Our commitments

Over the next 5 years, we will focus on:

**Improving the health and wellbeing gap** through:

- Prevention, self-management, education & early intervention

**Driving transformation to close the care and quality gap** through:

- Rolling out our integrated locality model – ‘The Village’ pilot
- Opening an integrated Urgent and Emergency Care Centre
- Development of a 24/7 Care Coordination Centre
- Building a Specialist Re-ablement Centre

These initiatives will contribute to **closing the finance and efficiency gap**.
1 Introduction

Rotherham’s Health and Social Care Community has been working in a collaborative way for the past several years to transform the way it cares for its population of 261,000. Our track record in developing and delivering new solutions makes Rotherham the perfect test bed for new innovations. We are passionate about providing the best possible services and outcomes for our population and are committed to a whole system partnership approach, as we recognise that it is only through working together that we can provide sustainable services over the long term.

Our common vision is:

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

Our ambition is to champion prevention and integration and establish a range of initiatives in Rotherham to serve as a proof of concept that can then be rolled out further across South Yorkshire and Bassetlaw.

1.1 Purpose and positioning of this document

This document, Rotherham’s Integrated Health and Social Care Place Plan (the Place Plan), details our joined up approach to delivering five key initiatives that will help us achieve our Health and Wellbeing Strategic Aims\(^1\) and meet the region’s Sustainability and Transformation Plan (STP) objectives\(^2\). Planning and delivery at an overarching STP level must be coordinated with planning and delivery at a local (Rotherham) level, as they represent different elements of the same system.

![Diagram showing the relationship between Place Plan, Transformation Work-Streams and STP](image)

**Figure 1 The Place Plan, Transformation Work-Streams and STP all represent different parts of the same system**

1.2 Our Place Plan on a page

We note that our Place Plan shows how our joint initiatives will help us address Rotherham’s challenges and achieve our aims, as illustrated in the diagram below. We have identified **£X net savings** from our joint initiatives and we have worked very closely as partners to ensure there is no double-counting of the estimated benefits and savings from each partner’s own transformation work-streams. What we present here is over and above the partners’ contributions to creating savings in the system. Some projects are difficult to quantify (e.g. prevention and education) but we expect they will result further savings.

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\(^2\) STP currently in draft
Three gaps

Our challenges

- Life expectancy is less than the England average by more than 1 year
- Life expectancy varies by eight years between different parts of Rotherham
- Increasing numbers of people with long term conditions
- Increase in hospital attendances, admissions and wait times and opportunity to reduce emergency admissions
- Rotherham has a joint financial gap of £X m over the next 5 years

Our five priorities

- Prevention, self-management, education & early intervention
- Rolling out our integrated locality model – ‘The Village’ pilot
- Opening an Integrated Urgent and Emergency Care Centre
- Operating a 24/7 Care Coordination Centre
- Development of a Specialist Re-ablement Centre

The impact

Benefits: Prevent ill-health and moderate demand for healthcare
Estimated savings: Evaluation of social prescribing service shows system benefits of £1.98 for each £1 invested. MECC potential return of £10 for every £1 spent.

Benefits: Improve patient experience and outcomes.
Reduce non-elective bed days by 10,000
Estimated savings: Recurrent saving £1.5 m per annum

Benefits: Single point of access and triage means reduced waste and duplication. Reduce inappropriate hospital admissions
Estimated savings: £30 m over 10 years

Benefits: Improve efficiency in managing capacity, further integrate health and social care services
Estimated savings: Formal evaluation shows at least £0.86 m additional system wide efficiencies

Benefits: Enhance clinical and caring environment
Estimated savings:

Enablers

1) One public asset approach 2) Asset-based approach 3) Integrated IT will help us achieve our five priorities and lead to system savings of £X per annum
2 Context

2.1 How this place plan was developed

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

The partners will continue working closely together to ensure that the initiatives in this Plan are implemented. The Place Plan and its implementation will be further refined with the Rotherham Together Partnership, to include South Yorkshire Police, South Yorkshire Fire and Rescue Service and Yorkshire Ambulance Service in its next iteration.

We have a strong record of delivery and evaluation of our innovative projects and to continue this, we have partnered with Sheffield Hallam University to evaluate our key projects in order to gather evidence and inform our investment decisions. Where we do not have local evidence, we will use evidence of cost benefit analysis from other areas.

2.1.1 Relevant documents

The Place Plan does not replace the partners’ individual plans but rather builds upon them by taking a common lens and identifying key areas of collaboration. This document is aligned with the following relevant documents:

- The Sustainability and Transformation Plan (July 2016) ‘shows how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency’. We note that our Place Plan does not describe how we will locally address all STP workstreams– instead we focus on our joint priorities as a Health and Social Care community. The CCG’s Commissioning Plan (below) covers all STP workstreams. We anticipate the yet to be developed Operational Plan will detail how changes developed through the STP process will be delivered on the ground.

- NHS Rotherham’s CCG Commissioning Plan 2016 – 20203 (v July 2016) ‘set(s) a clear strategic direction and long term (5 years) commissioning vision’. The document describes in detail how Rotherham CCG

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3 NHS Rotherham CCG Commissioning Plan 2016- 2020
will deliver the *Five Year Forward View* locally and the nine ‘must dos’/ key system priorities for 2016/17 within our local health economy.

- **Rotherham MBC’s Corporate Plan for 2016-17**, which sets out the council’s strategic vision for the future and how, through a range of headline priorities, its services will support better outcomes for the borough. A key element of this a commitment to work with partners to integrate health and care commissioning and delivery, to reduce duplication and provide single points of access in the interests of the customer.

