ROTHERHAM

PLACE PARTNERSHIP | HEALTH AND CARE

SUMMARY VERSION

HEALTH AND CARE PLACE PLAN

2023/25

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ROTHERHAM PARTNERS' COMMITMENT

Rotherham's Health and Care Community has been working in a collaborative way for many years to transform the way we care for and achieve a positive change for our population.

We are passionate about providing the best possible services and outcomes and are committed to a whole system approach. By working together to make decisions on a best for Rotherham basis, we can provide sustainable services over the long term that aim to help all Rotherham people **live well for longer.**

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.

We want everyone who works or lives in Rotherham – patients, people, families – to work together to establish an individual and collective widespread aspiration for improved health and social care.

Our shared vision

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

THE ROTHERHAM CULTURE

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 the Place Plan.

A high standard of integrity is set amongst all leaders and a culture of empowering and engaging with all staff, meaning staff are confident to challenge and change things that are not right to improve services for people. A key strength in Rotherham is the trust and openness between partners and the shared vision and principles by which we work to achieve our vision for Rotherham.

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.

The first Integrated Health and Care Plan was developed in 2016, the 2023-25 Place Plan is the 4th edition. It continues to deliver on 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.

Rotherham partners recognise the opportunities to be gained by working together across the South Yorkshire Integrated Care System, and as such are committed to supporting and playing their role in the delivery of the South Yorkshire Integrated Care Strategy and the NHS South Yorkshire Joint Forward Plan.

The Rotherham Place Plan closely aligns to the Rotherham Health and Wellbeing Strategy

The Place Plan does not replace partners' individual plans but builds upon them identifying areas where we can do more together. It uses insights from the Health and Wellbeing Strategy and the Joint Strategic Needs Assessment, and takes into account other relevant key documents:

- The Rotherham Plan 2025
- The Rotherham Prevention and Health Inequalities Strategy
- The South Yorkshire Integrated Care Strategy
- The NHS South Yorkshire Joint Forward Plan

WHAT WE KNOW ABOUT OUR POPULATION

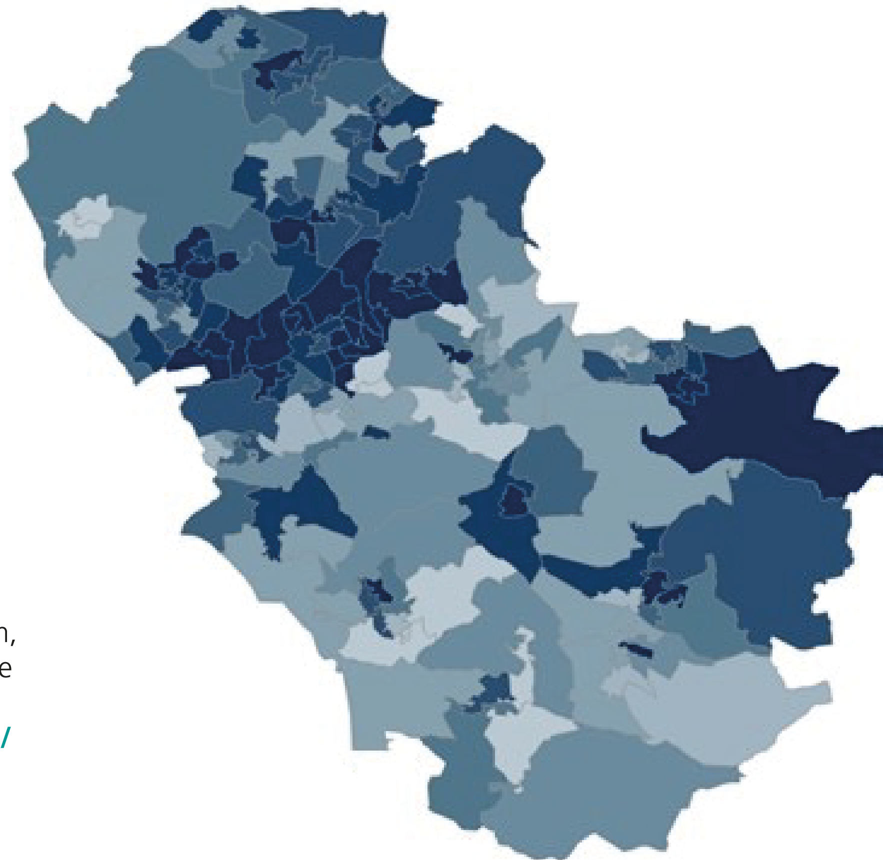
The health of people in Rotherham is generally poorer than the England average, and people are living shorter lives than they should and in poorer health for longer than they should.

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 in, 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.

- Rotherham ranks as the 35th most deprived upper tier local authority in England out of a total of 151
- 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 proportion spent by those in the least deprived areas.



For further information about Rotherham, its population and key challenges visit the JSNA Website:
https://www.rotherham.gov.uk/data/

ROTHERHAM PLACE PARTNERS

South Yorkshire
Integrated Care Board

Rotherham, Doncaster and South Humber
NHS Foundation Trust

The Rotherham
NHS Foundation Trust

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SOME OF WHAT WILL BE DELIVERED OVER THE COURSE OF THE 2023-25 PLACE PLAN

Children & Young People

Education and the family and social support networks have a huge impact on health and wellbeing. The development of **Family hubs** including the Start for Life offer, parent-infant mental health support and infant-feeding support services will ensure joined up, accessible and timely support to mitigate the impact of poverty and increase the number of children under 5 **achieving a good level of development.** 40% of children and young people in Rotherham wait longer than 18 weeks to access **mental health assessment and intervention**, we will improve this and ensure children receive timely access when the need has been identified.

