ROTHERHAM

PLACE PARTNERSHIP | HEALTH AND CARE

HEALTH AND CARE PLACE PLAN

2023/25

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CONTENTS

ROTHERHAM PLACE PARTNERS

NHS
South Yorkshire
Integrated Care Board

Rotherham, Doncaster and South Humber
NHS Foundation Trust

The Rotherham
NHS Foundation Trust

Rotherham Metropolitan Borough Council

Voluntary Action Rotherham

CONNECT HEALTHCARE ROTHERHAM CIC

1 - INTRODUCTION

ROTHERHAM PARTNERS COMMITMENT AND VISION

Rotherham's Health and Social Care Community has been working in a collaborative way for many years to transform the way it cares for and achieves a positive change for its population of 267,000. Our successful track record in developing and delivering new solutions makes Rotherham the perfect test bed for new innovations. We are passionate about providing the best possible services and outcomes for our population and are committed to a whole system partnership approach. Only through working together can we provide sustainable services over the long term that aim to help all Rotherham people live well for longer.

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

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

The first Rotherham Integrated Health and Social Care Place Plan was developed in November 2016. The Plan was refreshed in 2018, to ensure close alignment with the Rotherham Health and Wellbeing Strategy, and then again in 2020-22.

In July 2022 there was significant changes to the landscape with the dissolution of CCGs and the formation of the South Yorkshire Integrated Care System. The 2023-25 Plan, this plan, continues to be the delivery plan for the health and social care elements of the Rotherham Health and Wellbeing Strategy, but also aligns to the South Yorkshire Integrated Care Strategy and the NHS South Yorkshire Joint Forward Plan. The Plan is intended to work as a catalyst to deliver sustainable, effective, and efficient health and care support and community services with significant improvements underpinned by collaborative working through the continue development of the Rotherham Place Partnership.

Partners are fully committed to working together to make decisions on a best for Rotherham basis to achieve the transformations set out in this Plan. This is underpinned by robust governance arrangements, including the Rotherham Agreement, a document that captures how we work together. Rotherham Place has a strong, experienced, and cohesive executive leadership team who have set clear expectations and the spirit of collaboration and inclusiveness across the Rotherham Place with the key aim of driving forward the transformation set out within this Plan. It sets a high standard of integrity amongst leaders across all partners, and a culture of empowering and engaging with all staff. As well as a shared vision, Rotherham partners have agreed a shared set of principles by which we work to achieve our vision for Rotherham, these can be found in the Rotherham Agreement or terms of reference for the Place Board.

To realise our vision, we want everyone who works or lives in Rotherham – patients, people, families – to work together for a better Rotherham, to establish an individual and collective widespread aspiration for improved health and social care. The Rotherham culture means that staff are confident to challenge and change things to improve services for people, aligning to the vision and principles within this plan.

A key strength in Rotherham is the trust and openness between partners and their commitment to the shared vision. We can create a first-class strategy, but the hard part is implementation and achieving the goals it sets, this can only be done by winning the hearts and minds of our staff, through adapting to diverse approaches and styles and building mutual benefit.

Rotherham partners recognise the significant opportunities to be gained by working together across South Yorkshire, and as such are committed to supporting and playing their role in the delivery of the South Yorkshire Joint Forward Plan. This Plan sets out the additionality at Rotherham Place, but the priorities and actions within the South Yorkshire Joint Forward Plan and the role of Rotherham partners in its delivery should simultaneously be acknowledged.

SUMMARY OF TRANSFORMATION, ENABLING AND CROSS-CUTTING WORKSTREAMS

Rotherham Place Partnership Shared Vision	***'Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery'***					
Transformation Workstreams	**Best Start in Life** (maternity / children & young people)	**Improving Mental Health & Wellbeing**	**Support People with Learning Disabilities & Autism**	**Urgent, Emergency & Community Care**	**Palliative & End of Life Care**	**Live Well for Longer** (prevention, self-care & long-term conditions)
Key Priorities (key (projects to deliver the trans-formations)	1. Best Start in Life 2. Mental Health & Emotional Wellbeing 3. Special Educational Needs and / or Disabilities	1. Adult Severe Mental Illnesses in Community 2. Mental Health Crisis and Liaison 3. Suicide Prevention	1. Uptake of enhanced health checks 2. Benefits & independence of employment	1. Prevention & Alternative Pathways to Admission 2. Sustainable Discharge 3. Whole System Command Centre Model	1. Review Palliative and End of Life Care Medicine 2. Personalised Palliative and End of Life Care	1. Proactive (anticipatory) care 2. Personalised Care 3. Medicines Optimisation
Enabling work-streams	**Digital**	**Workforce & Organisational Development**	**Communication & Engagement**	**Estate & Housing**		
Cross-cutting	**Prevention and Health Inequalities** (priorities below)					
	Strengthen our understanding of health inequalities	Develop the healthy lifestyles prevention pathway	Support the prevention and early diagnosis of chronic conditions	Tackle clinical variation and promote equity of access & care	Harness partners' roles as anchor institutions	
	Primary Care					
	Finance & Best Use of Resources					
Business as Usual	There are other workstreams / projects supporting Business as Usual AND there are further priorities, projects and actions beneath our transformation, enabling and cross-cutting workstreams such as Planned Care, including diagnostics, elective recover and waiting times					

PLAN ON A PAGE

Rotherham Place Partnership Shared Vision	***'Supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery'***					
South Yorkshire Integrated Care System Key Purpose	**Improving outcomes in population health and health care**	**Tackling inequalities in outcomes, experience and access**	**Helping the NHS to support broader social and economic development**	**Enhancing productivity and value for money**		
Rotherham Place Key Challenges	The health of people in Rotherham is generally poorer than the England average	People living in our most deprived areas have both shorter lives and are living those years in poorer health	35% of Rotherham's neighbourhoods live in the 20% most deprived in England, and 22% live in the 10% most deprived	Increasing numbers of people with long term conditions and people living longer in poorer health	One in four adults experience a diagnosable mental health problem in any given year	Significantly more children affected by income deprivation particularly in the most deprived areas	Half of people aged 75 years and over live alone and most experience loneliness	Significant joint financial challenge
Transformation Workstreams	**Best Start in Life** Maternity, Children & Young People	**Improve Mental Health & Wellbeing**	**Supporting People with Learning Disabilities & Autism**	**Urgent, Emergency & Community Care**	**Palliative & End of Life Care**	**Live Well for Longer** Prevention, early identification & long term conditions		
Enabling Workstreams	**Digital** (including information technology)	**Workforce Development** (including organisational development)	**Communications** (including engagement)	**Estates** (including housing)				
Cross-cutting Workstreams	**Finance & Best Use of Resources**	**Primary Care**	**Health Inequalities**					
Rotherham Place Principles	**Focus on people and places**	**Encourage prevention, self-management, and early intervention**	**Design pathways together**	**Strive for best quality services based on best outcomes**	**Be innovative**	**Be financially sustainable**	**Jointly buy health, care, and support services once for a place**	**Work together to reduce health inequalities**
Rotherham Place Partners	**Voluntary Action Rotherham (VAR)**	**Rotherham Metropolitan Borough Council (RMBC)**	**Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)**	**Connect Healthcare Rotherham CIC**	**The Rotherham NHS Foundation Trust (TRFT)**	**South Yorkshire Integrated Care Board (Rotherham Place)**		

Read from left to right

2 - WORKING TOGETHER

HOW WE ARE ORGANISED

The first South Yorkshire Sustainability and Transformation Partnership was established in 2016, this then became one of the first non-statutory Integrated Care Systems in England in 2018. Following the Health and Care Act 2022 a statutory Integrated Care System (ICS) has come together from July 1st 2022.

New statutory Integrated Care Systems have been set up to bring local authorities, NHS organisations, combined authorities and the Voluntary, Community and Social Enterprise Sector together with local communities to take collective responsibility for planning services, improving health and wellbeing, and reducing inequalities.

Integrated Care Systems have four key purposes:

Improving outcomes in population health and health care	Enhancing productivity and value for money	Tackling inequalities in outcomes, experience, and access	Helping the NHS to support broader social and economic development

An Integrated Care Board

Is an NHS organisation responsible for planning and funding NHS services, in our case NHS South Yorkshire established in July 2022. NHS South Yorkshire has been established with Partner Board Members, including Healthwatch, Mental Health and the Voluntary Care Sector representation.

The Integrated Care Partnership

Is statutory committee jointly convened by Local Government and the Integrated Care Board, to bring together the NHS with Local Authorities, Combined Authorities, the Voluntary, Community and Social Enterprise Sector and other partners.

In South Yorkshire the membership of our Integrated Care Partnership (ICP) was proposed by the Health and Wellbeing Boards in the four local authority areas, Barnsley, Doncaster, Rotherham and Sheffield and NHS South Yorkshire. Oliver Coppard, Mayor of South Yorkshire Combined Mayoral Authority became Chair of the South Yorkshire Integrated Care Partnership in September 2022 and Pearse Butler the Chair of NHS South Yorkshire is vice chair.

Place, Provider Collaboratives and Alliances

South Yorkshire continues to build on the collaborative working arrangements. A key priority for the development of the South Yorkshire Integrated Care System is maturing ways of working across the system including provider collaboratives, alliances, and place-based partnership arrangements. It is through these arrangements that enables delivery of the NHS SY Joint Forward Plan and will require delegating and sharing responsibility with our Places and Provider Collaboratives.

In each of the South Yorkshire communities of Barnsley, Doncaster, Rotherham, and Sheffield there is a well-established place-based health and care partnership already working well together to provide joined up integrated health and social care, support, and services. These are the cornerstone of our health and care system and will have delegated authority from NHS South Yorkshire to deliver plans that meet the needs of local communities. As our key delivery vehicles, they each have an integrated health and care delivery plan.

Integrated Care Strategy for South Yorkshire

The first was created by the newly formed Integrated Care Partnership and was launched in March 2023. The vision in the SY Integrated Care Strategy is that

'Everyone in our diverse communities lives a happy, healthier life for longer'

It is in line with the Mayor's Manifesto, for South Yorkshire to become the healthiest region in the UK and underpinned by three overarching goals to see the people in all our communities:

1. live healthier and longer
2. have fairer outcomes for all
3. timely, equitable access to quality health and care services and support.

The vision and goals are supported by four shared outcomes. Which are reflected in all our Health and Wellbeing Strategies and support the transition through the life courses of starting well, living well, and aging well.

- Children and young people have the best start in life
- People in South Yorkshire live longer and healthier lives AND the physical and mental health and wellbeing of those with the greatest need improves the fastest
- People are supported to live in safe, strong, and vibrant communities
- People are equipped with the skills and resources they need to thrive

The NHS Five Year Joint Forward Plan for South Yorkshire

This was developed in collaboration with all NHS Trusts that operate in the South Yorkshire Integrated Care System. The JFP guidance was published alongside the annual NHS England Operational Planning Guidance for 2023/24 with a clear expectation of alignment. The 2023/24 Operational Planning guidance asks for a particular focus in 2023/24 on; prioritising recovering core services and productivity, return to delivery of the key ambitions in the NHS Long Term Plan (LTP); and continue transforming the NHS for the future and detailed plans and trajectories to deliver against each of the 32 specific national objectives as set out in the Operational Guidance.

The JFP sets out plans to deliver operational requirements, the NHS universal commitments, contribute to the four core purposes of an Integrated Care System (ICS) and dispatch statutory duties/legal requirements.

The Rotherham Plan 2025

The Rotherham Together Partnership provides a framework for partners' collective efforts to create a borough that is better for everyone who wants to live, work, invest or visit. The Health and Wellbeing Board and Strategy contribute to achieving the vision of the Rotherham Plan, particularly in relation to integrating health and social care and improving health and wellbeing outcomes for local people. The wider partnership also provides an opportunity to explore where better outcomes could be achieved in relation to the wider determinants of health, for example, the environment people live in, education, employment, financial inclusion, and transport. All of which contribute to the aims and priorities within the H&WB Strategy.

Rotherham Health and Wellbeing Board

Is a statutory sub-committee of Rotherham Metropolitan Borough Council (RMBC). Locally, it is the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health, and other services directly related to health and wellbeing.

The H&WB Strategy for Rotherham

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

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

Rotherham Partners' collective approach to delivery allows a 'Golden Thread' from our 'Health and Well Being' strategy aims through to the priorities within the Place Plan.

Partners have developed and agreed a Rotherham Place Agreement for how we will work together, based on a Memorandum of Understanding approach to provide an overarching arrangement which governs the development of integrated multi-party solutions for health, care, and support across the geographical area of Rotherham. First agreed in 2018, it has been updated to reflect the new NHS architecture from 1 July 2022. The Agreement is not intended to be legally binding except for specific elements but encompasses the spirit by which the Place partners have and will continue to collaborate in supporting work towards the transformation set out in the plan.

Collectively partners have worked towards an agreed governance structure and have agreed a shared vision and a set of principles by which the Rotherham Place Board, and sub-groups will adhere to. The structure can be seen above, setting out the relationship to the H&WB Board. All place partners are represented at each of the groups, along with other partners as appropriate.

A quarterly performance report is produced on the delivery of the Place Plan so that the Place Board can be assured on its delivery and can be sighted on any potential opportunities or risks to delivery. The Performance Report includes key milestones and key performance indicators (KPIs) for each of the priorities beneath the areas of transformation. The milestones provide a way of measuring that the actions and pace set for each of the priorities is being met. The KPIs have been chosen from existing metrics that are already collected and where there is baseline information and associated targets.

Rotherham Place Plan 2023-25, this plan, is the fourth in the series. It closely aligns to the H&WB Strategy and is the delivery mechanism for the health and social care elements of the H&WB Strategy. The Place Plan builds on the previous plans and takes into account the expectations set out in the NHS Long Term Plan, but also the new NHS landscape, and so aligns with the SY Joint Forward Plan and, through the H&WB Strategy, aligns to the SY Integrated Care Strategy.

