Rotherham's Integrated Health and Social Care Place Plan

DRAFT

7 November 2016

Getting the best out of Rotherham's Health & Social Care

1   Introduction

Our commitment

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.**

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.

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[1] Rotherham Borough Joint Health and Wellbeing Strategy 2015-18. Available online:
http://rotherhamhealthandwellbeing.org.uk/hwp/downloads/file/4/rotherham_borough_joint_health_and_wellbeing_strategy_2015-18
2 STP currently in draft

Local planning and delivery helps bridge local gaps

Place Based Plans

Transformation Workstreams

Partners' Plans (section 2.1.1)

SY&B STP

Both the place plans and the transformation workstreams will be crucial to bridging the three gaps at an overarching STP level

Figure 1 The Place Plan, Transformation Work-Streams and STP all represent different parts of 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 on the following 'plan on a page'. We have identified potential savings from our joint initiatives and 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.

1.3 Place Plan on a Page Diagram

Three Gaps	Health and Wellbeing Gap			Care and Quality Gap	Finance and Efficiency Gap
Our Challenge	Life expectancy is less than the England average by more than 1 year	Life expectancy varies by 8 years between different parts of Rotherham	Increasing numbers of people with long term conditions	Increase in hospital attendances, admissions and wait times, opportunity to manage growth in emergency admissions	Rotherham has a joint financial gap of £Xm over the next 5 years

	Prevention, self-management, education and early intervention	Roll out our integrated locality model – 'the Village Pilot'	Opening an integrated Urgent and Emergency Care Centre	Further develop the 24/7 Care Co-ordination Centre	Building a specialist Re-ablement Centre
Our Five Joint Priorities	We will work with communities to create environments where being healthy is the easy choice. This is the 'golden thread' that runs through 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; ensuing quick and easy referral to evidence based lifestyle services for those that are ready.	Our pilot 'the Village' is in Rotherham's town centre. It covers 31,000 patients in 1 of 7 localities. It showcases joint commissioning arrangements that drive the integration of services and promotes multi-disciplinary working between primary care, secondary care, social care, mental health, community services and the voluntary sector, reducing the reliance on the acute sector. We will be rolling out this model throughout our 6 other localities. In addition transformation of our care home sector will help keep people out of hospital	To be completed in Spring 2017 and open by July 2017, this will be Rotherham's 24/7 single point of access and triage for urgent and emergency cases. An innovative multi-disciplinary approach will reduce waiting times, support patient flow through the hospital and improve patient experience. It is expected to reduce inappropriate emergency admissions saving £30m over 10 years. In addition, our Adult Mental Health Liaison Service will help keep people out of hospital.	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 assessments and deploy appropriate teams to provide support and ensure patients are seen in the most appropriate care setting.	We will co-locate 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 whilst remaining in the community. It will also be more cost-efficient through the better deployment of professionals and teams and supporting an integrated, multi-disciplinary way of working.
The Impact	Benefits: prevent ill-health and moderate demand for healthcare Estimated Savings: evaluation of social prescribing 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 £1.5m per annum	Benefits: single point of access and triage means reduced waste and duplication, reduce inappropriate hospital admissions Estimated Savings: £30m over 10 years	Benefits: improve efficiency in managing capacity, further integrate health and social care services. Estimated Savings: formal evaluation shows at least £0.86m additional system wide efficiencies	Benefits: enhance clinical and caring environment Estimated Savings: tbc

Enablers

1) One public asset approach 2) asset-based approach 3) Integrated IT will help us achieve our 5 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.
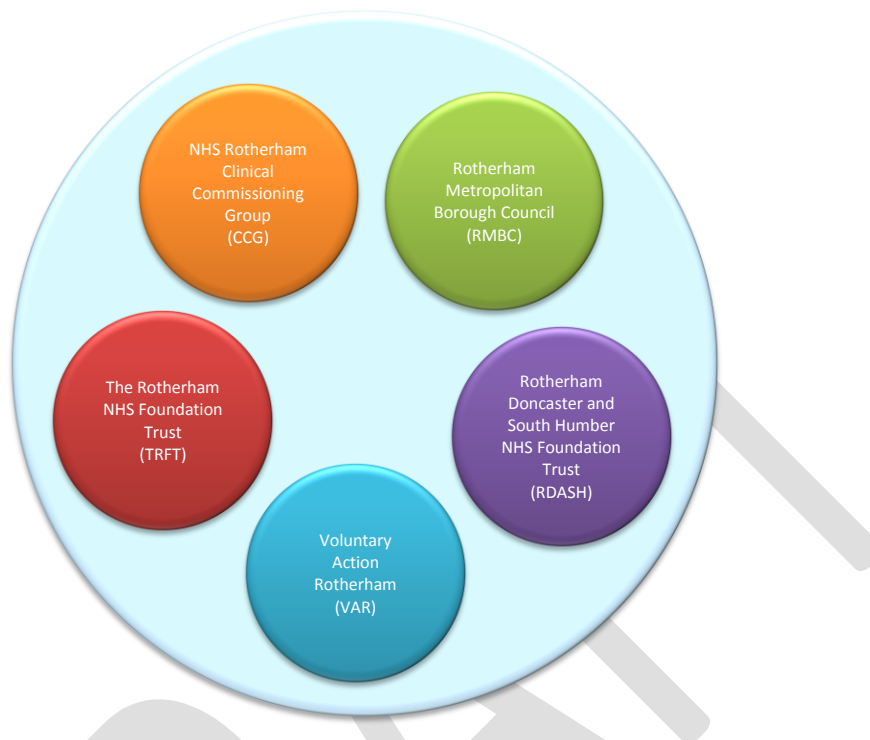

Figure 2 Partner Organisations involved in developing the Place Plan

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.

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 briefly describes, at section 10.2, how we will locally address all STP workstreams, but the main focus is 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 – 2020[3]** (v July 2016) 'set(s) a clear strategic direction and long term (5 years) commissioning vision'. The document describes in detail how Rotherham CCG will deliver the *Five Year Forward View* locally and the nine 'must dos'/ key system priorities for 2016/17 within our local health economy.

- **NHS Rotherham's Five Year Primary Care Strategy[4] 2016 - 2020 –** sets out how the CCG will work with GP practices to transform services over the next 5 years to improve consistency and equality in access to general practice, provide a seamless pathway for patients with GPs as the linchpin for care, and support patients to self-manage their conditions by utilising technology to connect with healthcare professionals.

- **The Five Year Forward View for Mental Health 2020-21** - sets out the case for transforming mental health care in England and describes the action required. Intended as a blueprint for the changes that NHS staff, organisation's and other parts of the system can make to improve mental health

- **Rotherham MBC's Corporate Plan for 2016-17[5]** - 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[6] -** draws together the actions required to ensure RMBC 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[7]** - TRFT reviewed and recommitted to their 2014/15 Strategic Plan, which sets out their strategic aims and objectives for the five year period. The strategic direction, as described in the plan has a clear focus on shaping services and developing new and collaborative models of care to meet the future needs of the population, embracing change and advancements in technology, effective financial management, enhancing partnership working and, importantly, engaging and supporting staff to deliver the best possible care for patients.

- **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[8].

- **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[9].

