HM Government

NHS England

# BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

## Rotherham Health and Wellbeing Board

**Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)**

At a local level Rotherham Place has been working in a collaborative way for several years to transform the way it cares for its population of around 265,800. Rotherham's older population (over 60 years) has increased from 61,500 (Census 2011) to 68,600 (Census 2021), which is 25.8% of the local population. The population of Rotherham aged 60 years and over is slightly higher than the England figure of 24.2% and the Yorkshire and Humber region of 25%.

The number of residents aged 65 years and over is also predicted to increase to 61,800 by 2030. It is estimated that the number of people aged 65 years and over who need help with at least one support need is around 15,640. This number is expected to increase by 8% to 16,891 by 2025 and by 16% to 17,867 by the year 2030. The age group of 75 years and over is showing the greatest rate of increase and the percentage of people aged 85 years and over has also increased from 2.1% (Census 2011) to 2.3% (Census 2021).

The population of people living with a primary need of a learning disability in Rotherham is estimated to be 5,202 in 2022. This number is predicted to increase by approximately 100 people every 5 years, with an overall increase of 5% by 2032.

The Rotherham Place Partnership [formerly the Integrated Care Partnership (ICP)] has been in place since 2018 and is responsible for the delivery of the Integrated Health and Social Care Plan and Better Care Fund Plan (2023/25). The Rotherham Place activity is also aligned to our newly formed NHS South Yorkshire Integrated Care Board (SY ICB) including ensuring governance processes support decision making at Place and at SY ICB (where appropriate).

The Rotherham Better Care Fund (including IBCF and ASC Discharge funding) continues to provide a substantial funding stream to some of our key priorities within the Urgent and Community Transformation Programme and surge and winter planning and is aligned to other funding streams such as Ageing Well. The Plan also supports elements of the Health and Wellbeing Strategy (A Healthier Rotherham by 2025) including commitments to support unpaid carers, people with autism and learning disabilities and to tackle health inequalities.

The governance arrangements through Rotherham Place ensure that all partners across the acute and community NHS Foundation Trust, Social Care, Local Authority Service Leads, Strategic Housing, DFG Leads, Mental Health, Public Health, Primary Care, Independent and the Voluntary and Community Sector are engaged strategically and operationally in the development of the Place Plan and BCF Plan, with several task and finish groups in place under an overarching operational and executive meeting structure.

Outcomes for the Rotherham population are jointly agreed and all partners are committed to a whole system partnership approach. The SY ICB Commissioning Plan aligns with the Joint Health and Wellbeing Strategy (A Healthier Rotherham by 2025) and the Integrated Place Plan and sets out, as a key partner, how we will support their delivery.

The Council, South Yorkshire ICB (Rotherham Place) and NHS England work closely together to ensure that all commissioning plans (including the BCF Plan) are aligned so that together we deliver the maximum amount for each 'Rotherham pound'. This includes the System Wide Winter Plan developed annually, within an identified Place fund of c£500K to spend on winter pressures across partners

**How have you gone about involving these stakeholders?**

The Council's Directorate Leadership Team and the Place Executive Team have been involved in the development of the BCF Plan 2023/25 including commissioning, adult care and integration, public health, LA service leads, Strategic Housing, DFG Leads, finance and performance and intelligence.

The BCF Operational and Executive Group members have also been fully consulted in the BCF planning process as well as members of the Health and Wellbeing Board (HWB). The HWB consists of Cabinet Member for Health and Social Care, Chief Executive, Chief Officers and Directors from the Council, South Yorkshire ICB (Rotherham Place) and The Rotherham Foundation Trust (TRFT), Housing, Public Health, Children and Young People's Services, Regeneration and Environment, Executive GP Lead, South Yorkshire Police, Voluntary Action Rotherham (VAR) and Healthwatch. Age UK Rotherham, community health services, in-house and independent sector care home providers have also been involved in development of the Rotherham Place plan and the BCF planning process.

## Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Rotherham has a strong record of joint commissioning between health and social care. This is underpinned by a joint commissioning framework and governance structure which incorporates joint needs assessment, supply mapping, market analysis, pooled budgets and performance management. This has prepared the way for new developments in integrated care which will support people with complex needs to remain independent in the community.

The Better Care Fund Section 75 Agreement for 2023/25 will be approved by the Health and Wellbeing Board which consists of Cabinet Member for Health and Social Care, Elected Members, Chief Executive, Chief Officers and Directors from the Council, South Yorkshire ICB (Rotherham Place) and TRFT, GP Leads, Voluntary Action Rotherham (VAR), Healthwatch on 28th September 2023.

The Health and Wellbeing Board has overall accountability for the delivery of the BCF plan and for the operation of the delivery of the Section 75 Partnership Framework Agreement.

The key responsibilities of the Health and Wellbeing Board include:

- Monitor performance against the BCF Metrics (national / local) and receive exception reports on the BCF action plan
- Agree the Better Care Fund Commissioning Plan
- Agree decisions on commissioning or decommissioning of services, in relation to the BCF

The management and oversight of the delivery of the BCF plan has been delegated to the BCF Executive Group, chaired by the Chair of the Health and Wellbeing Board and including senior representatives from both the Council and the South Yorkshire Integrated Care Board (Rotherham Place).

The key responsibilities of the BCF Executive Group include:

- Make recommendations for the strategic direction and management of the BCF to the Health and Wellbeing Board.
- The delivery of the Better Care Fund Plan for 2023/25
- The strategic operation and delivery of the BCF Framework Partnership agreement
- Setting up the strategy, parameters, criteria priorities and framework
- The fund's feasibility, business plan and achievement of outcomes.
- Defining and realising benefits and budgetary strategy and monitoring spending plans
- Monitor delivery of the BCF Plan through quarterly meetings and ensure performance targets are being met
- Ensure schemes are being delivered and additional action put in place where the plan results unintended consequences.

The BCF Executive Group is supported by the BCF Operational Group, which is made up of the identified lead officers at the Service Head level for each of the BCF actions within the plan, plus other supporting officers from the Council and SYICB (Rotherham Place). The BCF Operational Group meets on a quarterly basis and reports directly to the BCF Executive Group.

The BCF Operational Group is made up of the identified lead officers for each of the BCF priorities, plus other supporting officers from the Council and South Yorkshire Integrated Care Board (Rotherham Place).

The key responsibilities of the BCF Operational Group include:

- Making recommendations to the BCF Executive Group to ensure effective action and implementation of the plan
- Overseeing the delivery of the Better Care Fund Plan for 2023/25
- Co-ordination of the delivery of the BCF Performance Measures and BCF Action Plan
- Ensuring that effective performance management of the BCF Performance Measures takes place and where performance is not meeting targets appropriate and timely action is taken.
- Ensuring the effective delivery of the BCF action plan at an operational level
- Ensuring that the accountable leads of the BCF performance measures and the BCF action plan are collectively discussing their progress and key actions.
- Ensuring the BCF conditions are met.
- Ensuring the customer journeys/experience are delivering increased customer satisfaction as shown by the delivery of the measures, i-statements and the plan.

A financial governance process is in place and the financial monitoring and performance information is provided at quarterly BCF Operational Group meetings and quarterly at Director and Member level.

The financial framework will expose those areas of high risk in year and identify areas where slippage may be available to balance the financial pressure in year. The recurrent plans will be modified, where appropriate, as part of the planning cycle for both Health and Social Care in totality, through the Section 75 Framework Partnership Agreement for 2023-25.

## Executive Summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan

**Priorities for 2023-25**

The Rotherham Place Partnership: Health and Social Care Place Plan delivers a set of 'place' key priorities, which are aligned to the Health and Wellbeing Strategy which aims to transform mental health, learning disability, urgent care and community care services.

Rotherham partners are committed to supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery. Prevention, early intervention and the integration of health and social care services are the focus of the Place Plan and Better Care Fund Plan, to transform the way services are delivered. These plans in Rotherham have increased care delivered in a person's home over recent years to improve outcomes and system flow and reduce inefficiencies. Health and social care transformation programmes include developing alternatives to entering services, developing alternative pathways to hospital admission and facilitating timely discharge.

The Place Plan and Better Care Fund Plan (2023-25) provides an opportunity to build on this to take a more holistic and integrated approach across physical and mental health, social care and the voluntary and community sector to develop and embed an integrated model of care. This model supports individuals and their carers to remain/regain independence and focuses more on prevention. Narrowing inequalities and targeting resources towards areas of greatest need is a key principle of the Health and Wellbeing Strategy.

Rotherham as a Place participated in the joint NHS England and Local Government Association sponsored Place Development Programme and focused on Module C of this programme, Population Health Management (PHM). This programme captured a range of perspectives and insights on PHM. These insights will be taken through key forums such as the Place Prevention and Health Inequalities Enabler Group and our PHM operational group to embed a PHM approach. This will be supported by the Rotherham Office of Data and Analytics (RODA) arrangements and links into the wider Integrated Care Board, including the ICB Public and Population Health Analysis Team.

