Rotherham's Integrated Health and Social Care Place Plan

5 September 2018

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1 Introduction

1.1 Rotherham Partners' commitment

The Rotherham's Health and Social Care Community has been working in a collaborative way for many years to transform the way it cares for and achieves a positive change for its population of 261,000. Our successful 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. Only through working together can we provide sustainable services over the long term that aim to help all Rotherham people live well for longer.

Rotherham Partners' recognise that to realise our ambition and the necessary scale of transformation, we need to act as one voice with a single vision and a single Plan to deliver the 'Best for Rotherham'. Our shared vision is:

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

This plan updates our first Rotherham Integrated Health and Social Care (IH&SC) Place Plan, developed in November 2016, and closely aligns to the new Rotherham Health and Wellbeing Strategy. It describes our achievements to date, future strategic intent and how the relationships between the health and social care community have successfully matured to move us forward at pace within the Rotherham place.

The Plan is intended to work as a catalyst to deliver sustainable, effective and efficient health and care support and community services with significant improvements underpinned by collaborative working through the development of the Rotherham Integrated Care Partnership (ICP). Partners are fully committed to working together to make decisions on a best for Rotherham basis to achieve the transformations set out in this Plan. This is underpinned by robust governance arrangements and the 'Rotherham Agreement', a document that captures how we work together, developed and endorsed by all partners.

1.2 Rotherham Culture and leadership

The Rotherham Place strong, experienced and cohesive executive leadership team sets clear expectations and the spirit of collaboration and inclusiveness across the Rotherham ICP with the key aim of driving forward the transformation set out within this plan. It sets a high standard of integrity amongst leaders across all partners, and a culture of empowering and engaging with all staff.

To realise our vision we want everyone who works or lives in Rotherham– patients, people, families – to work together for a better Rotherham, to establish an individual and collective widespread aspiration for improved health and social care.

The Rotherham culture means that staff are confident to challenge and change things that are not right to improve services for people, aligning to the vision and principles within this plan. A key strength in Rotherham is the trust and openness between partners and their shared vision.

"Culture eats strategy for breakfast" is a well- known management phrase – we can create a first class strategy, but the hard part is its implementation and achieving the goals it sets. This can only be done by winning the hearts and minds of our staff and through adapting to diverse approaches and styles and building mutual benefit. This updated Plan therefore focusses, quite rightly, on how we will support and develop the systems workforce.

As well as a shared vision, Rotherham partners have agreed a shared set of principles by which we work to achieve our vision for Rotherham:

1. Focus on people and places rather than organisations, pulling pathways together and integrating them around people's homes and localities; we will adopt a way of working which promotes continuous engagement with and involvement of local people to inform this.
2. Actively encourage prevention, self –management and early intervention to promote independence and support recovery, and be fair to ensure that all the people of Rotherham can have timely access to the support they require to retain independence.
3. Design pathways together and collaborate, agreeing how we do pathways once collectively, to make our current and future services work better.
4. Be innovative, using international evidence and proven best practice to shape our pathways to achieve the best outcomes for people in the most cost effective way.
5. Strive for the best quality services based on the outcomes we want within the resource available.
6. Be financially sustainable and this must be secured through our plans and pathway reform.
7. Align relevant health and social care budgets together so we can buy health, care and support services once for a place in a joined up way.

1.3 Rotherham Success

We are proud that through collaboration, we have had significant success in moving forward the priorities within the 2016 Place Plan, examples include:

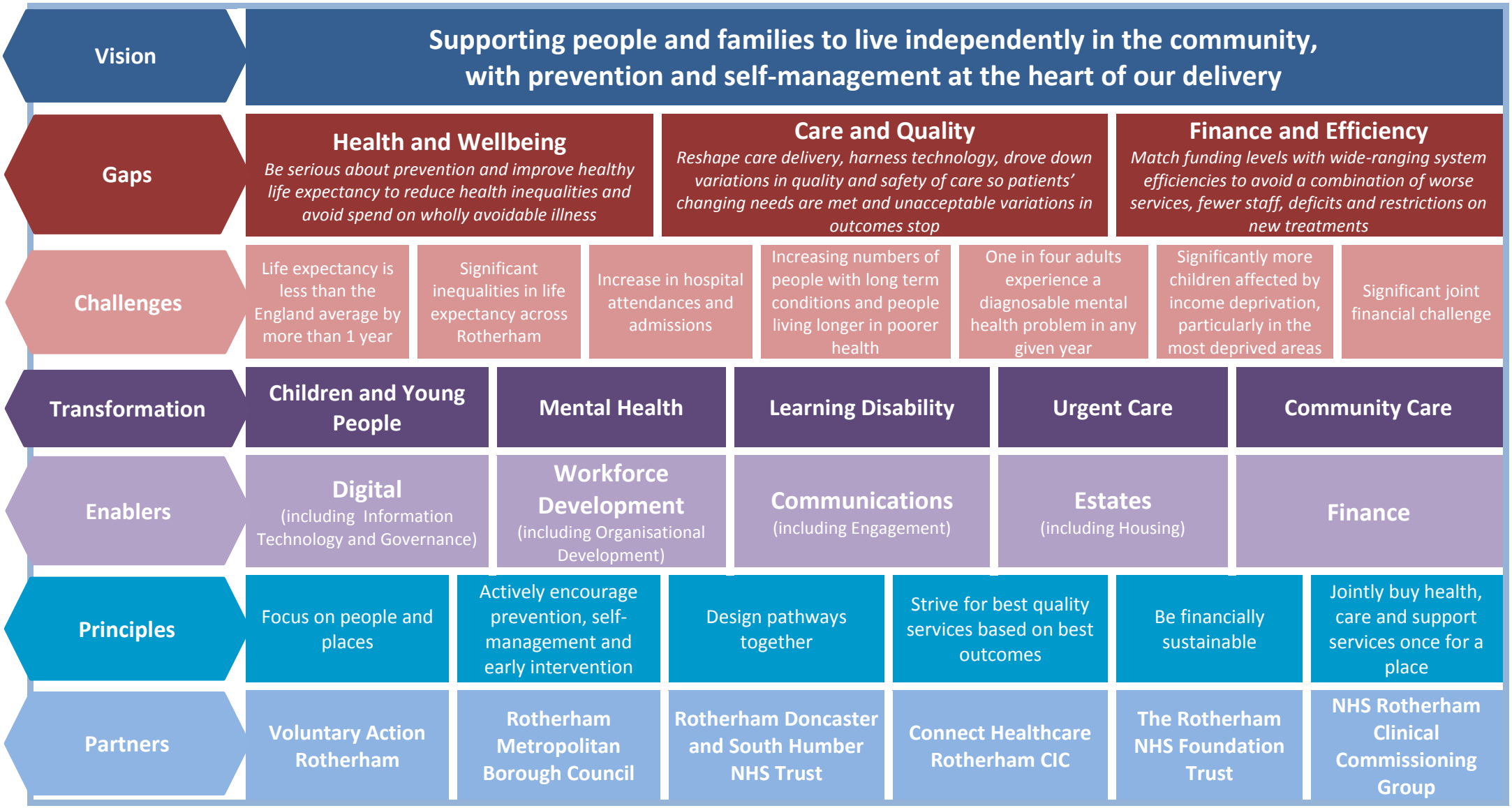
- The new state of the art, £15m, **Urgent and Emergency Care Centre** was successfully opened, delivering an innovative integrated model to improve co-ordination and delivery of urgent care provision.
- The new dementia friendly **Ferns Ward** was piloted, providing integrated specialist mental and physical health care expertise for The Rotherham NHS Foundation Trust (TRFT) patients who are physically well enough to be discharged from the acute setting, but are not yet well enough to be discharged home or to residential care due to a cognitive impairment.
- Implemented the **Rotherham Health Record**, enabling health and care workers to access patient information to make clinical decisions. Already used by TRFT (acute and community), it was rolled out to the Rotherham Hospice and some GP practices. An information sharing agreement has been agreed which will enable Rotherham Doncaster and South Humber NHS Trust (RDaSH) and Rotherham Metropolitan Borough Council (RMBC) social care to come on board during 2018/19.
- Continued success of the award winning **Social Prescribing Service** which helps adults over the age of 18 with long term health conditions to improve their health and wellbeing by helping them to access community activities and services. During 2017 it was extended to **mental health patients** and is now used for autism and social isolation.
- Significant progress with **Child and Adolescent Mental Health Service**, extensive service change leading to substantial improvement in both assessment and treatment: the number of assessments within six weeks rose from 30% in September 2016 to 100% in November 2017; the number of people waiting less than eight weeks for treatment rose from 42% in September 2016 to 84% in November 2017.
- The **Integrated Locality Pilot** has been evaluated to inform the next stage of implementation, it will deliver an integrated commissioning and operating model for community services, with joint leadership and accountability.

- A key enabler for the improvements seen in **Delayed Transfers of Care** (from 6.2% to 2.5%), was the integration and co-location of TRFT Transfer of Care Team and RMBC Hospital Social Work team to form the **Integrated Discharge Team.**
- Successful embedding of an **occupational therapy** offer within the RMBC **Single Point of Access Team,** has been complemented by the piloting of a member of staff from the mental health trust, voluntary sector and input from physical health.

These achievements have been enabled through:

- **Clear leadership and strong relationships -** The Rotherham ICP Weekly Executive meeting, established April 2016, is attended by Chief Executive Officers from all partners within the ICP, along with other senior officers. It has strengthened existing excellent relationships, provided clear leadership and ambition for place transformation and set the spirit and culture by which partners work together to achieve the best for Rotherham.
- **Robust governance and wider partnership engagement** has informed the robust structure to implement the Place Plan. We have:
  - convened the ICP Place Board, which reports to the Rotherham Health and Wellbeing Board.
  - created the Rotherham ICP Delivery Team, which reports to the Place Board and into our transformational workstreams.
  - consolidated our five transformational workstreams into three transformational groups; Children and Young People, Mental Health and Learning Disability; and Urgent and Community.
  - created a compelling and shared case for change for each of the transformational groups, aligned to the Place Plan.
  - identified a number of enablers: Digital, Workforce, Communications, Estates and Finance and have started to deliver programmes of work aligned with them.

1.4 Plan on a page



2 Local Context

2.1 Health and Wellbeing

The Health and Wellbeing (H&WB) Board is a statutory sub-committee of the Council. Locally, it is the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing. It aims to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The third H&WB Strategy for Rotherham was produced in March 2018, it sets the strategic vision for health and social care and improving health and wellbeing outcomes for local people. The role of the H&WB Board is to oversee its implementation and to take action where needed to remove blockages, identify gaps and to hold organisations, worksteams and strategy leads to account for delivery; ensuring opportunities for improving health and wellbeing are maximised.

The H&WB Strategy includes four aims which the H&WB Board have agreed are the most important things to focus on to improve health and wellbeing outcomes for all Rotherham people, and that can be best tackled by a 'whole system' approach:

- **Aim 1:** All children get the best start in life and go on to achieve their potential
- **Aim 2:** All Rotherham people enjoy the best possible mental health and wellbeing and have a good quality of life
- **Aim 3:** All Rotherham people live well for longer
- **Aim 4:** All Rotherham people live in healthy, safe and resilient communities

2.2 Rotherham Place Plan

The second Rotherham IH&SC Place Plan has been refreshed so that it closely aligns to the revised H&WB Strategy and will be the delivery mechanism for the health and social care elements of the H&WB Strategy.

The transformation approach has been to identify five closely interlinked transformational workstreams to maximise the value of our collective action and transform our health and care system so that we can reduce demand for acute services, achieve clinical and financial sustainability and thus close the three gaps. These five transformational workstreams align to the H&WB Strategy and will underpin its delivery:

- Children and Young People
- Mental Health
- Learning Disabilities
- Urgent Care
- Community Care

The transformational workstreams will be taken forward through three transformational groups, and will report through the ICP Delivery Team to the ICP Place Board. Existing mechanisms have been used so as not to duplicate any work within the system, the three transformational groups are; Children and Young People, Mental Health and Learning Disabilities and Urgent and Community Care.

Each of the three transformation groups have agreed a set of priorities that they will take forward over the next two years. These priorities are areas that will make the most impact if addressed collectively across health and social care. The transformational priorities are listed below and section 5 provides detail for each of these.

Children and Young People

1. Implementation of CAMHS Transformation Plan
2. Maternity and Better Birth
3. Oversee delivery of the 0-19 healthy child pathway services
4. Children's Acute and Community Integration
5. Special Educational Needs and Disability (SEND) – Journey to Excellence
6. Implement' Signs of Safety' for Children and Young People across partner organisations.
7. Transitions

Mental Health and Learning Disability

1. Deliver improved outcomes and performance in the Improving Access to Psychological Therapies service
2. Improve dementia diagnosis and support
3. Deliver CORE 24 standards for mental health liaison services
4. Transform the service at Woodlands 'Ferns' Ward
5. Improve Community Crisis Response and intervention for mental health
6. Better Mental Health for All Strategy
7. Oversee Delivery of Learning Disability Transforming Care
8. Support the implementation of the 'My Front Door' Learning Disability Strategy
9. Support the Development and Delivery of Autism Strategy

Urgent and Community

1. Creation of an Integrated Point of Contact for care needs across Rotherham
2. Expansion of the Integrated Rapid Response service
3. Development of an integrated health and social care team to support the discharge of people out of hospital.
4. Implementation of integrated locality model across Rotherham.
5. Develop a reablement and Intermediate Care offer
6. Develop a coordinated approach to care home support.

Our collective approach to Place Plan delivery allows a 'Golden Thread' from our 'Health and Well Being' strategy aims through to the transformational group delivery. We fully acknowledge that each of the transformation groups have identified priorities which cross cut between groups, we manage this through the ICP Delivery Team.

2.3 National Expectations

The NHS Five Year Forward View set out a clear goal that *"the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care".* It places integrated, holistic person-centred support at the heart of health and care systems, breaking down barriers to the traditional divides, further developing out of hospital services and fostering community resilience. With the aim that people and families can be better supported, services provided closer to home and demand for hospital services can be reduced.

The Five Year Forward View identifies three widening gaps; health and wellbeing, care and quality and finance and efficiency. These gaps resonate with the challenges faced at a Rotherham Place level, see section 3.4.

The Care Act 2014 sets out in one place, local authorities' duties in relation to assessing people's needs and their eligibility for publicly funded care and support. Under the Care Act 2014, local authorities must:

- carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care
- focus the assessment on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve
- involve the person in the assessment and, where appropriate, their carer or someone else they nominate
- provide access to an independent advocate to support the person's involvement in the assessment if required
- consider other things besides care services that can contribute to the desired outcomes (e.g. preventive services, community support)
- use the new national minimum threshold to judge eligibility for publicly funded care and support.

The Integrated Communities Strategy Green Paper invited views on the government's vision for building strong integrated communities where people – whatever their background – live, work, learn and socialise together, based on shared rights, responsibilities and opportunities.

The green paper sets out an ambitious programme of actions to deliver the vision at a local and national level. The consultation ended 5 June, and feedback is being analysed. The key proposals are to:

1. Strengthening Leadership
2. Supporting New Migrants and Resident Communities
3. Education and Young People
4. Boosting English Language
5. Places and Community
6. Increasing Economic Opportunity
7. Rights and Freedoms

The Place Plan will continue to drive the integration of health and social care in Rotherham.

