diabetes, and 40 per cent of cases of cancer could be avoided if common lifestyle risk factors were eliminated (World Health Organization (2005). Preventing Chronic Diseases: A vital investment. Geneva: World Health Organization. Available at: www.who.int/chp/chronic_disease_report/full_report.pdf)

- Further develop a self-care approach for patients using emerging technology such as approved health apps on smart phones and embracing the benefits of the 'Internet of Things' concepts for Health and Social Care. Patients would be encouraged and supported by professionals, the voluntary sector and peers to maximise the use technology as part of their approach to self-care.

- **Attainment of self-determined goals** to be captured in smart phone apps, e.g. to walk 5,000 steps per day or to take a daily blood pressure reading would be reinforced through a strengths based approach from community health champions and social prescribing services. Patients would be encouraged to record their progress and to electronically feed information into a single contact point. The access point would collate real time data and this would assist in more detailed risk stratification exercises and in determining where to target future interventions.

- '**Internet of Things'.** The approach would be applied to support people within their home environment to promote positive behaviours to alleviate harm e.g. through the use of talking fridges to ensure people eat regularly, pill dispensers to prompt medication and door sensors to alert if people are leaving the property at unusual times. The internet link would enable predetermined automated scenario based access to professionals, family members or friends should the alerts not trigger the necessary behaviours, thereby preventing escalation and ultimately A&E admission.

What is Rotherham's ambition for doing more on integration and sustainability?

- **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** which ensures that the most efficient use is made of the public estate and that surplus sites are released to support growth, housing and Capital receipts. 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

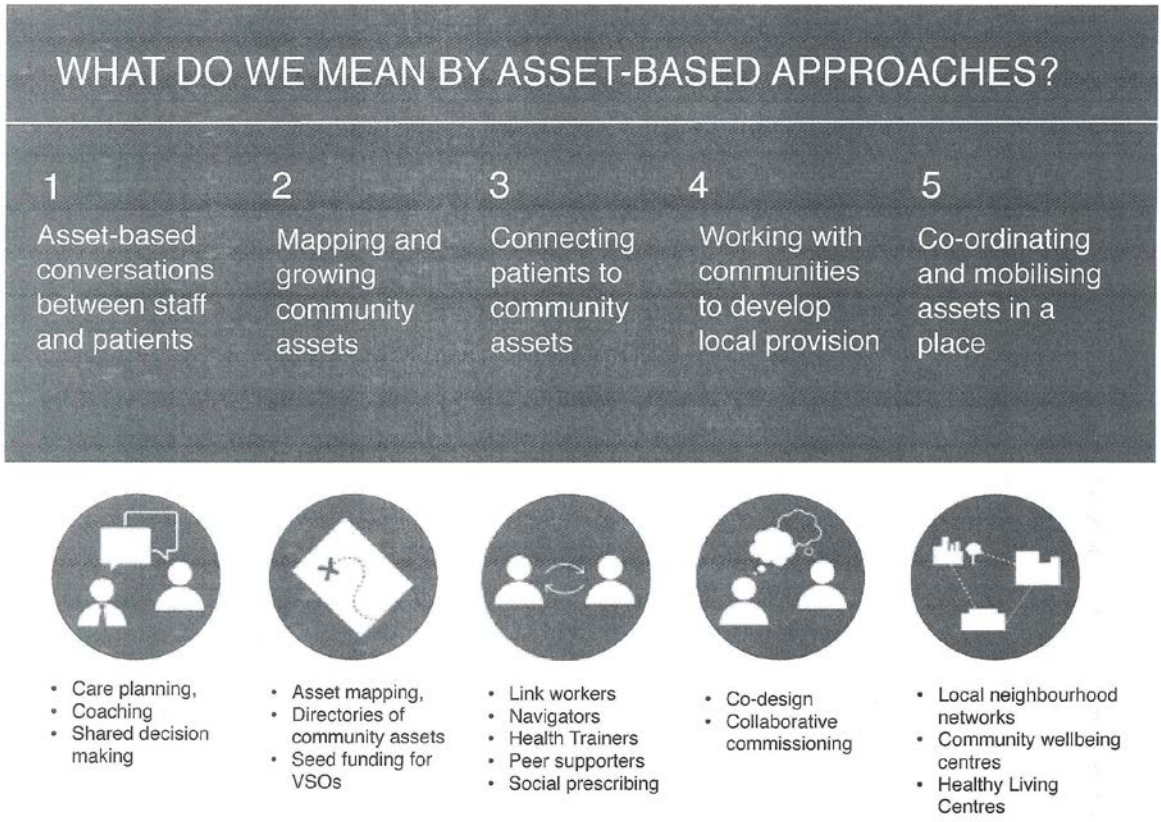
- **Integrated IT** across Health, Social Care and Care Homes. Linking up Health and Care records is a must do and we have already made good progress. Our model of one provider for Health IT has facilitated a coordinated approach.

- **Further development of 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.



Produced by the Greater Manchester Public Health Network / Innovation Unit

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 for prevention at scale?

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:

- **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 **£1.1m per annum**. Our evaluation shows we should expect further system benefits of £1.98 for each £1 in savings as well as 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. It is expected funding of £1.8m per year would be required .

- **Self-Care Proposal**

  Working in partnership with the strong voluntary sector in Rotherham to deliver innovative solutions to benefit the health and wellbeing of residents is a core element of the STP submission. In many instances impartial voluntary sector organisations can have more

positive impact on encouraging and delivering behaviour change messages to support residents to self-care than statutory partners. Further, this often offers better value for money.