The urgent and Community transformation group work streams (aligned to national priorities including the BCF and Ageing Well funding streams and Rotherham's Prevention and Health Inequalities strategy) are as follows:

**Workstream 1: Sustaining People at Home, Prevention and Avoidance**

The aim of this work stream is to develop a multi-disciplinary approach which provides the right level of care, at the right time and in the right place to support more people to remain/return to living in their own home as independently as possible and for as long as possible. Projects include:

1. Development of a prevention and anticipatory care model in localities to support those with complex needs, long term conditions and unplanned exacerbations aligned to Ageing Well priorities
2. Embedding and growing Rotherham's virtual ward offer for those who would otherwise be in an acute bed, supported by remote monitoring technology

3. Embedding and developing our urgent community response, growing referral numbers and ensuring a minimum 2 hour response at least 70% of the time
4. Delivering the 4 hour accident and emergency response standard including development of Rotherham's SDEC offer and alternative pathways to admission
5. Reviewing the falls offer to inform development of an integrated health and social care falls pathway

**Workstream 2: Integrating a Sustainable Discharge to Assess Model (Priority 4)**

The aim of this work stream is to develop and implement an integrated Discharge to Assess model, across 7 days, building on the changes made during the pandemic in response to national discharge guidance. We will target specific barriers to effective discharge, including those highlighted in the 100 day challenges, and enhance integrated working across acute and community health, care and the voluntary and community sector. Planned activity includes:

1. Developing and implementing a service improvement plan in the acute hospital to support early discharge planning with patients, carers and health, care and VCS colleagues to reduce those with no right to reside and long lengths of stay and support more people home.
2. Implement a Discharge to Assess model by moving assessment from the acute setting to the community and to further develop an integrated care co-ordination referral and triage hub for admission avoidance and discharge. Members of the hub will work together to identify the right pathway and level of care according to individual needs, facilitate movement across pathways as needs change and maximise effective use of resource.
3. Developing and implementing a service improvement plan in the community bed base to support early discharge planning with patients, carers and health, care and VCS colleagues to reduce those with no right to reside, long lengths of stay and support more people home
4. Review the community bed base offer in the post pandemic, home first context

**Workstream 3: Digital Whole System Flow**

This work stream aims to use technology to support patient care and improve efficiency. Activity includes:

1. Approval and roll out of an assistive care strategy to promote independence and wellbeing and reduce reliance on formal care
2. Procurement of remote monitoring to support the virtual ward. This is being progressed with Barnsley and Sheffield through a joint process co-ordinated by South Yorkshire ICB
3. Digitising record keeping in care homes, part of a wider South Yorkshire programme
4. Expanding the acute command centre to provide a whole system OPEL escalation overview and performance dashboards for operational and strategic decision making.
5. Refreshing our capacity and demand model for intermediate care and discharge

**Key Changes since Previous BCF Plan (2022/23)**

The BCF Plan also reflects the wider priorities within the Place Plan through supporting the transformation of mental health, learning disability, urgent care and community care services.

The key changes since the last BCF plan are as follows:

- Further integration of community health, social and voluntary sector services to support people at home. This includes the initial phase of establishing a co-located multi-disciplinary referral and triage hub to co-ordinate the right level of care for individuals and reduce avoidable admissions and facilitate discharge.

- Increase in health and social care services to support more people at home. This includes support for health rapid response services, reablement and home care as well as the equipment service to enable the needs of the individual to be met at home.
- Both changes detailed above has enabled Rotherham Place to rapidly roll out the 'PUSH' model with Yorkshire Ambulance service in response to industrial action. This was initially in response to low level falls which resulted in "long lies" and potential complications and is currently being expanded and embedded. Over 50 conveyances and potential admissions have been avoided in Quarter 1 through this pathway.
- Investment in the community bed base has supported a higher level of acuity / complexity for people who cannot be supported at home and facilitated system flow.
- Support for the VCS hospital after care service has facilitated more timely discharge from acute and community beds, reducing the reliance on formal services. As well as transport, settling in support and advice, the service now provides low level non personal enablement and a follow up safety netting service.
- Support for carers – a Carers Strategy Manager has taken up post. The role will focus on delivering the objectives of "The Borough that Cares" Strategy
- The publication of the Market Position Statement for the South Yorkshire Integrated Care System (ICS) in relation to housing with support for people with learning disabilities and / or autism
- Further roll out of ECHO e-learning platform to cover health related topics including End of Life Care, Dementia, Falls, Strokes, Diabetes.
- Increased the spend on the COT provision in year to support the demand profile and to reduce waiting times
- Continued funding for brokerage to provide support over the weekend to facilitate hospital discharges.
- Continued funding for a Public Health Specialist (and admin. support) for the programme management of the Prevention and Health Inequalities Strategy.
- Workforce investment has enabled innovative approaches to be taken including development of a hybrid health and social care support worker role to support more people at home
- Utilising technology as an alternative to formal care including use of assistive technology and promotion of Single Handed or Proportionate Care,an ethos which asks if the person's needs can be met by one carer with use of equipment, adaptations and techniques.

**National Condition 1: Overall BCF plan and approach to integration**

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

**Joint Priorities for 2023-25**

Please see Executive Summary for detail of our joint key priorities for 2023-25 and changes to our approach in supporting the transformation of mental health, learning disability, urgent care and community care services.

**Approaches to Joint / Collaborative Commissioning**

RMBC and SYICB (Rotherham Place) have a proven track record of successful joint / collaborative commissioning which is managed by the BCF Executive Group which acts as a key decision-making forum on areas of common interest and joint priorities across the health and social care community. There is a joint performance management framework in place which includes the monitoring of BCF funded schemes and development of pooled budget arrangements. Assurance of performance delivery is provided through the Place governance framework. Together this provides the framework for a more innovative, cross system multi-disciplinary approach to be taken with targeted investment to support new ways of working and integrated services and roles. It provides the means for the development of joint strategies and service reviews, facilitating stakeholder engagement and incorporating the views of service users, carers and service providers. There are 3 joint health and social care commissioning roles within the Adult Commissioning framework.

The Adult Social Care Pathway is a whole system approach with specialisms working together to fully explore the potential of individuals to become as independent as possible.

The community support offer within the Adult Social Care Pathway model connects people with their local social, community, housing and neighbourhood assets, through joint working with partners across Rotherham to allow people to access the support they need providing a variety of more sustainable support networks.

Rotherham Place fully recognises that individuals need to be at the centre of the adult social care pathway. People are encouraged to self-manage their care unless their requirements exceed the threshold. This means that people who have a care package will be re-enabled so that their needs decrease, resulting in either a reduced care package or no required package, an increased level of independence and enhanced quality of life, that is healthier and more fulfilling for the individual. This has led to a better understanding of what care is currently being provided and whether or not this is the most appropriate, with increased reviews and oversight, specifically with a recovery model that requires close working with the provider and individuals.

An initiative that the Place is looking at currently is to further develop our proportionate care approach, recognising the challenges with workforce across the social care sector, particularly home care. Single Handed or Proportionate Care is an ethos which asks if the person's needs can be met by one carer. With use of specific equipment, adaptations and techniques it is usually possible to enable someone to maintain their dignity and reduce their need for formal care. The benefit to the person and across the systems are being increasingly recognised across stakeholder groups. These benefits include a more strengths based, person centred approach, identifying the least intrusive options for care, and improving relationships with the individual, carer and family. It also supports the national shortage of care hours available within the system and can release resource to reinvest in essential care.

Specialist training has been provided to colleagues across the Reablement pathway including Occupational Therapists, Reablement Coordinators and Trainers from the Care Provider network.

The Council and South Yorkshire ICB (Rotherham Place) Commissioning Teams are working collaboratively together to increase the range and availability of equipment available to support this approach.

The aim of care and support is for people to live the best life that they can, meaning living independently, in their own home when possible, utilising the assets and the people around them to do the things that make them happy and leading a fulfilled life. This has required a strengthening of partnerships and collaboration with a wide range of key stakeholders including Public Health, Strategic Housing, DFG Leads, South Yorkshire ICB (Rotherham Place), Foundation Trusts and Mental Health Trusts, voluntary, community and independent sector to create more options for how care can be delivered through, for example, natural forms of support, universal services and community assets, as well as formal health and social care services.

The four key themes of the Adult Social Care Pathway model are as follows:

1. Prevention
2. Integration
3. Care co-ordination
4. Maximising independence and reablement.

The Integrated Discharge Team are moving towards a full discharge to assess model. The first phase of the transition has been completed with the establishment of an urgent community referral and triage hub with health, care and voluntary sector specialists co-located to enable a multi-disciplinary approach to providing the right level of care, at the right time and right place for individuals. As the hub is based in the community it is more attuned to the level of risk that can be safely supported in a person's home than an acute based service. This in turn reduces unnecessary conveyances to hospital and avoidable admissions, supports timely discharge and increases the number of discharges home. A core care co-ordination service for urgent responses is staffed 24 hours a day, 7 days a week with specialist teams available in core hours aligned to the higher periods of demand.

Responsibility for Reablement Service transferred to Adult Social Care Provider services in December 2022. Programming efficiencies have released capacity with the service operational from 7.00 am to 10.00 pm 7 days a week. The ability to re-able more people as soon as possible is a core commitment to improve outcomes for greater independence for individuals and to ensure that social care provision, which has been increasingly hard to source is channelled to those who need it most.

The Reablement Service is working closely with the Integrated Rapid Response Service to support assessment and case management. A reablement assessor and co-ordinator are both part of the urgent community hub to facilitate triage and a more flexible use of resource. A new hybrid health and social care support worker role has been developed and implemented. The role is hosted by the Foundation Trust providing a flexible resource which works across the urgent pathways including the virtual ward, urgent community response and pathway 1 discharges as demand requires.

The Place Workforce group has worked collaboratively across South Yorkshire and locally to develop recruitment strategies including joint recruitment events which have contributed to the recruitment to the hybrid health and care support worker roles. Apprenticeship opportunities to enhance the health and care offer are being developed.

**How BCF funded services are supporting our approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.**

The BCF funded schemes described above will continue to support our approach to continued integration of health and social care provision, working collaboratively with the voluntary and community sector. This will continue to support further improvements of outcomes for people with care and support needs to help people remain independent at home for as long as possible and ensure the right level of care according to an individual's needs at that time.