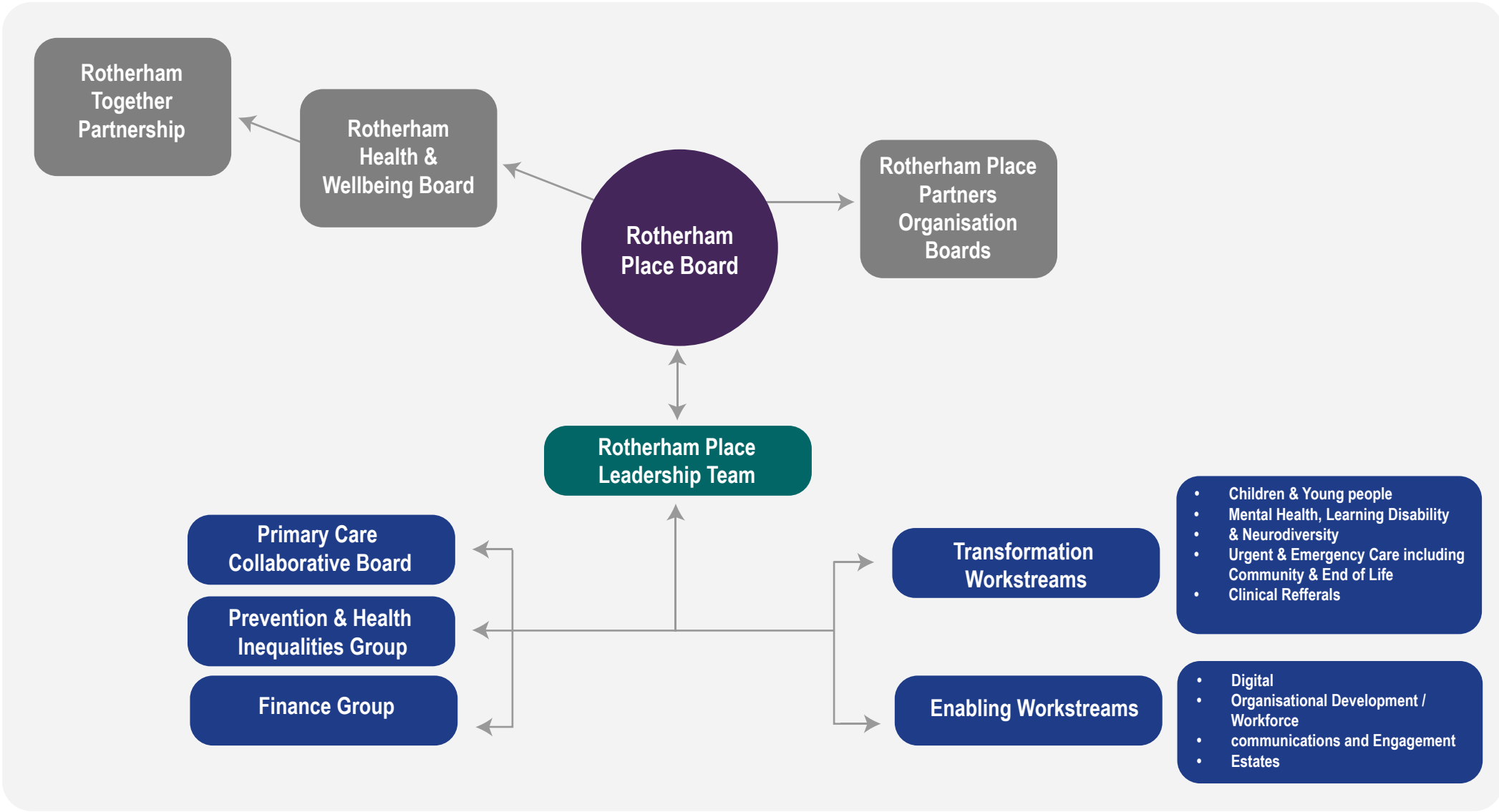
Progress in delivering the 2020-22 Place Plan is documented within this refreshed Plan. For further information on our delivery against priorities and for examples of key achievements please view the following documents:

- Place Partnership Updates (bi-monthly)
- Achievements (monthly as provided)
- Close Down Report for Priorities (for 2020-22 Plan)

CLICK HERE

Monthly Place Board Papers are also available at the above link.

ROTHERHAM PLACE DELIVERY

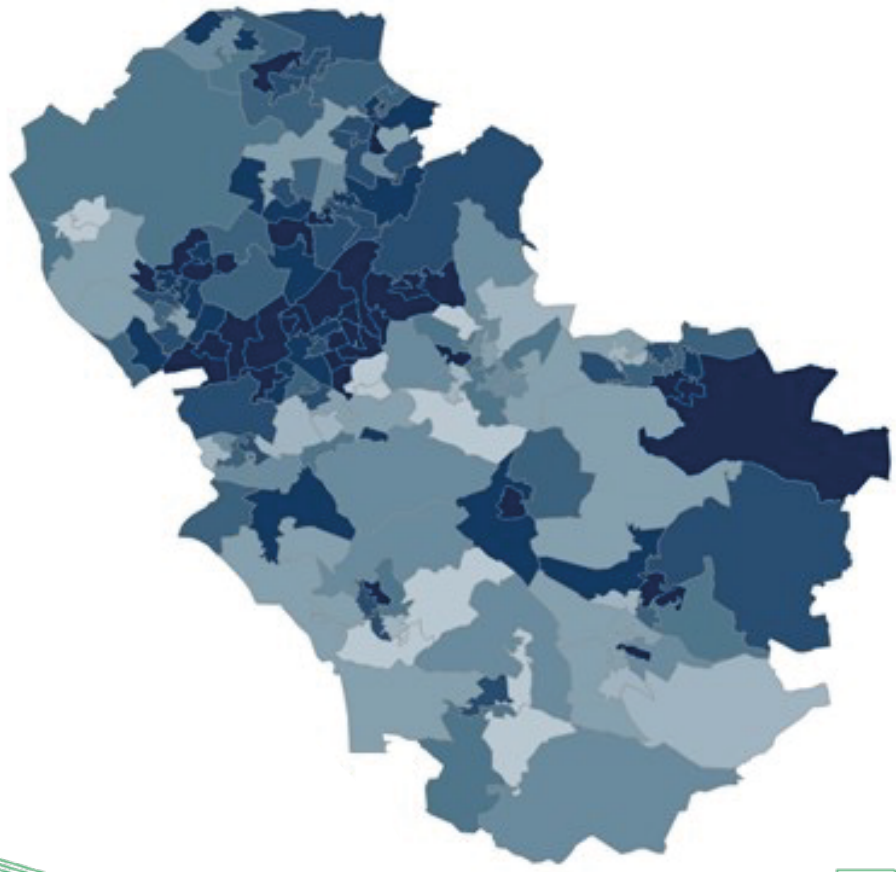


3 - ROTHERHAM OVERVIEW

WHAT WE KNOW ABOUT OUR POPULATION

20% Most deprived communities

- Rotherham ranks as the 35th most deprived upper tier local authority in England out of a total of 151 upper-tier local authorities
- 35% of Rotherham's neighbourhoods live in the 20% most deprived in England, and 22% live in the 10% most deprived
- No neighbourhoods in Rotherham are in the least deprived 10%
- People in the most deprived areas spend around a third of their lives in poor health, twice the population spent by those in the least deprived areas



The health of people in Rotherham is generally poorer than the England average. People are living shorter lives than they should and are living in poorer health for longer than they should.

A high proportion of Rotherham residents live in the 20% most deprived communities of England. Inequalities in access to the wide range of determinants (and protective factors) of health have led to inequalities in health outcomes.

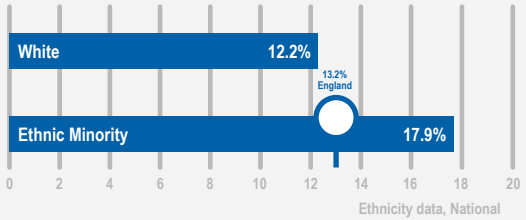
A range of factors impact on individual and population level health, such as the environment we live, the opportunities we have as well as the health care we receive.

To improve the health of Rotherham people we need to work collaboratively with all Rotherham partners and across South Yorkshire. And we need to pay particular attention to certain population groups such as those who live in the most deprived areas or those from ethnic minority populations as they are more likely to experience higher inequalities in health.

Wider Determinants

The estimated number of households in fuel poverty, 2020, is greater than the England average and expected to increase significantly with the rising fuel prices.
Those from ethnic minorities are likely to be in fuel poverty compared to white counterparts.

17.9% Rotherham
13.2% England

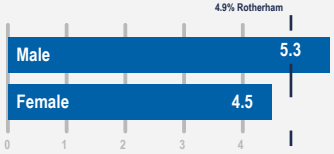


Being in work is good for both physical & mental health/wellbeing. The employability rate (16-64yrs) is 73% in Rotherham, 2021/22.

73.0% Rotherham
75.4% England

16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known, 2021. Young people who are not in education, employment or training are at greater risk of a range of negative outcomes, including poor health or depression.

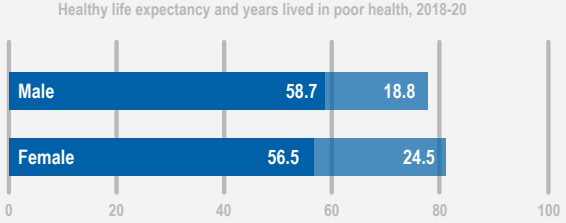
4.9% Rotherham
4.7% England



Life expectancy and healthy life expectancy

The healthy life expectancy at birth (2018-2020), is 58.7 years for a male and 56.5 for women; both lower than the England average of 63.1 and 63.9 years respectively

Life expectancy at birth is significantly lower for both males and females in Rotherham compared to England, 2018-20.



77.5% Rotherham
79.4% England

81.0% Rotherham
83.1% England

Life expectancy gap by deprivation (slope index of inequality).

9.7% England

7.9% England

- In primary care (2020/21), 15.9% recorded prevalence of depression (aged 18+), a total of 33,251 persons, this is higher than the England value of 12.3% and has been increasing since 2013/14.
- Data from 2018/19, show 12% of Rotherham residents reported a long-term mental health problem, which is significantly higher than the England value of 9.9%
- Deaths from drug misuse in Rotherham, 2018-20, were 6.4 per 100,000 compared to the England value of 5.0 per 100,000.
- Half of people aged 75 years and over live alone and most experience loneliness.

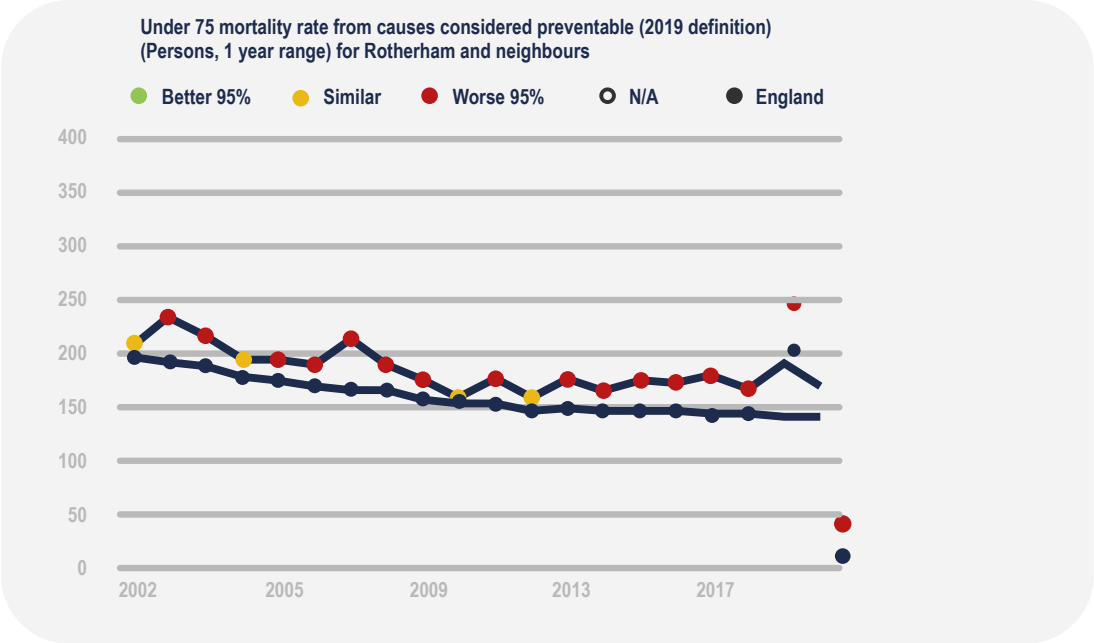
Improving the population's health and preventing illness and disease is key to reducing health inequalities and is at the heart of the NHS Long Term Plan.

Tackling health inequalities is a core priority for NHS England because people from more deprived backgrounds are more likely to have long term health conditions and suffer poor health. The NHSE prevention programme specifically looks at the early detection of disease and support for people taking their own action to better health through supported self-management.

Preventable early mortality

The under 75 mortality rate from causes considered preventable, in Rotherham, has remianed statistically worse than England for 8 years.

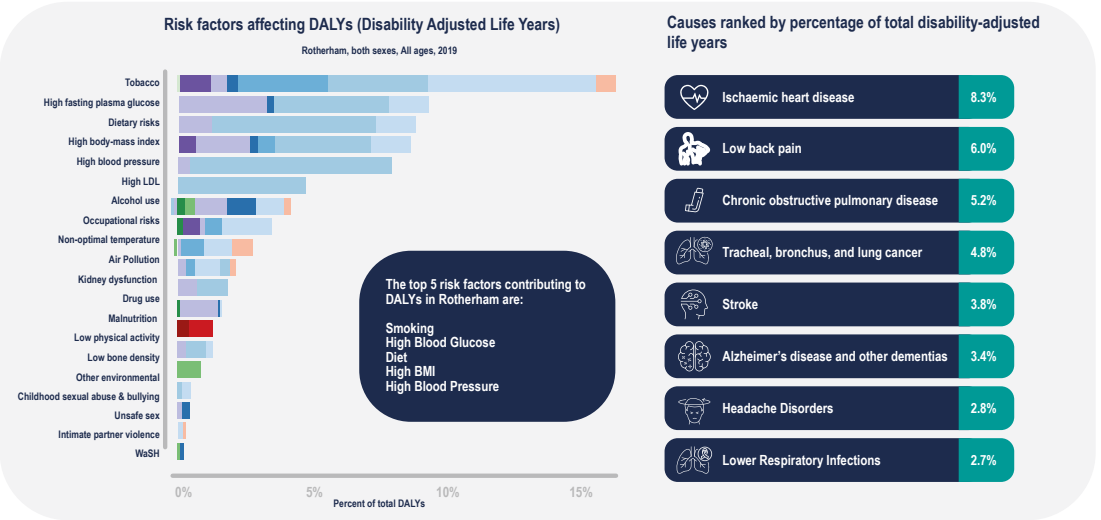
All or most deaths from the underlying cause (subject to age limits if appropriate) could mainly be avoided through effective public health and primary prevention interventions.