- **Rotherham Improvement Plan 2015** draws together the actions required to ensure the Council becomes the well-run, high-performing authority which local people deserve. This is in addition to wider changes to ensure effective management and leadership, ensure we are a “child-centred” borough and have excellent working relationships with our partner organisations.

- **The Rotherham Foundation Trust (TRFT) Annual Plan 2015/16**

- **Health and Wellbeing Strategy 2015 – 18**, sets the strategic priorities of the Health and Wellbeing Board, based on intelligence from the local joint strategic needs assessment. The strategy enables commissioners to plan and commission integrated services to achieve better health and wellbeing outcomes for local people. Crucially, the strategy is about working as an effective partnership with service providers, commissioners and local voluntary and community organisations all of whom have an important role to play in identifying and acting upon local priorities.

### 2.2 A snapshot of Rotherham

Below we provide a snapshot of Rotherham’s population.

- **Population 260,800** (2015) and forecasted to grow to 269,100 by 2025 (3.5%)  
- In line with the rest of the country, the most significant demographic change occurring in Rotherham is the *growth in the number of older people*. The number of older people (65+) is projected to rise by 8,800 (18%) between 2015 and 2025 and the number aged 85+ is projected to rise by 2,300 (40%) by 2025. This will mean an increase in the number of people with long term conditions such as heart disease, diabetes, dementia and cancer. As at 2014/15 there were almost 13,900 people in Rotherham with diabetes, and nearly 5,400 on GP stroke registers. By 2025 we project that there will be nearly 4,500 people in Rotherham living with dementia.

- **Life expectancy** at birth is 78.1 years for men and 81.3 years for women for 2012-14. This is below the national average by 1.4 years for males and 1.9 years for females.

- Rotherham people live longer with *ill-health and/or disability* than England average - men live 21 years and women 22 years in poor health.

- Rotherham is becoming **more ethnically diverse** with the Black and Minority Ethnic (BME) population doubling in size between the 2001 and 2011 Censuses, and continues to grow.

- **Significantly higher than average deprivation**, unemployment and long term unemployment. 50,370 Rotherham residents (19.5%) live in the most deprived 10% of England. Rotherham has 8,640 residents (3.3%) living in the most deprived 1% of England.

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*Available online: [http://www.rotherham.gov.uk/improvementplan](http://www.rotherham.gov.uk/improvementplan)*

*Available online: [http://www.therotherhamft.nhs.uk/key_documents/](http://www.therotherhamft.nhs.uk/key_documents/)*


*Health and Social Care Information Centre: Quality and Outcomes Framework 2014/15*


*Source: (2012-14 Healthy Life Expectancy at birth (PHOF))*

*ONS:2001 Census and 2011 Census*

*Department for Communities and Local Government and Local Government: Indices of Deprivation 2015*
3 Case for change

The health of the Rotherham population is generally poorer than the English average. We have a growing population, but notably, we will see a significant increase in the 85+ population. This leads to growing pressures on our health services, social care, informal care, supported housing and other services. Life expectancy, although lower than average, has been increasing. However, the average time spent in ill-health has also been increasing as people are living longer in poor health, resulting in a growing number of people with high levels of need.

Our key challenges are described in the diagram below.

![Figure 3 Rotherham's three gaps](image)

<Note, we will add TRFT figures to the efficiency gap when we know then and link to the figure in red in the plan on a page>.

We have already made significant progress on delivery of the key enablers to tackle our local gaps. 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.
4 Transformation approach

We have identified five priorities to maximise the value of our collective action and transform our health and care system so that we can reduce demand for acute services and achieve clinical and financial sustainability. We note that even though the priorities are presented as separate initiatives, they are all very closely interlinked.

1. Prevention, self-management, education & early intervention

- We will work with communities to create environments where being healthy is the easy choice. We will also focus on information, prevention, enablement, rather than on-going support which increases dependence and reliance on health and social care services. This is the 'golden thread' that runs throughout the plan. The specific initiatives proposed are:
  a) Extending our award winning Social Prescribing service
  b) 'Making Every Contact Count' through training of front-line staff on brief interventions around smoking-cessation, alcohol-consumption, healthy diets and physical activity; ensuring quick and easy referral to evidence based lifestyle services for those that are ready.

2. Rolling out our integrated locality model - 'The Village' pilot

- Our pilot 'The Village' is in Rotherham's town centre. It covers 31,000 patients in 1 of our 7 localities. It showcases joint commissioning arrangements that drive the integration of services and promotes multidisciplinary working between primary care, secondary care, social care, mental health, community services and the voluntary sector, reducing reliance on the acute sector.
- We will be rolling out this model throughout our 6 other localities.

3. Opening an integrated Urgent and Emergency Care Centre

- To be completed in spring 2017 and opening by July 2017, this will be Rotherham's 24/7 single point of access and triage for urgent cases. An innovative multidisciplinary approach will reduce waiting times, support patient flow through the hospital and improve patient experience. It is expected to reduce emergency admissions saving £30m over 10 years.
- In addition our Adult Mental Health Liaison service and transformation of our care home sector will help keep people out of hospital.

4. Further Development of a 24/7 Care Coordination Centre

- This single point of contact for professionals and patients to call for advice on the most appropriate level of care/most appropriate pathway has been in place for 18 months (currently receiving 4000 calls a month, 24/7)
- We will be expanding it to include mental health and social care.
- The purpose is to manage system capacity, carry out initial assessment and deploy appropriate teams to provide support, avoid potential hospital admissions and ensure people are in the most appropriate care setting.

5. Building a Specialist Re-ablement Centre

- We will colocate and integrate community rehabilitation services, residential intermediate care (step up and step down) and the current discharge to assess beds into a single site. This will enable Rotherham people to access a range of services while remaining in the community. It will also be more cost-efficient through better deployment of professionals and teams and supporting integrated multi-disciplinary way of working.