Voluntary Action Rotherham (VAR) have developed a public on line 'platform' for voluntary, community groups (VCS) and social enterprises in Rotherham. Rotherham GISMO (Group Information Services Maintained Online) is unique, in that it is the single, most comprehensive and largest directory of VCS groups and organisations publically available and easily accessible. 700 groups are members of GISMO.

VAR aims to develop the directory of groups on the Rotherham Gismo website. The aim is to make it more detailed, interactive and more widely used by groups, the general public and support staff in partner agencies. The particularly focus will be on promoting self-care and prevention, linked to the wider community assets and social prescribing agendas. This will require an investment of £0.045m In addition to expanding the website offer, VAR would like to run a small grants process to pump prime the sector with a total pot of £0.025m.

VAR also run a Community Health Champions scheme supported by volunteer health ambassadors who have talked to numerous people and groups about 'Right Care Right Time message, use of Pharmacy First and Prescription Waste Management. This approach has effectively targeted communities where there has been a high incidence of attendance at A&E. The pilot in Eastwood, Rotherham has proved to be successful in reducing attendance and a further roll out to other deprived communities in Rotherham would demonstrate fiscal benefits beyond the requested £0.025m.

What STP transformation funding do we need for integration at scale?

- **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.

  Additional one off funding of **£1.5m** would support the borough wide roll out the Rotherham integrated model 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 and to fund transformational support to ensure patients receive services in the right place, first time. This development should reduce non elective bed days by 10,000 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 our formal evaluation suggests this will 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**

  The Strategic Transformation Plan – Carter group / Proposed Estates Plan states that Rotherham will actively explore opportunities to align activity with the Sheffield City Region Alignment could include access to **£0.5m** revenue funding to support the realisation of ambitious plans and focus on a transformational asset based approach:

  - To divest of poor quality, poorly performing and surplus assets
  - Identification and release of major site opportunities, including joint bidding opportunities, skills and expertise sharing etc.; Pipeline developed by **Nov 16**
  - Development of agile working approaches allowing staff the flexibility to benefit from touch down facilities in partner buildings by **March 17**
  - Establishment and joint commitment to the development of a "Pain share/Gain share" approach which seeks to address issues relating to unintended consequences of individual organisational property decisions by **October 16**
  - Agreement of overarching principles focused upon seeing the estate in aggregate, with decision making informed by impact on the whole public sector community – rather than individual organisations by **September 16**
  - Establishment of joint metrics aligned to Carter Review enabling consistent measurement of utilisation, benchmarking, good practice sharing etc by **July 16**
  - Collective review of emerging property requirements to enable the best system-wide solutions to be established. On-going based on emerging service and clinical requirements

- **Integrated digital care records** across health, social care, care homes and citizens/patients. Excellent progress has already been made with over 5000 records being integrated through our Better Care Fund Plan, 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.

- **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 **£0.45m** 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.

- **Development of a Reablement Village**

  As part of our Community Transformation Programme, Rotherham will develop a Reablement Village, commencing in 2016/17. This single site development will consolidate existing provision and provide fully integrated community rehabilitation, residential intermediate care provision (step up and step down) and discharge to assess beds.

  The Village will incorporate an environment that supports integrated working, a combination of health and social care professionals working as part of a multi-disciplinary team. This model will enable Rotherham people to access a range of services whilst remaining in their community throughout their life course.

  The Reablement Village will deliver quality and drive efficiencies through economies of scale, a single point of access, shorter travel times, reduced duplication and lower running costs. We estimate that **£3m** per year STP funding will:

  - Allow the transition to new staffing and skill mix models of care
  - Enhance the clinical and caring environment to ensure that people receive reablement services in a world class caring environment
  - Allow the transition of long-stay residents from existing provision into new care home provision.

  To enhance our current provision we will work in partnership with an independent provider to deliver the capital solution, considering the most advantageous geographical location to meet local need, whilst offering opportunities for joint provision across the wider STP footprint.

- **Transformation of the care home sector**

  Partnership with the care home sector is an integral part of the management of frail older people. Whilst some people may be able to be assessed on a frail elderly unit and discharged home with appropriate support and others transferred to an intermediate care setting as part of the Reablement Village, there are a third and important group of people who are in hospital for legitimate medical reasons and then require an alternative level of care prior to decisions about their final destination. Not all these patients require intermediate care and so timely relocation to a care home facility in conjunction with hospital and community support is a preferable option to remaining an in-patient whilst ongoing care issues are decided. In addition we are aware that care home staff remain uncomfortable in managing a care home resident who is frail and deteriorating due to infection or dehydration. Whilst advance care plans can help inform decision-making there

is an important need to upskill staff in this sector with the assessment and practical skills to manage residents with higher acuity medical problems. We would like to develop a syllabus and upskill staff in some of our care homes to develop a subspecialty interest in higher acuity patients in order to reduce unnecessary transfers to different levels of care and also to facilitate earlier discharge from hospital. In the short term, this could be provided by the provision of 50 nursing home beds whilst the facilities and skill profile is addressed, and has potential fiscal benefits of up to £1200 per patient per week. We estimate that £0.6m funding would provide appropriate training and equipment to revitalise the nursing home sector to manage high acuity patients in a more appropriate setting.