Over the period 2023-25 the Council, along with partners, will continue to focus on a strengths-based approach, in partnership with staff, to ensure that community assets are utilised and self-directed support is maximised, thus increasing choice and control.

Over this period, we will also review our current offer including further capacity and demand analysis and utilising population health data to assess provision against outcomes and value for money, managed through the BCF assurance framework. We will continue to invest in services and development which support independence and self-management and support more people at home, whilst acknowledging the greater complexity, dependency and acuity of an ageing society in the post pandemic context.

To this end we will:

- Review our approach to pro-active care working in partnership with primary and secondary community care and the voluntary sector to target those at risk of deterioration and work with the individual, families and carers to agree advanced care plans which support what matters to them.
- Further strengthen our approach to integrated assessment and triage to ensure right levels of care for improved patient outcomes and effective use of system resources. This will include full role out of the community-based care co-ordination hub for admission avoidance and discharge and a fully implemented discharge to assess model
- Strengthen and embed our approach and use of assistive technology and proportionate care across partners.
- Focus on greater promotion of the use of individual budgets via a direct payment, strength based, focussed assessment of well-being and clear evidence of a person's needs. Consideration must be taken in relation to eligibility criteria, support planning, completion of Continuing Health Care and Decision Support Tool checklists.
- Provide targeted support in the community for the most complex, vulnerable and /or highest acuity people including those in crisis, mental health and complex continuing care which cannot be met through currently commissioned provision.
- Continue to develop our workforce, working in partnership across health and social care to provide attractive and flexible career opportunities, development schemes and integrated services and roles.
- Develop our digital offer including a whole system command centre and performance dashboard to help manage system flow and anticipate and respond to system pressure
- The Council's Aids and Adaptation Policy is also currently under review. As part of the process, consideration will be given to making use of the Regulatory Reform Order (RRO). The new policy will detail how the Council intend to exercise their powers under the RRO, as this allows the Council to use Government funding for the DFG more flexibly, improving outcomes for people with care and support needs. The aim is for the new policy to be approved in December 2023. ,

**National Condition 2**

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe your approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- Steps to personalise care and deliver asset based approaches
- Implementing joined up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these processes
- Multi-disciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- How work to support unpaid carers and deliver housing adaptations will support this objective.

The BCF funding enables people to stay well, safe and independent at home for longer and provides the right care in the right place at the right time. The BCF funded services will support delivery of these objectives through collaborative commissioning with primary, intermediate, community and social care services to help people to remain at home.

The aim of care and support is for people to live the best life that they can, meaning living independently, in their own home when possible, utilising the assets and the people around them to do the things that make them happy and leading a fulfilled life and provide personalised care and support planning based on a 'what matters to me' conversation.

At a service user level, the utilisation of the Better Care Fund 2023/25 is based on the experiences, values and needs of our service users, patients and carers. To demontrate the outcomes local people want from better integrated, person centred services, a number of "I statements" based on their testimonies have been defined and "We" statements for providers. The ambition is to link these to the Provider Assessment and Market Management Solution (PAMMS) to inform regular contract monitoring returns. The Rotherham Health and Wellbeing Board holds the responsibility for the Better Care Fund plan and will work towards achieving these outcomes:

'I am in control of my care' - People want to feel central to decision making and development of their care plans, they want all professionals and services to communicate with each other to understand their care needs and ensure they receive the most appropriate care for their circumstances, and they want to be provided with the right information to help them to manage their conditions and make informed choices about their own health and wellbeing.

'I am listened to and supported at an early stage to avoid a crisis' - People want support, advice and information at an early stage to help them look after their mental health and wellbeing, avoiding the need for more intense, high-level services when they reach crisis point.

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing' - People want a greater focus on preventative services and an increased

capacity in community activity to prevent high intensity use of services and more formal care, and to help them better manage their conditions. They also want services to be available 7 days a week and information and advice to be more accessible.

'I feel safe and am able to live independently where I choose' - People want to stay independent and in their own homes for as long as possible. They want to feel safe to do this and know that the right support is available when and where they need it.

To demontrate the outcomes of a better integrated, person centred services, a number of "We statements" include:

'We have conversations with people to discover what they want from life and the care, support and housing that will enable this, without restricting solutions to formal services and conventional treatments".

"We work with people to make sure that their personal plans promote wellbeing and enable them to be as independent as possible".

"We make sure people feel safe and comfortable in their own home, which is accessible, with appropriate aids, adaptations, technology and medical equipment".

The launch of the Provider Assessment and Market Management Solution (PAMMS) which is an on-line commissioning toolkit to support market shaping and oversight responsibilities and assesses the quality of care delivered by providers was embedded during 2022/23. This ensures better data collection, analysis and reporting to increase care quality and mitigate risks of provider failure. Adult social care providers will have completed their Quality Assurance self-assessments during 2022/23 and 2023/24.

The RMBC Insight system also provides a wealth of "live" performance data of how many individuals are being supported by adult social care commissoined services.

At a system level the avoidable admissions metrics for 2022-3 illustrate a sustained period of system pressure from the autumn through to December. This is expected to return to more standardised seasonal variation in 2023-4 as the impact of Covid outbreaks and children's seasonal respiratory conditions reduces. Emergency admissions due to falls have slighltly reduced in recent years, however there is evidence of duplication and gaps across the system. We believe we can improve this metric through a whole system review of falls pathway to develop a more integrated approach. This work will be taken forward through priority 1 of our Place plan which focusses on prevention and admission avoidance. BCF funding will be used to develop our out of hospital urgent and unplanned pathways including the virtual ward, urgent community response, intermediate care offer and transfer of care hub.

**Discharge**

Our metrics show that we are performing well against the national benchmark of discharges home with low rates of re-admission. However, the numbers remaining at home 91 days after discharge have dipped and admissions to residential care are above the regional benchmark. Factors influencing this include the aging population and the impact of Covid increasing the level of acuity and complexity of patients requiring support in the community.

There is a joint approach to discharge planning within Rotherham. We have made significant progress in implementing the acute, community and mental health 100-day challenges which have had a positive impact on system flow. A four-day quality service improvement and re-design event

was held in April 2023 which informed a system lead time out session to develop a discharge to assess model and action plan.

BCF funding contributes to the Rotherham Integrated Discharge Team (IDT) – funding posts such as the joint manager across health and social care and the capacity manager in The Rotherham Foundation Trust (TRFT) who provides daily oversight across Place and escalation levels (Opel).

The Rotherham pathway for discharge home was c 93-94% in 2022-23, against a target of 95%. Whilst the national target has not been achieved performance needs to be assessed against the backdrop of a very challenging post pandemic recovery and recruitment and retention and sustained system pressures. Rotherham's position compares favourably within the South Yorkshire footprint and is above the national average. Length of Stay (LOS) has fluctuated due to challenges with Covid pressures, although these are reducing, and Rotherham performs well in relation to low rates of re-admission.

Significant progress has been made in relation to:

**MDT Working** has been strengthened with the establishment of the community based urgent community referral and triage hub. This includes nursing, therapy, social care and the voluntary sector. There is a well-established contract with Age UK for hospital after care support which now supports discharge from the acute and community bed base providing transport, non-personal enablement, advice and access to low level equipment. The service also provides safety netting for those at risk. Two VCS pilots are underway. The first is a social prescriber link worker who in-reaches into the emergency department for admission avoidance and facilitates discharge. The second is piloting personal health budgets to facilitate timely discharge. This is through the Community Group 'We Ask You Respond".

**Home First/Discharge to Assess** The Place intermediate care and reablement strategy, developed and partially implemented before the pandemic, reduced the community bed base to free up resources to re-invest in home based services. Further investment in home-based services has been made possible through the Better Care Fund and use of short-term discharge monies in 2022-23. A discharge to assess pilot was trialled over the winter which provided important learning regarding barriers to implementation. The responsibility for co-ordination and management of the discharge pathways will move to the community in 2023-24 and will be managed through the urgent community hub, in order to fully implement a discharge to assess model.

**Rotherham's intermediate care, reablement and recovery pathway** is well established. BCF funding has been invested in a range of community services including urgent response, reablement and therapies. The Council has also increased the number of providers on the jointly commissioned home care framework (home first) to support the demands on the care sector and provided incentives to help offset recruitment and retention challenges through discharge fund monies. Additional resource has been invested to support the review of care packages, freeing capacity to provide better flow from hospital. Additional reablement co-ordinator and support worker roles (including the hybrid health and care role) have increased capacity. Investment has also been made in the brokerage service to provide an enhanced offer for complex care and extend working hours to better support discharge.

**Multi-disciplinary teams at Place Level –** which takes into account the vision set out in the Fuller Stocktake. Across the Rotherham system we are developing our plans for Anticipatory Care Planning (ACP). ACP is a person-centred, proactive "thinking ahead" approach whereby health and social care professionals support and encourage individuals, their families and carers to plan ahead of any changes in their health or care needs. The aim is to increase people's healthy, independent

years by up to five more years. Anticipatory care encourages people to make positive choices about what they should do themselves, and from whom they should seek support, in the event of a flare up or deterioration in their condition, or in the event of a carer crisis.

A multi partner steering group has been set up to lead this work stream with a cross system workshop held in April 2023 to define and develop the approach, to be implemented across the Borough in 2024. Discussions suggested that Rotherham has good foundations to build upon and that "what matters most" to patients and personalisation needs to be at the heart of discussions. The impact of health inequalities on long term conditions was explored and it was recognised that we need to take this into account as part of our plans and recognise that anticipatory care is all age groups.