2.4 South Yorkshire and Bassetlaw (SY&B)

Delivering the Five Year Forward View announced the requirement to develop Sustainability and Transformation Plans, where local leaders were asked to come together to develop a shared vision and plan for the future of health and care services in their area. The next step was for NHS organisations in partnership with local councils to form Sustainability and Transformation Partnerships (STPs) to continue to build on the collaborative work with the aim to improve health and care by looking at the needs of a whole population and not just those of individual organisations. Of the 44 STPS across England, nine were chosen to work towards becoming an Integrated Care System (ICS). An ICS can choose to take on collective responsibility for resources and population health, and in return get far more control and freedom over their health system. SY&B ICS was chosen of one of the nine.

Commissioning will be undertaken in accordance with statutory responsibilities at locality level or when it is most appropriate, by commissioners collaborating at South Yorkshire and Bassetlaw level through joint strategic commissioning arrangements and part of a regional function.

The SY&B ICS is made up of 25 health and care partners from across the region and its plan is based on the five 'places' within SY&B – Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield. The five place plans are the foundation of what will be delivered in each area. Planning and delivery at an overarching ICS level must be coordinated with planning and delivery at a local Place level, as they represent different elements of the same system.

The SY&B ICS has eight priority areas of focus:

- Healthy lives, living well and prevention
- Primary and community care
- Mental health and learning disabilities
- Urgent and emergency care
- Elective and diagnostic services
- Children and maternity services
- Cancer
- Spreading best practice and collaborating on support office functions

2.5 Primary Care

In 2017/18, general practice provided over 1.5 million appointments in Rotherham. General practice is essential to Place Plan delivery and is undergoing significant change. The key priorities for Rotherham, from the GP Forward View, are:

- **Implemented extended access** – Rotherham already provides 7 day extended access for the whole population and the number of hours available will increase significantly from October 2018 to support accessibility for the working population and also avoid wherever possible primary care attendance at the Urgent and Emergency Care Centre.
- **Implementing a quality contract for general practice** – this consists of 13 standards with key delivery requirements to provide a consistent primary care offer across Rotherham e.g. all GP urgent appointments to be seen within 1 working day and routine appointments within 5 working days.
- **Every practice undertaking productive general practice** – this is a support programme which NHS England are funding to develop practices to undertake LEAN techniques and review elements of practice e.g. front/back office, planning and scheduling.
- **Developing the primary care workforce** – working with practices to consider alternative roles and support the training of new primary care practitioners e.g. clinical pharmacists, newly qualified nurses, student nurses, apprentices, care navigators. Care navigators are now in place across 29 practices ensuring patients are navigated to the most appropriate service or clinician. In August, Physiotherapy First will be rolled out for the 10 pilot practices to all 29 who have care navigators in place and will enable patients with musculo- skeletal issues to be assessed more quickly by an experienced physiotherapist, it is envisaged that this will release GP and nurse capacity in practices by at least 10% improving access for other conditions.
- **Continuing to develop the Federation arrangements in Rotherham to strengthen general practice** – Rotherham now has a Community Interest Company, Connect Healthcare which consists of all 30 practices.
- **Roll-out of telehealth and other IT to support general practice capacity –** Telehealth has been rolled out to 29 practices and evaluated well for releasing capacity, reducing DNA (Did not attends), improving patient experience and reducing administrative costs. Remote consultation equipment has also been provided to all practices to enable both clinicians and patients to connect. Work is also ongoing in relation to a Rotherham Application to enable patients to

book and cancel appointments, receive self-care advice and information from their practices, access extended access appointments directly all from their smart phone or computer. The Rotherham Application has been commissioned on the basis that it can be developed further to incorporate secondary care and the wider place for example single point of access in RMBC.

- ***GP Case Management*** **-** The CCG will continue to expand the GP led, multidisciplinary, case management of patients in Rotherham at highest risk of admission to hospital through the continuation and expansion of the GP Case management programme. This includes maximising the visibility of case management plans to other clinicians. We already target the top 5% of people at risk of hospitalisation using risk stratification and GP judgement and we intend to work with our localities to utilise the tools available to us to ensure we are supporting the right cohort of patients collectively as an integrated system.

2.6 Planned Care

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.

2.7 How the Place Plan was developed

Rotherham's Place Plan details our joined up approach to delivering key initiatives that will help achieve the Rotherham Health and Wellbeing Strategy. All services should be provided as close to the patient as possible, the only reason for services being provided outside Rotherham is where there is a compelling reason of clinical safety or improved patient experience. Providing the right care in the right place will mean that more people will receive care closer to their home.

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.

The H&WB Board sets the strategic vision for health and social care in Rotherham and has refreshed its strategy in 2017/18. The IH&SC Place Plan is the delivery mechanism for the health and social care aims of the H&WB Strategy.

To underpin the delivery of the Place Plan, Rotherham ICP partners have collectively worked towards an agreed governance structure and have agreed a shared vision and set of principles by which the Rotherham ICP partners will work for the best for Rotherham approach. Further information can be found in section 4.5 of this Plan.

The Place Plan does not replace partners' individual plans but rather builds upon them identifying areas where we can do more together. It uses insights from the H&WB Strategy and the JSNA. The Plan also takes account of other key relevant documents:

- The Five Year Forward View
- Delivering the Five Year Forward View
- The Five Year Forward View for Mental Health
- Next Steps on the Five Year Forward View
- General Practice Forward View
- South Yorkshire and Bassetlaw Sustainability and Transformation Plan

3 Achieving our Aspirations

3.1 A snapshot of Rotherham

A Rotherham pen-picture:

- Rotherham is a borough covering 110 square miles.
- It has a population of 260,800 mostly living in urban areas, equating to 108 thousand households.
- It is also made up of many towns, villages and suburbs which form a wide range of geographic communities.
- Of the 260,800 population there are 50,000 children aged 0-15 and 27,300 young people aged 16-24.
- The population is ageing, with 64,600 people aged over 60, 21,800 are aged over 75 and 5,800 over 85 with an additional 1,000 over 85s expected by 2021.
- Rotherham has a diverse community which includes 20,000 people from minority ethnic groups (8.1%). The largest communities are Pakistani/Kashmiri and Slovak/Czech Roma.
- Rotherham has a wealth of green space across the borough, in the form of country and urban parks, nature reserves, woodlands and playing fields. Although used well in some areas, others offer an often untapped resource within communities.
- Rotherham has 94 primary schools, 16 secondary schools and 6 special schools.
- GCSE performance is above the national average, but the performance of children from Rotherhams poorer families compares unfavourably with the national averages on many educational attainment measures.
- The borough benefits from a vibrant voluntary and community sector (VCS), comprising almost 1,400 organisations with 3,600 staff and around 49,000 volunteer roles. It is estimated that the paid VCS workforce contributes £99m to the economy per annum and that volunteers provide approximately 85,000 hours of time per week.
- The average income is below national average and the average house price is six times the average income level, pricing a large proportion of the population out of home ownership and leaving them reliant on social or private rented housing.
- 11.4% of homes are in fuel poverty with localised rates up to 32%
- Rotherham needs to build 900 new homes per year to meet local need, we are currently not meeting this target which results in people living in accommodation that doesn't meet their current needs; which is either overcrowded, unaffordable, unsafe which in turn contributes to poor health.
- 8,214 people in Rotherham are entitled to Carers Allowance with 5,627 receiving the payment due to their role as a carer
- 70 businesses signed up as Rotherham pioneers; McLaren signed a 20 year deal to be based at the Advanced Manufacturing Park
- The Town Centre Masterplan has been agreed which includes; development of Forge Island as a major leisure destination including a new cinema, hotel, food and drink and potentially a new theatre; more than 350 high quality riverside homes; a new higher education development at Doncaster Gate scheduled to open in September 2018 and a refurbished bus interchange and multi-storey car park.

Local health and social care services:

14 nursing/residential homes	**One lead body for voluntary and community sector**	**31 GP practices**
One local authority	**261,000 population**	**One Clinical Commissioning Group**
One hospital (acute and community)		**One GP Federation**
One ambulance provider	**One mental health provider**	**One Hospice**

3.2 A snapshot of our population – Joint Strategic Needs Assessment

The H&WB Board is responsible for producing the JSNA and all members participate in the process. The JSNA is a public repository and summary of information from a wide range of sources relevant to health and wellbeing in Rotherham. It extracts available evidence of need into a series of answers to the following three questions for each issue or subject area covered: Why is this an issue? , What is the local picture? , What is the trend and what can we predict will happen over time? The JSNA is used in the development of commissioning and service planning for health and social care services in Rotherham.

It is good to highlight that whilst we have significant challenges we also have **significant successes**:

- Performance for children achieving a good level of development at the early years foundation stage (up to age 5) is above the national average.
- In the town centre, recent transformation work was recognised with an award in the town centre category of the Great British High Street Awards.
- Pre-recession (2007) workplace jobs in Rotherham reached a high of 104,100 but by 2012 this had fallen to 91,900, a fall of 12,200 (-11.7%). By 2016 job numbers reached 104,000 - a return to pre-recession levels.
- There are 6,810 VAT registered businesses in Rotherham, with the figure increasing by over 6% in 2016.
- Rotherham has a £4.3 billion a year economy and was a top performer in 2017 staying at the top of the UK Powerhouse rankings for gross value added (GVA) growth. GVA is predicted to be 1.3% higher at the end of 2018 compared to the end of 2017 and, looking further ahead to 2028, the researchers put Rotherham's GVA at £4.8 billion.
- From 2013 to 2016, Rotherham children have achieved better than national for a 'good level of development' (GLD), with an upward trajectory each year.
- There are less 16 to 18 year olds in Rotherham who are not in employment, education or training compared to national and statistical neighbours
- GCSE achievement are better than national averages.
- More people are having routine vaccinations and cancer screening in Rotherham than the national average.

- The rate of under 18 conceptions in the borough has more than halved in the last 10 years but is still above the England average.
- The rate of emergency hospital admissions due to injuries from falls in the elderly has decreased by a third in the past 5 years.
- The percentage of alcohol users who successfully complete treatment has increased and is now higher than England average.
- Mortality rates have reduced, in particular infant mortality and premature deaths from cancer.

However, some of our significant challenges, as shown in the JSNA are:

The health of people in Rotherham is generally poorer than the England average	Deprivation in Rotherham is amongst the highest 20% in England, 45% of the population live in one of the 30% most deprived SOAs in England	The gap in life expectancy between the most and least deprived parts of Rotherham for males is 10.9 years and females is 7.1 years - there is a direct correlation between social care needs and deprivation	71.2% of adults in Rotherham were overweight or obese in 2015/16, worse than the 61.3% average for England	22.2% of children leaving primary school are obese, above the national average
Life expectancy in Rotherham is lower compared to the national average by 1.7 years for males and 1.6 years for females and is 9 years lower for men and 7 years lower for women in the most deprived areas of Rotherham compared to the most affluent areas	9.4% of working age people in Rotherham are claiming long term sickness or disability-related benefits	Significantly more Rotherham children are affected by income deprivation 24.3%, compared to 19.9% nationally. This rises to 50% for children living in our ten most deprived areas	Rotherham's breastfeeding initiation rate is amongst the lowest in the region at 56.0%, contributing to levels of childhood obesity and paediatric hospital admissions	922 people aged 15-64 in Rotherham were newly diagnosed with a sexually transmitted infection in 2017, the rate being below the national average
Men in Rotherham will live 18 years of their lives with at least one long term health condition and women will live 26 years with at least one long term health condition	30% of the Rotherham population are estimated to drink at a level that puts their health at risk (14 units per week) and the rate of alcohol-related harm hospital stays is worse than the average for England	Half of people aged 75 years and over live alone and most experience loneliness, especially those who are widowed	Almost 500 smoking related deaths each year in Rotherham – 22% higher than the England average	Early deaths from cancer, heart disease and stroke have fallen, but remain worse than the England average
Mental health problems affect one in four people at some point each year	3.1% of 16-18 year olds in Rotherham are not in employment, education or training, higher than the 2.8% nationally	An estimated 18.3% of Rotherham adults smoke, above the national average of 15.5% and 17.1% of mothers smoke during pregnancy contributing to increased risk of stillbirth, low birth weight and neonatal deaths	There are about 6,550 Potential Years of Life Lost each year in Rotherham through causes considered amenable to healthcare, this is around 1,400 years more than might be expected based on the England average	The number of older people is increasing, especially in the oldest age groups, and people will live longer with poorer health

3.3 The Case for Change

The JSNA clearly tells us that we have significant challenges to address. In the coming years we anticipate growing pressures across a range of services. This will include not only health and social care but also supported housing, informal care and other services. We expect these pressures because of a range of factors, including:

- The health of Rotherham people is generally poorer than the English average
- Life expectancy in Rotherham is poorer compared to the National average and Rotherham has significant inequalities in life expectancy across the borough linked to deprivation
- Significantly more children are affected by income deprivation, particularly in our ten most deprived areas
- Increasingly people are living with multiple long term conditions at an earlier age, this is a significant driver of complex health and social care interventions
- We have a growing population and will see a significant increase in the 85+ population
- Mental health issues are impacting more significantly on people in Rotherham than the nationally recognised issue

These challenges for Rotherham resonate with the three national gaps, described further in section 3.4:

- **Health and Wellbeing** – a major cause of ill health and premature death is due to diseases that could be prevented by living healthier lives. We need to get serious about prevention and improve healthy life expectancy to reduce health inequalities and avoid spend on wholly avoidable illness.
- **Care and Quality** – there are variations in the quality of care received and differences in how services are delivered and the outcomes received. Partners need to work together to reshape care delivery, harness technology, drive down unwarranted variations in quality and safety of care so patients' changing needs are met and unacceptable variations in outcomes stop.
- **Finance and Efficiency** – the forecast is for demand for services to rise. We need to manage demand by supporting people to be healthy, increase productivity and efficiency to maximise available resources and redesign services to develop new ways of delivering joined up care. By matching funding levels with wide-ranging system efficiencies we will avoid a combination of worse services, fewer staff, deficits and restrictions on new treatments

We still, however, all want health and care services that can meet our needs now and in the future. Rotherham Partners aim to offer safe, compassionate and high-quality care, however, the challenges we face mean that we need to change the way we work to improve care and get better value for the money we have available.

As our population grows, and more people live with more long-term conditions, the demands on our services are changing and increasing. Current services are not necessarily designed for todays or future needs, and it is increasingly harder to keep up with rising costs. In the past 10 years, the number of people aged 65 and over in England has increased by 1.4 million, a 17% rise and the number of people reaching their 80th birthday has increased by 17%. These people are more likely to be living with complicated conditions that mean they need support. We need to make the most of opportunities to improve health and wellbeing, prevent illness and support people to manage existing conditions and stay independent.

Rotherham Partners have come together to commission and provide services. By working together can we transform the way we work and improve the health and wellbeing of our population, further and at pace.

Our vision is to put local people at the heart of services, helping people to stay well and independent in their own homes and communities and avoid being admitted to hospital, we want to:

- improve the health and wellbeing of local people
- deliver high-quality, joined-up health and social care
- offer access to the right care and support in the right place, at the right time
- ensure staff are able to continue to deliver the caring ethos of the NHS and social care
- better meet people's needs within existing funding
- build health and care services that are sustainable for years to come

The transformational workstreams - children and young people, mental health, learning disabilities, urgent and emergency care - aim to address both the challenges for Rotherham and close the three gaps - health and wellbeing, care and quality and finance and efficiency. Below is a synopsis of each tranformational workstream and in section 5 we provide further detail. In addition, we have identified a set of enabling workstreams to underpin delivery, these are described in section 4.

3.3.1 Children and Young People

The number of children and young people under 18 in Rotherham is slightly above the English average. The number of Children in Need, Looked After Children and children subject to Child Protection Plans in Rotherham are all above average. The social care needs for children and young people are clearly rising.