These initiatives, supported by our locally agreed Better Care Fund, provide 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.

Our approach to transformation is based on a multi-agency strategy of prevention and early intervention and integration of health and social care services. We also recognise the importance of addressing the wider determinants of health. Economic growth and getting people into employment remains a priority for the Borough. The links between poverty and ill health are well established and the pace of improvement in health is likely to be threatened if unemployment remains high or employment opportunities are low-paid.

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or insecure. The emphasis on narrowing inequalities, targeting resources towards areas of greatest need and poverty reduction are focuses for the Joint Health and Well-being Strategy. The quality of housing also has a direct impact on our health and wellbeing. Rotherham is aiming to build future proof housing and develop:

- Different housing solutions for people with long-term conditions
- Community environments where being healthy is the easy choice, e.g. healthy food in schools and in staff canteens.
- More extra-care facilities\(^{14}\) - there are 2,460 in-house and 370 independently provided sheltered housing units and 236 accommodation based support units for older people. Generally all the schemes run at full capacity. It is anticipated that demand may reduce in the future as more people are supported to remain at home, but it is possible that capacity will be filled with people who would otherwise have been placed in residential care.

The remainder of this section describes our five priorities and their associated initiatives in more detail.

### 4.1 Prevention, self-management, education and early intervention

We want health and care to be managed long before someone needs to have hospital treatment or experiences problems in their life. We want to do this in a way that is right for them, whether this is through providing information and advice, or through more active management. The diagram below presents Rotherham’s wider prevention and early intervention programme of work, organised by the scale of coverage of the interventions. It also highlights the initiatives this Place Plan focuses on as part of our priorities.

![Diagram of Rotherham's wider prevention and intervention programme](image)

We will better meet the needs of local people by targeting individuals that can gain most benefit through:

- Expanding our award-winning **Social Prescribing** service both for those at risk of hospitalisation and for mental health clients.
- Expanding systematic use of **Healthy Conversations** (brief interventions) and advice by ensuring every statutory organisation signs up to **Making Every Contact Count** (MECC) and by training front-line staff to talk about sensitive issues such as alcohol use, healthy eating habits, increasing

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\(^{14}\) Property that can be purchased or rented, usually in the form of a self-contained flat, apartment or bungalow, where people can be looked after by support and / or care staff
physical activity and quitting smoking. We will also ensure quick and easy referral to evidence based lifestyle services (e.g. smoking cessation) to support those that are ready to change and in a way that is right for them.

These initiatives will increase capacity across the health and social care system, allowing us to better support individuals to make positive, sustained lifestyle changes by adopting a person-centred and a whole community approach to improving health and well-being. We discuss these initiatives in the remainder of this section.

4.1.1 Social prescribing
Our national award winning Social Prescribing service was highlighted in the *Five Year Forward View* as exceptional practice, saving money and improving outcomes. There are two aspects to this service:

1. **Targeting people at risk of hospitalisation.** We already target the top 5% of people at risk of hospitalisation using admission risk stratification and GP judgement and we intend to expand this to target the top 10% at risk people as our patient level evaluation\(^\text{15}\) has shown this cohort will benefit from the service.

2. **Extend our social prescribing service to cover mental health clients.** This is a model of partnership working between primary care and the voluntary sector. We have piloted this approach for almost two years and the initial findings are positive\(^\text{16}\). Mental health clients could be part of the targeted 10% of people at risk of hospitalisation.

*Figure 5 How Social Prescribing for those suffering mental health problems can make a difference to someone’s life*

<table>
<thead>
<tr>
<th>Without social prescribing</th>
<th>With Social Prescribing</th>
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</thead>
<tbody>
<tr>
<td>Helen gave birth to a severely disabled daughter at the age of 16. She cared for her 24/7 for 20 years until she had no choice but to put her in to care.</td>
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<tr>
<td>Having struggled with her mood throughout – this decision plunged her further in to despair.</td>
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<tr>
<td>For years she has taken multiple medications. Her house has been repossessed because her husband is a gambling addict. Her self-esteem is non-existent and she is overwhelmed by guilt.</td>
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</tr>
<tr>
<td>Helen goes to the GP to fill her prescriptions. She spends a couple of months sleeping on friends’ sofas but eventually she finds herself homeless and alone. She doesn’t know who she can go to for help. After some time braving the cold, a chest infection deteriorates into pneumonia and she goes to ED.</td>
<td>Helen goes to the GP to fill her prescriptions and the GP persuades her that it is time to invest in herself. Helen reluctantly accepts the referral and attends ‘Radiance and Relaxation’ groups organised by a volunteer organisation. “I was terrified about going back on my own – but I had loved it, so I had to go. There are steps up to the building, by the time I got to the top I was so anxious that I couldn’t feel my legs – but I did it, and I’ve kept going.” Helen got her confidence back, found a job and was able to afford a place for herself again.</td>
</tr>
</tbody>
</table>

\(^{15}\) Centre for Regional Economic and Social Research, Sheffield Hallam University. *Evaluation of the Rotherham Mental Health Social Prescribing Pilot*. August 2016 draft. Available upon request.

\(^{16}\) Centre for Regional Economic and Social Research, Sheffield Hallam University. *Evaluation of the Rotherham Mental Health Social Prescribing Pilot*. August 2016 draft. Available upon request.
4.1.2 Making Every Contact Count (MECC) and Healthy Conversations

We want to make every contact count, maximising opportunities to create positive change by encouraging small, sustained, lifestyle changes to improve outcomes. The MECC approach empowers front-line staff to recognise the role they have in promoting healthy lifestyles, supporting behaviour change and contributing to reducing the risk of chronic disease. This will involve initiating undertaking simple brief intervention or healthy conversations with a person as part of a routine appointment or consultation, and where appropriate, signposting them to sources of further information and to local services. We will ensure quick and easy referral to evidence based lifestyle support services (e.g. smoking cessation) for those that are ready to change and in a way that is right for them.