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[3] NHS Rotherham CCG Commissioning Plan 2016- 2020
http://www.rotherhamccg.nhs.uk/Downloads/our%20plan/Rotherham%20CCG%20Commissioning%20Plan%202016-17%20Part%201%20and%202%20-%20final%20July%202016.pdf
[4] NHS Rotherham CCG Five year Primary Care Strategy
[5] Available online: http://www.rotherham.gov.uk/downloads/file/1491/corporate_plan_2013-16
[6] Available online: http://www.rotherham.gov.uk/improvementplan
[7] Available online: http://www.therotherhamft.nhs.uk/key_documents/
[8] Office for National Statistics: 2015, Mid-year estimate 2014 – based population projections, life expectancy at birth 2012-2014, 2001 census, 2011 census.
[9] Health and Social Care Information Centre: Quality and Outcomes Framework 2014/15

- **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[10].
- Rotherham people live longer with **ill-health and/or disability** than England average - men live 21 years and women 22 years in poor health[11].
- 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[12].
- 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[13].

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

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 public/patient level evaluation would also allow the wider system to learn from our innovations.

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[10] Public Health England: http://www.phoutcomes.info/public-health
outcomesframework#page/1/gid/1000049/pat/6/par/E12000003/ati/102/are/E08000018/iid/22303/age/164/sex/4
[11] Source: (2012-14 Healthy Life Expectancy at birth (PHOF)
[12] ONS:2001 Census and 2011 Census
[13] Department for Communities and Local Government and Local Government: Indices of Deprivation 2015

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 and early intervention

- We will work with communities to create environments where being healthy is the easy choice, we will also focus on information, prevention and 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; extending our award winning social prescribing service and; '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 multi-disciplinary 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 other 6 localities.
- In addition, transformation of the care home sector is an important part of our integrated locality model of care, ensuring there are solutions in the community.

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 multi-disciplinary 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, expanding access to our Adult Mental Health Liaison service will improve outcomes and experience of people experiencing a mental health crisis and will help keep people out of hospital.

4. Further development of a 24/7 care co-ordination 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 4,000 calls a month, 24/7).
- We will be expanding 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 co-locate 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 ways of working.

These initiatives, supported by our locally agreed Better Care Fund[14], 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.

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[14] Rotherham *Better Care Fund Plan*. Available online: http://www.rotherhamccg.nhs.uk/better-care-fund.htm

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 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[15]- 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.

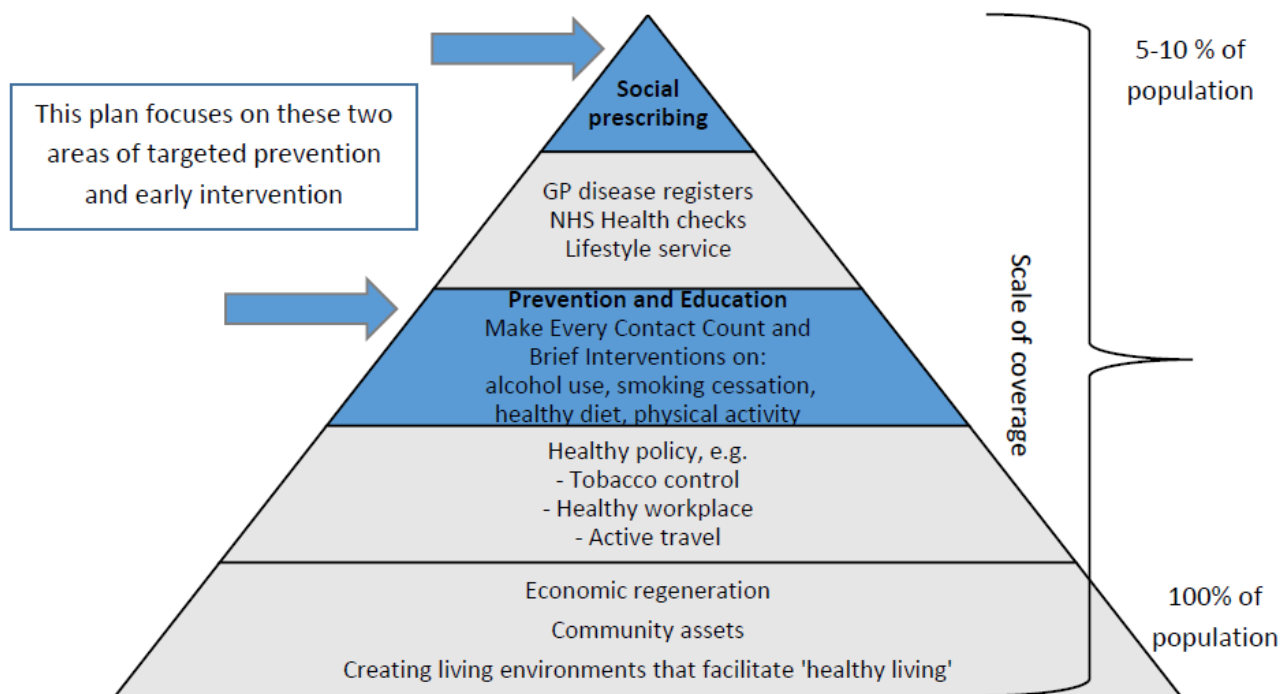*Figure 4 Rotherham's wider prevention and intervention programme*

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[15] 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

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

a) Expanding our award-winning **Social Prescribing** service both for those at risk of hospitalisation and for mental health clients.

b) 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 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[16] 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[17]. 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

Without social prescribing	With Social Prescribing
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.	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.
Having struggled with her mood throughout – this decision plunged her further in to despair.	Having struggled with her mood throughout – this decision plunged her further in to despair.
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.	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.
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.	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.

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[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.

[17] 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. We will continue to develop our lifestyle services to provide a more integrated, holistic and joined-up approach to lifestyle and behaviour change; that supports and empowers people to self-manage their health and promotes independence.

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[18].

There is a very large body of research evidence supporting Brief Interventions in primary care including at least 56 controlled trials[19] [20]. For every eight people who receive simple alcohol advice, one will reduce their drinking to within lower-risk levels[21]. This compares favourably with smoking where only one in twenty will act on the advice given[22]. 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.

Brief intervention	Evidence from NICE 2014[23]
Alcohol	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.
Physical activity and healthy diet	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.
Smoking	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.

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[18] http://www.wellbeingcharter.org.uk/index.php

[19] Moyer, A., Finney, J., Swearingen, C. and Vergun, P. (2002) Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment -seeking and non-treatment seeking populations. Addiction, 97, 279-292. Abstract available at http://www.ncbi.nlm.nih.gov/pubmed/11964101

[20] Kaner et al., 2007

[21] Moyer, A., Finney, J., Swearingen, C. and Vergun, P. (2002) Brief Interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment -seeking and non-treatment seeking populations. Addiction, 97, 279-292. Abstract available at http://www.ncbi.nlm.nih.gov/pubmed/11964101

[22] Silagy, C. and Stead, L.F. (2003) Physician advice for smoking cessation (Cochrane Review). Most recent version of this review (2013) available at http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD000165.pub4/full

[23] https://www.nice.org.uk/guidance/ph49/evidence/evidence-statements-69192109

Making Every Contact Count and Referral to Lifestyle Service

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[24]. 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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[24] 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

Why develop an integrated team?