Keeping children safe is only possible if we work together effectively across organisational boundaries. Strong partnership working is a way to support children to thrive and achieve positive outcomes in all aspects of their lives. Each of our priorities requires us to take partnership working to the next level, developing integrated pathways, joint commissioning arrangements and a shared view of our performance.

We are also determined that, throughout our work, the voice of the child will be loud, meaningful and embedded in our rationale and activity.

Each priority will focus on a distinct cohort of children whose needs and vulnerabilities require fully integrated pathways to enable them to achieve positive outcomes without the barriers of organisational silos or funding restrictions. Whilst the priorities are not necessarily part of a single integrated pathway, they are sometimes overlapping and interdependent.

Our aspiration is to put prevention and early intervention at the heart of what we do, and reduce the need for acute services that are more intrusive and traumatic for children and families and more costly to deliver. We will be accountable to each other and to children whose voice, individually and collectively, will guide our work.

3.3.2 Mental Health and Learning Disabilities

With advancement in identification, diagnostics and treatment for mental health services, as well as equality legislation and public awareness and understanding; there is a significant increase in demand for services. Mental health problems represent the largest single cause of disability in the UK, and suicide is now the leading cause of death for men aged 15-49. There is an explicit need to bring parity of provision between physical and mental health and to tackle the persisting stigma around mental illness and learning disabilities.

We have a higher rate of people with a learning disability in Rotherham, and the numbers are rising, leading to increased demand for services. We also we have a significant number of older carers who support people with a learning disability.

People with severe and prolonged mental illness are still at risk of dying on average 15 to 20 years earlier than other people. People in marginalised groups are at greater risk of developing mental health issues and receiving poorer outcomes.

We want to provide a better experience and better results. Services must change in order to provide the high quality services the people of Rotherham expect to meet their needs. Co-morbid mental health problems raise total health care costs by at least 45% for each person with an additional long-term condition. Too many people with mental health issues and learning disabilities are still receiving treatment and support in inpatient or residential facilities rather than in their communities, closer to home.

3.3.3 Urgent and Community Care

People are living longer, often with highly complex needs and multiple conditions that require ongoing management from both health and social care services. As the population ages and financial pressures increase, we need to be more proactive and preventative in our approach, providing services in the community that support independence for longer. Services need to work seamlessly together to; deliver better quality care; improve patient experience; improve clinical outcomes; and improve the health and care of local populations.

Only by exploiting the potential of integration and a drive for personalisation, can we create a resilient health and social care economy. Reform needs to happen at different levels – individuals, localities, partnership areas and borough wide.

The aggregation of a host of small scale projects is not enough, pace and large scale reform are the only options. We need a transformational reduction in demand for services across the health and social care system. This can only be achieved at scale through greater personal resilience, independence and well-being.

Our transformational priorities work together as a whole system approach to deliver a step change in how we deliver our services moving from a responsive, paternalistic approach to a proactive preventative integrated health and social care model which supports individuals to live as independently as possible in the community. Where people do need support it will be proportionate and joined up to make best use of limited resources and the emphasis will be on reablement, rehabilitation and recovery.

3.4 Addressing the three national gaps

The Five Year Forward View identifies three widening gaps; health and wellbeing, care and quality and finance and efficiency. These gaps resonate at a local level.

3.4.1 Better Health and Wellbeing

We aim to focus on prevention and improve healthy life expectancy to reduce health inequalities and avoid spend on wholly avoidable illness.

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. We want a culture in Rotherham where people feel empowered to be part of the decisions around their care and support, to maintain dignity and independence and drive their own care.

We will better meet the needs of local people by targeting individuals that can gain most benefit. We will do this through expanding our Social Prescribing service both for those at risk of hospitalisation and for mental health clients and through continued systematic use of Healthy Conversations (brief interventions) and advice by every statutory organisation using Making Every Contact Count (MECC). We will train 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.

In section 5 we detail further transformational priorities that will help us to achieve our aspirations for improved health and wellbeing for our population. This includes, such as; delivery of the 0-19 year old healthy child pathway, creation of a single point of contact for care needs across Rotherham and implementing a 24/7 adult mental health hospital liaison service, incorporating alcohol liaison.

These initiatives will allow 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.

3.4.2 Better Standards of Care and Quality

We aim to reshape care delivery, harness technology and drive down variations in quality and safety of care so patients' changing needs are met and unacceptable variations in outcomes stop.

We want health and care services that provide people with an alternative to entering services or having a hospital admission. We want to continue to support increased community care to improve patient outcomes, improve flow through the system and provide effective facilitated discharge, with a 'Home is Best' ethos.

We will continue to build on the progress so far , taking a more holistic and integrated approach across physical and mental health, social care and the voluntary and community sector in order to develop and embed an integrated model of care which supports individuals and their carers. We will use new technology to support the delivery of our key priorities.

In section 5 we detail further transformational priorities that will help us to achieve our aspirations for improved standards of care and quality for our population, such as; children's acute and community integration so that we can be responsive to needs, development of an integrated health and social care team to support

the discharge of people out of hospital and to further develop the Ferns facility for dementia patients who are physically well but need further support before they are well enough to go home.

These initiatives will increase quality and standards across the health and social care system, reduce hospital admissions and halt the rise in waiting times. We aim to provide equitable services to meet the needs of our population.

3.4.3 Better use of funds (spending the Rotherham £)

Collectively we spend in the order of £550m on Health and Adult Social Care and Children's Services in Rotherham.

System partners fully acknowledge that they are jointly responsible for ensuring the effective use of the available financial resource within the Rotherham place. Our 'place based' thinking and new ways of working is taking us beyond existing organisational boundaries for both the commissioning and delivery of provision. It is therefore not surprising that as we mature into our place base culture of working, we will increasingly make transparent financial decisions that not only support individual partners to be sustainable, but consider the impact on the wider place position.

Our commitment to working in partnership to best utilise the Rotherham £pound is strong. However we cannot under estimate the on-going significant financial challenge facing individual place partners within our system. The CCG, although in current (April 18) financial balance, has an identified £15m efficiency target in 2018/19, and expects the efficiency requirement to remain challenging beyond 2018/19. RMBC overspent by £11.8m on Adult and Children and Young People's services in 2017/18 and has new savings of £5.6m in 2018/19 identified in those services. In total therefore, RMBC needs to reduce its spend in 2018/19 on Adult Social Care and Children's Services by £17.4m and further significant cost reductions are required beyond 2018/19. In 2018/19 TRFT is operating to a financial plan of deficit £20.3m. RDaSH is operating to a financial plan of surplus £2m.

Given the respective financial positions of partners, we will need to continue to make difficult financial decisions within our Rotherham Place. Of increasing importance is that we do this wherever possible collectively, ensuring that we mitigate any impact on other place partners. Our aspiration is to have in place aligned financial strategy for the place for 2019/20 and beyond.

4 Enabling Workstreams

4.1 Workforce Development

People are key to delivering our vision – the people of Rotherham and our combined workforce. We want to support our workforce to think differently to help create a future system model that will work for them and for Rotherham people.

We know our workforce is our biggest asset, however we also know that alongside finance, workforce is our biggest challenge. Securing the workforce, both home grown and recruited from overseas, to deliver the healthcare services that are required by patients has been earmarked as one of three "major NHS challenges". Pay, staffing shortages and a surge in agency spending is a national issue which needs to be addressed alongside the capacity to deliver of high-quality and safe care, keep a grip on national targets and the added complexity of new commitments to seven-day working and easier access to GPs.

Place partners know that we need to invest in our workforce, not just in terms of changing roles to meet our place plan objectives, but also in organisational development to change behaviours and cultures at all levels. A skilled and experienced workforce, working within the right environment and culture is key to delivery. In our first Place Plan we were maturing as a system and our reference to the need to develop our workforce collectively across the Rotherham Place was understated.

As we move forward in our Place base working, aligning and integrating our system over time, we know there is a stronger need than ever to focus on our workforce, we need to build on the existing excellent work in areas such as Urgent Care, Mental Health and Integrated discharge and Joint Commissioning. We need to be proactive in changing behaviours at all levels across our place , which in turn will change our culture towards one of 'Place first, organisation second'.

4.1.1 Organisational Development

As a system we have spent time reflecting on models of international best practice with regard to organisation development, we acknowledge we need to adopt one framework that all partners will accept, adopt and own within each of their own organisations . The model of organisational development identified therefore is an 8 part model, which utilises concepts from the Burke-Lit win model for organisational development.

As a Place we have identified this model as a starting point in that it places emphasis on environmental factors that can be developed at the 'The Rotherham Place' and cross cuts our organisations. As the identified framework is in 8 parts, we can choose as a system where we put emphasis on our local development/improvement. Suggested opportunities for improvement have been identified below:

Organisation Development area		Areas of Opportunity
1. **Mission and Strategy**	→	• Build on the collective vision to improve communication to staff and the public • The vision allows a collectively focus on safety, quality and efficiency • We will work together to develop a collective brand for the Rotherham Place
2. **Leadership**	→	• Agree joint leadership training, designed for certain levels of leadership across Rotherham Place • Commitment to lead change together • Learn from people who have experience of system transition
3. **Culture**	→	• Changing behavior's to take a Rotherham Place first approach • Develop opportunities to co-produce initiatives such as staff well- being and resilience building
4. **Structure**	→	• Develop mechanisms that allow across organisational recruitment and retention • Where appropriate create opportunities to introduce across orgainsational posts
5. **Management Practice**	→	• Develop Rotherham Place 'talent' management opportunities • Develop mechanism to introduce across Rotherham Place apprenticeship / intern opportunities
6. **Policies and Procedures**	→	• Align induction processes to ensure place and organisation covered • Opportunities to advance the 'working together' passport, co-deliver or optimise training, through sharing of resource
7. **Tasks and individual value / behaviours**	→	• Agree a set of cross organisation, Place based staff values • Joint approach to identifying good and problematic areas of joint working • Develop an accepted approach to use of language in our Rotherham Place
8. **Engagement and motivation**	→	• Undertake across organisation engagement events • Engage staff on 'what matters to them'

4.1.2 The changing workforce

We describe in section 5 of our place plan, the many different priorities that we plan to enact across the Rotherham Place in order to transform our system over the coming years. As well as changing organisational approaches to the workforce through organisational development, we fully acknowledge that at a place level we need to develop existing and where appropriate introduce new roles.

In the last two years we have already had great success in changing the way in which our workforce commissions and delivers services in a more integrated way. Examples include; the mix of physical and mental health skills currently being delivered by staff within the Ferns Dementia ward; the adoption of the integrated Hospital and Social Care discharge teams; and also GP colleagues working increasingly within the Urgent and Emergency Care Centre. From a commissioning perspective we have also developed five joint commissioning posts are now in place.

Moving forward we expect a number of changes to our workforce, our agreed approach to locality working will require colleagues from health and social care to not only hold specialist skills, but also play a more generic role in their locality.

Our 'home first model' for Intermediate Care and Reablement will require a different level and skill of workforce working into peoples' own homes as opposed to offering a more traditional bed based care. As a place we fully understand that some of our hospital based specialities would benefit from a networked approach of workforce that would provide greater sustainability.

Rotherham has a diverse and active voluntary and community sector (VCS), underpinned by thousands of volunteers. We recognise that building on a 'community asset' based approach, that the VCS is rooted within our local communities and neighbourhoods. As part of this we recognise that the VCS plays a crucial role in prevention and early intervention, enabling self-help, and supporting community resilience. Our place ambition is to continue to work alongside our VCS partners who will support and enable the delivery of our place plan. As a system we fully recognise that a VCS offer of support delivery does not mean no cost within our place and that appropriate investment will be required, where the system requires support from a VCS partner to support delivery of our plans.

Across the Rotherham Place, partners have developed strong relationships, with local colleges, universities and also Health Education England. We see these relationships developing further and being built upon. These organisations are key to supporting the Rotherham Place to deliver our workforce challenges.

4.2 Communication and Engagement

The communications and engagement strategy describes the approach and direction that focusses on informing, sharing, listening and responding to the people of Rotherham.

Specific communication and engagement has taken place, with a variety of stakeholders, for each of our five transformational workstreams and we will continue to develop meaningful communication, in a simple and easy to understand way, that demonstrates how we will drive transformation. Planning and delivery of our communication and engagement in Rotherham will be co-ordinated with the activity at an overarching ICS level. Our inclusive approach to communication and engagement with key individuals and groups will include:

- proactively and effectively communicating our vision, transformation, priorities and achievements. Being proactive is central to our vision for communication and engagement with local people
- developing two-way communication opportunities where we share news, we listen and respond and are visible to local people
- implementing relevant and effective communication tactics with key audiences and stakeholders

We are committed to the active participation of patients and the public in the development of health and social care services and as partners in their own health and health care. Local people will have an important voice in how services are planned, delivered and reviewed. We need local people in Rotherham to influence change that will improve services, health outcomes and their experience of care.

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. The place 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.

4.3 Digital (IT and IG)

In September 2015 NHS England released further guidance on the development of the digital roadmaps titled "Paper-free at the Point of Care - Preparing to Develop Local Digital Roadmaps." The guidance required CCG's to identify the footprint for their local digital roadmap, the digital roadmap partners, and the proposed governance structure by end of October 2015. Rotherham Digital Roadmap was developed across the Rotherham place partner footprint. The rationale for this footprint selection was that the health and social care organisations in Rotherham have long established working relationships, including working together on the delivery of information and technology initiatives over many years.

The Rotherham Local Digital Roadmap is multi-agency IT strategy that was developed in partnership by the Place Plan partners and approved by the Health and Wellbeing Board. The roadmap sets out how locally in Rotherham we will take forward initiatives that support, through technology, collaborative working across services and the improved sharing of information across our organisations. It is comprised of a universal capabilities plan addressing ten 'must do' areas and an aspirational capability development plan covering the period 2016/2020. The Rotherham Health and Social Care Interoperability Group are responsible for managing and monitoring the delivery of the roadmap. Key deliverables of the roadmap over the period 2018/2020.

4.3.1 The Rotherham Health Record

The Rotherham Health Record (RHR) is an integrated web based system that consists of information pulled from a variety of underlying clinical systems, which is linked together and presented in a useful way according to who is accessing it, enabling colleagues from across Rotherham to work together effectively. The system is a bespoke solution developed by TRFT and governed by the Rotherham Health and Care Interoperability Group.

In parallel with on-going activities to develop the RHR system, significant work over the last 2 years has focussed on the development and approval of a robust information governance framework to support use of the system and the establishment of an associated communications programme to ensure that patients and the public are aware of the system and their rights with regard to its use.

The RHR system currently presents information from systems used in TRFT (acute and community services), Rotherham Hospice and some General Practices. Work is underway to link social care information from RMBC into the system, which we aim to conclude over summer 2018. Following on from this, later in 2018/19, it is expected that mental health information from RDASH will also be integrated into the system. The Rotherham Local Medical Committee (LMC) endorsed the RHR Information Sharing Agreement in June 2018, and we are actively working with all Rotherham practices to sign-up for use of the system

The RHR system is used widely in TRFT and in some area of Rotherham Hospice, General Practice and RDaSH. As we work to introduce additional organisations and their data into the system we will seek to increase usage of the system across all partners, including the introduction of social care users.

In addition to the increased scope and usage of the system outlined above, there are specific milestones and plans to:

- Build patient access capabilities, focusing on patients on particular care pathways, e.g. diabetes, stroke, cancer, obstetrics
- Create more tailored views of information for specific pathways
- Extend the document sharing capability to include more partners' information
- Implement subscription-based text messaging alerts for staff triggered by patients being admitted or attending

4.3.2 Rotherham Population Segmentation Model

The Rotherham Place Plan partners wished to expedite their work on sustainable, place-based health and care models for the people of Rotherham with the aim of achieving:

- An aligned vision and outline operating model for integrated, place based, health and care.
- A clear understanding of the baseline budget position for the Health and Social Care economy, its impact on localities and what will happen without change.
- The development of virtual budgeting tool, designed based on local needs that will enable targeted interventions for priority population cohorts and assessment of impact.
- An initial view of the transformation programme required, with priority areas for detailed design and definition.