**Flexible Working and Trusted Assessments-** Within Rotherham there is a 7 day discharge service which includes the integrated discharge team, brokerage and dispensing. Community colleagues are working into the acute and community bed base to support timely discharge. This includes nurse consultants in-reaching to case find and support discharge to the virtual ward to support people who are not yet medically fit to be discharged home, as well as ACPs, nurses and therapists in-reaching to the emergency department, Same Day Emergency Care (SDEC), admission units and wards. However, issues remain particularly in relation to the ability of care homes and home care to accept discharges over the weekend. A trusted assessor approach has worked well in home care and a model is being explored for care homes. Where discharges cannot be completed over the weekend, arrangements are planned through the weekend for early discharge Monday morning.

**Choice** - The Deputy Chief Nurse has carried out extensive work to improve communication and engagement with patients and their supporters. This includes banner stands on wards and an information pack for each bedside. All discharge letters have been reviewed with new information leaflets developed. Work is underway to improve communication and support for carers as part of the discharge process.

**Discharge to Care Homes -** Rotherham has carried out two self-assessments against the enhanced health in care homes framework. Each care home has an allocated GP. Commissioners are working with GP practitioners to develop a proportionate continuum of care appropriate to the needs of the individual. The physical and mental health care homes teams provide proactive support and training. The teams continue to work closely with Public Health and Commissioners to ensure Care Homes remain up to date and supported with changing guidance on infection control, use of PPE and regulatory requirements.

Domains identified as requiring additional development include:

**Discharge**

1. **Early Discharge Planning** in line with the 100 day challenges all patients now have an expected date of discharge set within 24 hours. Plans are in place to support earlier discharge planning in practice and provide better co-ordination between acute and community services and involving patients, families and carers at an early stage.
2. **Discharge Home -** Rotherham does not currently have a discharge to assess model in place. We will move the majority of assessments to the community setting in order to ensure the right level of care is provided. This will be enabled by moving most of the acute based discharge team to the community setting and fully integrating it with the urgent community hub.

3. **Review of the bed base** we currently have a high occupancy rate in the acute setting. We will grow the number of acute beds according to national guidance. We will review the community bed offer within the context of home first to better manage higher levels of acuity and surge.

**Falls -** Our current offer is fragmented across health, care and the voluntary sector. We will review the offer and develop a more integrated approach.

**End of Life** - We are working with South Yorkshire and Place partners to ensure people at the end of life and their families receive timely support and a positive end of life experience in accordance with their wishes.

**Assistive Technology -** The Council will develop an assistive technology strategy and promote proportionate care. We will seek to invest in this area to increase awareness and grow use across health, care and the VCS.

**Housing** – The housing service is now more proactively involved in discharge planning. We will seek to grow this relationship to develop short term placement opportunities and more effective use of voids. The Disabled Facilities Grant (DFG) provides funding for Housing to support for the provision of aids and adaptations to disabled people's homes to enable them to live independently in their own homes and to improve their quality of life.

**Unpaid Carers –** A Carers Strategy Manager role has been employed using BCF funding to achieve the objectives of "The Borough That Cares" Strategy to support the co-ordination of the co-production exercise, achieve inclusion of all relevant stakeholders, develop the resulting action plan and administer any commissioning intentions. This enables unpaid carers to support their loved ones to stay well, safe and independent at home for longer.

**Brokerage -** The brokerage function has also been increased to cover weekends to support hospital discharges.

The above BCF funded services improves the discharge process from hospital and ensures that people get the right care at the right time. We will continue to utilise BCF funding to support and develop these initiatives.

Rotherham is working across Place and ICS partners to share knowledge and develop our capabilities in understanding and addressing Health Inequalities and Population Health Management (PHM). Place partners meet monthly as a Prevention and Health Inequalities Enabler Group, chaired by the Director of Public Health. This group leads the multi-agency approach to address Prevention and Health Inequalities across Rotherham, linking to the wider South Yorkshire Integrated Care Board. This has included developing Rotherham's partnership strategy and plan around prevention and tackling health inequalities, looking at the whole population and the individual.

This Enabler group is supported by a data network across Place to share knowledge and learning in relation to Health Inequalities Data. The Rotherham Place system has developed a network of BI professionals as a virtual Rotherham Office of Data and Analytics (RODA) as a Place wide capability in analysing and interpreting Public Health Management and Health Inequality data, supporting the Place wide Health Inequality and Prevention Group work programme. RODA aims to generate insight into areas such as the inclusive restoration of services and population segmentation. Rotherham as a Place also participated in the joint NHS England and Local Government Association sponsored Place Development Programme and focused on Module C of

this programme, Population Health Management. As part of this programme the Place have undertaken a series of externally facilitated Action Learning Sets, to test out a PHM approach. This programme has generated a wide range of quantitative and qualitative knowledge and insight on Health Inequalities, acting as a foundation for a work programme to address these. Rotherham has also worked with Sheffield University to consider how to gain better insight into PHM.

RODA colleagues also link with the wider ICB intelligence arrangements, including being part of the DAISY (Data, Analytics and Intelligence for South Yorkshire) group, led by the ICB Associate Director of Public Health Analysis.

Rotherham Place continues to focus on inequalities and CORE20PLUS5 through the creation of a Health Inequalities Monitoring Tool and Outcomes Framework to inform the work of the Prevention and Health Inequalities Enabler Group. The Place is also keen to work across partners to develop insights for groups where available data is more limited currently.

The Place system has also started to focus on the impact of the pandemic and taking a population approach to meeting those needs and preventing further demand. This includes resources funded through BCF and working with partners to review/audit access to acute care for those with long Covid. Physical and mental health needs are rising, it is timely to deliver a focused piece of work. This will include looking at risk factor prevalence, with a focus on cardio-vascular disease, diabetes, mental health.

The Rotherham Place is working on our Anticipatory Care model, the national ask is for systems to provide proactive health and care interventions for all ages. To be targeted at frailty, multiple morbidity and / or complex needs for people living in their own homes. The focus is on what is important to individuals, and it is delivered and co-ordinated through cross system MDT working. The Rotherham Place has allocated funding in year to scope the development, which will use population health and local data to identify those at risk by PCN / Offer, carry out a proactive needs assessment with individuals, provide personalised care and support planning based on a 'what matters to me conversation' and establish a digital MDT to agree what interventions the person needs

**National Condition 2 (continued)**

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- Learning from 2022/23 such as:
  - where numbers of referrals did and did not meet expectations
  - unmet demand i.e where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - patterns of referrals and impact of work to reduce demand on bedded services – eg admissions avoidance and improved care in community settings, plus evidence of un-derutilisation or over-prescription of existing intermediate care services)

- Approach to estimating demand, assumptions made and gaps in provision identified
  - Where if anywhere, have you estimated there will be gaps between the capacity and the demand?

- How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans.

**Capacity and Demand for Intermediate Care to Support People in the Community**

**Learning from 2022/23**

The Rotherham Place has developed an acute clinical command centre which provides full visibility of patient flow, in real time, to and through the acute hospital to enable strategic and operational decision making. BCF monies have been used to develop the acute escalation wheel which provides a real time automated view of OPEL escalations levels to cover community services. This will replace a manual daily snapshot report circulated to all partners.

In parallel, a capacity and demand tool has been developed to support development of intermediate care and reablement and discharge pathways. A robust escalation ladder is in place including an executive lead meeting held three times a week during periods of heightened pressure.

Over the last two cycles patterns of referrals for community and hospital discharges have been high during summer and winter periods reducing in the spring and autumn. There have been sustained periods of system pressure due to the impact of the pandemic and recruitment and retention issues particularly in relation to care and some qualified roles such as social workers and therapy.

The number of referrals to intermediate care beds have increased and a bed occupancy rate of 89% has been achieved in 2022/23. The capacity of the Council's reablement team was also increased over the winter period which was funded by discharge monies

The surge community beds were well utilised over the winter period which were also funded by discharge funding which offered care and support for those that were waiting for a home care package, equipment or other ongoing services, with the plan for them to return home safely. The referral pathway for these beds has been widened to the community for admission avoidance purposes.

**Approach to Estimating Demand, Assumptions Made and Gaps in Provision Identified**

Capacity and demand modelling has been based on establishing a baseline level of resource required throughout the year to support our avoidance and discharge pathways. However, this approach will be developed prior to winter 2023-4 through Priority 3 of the Rotherham Place Urgent and Emergency Programme. The aim of this work-stream is to gain a better understanding of whole system flow, including pressure points. This includes improving our understanding of current capacity and demand, by refreshing our performance tool and developing an integrated performance dashboard which will be monitored through our monthly Place Urgent and Emergency Care Group. As part of the development work the information will be mapped to gain a better understanding of seasonal variation and the impact of interventions so we have a more robust baseline and can better target short term seasonal investment strategies. We will use BCF monies to secure specialist resource to help with the modelling of this information as well as planning and implementing a step change in how we support admission avoidance and discharge.

We will continue to use the BCF to support winter pressures. A review of 2022-3 has been completed highlighting a number of successful schemes with recommendations for 2023-4 including extending operational hours in key areas such as pharmacy, the discharge lounge and weekend working, additional seasonal capacity, targeted winter roles and beds, investment in

avoidance pathways, development of the integrated transfer of care hub and D2A model and the Place escalation wheel

Our plan is to continue increasing capacity within the community through increased use of reablement services, assistive technology aids and adaptations, supporting unpaid carers and other housing options. This in turn will reduce the number of existing intermediate care beds, although they are well utilised at present.

Through development of the discharge to assess model with the majority of assessments taking place in the community and the expansion of our urgent and community referral and triage hub we are expecting to make some efficiency savings through a reduction in the level of care required and hand offs and more flexible allocation of resources.