Global Burden of Disease, Rotherham 2019

Rotherham is similar to the rest of South Yorkshire; the Joint Forward Plan tells us that:

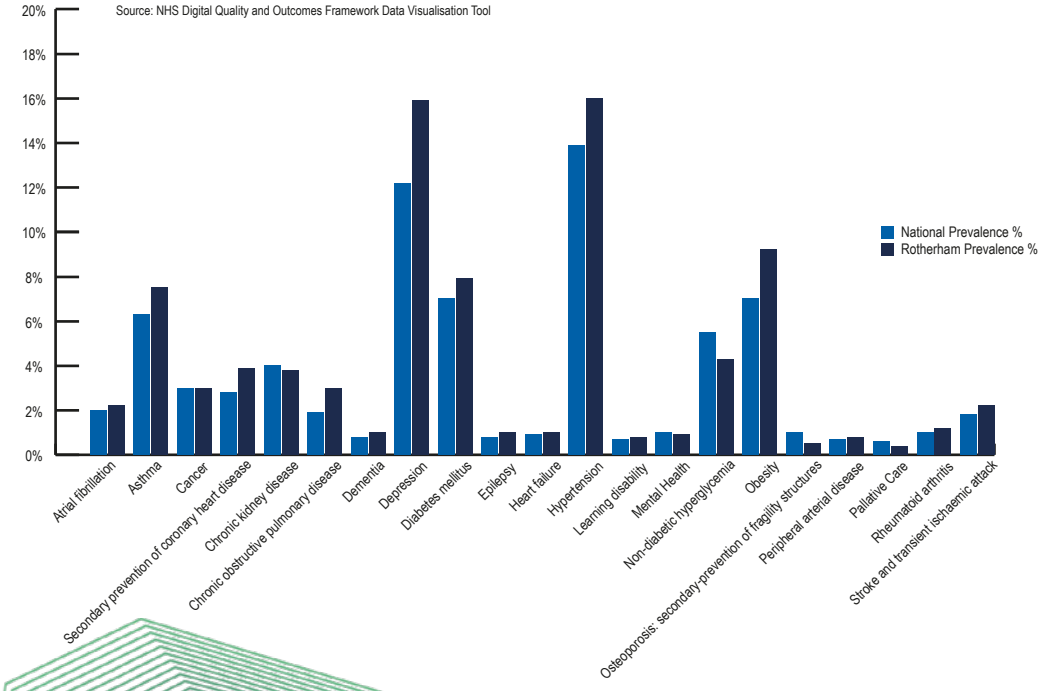
- The biggest underlying causes of deaths in South Yorkshire were heart disease, COVID19, Dementia, lung cancer, Stroke and lower respiratory disease.
- The biggest causes of living in poor health were attributable to musculoskeletal disease, Mental disorders (including depression and anxiety), CVD and diabetes and neurological conditions.
- Impact of Covid-19 pandemic had a significant impact on our elective admission rates as well as our waiting times for interventions.
- We also observed that there was an increase in the referrals to children's mental health services.



Health behaviours and disease prevention

Rotherham has a high prevalence of behaviours likely to cause harm. But many of the risk factors associated with our main diseases are modifiable and we can have impact on these early deaths by focussing on our role in prevention, these are picked through our prevention and health inequalities work, see section Cross-cutting workstreams - Prevention and Health Inequalities:

- 16.9% of the Rotherham population smoke
- 68.3% of Rotherham residents are overweight or obese
- 26.6% of reception age children were overweight or obese (2019/20) compared to 23.0% nationally; 37.9% of Year 6 children were over weight or obese in 2019/20, compared to 35.2% nationally
- Deaths from drug misuse in Rotherham, 2018-20, were 6.4 per 100,000 compared to the England value of 5.0 per 100,000.
- Rotherham's breastfeeding initiation rate is amongst the lowest in the region at 62.5%, contributing to levels of childhood obesity and paediatric hospital admissions
- 12.8% of mothers were smokers during pregnancy in 2021/22 (whilst this is significantly improved on the previous rate of 17.1%, it is still above the national rate of 9.4% nationally for the same period). Smoking in pregnancy contributes to increased risk of stillbirth, low birthweight, and neonatal deaths
- 69% of residents in Rotherham indicated they used natural environment for health and exercise purposes compared to 82% for England (2017).



Long-term conditions

The number of people experiencing more than one long term condition (multi-morbidity) is increasing and the age at which this happens in getting lower, especially for those living in the most deprived parts of Rotherham.

For further information about Rotherham, its population and key challenges visit the JSNA website: CLICK HERE

Inclusion Health

Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

People belonging to inclusion groups, tend to have very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities.

Poor access to health and care services and negative experiences can also be commonplace for inclusion health groups due to multiple barriers, often related to the way healthcare services are delivered.

Access to the internet: 21.2% (38 LSOAs) in Rotherham are classified as e-withdrawn and have least engagement with the internet, with one measure associated with the classification being the highest ratio of people with no broadband access.

21.2% Rotherham

This group have;

- **The highest ration of people that don't have access, or have access but never engage with the internet**
- **The lowest rates of engagement in terms of information seeking and financial services**

Homelessness: households owed a duty under the Homelessness Reduction Act, 2020/21

13.6% Rotherham
11.3% England

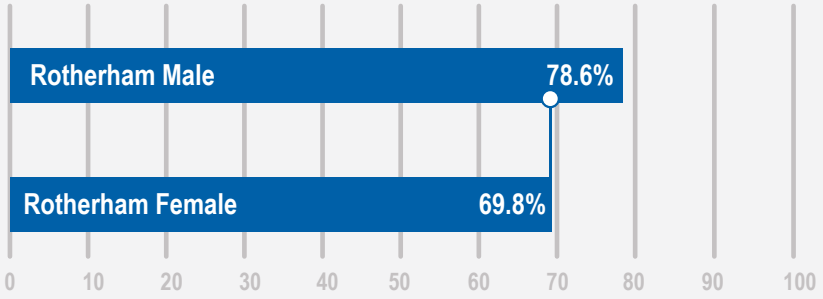
Homelessness is associated with poor health, education and social outcomes, particularly for children.

Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate, 2020/21.

Employment rates amongst disabled people reveal one of the most significant inequalities in the UK.
Rotherham is significantly worse than England.

74.0% Rotherham
70.0% England

Source:: https://data.crdc.ac.uk/dataset/internet-user-classification
OHID, Public Health Profiles, Public Health Outcomes-Framework - OHID (phe.org.uk)



4 - TRANSFORMATION WORKSTREAMS

BEST START IN LIFE: MATERNITY, CHILDREN & YOUNG PEOPLE

Rotherham has 57,453 children aged under 18 representing 21.7% of the local population (ONS, mid 2020), 23% of children live in low-income families (England 18%). Our Free School Meals (FSM) entitlement rate is above the English national average (23.8% compared to 21.6% at Primary, 21.4% compared to 18.9% at Secondary – DfE 2020/21). 19.4% of Rotherham's school age population is from ethnic minorities background (England 35.1%) (DfE 2020/21). 34.6% of Rotherham children were living in poverty in 2020, based on research from End Child Poverty. 64.5% of children under 5 are achieving a "good" level of development, compared to 65.2% nationally (DfE 2020/21).

Significant progress has been achieved through delivery of the previous plan with:

- The development and implementation of the Best Start and Beyond Framework which now provides a context for priorities for all commissioning and delivery, ensuring all activity aligns to our ambition for children to have a better start in life.
- Successful realignment and recommissioning of the 0-19 children's public health service, a key outcome for the recommissioning was to align with the reviewed and updated Healthy Child Programme and the High Impact Changes.
- The launch of a re-developed and co-produced Local Offer website providing children and young people with Special Educational Needs and Disabilities (SEND) and their families with relevant, up to date information in an easily accessible way.
- Delivery of training and support to health practitioners to ensure good quality, timely information is submitted to inform Education, Health, and Care Planning
- Improved dental registration and attendance at appointments for Looked After Children to above 80% from 53% last year.
- The development of good practice guidance for protocols of effective transitions.

All this has been achieved against a backdrop of; increased demand post-pandemic, delivering post pandemic recovery plans, the impact of the pandemic with higher levels of acuity, dependency and complexity, unprecedented and sustained system pressures, in particular for children with complex needs, recruitment, and retention issues, particularly. relating to some professional roles and low paid roles. These factors have a disproportionate impact on our most deprived individuals, families, and communities which make up over 20% of our population.

Our Key priorities are:

- **Best Start for Life**
- **Mental Health and Emotional Wellbeing**
- **Special Educational Needs and Disabilities**
- **Looked After Children**
- **Preparation for Adulthood**

AIM: ALL CHILDREN GET THE BEST START IN LIFE AND GO ON TO ACHIEVE THEIR POTENTIAL

Pathway design

- Children's Community Nursing and Community Paediatrics
- Child Development Centre
- Looked After Children
- Neurodevelopmental
- Sensory Support

Enablers

Information sharing
- Develop shared information tool across health and care.

Digital solutions
- Health Passport for Transitions
- Digital Assessment - Neuro

Workforce
- OD
- Training and Development
- Employer of choice
- Place recruitment and retention

Comms & Engagement
- Children/ Young People
- Parent/ Carer Inc. Panel
- Impacted staff.
- Providers
- Partners

Review of funding streams
- Joint strategic commissioning
- BCF/winter monies
- Discharge/UEC monies

PRIORITIES AND HOW THEY WILL ADDRESS THE KEY ISSUES.

Best Start for life

Partners in Rotherham are passionate about children getting the best start in life and going on to achieve their potential, this is reflected as an aim of the Health and Wellbeing Strategy, however over 35% of children under 5 do not achieve "good" level of development. The importance of giving children in Rotherham the best possible start in life was identified in the Government's Best start for life report (2021).

Both education and the family and social support networks available to people have a huge impact on health and wellbeing. The Development of family hubs including publication of the Start for Life offer, Parent-infant mental health support and infant-feeding support service will ensure that people have integrated, accessible support when and where they need it is vital to mitigate the impact of poverty and increase the number of children under 5 achieving a good level of development.

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

1. Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injuries.

2. Increase fill rates against funded establishment for maternity staff.

Delivery Milestones during the period of this plan include:

- Develop and implement the "Start for Life Pack" for all families taking a proportionate universalism approach to targeted engagement
- Embed the Breastfeeding friendly Borough Declaration through the delivery of Breastfeeding Friendly initiatives
- Review the Child Development Centre to ensure children in Rotherham will have timely access to an assessment and intervention when developmental needs are identified

Children and young people's mental health and emotional wellbeing

The impact of the pandemic on mental health has been significant and has made it more difficult for professionals to identify problems at an earlier stage. More people are seeking assessment, diagnosis, and support for children's mental health, learning and developmental needs. 40% of Children and Young People in Rotherham wait longer than 18 weeks to access mental health assessment and intervention. Timely diagnosis of Autism is a high priority nationally and a key strand within The NHS Long-term plan, Rotherham's Autism Strategy and Rotherham Partnership's special educational needs and disabilities strategy.

Sleep issues are a common phenomenon in children and young people. Additional to the physical and psychological issues linked with sleep deprivation, there is a significant financial cost in prescribing sleep medication to children in Rotherham. £400,000 was spent on Melatonin prescribing in 21/22. It has been reported that 40% of all children and young people will experience sleep disorders at some time in their early lives. This percentage rises in children with Special needs particularly children on the autism spectrum and in Looked after Children. 80% of children in the portage service have sleep disorders of some sort. A high number of children and young people are prescribed melatonin to manage their sleep disorder. Earlier identification and improved access to assessment and intervention will support children's emotional wellbeing, mental health, neurodevelopment, and sleep hygiene.

Delivery Milestones during the period of this plan include:

- Children in Rotherham will have timely access to an assessment and intervention for neurodevelopment disorders when a need has been identified
- Development of a framework to support consistent aspirations for children and young people's social emotional and mental health (SEMH) across the continuum with appropriate support identified, a workforce competency framework and workforce development frame work and a communications plan
- Re-develop, implement, and embed a tiered sleep pathway

Looked After Children

Looked-after children and young people in care are a vulnerable group; their issues feature prominently in the United Nations Convention on the Rights of the Child (UNCRC). Looked after children are statistically more likely to experience poor outcomes, to address this NICE set quality standards for the health and wellbeing of looked-after children and young people. One of the key priorities for Rotherham, and a key ambition as corporate parents, is to recruit, retain and grow the best inhouse foster carers locally. It is well understood that the needs of children and young people can only be met effectively if they live in an environment that provides a high quality of care and support. In general, this is achieved within a family home setting within their own community. Targeted, high-quality support will ensure Looked-after children and young people in care achieve their potential.

Delivery Milestones during the period of this plan include:

- Embed the Looked After Children pathway into child and adolescent mental health services (CAMHs)
- Redevelop and implement our therapeutic offer to looked after children, in-house foster carers/ residential care providers
- Actively engage in recruitment activity to increase the number of foster carers

Children and Young People with Special Educational Needs and/ or Disabilities

The Special Educational Needs Code of Practice (2015) sets out the requirements for the NHS to identify children with additional needs at the earliest possible opportunity and work with Local Authorities to plan to meet their needs. Disability Living Allowance (DLA) is claimed for 5.3% of children aged under 16 years in the local authority area compared with 3.8% in England as a whole. Learning Difficulties affect 55% of DLA claimants under 16 years in Rotherham. (DWP 2018). Increasing numbers of children and young people with SEND need a local offer to meet their needs to support them to achieve their potential.

Delivery Milestones during the period of this plan include

- Ensure children and young people with special educational needs and disabilities (SEND) and their families have access to accurate and relevant information on the Local Offer
- Develop, implement, and embed the accessibility strategy including the policy for funding equipment
- Review joint decision making for children with complex needs, including those with complex health and medical needs

Preparation for adulthood

Improving communication and addressing barriers will help to ensure young people and their families feel supported as they transition to Adulthood.

Delivery Milestones during the period of this plan include:

- Produce a mental health transition pathway to support effective transition for looked after children and care leavers with social emotional and mental health (SEMH) needs
- Maximise the use of the Rotherham Health Record to provide a 'health passport' to support transition from paediatric to adult
- Implement and embed preparation for adulthood guidance, including involving families in transition planning

IMPROVING MENTAL HEALTH AND WELLBEING

The Rotherham Adult Mental Health priorities are aligned with the national and regional drivers as outlined in the Operational Planning, Mental Health Long-term Plan and Core20PLUS5 documents, and reflects the priorities of South Yorkshire ICB, South Yorkshire MHLDA Provider Collaborative and South Yorkshire Specialist Commissioning MHLDA Provider Collaborative priority programmes.