In order to do so we worked to produce a dynamic and adaptable model to segment the population according to their location, demand for services and historic service usage, demographic profile and likely future service demand (especially where it is likely to increase). The aim was for demand to be profiled by neighbourhood localities and at a citizen-identifiable level where the data is readily available.

During 2017 an online model was developed which brought together and presented baseline data (activity and cost), with the baseline allocated to medical areas, care settings and local care networks. This helped to understand the "do nothing" scenario using annual growth assumptions for activity and cost. Then it allowed evaluation of the impact of modifications to current service use including, but not limited to:

- Activity and cost shifts between existing care settings e.g. from acute to primary care.
- Activity and cost shifts between existing care settings and new care settings defined in the model e.g. preventative measures that may require investment per member of the population, but will decrease activity and cost across the existing care settings.
- Provide flexible reporting that will help determine the preferred option.

This provided an aggregate view of the health economy both in terms of activity and cost and by locality. It additionally provided a segmentation view based on population and a forecast view for the next ten years. Initial population of the model provided a 'current state' view and a forward look based on no change. This work was completed as part of Phase 1 in December 2017.

Phase 2 of the Project is now underway to produce a Super-utiliser Patient Level Analysis Tool . This will allow patient level analysis upon which different personae can be developed to support and inform the various case for change options. To undertake this will require the collation and linking of patient level data into a single view. In order to populate the models we require data inputs from various components that comprise the Health and Social Care Economy in Rotherham, to include: Acute Trusts, Community Services, Mental Health, Primary Care, Ambulance and Transport Service and Social Care. To achieve this we have asked for the support and enablement from partner organisations and their data leads in data collection and provision to support this work.

Activities currently include finalising the Information Governance arrangements and development of the Pseudonymisation tool, building the technical platform and design mock up presentation models that will allow users to query and enquire using factors such as disease, age, location, sex, diagnoses and co-morbidities, care activity, deprivation. The data will then be loaded into the model, documentation and training to be provided. We will confirm and agree resources for on-going model administration and licencing as part of the transition to Business as Usual. This is expected to be complete by September 2018.

4.3.3 Shared Wi-Fi (GovRoam)

In partnership with organisations across the South Yorkshire and Bassetlaw, Rotherham is introducing the GovRoam Wi-Fi solution to support cross working and improve our mobile and agile working capabilities. Partners to the GovRoam solution are able to use it to connect their staff to IT systems and services wherever another partner is broadcasting it. GovRoam is now broadcasting across TRFT, RDaSH and CCG estates. It is currently being implemented in all General Practice sites and plans are being developed for implementation at RMBC sites.

4.4 Housing, Communities and Estates

If we are to have success in the delivery our place ambition, we need to ensure that our available housing and estates support and acts as an enabler to our strategic transformation workstreams. Partners recognise the value of working together and taking a strategic approach to asset management and getting the most from our collective assets. Working within a 'One Public Estate' model, system leaders within the Rotherham place have agreed four key principles for how we will approach our place discussions regarding housing and estates:

1) We collectively value our best assets and will engage in constructive dialogue to maximise the optimisation of these
2) When making decisions we will take into account the impact on partners and not just our own organisations
3) We will work together to produce a Rotherham Estates Strategy
4) Our estate decisions will support the wider Rotherham Economic and Regeneration Strategy, Housing Strategy and the wider Rotherham Together Partnership

Our established Strategic Estates Group continues to work constructively, identifying available estate across the system, ensuring it is fit for purpose and identifying disposals where possible. It will continue to respond to the changing needs of services and the population. Examples of work to date include the successful One Public Estate Phase 6 (OPE6) bid for resources to support transformation including a scheme to create shared storage across the system.

Rotherham place was also successful in 2017 in securing funding to facilitate agile working across providers to enable community teams to work more effectively and reduce the footprint required. Rotherham place is also working with the ICS and Sheffield City Region to ensure estates strategies work beyond the Rotherham boundary. System leaders are clear that our approach to utilising estate needs to be driven by our Place Plan transformation, there are a number of key estate decisions that will need to be made at a Place level during the period of this plan. These will include, but not limited to, the future use of Rotherham Community Health Centre, Joint Service Centre at Rawmarsh and the future use of Badsley Moor Lane.

It is important that people have access to local, well managed services but the type of housing they live in also has a huge impact on health. Good quality, affordable housing provides the basis for people to live healthy, independent and fulfilling lives.

The population continues to age at a rapid pace and pressures on the health services to support individuals is increasing. Therefore it is important that we plan for housing that is care and support ready so that people can live in their home for as long as they wish, whilst reducing reliance on public services and encouraging independence. The Housing Strategy sets out how RMBC and partners can deliver the right homes in the right places so we continue to meet people's needs now and in the future. The role of housing goes beyond bricks and mortar; providing investment in council stock, encouraging improvements in private housing provision, development of new homes, and engagement with tenants and residents all contribute to creating healthy, stronger and more resilient communities. Getting people in the right housing and building community resilience can lead to improved health outcomes, reduce social isolation and financial wellbeing.

4.5 Governance to support delivery

The ICP Place Board is the group responsible for directing and leading the ICP, reporting to the H&WB Board for progress against the Place Plan as well as liaising where appropriate with:

- the South Yorkshire and Bassetlaw ICS to communicate the views of the ICP on ICS level matters; and
- national stakeholders (including NHS England and NHS Improvement) to communicate the views of the ICP on national matters relating to integrated care.

Partners represented at the Place Board have developed and agreed an ICP Agreement for how we will work together. The Agreement is based on a Memorandum of Understanding (MoU) approach to provide an overarching arrangement which governs the development of integrated multi-party solutions for health, care and support across the geographical area of Rotherham. The format is designed to work alongside the NHS Standard Contract and arrangements for the delivery of non-NHS care, support, and community services via RMBC. The Agreement is not intended to be legally binding except for specific elements, but encompasses the spirit by which the ICP partners have and will continue to collaborate in supporting work towards the transformation and better integration of health, care, support and community services for local people.

Collectively the ICP has worked towards an agreed governance structure and have agreed a shared vision and a set of principles by which the Rotherham Place Board, and sub-groups will adhere to. These can be found in section 1.2.

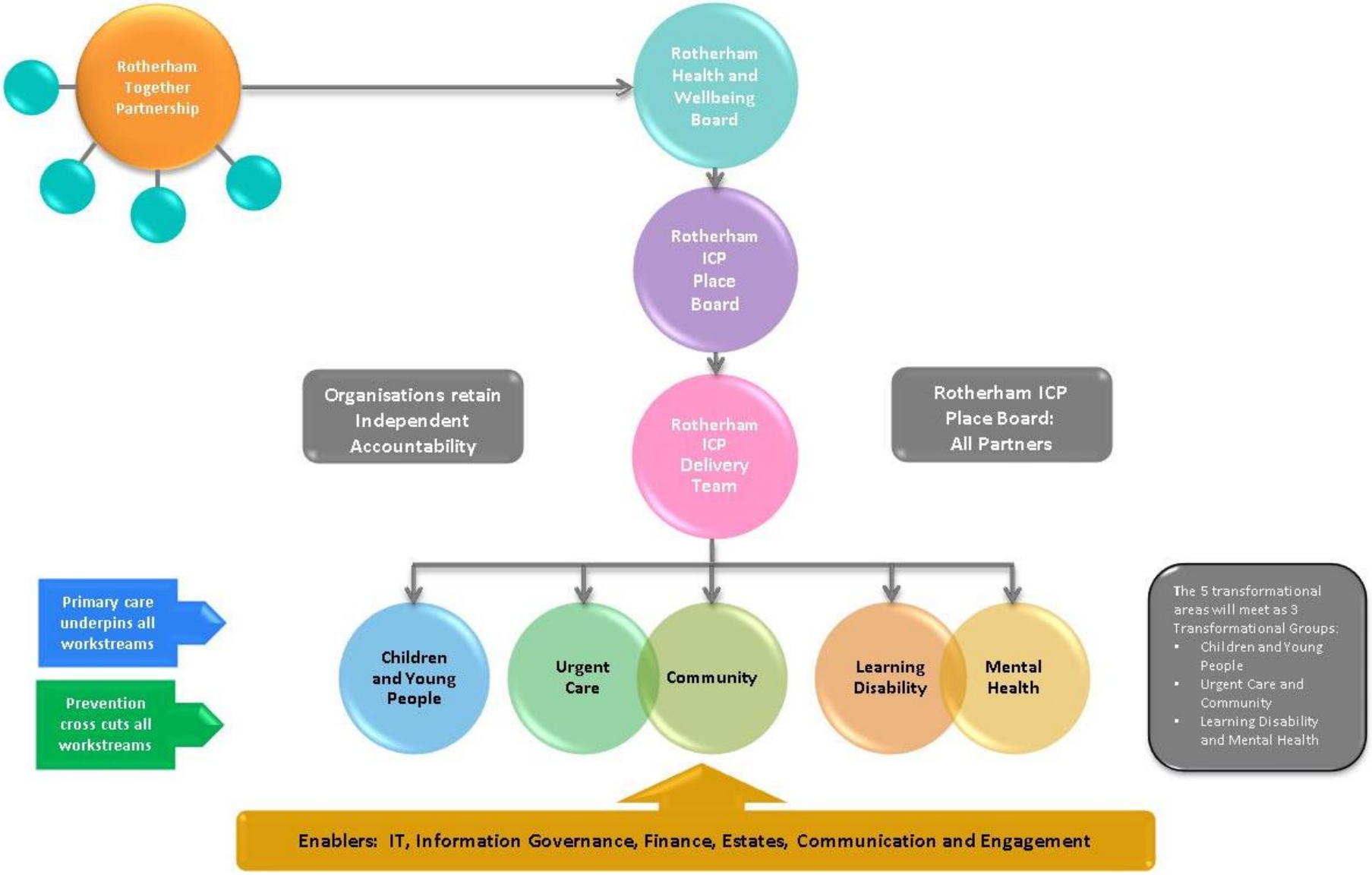
The Place Board will act in accordance with its Terms of Reference and will:

- promote and encourage commitment to the Place Plan and ICP Principles amongst all partners;
- formulate, agree and implement the transformational priorities of the Place Plan;
- ensure alignment of all organisations to facilitate sustainable and better care which is able to meet the needs of the population;
- review performance of partners against the Place Plan and the ICP outcomes and determine strategies to improve performance or rectify poor performance;
- agree policy as required, including values to be adopted and annual and short-term performance outcomes/targets;
- report on progress against the Place Plan to the H&WB Board as required;
- communicate the collective interests and views of the ICP at meetings of, or when liaising with, the ICS and national stakeholders;
- oversee the implementation of the Place Plan in line with the ICP Principles.

The ICP Delivery Team is the group responsible for managing the collaborative operation of partners and the delivery of the Place Plan and will:

- make recommendations to the Place Board for its approval or rejection as to how the services should be delivered in a more integrated and best for Rotherham way so as to deliver the Place Plan; and
- provide clinical and professional leadership with regard to the services.

The diagram bellows shows the governance structure for the Place Board, setting out the relationship to the H&WB Board.



4.6 High level risks

In addition to the robust governance arrangements and structure established to delivery this plan, we have considered the potential risks and mitigations.

Organisational behaviour – potential impact of individual organisations financial and delivery targets on the overall system wide delivery of the Place Plan.	→	• Open and transparent discussions. • Robust governance arrangements. • System wide commitment to joint plan.
Capacity to deliver the Plan – risk of organisations not having the capacity/workforce within existing resources to deliver the plan.	→	• Realistic implementation plans, 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.
Capability to deliver the Plan - risk of organisations not having sufficient capability / skills within existing workforce to deliver the plan.	→	• Skills gaps analysis/ competency Framework / training plan. • Effective change management / culture change. • Joint Organisational Development Plan.
Impact of national policy / regulations – unknown impact of national policies and changes to business rules.	→	• Robust governance arrangements. • Work with statutory and regulatory bodies to inform development of revised policy / regulations.
Public opinion – risk of not undertaking relevant public consultation on the key initiatives of our plan.	→	• Open and transparent discussions. • Robust governance arrangements. • Use existing consultations and ensure robust consultation is continued to be undertaken on future developments. • Make best use of joint working arrangements and shared resources.
Impact on organisational reputation - risk of adverse publicity in relation to the Place Plan and its objectives.	→	• Open and transparent discussions. • Utilise collective communication and engagement resources to ensure robust approach continues.
Resident Behaviour – risk that current behaviour in terms of access and use of services is not changed as a result of the plan.	→	• Open and transparent discussions. • Effective public education. • Effective communication plan. • Understanding /insight in to local behavior and create environments to make healthy lifestyle choices.
IT Infrastructure – impact of not successfully integrating health and social care systems and not driving forward IT solutions to support self-management.	→	• Joint Interoperability group and partner sign up. • Effective training. • One provider for Health IT.
Wise use of current resources – use of current funding and impact of not being successful in securing additional funding to deliver the place plan at pace and scale.	→	• 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.

4.7 Performance Management

A quarterly report will be produced on the delivery of this Place Plan so that the ICP Place Board can be assured on its delivery and can be sighted on any potential opportunities or risks to delivery.

The Performance Report includes key milestones and key performance indicators (KPIs) for each of the priorities beneath the three areas of transformation. The milestones provide a way of measuring that the actions and pace set for each of the priorities is being met. The KPIs have been chosen from existing metrics that are already collected and where there is baseline information and associated targets. For a small number, further work will be undertaken to develop / identify more appropriate metrics.

In section 5 where we have described each of the transformational workstreams and priorities we have also documented the associated milestones and KPIs

5 Transformation Workstreams

5.1 Children and Young People's Transformation

5.1.1 Overview

The imperative to work together to meet the needs of children and young people has been long recognised. Keeping children safe is only possible if we work together effectively across organisational boundaries. As well as the safeguarding imperative, partners are familiar with strong partnership working as a way to support children to thrive and achieve positive outcomes in all aspects of their lives. The Children and Young People's Partnership has been a strong forum to drive forward partnership activity for some time. The Place Plan provides a new impetus to focus on key priorities where we must work together to deliver the services that children and young people need. Each of our priorities requires us to take partnership working to the next level, developing integrated pathways, joint commissioning arrangements and a shared view of our performance.

We are also determined that, throughout the work, the voice of the child will be loud, meaningful and embedded in our rationale and activity.

Each priority will focus on a distinct cohort of children whose needs and vulnerabilities require fully integrated pathways to enable them to achieve positive outcomes without the barriers of organisational silos or funding restrictions. The need for collaborative working has, in some cases, been identified by central government and there are legislative drivers that will inform and drive our transformation. Whilst the priorities are not necessarily part of a single integrated pathway, they are sometimes overlapping and interdependent. Our work together will enable us to identify if these overlaps provide opportunities or challenges and to respond accordingly.

What is consistent across the work of the children's transformation group is an aspiration to put early intervention at the heart of what we do, and reduce the need for acute service that are more intrusive and traumatic for children and families and more costly to deliver. We also recognise that, wherever possible, it is better to take a whole family approach, with a single lead worker and a single integrated plan. As professionals we will work together to develop a shared language to help us understand each other and the children and families we support, we will be strengths-based and outcomes-focused. We will be accountable to each other and to children whose voice, individually and collectively, will guide our work.