**National Condition 2 (continued)**

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- Unplanned admissions to hospital for ambulatory care sensitive conditions
- Emergency hospital admissions following a fall for people over the age of 65
- The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

The Rotherham NHS Foundation Trust are developing their (Same Day Emergency Care (SDEC) offer as part of the re-introduction of the 4 hour response standard. Part of this work includes the development of urgent response pathways and alternative pathways to ED and admission. This includes supporting the expansion of the PUSH model with the Yorkshire Ambulance Service including support for Rothercare and urgent community response teams and support to care homes following a deterioration or fall to grow the number of accepted referrals. Evidence shows that such pathways can significantly reduce avoidable conveyances which often go on to result in an unnecessary admission.

We will be updating our capacity and demand model in quarter one and will use the outcomes to inform the allocation of resources over the next 12-24 months, taking into account seasonal variations. We will seek to invest in continuing health care to support higher levels of acuity at home and provide targeted support to meet needs relating to mental health, learning disabilities and autism.

BCF funded schemes will continue to have an impact on reducing unplanned and emergency hospital admissions (including falls for older people aged 65 years and over) and decrease the number of older people whose long-term support needs were met by admission to residential and nursing care homes.

Training, development and investment in proportionate care and assistive technology and provision of aids and adaptations will enable more people to be independent at home for longer, with reduced care and support needs. Urgent community response, reablement and rehabilitation services and intermediate care bed services will also continue to support admission avoidance.

**National Condition 3**

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge including:

- Ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.
- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.
- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Rotherham has had a longstanding commitment to home first principles. This approach was refreshed in the intermediate care and reablement strategy developed and approved in 2018. The strategy was to streamline discharge pathways, reduce the community bed base and re-invest in home-based services. 7 disparate discharge pathways were reduced to 3 which were then aligned to the national pathways following publication of the national discharge to assess guidance in March 2020. The community bed base was reduced and consolidated on 3 sites with two centres for intermediate care and one for intermediate care with nursing and discharge to assess beds.

Increasing out of hospital, home based care continues to be our strategy, in line with national drivers. We have utilised Improved Better Care Funding and additional national discharge monies to this end and to reduce seasonal and exceptional system pressures and improve flow.

Investment schemes have included:

1. Increasing capacity and providing incentives to home care providers to address increased demand and recruitment and retention barriers.
2. Commissioning a care broker service and home care bridging service
3. Increasing capacity in urgent response nursing and therapy services and reablement to support discharge and assessment at home
4. Supporting extended hours, including evenings and weekends according to demand in services such as transport, brokerage, pharmacy, the discharge lounge and discharge team.
5. Supporting unpaid carers
6. Commissioning additional community bed capacity on a short term block and spot purchase basis to manage increased demand and complexity. This included 15 additional residential step down beds, nursing EMI beds and crisis mental health beds.
7. Investing in the voluntary and community sector including extension of the hospital after care service, piloting of personal health budgets and befriending services

8. Investing in assistive technology and purchasing equipment, deep cleaning and decluttering (hoarding) to enable faster turn-around of community beds and bariatric equipment to support a growing need.

The schemes are currently being evaluated and will inform future development and spend. However, given the short-term nature of funding in 2022-23 there was insufficient time for some of the schemes to be established and developed.

We therefore plan to allocate some of the 2023-25 funding to an 'innovation' scheme, to enable us to pilot activity which has either evaluated well or is evidence of good practice from elsewhere and can be used to pump prime new ways of working or helps address an identified barrier to discharge. Evidence from our whole system flow improvement work will highlight areas of variation which we will seek to smooth out through the year using targeted short term investment opportunities.

We will also use discharge funding in 2023/25 to ensure that people receive the right care in the right place at the right time and commissioning of these services will ensure services are being delivered to support safe and timely discharge, thus freeing up hospital beds.

This funding will provide resource to deflect/support at the front door and increase capacity to support more people at home including reablement and home care. We have identified a number of barriers to 7 day discharge and will invest in shortage areas including a Housing Officer to work with the Integrated Discharge Team, CHC co-ordinators in the practice hub, a mental health discharge co-ordinator and a trusted assessor for discharges to care homes.

We will continue to support additional community beds during the transition period as we develop our discharge to assess model as well as incentive payments for nursing EMI beds, an area of concern within the Borough. In addition to this we will invest in community equipment, short-term stays to help manage in a crisis situation, hospice clinical nurse specialist to increase community activity, increase hospice bed availability and increase in CHC assessments to improve flow.

**National Condition 3 (continued)**

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- Learning from 2022/23 such as:
  - where numbers of referrals did and did not meet expectations
  - unmet demand i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - patterns of referrals and impact on work to reduce demand on bedded services – eg improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services)

- Approach to estimating demand, assumptions made and gaps in provision identified
  - Where if anywhere, have you estimated there will be gaps between the capacity and the demand?
  - How have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

**Capacity and Demand for Intermediate Care to Support Discharges from Hospital**

**Learning from 2022/23**

We will be conducting a capacity and demand exercise of intermediate care in quarter 1 alongside evaluating the impact of the national discharge monies. The outcomes will inform future allocation of resource. When last carried out this evidenced a significant gap in reablement and rapid response services which the BCF was used to support. It is anticipated that there will be a continued need for further reablement and urgent care resource in order to support short term care and grow out of hospital capacity. Our new hybrid health and social care support worker role has proved attractive in the recruitment market. This is a likely area of expansion, particularly as we seek to extend service hours.

Whilst the model suggested the level of resource in the discharge team and therapies was appropriate at the time the integrated discharge team has seen an increase of over 46% since 2019. In parallel to this we have experienced significant challenges in recruiting social workers and therapists resulting in a number of ongoing vacancies. Alternative solutions have been put in place where possible, including development schemes and the appointment of ARCs instead of social workers. However, this does leave an experience and knowledge gap.

It is anticipated that challenges in the home care and care home market are reducing following an uplift in payments. However, there is recognition that our fee rates are lower than some neighbouring areas. We have identified a particular risk in nursing EMI provision which may require some targeted intervention.

Investment in the voluntary sector has been productive, providing flexible resource closer to home and reducing reliance on formal care. However, it takes time for these services to embed, particularly in relation to communicating the offer across a wide range of acute and community services. To this end VCS colleagues are attending our discharge and community hub MDTs to raise awareness and case find. This is increasing the number of referrals, but is resource intensive.

**Approach to estimating Demand, Assumptions Made and Gaps in Provision Identified**

Whilst occupancy rates in the block purchased community beds were good, this was partly due to challenges in supporting more people at home. We believe there is some capacity in the system to support more people at home but that it was not possible to develop and implement new ways of working during the height of system pressures. This will be addressed over the course of 2023/24 through conducting Quality, Service Improvement and Redesign (QSIR) events across acute and community discharge services, the implementation of a discharge to assess model and the extension of the urgent community hub. This will ensure that unmet needs will be identified, and that people are offered support in the most appropriate service. However we anticipate that this alone will not be sufficient to meet higher periods of demand and that further targeted investment will be required.

Where possible we will seek to re-invest resource from elsewhere in pathways. The development of the urgent community hub has enabled a more flexible use of resource with the ability to move people more easily across pathways as their condition changes and to provide alternative care where there are shortages. For example, the rapid response team and support workers provide a bridging offer where a care package cannot be sourced or there is a shortage of reablement resource. We anticipate development of this approach will release capacity by reducing duplication and hand offs. The introduction of Rotherham's virtual ward in December 2022 enables people who would otherwise be in an acute bed to remain at home or to be stepped down from an acute

bed prior to being declared medically ready. As people improve on the virtual ward, they are stepped down to other unplanned services according to their need and likewise patients can be stepped up where their condition worsens. This reduces the length of stay on the virtual ward and enables the right level of care to be assigned according to need.

Currently there is an issue in the quality of information received from ward staff to make informed decisions around the correct pathway. In the coming months we are moving to a model where ward staff 'describe' the situation rather than 'prescribe' the need. A patient passport is being planned which will be developed through the patient journey. Our aim is to link this with the anticipatory care work to start the passport in a planned way so advanced care plans are in place, and accessed in the event of an urgent exacerbation. It is envisaged that the VCS could play a significant role in the initial development of the plan.

**National Condition 3 (continued)**

Set out how BCF funded activity will support the delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

BCF Funded schemes will support the further development of the integrated urgent and community hub and discharge to assess model. Schemes will include investment in the voluntary sector, reablement and urgent response. This will enable more people to be allocated to the right level of care at the right time and place and will reduce delayed discharges.

The development of our whole system command centre, performance dashboard and Opel Escalation Wheel will enable us to make evidence-based decisions to inform strategic commissioning and operational decision making.

**National Condition 3 (continued)**

Set out progress in implementing the High Impact Change Model for managing transfer of care, any areas for improvement identified and planned work to address these.

The initial self-assessment against the High Impact Change Model led to the establishment of the Rotherham integrated health and social care discharge team and a range of process and system service improvements.

The model has informed planning for the full implementation of our Discharge to Assess (D2A) model. Significant progress has been made against 7 of the 9 domains and we are active in all 9. Further work is planned during 2023/25.

**National Condition 3 (continued)**

Please describe how you have used BCF funding, including the IBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

Adult Social Care, Housing and Public Health Services work collaboratively together in responding to the Care Act (2014) requirements to prevent, reduce or delay care and support needs, provide timely Care Act assessments and to support the role of unpaid carers to continue their caring role in the community.

The BCF, IBCF and DFG funding is used to commission a range of services including intermediate care, reablement, therapy, assistive technology, community equipment, aids and adaptations, carers support services, direct payments, advocacy, supported living, transitional placements for learning disabilities, social work teams, care home support, adult mental health liaison teams, GP medical cover, social prescribing, end of life care and exercise programmes. Funding also supports digital enablers to support integration of community services and to support IT infrastructure and promote integrated working. There is also project support for the implementation of our population health strategy to reduce health inequalities. IBCF is also used to support sustainability of the adult social care market and to increase capacity over the winter period.