Since the publication of the previous plan significant progress has been made in the development and enhancement of mental health provision across Rotherham.

- Transformation of the dementia care pathway, including the implementation of a new computed tomography (CT) scan pathway and transfer of 320 to primary care to receive their ongoing dementia monitoring.
- Achievement of the Long-term Mental health Ambitions for Early Intervention in Psychosis, which has consistently achieved its 60% access target, as well as achieving a Level 4 rating of 'top performing' (national ambition level 3).
- Working with colleagues from across SY ICB, Rotherham has successful commissioned and mobilised the Individual Placement Support (IPS) service delivered by South Yorkshire Housing.
- Developed and launch of several new services, including a new expanded Community Adult Eating disorder service delivered by SYEDA, Rotherham Safe Space Service, delivered by Touchstone in September 2022, which has supported 118 people since its launch; and Rotherham Samaritan's Wellness Check Pathway as a follow-up from a crisis call in April 2022, to date has supported 178 people.
- The continued development and expansion of the mental health communication programme across the borough, examples are the development and delivery of the Be the One 22/23 Campaign; and ongoing development of the Rotherhive digital platform, which received over 3.6 million hits since its launch in May 2020.

All of this will be achieved against a backdrop of' an increasing demand for mental health and emotional wellbeing support across the VCSE, Health and Social care system, people presenting with greater complexity and acuity, a need to ensure the successful delivery of post pandemic recovery plans, workforce recruitment and retention challenges across the whole of the mental health pathway, and a cost-of-living crisis and the impact of this on people mental health and emotional wellbeing.

Successful delivery of these priorities will require; partnership working across wider Place organisations supporting the delivery of acute, neurodivergent, children and young peoples' provision; consideration of the cost cutting themes of enabling digitalisation, address inequalities and disparities; that the voice of those with living Experience and their families / carers is central to the transformation undertaken.

Our Key priorities are:

Delivery of the Adult Severe Mental Illness in Community Health transformation plan.

Delivery of the Mental Health Crisis & Liaison programme

Suicide-prevention programme

Dementia pathway transformation

Delivery of the Better Mental Health for All Plan (note this also includes the loneliness delivery plan).

Delivery of the Adult Severe Mental Illness (SMI) in Community Health Transformation Plan.

Additional funding has enabled the increase in the mental health workforce within the primary care setting; and expansion of the RDaSH community mental health workforce to support the mental health needs across the primary / secondary care pathway. This has supported the increase of psychological support in the pathway provision.

The aim of which is to ensure that people with SMI access the right care and support at their earliest point of need and have wide ranging support closer to home and can live as healthy and fulfilling lives as possible in their community. Delivery of this priority will require Rotherham Place partners to work with the wider South Yorkshire ICB groups. Next steps will be to work together to continue the transformation of adult mental health services for those with SMI, this includes implementation of the integrated primary care hubs, enhance support for people by improving access to SMI physical Health Checks and employment Support; develop new personalised models of care by moving away from 'traditional' CPA and undertake targeted work on Adult Eating Disorders, Personality Disorder and Community Rehabilitation. For the past two years partners across Rotherham have been working together to support the transformation of the communit- mental health pathway across community, primary and secondary care.

Delivery Milestones during the period of this plan include:

- Implementation of Mental health ARRs roles in Primary Care in line with year 3 ambition
- Launch Primary care integrated Mental Health Hubs
- Community Mental Health Transformation pathways in place (targeted work on Community rehabilitation, complex needs/ Personality & eating disorders)

Delivery of the Mental Health Crisis & Liaison programme

In recent years, the demand for crisis supports across the whole of the mental health pathway. The combination of the pandemic and cost-living crisis are undoubtedly having an impact on people's mental health and emotional wellbeing. This is reflected in not only the increasing demand for mental health support but also the complexity and acuity of presentation. This will provide an opportunity for partners to collectively strengthen the mental health crisis pathway (including prevention and intervention, alternatives to crisis, crisis, reablement and post crisis support) to improve the journey and outcomes for people with mental ill-health. It will be achieved by redesigning the pathway, to embed principles and practices that prevent, reduce and delay people's need for care and support, including embedding a 24/7 'Making Safe' and reablement model, focussed on community-based recovery.

Delivery of this priority will require Rotherham Place partners to work with the wider South Yorkshire ICB groups

Delivery Milestones during the period of this plan include:

- Rotherham Crisis Care Concordat established
- Place Crisis pathway Health and Social Care delivery action plan agreed and considered at RMBC Cabinet
- Development of a Place Crisis Service specification
- Expansion of the alternative to crisis offer
- Implementation of a new Health and Social Care Crisis Pathway
- 111 'option 2' live for patients to have the option to press 2 for mental health in Rotherham
- 111 option 2 reporting in place via SDCS

Suicide-prevention programme

Suicide prevention is a high priority for Rotherham. Males (18.2) have seen a decrease and we are now statistically similar to the England average (15.9). (Y&H 18.8) However, females have increased to 8.5 compared to England at 5.2 which is statistically higher (Y&H 6.5). For All Persons- Rotherham is 13.2 compared to 10.4 (England) and Y&H 12.5. statistically higher. Rotherham has a partnership suicide prevention group which over-sees the implementation of the local action plan. The action plan reflects the national strategy and local priorities as outlined in the real time surveillance data. Rotherham works closely with colleagues across the ICB to deliver elements of suicide prevention, for example postvention support for all those bereaved and affected by suicide.

Delivery Milestones during the period of this plan include:

- Mobilisation and launch of the attempted suicide Prevention Pilot
- Refresh of the suicide prevention and self-harm action plan in line with the National strategy

Dementia pathway transformation

Rotherham has consistently performed well against the national diagnosis prevalence target. During the last year work has also been undertaken to support the transfer the ongoing monitoring of some people with dementia from secondary care to primary care, develop and mobilisation a new CT scan pathway and develop Admiral Nurses in each of the PCNs. More recently, a dementia partnership group has been established to consider how partners can work together to increase awareness of dementia and the support available. It is the work of this partnership group which will be one of the keys the focuses of this priority.

Delivery Milestones during the period of this plan include:

- Dementia Partnership Plan to be developed and approved

Delivery of the Better Mental Health for All Plan (note this also includes the loneliness delivery plan)

In 2019, Rotherham was ranked 44th most deprived authority in England, making the borough amongst the 14% most deprived local authorities in England. Even before covid, the estimated Rotherham prevalence for common mental health disorders was high in the over 65 age group (11.6% compared to 10.2% nationally) and 16+ population (18.6% compared to 16.9% nationally).

The ONS estimates of loneliness and personal well-being during the COVID-19 pandemic by showed that 7.6% of Rotherham residents felt lonely often or always and 43% of Rotherham residents felt lonely in the previous 7 days. (14 October 2020 to 22 February 2021). Loneliness can fluctuate over the life course and most people at some point in their life will experience loneliness. It is difficult to say what exactly causes loneliness but there are some known trigger factors which can be seen at an individual, community and societal level. The Rotherham Place Better Mental Health for All Group, looks at early intervention and prevention in relation to mental health and oversees the development and implementation of the Rotherham Loneliness Action plan.

Delivery Milestones during the period of this plan include:

- Health and Wellbeing Board to sign up to Prevention Concordat for Mental Health
- Develop and mobilise action plan in response to application
- To increase the number of practitioners receiving Making Every Contact Count (MECC) training

SUPPORTING PEOPLE WITH LEARNING DISABILITIES & AUTISM

The Rotherham Learning Disability and Autism priorities are aligned to national and regional drivers. It is also aligned to the Rotherham Plan of:

- Building an inclusive economy – ensuring people with a learning disability and autistic people enjoy the benefits and independence that employment brings.
- Building better health and wellbeing - to improve access for people with a learning disability and autistic people to better health and wellbeing.
- Building stronger communities - people with a learning disability and autistic people are partners in developing services.

Significant progress has been achieved through delivery of the previous plan with:

- Rotherham has been relatively successful in preventing admissions of people with a learning disability under the Mental Health Act. This is evidenced by the fact that Rotherham reported the lowest number of people with learning disability detained in hospitals under the Mental Health Act than any of the South Yorkshire partners.
- Up to 72% of people with a learning disability have accessed enhanced health checks.

There have been significant challenges due to the pandemic, the current cost of living and housing emergencies and staffing in health and social care issues. The learning disability mortality review (LeDeR) summarises the lives and deaths of people with a learning disability and autistic people who died in England in annual reports. In Rotherham the mean age at death in 2021/2022 in Rotherham was 56 years, with all notified deaths being in respect of adults with a learning disability.

Rotherham Place and Rotherham Council Adult Care has seen an increase in autistic people presenting in crises. The need to develop place plans to prevent autistic people from escalating into crises (defined in this case as mental health crises, suicide risk, forensic risks, or placement breakdown) is also highlighted.

With this in mind, the overarching theme is improving access. The focus of work over the next 2 years will be to improve access to health and improve well-being.

Rotherham Place and Rotherham are working to Develop proposals for day opportunities for people with high support needs through a redesigned new build specialist day support provision at Castle View and a £2.1m capital investment.

Our Key priorities are:

Increase the uptake of enhanced health checks for people with a learning disability aged 14 upwards

Ensure people with a learning disability and autistic people have better access to employment opportunities

Support the development of South Yorkshire pathways to reduce the need for inappropriate admissions into mental health services

To further develop accommodation with support options

Refresh the Vision and Strategy for people with a learning disability through coproduction and codesign

Develop a new service model for day opportunities for people with high support needs

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

9. Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
10. Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit.

Increase the uptake of enhanced health checks for people with a learning disability aged 14 upwards

People with a learning disability often have poorer physical and mental health than other people. This does not need to be the case. It is important that everyone over the age of 14 who is on their doctor's learning disability register has an annual health check. RDaSH offer support to GP practices to offer enhanced health checks.

Delivery Milestones during the period of this plan include:

- Additional support will be offered to GP Practices to undertake enhanced health checks
- Peer Support offered to people with a learning disability to access enhanced health checks
- Focus on increasing the numbers of eligible young people to access GP enhanced health checks

Support the development of South Yorkshire pathways to reduce the need for inappropriate admissions into mental health services.

The proposal is to commission 4 safe place beds across South Yorkshire to prevent unnecessary hospital admissions, with clear protocols and a robust memorandum of understanding between health and social care to further the South Yorkshire Memorandum of Understanding for Ordinary residence with cross-authority supported living services, to ensure the beds are used appropriately as a system resource, with ongoing specialist team input and a clearly defined pathway. Due to the low numbers of admissions, it is not cost-effective to develop these solely at place level, so it is suggested that an ICS joint commissioned resource will be more achievable.

Delivery Milestones during the period of this plan include:

- SY ICB to source a suitable provider who has the skills, knowledge and values who can provide this service (SY ICB led)

Ensure people with a learning disability and autistic people have better access to employment opportunities

RMBC successfully bid for the Department for Education Supported Internships Grant. Over a three-year period, Rotherham will work with partners (Rotherham Opportunities College, Rotherham College and Dearne College) to increase the number of young people accessing supported internships for young people with SEND needs. Employment is for Everyone aims to bring together all partners, projects and opportunities relating to employment across South Yorkshire for people with learning disabilities and autistic people and will support the engagement with employers. In addition to Supported Internships RMBC have established a Supported Employment team that will provide specialist support to access sustainable employment for our residents with a learning disability and or autism. The project is commissioned for a two-year initial period with delivery expected from late June 2023, it can be accessed through the RMBC Employment hub.

Delivery Milestones during the period of this plan include:

- Develop a special educational needs and disabilities (SEND) supported internships action plan

To further develop accommodation with support options

RMBC has a strong commitment to expanding supported living for people with a learning disability and autistic people through the My Front Door Project, this enables better outcomes for people and is more cost-effective than traditional forms of housing. Rotherham's population of people with a learning disability and autistic people is changing, both in complexity and with an ageing population. As an example, some young people with SEND needs often require a home that is specially adapted and includes support which will enable them to be more independent. Speaking to people with a learning disability and autistic people across all communities, people told us that they want good quality homes that are close to friendship circles and their families. People want homes that offer flexibility and choice and are places "where we can relax, unwind and work off that stress". Cabinet approved the creation of a Flexible Purchasing System (FPS) to ensure that for the development of future Supported Living contracts, providers are aligned to Rotherham's vision of providing housing for people with learning disabilities and autistic people. These developments will be based on the principles contained in 'Building the Right Home'. In addition, the peer support system via key ring has been expanded.

Delivery Milestones during the period of this plan include:

- To launch Rotherham's supporting living Flexible Purchasing System (FPS)
- To build an agreed number of supported living units each year

Refresh the Vision and Strategy for people with a learning disability through coproduction and codesign

To deliver on this the Council and Rotherham Place needs to refresh the vision and strategy for people with a learning disability from 2023 and beyond. The approach will be co-produced with people with a learning disability, young adults and their families, parents, and carers, as well as partners and providers who are delivering services and supporting people with a learning disability. Rotherham will also refresh its autism strategy. This will be coproduced with autistic people, young people and their families, parents, and carers.

Delivery Milestones during the period of this plan include:

- Refresh the Vision and Strategy for people with a Learning Disability and Autism Strategy

Develop a new service model for day opportunities for people with high support needs

The ongoing commitment to the transformation of Learning Disability Services includes a new service model focussed on day opportunities for people with high support needs. This includes the construction of a new day centre facility in Canklow replacing the existing Learning Disability Day Service, providing a modern, state of the art facility whilst providing a welcoming, calming, and exciting purpose-built environment. The new service will:

- Offer modern accessible day opportunities with multifunctional fit for purpose facilities within the heart of the community, promoting independence, wellbeing, and social inclusion and supporting a focus on community connectivity
- Welcome support and involvement from local businesses, community groups and voluntary sector organisations.
- Act as bespoke day support for those with the most complex needs delivered in a person-centred manner, but also be a hub for wider activity, learning and skill development. The hub will also act as a place for anyone with a learning disability to access general support with getting on with their lives', therefore reducing the need for formal contact with adult care for low level support and dealing with the small issues thus supporting a prevention and early intervention model.
- Consider extended opening times and also enable the use of the facilities during evenings and weekend for events and social gatherings
- Support young adults in transition to achieve a life of their own.
- Support an outcome focused strength-based approach in accordance with good practice and the principles of the Care Act 2014.