5.1.2 Priority 1: Implementation of CAMHS Transformation

Future in Mind is a government initiative aiming to transform the way child and adolescent mental health services (CAMHS) are delivered nationally.

75 per cent of adults with mental health conditions experience symptoms before the age of 18. However, it is reported that as few as one-in-four children and young people in the UK that could be helped are being reached. Future in Mind, published in 2015, is about how each area will set about tackling the problems to create a system that brings together the potential of the web, schools, social care, the NHS, the voluntary sector, parents and of course children and young people.

The Rotherham CAMHS Local Transformation Plan identifies a scheme of work that will ensure that Rotherham responds to the recommendations of 'Future in Mind'. In addition to the policy drivers, the work is informed by a needs assessment conducted in February 2018 for Emotional Wellbeing and Mental Health for Children and Young People. This priority will focus on key milestones including:

- Reducing waiting times
- Embedding positive transitions between children's services and post-18, leveraging where possible links to the social prescribing pilot for mental health services
- Reducing demand pressure on the Looked After Children's Therapeutic Team
- Developing a single commissioning framework for children's mental health
- Working effectively with schools to deliver a graduated response and reduce demand on higher tier services
- Identifying clear evidence of outcomes
- Responding to opportunities from the December 2017 Green Paper – 'Transforming Children and Young People's Mental Health Provision'

Milestones

• Work with all stakeholders to review the RDaSH CAMHS ASD/ADHD diagnosis pathway	Q4 18/19
• Integration of the CAMHS Single Point of Access (SPA) and RMBC Early Help access point	Q4 18/19
• Improved CAMHS Crisis service out of hours	Q4 18/19
• Clarification of the pathways between the CAMHS service and Youth Offending Team (YOT) and 'Liaison & Diversion' service	Q3 18/19
• Scoping out of a Schools 'CAMHS' service in line with the government 'Green Paper' recommendations	Q4 18/19

Key Performance Indicators

- Percentage of referrals assessed within 6 weeks
- Percentage of referrals receiving treatment within 18 weeks
- Percentage of referrals triaged for urgency within 24 hours of receipt of referral
- Percentage of all appropriate urgent referrals assessed within 24 hours of receipt of referral

5.1.3 Priority 2: Maternity and Better Births

We have a strong vision and ambition to ensure that maternity services in Rotherham are safe, personalised and family friendly; where every woman has access to information that allows her to make an informed decision regarding her choice of antenatal care, place of delivery and the type of post natal support.

At the centre of our overall vision, as defined in the 'Better Births Programme', 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.

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.
Supporting the achievement of this vision the SY&B ICS has brought together maternity commissioners from across the region to develop a Local Maternity System. The Local Maternity System will ensure that the recommendations within the national 'Better Births' programme are delivered locally through the Maternity Transformation Programme. The Rotherham place plan reflects the ambition within 'Better Births' aiming to deliver safer, more personalised care for all women and every baby, improve their outcomes, and reduce inequalities. Our aim is to maximise choice and support whilst minimising clinically unnecessary interventions.

Six formal trajectories or Key Lines of Enquiry (KLOEs) will be reported at a national level and in addition, the SY&B Local Maternity System has agreed to focus on reducing smoking in pregnancy as a local aspiration. The seven KLOEs are as follows:

- Stillbirths and neonatal deaths
- Intrapartum brain injuries
- Personalised Care Plans
- Choice of Birth environment
- Continuity of Carer
- Support delivery in Midwifery settings
- Smoking in pregnancy

Each of the above work streams is reflected in the Rotherham Maternity Transformation Plan with a defined improvement trajectory from the current baseline.

Our improvement plan will measure the following key performance indicators:

Milestones
tbc

Key Performance Indicators

- Reduce stillbirths and neonatal deaths
- Reduce Intrapartum brain injuries
- All women to have Personalised Care Plans

- At least three choices for place of birth
- Increase the number of women with Continuity of Carer
- Increase the number of women giving birth in midwifery settings
- Reduce the number of women smoking in pregnancy

5.1.4 Priority 3: Oversee delivery of the 0-19 healthy child pathway services

The development of a 0-19 Integrated Public Health Nursing (IPHN) Service model presents new opportunities for strengthening primary prevention, health promotion, early help and safeguarding by developing a robust approach to improving health outcomes for children, young people and families across Rotherham. The integrated offer means moving away from the traditional health visitor and school nurse roles and the associated focus on 0-5 years and 5-19 years respectively, towards a 0-19 practitioner workforce that incorporates a broad skills mix and works across the age boundaries. This will enable the service to become needs focused, building in flexibility, to better provide a seamless service within a reduced financial envelope. It will require a wholescale workforce reconfiguration which not only looks to increase the skills mix of the workforce but also the location of practitioners to promote multi-functional working alongside the Council workforce in localities. Key to this transformation will be to work in partnership with the Council to ensure that joint models in the borough (such as Signs of Safety and Early Help Assessments) are trained and embedded across the restructured workforce.

The 0-19 IPHN Service is primarily a universal preventative and early help service designed to identify health and social issues at the earliest opportunity and put in place interventions accordingly. However, in response to the rising demand at the more acute end of the needs continuum, the service is at risk of investing increasing resource towards the safeguarding end of the spectrum to the detriment of its early help role. In order to address this, the service must develop a strategy with its partners that enables it to meet its Working Together Agenda duties whilst fulfilling its primary preventative role.

The service has a range of interventions to deploy according to need. Most of these interventions are delivered unilaterally, but a number are delivered in partnership with other agencies – identified as Universal Partnership Plus interventions in the national Healthy Child Programme. As the financial envelope reduces it will be key to review these “touch points” with partners to identify opportunities for streamlining delivery and lean practice. Pathways will be mapped to provide intelligence to inform this review with the aim of developing a broader 0-19 offer which encompasses pathways across a range of services including GPs, Pharmacies, Education, Social Care and the borough’s Early Help offer.

Milestones

- To map the 0-19 / RMBC pathways to identify opportunities for efficiencies and highlight any gaps — Q4 18/19
- To address the barriers to 0-19 IPHN EHAs and increase the numbers submitted by the service — Q4 18/19
- All 0-19 Practitioners will have completed Signs of Safety training by the end of 2018/19 — Q4 18/19
- We will work with partners to develop a tool and resources in order to capture the voice of the child Q4 18/19 — Q4 18/19

Key Performance Indicators

- Increased Early Help Assessments completed by 0-19 practitioners to a minimum of 10 per month
- Evidence of voice of the child being considered in care planning through audit of individual records

5.1.5 Priority 4: Children's Acute and Community Integration

Agencies who work with Children and Young People are under pressure to meet acute demand. We are committed to identifying need as early as possible and responding appropriately to ensure that children /young people are discharged from hospital in a safe, planned and timely manner which supports the demands on acute hospital services. We also recognise that some children and young people need intensive services and that we must work together to ensure we provide the right care at the right time.

By taking a system-wide approach that responds to families holistically across thresholds of need and clinical need; we will aim to deliver services that are clear and transparent to children and young people and their families in places that are easy to access and close to home wherever possible. At the same time we will evidence and evaluate this approach to demonstrate that it reduces demand on higher tier services.

There is an opportunity to join up children's health and social care transformation work to develop a shared language and understanding across the children's workforce as well as creating clear pathways between services that will enable children, young people and families to experience a holistic response that prevents potential deterioration, and supports children and young people to recover and thrive in the most appropriate environment for them and their condition.

The scheme will focus on:

- Continuing a programme of workshops to develop shared understanding of health and social care (including Early Help) services delivered in community and acute settings
- Developing an integrated multi-agency referral and discharge pathway for children and young people
- Developing a link between the Community Nursing Team / Rapid Response Team and Early Help services

Identifying a dedicated resource from the local authority to support discharge planning

- Developing guidance to ensure that recording systems are well understood and visible to the right professionals
- Developing a shared toolkit to capture the voice of the child

Milestones

• Embed the work of the rapid response team with referral routes established across the system / Work with GPs and test direct referrals from General Practice to the Rapid Response Team	Q4 18/19
• Establish links between Rapid Response Team and Early Help	Q3 18/19
• Pilot a direct link between Children's Ward and Children's Service to support timely discharge plans	Q3 18/19

Key Performance Indicators

- Increase the number of referrals to Early Help from Acute Clinical Services (*Hospital A&E, hospital Children's Ward, maternity ward and other department / ward)*

5.1.6 Priority 5: Special Education Needs and Disability (SEND) – Journey to Excellence

There is an opportunity to improve the SEND offer in Rotherham through a more integrated approach across all agencies and individuals involved in the commissioning, provision and use of the SEND services. A commitment to joint needs assessment and joint working will mean children and young people receive improved identification, their needs are more effectively met, and they experience improved outcomes. A SEND Strategy has been co-produced through joint working and consultation with parents, young people, schools, specialist services, educational providers, health and social care partners and the voluntary and community sector. The strategy will ensure that at a local level Special Educational Needs and Disability statutory duties are delivered in line with the Children and Families Act (2014) and the Special Educational Needs and Disability Code of Practice Statutory Guidance (2015).

The work of the SEND Transformation Programme is wide ranging; there are five priority action areas:

- Shaping provision through co-production and communication; this will impact on the Local Offer; SEND workforce training and the CAMHS parent expert training programme
- Joint commissioning, informed by a shared understanding of business intelligence to enable streamlined decision making through agreed and transparent funding arrangements
- Sufficiency of provision, including the identification of additional placements to meet need providing sufficient volume and choice
- Assuring quality with the provision of a consistent graduated response in mainstream schools and early planning for adulthood
- Value for money, including a sustainable budget model for special schools and identifying the best future delivery model

Milestones

• Develop Voices Action Plan	Q2 18/19

• Undertake the following in respect of Joint Commissioning:
  • Implement the joint financial protocol and service specifications
  • Implement the Special School Funding Model
  • Review of SEMH Support Centres (PRUs)
  • Review of Traded Models
  • Review of service provision within the High Needs Budget
	Q4 18/19

• Create a plan to reduce placements outside Rotherham (including residential provision offer, reduce OOA provision arrangements	Q2 18/19

• Implement Phase 1 of the SEND Sufficiency Plan Complete building work resulting in additional provision at the following locations:
  • SEND Hub (co-location of services) - Complete
  • Cherry Tree / Kelford Schools (Open as SLD provision)
  • Abbey School (20 additional places)
  • 19-25 Provision (15 new college places)
  • Rowan Centre (15 additional places)
	Q3 18/19

• Appoint a lead officer and implement the Joint Preparation for Adulthood Action Plan	Q1 18/19

Key Performance Indicators

- Reduction in the number of young people 16/17 year old who have SEND who are NEET or Not Known
- Reduction in the number of young people 18/19 year old who have SEND who are NEET or Not Known
- Reduction in the number of young people 20-24 year old who are NEET or Not Known
- Reduction in the number of exclusions
- Increased number of Children in Local Provision (reduced OOA)

5.1.7 Priority 6: Implement 'Signs of Safety' for Children and Young People across partner organisations

The implementation of this priority will ensure that all partner organisations who work with children and young people understand the Signs of Safety operating model and Rotherham Family Approach and embed this in their work to identify and respond to risk when working with children, young people and families. Furthermore work will identify how a single operating model (Rotherham Family Approach) might enable all-age models in the future.
The Signs of Safety approach will be the preferred practice approach that all practitioners and managers will use to work directly with children, young people and families across all Early Help, Children's Social Care, Education & Skills and Commissioning, Quality & Performance Services.

The Rotherham Family Approach and Signs of Safety methodology will give practitioners the necessary understanding, skills and confidence to work collaboratively and in partnership with children, young people and their families. The approach will establish a common framework and language for building safety, stability and success by identifying areas that need to change and focussing on strengths, resources and networks that the family can offer.

Milestones

- The RLSCB will be sighted on the roll out to partners and this will include training to all levels of practitioner — Q2 18/19
- Phase 1 of roll out of training — Q3 18/19
- Phase 2 of roll out of training — Q4 18/19
- Evaluation and next steps — Q4 18/19

Key Performance Indicators

- Number of practitioners from across the Multi-agency partnership who have accessed the Rotherham Family Approach and Signs of safety Training (½ days and extended 2 day for safeguarding leads)
- An increase in the conversion rate from contacts to referrals from Partnership agencies highlighting a better shared understanding & assessment of risk and threshold - Evidence of embedding the change & maximising impact

5.1.8 Priority 7: Transitions

Good person centred transition is essential to help young people and their families prepare for adulthood. Government guidance *'Preparing for Adulthood'* will inform this work to ensure that Rotherham has put in place the right support for young people who are transitioning from children's to adult services. It is

important to work together because the legislative drivers of the Children and Families Act (2014) and the Care Act (2014) both outline an entitlement to support for young people aged 18-25.

In order to deliver this Adult Care, Housing and Public Heath Directorate (who lead on Transition) and Children and Young People are proposing to reform the offer made to young people and their families with (Special Educational Needs and Disability SEND) to ensure that they have the right support in their transition from childhood to adulthood. The priority is to prevent gaps forming, particularly for young people with autism. It will also ensure better coordination in response to the 2 year SEND Tier 1 tribunal pilot.

Milestones

- The Transitions team to work jointly with Children Young People Services (CYPS), health and education for all new referrals for young people aged 14 to 18 with an Education, Health and Care Plan (EHCP) / Care Needs Assessment (CAN) who may be in need of a social care assessment using the Preparing for Adulthood model — Q3 18/19
- Develop a transition pathway based on Preparing for Adulthood model — Q3 18/19
- Create a data matrix of the full cohort and risk register — Q2 18/19
- Publish transition pathway on the Council website — Q3 18/19

Key Performance Indicators

- Number of out of Borough residential placements
- Ofsted CQC ratings for services used for transitions
- Numbers of SEND Tier 1 tribunal applications

Add a 'So what' case study……

5.2 Mental Health and Learning Disability Transformation

5.2.1 Overview

In relation to the imperative to improve mental health and learning disability services, the case for change is clear:

Demand for Services – with advancement in identification, diagnostics and treatment for mental health services, as well as equality legislation and public awareness and understanding; there is a significant increase in demand for services. 1 in 4 adults experiences a diagnosable mental health problem in any given year. Mental health problems represent the largest single cause of disability in the UK. Suicide is now the leading cause of death for men aged 15-49.

In Rotherham, there is a higher rate of people with a learning disability per 100,000 population at 371.77. This is compared to a regional rate of 346.06 and our neighbouring authorities - Barnsley with 313.76 and Doncaster with 348.53. Rotherham also has significant cohorts, for example, 204 people aged 18-30 years and 164 people aged 51-64 years. It should also be noted that there are 347 carers aged between 55 and 69 who support a service user with a learning disability. The number of people with a learning disability in Rotherham is increasing and, understandably this leads to increasing demand for services.

Bringing parity with physical health services – the Five Year Forward View for Mental Health has been explicit in the need to bring parity of provision between physical and mental health and to tackle the persisting stigma around mental illness and learning disabilities. There are fundamental requirements such as the need to ensure that people can access mental health care 24 hours a day, 7 days a week in the same way that they are able to access urgent physical healthcare. This sits alongside other central mandates supported by national reporting targets to deliver early intervention in psychosis and access to psychological therapies for a greater number of people. These imperatives have been supported by additional funding allocations. Locally, we need to ensure the people of Rotherham are receiving services to meet their expectations which have been set for the whole country.