Part of our MECC approach is considering the health and wellbeing of our staff. We will promote healthy working environments and ensure organisations sign up to the Workplace Wellbeing Charter\(^\text{17}\). There is a very large body of research evidence supporting Brief Interventions in primary care including at least 56 controlled trials\(^\text{18} \text{,19}\). For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels\(^\text{20}\). This compares favourably with smoking where only one in twenty will act on the advice given\(^\text{21}\). This improves to one in ten with nicotine replacement therapy. The following table summarises evidence from NICE (2014), showing brief interventions can be effective for reducing alcohol consumption, increasing physical activity, reducing diabetes risk and aiding smoking cessation attempts.

<table>
<thead>
<tr>
<th>Brief intervention</th>
<th>Evidence from NICE 2014(^\text{22})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>The most effective interventions for reducing alcohol consumption in adults and vulnerable young people appear to be brief counselling interventions and extended brief interventions. For people classed as problem drinkers there is evidence from multiple systematic reviews supporting the effectiveness of brief interventions delivered in primary care with a range of underlying behavioural change components.</td>
</tr>
<tr>
<td>Physical activity and healthy diet</td>
<td>Brief interventions in primary care can be effective in producing moderate increases in physical activity in middle aged and older populations in the short term (6–12 weeks), longer term (more than 12 weeks) or very long term (more than 1 year). For the effect to be sustained at 1 year, the evidence suggested that several follow-up sessions over a period of 3–6 months are needed after the initial consultation episode. There is evidence that lifestyle interventions combining physical activity and diet are more effective at reducing diabetes risk than those of diet or physical activity alone based on a meta-analysis of 12 RCTs.</td>
</tr>
<tr>
<td>Smoking</td>
<td>Strong evidence from 7 trials suggests that multi-session smoking interventions can be effective at aiding cessation attempts among smokers who are motivated to quit or report intending to quit within 6 months.</td>
</tr>
</tbody>
</table>

\(^{19}\) Kaner et al., 2007
\(^{22}\) [https://www.nice.org.uk/guidance/ph49/evidence/evidence-statements-69192109](https://www.nice.org.uk/guidance/ph49/evidence/evidence-statements-69192109)
Robert was referred to a Health Trainer in April 2015 as he wasn’t happy with his weight and current lifestyle. He felt that he was lacking in confidence and had little motivation to do anything. Robert was very unhappy, did not feel very positive or see himself in a good light. He has high blood pressure and takes medications to manage it.

At first Robert found the idea of setting goals quite daunting, but over the next few weeks Joe (Health Trainer) worked with Robert on helping him to set small realistic goals that would, over time, help him to achieve his bigger goals. Together they looked at better portion control, healthier food choices and increasing physical activity. Robert joined a local exercise class and is now walking more than he ever thought he could. He has started growing his own fruit and veg in a small plot that he and his partner have built in their back garden and now shares the knowledge he has acquired by passing on tips to help his family and friends. Although Robert found things difficult at first, he now feels that he has adjusted to his new lifestyle and feels much more positive about himself. Family and friends have all noticed the positive changes in Robert and his levels of self-confidence are much higher. He has lost 31lbs over 13 weeks and his blood pressure has reduced. As a result, he has also been able to reduce the amount of blood pressure medication that he takes.

Our volunteers and carers will help us achieve our prevention priorities. Access to voluntary services can be prescribed as an alternative to a traditional medical response and given the size of our volunteer services base, we have ample opportunity to expand our offering of social prescribing services.

Rotherham has a strong and vibrant voluntary, community and social enterprise sector. There are approximately 1,382 Voluntary and Community Groups in Rotherham of varying sizes and supporting a range of activity – over 55% of which are directly involved in health, welfare and social care. Volunteers and carers are a core part of Rotherham’s social and economic offer and an important component of this Plan. In many instances impartial voluntary sector organisations can have more positive impact on encouraging and delivering behaviour change messages to support residents to self-manage 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 publicly available and easily accessible. 700 groups are members of GISMO. VAR aims to further 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 particular focus will be on promoting self-management and prevention, linked to the wider community assets and social prescribing agendas.

VAR also run a Community Health Champions scheme supported by volunteer health ambassadors who spread the ‘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 to A&E and we are seeking to further develop the model and expand it into other deprived communities in Rotherham.

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23 Rotherham State of the Sector of the Voluntary and Community Sector 2015, Rotherham Social Prescribing Service for People with Long Term Conditions Jan 2016 both by Sheffield Hallam University Centre for Regional Economic & Social Research
4.2 Roll out our integrated locality model – ‘The Village’ pilot

The integrated locality model is in its third year of development and ‘The Village’ pilot was established in July 2016 to develop and test the model’s concept of a multi-professional team delivering health and social care to a General Practice population in a single, seamless pathway. It is located in Rotherham’s town centre and covers 31,000 people in one of our seven localities.

The team aims to provide seamless care to the designated General Practice cluster population (using the same GP register list), ensuring the client receives coordinated care from a single case management plan and lead professional. Resources are pooled from the Rotherham NHS Foundation Trust, Rotherham Borough Council and others to deliver quality care closer to people’s homes. The integration of care is supported through the alignment of resources, single line management arrangements, and the sharing of information for a designated practice population through an innovative, secure technology portal. The model will overtime move towards including closer alignment with the care homes within the locality and the co-location of other support services, all around a common vision and purpose: a more efficient and effective way of working, with reduced duplication of assessments and avoidance of multiple referrals leading to individuals being transferred between services. The approach allows the team to be more proactive and less reactive in caring for the population and by working with individuals, families and communities we aim to reduce dependence, promote self-management and increase overall systems resilience. The majority of the population who are benefiting are older people and as such are the pilot’s initial focus. However, younger people, children and families are also expected to benefit from the integrated approach. The difference in approach to care is shown schematically below:
A key component of the model is the interface between secondary and primary care with hospital and community physician’s being able to manage and run advanced virtual wards (and deploying interactive virtual ward rounds), enabling people to stay closer to home, in the community.