Delivery Milestones during the period of this plan include:

- Opening of new facilities for people with learning disabilities, autism and complex needs

URGENT, EMERGENCY AND COMMUNITY CARE

The Rotherham Urgent and Emergency priorities are aligned to national and regional drivers for out of hospital care including the Urgent and Emergency Action Plan. The approach continues to build on Rotherham's strategic vision of supporting people and families to live independently in the community, with prevention and self-management at the heart of our delivery. Significant progress has been achieved through delivery of the previous plan with:

- the implementation of a virtual ward and urgent community response to support admission avoidance
- development of an integrated discharge service, with over 90% of people being discharged home.
- the launch of a multi-disciplinary referral and triage hub to provide the right level of care, at the right time and place according to patient need including improving 111/999 referral processes.
- improved multi-disciplinary working to enhance health in care homes.

WORKING TOGETHER FOR WHOLE SYSTEM FLOW

Aim: to work collaboratively to enable more people to be cared for at home, with the right care, the right time and in the right place - leading to improved patient and carer outcomes and reduced avoidable conveyances and admissions.

Pathway design	**Prevention** • 111/999 including push model. • Front door deflection • Proactive (anticipatory) Care • SDEC • Grown virtual wards and UCR. • Falls review	**Discharge** • Develop a discharge to assess model • Establish an integrated Transfer of Care Hub for referral and Triage		
System command centre	**Transfer of Care Framework & Delivery Model (avoidance & discharge)** • Develop and improve access to 7 day/integrated hub with out of hours offer. • Capacity and demand: community @ home; acute & community bedded offer (IC & complex commissioning of bed offer	**Digital Solutions:** • Practitioner: remote tech, assistive tech • Whole system community and acute digital command centre and performance dashboard		
Enablers	**Workforce** • OD • Training and Development • Employer of choice • Place recruitment and retention	**Comms and engagement** • Patients/carers • Impacted staff. • Providers • partners	**Review of funding streams** • Joint strategic commissioning • BCF/winter monies • Discharge/UEC monies	

Our Key priorities are:

Prevention and alternative pathways to admission

Sustainable Discharge

Whole System Command Centre Model

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

11. Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
12. Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
13. Reduce adult general and acute (G&A) bed occupancy to 92% or below.
14. Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard.

All this has been achieved against a backdrop of; an increasingly aging population, delivering post pandemic recovery plans, the impact of the pandemic with higher levels of acuity, dependency and complexity, unprecedented and sustained system pressures impacting on attendances in the emergency department and pressure on acute beds, recruitment, and retention issues, particularly relating to some professional roles and low paid roles.

These factors have a disproportionate impact on our most deprived individuals, families and communities which make up over 20% of our population. Whilst Rotherham is performing comparatively well on national discharge indicators there is still work to do to reduce the number of people remaining in our acute and community bed base with no right to reside and we still have a heavier reliance on our community bed base than comparative Places.

Against this backdrop and significant financial challenges across the system the aim of this work steam is to work collaboratively together to enable more people to be cared for at home, with the right care, at the right time and in the right place. Leading to improved patient and carer outcomes and reduced avoidable conveyances and admissions. To achieve the priorities, we will:

- Take stock of our current provision and impact of out of hospital services in order to prioritise the areas which have the greatest impact and relieve pressure points.
- Re-introduce the 4-hour A&E response standard, including reviewing the patient experience, pathways, ways of working and workforce.
- Develop alternative pathways to ED and acute admissions to reduce unnecessary conveyances and avoidable admissions. Most of our service users tell us that they want to be cared for at home. National evidence shows that patient outcomes are better for people who are cared for at home. This is particularly the case for the frail elderly and people with dementia who are at higher risk of harm through deconditioning and infection following an acute admission.
- Further develop and embed a sustainable whole system approach to patient flow to relieve the pressure on ED, ensure acute beds are available for those who need them and ensure people who do require admission are discharged in a timely way with the right support for them.
- We will utilise technology for direct patient care and business management wherever possible and draw on support from our enabler groups for workforce, communications, finance, and digital expertise. Where appropriate, and of benefit, we will work with colleagues from other Places and the South Yorkshire footprint to benefit from good practice, lessons learned and economies of scale

Each of our priorities will work together to create an overall step change in delivery. There are interdependencies with the mental health work stream and services particularly in relation to crisis. At South Yorkshire level there are interdependencies with the virtual ward (including a joint procurement of remote technology), proactive (anticipatory) care including roll out of respect and potentially a digital risk stratification tool, work to review end of life care and digital solutions for record keeping in care homes.

BRIEF SUMMARY OF EACH PRIORITY

Prevention and alternative pathways to admission

This priority is based on the principle 'prevention is better than cure', that is it is better to help maintain people to live independently for longer for their own and family/carer's health and wellbeing and thereby reduce avoidable reliance on services. The priority will bring together a number of work streams in order to take a cross system strategic overview whilst progressing areas of national/local priority. These include:

- Proactive (Anticipatory) care which is an approach which identifies and engages people living with frailty, multiple long-term conditions and/or complex needs to help them stay independent and healthy at home, for as long as possible.
- Develop alternative pathways to ED and admission working with 111/999 to grow referrals and develop and embed the PUSH model.
- Grow the virtual ward and urgent community response to support more people at home who would otherwise be in an acute bed or at risk of admission.
- Review deflection at the front door streamlining avoidance and frailty services and developing and embedding our Same Day Emergency Care offer as an alternative to ED and admission.
- Review of falls services to develop a fit for purpose, affordable, multi-disciplinary falls pathway.

Delivery Milestones during the period of this plan include:

- Grow the Virtual Ward and Urgent Community response according to agreed trajectories
- Implement Virtual Ward remote monitoring
- Review Falls offer and deliver revised model
- Scope and develop the Proactive (Anticipatory) care model with phased implementation including delivery of a risk stratification tool
- Review Services which deflect admission at the front door

Discharge

Rotherham has carried out extensive incremental change to facilitate timely discharge. C93% of our patients are discharged home. We have invested in home-based services with some excellent examples of good practice. Whilst we believe we have all the constituent parts to deliver a timely discharge to assess model these parts need to be bought together into a coherent multi-disciplinary discharge to assess model with an integrated Transfer of Care hub for referral and triage which

- enables community expertise to assess the level of risk that can be safely supported at home and in the community bed base.
- enables assessment to be carried out at home.
- enables resource to be allocated flexibly across pathways to meet demand and acuity across 7 days

Delivery Milestones during the period of this plan include:

- Implement integrated transfer of care hub and discharge to assess model
- Review and streamline discharge pathways
- Review community home and bed base care in line with demand
- Capacity and demand modelling of intermediate care and discharge provision

Whole System Command Centre

This priority is the link which brings together admission avoidance activity and discharge to inform strategic and operational decision making to improve whole system flow:

- Capacity and demand modelling of domiciliary and rehabilitation intermediate home based and commissioned bed services and discharge provision.
- Commissioning of community bed offer
- Development of a whole system command centre and performance dashboard

Delivery Milestones during the period of this plan include:

Development of a whole system digitised Command Centre and performance dashboard:

- Community escalation wheel
- Community dashboards and performance reports

PALLIATIVE AND END OF LIFE CARE

We believe that people approaching the end of their life are entitled to high quality care, wherever that care is delivered. Good end of life care should be planned with the individual and the people close to them to ensure it is tailored to their needs and wishes and including management of symptoms, as well as provision of psychological, social, spiritual, and practical support. More people in Rotherham should be able to exercise choice over their end of life care and the place of their death. Rotherham partners will play an active role in delivering the ICB ambitions.

At a place level we want earlier identification of people at the end of life, to improve the care and support they receive, make sure people are able to voice their preferences and that more people die in the place of their choice and that we reduce the number of hospital admissions for people in the last months of life.

Actions we will take are:

- We will carry out a review of PEOLC Medicine across Rotherham, to obtain a comprehensive understanding of the PEOLC pathway across Rotherham, paying particular attention to access to specialist palliative care services, bereavement services, pharmacy services, equipment, spiritual care (as part of mental health and wellbeing support) and access to information.
- Enhance personalised PEOLC by undertaking work to identify Rotherham patients and carers experience to inform future commissioning and introduce co-production opportunities.
- The ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process creates a personalised recommendation for clinical care in emergency situations where patients are not able to make decisions or express their wishes. Partners will work together to implement ReSPECT across Rotherham, ensuring that all partners are involved, and that training and communication is carried out effectively.
- The Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026, sets out the vision to improve end of life care through partnership and collaborative action between organisations at Place level. During May/June 2023 we will undertake the benchmarking against the Ambitions Framework using the self-assessment tool, following which a SY wide event will take place and we will contribute to the development of a full PEOLC SY ICB action plan.
- We will start the development of a Rotherham PEOLC Data Dashboard to feed into a SY wide dashboard.
- ECHO is an online learning and support methodology. It supports knowledge sharing between staff from across health and social care and facilitates the exchange of specialist knowledge and best practice. Rotherham and Doncaster have joined up to provide an ECHO training programme across the two Places. During Q1 of 2023/4 the ECHO PEOLC training plan for Care Home staff and Community Nursing will be developed further and will be expanded to other community and primary care teams.
- The Palliative and End of Life Care Statutory Guidance for Integrated Care Boards (Sept 2022) has been developed by NHSE to support ICBs with our duty to commission PEOLC services within the ICS and ensure that people can receive high quality personalised care and support. We will work collaboratively across the ICB to implement the requirements of guidance.

Our Key priorities are:

Complete a review of PEOLC Medicine

Enhance personalised palliative and end of life care.

Implementation of ReSPECT across Rotherham

Benchmark against the Ambitions Framework

Inform future commissioning through patient and carer experience.

Delivery Milestones during the period of this plan include:

- Review of Palliative and End of Life Care (PEOLC) Medicine across Rotherham
- Undertake work to identify Rotherham patients and Carers experience to inform future commissioning
- Implement Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) across Rotherham, including relevant training
- Benchmark against the ambitions for PEOLC framework
- Develop an action plan to address the outcomes
- Develop Rotherham PEOLC Dashboard

LIVE WELL FOR LONGER

Life expectancy and health life expectancy in Rotherham are both lower than average for men and women and this is significantly worse in the most deprived areas of the borough compared to the most affluent. This inequality in health leads to around 6,500 years of life being lost each year in Rotherham (2023-2024 average) through causes considered amenable to healthcare, this is almost 1,400 years more than might be expected based on the England average.

The impact of a long-term condition or disability may mean that a person may not have 'good' health, but they should still be able to live well through the right support and by keeping mentally, physically, and socially active. Making sure people get the right care when they need it is important, but importantly we need to understand and make sure that **what matters most to people** is considered, not just looking at what is the matter with them (their presenting needs/issue), in line with the Rotherham Health and Wellbeing Strategy key aims for ensuring people live well for longer include:

Proactive (Anticipatory) Care

Proactive Care Planning (previously referred to as Anticipatory Care) 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. It is targeted at people of all ages living with frailty, multiple long-term conditions and/or complex needs to help them stay independent and healthy for as long as possible at home, in the place they call home or in their local community. It focuses on providing the support based on what is important to the individual, improving health inequalities and health outcomes. Proactive Care reduces the risk of long-term health conditions worsening that would result in an individual needing a hospital stay or visit.

Proactive Care aims to increase peoples' healthy years by up to 5 more years, typically it involves structured proactive care and support from multidisciplinary teams within the system and focuses on groups of patients with similar characteristics, such as living with multimorbidity, frailty and/or complex needs. Patients are often identified through risk stratification and population health management tools alongside clinical judgement.

Our Key priorities are:

- **Proactive Care (formerly Anticipatory Care)**
- **Personalised Care**
- **Medicines Optimisation**
- **Social Prescribing**
- **Address the Major Health Conditions Strategy**
- **Prevention and High impact Interventions**

During 2023/24 we will work as a system to develop our Proactive (anticipatory) Care model based on the following components:

- Identification of specified key segments of PCNs registered practice populations who have complex needs and are at high risk of unwarranted health outcomes.
- Maintenance of a comprehensive and dynamic list of individuals who would benefit from Proactive (anticipatory) Care, based on the outcome of the population segmentation approach.
- The delivery of a comprehensive set of support for those individuals identified as eligible through the Proactive (anticipatory) Care list, through an MDT based across health and social care providers.

Personalised Care

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths, needs and preferences. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families, and communities in delivering better health and wellbeing outcomes and experiences. The NHS LTP makes personalised care business as usual across the health and care system, as one of the 5 major practical changes to the NHS service model. Personalised care takes a system-wide approach, integrating services around the person including health, social care, public health, and wider services. It provides an all-age approach from maternity and childhood right through to end of life, encompassing both mental and physical health and recognises the role and voice of carers, and the contribution of communities and the voluntary and community sector to support people and build resilience. There are several national documents on the person-alisation, with outline strategic aims, priority areas, enablers, comprehensive models of care, to universal models of care with targeted approaches and it is easy to become lost in the complexity and scale of the ask.

The thread running through all the documentation is that places should work together to:

- Embed a personalised care ethos across the place.
- Reduce health inequalities.
- Enrich personalised care approaches across health care.
- Focus on workforce development – so teams focus on the patient and what matters to them most, involving them in decisions about their care to get the best outcomes for that individual.

Medicines Optimisation

Prescribing is the second largest area of expenditure for Place and the South Yorkshire Integrated Care Board (ICB). Prescribing costs are influenced by a wide range of factors that are often outside of the individual clinician's control such as: National guidance (NICE etc), new clinical evidence, drug shortages – resulting in having to prescribe less cost-effective alternatives and drugs not available at drug tariff price (NHS contract price). Drugs are global commodities and supply chains into the UK are international. The ever-increasing number of drug shortages/supply problems and the inability to obtain drugs at drug tariff prices, will all impact on prescribing costs. The Rotherham medicines management team engages with prescribers to get them to accept ownership of the financial impact of their prescribing, even though increased prescribing costs will have little direct impact on the clinician. The team, in conjunction with the primary care team, monitors performance across three GP local enhance services: anticoagulant monitoring, Palliative Care End of Life care drugs and Transgender prescribing. The team also designs and monitor two prescribing incentive schemes, where practices are rewarded for their performance against these two schemes.

The 2022-23 Work plan includes:

- Implementation of the agreed strategies for Diabetes, Hypertension, and antibiotic prescribing
- Eclipse Live a risk stratification tool will be introduced.
- Launch of the new Prescribing Incentive scheme
- The antidepressant review programme will be continued.
- Care home hydration project to be relaunched capitalising on the national funding.
- Aim to establish a chronic pain man agement service pilot.
- Continued improvement of diabetes management, with particular focus on patients receiving high doses of insulin and poor HbA1c control.
- Work is underway to build a system utilising AccWeb to maximise the potential of the community pharmacy BP monitoring service commissioned by NHSE.