Improving Services and Outcomes – People with severe and prolonged mental illness are still at risk of dying on average 15 to 20 years earlier than other people. People in marginalised groups are at greater risk of developing mental health issues and receiving poorer outcomes. Little is known about the outcomes and experiences of service users accessing mental health and learning disability services, yet mental health issues will affect 1 in 4 adults. We want to provide a better experience and better results. Services must change in order to provide the high quality services the people of Rotherham expect to meet their needs. Co-morbid mental health problems raise total health care costs by at least 45% for each person with an additional long-term condition. Too many people with mental health issues and learning disabilities are still receiving treatment and support in inpatient or residential facilities rather than in their communities, closer to home.

In 2017/18 2382 adults in Rotherham were registered with GP's as having a learning disability, and 822 have had their annual health check. We know that:

- Carers of people with a learning disability are often parents and they experience difficulties with increasing age.
- People with learning disability want the right to lead full and inclusive lives.
- Having relationships, a home and employment is very important to a person with a learning disability.
- Currently there are 686 Learning Disability customers aged between 18 and 64 accessing 1154 placements/services.
- The total number of young people with a learning disability aged 14-18 in Rotherham is approximately 45.
- There are 99 people with learning disabilities who also have autism known to the Council.
- Rotherham has 80 older people with a learning disability over the age of 65.
- Rotherham's older (65 plus) learning disabled population is estimated to increase 29% by 2035

The scope of the programme relates to adult services, or where a person under eighteen would be better supported in an adult service. Priorities in relation to mental health and learning disabilities for children and young people will be led by the Children and Young People Transformation Group.

The priority schemes outlined below will deliver a transformation in services for adults with mental health issues and learning disabilities.

5.2.2 Priority 1: Deliver improved outcomes and performance in the IAPT service

Mental health issues are impacting more significantly on people in Rotherham than the nationally recognised issue. The baseline data taken as part of the development of the Rotherham Mental Health and Wellbeing Strategy identified that:

- In 2014/15 10.8% of adults over 18 in Rotherham had depression compared with an England average of 7.3%
- By 2020 4,655 people aged 65 and over are projected to have depression in Rotherham

- For self-reported emotional wellbeing, in 2015/16 Rotherham residents reported high levels of; low satisfaction with life, low happiness and high anxiety. These rates were higher than the average for England and for the Yorkshire and Humber region as a whole
- 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. To optimise the physical health care of patients with long-term conditions, it is essential that their mental health and wellbeing are addressed at the same time.

Set against the local demographic picture is the national mandate to improve access to psychological therapies (IAPT) against the access and recovery targets. The Rotherham IAPT service has experienced a sustained period of improvement following significant challenges and the service is now performing well against these targets. IAPT continues to be a priority in order to meet the trajectories prescribed including to ensure that people with long-term conditions are accessing support from psychological therapies.

Building on improvements to the IAPT service in Rotherham, there is a continued need for focus to meet the national access and recovery targets as well as to reduce DNA rates and increase IAPT take-up in primary care by people with long-term conditions.

Milestones

- Identify and agree workforce development and training requirements (LTC & Core) - IAPT Q1 18/19
- Apply for NHS England LTC training (training commences October-18 & March-19) – IAPT Q1 18/19
- All GP practice review support visits completed - IAPT Q4 18/19
- Delivery of 5 year forward IAPT 18/19 plan - IAPT Q4 18/19

Key Performance Indicators

- Percentage of people referred to IAPT commencing treatment within 6 weeks of referral.
- % Compliance of those who have entered (i.e. received) treatment as a proportion of people entering treatment with anxiety or depression
- % of people who have completed treatment having attended at least 2 treatment contacts and are moving to recovery

5.2.3 Priority 2: Improve dementia diagnosis and support

The Rotherham population is 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 detected cases of dementia has increased year on year and this trend is predicted to continue. By 2025 it is projected that there will be nearly 4,500 people in Rotherham living with dementia.

Rotherham is the highest performing CCG area within Yorkshire and Humber for dementia diagnosis and has commenced work to enable more diagnosis of dementia in primary care via a Local Enhanced Service (LES). Follow-up support after diagnosis continues to be provided in Memory Clinic rather than in primary care. The Dementia Carers Resilience Service commissioned from Crossroads provides support to carers across Rotherham.

The introduction of the Local Enhanced Scheme (LES) to increase diagnosis of dementia in primary care has seen a number of practices take up this LES, overall, diagnostic rates remain high at a positive 82.5%. There are currently 14 practices actively reporting dementia diagnosis to varying degrees and overall the numbers completing the diagnosis pathway in primary care is increasing.

Referrals for diagnosis in Memory Clinic fell in 2017/18 when compared with the previous financial year but has remained static for the last two quarters. Referrals to the Dementia Carers Resilience Service have seen an overall upward trajectory with static performance in Q2 and Q3 of 2017/18 suggesting that current referral rates have reached a steady state.

Current issues are:

- Only 14 of 31 practices are actively undertaking dementia diagnosis with large variation in frequency and volumes of activity.
- All follow-up support (regardless of where the diagnosis is made) is delivered by secondary care services (RDaSH) in the Memory Clinic.
- The Dementia Carers Resilience Service is reporting high caseloads and referrals above expected levels. A further increase in demand may result in waiting lists for the service which could be detrimental to delivery of outcomes.

Rotherham has focused its dementia strategy in the community on increasing the proportion of dementia diagnoses in primary care and is striving to maintain its good performance. In order to address some of the gaps and issues highlighted, the next phase of work for delivery in 2018/19 will be focused on:

- Further increasing the number of dementia diagnoses taking place in the community, enabled by the LES becoming mandatory for practices from April 2018.
- Developing post-diagnostic support in the community including:
    - Increasing follow-up support in primary care to offer the majority of this routine activity in a community setting
    - Re-shaping the Memory Service to provide specialist advice and support
    - Maximising support for carers.

Milestones

- Review dementia diagnosis pathway Q4 17/18
- Develop new dementia pathway for post diagnostic care Q4 18/19

Key Performance Indicators

- Dementia diagnosis rates (%)
- % of GP practices achieving 62% of Post diagnostic support plan recorded in last 12 months

5.2.4 Priority 3: Deliver CORE24 standards for liaison mental health services

In its recent review of crisis care, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for

mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police.

Rotherham has invested in both mental health liaison and alcohol liaison services to work into A&E and inpatient wards in TRFT, the impact of the two services have been evaluated. Services currently operate extended twilight hours but at present do not comply with the CORE 24 standards to deliver a 24/7 service and the associated pathways across a 24/7 period.

Rotherham was successful in a bid via the South Yorkshire and Bassetlaw Integrated Care System in obtaining CORE 24 funding from NHS England for 2018/19 (for a 9 month period). The aim of this funding is to pump prime the existing liaison service to meet CORE 24 standards. Recurrent funding and sustainability of the service needs to be locally determined following the ceasing of the time-limited funding.

Building on the investment in mental health liaison services in Rotherham, central funding has been secured to implement CORE 24 national standards and deliver a 24/7 adult mental health liaison service into the acute hospital in Rotherham from April 2018. This is a joint delivery project between RCCG, RDaSH and TRFT.

Phase I will focus on planning for implementation of the model before funding stream commences in April 2018. This planning phase will focus on determining the service model, staff engagement, recruitment and review and redesign of existing pathways where required. NB - Staffing model is interdependent with the community crisis response and intervention model and therefore linked to the CORE fidelity review.

Phase II will focus on implementation of the model. This will be a phased implementation with CORE 24 standards delivered from May 2018. The model must be self-sustaining by 2019-20 and the implementation phase will be used to plan and manage transition to a sustainable model.

Milestones

- Funding received to support expansion of service to CORE 24 compliance — Q2 18/19
- CORE 24 standards delivered in Rotherham. — Q2 18/19
- Core 24 Service self-sustaining. – 19/20 onwards — Q1 19/20

Key Performance Indicators

- Urgent and emergency MH response within 1 hour of receiving an urgent referral (Core 24 liaison)

5.2.5 Priority 4: Transform the service at Woodlands 'Ferns ward'

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.

The number of detected cases of dementia has increased year on year and this trend is predicted to continue. By 2025 it is projected that there will be nearly 4,500 people in Rotherham living with dementia.

Due to improvements in the management of mental health patients in the community, there has been a recent sustained reduction of inpatient admissions. This has given RDaSH and TRFT the opportunity to utilise the Ferns, one of the three inpatient mental health wards at Woodlands differently. The Ferns, a 12 bedded ward, is being used to meet the needs of patients with diagnosed mental health conditions who are accessing treatment in the acute hospital setting at TRFT. The aim of the pilot is to improve patient outcomes, reduce length of stay and provide care in a holistic caring environment.

Rotherham's acute hospital population is no exception to the national picture. Indeed given the health and social demographics and determinants of the town, there are higher than average levels of incidence and need in Rotherham in relation to patients with dementia and other long term health conditions. Consequently TRFT has a number of workstreams aimed at reducing delays in improving care and outcomes for patients with dementia and in turn, improving system efficiency.

Current intermediate care services have limitations; in particular if the person with dementia has unpredictable or variable abilities, does not easily engage, has communication or capacity issues or there is a level of risk too high for intermediate care settings (such as being unable to summon help, follow safety advice or use call bell systems, is non-compliant or has significant behavioural needs). The most recent National Audit of Intermediate Care (2014) recognised difficulties people with dementia / cognitive impairment have in accessing and benefitting from intermediate care services; advocating further service development in this area.
RDaSH and TRFT have conducted a pilot to develop Ferns as a facility for TRFT patients with who are physically well enough to be discharged from the acute setting, but are not yet well enough to be discharged home or to residential care due to a cognitive impairment. The aim of the pilot has been in place to improve patient outcomes, reduce length of stay and provide care in a holistic caring environment.

The next phase of work will determine the future of the Ferns provision after the pilot ends in March 2018; developing a business case to determine the future model for 2018/19. Evaluation of this will then support the determination of the long-term future model for 2019/20 and beyond.

NB - There is an interdependency with the Community and Urgent Care programme bed review.

Milestones

- Implementation of agreed model of provision at Ferns and continuous evaluation Q3 18/19
- Agree long-term model and funding source for Ferns. Q3 18/19

Key Performance Indicators

- Average length of stay (Ferns)

5.2.6 Priority 5: Improve community crisis response and intervention for mental health

Nationally, the number of adult inpatient psychiatric beds reduced by 39 per cent overall in the years between 1998 and 2012. Bed occupancy has risen for the fourth consecutive year to 94 per cent. Many acute wards are not always safe, therapeutic or conducive to recovery. Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances outside of their area.

In its recent review of crisis care, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. The Five Year Forward View for Mental Health was clear that people in a crisis should have access to mental health care 24 hours a day, 7 days a week in the same way that they are able to access urgent physical healthcare.

The CORE fidelity scale was developed in the context of the Crisis Team Optimisation and Relapse Prevention (CORE) study. This is a research study funded by the Department of Health through the National Institute for Health Research and managed by a research team from University College London and Camden and Islington NHS Foundation Trust. The purpose of the study is to identify how Crisis Response Teams (CRTs) can achieve positive practice and function as effectively as possible. *Implementing the Five Year Forward View for Mental Health* required that all areas review their Crisis Resolution and Home Treatment services against CORE standards during 2016/17. Rotherham has not yet undertaken this review.

Crisis response and intervention in Rotherham requires a focus in order to deliver the standards outlined in the Five Year Forward View for Mental Health.

The first phase of this work is to undertake a detailed review of CORE fidelity services (Crisis Response Team and Home Treatment Team) using the CORE fidelity standards and guidance. Following this review, a series of recommendations will be made to support crisis response services in Rotherham to meet CORE standards and detail investment required. **NB** - The staffing model is interdependent with the long-term CORE 24 model and also with the Urgent and Community Transformation's Group priority to create integrated rapid response services.

The second phase of this work will be to undertake redesign and service improvements where required in order to meet the CORE fidelity standards which the review find are not yet met.

Milestones

- Complete CORE Fidelity review, recommendations and action plan for improvement (including investment requirements) Q4 18/19
- SY&B ICS NHS England Suicide-prevention – delivery of Rotherham element of the plan Q4 18/19
- Refresh of the Rotherham suicide prevention and self-harm action plan Q3 18/19

Key Performance Indicators

- To reduce the suicide rate by 10% from the 2013-15 baseline (14.2 per 100,000)
- Referrals who require a Face to Face assessment who were seen within 4 Hours % Compliance (crisis)

5.2.7 Priority 6: Better Mental Health for All

Rotherham place partners have joined together to promote the Five Ways to Wellbeing campaign in Rotherham. This campaign is about getting people of all ages to look after their mental health. It is about accessing things which are around them so it does not need to cost money.

There is a range of resources available, including a toolkit and presentation which are available on the Council's website www.rotherham.gov.uk/health. This includes a film to launch the campaign which can be viewed at www.rotherham.gov.uk/health

We all have mental health, just like we have physical health and it's important that we take steps to look after it. The following steps, known as the 'Five Ways to Wellbeing' are easy and can be incorporated into our daily lives almost straight away.

Be Active: Regular physical activity is associated with lower rates of depression and it doesn't have to be intense to make a difference. Do as much or as little as you can – you could try walking, dancing, running, cycling or gardening.

Connect: People who are connected with family, friends or people living in their community are happier, physically healthier, live longer and generally have fewer problems mental health problems. To connect with others, you could join a group, help a friend, family member or colleague or try volunteering.

Give: It has been proven that people who offer an act of kindness once a week over a six-week period report an improvement in their wellbeing. Giving could be smiling at someone and saying thank you. It could be volunteering within the local community or doing something nice for a colleague or friend.

Keep Learning: People should never stop learning. Learning throughout life enhances self-esteem, increases confidence, encourages social interaction and generally leads to people having a more active life. Why not learn a new skill like cooking, playing an instrument, fixing a bike, photography or painting.

Take Notice: Life can be very busy with little time to stop and reflect. Studies have shown that when people are aware of what is taking place in the present it directly enhances well-being. People worry less about the future and what has happened in the past and can see what really matters, allowing them to make positive choices. Stopping and observing; spending time with friends and family; enjoying nature; and taking a different route home from work or the shops noticing what is different are all ways to take notice.

Milestones

- Launch of Five Ways to Wellbeing campaign — Q1 18/19
- Five Ways communication and marketing plan for 2018/19 - agreed and delivered by partners — Q1 18/19
- Evidence of integration of Five Ways messages within provider and commissioned services — Q4 18/19

Key Performance Indicators

- *TBC*

5.2.8 Priority 7: Oversee delivery of Learning Disability Transforming Care

In October 2015 NHS England, ADASS and the LGA jointly published Building the Right Support- a national plan that outlines how the programme would ensure that more people can live in the community, with the right support, closer to home.

Following on from Building the Right Support a national service model was published called 'supplementary guidance for commissioners' which sets out what good services should look like and should be in place by March 2019 when the national programme closes.

Transforming care will mean that fewer people will need to go into hospital for their care. This will mean a reduction in the number of beds across England and to do this we are making sure that services in the community are much better.

For people who do need to go into hospital the aim is to make sure that they are as close to where they live as possible. This means that in some areas of the country new hospital services need to be developed at the same time as community support.

The South Yorkshire and North Lincolnshire TCP target by 2019 is to have **10-15** people with learning disabilities in CCG commissioned beds, and **20 – 25** people with learning disabilities in NHSE beds. Rotherham CCG has set a local target of having no more than 3 people with a learning disability detained in CCG commissioned beds which is lower than the NHSE / TCP target of 5. The NHSE/ TCP target for NHSE Secure beds is **6.**

We will continue to work with partners across the Transforming Care Partnership (TCP) to ensure delivery of the South Yorkshire and North Lincolnshire TCP Plan.

A Rotherham 'at risk of admissions' process remains in place (including C&YP /Autism), work will continue to review the people who are included this this cohort to understand needs and ensure that community services are fit for purpose to meet the needs of people with behavioural support needs.