- The capacity at Rotherham Hospital is frequently close to full.
- People prefer care at home and we know being at home is better for our wellbeing.
- Health and Social Care teams deliver excellent care, but often this is poorly coordinated with others. This can lead to 'silo working', which does not benefit the client.
- There is frequent duplication of information gathering from the client. This is especially so when different teams initially assess client need, often asking the same type of questions.
- Funding is struggling to maintain resources in order to meet growing demand.

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 over time 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 in figure 6.

Figure 6 From fragmentation to integration

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[25] 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

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) 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.

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[25] Aligned with the outcomes set out in Rotherham's Health and Well Being and Rotherham CCG's Commissioning Plan.

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[26], there are still opportunities to *manage growth* in emergency admissions to hospital and to *reduce growth* in hospital attendances and admissions.

Attendances at A&E and onward admission into hospital continue to grow year on year. Admission rates from A&E, 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 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[27].

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, A&E 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. Figure 8 illustrates the key aspects of the Centre's innovative model:

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[26] Right Care Analysis. Available online: https://www.england.nhs.uk/wp-content/uploads/2016/03/rotherham-ccg-cfv.pdf

[27] NHS Rotherham CCG, The Rotherham NHS Foundation Trust, Care. *Business Case for Emergency Centre: Right Care, First Time.* 2015. Available upon request.
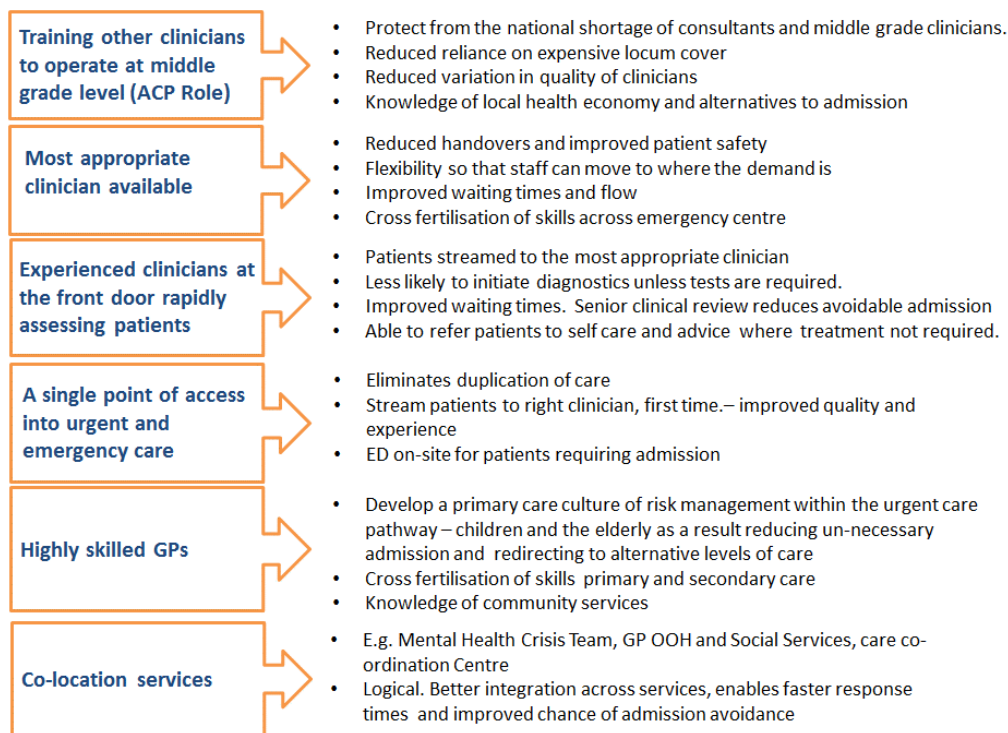
Training other clinicians to operate at middle grade level (ACP Role)	• Protect from the national shortage of consultants and middle grade clinicians. • Reduced reliance on expensive locum cover • Reduced variation in quality of clinicians • Knowledge of local health economy and alternatives to admission
Most appropriate clinician available	• Reduced handovers and improved patient safety • Flexibility so that staff can move to where the demand is • Improved waiting times and flow • Cross fertilisation of skills across emergency centre
Experienced clinicians at the front door rapidly assessing patients	• Patients streamed to the most appropriate clinician • Less likely to initiate diagnostics unless tests are required. • Improved waiting times. Senior clinical review reduces avoidable admission • Able to refer patients to self care and advice where treatment not required.
A single point of access into urgent and emergency care	• Eliminates duplication of care • Stream patients to right clinician, first time.– improved quality and experience • ED on-site for patients requiring admission
Highly skilled GPs	• Develop a primary care culture of risk management within the urgent care pathway – children and the elderly as a result reducing un-necessary admission and redirecting to alternative levels of care • Cross fertilisation of skills primary and secondary care • Knowledge of community services
Co-location services	• E.g. Mental Health Crisis Team, GP OOH and Social Services, care co-ordination Centre • Logical. Better integration across services, enables faster response times and improved chance of admission avoidance

Figure 8 Key Aspects of our Urgent and Emergency Care Centre 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[28]. 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.

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.

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[28] Joint Commissioning Panel for Mental Health (2013) *Guidance for Commissioners of Liaison Mental Health Services to Acute Hospitals*. http://www.jcpmh.info/wp-content/uploads/jcpmh-liaison-guide.pdf

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[29]. 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.

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[29] London School of Economics. Economic Evaluation of Liaison Psychiatry Services. Available online: http://www.bsmhft.nhs.uk/our-services/urgent-care/rapid-assessment-interface-and-discharge-raid/lse-report-on-raid/

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.

4.5.1   The Woodlands Mental Health Unit

The Woodlands Mental Health Unit was opened four years ago. The unit is operated by RDaSH, however it sits within the grounds of TRFT site.

Woodlands is a modern, purpose-built unit caring for people aged over 65 who are in need of acute care for functional and organic mental health problems.

Due to improvements in the way we are managing mental health patients in the community, we have seen a recent sustained reduction of inpatient admissions. This has given us the opportunity to utilise one of the three inpatient mental health wards at Woodlands differently. We plan to use one of the 12 bedded wards to meet the needs of patients with diagnosed mental health conditions who are accessing treatment in the acute hospital setting at TRFT. We expect to improve patient outcomes, reduce length of stay and provide care in a holistic caring environment.

5   Enablers

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

5.1   Accountable Care

The term Accountable Care Organisation is gaining ground in the NHS and describes arrangements where groups of providers come together to jointly deliver new pathways of care in ways that maximise efficiency, reduce cost and improve patient experience and outcomes.

In Rotherham 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 work towards an Accountable Care System (ACS). The aim of an ACS is to design and deliver services to meet the needs of the local population and improve health and wellbeing outcomes, within an agreed budget.

The Rotherham ACS model will include commissioners and bring important functions such as; needs assessment, identification of priorities, service redesign skills, setting and monitoring outcomes and quality and engaging with public and professional stakeholders.

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[30]:

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 to lead the Joint Assets Board to ensure that the most efficient use is made of the public estate and that surplus sites are released to support growth.