Prevention and High Impact Interventions

Improving the population's health and preventing illness and disease is key to reducing health inequalities and is at the heart of the NHS Long Term Plan. Tackling health inequalities is a core priority for NHS England because people from more deprived backgrounds are more likely to have long term health conditions and suffer poor health. The NHSE prevention programme specifically looks at the early detection of disease and support for people taking their own action to better health through supported self-management. In December 2022 NHS England published range of prevention and high impact interventions for: modifiable risk factors, diabetes, cardiovascular disease, and diabetes.

During 2023/24 we will:

- undertake a piece of work baselining where we are in Rotherham against the published prevention and high impact interventions and including the Core20Plus5 clinical areas for adults and children and young people.
- use the outcomes to inform and update the prevention and health inequalities action plan.

Social Prescribing

Rotherham has an award-winning Social Prescribing programme. From the original two schemes, (one for people with long term conditions who are referred through their GP to Voluntary Action Rotherham (VAR), and one to help patients under the care of RDaSH with a mental health diagnosis to be supported out of long term statutory mental health services). Both of these Social Prescribing Programmes are funded through the Integrated Better Care Fund.

The Rotherham Social Prescribing work has expanded in a number of ways. This includes working with a number of Rotherham PCNs, through the GP Federation, to host social prescribing link workers, supporting patients who are able to benefit from non-clinical interventions. The 'link workers' complement the existing social prescribing work by supporting patients who otherwise would miss out. Social Prescribing has, very successfully, for well over a year now, also been part of the 'Long Covid Pathway'. A Social Prescribing pilot is also underway, as part of the UECC offer; working with TRFT colleagues to enable patients to have their wider support needs met. Rotherham is also part of a South Yorkshire programme of implementing social prescribing to be part of the Stoke Service/s pathway; where social prescribing link workers, will work along a multi-disciplinary team to ensure Stroke patients' needs are met holistically. The Rotherham Social Prescribing work recognises that as well as the Advisors and Link Workers, that resources are made available to support the voluntary and community sector to develop, grow and sustainably provide the 'social prescriptions and related interventions.

Major Health Conditions

The Department of Health and Social Care is developing a Major Conditions Strategy in consultation with NHS England which is due to be published later in 2023. The strategy will seek to shift the policy agenda towards a whole-person care approach, setting out patient standards in the short term and over a five-year timeframe. It focuses on major conditions including Cancers, Cardiovascular diseases, including stroke and diabetes, Chronic respiratory diseases, Dementia, Mental ill health, Musculoskeletal disorders

The Strategy aims to alleviate pressure on the health system, reduce economic inactivity caused by ill-health, support the Government's manifesto commitment of gaining five extra years of Healthy Life Expectancy by 2035, and fulfil its levelling up mission to narrow the gap in Healthy Life Expectancy by 2030. It also seeks to cater to patients with increasingly complex needs and with multiple long-term conditions. Preserving good health, early detection and treatment of diseases have been highlighted by the Strategy, as has the need for joint working between health and care services, local government, NHS bodies, and others.

We will work with partners across SY ICB to deliver the plans against the National and Local Requirements, in addition examples of work at a Rotherham Place are:

- Implement Targeted Lung Health Checks
- Phase 1 development of the CDC – focused on respiratory
- Increase promotion/awareness of cancer screening programmes (breast, bowel and Cervical)
- Greater input from PCN pharmacist into diabetes & heart failure management
- Improve CVD Prevention and Diagnosis in primary care
- Community Diabetes Specialist Nursing Service in place, joint dietetic and nursing clinics
- Pilot centralised spirometry across primary care to inform commissioning Pulmonary rehab
- Increase referrals to all weight management programmes
- Identify overuse of SABA inhalers, to improve management/reduce admission
- Targeted management of heart failure in the community

.

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

15. Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days.

16. Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.

17. Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024

18. Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%

19. Continue to address health inequalities and deliver on the Core20PLUS5 approach.

5 - CROSS-CUTTING WORKSTREAMS

PREVENTION AND HEALTH INEQUALITIES

To drive delivery against South Yorkshire's Joint Forward Plan in Rotherham and our ambitions around improving the health of the local population, Rotherham's Prevention and Health Inequalities Strategy was adopted in 2022. As a Place partnership, we want more people in Rotherham to experience better health and wellbeing. Focussing on preventing problems from arising in the first place and intervening early will not only lead to better health outcomes for local people but is also vital to ensure a sustainable future for our services. Where problems do arise, we want to focus on preventing them from escalating further, so that people can live happy, healthy, and fulfilling lives for as long as possible.

There are also significant health inequalities between different groups in Rotherham, which means we need to support communities at a level that is proportionate to the degree of need – taking a universal approach where appropriate whilst also providing targeted support to those who most need it. To effectively address health inequalities, this principle of 'proportionate universalism' should be embedded within everything we do. Our Prevention and Health Inequalities Strategy identifies 5 priorities, see plan on a page below is a summary of the work taking place:

PEOPLE IN ROTHERHAM LIVE WELL FOR LONGER.

Strengthen our understanding of health inequalities.

Improve the understanding of health inequalities in Rotherham.

Ensure that partners have access to bespoke data products.

Ensure that data around health inequalities informs commissioning, decision-making and service-delivery.

Develop the healthy lifestyles prevention pathway.

Reduce the prevalence of smoking in Rotherham and narrow the gap between population groups.

Increase the proportion of people in Rotherham who are a healthy weight.

Reduce alcohol-related harm for people in Rotherham.

Support older people in Rotherham to retain their independence and age well.

Support the prevention and early diagnosis of chronic conditions.

Reduce the health burden of cardiovascular disease in Rotherham.

Improve the management of diabetes.

Reduce the health burden of chronic respiratory disease in Rotherham.

Increase the proportion of cancer diagnoses made at stage 1 or stage 2.

Ensure people get support with their mental health at the earliest possible stage.

Tackle clinical variation and promote equity of access and care.

Narrow the gap in maternity outcomes for ethnic minority women and women from deprived communities.

Reduce premature mortality for people with learning disabilities, autistic people, and those with severe mental illnesses.

Improve access to social prescribing for ethnic minority communities.

Mitigate against digital exclusion.

Harness partners' roles as anchor institutions

Improve the health and wellbeing of our workforce across the place partnership.

Employ people from deprived communities and inclusion groups in Rotherham.

Increase our local spend to support Rotherham's economy.

Reduce our environmental impact.

ADVOCATE FOR PREVENTION ACROSS THE WIDER SYSTEM

1 Strengthen our understanding of health inequalities

To make a compelling impact on health inequalities, we must act based on a strong understanding of the needs and experiences of our communities. This includes having a clear understanding of who our target groups are, to enable us to take a proactive approach and make the biggest difference to population health. Work to build our understanding of health inequalities will inform our approach to tackling health inequalities; the intention is that our local Prevention and Health Inequalities Strategy will evolve as we build our understanding of the data and intelligence, ensuring we are responsive to the best evidence available and emerging needs. We will also share the data and intelligence we collate more widely to influence across the wider system. Integral to this work will be the inclusion of community intelligence and the voice of local people. Listening to and acting on what people tell us is essential to addressing inequalities in our communities, including identifying any barriers to accessing care and disparities in the experiences and outcomes of different groups.

2 Develop the healthy lifestyles prevention pathway

Modifiable risk factors, such as smoking, alcohol, and obesity are all associated with disability adjusted life-years and are key drivers of poor health. Rotherham has higher rates of smoking, obesity and alcohol-related harm when compared with the England average and there are also significant disparities in the prevalence of these issues between the most and least affluent communities and for specific communities. This means that focussing on these preventable risk factors is an important part of addressing inequalities within the borough, as well as between Rotherham and the national average. Working in partnership, we will aim to ensure that our services operate within a person-centred, joined-up and effective pathway. We will aim to support and empower local people by taking a compassionate approach, which means promoting health gains for all people, without stigma or judgement, and taking into account the wider context of their lives.

3 Support the prevention and early diagnosis of chronic conditions

It is estimated that two thirds of premature deaths could be avoided through improved prevention, early detection, and better treatment, meaning that focussing on the prevention and early diagnosis of long-term conditions has the potential to have a significant impact on mortality in Rotherham. Early detection and effective treatment are also vital to ensure that people with long-term conditions experience a good quality of life. Additionally, having one long-term condition can increase the risk of developing another, and multimorbidity is higher in the most deprived communities. To provide the best treatment and care, we will take a person-centred and holistic approach, rather than focussing on individual diseases. We will also ensure that a focus on sustainable behaviour change, such as integrating physical activity as treatment within clinical pathways, is part of our approach to supporting people with LTCs.

4 Tackle clinical variation and promote equity of access and care

The COVID-19 pandemic and the cost-of-living crisis have shone a harsh light on some of the health and wider inequalities that persist in our society, and we know that people do not receive services or support on an equal footing. This includes disparity in both access to services and the experience and outcomes from treatment. Ensuring that every person in Rotherham has access to quality care is a key component to addressing health inequalities across the borough. This will often require a tailored and targeted approach to meet the needs of specific communities.

5 Harness partners' roles as anchor institutions

The term 'anchor institutions' is used to refer to organisations which have an important presence in a place, usually through a combination of being largescale employers; the largest purchasers of goods and services in the locality; controlling large areas of land; and/or having relatively fixed assets. Being such large institutions within Rotherham means that Rotherham Place partners have the potential to improve population health by addressing the socioeconomic and environmental conditions that influence health outcomes. By working collectively on joint commitments, we have the potential to have a significant influence on these determinants, making Rotherham a healthier place to live and work.

In addition, **we will advocate for prevention across the wider system -** Evidence shows that the wider determinants of health – (the conditions in which people are born, grow, live, work, and age) – are more influential in shaping people's health and wellbeing than the healthcare that people receive. Whilst the Place Plan and Prevention and Health Inequalities Strategy are focussed on the health and social care system, it will be important to use partners' collective influence and the intelligence we gather to shape action to address the wider determinants of health.

To support this, Place partners will provide evidence to key stakeholders and partnership forums such as the Health and Wellbeing Board to influence action on the wider determinants of health and will also advocate for prevention within each of our own organisations.

The NHS Long Term Plan requirements set out action relating to prevention and health inequalities, such as:

- Providing more personalised care and giving people more control over their own health.
- Taking action to address the key drivers of ill-health such as smoking, obesity, alcohol, air pollution and antimi crobial resistance.
- Supporting a strong start in life for children and young people, including a focus on maternity and neonatal services, children, and young people's
- Providing better care for major health conditions, including cancer, cardiovascular disease, strokes, diabetes, respiratory disease, and mental health.
- Deploying population health management solutions to understand the areas of greatest health need and match services to meet them.

Over 2022/23, work started to deliver on the strategy, some of the key achievements include:

- Development of a prevention campaign to support engagement with local people around their health and wellbeing.
- Expansion of the RotherHive website to incorporate sections on smoking, food, and physical activity.
- Embedding of the QUIT programme across TRFT and RDaSH.
- Relaunch of the NHS Health Checks programme, with a focus on areas of high deprivation in line with proportionate universalism.
- Rollout of the lung health checks programme in Rotherham.
- Delivery of OHID-funded projects to support people with their mental health, which included an award-winning befriending project delivered by voluntary sector partners.
- Launch of the continuity of care model within maternity services in TRFT.
- Engagement in the national Place Development Programme, which provided insights around multimorbidity.
- Development of an interactive health inequalities tool, which includes an assurance framework to measure delivery of the strategy as a profile of the
- Engagement with local ethnic minority communities on mental health to support the development of cultural competency training for GPs and other clinicians.

The Rotherham Place Prevention and Health Inequalities Group is committed to building our understanding of health inequalities in Rotherham, which will include analysis of disparities in access, outcomes and experience for ethnic minority communities. This will inform the delivery of the entirety of the Place Plan, with all workstreams contributing towards narrowing the gap.

The Operational Planning Guidance includes 32 national objectives covering 12 areas of the NHS, some of the key objectives relating to prevention and health inequalities include:

- Making it easier for people to contact a GP practice and delivering 50 million more appointments by the end of March 2024.
- Continuing to recruit Additional Roles Reimbursement Scheme (ARRS) roles.
- Recovering dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels.
- Focussing on cancer diagnosis, including meeting the cancer faster diagnosis standard, and increasing the percentage of cancers diagnosed at stages 1 and 2.
- Increasing the percentage of patients that receive a diagnostic test within six weeks and delivering diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.
- Improving access to mental health support for children and young people.
- Increasing the number of adults and older adults accessing IAPT treatment and achieving a year-on-year increase in the number of adults and older adults supported by community mental health services.
- Recovering the dementia diagnosis rate.
- Improving access to perinatal mental health services.
- Ensuring people aged over 14 on GP learning disabilities registers received an annual health check and health action plan.
- Reducing the reliance on inpatient care for people with learning disabilities and autistic people, whilst improving the quality of inpatient care.
- Increasing the percentage of patients with hypertension treated to NICE guidance.
- Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies.