We are planning on rolling out the model to all seven localities taking into account any lessons learned from the ongoing evaluation (with the pilot due to conclude in July 2017). Joint care planning and support will address both the psychological and physical needs of the individual, recognising the huge overlap between mental and physical well-being. Service integration therefore becomes a vehicle to deliver “parity of esteem”. The team also seeks to incorporate other key players in the community: South York Police, South Yorkshire Fire and Rescue Service and Yorkshire Ambulance Service to supplement the care provided.

Locality teams will also champion and support the Making Every Contact Count (MECC) approach as a part of their daily delivery of care.

**Case study on integrated locality model**
Grant has severe depression and diabetes. His GP referred him to a social worker specialising in mental health and to a district nurse who helped him to better understand and manage his diabetes. They both met with Grant together and drew up a care plan. The GP also has access to this same care plan. Through the social worker, Graham was referred to talking therapy and put in touch with a peer support worker. This has helped him regain his hope for the future.

The partners are committed to working together to achieve the following objectives for the whole of Rotherham:

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.

4.2.1 **Transformation of the care home sector**
An important part of our new integrated locality model of care and of ensuring there are appropriate care solutions in the community, is the transformation of our care home sector. Approximately 15% to 18% of emergency admissions into the hospital are from care homes and the length of stay for these people tends to be higher than for average admissions. Most people want to be cared for in their own homes and we know that this is best for their wellbeing. Partnership with the care home sector is therefore critical to reducing demand for acute services. Our aim is for:

- Fewer admissions from care homes into hospital
- Patient length of stay to be more proactively managed through technology (e.g. automated systems from providers to case management systems to alert on bed availability)
- Less people to be automatically placed in care homes when they could stay in their own home and be supported within their community

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24 Aligned with the outcomes set out in Rotherham’s Health and Well Being and Rotherham CCG’s Commissioning Plan.
To help us achieve this, we will further develop our care home liaison service linking medical staff into care homes and also linking in with mental health liaison services (described in Section 4.3.1 below) and with the integrated locality team. Currently physiotherapy assessment is carried out in the hospital ward and then another one upon admission to the intermediate care beds. We plan to introduce a ‘Trusted Assessor’ model to streamline the assessment - with one person/team appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols.

We are also aware that a number of care home staff remain uncomfortable in managing a care home resident who is frail and experiencing deterioration in their health due to an infection or dehydration. Whilst advance care plans can help inform decision-making, there is an important need to upskill staff in this sector with the assessment and practical skills to manage residents with higher acuity medical problems. We would like to develop a syllabus to help upskill staff in some of our care homes and for them to develop a subspecialty interest in higher acuity patients in order to reduce transfers to different levels of care and also to facilitate earlier discharge from hospital. One option being considered is to increase opportunities for care home staff to work within the hospital and develop the necessary skills to take back within the care home setting.

4.3 Urgent and Emergency Care Centre

Figure 7 Front of Urgent and Emergency Care Centre (at the front of the hospital)

The pressures that our health and social care system are facing are greater than elsewhere in the country – we are not only growing in numbers (3.5%); our older population, particularly those 85+ will see significant growth (40%) by 2025. The resulting changes in size and complexity means that despite our Hospital performing better than most, there are still opportunities to manage growth in emergency admissions to hospital and to reduce growth in hospital attendances and admissions.

Attendances to ED and onward admission into hospital continue to grow year on year. Admission rates from ED, whilst below the national average, can vary and sometimes be linked to the seniority of the clinician within the department at the time. Analysis undertaken shows we could potentially avoid 1,800 admissions per year through more consistent senior clinical review, which would also improve outcomes

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for patients. The alternative, is that if we do nothing to mitigate the rising demand for urgent and emergency care, we estimate £11m additional expenditure would be required in 10 years\textsuperscript{26}.

We therefore have ambitious plans to contain growth in emergency admissions and assessments and the new Urgent and Emergency Care Centre is one of our primary initiatives to tackle this challenge. The Centre will be fully operational by Summer 2017 and will ensure improved co-ordination and delivery of urgent care provision across Rotherham by creating a single point of access and triage for patients.

The Centre will house a team of specialists 24/7 so patients can be seen straight away by the right support. The aim is for patients to be assessed and possibly treated as early as possible and we will pioneer an innovative ‘next available clinician staffing model’ which integrates GPs, ED consultants and highly trained nurses. This will also reduce reliance on middle grade medical staff, for which there is anticipated to be an ongoing national shortage. It will also accommodate social workers, mental health teams and care coordination teams. The diagram below illustrates the key aspects of the Centre’s innovative model:

4.3.1 Expanding access to the Adult Mental Health Liaison Service

Physical and mental health are inextricably intertwined. Long-term conditions (LTCs), such as diabetes, are associated with high rates of mental illness. Some 70% of NHS spend goes on the treatment of LTCs, a great deal of which currently involves treatment in acute hospitals\textsuperscript{27}. To optimise the physical health care of patients, it is essential that their mental health and wellbeing are addressed at the same time. Guidance for Commissioners is that liaison services should be provided throughout the acute hospital, including in A&E departments; and that a liaison service should be an integral part of the services provided by acute hospital trusts, as trusts that have incorporated a liaison service have demonstrated much better cost effectiveness.