5.3   Asset-based approach

Figure 9 illustrates that by 'assets' we mean more than just buildings.

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. Figure 10 summarises how we see this working in practice:

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 Health Record connecting disparate health systems and with the population of Social Care systems with NHS Numbers in preparation for further connectivity. Our model of one provider for acute, community and GP IT has facilitated a coordinated approach.

We plan to further integrate systems by engaging suppliers to use national technical standards for sharing information across Health and Social Care and using the Rotherham Health Record as a secure "window" into organisational systems. To support our self-care agenda, people will be able to view and add their own data via the Rotherham Health Record 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.

The delivery of integrated digital care records across Health, Social Care and Care Homes will require detailed planning and significant multi-year investment to support the move of organisational processes from traditional paper based systems to electronic systems on a robust shared infrastructure platform. To support this delivery we have established a multi-agency Interoperability Group for Rotherham that has produced a Local Digital Roadmap setting out our vision and ambitions for digital services over the next 5 years. The cost for our integrated care record is estimated in section 6.

The implementation of integrated digital records will be dependent on robust agreements and protocols to ensure that personal information is shared safely, securely and appropriately. We are working in partnership to develop the information sharing model for Rotherham and will engage with partners, patients and the public to support this initiative.
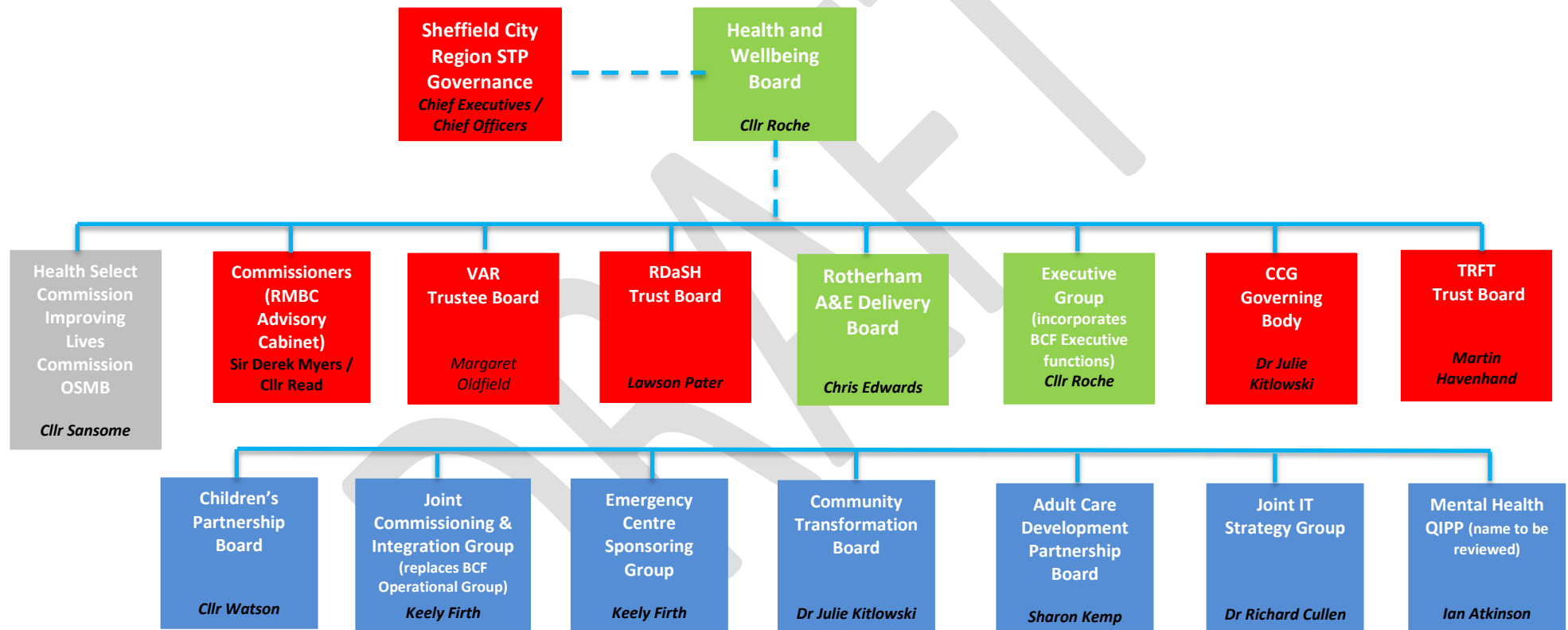
5.5   Emerging technology and the 'internet of things'

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

Please note: *The diagram below describes the developing governance structure, there is partner acknowledgement that the structure will continue to be reviewed and evolve.*

Sheffield City Region STP Governance
Chief Executives / Chief Officers

Health and Wellbeing Board
Cllr Roche

Health Select Commission Improving Lives Commission OSMB
Cllr Sansome

Commissioners (RMBC Advisory Cabinet)
Sir Derek Myers / Cllr Read

VAR Trustee Board
Margaret Oldfield

RDaSH Trust Board
Lawson Pater

Rotherham A&E Delivery Board
Chris Edwards

Executive Group (incorporates BCF Executive functions)
Cllr Roche

CCG Governing Body
Dr Julie Kitlowski

TRFT Trust Board
Martin Havenhand

Children's Partnership Board
Cllr Watson

Joint Commissioning & Integration Group (replaces BCF Operational Group)
Keely Firth

Emergency Centre Sponsoring Group
Keely Firth

Community Transformation Board
Dr Julie Kitlowski

Adult Care Development Partnership Board
Sharon Kemp

Joint IT Strategy Group
Dr Richard Cullen

Mental Health QIPP (name to be reviewed)
Ian Atkinson

Key
Green – Statutory Governance
Red – Decision Making
Blue – In scope for Place Plan development and discussion
Grey – Scrutiny function
Chairs denoted in boxes

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6   Communication

Our approach to communications activity will focus on informing, sharing, listening and responding to the people of Rotherham. Specific communication and engagement has taken place, with a variety of stakeholders, in developing each of our five priority initiatives and we will continue to develop meaningful communication, in a simple and easy to understand way, that demonstrates how we will drive transformation to close the care and quality gap. Planning and delivery of our communication in Rotherham will be co-ordinated with the activity at an overarching STP level. Our inclusive approach to communication with key individuals and groups will include:

- proactively and effectively communicating our vision, priorities and achievements. Being proactive is central to our vision for communication with local people.
- developing two-way communication opportunities where we share news, we listen and respond and are visible to local people.

An infographic and animation will be used across the health and social care system as a key tool in articulating how our five priorities are closely interlinked to deliver better, more accessible services in the coming years.

7   Consultation

7.1   Local Partners

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

The Plan and its implementation will be further refined to include South Yorkshire Police, South Yorkshire Fire and Rescue and Yorkshire Ambulance Service.

7.2   Existing Consultation

The five key initiatives identified by partners to address Rotherham's challenges have all been informed by feedback from patients, public and stakeholders. The following describes the existing consultation that has informed its development.