The Core20Plus5 framework

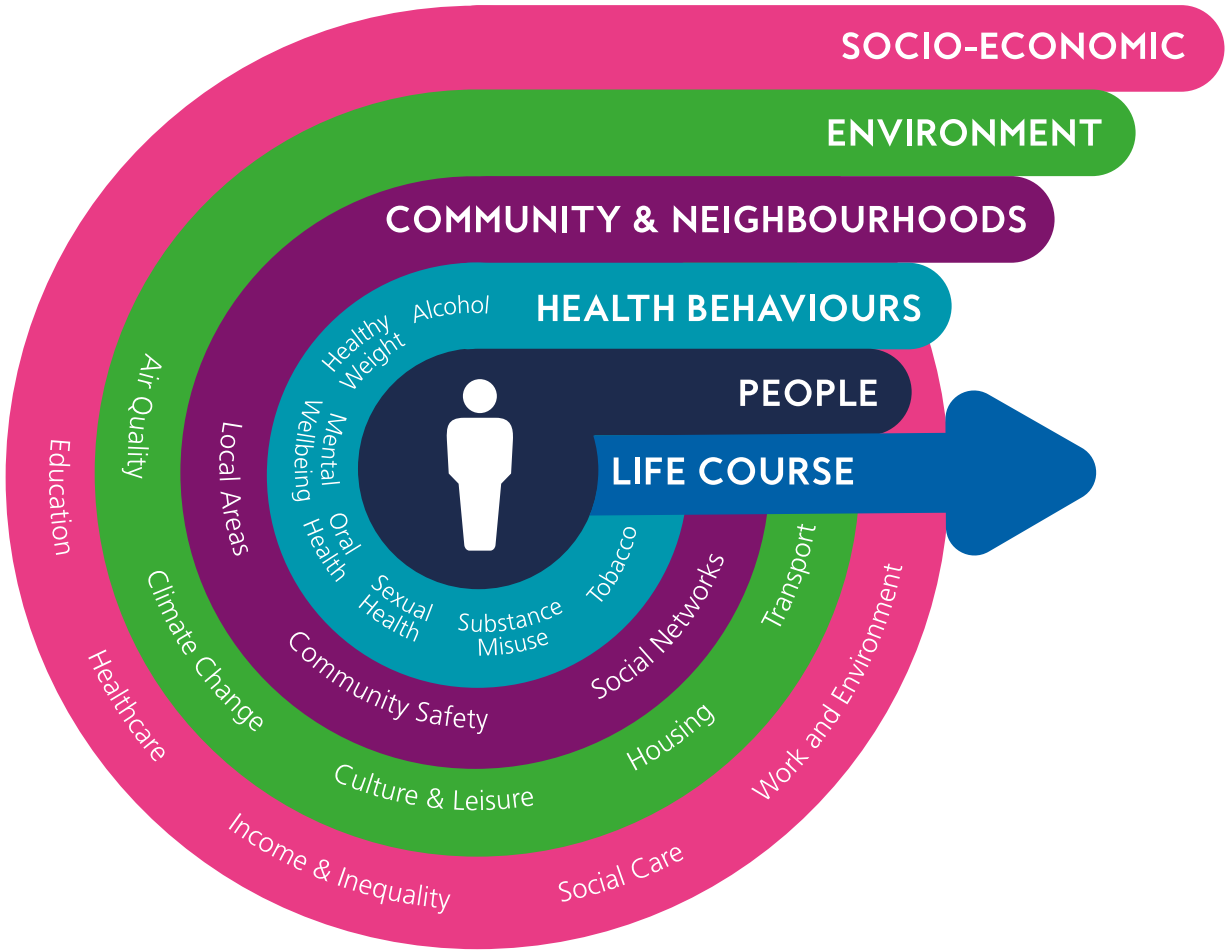
For adults and for children and young people is the national NHS framework for tackling healthcare inequalities. This framework sets out a focus on the 20% most deprived communities nationally according to the Index of Multiple Deprivation (IMD), 'plus' inclusion health groups, which are identified locally and a number of priority clinical areas. Rotherham's Place Plan and the Prevention and Health Inequalities Strategy both draw from and seek to deliver against this national framework. This means a commitment to focussing on:

The **20%** most deprived of the national population according to the Indices of Multiple Deprivation.	According to the IMD (2019), 36% of the Rotherham population live in the 20% most deprived areas of England. There are significant inequalities in health outcomes for the most and least deprived communities in Rotherham, and we know that deprivation also influences the way that people access and experience our services.
Plus, any locally identified priority groups. Several inclusion groups for Rotherham have been identified as it shown in the box to the side. It should be noted that this list is far from comprehensive, and other inclusion groups will be of particular import for certain pathways and health concerns. Moreover, the identification of 'plus' inclusion groups for Rotherham will be an iterative and ongoing process which will inform the delivery of Rotherham's Place Plan on an ongoing basis.	• Ethnic minority communities • Gypsy, Roma, and traveller communities • People with severe mental illnesses (SMIs) • People with learning disabilities and autistic people • Carers • Asylum seekers and refugees As well as facing structural inequalities, many of the inclusion groups within this list are more likely to also live in Rotherham's 20% most deprived communities, leading to multiple disadvantages. A focus on these cohorts will inform the delivery of Rotherham's Place Plan.
Delivery across **5 key clinical areas** for adults and 5 for children and young people. These areas are outlined in the table to the right. All of these clinical areas have been factored into the workstreams within this plan.	**Children and young people** • **Asthma** – Reduce reliance on reliever medications for asthma and decrease the number of asthma attacks. • **Diabetes** – Increase access to Real-Time Continuous Glucose Monitors and insulin pumps in the most deprived communities and from ethnic minority backgrounds and increase the proportion of young people with Type 2 Diabetes experiencing annual health checks. • **Epilepsy** – Increase access to specialist nurses and ensure access in the first year of care for those with a learning disability or autism. • **Oral health** – Address the backlog for tooth extractions in hospital for under 10s. • **Mental health** – Improve access rates to children and young people's mental health **Adults** • **Maternity** – Continuity of care within maternity services for women from Black, Asian and minority ethnic communities and from the most deprived groups. • **SMI** – Annual health checks for those living with SMI. • **Respiratory** – A clear focus on Chronic Obstructive Pulmonary Disease (COPD) and driving uptake of COVID, flu and pneumonia vaccines. • **Cancer** – Early cancer diagnosis. • **Hypertension and lipid management** – Hypertension case-finding and optimal management and lipid optimal management.

The wider determinants of health and the cost-of-living crisis.

Health is influenced by a broad range of factors. The wider determinants of health include socioeconomic factors, environmental conditions, and the social and community networks people have access to. Evidence indicates that these wider determinants have a greater influence on health than the healthcare people receive. As a health and social care system, it is therefore vital that partners work in a way that takes into account these wider factors.

A pressing example of this is the cost-of-living crisis. Struggling to afford essential items, like food, rent, heating, or transport has wide-ranging negative impacts on mental and physical health and wellbeing. Working within this context makes it even more critical that Rotherham's Place Partnership remains focussed on tackling health inequalities as part of everything we do. Tackling the cost-of-living crisis requires a twofold approach; mitigating against the immediate effects within our population and seeking to address the underlying inequalities which make certain groups more vulnerable to such crises. Locally, action has been taken to support local people through the cost-of-living crisis.



PRIMARY CARE

The challenges and actions for primary care are consistent across South Yorkshire and there are significant gains by working at scale. Our key aim is to provide high quality healthcare for all through equitable access, excellent experience and optimal outcomes and the development of new service models.

We have strong, well connected Primary Care leadership across place and at South Yorkshire level. The Primary Care Collaborative Board provides strategic leadership across all Rotherham primary care, at all levels. It is embedded within the Rotherham Place Delivery Structure and has the ability to interact and influence on behalf of the wider primary care community. The GP federation provides strategic leadership and a strong voice for primary care provision. There are six well-established Primary Care Networks (PCNs), with Clinical Directors meeting regularly and connected into the broader system discussions and decisions.

We recognise that primary care is critical to our integrated health and care system and in our vision to improve population health. Key priorities across South Yorkshire are improve access, workforce, and integration. Rotherham will support at South Yorkshire level but also has additional actions that are being taken forward:

Workforce is the key risk as it is difficult to recruit and then retain staff within primary care it also poses a risk to other services e.g., appointment of paramedics and pharmacists is taking them away from other sectors, other risks include continued increase in demand which is in excess of capacity and sustainability of the Federation if PCNs take on services directly

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

20. Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals.
21. Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.
22. Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
23. Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
24. Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels.

Our Key priorities are:

- Workforce; recruitment (ARRS), new roles development
- Pilot of centralised spirometry across primary care to inform commissioning of respiratory services
- Development of primary care to support personalisation.
- Continued development and roll out of the Rotherham health app to support patient to take control of their health Primary Care Estates development:
- Virtual Wards see section 4.4 and for Proactive (anticipatory) Care see section 4.6
- Development of a Primary Care Medicines Dashboard
- Increase primary care referrals to the NHS Diabetes Prevention Programme
- Work with primary care to deliver the early diagnosis DES, embed CtheSigns, promote FIT and tele dermatology.
- Integrate adult community mental health services for those with SMI with Primary care with a focus on Early Intervention for Psychosis
- Continue PCN development with layers of scale as outlined in the SY Primary Care Strategy

Delivery Milestones during the period of this plan include:

- Continue the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
- Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels.

PLANNED CARE

The delivery of high-quality and sustainable elective care continues to be a key priority across Rotherham Place. Historically, Rotherham has performed well in regard to planned care delivery, however covid brought about significant challenges to the way we work and deliver. Rotherham partners will continue to work together to build on our success to transform how we deliver planned care, how we share and roll out good practice and how we develop our care pathways to be as effective as possible, managed through our Rotherham Place clinical referral management committee.

Recovery of diagnostics has been extremely good in Rotherham. Phase 1 of the Community Diagnostic Centre is currently underway which will bring together all respiratory diagnostics into a community setting, this is really important as these are some of our most vulnerable patients who feel nervous attending hospitals for tests.

Whist significant progress has been made all partners recognise that there is further work required as we continue to develop and transform our planned care services. The implementation of clinical protocols across Rotherham will allow for a further reduction in unnecessary follow up appointments which will be supported by our ambition to improve clinical triage of referrals, helping to make sure the right patients get the right treatment at the right time. Work will also take place with specific services where a step change reduction in face-to-face outpatient consultations can take place while improving the quality of service offered. Initially this will include Dermatology and Ophthalmology.

We will continue to make improvements to our surgical pathways to enable an increasing number of patients to be treated as day cases. We will also continue to work collaboratively across partners to expand access, through initiatives such as direct access to Musculo Skeletal First Contact Practitioners and our integrated community approach using the principle of every contact matters, to offer better access to services closer to, or even in, the patient home. All partners in Rotherham accept that to continue to deliver high quality, safe and sustainable planned care across Rotherham we must continue to work together with an increasing focus on proactive and preventative care, a move of activity out of the acute setting and an increasing use of digital technologies. Rotherham will support at South Yorkshire level but also has additional actions that are being taken forward at Rotherham Place.

Workforce is the key risk to elective care, along with the continuing impact of covid and other illnesses increasing non-elective activity impinging on elective beds.

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

25. Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
26. Deliver the system- specific activity target (agreed through the operational planning process)
27. Continue to reduce the number of patients waiting over 62 days
28. Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
29. Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition.

Our Key priorities are:

- Recovery of waiting lists
- Maintain electives and referrals within affordable levels.
- Reduce follow ups to national follow up ratios.
- Audits Projects / Schemes
- iRefer
- Advice and Guidance
- Review of Pathways and PIFU
- Patient portal
- Implementation of a breast pain pathway to de-medicalise breast pain and ensure patients receive full support to manage their pain.
- Implementation of a menopause pathway to ensure patients are directed to the most appropriately experienced clinician.
- Transforming outpatient services to ensure patients not requiring tests or physical examination can have a virtual appointment and patients who are appropriate for patient initiated follow up are able

Delivery Milestones during the period of this plan include:

- Diagnostic Centre – Stage 1 by June 2023
- Increasing day case and theatre utilisation to 85% at minimum by March 2023
- No waits over 65 weeks by March 2024
- GP Direct Access for Brain MRI by July 2023

6 - ENABLING WORKSTREAMS

DIGITALLY ENABLING OUR SYSTEM

The Rotherham Place Partnership Digital Group has been operating for many years, it has representation from all key partners and has supported the development of strong working partnerships between the digital teams across Rotherham, which helps to drive forward our joined up digital initiatives. Our first place-wide digital strategy was co-produced in 2019, it supported us in our bid for funding from the national Digital Aspirant Programme (DAP) in 2020, which in turn supported the significant acceleration in delivery of the strategy over the period 2020 – 2022. Our inclusive partnership approach to working together enabled us to use the DAP funds to support the delivery of digital transformation across the place including in health, care, and voluntary services.

In 2022 we updated and refreshed our place digital strategy, acknowledging that much has changed for the health and social care organisations in the place because of the Covid-19 pandemic. This unprecedented period of demand for public services dramatically changed the preconceptions of both citizens and the health and social care workforce about how those services should be provided, with a surge to digital and remote delivery. We need to take stock of the ongoing ramifications of the pandemic, updated strategy elaborates on the following five overarching objectives. We will:

1. ensure that place partners build integrated digitally supported care pathways in a way that involves the wider health community (e.g., community pharmacy and ambulance), puts citizens and their needs at the centre of service design, and gives staff the skills they need to manage these services effectively.
2. keep digital innovation at the heart of our service commissioning and delivery planning.
3. continue to work towards ever closer alignment of our individual organisations' digital programmes and increase the information that is shared for patient care.
4. continue be full partners in the development of NHS South Yorkshire's digital strategy and plans and contribute to ICS wide initiatives.
5. continue to leverage the power of our collective data to design and commission services to meet the needs of the population.

These objectives are then augmented by specific actions set out in four themed sections, which reflect on Rotherham's ambitions in those areas, the challenges experienced, and the steps required to achieve them: The themes and associated actions are detailed in the following pages.

1 Digital infrastructure

Acknowledging that many new digital technologies have been implemented across Rotherham to support the Place-wide Covid-19 response, we commit to a review programme that will consolidate and optimise them and develop and document use cases and standard operating procedures, we will:

- ensure that all digital solutions implemented are fully compliant with mandated standards and staff are fully trained to use them.
- Build on the implementation of remote patient monitoring technologies in Rotherham, we will develop service models that harness the potential to support patients in their own homes, intervene when patients' health deteriorates, and reduce unnecessary face-to-face attendance.
- ensure that care homes and PODAC providers have robustand secure digital infrastructure, and access to key systems, building on the pharmacy integration work started between TRFT and community pharmacies to implement the NHS Discharge Medicines Service.
- continue our programme of reviewing and improving GP network performance.
- support our NHS partners and care homes to meet required bandwidth capacities

2 Shared care records - we will:

- assess the long-term role of the Rotherham Health app in the context of:
  - the 2022-23 Priorities and Operation Planning Guidance requirement to raise NHS app registrations to 60% of GP adult lists size.
  - potential to secure NHS Digital's support for integration of the Rotherham Health app into the NHS app.
- review, and if required develop and communicate a set of use cases for the Rotherham Health Record.
- work with partners across the ICS and Yorkshire and Humber region to build the availability of data and number of people using the Yorkshire Humber Care Record.

We will continue with work to improve the datasets available in Rotherham Health Record.

3 The digital citizen - we will:

- review the impact of the Covid-19 pandemic on the digital maturity of the voluntary sector, recognising the significant contribution that the sector makes to the lives of Rotherham citizens.
- when we procure or design digital tools for public use, we will engage citizens or citizen groups in co-design and testing, to ensure ease of use is built in.
- continue to work with GP surgeries to align their website to those of their PCN.
- continue to develop Gismo as a tool to signpost citizens to voluntary organisations, by increasing its functionality and driving higher usage.
- support the work of the Digital Inclusion Team and look for opportunities to share learning across the place partners.