\textsuperscript{26} NHS Rotherham CCG, The Rotherham NHS Foundation Trust, Care. Business Case for Emergency Centre: Right Care, First Time. 2015. Available upon request.

As part of our wider Mental Health services transformation plan, we launched the Rotherham Mental Health Liaison Service (April 2015) to provide round the clock mental health care (assessment, treatment and management) to patients who attend Rotherham Hospital. The two year pilot is currently being externally evaluated by Sheffield Hallam University who are due to report in Autumn 2016. This is part of the CCG’s plan to move toward the national 2020/21 expectation that local acute hospitals should meet or aim for the ‘Core 24’ standards for mental health liaison as a minimum.

Case study on adult mental health liaison service

Agnes is an 80 year old retired accountant. She has been a widow for 13 years and lives with one of her six adult grandchildren. One day, her daughter finds her on the floor at home and calls an ambulance.

A&E treat Agnes for opiate overdose. The mental health liaison team assesses her and finds that although she is in relatively good health, she has some chronic pain issues that have not been addressed and she also admits to feeling increasingly low in mood, eventually leading to her overdose. She is afraid of losing her independence and being a burden on her family.

The team provide her with support while she’s in the ward. They discuss her feelings and concerns and a psychiatrist prescribes her medication for her depression and anxiety. Agnes and the team agree a care plan and she is able to return home that same day. She and her family know that she will be followed up at home by community staff who will provide on-going risk assessment and care planning.

Agnes feels ‘listened to’ and further admission to mental health inpatient facility or a longer stay in hospital is avoided.

Working with partners from across Rotherham the service has also developed:

- A new adult mental health emergency centre pathway as part of the CCG’s Urgent Care Programme of work.
- Close working partnerships with both the Acute Hospital Lead Alcohol Liaison service and the new implemented Children and Adolescent Mental Health Services (CAMHS) Liaison service based in the acute hospital.

We aim to expand access to this service to improve the outcomes and experience of people experiencing a mental health crisis and to achieve the following benefits:

- improved access to mental health care for a population with high morbidity
- reduced emergency department waiting times for people with mental illness
- reduced admissions, re-admissions and lengths of stay
- reduced use of acute beds by patients with dementia
- reduced risk of adverse events
- enhanced knowledge and skills of acute hospital clinicians
- improved compliance of acute trusts with legal requirements under the Mental Health Act (2007) and Mental Capacity Act (2005)

4.4 Development of Rotherham 24/7 Care Coordination Centre (CCC)

The CCC has been in place for 18 months and currently takes 4000 calls a month, 24/7. Its aim is to act as a central point of access for health professionals and people into community and hospital based urgent care services. Our aim is to expand the scope of the CCC to include mental health, voluntary and social care sector services, improving access through a comprehensive directory of services, driving efficiency and cutting down waste.

Through managing system capacity, carrying out an initial assessment (currently done by specially trained senior nurses but in future this might be by other professionals) on the most appropriate level of care
needed, and deploying the right teams (e.g. integrated rapid response team), the CCC has assisted in meeting targets for emergency admissions, reducing the number of avoidable admissions and ensuring full and appropriate utilisation of community services\textsuperscript{28}. It also relieves pressure on GPs by streamlining the referral process into urgent care services and ensuring that GPs are able to make informed choices about the most appropriate level of care for people. The CCC is crucial to The Rotherham Foundation Trust (TRFT) vision of developing a whole system integrated service approach where people receive the appropriate care at the appropriate time in the appropriate place provided by the appropriate professional.

Over the next two or three years we expect our CCC to allow our health and social care services to:

- Develop information sharing among all health and social care professionals to quickly identify individuals at risk and where a needs assessment can be made
- Develop and maintain a register of patients who are medically fit for discharge and ensure that they are placed on the correct care pathway
- In addition to being the single point of access for community nursing referrals, the CCC will also start to support GPs in the case management of people with long term conditions

New technology will also be deployed which will provide access to single care records and also allow the CCC to see people in the various care settings throughout the health and social care community. The CCC will also help support the integrated locality teams in providing advice and support around pathways and to also act as a trigger when people from the locality (case managed by the locality team) access hospital services.

4.5 Building a Specialist Re-ablement Centre

We want to develop a more integrated approach to the provision of intermediate care services for those patients who cannot be treated at home, but who do not need to be treated in a hospital setting. Our aspiration is to locate all rehabilitation services on a single, co-located, non-acute setting to create an environment that support integrated working, with a combination of health and social care professionals working as part of a multi-disciplinary team.

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

We anticipate the Re-ablement Centre will deliver quality and drive efficiencies through creating economies of scale, a single point of access, shorter travel times, reduced duplication and lower running costs. We recognise there is a limited evidence based and for this reason we are building a robust performance framework and audits which will allow us to monitor the success of this initiative. We will allow enough flexibility so we can respond promptly to any changes required.

“Re-ablement is one of council’s main tools in managing the costs of service provision for an ageing population and has proved an important area where joint integration commissioning can make savings, when faced with the necessity of streamlining budgets” – Plymouth Pilot Review

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.

5 Enablers
This section outlines the enablers that will support our five priority initiatives.

5.1 Accountable Care
We view ourselves as collectively accountable for the health and wellbeing of our population and consider this plan to be our framework for jointly providing Acute, Community and Emergency Primary Care Services. Our new governance arrangement (Section 5.6) enables us to become an accountable care system. We will be considering options for exploring moving towards an Accountable Care Organisation arrangement.

5.2 One public estate approach
One public estate partnerships across the country have shown the value of working together across the public sector and taking a strategic approach to asset management. At its heart, the programme is about getting more from our collective assets – whether that’s catalysing major service transformation such as health and social care integration and benefits reform, unlocking land for new homes and commercial space, or creating new opportunities to save on running costs or generate income.

