Progress Report

Locality Working

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Place Plan Priorities

1. Integrated Point of Contact
2. Integrated Discharge Team
3. Intermediate Care and Reablement
4. Integrated Rapid Response
5. Integrated Localities
6. Integrated Care Home Support

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What have we learned about Locality Working?

- The Health Village Pilot was a great start
- There is evidence of a positive impact on emergency admissions from locality working.
- All localities saw an **increase of 0.7%** in emergency admissions between 15/16 to 16/17, excluding the health village. The **health village saw a 2.1% decrease** however between these periods.
- All localities excluding the health village, seeing a **3.5% and 11% increase in 65+ and 85+ respectively**. Emergency admissions from the health village locality however saw lower increases, **1.8% (65+) and 9.6% (85+).**

How will Integrated Locality working look?

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The Emerging Model

- Re-alignment of GP practices across 7 Localities
- Localities split into 3 partnership areas
- Community Nursing working directly into 7 Localities
- Adult Social Care and Community Health Teams (inc Mental Health) working across 3 partnerships North, Central and South
- Information sharing via Rotherham Health Record
- Integrated Management (Partnership level)
- Integrated MDT approach

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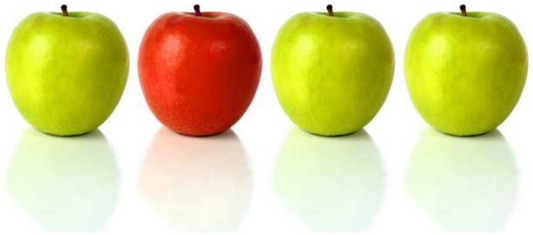
What Will Be Different

- Develop a joint culture of prevention
- 'Blurring' of professional boundaries
- Develop new ways of supporting Primary Care
- Enhanced Social Care Assessment and Care management
- Management of Long term Conditions
- Focus on the needs of Physical and Mental Health
- Work into hospital based services to reduce LOS
- Improved opportunities for post discharge follow up



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Joint Outcomes Framework

No.	Description	Strategic Relevance		Trajectory
		Health	Social Service	
1	Average cost of care home package		✓	↓
2	Total cost of home care to RMBC		✓	↓
3	No. of new home care packages commissioned		✓	↓
4	No. of adult social care customers / 10k population		✓	↓
5	No. of residential / nursing placements per 100k population		✓	↓
6	% on supported discharge who enter long term care		✓	↓
7	Total weekly adult care spend	✓	✓	↓
8	Admissions to intermediate care beds	✓	✓	↓
9	No. of home based reablement packages commissioned		✓	↑
10	Admissions into hospital	✓		↓
11	Admissions from care homes	✓		↓
12	Total number of non-elective bed days	✓		↓

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Timelines and Implementation

0 to 6 Months	6 to 24 months	> 24 months
• Teams aligned / co-located • Baselines agreed • Outcome framework agreed • Joint case-loads developed • Ways of working outlined • Team configuration defined • Leadership team in place • 1 Partnership / 2-3 localities model 'operational'	• Pooled budget principles agreed • Outcomes being 'realised' • Outlying performance addressed • Transition model (Phase 3) being defined • 3 Partnerships / 7 localities 'operational'	• New models and transition defined • Organisational alignment clear • Integration of teams • Pooled budgets and investment