Looked After Children and Young People in care are more likely to experience poor outcomes, a key priority for Rotherham is to r**ecruit, retain and grow the best inhouse foster carers locally** so that the needs of children and young people can be met effectively in an environment that provides high quality care and support.

Sleep issues are common in children and young people, and more so for children with special needs. The impact can be both physical and psychological and can affect 40% of children and young people, rising to 80% of those with special needs. We will **implement and embed a tiered sleep pathway** that will improve identification, assessment, and intervention.

Learning Disabilities & Autism

Everyone over the age of 14 who is on their doctor's learning disability register should have an **annual health check**. Often people with a learning disability have poorer physical and mental health than other people, and this does not need to be the case

We will provide specialist support to **access sustainable employment** for our residents with a learning disability and/or autism. Partners will work together to increase the number of young people accessing supported internships and other opportunities for employment, utilising such as the Supported Internships Grant; Employment is for Everyone projects and the RMBC Supported Employment team.

Our ongoing commitment to **transformation of learning disability services** includes a new service model focussed on day opportunities for people with high support needs. This includes a new day centre facility replacing the existing day service, providing a modern, state of the art facility in a calming and exciting purpose-built environment.

Mental Health and Wellbeing

To ensure that people have access to the right care and support at their earliest point of need and closer to home so they can live as healthy and fulfilling lives as possible in their community, we will **transform adult mental health services**. This will include integrated primary care hubs, improved access to physical health checks, employment support and targeted work on adult eating disorders, personality disorders and community rehabilitation.

We will strengthen the mental health crisis pathway to improve the journey and outcomes for people with mental ill-health. Pathways will be redesigned 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.

Loneliness can fluctuate over the life course and causes are difficult to pinpoint. We will continue to take action to tackle the known trigger factors at an individual, community and societal level.

Suicide prevention continues to be a high priority for Rotherham. Action across Rotherham and across South Yorkshire will continue to be delivered.

Palliative and End of Life Care

To get a comprehensive understanding of the pathway we will **review palliative and end of life care services**, focussing on access to specialist palliative care services, bereavement services, pharmacy services, equipment, spiritual care, and access to information.

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) will be implemented across Rotherham. The ReSPECT process creates a summary of **personalised recommendations** for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

Building on the experience of Rotherham patients and carers we will **enhance personalised palliative and end of life care services.**

We will support the development and **knowledge sharing between staff** including through online learning and support methodology, this will include care homes, community nursing and will be expanded to other community and primary care teams.

Urgent, Emergency and Community Care

Based on the principle **'prevention is better than cure'**, we aim to support people to live independently for longer which will in turn will support their own and their family/carer's health and wellbeing and reduce avoidable reliance on services. We will do this by:

- Proactive (Anticipatory) care to identify and engage people living with frailty, multiple long-term conditions and/or complex needs to help them stay independent and healthy at home, for longer
- Identifying alternative pathways to emergency care and admission
- Implementing 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
- Improving frailty services, embedding same day emergency care offer, and reviewing the falls services

We will create a coherent **multi-disciplinary discharge to assess model** with an integrated transfer of care hub. This will enable referral and triage assessment of the level of risk that can be safely supported at home and in community beds, assessments will be carried out at home and resource allocated flexibly. The **care home trusted assessor** post will support discharges to care homes.

Admission avoidance activity and discharge will be linked to inform decision making to improve whole system flow, including the development of a whole system command centre.

The Urgent and Emergency Care Social prescribing service will work with health and social care professionals to support patients experiencing social, emotional and/or practical barriers to better health and wellbeing, it will support admission avoidance and discharge and provide holistic wrap-around support for patients.

Live well for Longer

The Proactive (Anticipatory) Care model will be developed further to identify registered practice populations who have complex needs and are **at high risk of unwarranted health outcomes**; to help understand those who would benefit from proactive care and deliver comprehensive support for those individuals.

We will support people to 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 by continuing to embed the **personalised care** ethos across place and by a focus on workforce development.

Significant work in the management of medicines will see continued improvements delivered for **diabetes, hypertension**, and **antibiotic prescribing.**

The well-established **care home hydration** project will continue, and we will implement an **antidepressant** review programme and establish a **chronic pain management** pilot.

Primary Care

The 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 will improve access, empower patients by enabling them to access their records and use the NHS App; expand self-referral pathways and the use of pharmacy services, including the launch of Pharmacy First.
- Practices will be supported to move to digital telephony, including call back functionality, and be provided with digital tools and care navigation training.
- To build capacity more direct patient care staff will be employed and more appointments delivered
- The covid vaccine booster programmes will continue to be delivered

Primary care estate developments in partnership across Rotherham, includes a new medical centre at Olive Lane (Waverley), significant improvements/extensions to several practices across Rotherham and plans to deliver a town centre diagnostic hub.

Prevention And Health Inequalities

We want more people to experience **better health and wellbeing**. Focussing on prevention and intervening early will lead to better health outcomes and is vital to ensure sustainable services. Where problems arise, we want to focus on preventing further escalation, so people can live happy, healthy, and fulfilling lives for as long as possible.

There are significant health inequalities between different groups in Rotherham, which means we need to provide targeted support to those who most need it alongside taking a universal approach where appropriate. Our **Prevention and Health Inequalities Strategy** identifies five priorities, with significant work taking place for each:

- 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 and care
- Harness partners' roles as anchor institutions

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 transformations)	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 workstreams

- **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