This is encompassed in four core objectives:29

1. creating economic growth (new homes and jobs)
2. more integrated, customer-focused services
3. generating capital receipts
4. reducing running costs.

In alignment with these national programme objectives, we aim to:

- Adopt a ‘common sense’ sharing of Rotherham’s resources.
- Use our public buildings more efficiently
- Site services in locations which make them easier to access
- Release surplus sites to support growth or for community care

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 (£0.5m) 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 ensures that the most efficient use is made of the public estate and that surplus sites are released to support growth.

29 Cabinet Office and Local Government Association. One Public Estate Invitation to Apply (April 2016)
http://www.local.gov.uk/documents/10180/7632544/L16-57+OPE+Phase+4+prospectus_v05.pdf/1bdec934-9819-425d-8ff3-01c22c5f4e97
5.3 Asset-based approach

The diagram below illustrates that by ‘assets’ we mean more than just buildings.

![Diagram showing types of assets: Neighbourhood assets (e.g., physical spaces and buildings that contribute to health and wellbeing), Community assets (e.g., voluntary sector organisations, associations, clubs and community groups), Social assets (e.g., relationships and connections that people have with their friends, family and peers), Personal assets (e.g., the knowledge, skills, talents and aspirations of individuals)].

Figure 9 What do we mean by assets?

We recognise the crucial role that individuals, families and our communities can play in helping us improve our health and wellbeing. The diagram below summarises how we see this working in practice:

![Diagram outlining steps: 1. Asset-based conversations between staff and patients, 2. Mapping and growing community assets, 3. Connecting patients to community assets, 4. Working with communities to develop local provision, 5. Coordinating and mobilising assets in a place].

Figure 10 Our asset-based approach (based on Greater Manchester Public Health Network/Innovation Unit)

This approach embeds an owned culture of wellbeing and prevention across communities as well as within statutory services in addition to shifting demand 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. For now, we provide evidence from Wigan Council in section 6.

5.4 Integrated IT

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

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, people will be able to view and add their own data and interact with Health and Social care professionals using modern technology. 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. This is estimated in section 6 below.

5.5 Emerging technology and the ‘internet of things’
We are exploring options for expanding the use of emerging technology to encourage and support people as part of their approach to self-management. Examples of this includes:

- 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. People 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.

- The ‘Internet of Things’ 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.
5.6 Governance structure

<to be included>
6 Expected benefits and investment required

As a Health and Care Community we are committed to these initiatives over the next 5 years, but 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. This section summarises the benefits we expect from our initiatives and an estimate of transformation funding we require for each. <Table to be updated with most recent financial analysis>

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Benefits</th>
<th>Investment required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Prevention &amp; self management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Making Every Contact Count and brief interventions</strong></td>
<td>Prevent ill-health and moderate demand for healthcare:</td>
<td>£1.8m per annum</td>
</tr>
<tr>
<td></td>
<td>• estimate 80% of heart disease, stroke and type 2 diabetes cases &amp; 40% of cancer cases could be avoided if common lifestyle risk factors were eliminated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 1:8 individuals will change their alcohol consumption behavior as a result of brief intervention and 1:20 individuals will change their smoking behavior as a result of brief intervention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Every 5,000 patients screened in primary care may prevent 67 A&amp;E visits and 61 hospital admissions. Costs £25,000, Saves £90,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Every £1 spent smoking prevention programmes in schools can return as much as £15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Every £1 spent on physical activity initiatives returned an estimated £23 in quality of life, reduced NHS use and other gains</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Making Every Contact Count could show a return of £10 for each £1 spent and would be expected to save households and employers some £28 for each £1 spent, by reducing spending on cigarettes, alcohol and care and improving employment and income</td>
<td></td>
</tr>
<tr>
<td><strong>Social prescribing</strong></td>
<td>Increase target from 5% to 10% of people at risk of hospitalisation</td>
<td>£1.1 million per annum</td>
</tr>
<tr>
<td></td>
<td>Expand service to cover mental health clients</td>
<td>£45k for VAR website offer, £25k for VAR Health Champions</td>
</tr>
<tr>
<td></td>
<td>Savings &amp; improved outcomes from social prescribing targeting people at risk of hospital admission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evaluation shows system benefits of £1.98 for each £1 invested</td>
<td></td>
</tr>
</tbody>
</table>

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30 Identification and Brief Advice (IBA) - Provide more help to encourage people to drink less. Available online: http://www.alcohollearningcentre.org.uk/Topics/Browse/HIC/IBA/
32 Making the case for Public Health interventions, Kings’ Fund and LGA, 2014
33 Making the case for Public Health interventions, Kings’ Fund and LGA, 2014
34 Making Every Contact Count: Value for Money, MECC Advisory Group
### 2. Integrated Locality Model

<table>
<thead>
<tr>
<th>Transformation of Care Homes</th>
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</thead>
<tbody>
<tr>
<td>Improved patient outcomes</td>
</tr>
<tr>
<td>Reduced utilisation of secondary services through proactive management of patients</td>
</tr>
<tr>
<td>Reduction in non-elective bed days by 10,000 (estimated saving £1.5m per annum)</td>
</tr>
<tr>
<td>One off funding of £1.5m</td>
</tr>
<tr>
<td>£1.25m per annum to trial new staffing models in primary care &amp; to fund transformational support</td>
</tr>
<tr>
<td>£0.6 funding would provide appropriate equipment and training to revitalise the care home sector to manage high acuity patients out of hospital</td>
</tr>
</tbody>
</table>