4 Intelligence and analytics - we will:

- continue to develop the sustainable analytical resources that we need to support the delivery of population health management across the Place, from data analysis tools techniques to skilled analysts and general data skills in the workforce.
- contribute to better population health management at ICS-level by developing and improving data links with health and social care organisations outside Rotherham.
- create information products in collaboration with all of the ICP partners, ensuring that they provide insights from which commissioning and service redesign decisions can be made.
- maintain a forward view of innovative data analysis techniques and technologies, e.g., artificial intelligence and machine learning.

The table below show some of the key ongoing projects from our digital strategy mapped to the strategic aims for the Rotherham Place that are detailed in this plan:

Prevention and Health Inequalities

Dedicated digital inclusion programme underway in Rotherham

Closely linked with work to reduce health inequalities and response to cost of living crisis

- Flexible digital support arrangements planned to complement formal digital skills courses already available
- Established strong links with communications teams to improve how we shared information and guidance with our local populations
- Partnership with local colleges and voluntary groups are under discussion
- Plans for access to devices, mobile data packages, free wi-fi sites. Training and support in development

Work to support deliver of the Proactive (anticipatory) Care programme is ongoing. Initiatives include:

- Providing appropriate digital solution to support the identification of people for Proactive (anticipatory) Care support
- Providing the MDT with the necessary information to fully support Proactive (anticipatory) Care delivery in a joined-up way
- Enabling the sharing of care plans with the patient and across the MDT

Enjoying the Best possible Mental Health and Wellbeing

- Working with place partners to ensure digital is embedded within mental health transformation projects
- Supporting community mental health reporting requirements (MHDS specification) for ARRS identifiable activity
- Scoping the use of eReferrals for mental health services
- Development of the Community Mental health Transformation Hubs
- Reconciliation of SMY registers across the place
- Development of the Bluebox devises for outreach SMI health checks

Transforming Healthcare Delivery

Primary care digital plan for FY 23/24 developed to continue optimised use of core systems and tools to support primary care colleagues to:

- Improve access and personalised care
- Increasing and optimising capacity
- Addressing variation and encouraging good practice
- Improving communications with the public

Urgent, Emergency and Community Care:

Virtual Wards – understanding gaps in information sharing across the end to end pathway to help ensure patients get the best outcomes and can avoid unnecessary hospital (re) admissions and get the care they require in their usual place of residence

Improving information sharing: linking our place shared records with the wider Regional record (Yorkshire and Humber Care Record)

Ensuring the Best Start in Life

- Supporting the development of a joined up digital offer for the Family Hubs that will be developed in Rotherham
- Integration of data from RMBC Children and Young Peoples Service (CYPS) into the Rotherham health Record, starting with inclusion of a SEND data set
- Onboarding staff from CYPS as users of the Rotherham Health Record

Enabling people to Live Well for Longer

- Supporting the development of a joined up digital offer for the Family Hubs that will be developed in Rotherham
- Integration of data from RMBC Children and Young Peoples Service (CYPS) into the Rotherham health Record, starting with inclusion of a SEND data set
- Onboarding staff from CYPS as users of the Rotherham Health Record

Improving care for Life-limiting illnesses and End of Life Care

- Digital transformation for Enhanced Health in Care Homes:
- Rolling out secure access to the Rotherham Health Record in care homes to improve information sharing between settings
- Enabling key documentation to be uploaded to the Rotherham Health Record, enabling detailed plans and information to be shared more effectively across care settings
- Working with the ICB wide programme to increase the uptake of digital care record systems and falls detection systems in our care homes

WORKFORCE AND ORGANISATIONAL DEVELOPMENT

To achieve the ambitions, we have as a Health and Social Care partnership, and bring our Place Plan to life, will require the dedication, understanding and commitment from across our collective workforce at all levels. We are committed to investing in our workforce; ensuring that there is a skilled, experienced, and motivated workforce working within the right environment and demonstrating the right behaviours that are vital for delivery. As partners we will continue to build on our existing partnership strengths, encouraging and supporting our workforce to think creatively and adopt new ways of working to further enhance service provision that puts the Rotherham people at the very heart of everything we do. This includes engaging with residents and communities to support them to proactively maintain their physical, mental, and social health, and ensure they know how to access health and support services at the right time to meet their needs.

The approach we are taking to workforce and organisational development is based on the Burke-Litwin model (see diagram below) which provides a framework that is adopted across all partners. The model identifies that change is influenced from environmental factors not just organisational factors and by embracing these concepts within the 'Rotherham Place' we can develop and deliver positive change across all partner organisations.

To support this approach the partnership has agreed on four key areas to focus our current and future activities around:

- **Place as an Employer of Choice**
- **Culture, Values and Ways of Working**
- **Equality, Diversity, and Inclusion**
- **Health and Wellbeing**

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

30. Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise

Workforce challenges

Rotherham as a Place aspires to be an employer of choice, and a key enabler of this aspiration is firmly grounded in ensuring that recruitment and retention is effective, streamlined and provides a positive user experience in a very competitive employment market. In addition, activity is taking place to ensure that all the key benefits of working within health and social care are promoted. This includes being a flexible employer, identifying and promoting career pathways and opportunities and having an inclusive and compassionate culture where everyone can thrive.
he workforce shortages and recruitment challenges should not be underestimated with vacancies and a lack of stability across several key professions within the system. There is a definitive

need to ensure that as a Place we develop a talent pipeline that feeds the workforce. This needs to be sustainable and meet the demands of the changing population. This will include engaging and enthusing the next workforce generation by working with academic partners, connecting the existing workforce with the purpose of Place, identifying opportunities to truly transform and being open and honest about the capacity and resourcing pressures and identifying key skills for the future.

Rotherham has a diverse and active voluntary and community sector (VCS), underpinned by thousands of volunteers which supplements our workforce. It is recognised that the VCS plays a crucial role in prevention and early intervention, enabling self-help, and supporting community resilience. As a Place there is acknowledgement that a VCS offer of workforce support does not mean zero cost and that appropriate investment is required to support delivery of our plans.

	OD Area	Organisation Development Area
1	Mission and Strategy	Create a collective vision to enable improved communication with our staff and communities Ensure that safety, quality, and efficiency underpin our vision. Collaboratively develop a collective brand for the Rotherham Place
2	Leadership	Create a multidisciplinary leadership programme, which has the vision of ICP plan embedded within it. Commitment to lead change together
3	Culture	Change culture and behaviour to take a Rotherham Place first approach. Develop opportunities to co-produce initiatives such as staff well- being and resilience building
4	Structure	Develop mechanisms that allow cross organisational recruitment and retention, using values-based recruitment. Where appropriate create opportunities to introduce cross organisational posts
5	Management Practice	Create Rotherham Place 'talent' management opportunities. Introduce Rotherham Place apprenticeship / intern opportunities – including levy sharing
6	Systems	Align induction processes to ensure place and organisation is covered. Create an accredited training programme that supports transferable skills and ensures cross working across partner organisations
7	Tasks & individual values & behaviours	Agree a set of cross organisations "Place Based" staff values Have a collaborative approach to identifying good and problematic areas of joint working. Develop an accepted approach to use of language in our Rotherham Place
8	Engagement & motivation	Undertake across organisation engagement events - 'The Best solutions come from staff themselves.' Engage staff on 'what matters to them'

BEST USE OF OUR ESTATE AND HOUSING

If we are to be successful in the delivery of our place ambition, we need to ensure that our available housing and estates act as an enabler to our strategic transformation workstreams. Partners recognise the value of working together and taking a strategic approach to asset management and getting the most from our collective assets. As well as buildings, this includes community assets: the skills and knowledge of local people; community groups; informal networks; and public spaces. Key priorities will be primary care estate, the green agenda and better utilisation.

Our established Strategic Estates Group continues to work constructively, identifying available estate across the system, ensuring it is fit for purpose and identifying disposals where possible. It will continue to respond to the changing needs of services and the population. Rotherham place is also working with the ICS Strategic Estates Board in developing and delivering the ICS Estates Strategy and with the Sheffield City Region's Public Asset Development Group to develop their Estates Transformation Strategy, to ensure estates strategies work beyond the Rotherham boundary. System leaders are clear that our approach to utilising estate needs to be driven by our Place Plan transformation.

It is important that people have access to local, well managed services but the type of housing they live in also has a huge impact on health. Good quality, affordable housing provides the basis for people to live healthy, independent, and fulfilling lives. The population continues to age and pressures on the health services to support individuals is increasing. Therefore, it is important that we plan for housing that is care and support ready so that people can live in their home for as long as they are able, whilst reducing reliance on public services and encouraging independence.

The role of housing goes beyond bricks and mortar; providing investment in council stock, encouraging improvements in private housing provision, development of new homes, and engagement with tenants and residents all contribute to creating healthy, stronger, and more resilient communities. Getting people in the right housing and building community resilience can lead to improved health outcomes, financial wellbeing and reduced social isolation.

BEST USE OF OUR FINANCIAL RESOURCES

System partners recognise the challenges of delivering improvements and transforming health and care services at a time of increased demand and lower growth in resources and understand the importance of working collaboratively to address these challenges. To help facilitate this, the Place Finance group was established in May 2019, membership consists of Chief Finance Officers and Directors of Finance representing all Rotherham Place partners.

Its role is to support delivery of the Place Plan by providing specialist financial advice; this includes assessing and advising on financial matters linked to or arising from the Place Plan and its underpinning initiatives and schemes. Importantly, the group provides a forum for the Place Board to refer financial matters to and a forum for individual system finance leaders to refer financial matters to.

The Finance group works to the place principles, but in addition has specific aims to; ensure the best possible use of the Rotherham pound; be open and honest, fostering an open book approach to disclosing and sharing of financial information; observe and respect the financial sustainability of partner organisations by ensuring financial impact is jointly acknowledged and made transparent.

Whilst system partners acknowledge the joint responsibility for the effective use of the available financial resource within the Rotherham place, each partner also has its own challenges and mitigations. Our aspiration is to better direct financial resources to deliver more impact on health outcomes.

Key deliverables include:

- developing a joint understanding of the financial impact of place initiatives on individual partner organisations and on the place as a whole.
- developing appropriate financial strategy and governance arrangements to support delivery of place and partnership working.
- observing and documenting the financial impact on individual organisations of Place Plan initiatives.
- developing a Place based financial framework including any transitional funding arrangements.

Which of the 31 NHS National Objectives that we will be measured by in this workstream:

31. Deliver a balanced net system financial position for 2023/24

COMMUNICATION AND ENGAGEMENT

The approach and direction for communications and engagement will focus on informing, sharing, listening, and responding to the people of Rotherham and how we can work together collaboratively to improve both services and lives. We know that real and meaningful engagement with the people that are using or may use our services is fundamental in ensuring that plans will be effective and practical. Specific target activity will take place, with a variety of stakeholders, for each of our workstreams and we will continue to develop meaningful communication, in a simple and easy to understand way that meets their needs. We will consider the most effective ways of communicating and engaging with local people, including those who are seldom heard, which includes residents whom English is not their first language.

We will aim to bring the plan to life, focussing on what it means for children, young people, and adults in Rotherham, making the plans more tangible and encouraging participation and involvement. As the work continues to develop, we will share the impact and success through stories and case studies. As a core part of the Rotherham Together Partnership, we will ensure that health and care communications activity reflects and enhances the profile of the partnership by using the Rotherham brand identity within campaigns and resources that support this plan. Planning and delivery of our communication and engagement in Rotherham will be co-ordinated with the activity at an overarching South Yorkshire level.

We recognise our staff as one of our biggest assets in the development and transformation of health and care. We will develop co-ordinated and timely staff activity across all partner organisations, allowing them to shape and support the transformation of health and care.

We are committed to the active participation of local people in the development of health and social care services and as partners in their own health and health care. Local people will have an important voice in how services are planned, delivered, and reviewed. We need local people in Rotherham to influence change that will improve services, health outcomes and their experience of care. We will build on information gathered from views shared by our people as part of the engagement exercise for the South Yorkshire Integrated Care Partnership Strategy and Joint Forward Plan where residents told us what matters most to them about their health and wellbeing. This feedback has informed the place plan and will also be reflected in our communications and engagement activity.

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

Our Inclusive Approach will:

- proactively and effectively communicating our vision, transformational priorities, and achievements
- develop two-way communication opportunities; where we share news, we listen and respond and are visible to local people. Where appropriate, we will look to use new and innovative ways to engage and communicate with our local communities in an ever-growing digital environment, whilst considering the needs of individuals with limited digital access or knowledge
- implement relevant and effective communication and engagement tactics with key audiences and stakeholders
- encourage people of Rotherham to take care of themselves, making healthy choices with a focus on prevention and self-management. We want people to be active, happy, and comfortable in their own homes where possible
- use an asset-based approach; making the most of our joint resources; avoiding duplication of activity, and building on the skills and knowledge of Rotherham people
- use a variety of mechanisms for communication and engagement, utilising skills, resources, and contacts in a manner proportionate and appropriate to the issue; with opportunities covering the spectrum from seeking feedback to co-creation

GLOSSARY

A&E	Accident and Emergency
ICS	Integrated Care System
NHS LTP	NHS Long Term Plan
BCF	Better Care Fund
H&SC	Integrated Health and Social Care
PCN	Primary Care Network
BME	Black Minority Ethnic
IRR	Integrated Rapid Response
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust
CAMHS	Child and Adolescent Mental Health Services
IT	Information technology
RHR	Rotherham Health Record
CCC	Care Co-ordination Centre
IDT	Integrated Discharge Team
RMBC	Rotherham Metropolitan Borough Council
CHR CIC	Connect Healthcare Rotherham CIC
JFP	Joint Forward Plan
SEND	Special Educational Needs and Disabilities
CT	Computed Tomography
JSNA	Joint Strategic Needs Assessment
SY&B	South Yorkshire and Bassetlaw
C&YP	Children and Young People
KPI	Key Performance Indicator
STP	Sustainability and Transformation Plan
DTOC	Delayed Transfers of Care
LAC	Looked After Children
TRFT	The Rotherham NHS Foundation Trust
FSM	Free School Meals
LMC	Local Medical Committee
UEC	Urgent and Emergency Centre
H&WB	Health and Wellbeing
LOS	Length of Stay
VAR	Voluntary Action Rotherham
ICP	Integrated Care Partnership
MOU	Memorandum of Understanding
VCS	Voluntary and community sector