The ASC Discharge Fund (2022/23) provided an increase in the number of Care Act assessments to increase patient flow from the hospital, to support unpaid carers in their caring role which provided an opportunity to pilot a support service and to provide incentive payments to recruit and retain the adult social care workforce to ensure sustainability of the adult social care market.

Housing will also ensure that information and advice is provided within the Council's Aids and Adaptations Policy which is currently under review.

**Supporting Unpaid Carers**

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The Rotherham Health and Wellbeing Board's (HWB) vision is for Rotherham to be a carer friendly Borough. There are around 31,500 unpaid carers in Rotherham, which shows that at least 12% of people living in Rotherham fulfil an unpaid caring role.

As Rotherham's ageing population increases, it is predicted that more people will identify as an unpaid carer. The Council's Borough that Cares Strategic Framework 2022-25 provides a strategic framework with a purpose to ensure unpaid carers can live well, be active and have fulfilled lives.

The Carers Strategy – *The Borough That Cares* has been co-produced with carers, carer organisations, colleagues across the Council, Health and the voluntary sector and has been signed off by the Health and Wellbeing Board. This is 'live' document which will be updated on an ongoing basis to reflect required actions and activity. The carers voice is embedded throughout the framework.

The Strategic Framework (2022-25) sets out a vision for working with and supporting carers, it also provides an action focused road map for how the Rotherham Place will achieve this change directly with carers. Over the next three years, the Place system will work to deliver the actions, and will continue to put carers at the heart of this process through their direct involvement in *The Borough That Cares* Strategic Group.

The purpose of the strategic framework is to ensure carers can live well, be active and have fulfilled lives. It recognises that carrying out an unpaid carer role can be rewarding and life affirming.

The Council Plan also shows priorities that we work with health and community partners to provide accessible, high-quality services for adults with support needs, including those with disabilities, older people and their carers

The Better Care Fund currently has a budget allocation of around £600,000 to provide support to a range of Carers Support Services. The BCF funding to support carers has been reinvested to provide dedicated resources to oversee implementation. An investment will be made to increase the number of carers assessment / carers direct payment to provide carers breaks and support to carers as per the requirements of the Care Act duties and the BCF Planning Requirements 2023/25. This approach is aligned to the priorities of the Carers Strategy and the BCF NHS minimum contribution will be used to improve outcomes for unpaid carers.

The Better Care Fund currently provides funding for a Carers Emergency Service which is available for a period of up to 48-72 hours when substitute care is necessary as a result of any sudden or unplanned event that incapacitates the unpaid carer and it would be unsafe to leave the cared for person without support. The service is free of charge and provides peace of mind for unpaid carers registered to the scheme who are undertaking regular and substantial care of vulnerable adults should informal replacement care and support be unavailable. This is currently being provided within the Integrated Rapid Response Service which is also financed by the Better Care Fund.

The Better Care Fund also currently provides funding for home care and support services for unpaid carers who provide support to people who live with or receive support from an unpaid carer. The specialist nature of this service provider means that they are able to provide support to connect unpaid carers to relevant statutory or voluntary services. Expected outcomes for eligible unpaid carers and the person that they care for include improving quality of life for unpaid carers and the person they care for, enabling unpaid carers to enjoy a life outside of their caring role, achieving greater independence for the unpaid carer, having an improved sense of carer wellbeing, and their mental and physical health, reducing carer isolation and increasing local community, voluntary sector, and social enterprise involvement. Maintaining/increasing the independence of the person being cared for and sustaining the unpaid carer should increase the likelihood of the cared for person remaining at home for longer.

A significant range of support that aligns with the outcomes of the Carers Strategic Framework is currently provided by an independent sector home care provider which includes carers groups, carer activities and events, complementary therapies and volunteering opportunities.

The Council also currently provide 8 respite care beds at Conway Crescent for people with learning disabilities / autism which is used for short stays to support informal carers to take a break from their caring role. There were a total of 412 admissions during 2021/22.

### Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

The Strategic Director for Adult Social Care, Housing and Public Health is fully engaged in the planning and approval process for the BCF 2023-25 and is a member of the Health and Wellbeing Board (HWB) and BCF Executive Group.

Both the HWB Board and BCF Executive Group includes representatives from SYICB (Rotherham Place) including the Chief Officer and Chief Finance Officer. This ensures there is a joined-up approach in improving outcomes across the health, social care and housing sector

The Housing Strategy (2022-25) aligns to the Integrated Place Plan and BCF Plan (2023/25) by supporting people to live at home for longer and has benefits for the individual's health as well as a positive impact on health, housing and social care budgets. Instead of providing everyone with the same service regardless of need, housing support or adaptations are tailored to the individual and used to empower people to make choices for themselves.

The Housing Strategy focuses on increasing the supply of affordable housing, both through new build and from bringing empty homes back into use. The Adult Care Housing and Public Health Market Position Statement shows that the Council owns a large stock of social housing, although this number reduces by approximately 200 units annually through the Right to Buy scheme. 566 new homes were built in 2020/21 across all sectors. The private rented sector in Rotherham has grown significantly and currently provides 16% of the total housing stock in the borough.

Surveys of people who have moved into new Council built homes are conducted and feedback is used to inform the future development of schemes. 10 bungalows have recently been completed in the South area of Rotherham. The plan is for more bungalows to be built alongside the purchase of additional bungalows from private developers to support people with accessibility needs to continue to remain living in the community.

Extra Care Housing in Rotherham is currently based across three sites providing 108 units. Each site provides accommodation aimed at enabling people to remain independent within their home for longer. Extra care housing combines a safe secure environment in a community setting and is seen as a way forward to provide older people with their own high-quality accommodation, with access to housing related support and personal care when required.

The Council will continue to support older people, to remain at home in the community for as long as appropriate and would like to expand housing options for older people, including housing related support provision such as Supported Living, Extra Care and Shared Lives models and other models of support such as 'live in' care.

Council owned housing stock is also ageing, and it is essential that investment continues so that the Council can continue to provide good quality, safe and affordable homes in sustainable neighbourhoods that meet the needs of local people. As people's needs evolve, the Council will

seek opportunities to make better use of its stock and consider conversions and adaptations to provide more suitable homes where appropriate. The strategy sets out a clear direction for aiming to increase the overall number of homes through the creation of new housing, as well as continued investment to making the best of existing homes and communities. Council priorities are focused on the right homes to meet the needs of Rotherham's people which need to be safe, comfortable, affordable and energy efficient.

The plan is also to maximise the use of aids, adaptations, and assistive technology to support independence in the home to meet the needs of a range of people and support the creation of mixed communities. This supports the principles of Home First.

The Council's Adaptations Policy aims to assist people in living independently through either the provision of equipment and/or adaptations in their current home or re-housing to a suitable property that meets their needs.

The Disabled Facilities Grant (DFG) provides funding for Housing to support for the provision of aids and adaptations to disabled people's homes to enable them to live independently and to improve their quality of life.

The DFG has provided funding for aids and adaptations for older people, people with physical disabilities and care needs, children and those living in owner occupied, private and social tenancies in 2022/23. Grant approvals range from £1,000 to around £80,000 and in exceptional circumstances has been as high as £120,000.

The release of the Government's White Paper – 'People at the Heart of Care: Adult Social Care Reform White Paper' (modified in March 2022) focussed on 'Providing the Right Care, in the Right Place at the Right Time'. It gives more people the choice to live independently and healthily in their homes for longer. It includes updated guidance advising Local Authorities on the efficient and effective delivery of DFGs, including more flexibility on the areas and amount of spend.
This ensures that people can quickly access the adaptations they need, in a way that is co-ordinated with other practical support they receive. The Council now applies discretion to larger more expensive projects such as major internal conversions and extensions to meet this need. A clear case is made that by providing the adaptations, the customer can live independently for longer in their home and cost savings are made in terms of long-term care requirements from the NHS.

The DFG also provides funding for community equipment to enable and support people with their daily living activities which are supplied by our Integrated Community Equipment Service delivered by an independent sector provider. Mandatory functions for DFG are always considered annually before continuing to agree funding for community equipment.

The IBCF funded a project lead for Assistive Technology and Occupational Therapy in 2022/23, which we are looking to continue. The role of Occupational Therapy (OT) in supporting the 'prevent, reduce and delay' agenda within Adult Social Care and Housing is well established, and the impact of extended roles are also being increasingly recognised. The DFG is also used to fund assistive technology equipment.

The Council funded a further 1 x full time equivalent Community OT to support the increasing caseload of the service in 2022/23. The postholder took the lead, alongside the commissioning team, in a review of the current service offer, including benchmarking with other Adult Care based services regionally. The recommendations from the review have been taken forward with the Community OT Service providers and other stakeholders to ensure effective and efficient use of the

OT resource. A recovery plan was been agreed with the COT provider and good progress is being made against targets.