### 3. Urgent & Emergency Care Centre

<table>
<thead>
<tr>
<th>Urgent and Emergency Care Centre</th>
<th>Adult Mental Health Liaison Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment would mean we can go further &amp; faster in developing the model and help us realise system savings of £30m over 10 years</td>
<td>The recent evaluation of the RAID service in Birmingham has provided compelling evidence of the cost effectiveness of an integrated liaison psychiatry service for people with dementia showing a return for investment of £4 for every £1 invested</td>
</tr>
<tr>
<td>New capital build and transformation investment of £0.45m</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Care Coordination Centre

| Formal evaluation shows at least £0.86m additional system wide efficiencies and also improve the efficiency, and further integrate health and social care services |
| Non recurrent infrastructure cost: £0.46m |

### 5. Re-ablement Centre

| Allow transition to new staffing and skill mix models of care |
| Enhance clinical and caring environment |
| Allow transition of long stay residents from existing provision into new care home provision |
| Plymouth reviewed its Re-ablement Service in 2014 and found that it achieved the financial objectives stated in the Council’s business case of £500k in savings in the first year of delivering these services |
| £3m per annum |

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35 Based on TRFT estimated based on current cost of a hospital bed versus benchmarked equivalent care beds in the independent sector.
36 The Emergency Care Centre Business Case sets out the savings in non-elective admissions (pg 19) – the assumption is that by doing nothing, activity growth will be 3% per annum. Implementing the new emergency centre will save 5 admissions per day against the do nothing scenario.
NHS Confederation (2009). Healthy mind, healthy body: how liaison psychiatry services can transform quality and productivity in acute settings. London: NHS Confederation
It also estimated that the re-ablement of 528 service users reflects a possible saving of £3.8m (when compared to 12 months domiciliary care provision as an alternative)\(^{38}\)

<table>
<thead>
<tr>
<th>Enablers</th>
<th>This requires more scoping work to estimate</th>
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<tbody>
<tr>
<td>One Public Estate Approach</td>
<td>This requires more scoping work to estimate</td>
</tr>
<tr>
<td>Asset Based Approach</td>
<td>The Wigan Council, through its Wigan Deal Programme(^{39}) has demonstrated that for every £1 invested in community assets generates benefits of £1.95 per person over a five year period</td>
</tr>
<tr>
<td>Integrated IT</td>
<td>Potential cash and non-cash benefits would be circa £0.96m</td>
</tr>
<tr>
<td>Emerging technology</td>
<td>This requires more scoping work to estimate</td>
</tr>
</tbody>
</table>

**6.1 Key Performance Indicators**

We will measure our success by:

- A reduction in the number of unscheduled hospital attendances and admissions
- A reduction in the length of stay in an acute hospital setting for locality residents
- A reduction in the number of A&E attendances and hospital admissions from care homes
- A reduction in the length of stay in an acute hospital bed for care home residents
- A reduction in the number of residents requiring home care packages
- A reduction in the cost of providing home care packages
- A reduction in the number of patients requiring alternative levels of care (either on an intermediate or permanent basis)

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7 Overview of implementation

Below we present a high level overview of our activity to 2020. We have included an asterisk (*) next to those activities that are particularly dependent on transformational funding.

<consider adding a column with the estimated required investment for some of these activities>

<table>
<thead>
<tr>
<th>1. Prevention, self-management, education &amp; early intervention</th>
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<tbody>
<tr>
<td><strong>Social Prescribing</strong></td>
</tr>
<tr>
<td>Mental Health Social Prescribing 2 year pilot</td>
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<tr>
<td>Evaluation of the Mental Health Social Prescribing pilot</td>
</tr>
<tr>
<td>*Expand cover to mental health clients/increase referrals to 2000 per year</td>
</tr>
<tr>
<td>*Increase target from current 5% to 10% (patients at risk of hospitalisation)</td>
</tr>
<tr>
<td><strong>Making Every Contact Count and Healthy Conversations</strong></td>
</tr>
<tr>
<td>All key statutory organisations signed up to MECC</td>
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<tr>
<td>*Frontline staff cohort trained</td>
</tr>
<tr>
<td>Introduction of small grants process to pump prime VCS sector</td>
</tr>
<tr>
<td>*Develop robust Community Health Champions Scheme</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>2. Integrated locality model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of the integrated locality team pilot</td>
</tr>
<tr>
<td>Final evaluation of the pilot ‘The Village’</td>
</tr>
<tr>
<td>Roll out of the integrated locality teams across the Borough</td>
</tr>
<tr>
<td>*Care home transformation (timeframes to be confirmed)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. 24/7 Care Coordination Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoping and planning expansion to other health and social care services</td>
</tr>
<tr>
<td>*Expansion to involve other Health and Social Care services</td>
</tr>
<tr>
<td>Evaluation of upscaled service</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Urgent and Emergency Care Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redesigned structure of acute intake/walk-in centre/new workforce model</td>
</tr>
<tr>
<td>Urgent and Emergency Care Centre IT Solution implemented</td>
</tr>
<tr>
<td>Completion of the capital Build for the Emergency Care Centre</td>
</tr>
<tr>
<td>Full implementation of the Emergency Centre Model</td>
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<table>
<thead>
<tr>
<th>Adult Mental Health Liaison</th>
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<tbody>
<tr>
<td>External evaluation Adult Mental Health Liaison service pilot</td>
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<tr>
<td>Determine future commissioning intentions for Adult Mental Health Liaison</td>
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</table>

<table>
<thead>
<tr>
<th>5. Re-ablement Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Full implementation of the Integrated Rapid Response service</td>
</tr>
<tr>
<td>Review of the current intermediate care service model</td>
</tr>
<tr>
<td>Undertake full review of acute and community respiratory pathways</td>
</tr>
<tr>
<td>*Development of the re-ablement hub</td>
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</tbody>
</table>