We will ensure that STOMP (Stopping the overmedication of people with a learning disability and autism) is implemented by working with partners to ensure that the use of psychotropic medication is always appropriate.

Milestones

- RMBC and CCG to agree process for funding learning disability joint placements — Q2 18/19
- Identify Indicative costs for transforming care cohort (including those on the risk register) — Q2 18/19
- Commissioning solutions to be in place to meet national deadline — Q4 18/19

Key Performance Indicators

- Ensure that patients receive a CETR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: adults.
- Ensure that patients receive a CETR prior to a planned admission to an Assessment and Treatment Unit or mental health inpatients: children.
- Ensure that patients in an Assessment and Treatment Unit receive a Care and Treatment Review (CTR) every 6 months.
- Reduce the number of people admitted in line with the South Yorkshire and North Lincolnshire LD TCP trajectory – *Local Reporting*

5.2.9 Priority 8: Support the Implementation of the My Front Door – Learning Disability Strategy

The needs of people with a learning disability are continuing to change and are becoming more diverse. People and families have higher expectations of what it means to have an independent life in their community, and want more control over their lives.

People with a learning disability have been telling people who commission and provide services that they want the same quality of life as anyone else; that they have the same dreams and wishes as other people; and that they want the same chance as anyone else of being able to realise these dreams.

People with a learning disability want access to a wider range of services and support which are part of their local community; they want access to employment, jobs, good leisure time, friendships and to travel as independently as possible around the borough.

People with a learning disability in Rotherham are living longer. The challenge is that learning disabled people are more likely to experience chronic health conditions (e.g. obesity, diabetes) much earlier than the general population. It is estimated that people with a learning disability are 58 times more likely to die prematurely. They are more likely to receive poor levels of health treatment as a result of 'diagnostic overshadowing', where people's health needs are overlooked due to focusing on their learning disability.

Good practice and national research tells us that it is possible for people to develop skills and gain greater independence through providing alternatives to services each person with a learning disability has the right to a "Good Day" which will mean different things for different people. For some this means improved access to employment. This is achieved through volunteering projects (such as cafes, volunteering in a community/hospital radio station, a park warden service and other services run by the large statutory organisations) and through real, paid jobs. There are people with high support needs in paid employment in places such as large department stores, supermarkets, and the entertainment sector. There are job share schemes, where jobs are broken down into a number of tasks and the tasks undertaken by a number of people who together complete the whole job. Some people become self-employed and are supported by the development of a number of projects.

There are new ways of developing supported employment by bringing together employers and work with them strategically and supportively to employ people from many different under-represented groups, including people with a learning disability.

Rotherham CCG is participating in the following NHS England programmes: LeDeR (Learning Disability Mortality Review) and STOMP - (Stopping the Over Medication of People with a learning disability).

NHS England's ambition is for 75% of people on GP Learning Disability Registers to have an Annual Health Check (AHC) by March 2020. There is also a commitment to increase the number of people on GP Learning Disability (LD) Registers by 10% year on year. Rotherham has an enhanced service for the delivery of health checks, efforts will be made to increase uptake of annual health checks for people with learning disabilities so that the number of people receiving an annual health check from their GP is 64% higher than in 2016/17. We will ensure that all people with a learning disability aged 14 plus are offered a health check.

Milestones

- Delivery of joint Learning Disability transformation strategy — Q4 19/20

Key Performance Indicators

- Proportion of eligible adults with a learning disability having a GP health check
- Proportion of adults with a learning disability in paid employment
- Proportion of adults with a learning disability who live in their own home or with their family

5.2.10 Priority 9: Support the Development of Autism Strategy

The Autism Act (2009) says people with autism may not always get what they need. This could be because services do not understand what they need or public places are not inclusive. The statutory guidance says each area in the country will have a plan; in Rotherham it was decided to make a new all age plan for everyone with autism.

Autism touches the lives of many people in Rotherham. It is a life-long condition affecting about 1 in every 100 people. It affects how people see, hear and feel the world. Everyone with autism will experience it differently.

Rotherham wishes to be an autism-friendly borough in which people with autism are able to reach their full potential at all stages of their lives. We have developed a strategy for the next five years which includes all ages - children, young people and adults with autism and the needs of families and carers. We have listened to the views of a wide range of people in developing this strategy. A delivery plan has been created which maps out for development of Rotherham's Autism Strategy. The ambition is that all children, young people and adults with autism in Rotherham are able to:

1. Live fulfilling and rewarding lives within a community that accepts and understands them
2. People with autism can get a diagnosis and access support if they need it
3. They can depend on mainstream public and third sector services to treat them fairly as individuals to get the right information and helping them make the most of their talents

Rotherham is committed to improving the lives of adults with autism. This will be done by working with families, local autism groups and partner agencies to address some of the frustrations with existing patterns of services and the difficulties in accessing support.

Milestones

- Complete the development of the Autism Strategy (including Action Plan) — Q3 18/19
- Development of Rotherham based Autism and ADHD diagnostic pathway — Q4 18/19

Key Performance Indicators

- *TBC*

Patient story about Ferns Ward

The Ferns have reopened as a service for dementia patients with physical health needs with both mental health and acute staff.
Below is a copy of an emotive e-mail sent from a daughter of a Ferns patient; demonstrating how important the right care is to patients and families at Rotherham Hospital….

Monday *–dad was sweating, temperature sky high, and violently shaking (looked like he was having little fits) – went home late that night, expecting the worst.*
Tuesday*–dad's temperature sorted, but violent. Hitting and kicking out at nurses, I tried to help as they changed the bedding and finished up punched in the face. He was also shouting out that the nurses and me were 'bitches!' (This is just not my dad!)*
Wednesday*–I couldn't see him as I was preparing for hospital myself the next day.*
Thursday *– popped in to see dad after my procedure, he didn't know who I was.*
Friday *– moved to The Ferns. Friday evening visiting, dad knew me and mum, no violence, no abuse coming out of his mouth, he was calmer.*
Saturday *– calmer again.*
Sunday *– I visited twice, got value for money from his father's day card/pressies, as he couldn't remember he'd got them first time round ...so had the surprise and smile again in the evening when I showed them him again. He was also having physio and walked down the corridor. He was admitted to Rotherham hospital two weeks ago because his legs just wouldn't work.*

The Ferns have already given me a bit of my dad back. (I know he's got dementia – but I got a little piece of him back.) I don't know if it's the different nursing (more attention) or the calm environment, but whatever it is, The Ferns have worked magic. I got something back in my dad that I never expected. ***Giving me a bit of my dad back is priceless! You can't put a budgetary amount on that. And mum, me, and my kids are so grateful.***

5.3 Urgent and community Transformation

5.3.1 Overview

In relation to health and social care integration, the case for change is clear:

Improving Services and Outcomes – service users expect and we want to provide a better experience and better results. We need to make better use of the people and resources we have by working more effectively together. If we do not change, we will not be able to continue the high quality services the people of Rotherham expect to meet their needs because of the growing demand on services.

Demand for Services – with a growing ageing population, more people need our health and social care services and will continue to do so. We cannot afford the future elderly population to be anything other than healthier for longer. Current models of service provision are not fit for the coming financial and quality challenge.

Better Resilience – the rise in demand puts pressure on our limited resources. This is happening at a time of constraint on public sector funding and rising costs of health and social care services. Only by exploiting the potential of integration and a relentless drive for personalisation, can we create a resilient health and social care economy. Reform needs to happen at different spatial levels – the individuals, localities, partnership areas and borough wide.

Need for Scale – Significant individual organisational efficiencies and the aggregation of a host of small scale projects will not be enough to meet the funding gap. A system wide approach to health and social care which engenders personal resilience, independence and wellbeing is the only option to reduce overall demand for services, enabling the right level of care to be targeted where there is a need.

In order to achieve the Place Plan objectives six closely interlinked transformational priorities have been identified, to maximise the value of our collective action and transform our health and care system so that we can reduce demand for acute services, achieve clinical and financial sustainability and thereby close the three gaps. The scope of the programme relates to adult services, or where a person under eighteen would be better supported in an adult service.

The six priority schemes work together as a whole system approach to deliver a step change in how we deliver our services moving from a responsive, paternalistic approach to a proactive preventative integrated health and social care model which supports individuals to live as independently as possible in the community, through a focus on 'home first'/ 'home is best'. Where people do need support it will be proportionate and joined up to make best use of limited resources. The emphasis will be on reablement, rehabilitation and recovery.

5.3.2 Priority 1: Integrated Point of Contact

There are multiple access points for adult health and social care in Rotherham. These will be consolidated around the two main health and social care referral points: the Care Co-ordination Centre (health) and Social Care Single Point of Access (SPA).

RMBC has strengthened the adult social care single point of access (SPA) investing in an MDT approach to develop a preventative model. The service includes social care advisors, social workers and the voluntary sector and is trialling pilots with an occupational therapist and physical and mental health. In June /July 2018 78.7% of customer contacts were resolved at the front door. Contacts to localities which averaged c 350 referrals a week to locality teams before the development are now average c just 39 for North, South and Central.
The CCG commissioned the health Care Co-ordination Centre in 2014 to facilitate sign posting to alternative levels of care; to support patients who are at risk of admission in the community and facilitate discharge. Historically, the Rotherham health community has been an outlier for emergency admissions to hospital, and a more recent challenge for Rotherham has been achieving A&E targets. There is evidence that individual clinicians involved in hospital admissions, such as GPs, ambulance staff and A&E doctors have different thresholds for admission. And whilst hospital admission may seem like the safest and easiest way of dealing with an emergency, for many people high quality care at home or in a community setting is a better, safer option, particularly for those on palliative care and end of life pathways. The service was extended to a 24/7, 365 days a year service in 2015, including referrals to community nursing. The service is now processing c 3,000 contacts a month. As a result the service has become more focussed on managing volume rather than effective co-ordination to the right level of care.

As the health and social care system moves to 'Home First' as an underpinning philosophy and approach promoting independence and care co-ordination becomes increasingly important. Therefore this priority is a lynch pin to effective delivery of the Urgent and Community Place Plan.

The remit of this priority is to develop an integrated front door which promotes independent living at home, admission avoidance and timely discharge through co-ordination of activity to ensure individuals receive the right level of care, at the right time and in the right place. Integration may be achieved either through physical co-location or virtual interconnectivity. The service will:

- Promote a prevent and self-support model
- Resolve up to 80% of contacts at the front door (the percentage will vary according to the specialism), reducing reliance on statutory services and utilising community assets
- Co-ordinate care to ensure the most appropriate level of intervention and support for people to remain at home wherever possible
- Continue to provide a 24/7, 365 day a year urgent service for health with specialist provision provided in core hours, determined according to specific specialist need
- Use a trusted assessor model, sharing information to facilitate decision making, removing the need for repeated questioning

The integrated service will be a blend of co-located MDTs for effective triage and resolution and virtual links facilitated through shared information and trusted assessor protocols. The collective skills set will include admin and clerical staff; non-qualified advisors and qualified physical health, mental health nurses (including nurse prescribers), therapists, social workers and AMHPs, re-ablement, pharmacy and palliative care. A leadership and management structure will be developed with specialist clinical / professional supervision and a tiered support structure including non-qualified advisors and specialist qualified staff.

Milestones

• Transfer mental health referrals to the Care Co-ordination Centre	Q2 18/19
• Agree joint working arrangements between Integrated Rapid Response/Care Co-ordination Centre /Single Point of Access to test the models	Q2 18/19
• Co-locate Care Co-ordination Centre with Integrated Rapid Response	Q3 18/19
• Evaluate joint working arrangements between health and RMBC Single Point of Access	Q3 18/19
• Partners agree integrated service model for Single Point of Access and Care Co-ordination Centre	Q4 18/19
• New service model in place	Q2 19/20

Key Performance Indicators

- Percentage of people provided with information and advice at first point of contact (to prevent service need)
- Number of GP urgent admissions to AMU (including those referred through CCC)
- Percentage of new clients who have had a formal social care assessment completed this year, that went on to receive long term social care support
- Proportion of new clients who receive short term (enablement) service in year with an outcome of no further requests made for support
- New permanent admissions to residential nursing care for adults
- Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduce non elective admissions
- Number of emergency re-admissions within 30 days of hospital discharge (all age)

5.3.3 Priority 2: Integrated Rapid Response

The TRFT Integrated Rapid Response service was established to improve the process for planned hospital discharge and admission prevention. It was recognised that at any one time there were a proportion of patients in an acute bed, whose medical episode was complete, but were awaiting further assessment, care package initiation or decisions on choice of care home. There was also a significant proportion of patients whose care needs could have been met at home, if appropriate services were in place.

The service provides:

- Support to patients who are at immediate risk of hospital admission, co-ordinating health and social care in the community to prevent an avoidable admission
- Assesses patients who are medically stable but need additional support to remain at home. Nursing support is provided for up to 72 hours, or to a maximum of 7 days if required.
- The service is supported by RMBC's Enablement Service, delivering home-based reablement and home care support.
- Out of hours district nursing
- Intensive clinical care and support to older people who live in CQC registered Care Homes

In addition the service triages community referrals from the Care Co-ordination Centre.

The service has recently established a borough wide urgent hub to ring fence resource for unplanned referrals so that planned work is not delayed or cancelled due to high volumes of urgent cases.

Mental health rapid response services are currently provided separately and are made up of the Crisis and Home Treatment teams, including RMBC Adult Mental Health Practitioners, the Mental Health and Alcohol Hospital Liaison Team and the Learning Disabilities Intensive Support team. Their collective remit is to reduce avoidable admissions and facilitate discharge.

The rapid response function is a key component of both the Integrated Point of Contact through providing crisis support, triage and brief interventions and the home first pathway through admission avoidance and facilitating discharge. This priority therefore needs to be aligned with priority 1: Integrated Point of Contact, priority 3: integrated discharge and priority 5: the review and development of the re-ablement and intermediate care offer.

Remit

The aim of the scheme is to incorporate rapid response functions into an integrated multi-disciplinary team to provide time limited brief interventions and wrap around support to enable individuals to remain or return home after an admission. It is therefore a cornerstone of the Home First pathway. The service will provide:

- advice and expert triage to the Integrated Point of Contact for signposting and co-ordinating to the appropriate level of care
- assessment, using trusted assessor protocols where appropriate
- support to people who are at risk of admission to remain at home or who, with additional support, can be discharged home

- provide brief, time limited, interventions of up to 7 days (or an appropriate time period for the specialism eg palliative care) to support individuals to prevent deterioration and reduce the need to enter service
- where further support is required determine what should happen next following a stepped care model
- liaise effectively with services across the care model to enable patients to be cared for at home
- provide out of hours support for unplanned health and social care needs which would otherwise result in an admission or serious deterioration / escalation

This priority provides the bridge between hospital and home in pathway terms and the Initial Point of Contact and Locality Teams in structural terms. It is anticipated that it will include rapid response services (including physical health, Mental Health Crisis and Home Treatment and social care front line services), therapies, integrated discharge, intermediate care and re-ablement and domiciliary care. An initial model will be developed for Winter 2018.