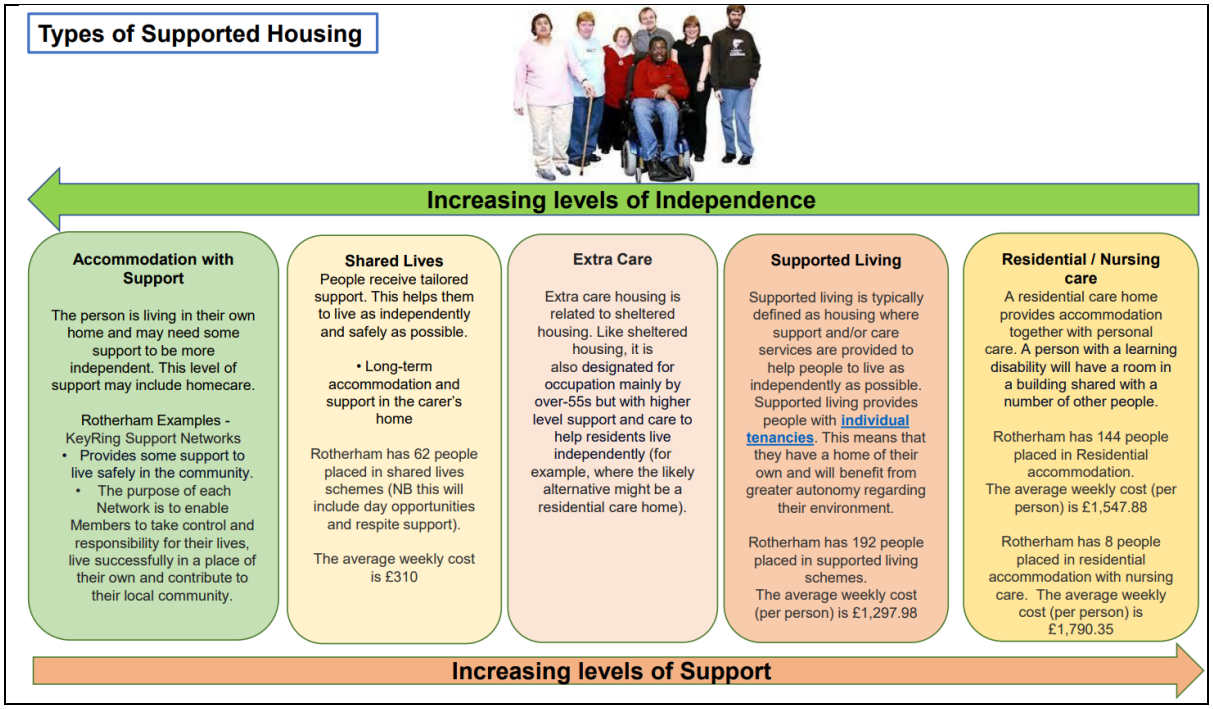
The Adult Social Care Discharge Fund for 2022/23 has also been utilised to commission an independent sector OT service to reduce the waiting list by around 150. The post is also supporting adult social care to better utilise care technology. There is a wide range of Technology Enabled Care (TEC) equipment in use including exit sensors, GPS trackers and pre-set reminders enabling people with memory difficulties to remain safe and live their lives well, as well as several falls detection options. Robotic pets are also proving successful in reducing anxiety, purposeful walking and challenging behaviours.

A relaunch of the Assistive Technology Champions scheme has started to raise awareness across teams and develop new ideas for better utilisation of the Technology Enabled Care currently available. Links have been made with corporate customer services and communications teams to further raise the profile within the Digital Strategy work streams. This work needs to be rolled out and embedded across Place.

A Remote Monitoring Pilot was undertaken with Care Homes in relation to monitoring vital signs. The aim was to keep people out of hospital and reduce the length of stay in hospital if a person was to be admitted. The pilot is currently being evaluated.

The Market Position Statement for the South Yorkshire Integrated Care System (ICS) has been published in 2022/23 in relation to housing with support for people with learning disabilities and / or autism. This sets out the opportunities for developing new supported living provision across the ICS. The principles for providing housing for people with learning disabilities and / or autism are based on those contained in “Building the Right Home”.

There are a total of 753 individuals with learning disabilities and / or autism who are in receipt of long-term adult social care services who have moderate to severe learning disabilities. There are a total of 203 supported living units in Rotherham where the Council has nomination rights with the majority of commissioned supported living owned or managed by housing associations and the private sector. In Rotherham there are 14 supported living units which are currently being developed in the north of the Borough which includes 8 flats and 6 bungalows. There is also a shared unit that is currently being developed through exempt Housing Benefit for a group of 4 individuals, as well as another 4 units that are currently in development. Rotherham is looking to expand its accommodation with support offer for people with a learning disability and autistic people as needs and expectations change. This will aim to extend peer support networks, shared lives and extra care as well as supported living. The chart below shows the types of supported housing according to levels of support and independence.




**Additional information (not assured)**

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? **(No)**

The Council's Aids and Adaptation Policy is currently under review. As part of the process consideration will be given to making use of the Regulatory Reform Order (RRO) 2002.

The policy review provides an opportunity to explore opportunities on how the Council will exercise their powers under discretionary provisions of the RRO. The review will explore how the Council facilitates earlier prevention and intervention to maximise independence and reduce risk to the client more quickly, as well as facilitating hospital discharges.

Further discussions will continue between DFG strategic / operational leads and BCF leads in the use of the DFG, how delivery is contributing to BCF plans including facilitating hospital discharges, improving outcomes and development of the new Aids and Assistance Policy which will illustrate how the mandatory and flexible grants will contribute to BCF plans in 2023/25. These plans will be supported by the Health and Wellbeing Board.

If so, what is the amount that is allocated for these discretionary uses and how much districts use this funding?

This will be detailed in the new Aids and Assistance Policy – the aim is to complete the review by December 2023

## Equality and Health Inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include:

- Changes from previous BCF plan
- How equality impacts of the local BCF Plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

**Changes from Previous BCF Plan**

There is a recognition by the South Yorkshire ICB (Rotherham Place) that tackling Health Inequalities (HI) is integral to everything the system needs to do to keep people healthy and independent and reduce statutory service demand.

Rotherham's Prevention and Health Inequalities Strategy and Action Plan: 2022-25 was agreed in by the Place Board and endorsed by the Health and Wellbeing Board. This strategy is focussed on supporting people in Rotherham to live well for longer through driving prevention-led approaches across health and social care. Working in partnership, the aim of the strategy is to:

- Improve the overall health and wellbeing of the Rotherham population when compared with the England average.
- Reduce health inequalities within Rotherham, including within our most deprived communities as well as between protected characteristic and other inclusion groups.
- Manage, delay, and prevent future demand for our health and social care services.
- Support the delivery of other agendas, including our economic strategy for the borough, by ensuring more people in Rotherham are healthy and empowered.

Delivery of the strategy is focussed on five main priorities:

1. Strengthening the Place understanding of health inequalities. Work around this priority is centred around data and intelligence, which links with the further detail around population health management outlined above.
2. Developing the healthy lifestyles prevention pathway. This priority is focussed on the factors closely associated with disability-adjusted life years in Rotherham, such as smoking, obesity and alcohol.
3. Supporting the prevention and early diagnosis of chronic conditions. This includes cardiovascular disease, diabetes respiratory disease, cancer, and mental health conditions.

4. Tackling clinical variation and promote equity of access and care for underserved groups.
5. Harnessing partners' collective roles as anchor institutions to address health inequalities.

Additionally, the strategy sets out the local approach to delivering the Local Authority's priorities under the Equality Act and NHS Core20Plus5 framework. This means that as part of the programme, partners have committed to addressing inequalities for:

- Those living in the 20% most deprived communities of England according to the Indices of Multiple Deprivation (IMD). In Rotherham this accounts for 36% of the population.

- A number of inclusion groups include:
  - Ethnic minority communities
  - Gypsy, Roma and Traveller communities
  - People with severe mental illnesses
  - People with learning disabilities and neurodiverse people
  - Carers
  - Asylum seekers and refugees
  - Those in contact with the criminal justice system

An action plan is in place to deliver against the strategy and progress is overseen by the Prevention and Health Inequalities group. The group includes representatives from the Council, NHS South Yorkshire ICB, TRFT, RDaSH, Primary Care and the Voluntary Sector.

The BCF has also been utilised to partly fund a Public Health Specialist who is responsible for programme management of the Prevention and Health Inequalities Strategy and reporting into the Place Partnership and Health and Wellbeing Board. The BCF also partly funds an Administrative Assistant to support and arrange meetings relating to the programme.

**How equality impacts of the local BCF plan have been considered**

Health inequality remains an issue for the Learning Disability client group and neurodiverse people that will continue to be addressed. It is still evident that people in these client groups are dying at an earlier age than within the general population. Continued reviews of early deaths through the LeDeR Programme influences future practice around health and aging well. The LeDeR programme has now been extended to review early deaths in people who are neurodiverse.

Work has been undertaken across Rotherham to ensure that Annual Health Checks are completed in a timely manner by local GP's and people are aware of and have access to appropriate health screening services. Support and information for the individuals and service providers is regularly distributed around accessing Annual Health Checks, promoting healthy lifestyles and healthy choices. Future Care and Support contracts both in Care Homes, Supported Living and Day Opportunities will continue to focus on reducing these inequalities and improving the lives of people with Learning Disabilities and Neurodiverse People in Rotherham.

**How these inequalities are being addressed through the BCF plan and BCF funded services**

Rotherham Prevention and Health Inequalities Strategy includes an aim to improve access to social prescribing (BCF funded scheme) for ethnic minority communities. The plan is to deliver a programme to promote social prescribing amongst ethnic minority communities and increase referrals from clinicians.

Breathing Space is also a BCF funded scheme and the aim is to reduce the health burden of chronic respiratory disease in Rotherham. The plan is to restore diagnosis, monitoring and

management to pre-pandemic levels, as per the Quality and Outcomes Framework (QOF), Integrated Investment Fund and Direct Enhanced Service targets for asthma registers and spirometry checks and COPD registers for adults and children.