7.2.1   Prevention, self-management, education and early intervention

All GP practices in Rotherham take part in the Case Management programme which targets the most vulnerable to facilitate improved quality and co-ordination of care in the community, promote self-management and take patients views into account. Below is a link to feedback from case management focus group:
http://www.rotherhamccg.nhs.uk/Downloads/Your%20Say/PPG%20Events/Case%20Management/Notes%20from%20Case%20Management%20Focus%20Group%20notes.pdf

As part of the *integrated* case management plan, patients can be signposted to the social prescribing service. This service has undergone extensive evaluation by Sheffield Hallam University, see link below. The evaluation documents social and economic benefits and describes several case studies:

http://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf

VAR Community Health Champions engage with the public on a variety of health messages and in the promotion of self-care, prevention and patient education. These have included messages around the Right Care, First Time campaign and the use of pharmacies. The CCG Medicines Management Team regularly engage with the public in the development of self-care leaflets.

In addition, the feedback of carers is vital in supporting patients with long term condition, and we are working with carers to re-invigorate a local carers forum, it is hoped this group will contribute to discussions going forward.

7.2.2 Integrated Locality Model – 'The Village' pilot

Joint consultation has taken place on the development of the integrated health and social care teams. A stakeholder event was held in June 2016 to inform the health village pilot, the attached document shows case studies and what organisations can bring to the model.

What Organisations can bring.pdf   Case Scenarios.pdf

Views from the public and patients around our plans for Community Transformation were sought at the CCG AGM in July 2016.

Consultation has taken place with the Integrated Rapid Response (IRR) team regarding how the service will work effectively to manage people at home and to support discharge, this informed the development of the service specification.

In line with the Better Care Fund Plan 2016-17, in July 2016 partners began to meet to examine the appropriate process for integrating the social work element into the IRR service.

Linked to the BCF Plan 2016-17, a survey has been developed to measure customer experience of Intermediate Care services with a view to improving its effectiveness. Included are questions/prompts to document qualitative and quantitative data and an overall rating, this work took place throughout August/September.

Consultation to support the alignment of community nursing teams and practices with **care homes** includes a regular survey of care homes and practices to see how things are progressing. The Home from Home initiative assesses 36 care homes in the borough through a number of approaches, including face to face meetings with residents, relatives and staff. This information feeds in to an overall rating awarded to the home and a report to help people/carers make an informed decision when and where to live.

As part of their annual review of care home provision, officers speak to residents and gain their views of the service including how they work with key partners.

7.2.3 Urgent and emergency care centre

Extensive pre-consultation work followed by a formal consultation process informed the plans for the Urgent and Emergency Centre. The period of public consultation ended on 26 July 2013, and was the culmination of over 18 months of engagement activities including structured discussions, focus groups, market research and briefings, please see full report:
http://www.rotherhamccg.nhs.uk/Downloads/Your%20Say/Urgent%20care%20consultaion%20-%20outcome.pdf

This process created substantial interest in the project, and as a result a number of community groups asked for, and receive regular updates. There continues to be high levels of engagement across all staff and stakeholder groups and we continue to engage with the public, this included stands for the public at both the TRFT and CCGs AGMs in July.

People have told us that they want a system that is integrated and that does not ask for the same information twice. They want an urgent care system that responds to their needs without referring to another service. Through integration, we would like to create a seamless pathway into urgent care, whether access to the service is by walk in, telephone or via the ambulance service and that would support a self triage environment.

Working with the voluntary sector, we have established a number of community ambassadors who help us to deliver the 'Right Care, First Time' message, reaching into communities. During the summer of 2015, we also worked with Rotherham Older People's Forum, who spoke to a number of older people about crises, and the use of A & E, we will use this to inform future work, including the information we provide for older people about the services available.

The **Adult Mental Health Liaison Service** is part of the overall Mental Health Transformation programme and as part of the development RDaSH has fully engaged with stakeholders from across the borough. This has included; 18 workshops (some whole system, some mixed groups and some internal) involving 621 attendees, two rounds of visiting all GP localities, meetings and completion of an online GP survey, CCG and RDaSH representatives have attended the Rotherham Health Select Commission in December 2015 and met with NHS England as part of their Effective Service Change process: (http://www.eoesenate.nhs.uk/files/9314/0862/2233/Effective_service_change_toolkit_FINAL.pdf) Updates on the development of the proposal have been received at regular intervals at both the Mental Health and Learning Disability QIPP and System Resilience Groups, with views fed verbally through to GP Members committee.

7.2.4   Rotherham 24/7 Care Co-ordination Centre

Ongoing work with a wide variety of patient groups and public consultations has reinforced the basic premise that patients want to receive care as close to home, and as conveniently as possible, as long as this is safe, and quality care is provided. This has included feedback on our plans from the Rotherham PPG network; from a focus group on case management, and informal discussions with a variety of community groups.

In considering the use of the Care Co-ordination Centre for other Health/Social Care services, a Working Group has been established to examine opportunities to integrate services. A business case is being developed by all partners to consider options for a future single point of access and consultation on the options is planned, (late 2016- early 2017) once the business case is developed.

7.2.5   Specialist Re-ablement Centre

Telephone surveys are carried out between January and March each year to determine the % of older people discharged from hospital into rehabilitation/re-ablement services and are living at home 91 days later. This is one of the national BCF metrics for 2016/17 which measures how effective the intermediate care service is in supporting people to continue to live independently in their own homes. Surveys also include customer satisfaction rates and also signposts customers to other services for further support.

A review of acute and community respiratory pathways will include the provision at Breathing Space. Intelligence from the Friends and Family Test is available for Breathing Space, and TRFT self assessment includes stakeholder and patient information as well as performance against national targets. A further review of provision is to take place throughout 2016-17 and the review of Breathing Space is part of the BCF review programme for 2016-17. This may include further consultation with patients who access the service, but is to be determined.

Views from the public and patients around our plans for Community Transformation were sought at the CCG AGM in July 2016.

The development of a specialist re-ablement centre would be a great opportunity to co-create engagement activity with patients and service users.

8   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.

Initiative	Benefits	Investment required
1.Prevention & self management		
Making Every Contact Count and brief interventions	Prevent ill-health and moderate demand for healthcare: • estimate 80% of heart disease, stroke and type 2 diabetes cases & 40% of cancer cases could be avoided if common lifestyle risk factors were eliminated • 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[31] • Every 5,000 patients screened in primary care may prevent 67 A&E visits and 61 hospital admissions. Costs £25,000, Saves £90,000[32] • Every £1 spent smoking prevention programmes in schools can return as much as £15[33] • Every £1 spent on physical activity initiatives returned an estimated £23 in quality of life, reduced NHS use and other gains[34] • 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[35].	£1.8m per annum
Social prescribing - increase target from 5% to 10% of people at risk of hospitalisation and expand service to cover mental health clients	Savings & improved outcomes from social prescribing targeting people at risk of hospital admission • Evaluation shows system benefits of £1.98 for each £1 invested	£1.1 million per annum £45k for VAR website offer, £25k for VAR Health Champions
2.Integrated Locality Model		
Integrated Locality Model	Improved patient outcomes Reduced utilisation of secondary services through proactive management of patients Reduction in non-elective bed days by 10,000 (estimated saving £1.5m per annum)	One off funding of £1.5m £1.25m per annum to trial new staffing models in primary care & to fund transformational support