Milestones

- Complete separation of planned/unplanned activity within District Nursing — Q2 18/19
- Co-locate the unplanned and Integrated Rapid Response teams — Q3 18/19
- Incorporate unplanned specialist community nursing work into the Integrated Rapid Response team — Q1 19/20

Key Performance Indicators

- Percentage of new clients who have had a formal social care assessment completed this year, that went on to receive long term social care support
- Proportion of new clients who receive short term (enablement) service in year with an outcome of no further requests made for support
- New permanent admissions to residential nursing care for adults – 65+
- Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduce non elective admissions
- Number of emergency re-admissions within 30 days of hospital discharge (all age)
- Length of stay in hospital (over 64's)
- Reducing long lengths of stay (super stranded patients)
- Number of patients discharged to their usual place of residence (over 64's)
- Intermediate Care - Average length of stay (general rehabilitation)
- Intermediate Care - Average length of stay (specialist rehabilitation)
- Intermediate Care - Late discharge - LOS > 6 weeks (general rehabilitation)

5.3.4 Priority 3: Integrated Discharge Service

Evidence suggests that patients are more likely to make a better recovery at home and regain or retain independence the earlier they return home or to a suitable care home setting.

Delayed discharges are under national scrutiny and whilst Rotherham delays have been comparatively low there has been a drop in performance compared to the national standard. Following an external independent review the following recommendations have been agreed:

1. Development and implementation of an integrated service for discharge planning and assessment
2. Data and Reporting – clear process for the capture, collation and reporting mechanisms for data related to discharge
3. Development of clear pathways to support the principles of Home First, Intermediate Care and Discharge to Assess, consideration of NHS Continuing Healthcare Funding
4. Escalation processes and systems across discharge planning to support effective patient flow and responses in times of pressure
5. Development and implementation of a training programme which can provide on-going sustainable support for all staff involved in discharge planning

The remit is to develop an integrated MDT approach for timely hospital discharge with planning that starts on arrival and is based on a home first ethos. The scheme has been divided into two phases.

Phase 1 (September 2017- January 2018) focussed on targeted activity to reduce delayed discharges - the following has been achieved in phase 1:

- Both Hospital Discharge Teams, Transfer of Care and Supported Discharge Pathways Teams, co-located in a single space
- Single-reporting process and clear sign-off procedures in place for formal reporting of DTOCs both locally and nationally
- Simplified pathways and an improved understanding of how those pathways can work
- Initial stakeholder consultation, training sessions and workshops held across a broad range of multi-disciplinary teams and staff
- Range of documents, such as Standard Operating Procedures, developed to support staff in achieving a sustained approach to recording and reporting accurately
- Overall reduction in the number of patients who remain in hospital for consideration of NHS Continuing Healthcare Funding
- Overall reduction in the numbers of patients delayed in hospital and reported as a DTOC

Phase 2 is to develop an integrated service model which will be a corner stone of the Home First pathway, aligned to the wider Place Plan activity, particularly priority 5, intermediate care and reablement. This will include:

- a costed business case for an integrated discharge team with single line management which operates 7 days a week. The service will be hospital based, though it is envisaged that when the team matures it will move into the community
- Clearly articulate and educate colleagues on the 3 discharge pathways, embedding discharge home as the default pathway
- develop a trusted assessor role with a view to reducing the number of assessments currently undertaken when people are being discharged from hospital

Milestones

• Appointment of Integrated Service Manager	Q2 18/19
• Appointment of Ward Co-ordinator Roles	Q2 18/19
• Partners approve Service Model (incl. team structure and 7/7 working and front door interface)	Q4 18/19
• Implement new model	Q2 19/20

Key Performance Indicators

- Number of patients discharged to their usual place of residence (over 64's)

- Intermediate Care - Average length of stay (general rehabilitation)
- Intermediate Care - Average length of stay (specialist rehabilitation)
- Intermediate Care - Late discharge - LOS > 6 weeks (general rehabilitation)
- Delayed transfer of care from hospital

5.3.5 Priority 4: Integrated Localities

Locally, there continues to be funding and demand challenges. This includes high levels of non-elective hospital admissions, GP attendances/home visits and social care interventions. In order to address these challenges a strong partnership approach is required to create an operating model that works with Rotherham people to take more responsibility for their own wellbeing. Where people do need support it must be proportionate and joined up; making the most of limited resources.

The Integrated Localities priority builds on the learning from development of the RMBC SPA and the Health Village Integrated Locality Pilot. Outcomes from the SPA evidence how timely co-ordination and short term interventions can reduce the volume of people drawing on health and social care services in localities. The Locality Pilot demonstrated the benefits of an MDT approach to support longer term and more complex cases, facilitating independent living, admission avoidance and timely discharge.

This scheme of work will take a case based approach to identify and embed how physical health, mental health, social care and the voluntary sector can work with individuals in a more effective multi-disciplinary way to facilitate independent living for those with longer term and more complex issues. Annual case reviews known to both social care and health services will be taken as a starting point in order to realise early benefits.

Health and social care localities have been mapped into three partnerships: north, south and central. The partnerships will be the vehicles for progressing the work. There will be a common core across each of the partnerships with flexibility to adapt to the local demographic, priorities and maturity of the partnership. Functions will include Social Care, District Nursing & Phlebotomy, Community Matrons, Nurse/AHP Consultants, Therapies & Reablement, Mental Health and the Voluntary and Community Sector including Social Prescribing.

These teams will work together to achieve the required outcomes for their caseloads with a shared responsibility to maximise impact. They will work closely with the urgent, rapid response and discharge functions to facilitate escalation and de-escalation, ensuring that local knowledge of what is the 'norm' for an individual is available and accessible to enable informed decisions of care based on acceptable levels of risk.

Milestones

• Map of current resources in each Partnership area for all organisations complete	Q3 18/19
• Agree outcome framework with partners - identify joint outcomes, agree governance and identify accountable officers for delivery within provider organisations	Q3 18/19
• Hold launch workshops (to agree work plans and targets and working principles)	Q3 18/19
• Partnership leadership teams agreed by partners	Q3 18/19
• Team configuration agreed by partners	Q4 18/19

- Implementation plan for full roll out agreed by partners Q4 18/19
- Agree Long Term Conditions LES to ensure that it links with the localities Q1 19/20

Key Performance Indicators

- Percentage of new clients who have had a formal social care assessment completed this year, that went on to receive long term social care support
- Proportion of new clients who receive short term (enablement) service in year with an outcome of no further requests made for support
- New permanent admissions to residential nursing care for adults – 65+
- Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Reduce non elective admissions
- Number of emergency re-admissions within 30 days of hospital discharge (all age)
- Length of stay in hospital (over 64's)
- Reducing long lengths of stay

5.3.6 Priority 5: Home First Model; Reablement & Intermediate Care

Local systems interpret Intermediate Care provision differently, it does not define a single service; it is a term that incorporates elements of reablement, rehabilitation and recovery. The Nice Guidelines for Intermediate Care including Reablement provide a clear vision of the model which corresponds with our local aspirations. The guidelines state that local areas should offer all 4 types of intermediate care; Crisis response, Home-based intermediate care, Bed-based intermediate care and Reablement.

The number of people aged 85 and over will increase by a third over the next ten years, and the number of people living with dementia is expected to grow to around 1.3 million in 2025. One estimate suggests that if admission rates continue to increase, the growing and ageing population alone means that the NHS would need approximately 17,000 additional beds by 2022. Responding to these challenges with 'more of the same', acute hospital beds and care home places is not sustainable or the best option for individuals. Commissioners are increasingly investing in reablement services as a means of increasing people's independence and reducing their need for ongoing support.

The majority of Rotherham's provision, both home and bed based, is currently focused on frail elderly with limited reablement/rehabilitation support for those with learning disabilities and physical disabilities to recover their independence. This is not how we see the future model, our vision is for a whole life journey approach for the adult population.

Rotherham has a strong record on joint working across health and social care, there are a number of jointly commissioned services in existence through the Better Care Fund including the Rotherham Intermediate Care Service (residential bed base provision), the Integrated Rapid Response Service and more recently the introduction of an Occupational Therapist into the Reablement service. There is evidence that these services have contributed to positive outcomes for service users and carers.

Rotherham is an outlier in the number of community beds we have. Audits show that there are still a number of hospital admissions that could be redirected to intermediate care and discharges that could be supported by community intermediate care rather than bed based provision. Therefore, a priority of the Rotherham Place Plan is to consider options for the redesign of intermediate care and reablement services. Our aspiration is to create an environment that supports integrated working across these services ensuring a model of recovery for all predicated on 'your bed is the best bed', with a combination of health and social care professionals working as part of a multi-disciplinary team to support clients at home.

We will review the community bed offer to ensure that services are fit for purpose and streamlined to create a reduced dependency on bed based provision. Rationalising the number of community beds in Rotherham will ensure we are in line with our comparators and support the ethos of Home First. To achieve this vision we will divert resources (therapy, nursing and social care) into the reablement and discharge to assess at home.

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, 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.

Milestones

- Carry out financial modelling of current pathways — Q2 18/19
- Programme lead to develop a comprehensive milestone and action plan for delivery of this priority — Q2 18/19
- Develop draft service model and service specifications for reablement, intermediate Care and Home First — Q4 18/19
- Phase 1 of new service model implemented — Q4 18/19

Key Performance Indicators

- Number of GP urgent admissions to AMU (including those referred through CCC)
- Proportion of new clients who receive short term (enablement) service in year with an outcome of no further requests made for support
- New permanent admissions to residential nursing care for adults – 65+
- Proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Number of patients discharged to their usual place of residence (over 64's)
- Intermediate Care - Average length of stay (general rehabilitation)
- Intermediate Care - Average length of stay (specialist rehabilitation)
- Intermediate Care - Late discharge - LOS > 6 weeks (general rehabilitation)

5.3.7 Priority 6: Develop a Coordinated Approach to Care Home Support

The Five Year Forward View *states that 'One in seven people aged 85 or over are living permanently in a care home'.* Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission.

- Around 12% to 15% of all emergency admissions are patients aged 85 or over, including both care home and non-care home resident patients.
- Emergency admissions from care homes make up approximately 11% to 13% of all emergency admissions in patients 65 and over and 25% of all emergency admissions in patients 85 and over.
- Patients admitted as an emergency from care homes spend approximately an extra 2 days in hospital, compared to emergency admissions for all patients, all ages.
- Care home admissions appear to be increasing but the trend is difficult to establish due to recording issues and the general margin of error associated with identifying care home admissions.

An important part of our new integrated locality model of care, is the transformation of our care home sector. The Enhanced Health in Care Homes Framework (NHSE) published in September 2016 lays out a clear vision for working with care homes to provide joined up primary, community and secondary, social care to residents of care and nursing homes, via a range of in reach services. The Rotherham ICP are committed to working collaboratively to improve the quality of life, healthcare and health planning for people living in care homes.

Most people want to be cared for in their own homes and we know that this is best for their wellbeing. Commissioners of health and social care are increasingly investing in reablement services as a means of increasing people's independence and reducing their need for ongoing support. However, there will be some people who need ongoing care in a care home setting, the aim of which will still be to maintain independence. The evidence suggests that many of these people are not having their needs properly assessed and addressed. As a result, they often experience unnecessary, unplanned and avoidable admissions to hospital, and sub-optimal medication. Therefore, we must ensure that the best possible care is provided to those in residential settings.

The Enhanced Health in Care Homes states that the care for people who are living in care homes or who are at risk of losing their independence is being held back by a series of care barriers, financial barriers, and organisational barriers.

Rotherham's self-assessment against the Enhanced Health in Care Homes Framework evidences areas of innovation and best practice. For example multiple teams and resources dedicated to care homes across Rotherham's health and social care economy; a care assessor, a care home support team, GP's aligned to care homes, the hospice at home team, advanced nurse practitioners, rapid response service, clinical quality advisor and social care contract compliance officers . However there still remains a significant opportunity to bring teams together to work in a more joined up way.

We also want to pursue the development of technology to link homes up better, use the initial point of contact as their first point of contact to access the most appropriate professional and support better end of life care planning to improve this service and offer.

A pilot project will run for 18 months through the Hospice service that will address both immediate advice and rapid response in emergency situations and the provision of education and supervision of front line care and residential home staff for End of Life. The project will also look to improve relationships across community teams, the wider health and social care network and care homes themselves.

Milestones

- Local implementation of Red Bag Scheme — Q1 18/19
- Implement and evaluate care home pilots: Trusted Assessor, Telehealth and End of Life — Q1-Q3 18/19
- Review training requirements for Care Home staff to enable effective delivery of service — Q4 18/19
- Continue to ensure the Care Home LES is fit for purpose — Q4 18/19

Key Performance Indicators

- Number of A&E attendances from care home residents (local)
- Percentage of attendances that resulted in hospital admission

CASE STUDY: Trusted Assessor working in the Emergency Department

The following case study illustrates how the different priorities of the place plan join together across the system to improve the outcome for patients. A Trusted Assessor Pilot was established in the Urgent and Emergency Centre in June 2018. The following example is an early case study.

***A**, an 82 year old woman, was assessed by Trusted Assessor in the emergency department. She came in by ambulance via a 999 call with query Cerebrovascular accident (CVA). Her home carer that morning was unable to stand her up and thought she was leaning more to the left side and had left sided facial palsy. **A** was assessed in A&E by a medic and nursing staff with her son present. Her son stated that the left -sided lean is usual due to ataxia relating to previous CVA and that left sided facial palsy is also normal for her. Past medical history includes hypertension and hyperthyroidism and previous falls. There were no FAST symptoms and she scored 0 on MEWS (vital signs) so no CT was required. **A** was deemed medically fit for discharge. She had reduced mobility potentially due to mild dehydration and fatigue due to a bad night's sleep due to hot weather.*

*The Trusted assessor was called to help get the patient back home from the emergency department. Taking details about her home situation from the patient and her son, a mobility and transfers assessment was carried out with the help of nurse. **A** needed assistance of 2 sit to stand, assistance of 2 with toileting and personal ADL's and assistance of 1 and rollator frame when mobilising due to sudden lean to left side and so loosing balance. The trusted assessor organised a rollator frame and contacted the care company to organise assistance for 2. The Care manager stated that they would not be able to resume care that evening as they would need social work input to increase to double handling calls. Usually this would have meant the patient would be unable to return home and would need hospital admission for social reasons.*

*The trusted assessor made contact with a hospital social worker who works alongside the Frailty team. He was able to carry out the necessary work to increase the home care to double handling so that the lady could return home that afternoon. The Trusted Assessor liaised with the urgent therapy team in the community and it was agreed (as in a "discharge to assess" model) that they would assess the lady at home the next day (Saturday) for any extra equipment needs, progress her mobility and give her some exercises to help improve her strength. She was therefore able to return home without needing a hospital admission over the weekend. As the Trusted Assessor also works in the urgent therapy community team she provided continuity by visiting **A** after the weekend to continue therapy.*

6 Glossary

A&E	Accident and Emergency	**KPI**	Key Performance Indicator
BCF	Better Care Fund	**LAC**	Looked After Children
CAMHS	Child and Adolescent Mental Health Services	**LMC**	Local Medical Committee
CCC	Care Co-ordination Centre	**LOS**	Length of Stay
CCG	Clinical Commissioning Group	**MOU**	Memorandum of Understanding
CHR CIC	Connect Healthcare Rotherham CIC	**RDaSH**	Rotherham Doncaster and South Humber NHS Foundation Trust
C&YP	Children and Young People	**RHR**	Rotherham Health Record
DTOC	Delayed Transfers of Care	**RMBC**	Rotherham Metropolitan Borough Council
H&WB	Health and Wellbeing	**SEND**	Special Educational Needs and Disabilities
ICP	Integrated Care Partnership	**SY&B**	South Yorkshire and Bassetlaw
ICS	Integrated Care System	**STP**	Sustainability and Transformation Plan
IH&SC	Integrated Health and Social Care	**TRFT**	The Rotherham NHS Foundation Trust
IRR	Integrated Rapid Response	**VAR**	Voluntary Action Rotherham
IT	Information technology	**VCS**	Voluntary and community sector
JSNA	Joint Strategic Needs Assessment		