The Council have also refreshed the Equality, Diversity and Inclusion Strategy and Objectives (2022/25) which set out the ambition to create an inclusive borough for people to live, work and enjoy. A borough where no-one is left behind and where all are welcome and treated fairly. The aim is to ensure no-one is held back and that regardless of age, disability, race, sex, religion or belief, gender re-assignment, sexual orientation, marriage and civil partnership, pregnancy and maternity that people can achieve.

Rotherham's Joint Strategic Needs Assessment (JSNA) identifies the current and future health and wellbeing needs of Rotherham's local population. Data to inform commissioning is obtained from the JSNA, Census, POPPI and PANSI, ongoing consultations and engagement activities, feedback from individuals and targeted or specific health assessments. The JSNA also details Rotherham's diverse communities, their needs, and the aspirations of all partners in addressing these identified gaps in provision and used to identify commissioning priorities and areas of health inequalities to target interventions. An Equality Analysis is also carried out when commissioning significant changes to service to identify the potential impact on individuals to ensure that equality duties are met and that changes benefit individuals.

The Council will continue to look to advance equalities through their third-party contracts and this is now included in a commissioning toolkit, tender documents and contract documentation. The Council will also continue to focus on the way services are designed, commissioned, and delivered and contributes to ensuring that the needs of diverse communities are served and that nobody is excluded from accessing services.

**Changes to local priorities related to health inequality and equality and how activities in the document will address these**

Changes to local priorities in relation to health inequality are described above.

**Equality, Diversity and Inclusion**

Equality, Diversity and Inclusion are embedded in commissioning activity. Equality Analyses are carried out within commissioning activities including service development. This includes an equality screening process which takes into account the requirements of the Equality Act 2010 including protected characteristics - age, disability, sex, gender reassignment, race, religion or belief, sexual orientation, civil partnerships and marriage, pregnancy and maternity and other socio-economic groups eg parents, single parents and guardians, carers, looked after children, unemployed and people on low incomes, ex-offenders, victims of domestic violence and homeless people.

The equality analysis considers whether commissioned services meet the needs of different communities and groups and whether this presents any barriers to communities or groups and identifies positive impacts. The data derived from the Council's social care management system, Joint Strategic Needs Assessment, Census, POPPI and PANSI also informs the development of new services, through needs analyses and our commissioning plans to accommodate unmet need. It is also a mandatory requirement that an equalities screening and analysis are completed for all Cabinet reports and commissioning activity which requires a key decision. Commissioned providers are required to comply with the Equality Act, under standard terms for all contracts with the Council.

**Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered**

The Council collects and analyses information from internal and external data sources including the Indices of Multiple Deprivation (IMD) to better understand the make-up of their communities. This range of data sources are shared through the Rotherham Data Hub.

The Market Position Statement provides an overview of the opportunities available to providers and presents the Council's future strategic priorities and upcoming procurement opportunities. It also aims to provide the background information and context to support any future business proposals. It outlines the number of people we support through commissioned services, predicted future demand and overall commissioning intentions. The "live" data is supplied on Insight, the Adult Social Care's case management system, on the number of individuals supported by adult social care commissioned services.

Services are encouraged to use the data available for service planning, commissioning, decision making and preparation of strategic documents such as the Joint Strategic Needs Assessment and contracts / service specifications. The data is also used to assess the health needs of the local population. Housing is a wider determinant of health and has a significant impact on the wellbeing of our residents.

In 2021/22, there were 22 deaths of people in Rotherham with a learning disability notified to LeDeR. An average of 14 deaths are reported per year for Rotherham, therefore this shows an increase of 57%. The mean age at death was 56 years in 2021/22, with all notified deaths being in respect of adults. This is a decrease in age of 7 years from 2020/2021, therefore this shows that people with a learning disability are dying younger. The median (middle) age at death in Rotherham was 62 years for females and 61 years for males. This is a reduction in age at death of 5 years for females and an increase of 3 years for males since 2020/2021. Ethnicity of the LeDeR notifications were recorded as: 88% were White British, 8% were mixed or multiple ethnic groups and 4% were Black, African, Caribbean or Black British. Addressing health inequalities faced by people with learning disabilities and autism is a key priority for South Yorkshire ICB and Rotherham Council.

Customer satisfaction surveys for jointly commissioned services include the nine protected characteristics identified in the Equality Act 2010 to ensure that the Council is fully compliant with the Public Sector Equality Duty. This ensures Place partners have the ability to analyse the effect on all protected groups. Having the ability to collect, analyse and use equality information in a consistent way will help Rotherham to better understand our customers and help to evaluate how our policies and activities are impacting on our local communities. Where existing or developing inequalities are identified, an action plan is put in place to tackle these inequalities and the impact is monitored.

**Any actions moving forward that can contribute to reducing these differences in outcomes**

The Council have launched a commissioning toolkit for commissioners, contract managers and suppliers. The toolkit will address equalities through social value in the commissioning and procurement of services and managing external contracts. A suite of training materials has been produced to support its implementation. The Council will also ensure new in scope contracts are in line with Living Wage accreditation.

South Yorkshire ICB (Rotherham Place) has also produced an annual report for 2021/22. This shows that Equality and Diversity is central to the work of the SYICB to ensure there is equality of

access and treatment within the services that they commission. The SYICB is committed to embedding equality and diversity values into its commissioning processes that secure health and social care for our population, and into our policies, procedures and employment practices. The ICB's vision is "Your Life, Your Health, Better Health and Care for Rotherham People". The Annual Report will be published for 2022/23 once these have been approved in 2023.

**Healthwatch Rotherham**

Healthwatch Rotherham has run several surveys over the past year to establish the quality of health and social care services, what residents want from services and how services can improve the patient experience. They have ensured as a priority that they engage with seldom heard and harder to reach communities in Rotherham to hear their views, opinions and experiences of services.

In September 2022, Healthwatch Rotherham conducted a survey to find out the challenges residents of Rotherham with English as an additional language encountered when trying to access health and social care services. The findings made clear that getting an appointment proved to be the most challenging aspect of accessing primary care services, due to the language barrier faced between patient and receptionist / GP. This research highlighted the need for translators to be present and available through the whole process of accessing medical service (booking an appointment through to attending one). Healthwatch Rotherham passed their comments onto the SYICB (Rotherham Place) who responded and acknowledged the translator issue and confirmed this is something that they are working on.

Healthwatch Rotherham also ran a survey on how residents of Rotherham access health and social care information, the cost of living crisis is limiting people's access to the internet, necessitating the need for health and social care information in different formats. Since the Covid-19 pandemic, many people are also being digitally excluded from accessing the information they need. When asked, respondents preferred if information created by health and social care providers is made available in many formats, including braille, easy read, translated to other languages, and physical copies.

Based on these findings, Healthwatch Rotherham created a service booklet that highlights local health and social care services, including primary care, urgent care, adult social care, sexual health, homelessness, and healthy living. During public outreach activities, physical copies of the booklet will be distributed to members of the general public and can be translated into other formats. In addition, Healthwatch has created a digital directory of mental health services. Based on the feedback from Rotherham residents, Healthwatch Rotherham plans to create other in-depth and detailed directories / guides for different areas and issues of health and social care.

In 2023, Healthwatch Rotherham began their first Enter and View inspections of care homes. They have currently visited two care homes in Rotherham, which were suggested by the CQC. They have really enjoyed interacting with residents, speaking with staff, friends and family to hear their stories, experiences and views. Both inspections have resulted in a report and any recommendations have been highlighted to the care home managers in order to improve the resident and staff experience. Healthwatch Rotherham look forward to participating in more Enter and Views during 2023/23.

For the past three years, Healthwatch has successfully hosted monthly "Let's Talk" events via Zoom on various topics. This year, they also organised Let's Talk events in person in Rotherham on a variety of topics to increase community awareness of health promotion, disease prevention, screening, and treatment. Over 300 people from various walks of life have attended these events.

Healthwatch Rotherham has focused heavily on in-person engagement and outreach in the past year. This in-person engagement has allowed them to engage with more people than ever before, championing the voice of those who are seldom heard and highlighting health inequalities faced in different communities and areas of Rotherham. Their Engagement Officer hosted in-person events at various libraries in Rotherham, with link workers also joining to ensure they were engaging with different communities in Rotherham, hearing about their experiences, and making connections and relationships with the community.

Healthwatch Rotherham also attended the Rotherham Show and various community events, where they had a stall that allowed them to engage with residents and highlight the work that is carried out by them. They also visited various local services including Hygge Tots Group, Shiloh and Dementia Cafes on both a weekly and monthly basis, listening to service users and creating 'spotlight shares'; posters which highlighted both good and bad experiences from different services in Rotherham. In the last year, Healthwatch Rotherham have spoken with more than 1,500 individuals in Rotherham from a variety of backgrounds to better understand their needs, concerns, and experiences with health and social care services.

**How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS Actions in line with Core20PLUS5.**

Rotherham's Prevention and Health Inequalities Strategy sets out the local approach to delivering the Local Authority's priorities under the Equality Act and NHS Core20Plus5 framework. This means that as part of the programme, partners have committed to addressing inequalities which are highlighted within this narrative plan above.

**BCF Funded Schemes which Reduce Health Inequalities**

BCF funded schemes which reduce health inequalities include:

- Social Prescribing programmes which provides interventions on tobacco, weight, alcohol, physical activity, obesity reduction, smoking cessation and diabetes prevention programmes.

- Breathing Space is delivering respiratory services within the Right Care pathway. There are projects underway, focused on Frailty and Anticipatory Care including the use of external support to agree a capacity/demand modelling tool for community services (including the 2 hour urgent community response).

- Project support for the implementation of Population Health Management (PHM) priorities

The above BCF funded schemes are included in the BCF Section 75 Agreement which will be signed off by the Health and Wellbeing Board on 28th September 2023.