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[31] 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] PHE publications gateway number: 2013-190 http://www.nta.nhs.uk/uploads/alcoholanddrugswhyinvest2015.pdf
[33] Making the case for Public Health interventions, Kings' Fund and LGA, 2014
[34] Making the case for Public Health interventions, Kings' Fund and LGA, 2014
[35] Making Every Contact Count: Value for Money, MECC Advisory Group

Initiative	Benefits	Investment required
Transformation of Care Homes		£0.6 funding would provide appropriate equipment and training to revitalise the care home sector to manage high acuity patients out of hospital[36]
3. Urgent & Emergency Care Centre		
Urgent and Emergency Care Centre	Investment would mean we can go further & faster in developing the model and help us realise system savings of £30m over 10 years[37]	New capital build and transformation investment of £0.45m
Adult Mental Health Liaison Service	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.[38]	
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. 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)[39]	£3m per annum
Enablers		
One Public Estate Approach	This requires more scoping work to estimate	More scoping work required
Asset Based Approach	The Wigan Council, through its *Wigan Deal* Programme[40] has demonstrated that for every £1 invested in community assets generates benefits of £1.95 per person over a five year period	

[36] Based on TRFT estimated based on current cost of a hospital bed versus benchmarked equivalent care beds in the independent sector.

[37] 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.

[38] NHS Confederation (2011) With money in mind: the benefits of liaison psychiatry. London: NHS confederation.
NHS Confederation (2009). Healthy mind, healthy body: how liaison psychiatry services can transform quality and productivity in acute settings. London: NHS Confederation
Parsonage, M. and Fossey, M. (2011) Economic evaluation of a liaison psychiatry service. London: Centre for Mental Health.

[39] Human Support Group. *Reablement – Standing at the Junction of Health and Social Care*. Plymouth Review. (2014) Available online: http://www.humansupportgroup.co.uk/wp-content/uploads/2015/10/Reablement-brochure.pdf

[40] The Deal for the Future. Wigan Council 2020. https://www.wigan.gov.uk/Docs/PDF/Council/Strategies-Plans-and-Policies/Corporate/Deal-for-future/The-plan.pdf

Initiative	Benefits	Investment required
Integrated IT	Potential cash and non-cash benefits would be circa £0.96m	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.
Emerging technology	More scoping work required	More scoping work required

8.1 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 hone 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)

9 Overview of implementation and Prioritisation

9.1 High Level Implementation Plan

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. Please note the key on the next page.

Rotherham Integrated Health and Social Care Place Plan: High Level Implementation Plan

Funding Requested	Priority Area	Priority for funding 1 being highest priority	April 16 - March 17	April 17 - March 18	April 18 - March 19	April 19 - March 20	April 20 - March 21	Impact of funding explained
£	**1. Prevention, self-management, education & early intervention**	3						
	Social Prescribing							Social Prescribing in Rotherham is well established, evidenced practice and highlighted as an exceptional service in the Five Year Forward View. The 2 year pilot extending the service to Mental Health is due to end in October, and early indications show very positive outcomes. Additional funding, will enable the roll out of the service and to significantly increase the number of patients we can target who are at risk of hospitalisation. Without additional funding social prescribing will continue at its current level, but we would not be able to realise the significant gains for both patients and services for some years in terms of improving outcomes and saving money. If immediate funding is not available the Accountable Care System would work jointly to explore further implementation in 2018.
1.17m per annum	Mental Health Social Prescribing 2 year pilot		Q1-Q3 (purple)					
	Evaluation of the Mental Health Social Prescribing pilot		Q4 (purple)					
	*Expand cover to mental health clients/ increase referrals to 2000 per year			Q1-Q2 *100% / Q3 *50% / Q4 *0%				
	*Increase target from current 5% to 10% (patients at risk of hospitalisation)			Q1-Q2 *100% / Q3-Q4 *50% / *0%				
	Making Every Contact Count and Healthy Conversations							The ambition for all key Rotherham statutory partners to sign up to MECC will be realised next year, but the extent to which we can achieve benefits from this commitment depends on the level of additional funding. We have an extensive resource in our staff, and with additional funding we can provide training, so that we can benefit from the far reaching opportunities to make a difference through brief interventions / healthy conversations with people as part of routine apointments. Without funding, the commitment remains but the opportunities to make a real difference are potentially lost. We have a vibrant VCS, who play a key role in the delivery of our plan, with additional funding we would be able to support development and sustainablity of the sector. If immediate funding is not available the Accountable Care System would work jointly to explore further implementation in 2018.
1.1m per annum 0.07m one off	All key statutory organisations signed up to MECC			Q1 (purple)				
	*Cohort of frontline staff trained			Q2-Q3 *100%/50% / Q4 *0%				
	*Introduction of small grants process to pump prime VCS sector			Q1 *100% / Q3 *50% / Q4 *0%				
	*Develop robust Community Health Champions Scheme			Q1 *100% / Q3 *50% / Q4 *0%				
	Develop approach for patients using emerging technology			Q3-Q4 (purple)				
1.5m one off 1.25m per annum	**2. Integrated locality model**	1						The integrated locality team pilot is on track and the aspiration is to roll out this out across the remaining 6 localities, but the pace and breadth of the roll out is dependent upon the level of additional funding received.
	Implementation of the integrated locality team pilot		Q2-Q3 (purple)					
	Final evaluation of the pilot 'The Village'		Q4 (purple)					
	*Roll out of the integrated locality teams across the Borough			Q1-Q2 *100% / Q3 *50% / Q4 *0%				
0.6m one off	**Care Home Transformation**							Our aspiration is to work with Care Homes to ensure there are appropriate solutions / options in the community. Additional funding would provide the opportunity to provide equipment and training to revitalise the sector, with no funding this would remain aspirational.
	*Care home transformation			Q2-Q4 *100%	Q1-Q3 *50% / Q4 *0%			
0.44m one off	**3. Urgent and Emergency Care Centre**	4						The Urgent and Emergency centre will see the aspiration of over 6 years come in to fruition. Additional funding would mean that we could move further and faster in the development of new models of working and help us to realise system savings earlier. If immediate funding is not available the Accountable Care System would work jointly to explore further implementation in 2018.
	Redesigned structure of acute intake/walk-in centre/new workforce model		Q2 (purple)					
	Urgent and Emergency Care Centre IT Solution implemented		Q3 (purple)					
	Completion of the capital Build for the Emergency Care Centre			Q1 (purple)				
	Full implementation of the Emergency Centre Model				Q1 (purple)			
	*Further enhance acute assessment capacity				Q2 *100% / Q4 *0%			
	* Enhance voluntary sector prescence in A&E				Q4 *100% / *0%			
0.1m one off	**Adult Mental Health Liaison**							The CCG jas already resourced RDaSH £800K to commisioning a specific liaison service. The provision is currently in evaluation . The system acknowledges the need to move to Core 24 Standards. If immediate funding is not available the Accountable Care System would work jointly to explore further implementation in 2018.
	Externally evaluate the Adult Mental Health Liaison service pilot		Q2 (purple)					
	Determine future commissioning intentions for Adult Mental Health Liaison		Q3 (purple)					
	*Deliver core 24 Standards		Q4 *100%	Q1 *0%				
0.46m	**4. 24/7 Care Coordination Centre**	2						The Care -Co-ordination Centre already takes 4000 calls a month 24/7, but we want to expand the scope to include mental health, voluntary and social care sector services. With additional funding we can achieve this aim and make the CCC a comprehensive directory of services to drive efficiencies and reduce waste. This goal is significant impacted upon without additional funding.
	Scope and plan extension to other health and social care services		Q2 (purple)					
	*Expansion to other Health and Social Care services			Q1 *100% / Q2 *50% / Q4 *0%				
	*Evaluation of upscaled service			Q2 *100% / Q3 *50% / Q4 *0%				
3.0m per annum	**5. Re-ablement Centre**	5						We are committed to the review of both the intermediate care pathway and the acute and community respiratory pathways, but additional funding would enable faster implementation of the integrated rapid response service. With no additional funding our aspiration to develop a reablement hub will be significantly delayed or potentially abandoned.
	*Full implementation of the Integrated Rapid Response service		Q4 *100%	Q2 *50% / Q4 *0%				
	Review current intermediate care service model		Q3 (purple)					
	Undertake full review of acute and community respiratory pathways		Q4 (purple)					
	*Development of the re-ablement hub			Q2-Q3 *100%	Q1-Q2 *50% / Q4 *0%	Q1-Q2 *0%		

9.2   Prioritisation Matrix

By undertaking the following high level prioritisation exercise, partners identified how any additional transformational funding would be prioritised.

Difficulty to implement

High

Develop Re-ablement Centre
D – significant resource needed to drive forward (money and officer time)
I – limited evidence base

Medium

Urgent & Emergency Care Centre
D – significant build due Spring 2017 completion
I – investment would enable us to go further and faster

Expand Care Co-ordination Centre
D - already well-established
I - linchpin to enable further integration of services /savings higher than investment

Low

Prevention, self management etc
D – MECC will use current workforce / Social Prescribing established
I –potential to moderate demand for healthcare / improve

Roll-out integrated locality
D = 'pilot' findings can inform roll-out across all Rotherham
I - savings higher than investment /significant impact on non elective activity

Low	Medium	High

What's the Impact

Rate	Priority (1 being high)
	1
	2
	3
	4
	5

Rationale
D = key rationale for difficulty
I = key rationale for impact

10   Wider STP Workstreams

10.1   How the Rotherham Place Plan links to the wider STP Workstreams

ROTHERHAM PLACE PLAN

South Yorkshire and Bassetlaw STP Workstreams

Five Place Based Plans

- Prevention
- Healthy children
- Primary care at scale
- Risk stratification
- End of life

Five Transformational Programmes

- Urgent and Emergency Care
- Elective Care
- Cancer
- Children's & Maternity
- Mental Health & learning disabilities

Five Cross Cutting Themes

- Workforce
- Digital and IT
- Carter, Procurement and estates
- Finance
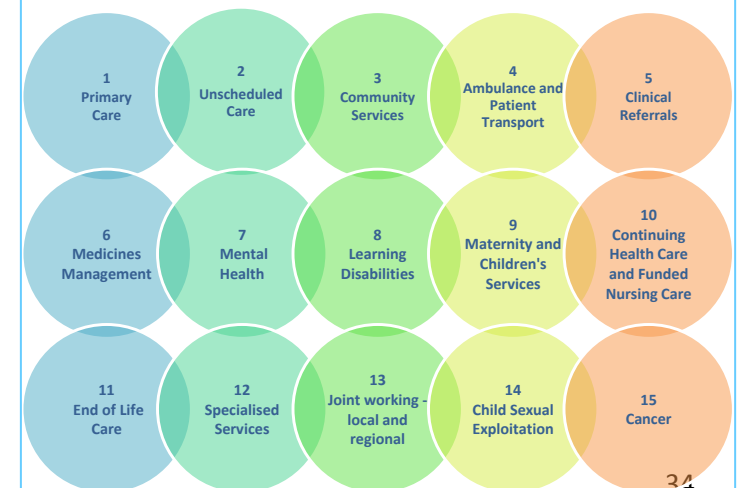- Public services reform

The **Rotherham Place Plan** describes 5 joint priorities that Rotherham partners have identified to address Rotherham's challenges, achieve our Health and Wellbeing strategic aims and meet the SY&B STP objectives.

In addition to the 5 priorities there are 15 priorities within the CCG's Commissioning Plan that have been identified and consulted upon to meet the needs of the Rotherham population and to address national planning requirements.

These 15 priorities will be delivered in partnership. Full details can be found at: http://www.rotherhamccg.nhs.uk/our-plan.htm

NHS Rotherham CCG Commissioning Plan: Strategic Priorities

1 Primary Care	2 Unscheduled Care	3 Community Services	4 Ambulance and Patient Transport	5 Clinical Referrals
6 Medicines Management	7 Mental Health	8 Learning Disabilities	9 Maternity and Children's Services	10 Continuing Health Care and Funded Nursing Care
11 End of Life Care	12 Specialised Services	13 Joint working - local and regional	14 Child Sexual Exploitation	15 Cancer

10.2 Transformational Programmes

It is important that the 5 transformation initiatives described within Rotherham's Place Plan, compliment the wider SY&B STP agenda.

The section below articulates how the strategic direction within Rotherham will support the delivery of the five wider transformation challenges within the SY&B STP[41]:

10.2.1 Urgent and Emergency Care

STP Challenge
- Increasing complexity and acuity of patients and a high volume of A&E adult attendances (431k) and non-elective adult inpatient admissions (147k) in 2014/15 at a combined cost of £385 million.
- Lack of alternative options: data analysis suggests that up to 30% of attendances (129k p/a) could be managed in an alternative setting. Using the costs of a GP appointment as a proxy, this could equate to savings of £7.5m per annum.
- Workforce challenges / capacity issues, resulting in quality issues, failure to meet NHS constitutional standards and inability to sustain services across all localities in their current form.
- Financial sustainability: difficulty in meeting current demand with current resources.

Rotherham Direction

Within our Rotherham place plan we have clearly articulated how our strategic intentions for Urgent Care will deliver a new Urgent and Emergency Care Centre from July 2017, adopting new models of delivery in line with national best practice guidelines. Given our local approach, the Rotherham place will be in a very strong position to respond to any proposals regarding the future configuration of Urgent Care provision across South Yorkshire and Bassetlaw.

10.2.2 Elective Care

STP Challenge
- Work within elective and urgent care needs to be aligned to ensure quality is not impeded due to the inter-dependencies.
- Across the system there is increased demand in both elective and diagnostic care across clinical pathways.
- Information shows that there has been a progressive shift of elective activity from district general hospitals to major trauma centres, some unplanned as result of instability and a way of managing clinical risk.
- 6% increase in first outpatient activity across all providers, with a corresponding 3.7% increase in costs. Follow ups have decreased by 2%.
- Increasing demand for diagnostic capture & reporting at 10% pa compound with private sector supply chain at capacity.
- Inequity in access to diagnostics and radiology across the footprint, with a static workforce and need to modernise roles and deployment of assets.

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[41] South Yorkshire and Bassetlaw STP 30 June 2016 submission

Rotherham Direction

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

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

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

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

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

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

10.2.3 Cancer

STP Challenge
- An ageing population and a rise in lifestyle related risk factors mean that cancer incidence is increasing, the 14,000 people being treated each year currently in South Yorkshire and Bassetlaw is expected to increase to 18,000 by 2030.
- Improvements in cancer survival rates estimate almost 45,000 people living with and beyond cancer, which is expected to rise to as many as 78,000 by 2030.

Benchmarking of clinical outcomes highlights that one year survival rates post Cancer diagnosis are lower in Rotherham than the National average. Mortality rates from any cancer in both the over and under 75's are also above the national average. Our challenge is therefore to improve one and five year survival rates. This begins with supporting the challenging social demographics and lifestyle choices and promoting the prevention agenda by all partners across Rotherham. Signposting individuals to services and support groups who can help individuals with such lifestyle choices.

Commissioning high quality cancer pathways that deliver treatment within the required national waiting times is therefore a priority for Rotherham. We will work across commissioning, primary care and acute care, as well as public health and the wider community, to ensure that assessment and treatment targets are delivered. Where Rotherham residents require highly specialist treatment in 'tertiary centres' we will work with STP partners to improve existing pathways and we anticipate that this work will reduce the risk of breaching the key 62 day cancer treatment standards.

We are also aware that in some specific areas of cancer provision, such as lung cancer, spend on acute care is significantly higher than peer averages and we are working with partners to address this. We also intend to pursue opportunities to introduce one-stop services, more community based services as well as explore the greater use of technology to help with cross site working, sharing of information etc. There are also services where consolidation across the STP could provide greater clinical, operational and financial sustainability.

Our key strategic objective is to commission high quality, timely seamless pathways of cancer care, working with our partners across pathways to achieve this, and we will do this locally by focusing our efforts in the following areas:

1. **Raising Awareness to support early identification and early diagnosis** - specific focus on 2week waits for urgent cancer referrals.
2. **Treatment –** Commission high quality pathways of care for both local and tertiary cancer treatments.
3. **Survivorship** – Focus on the need to address complications as soon as required to reduce the need for unnecessary follow ups and   support individuals to return to work.

10.2.4 Children's & maternity

STP Challenge
- Children not always having the best start in life, with high rates of preventable health problems arising such as obesity, mental illness and dental decay.
- Mortality and morbidity rates higher than the European average, which is considered to be associated with the fragmented provision of services.
- Providers of services meeting national standards for the safe care of acutely unwell children or for children undergoing surgery, with challenges in meeting new standards for maternity care.
- Rising demand and consistent inappropriate high use of acute services.
- Workforce shortages across all areas, with providers unable to recruit enough staff to fill rotas and shifts, thereby relying on expensive agency staffing.
- Inadequate and fragmented community based provision and variable knowledge in primary care about children health and poor health literacy.

Rotherham Direction

The **children's plan** is based on the principle that every child should have access to high quality unscheduled care which is safe, effective and caring. To this end all providers are committed to design and deliver care which is local and responsive to the needs of the local children, parent and carers.

Our ambition is to provide care closer to home in close partnership with the primary care team community and social services thus 'making care closer to home a reality'.

A significant number of these consultations could be managed through effective and efficient community services delivered by multi-professional collaborative teams working in close proximity with primary care. We envisage 3 hubs within Rotherham encompassing the 0-19 year service.

The benefits for the parent and child are:

- Easier access to services
- Earlier identification and resolution
- Faster co-ordinated and appropriate response
- One assessment, planning and evaluation
- Better service experience

Each hub will comprise:

- GPs with special interest and expertise in child health working at the front line with a team of paediatricians, mental health professionals, nurses, and Allied Health Professionals
- Community acute nursing team supporting earlier discharge and home/outpatient support
- Rapid access clinics for urgent specialist help
- A 24-hour hotline for healthcare professionals to speak with a Consultant
- Specialist paediatricians holding clinics on site. These may be rotational for specialist clinic (Rapid Access Centre, Safeguarding, Constipation/enuresis, Sleep disorders, General and specialist clinics)

The acute hospital will deliver ambulatory care through a short-stay assessment unit with pathways to transfer to tertiary care if required through the managed acute clinical network.

Better Births aims to increase personalisation of care, "centred around individual needs and circumstances". There is a strong focus upon personalised care and choice of provision, with this recognised as a route to improved safety ("Safe care is personalised care"). Continuity of care is an integral part of the approach.

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

This would involve strengthening provision for:

- Home births
- Group midwifery / Midwife Led Unit births
- Births in other community settings in the future (family hubs)

For women who begin on higher risk pathways, there will be consultant-led obstetric care, although there will be named midwife contact throughout and a process of ongoing assessment and monitoring which will enable women to transfer to the lower risk pathway choice and flexibility to all women, with personalised plans throughout enabling an ongoing dialogue around education and prevention. Our aim is to maximise choice and support whilst minimising clinically unnecessary interventions.

Midwifery-led provision would increase, whilst we are also working to consolidate and secure consultant-led obstetric care, making the best use of our scarce obstetrician resources.

We will:

- Ensure that every woman has a personalised care plan with their midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses.
- Reorganise midwifery staffing rotas into smaller teams as identified in 'Better Births' to ensure all midwifery teams have an identified obstetrician who can get to know and understand their service and advise on issues as appropriate.
- Work to offer the three choices of maternity care provision recommended in Better Births, with consideration to be given to a fourth choice (community hubs) on a regional footprint to expand choice for women.

10.2.5 Mental Health & Learning Disability

STP Challenge
- Approximately 25% of the population experiences some kind of mental health problem in any one year.
- People with severe mental illness can lose 20 years of life.
- Co-morbid mental health problems raise total health care costs by at least 45% for each person with an additional long-term condition.
- These challenges are compounded by a stigma that exists around mental health and learning disabilities, and the lack of parity of esteem with physical health services.

Rotherham Direction

The Rotherham Place Plan has developed a clear strategy for improving Mental Health (including Child and Adolescent Mental Health Services) and Learning Disability provision across the borough. We have detailed our strategy within the CCG's commissioning plan. Rotherham mental health services are working closely with primary care colleagues to identify and meet the needs of people's physical healthcare alongside their mental health. Delivering transforming care partnership plans with local authority partners in order to enhance community provision for people with a learning disability and/or autism and improving access to healthcare within this patient group are key to closing the gaps.

The Rotherham Place Plan will continue to prioritise joint working with partners across South Yorkshire to reduce the reliance on bed based provision for people with learning disabilities. Mental Health Liaison services should be available 24/7 across the STP footprint as should mental health crisis care, in line with the local crisis care concordats. Within our place plan we articulate the current work taking place in Rotherham with regard to Liaison Psychiatry and we will share any learning with our system wide partners.

Early Intervention in Psychosis and Improving Access to Psychological Therapies (IAPT) access and waiting times are a key priority for Rotherham and are in line with the NHS Planning Guidance (2016) which asks for an increase from 15-19% people accessing psychological therapies and 53% of first episode psychosis patients accessing treatment within two weeks of referral. More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Child and Adolescent Mental Health IAPT by 2018. Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.

11 Risk

The following lists the key high level risks affecting the Place Plan and its implementation.

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

Red	Significant Risk	**Orange**	Of concern	**Yellow**	Of some concern