Rotherham Clinical Commissioning Group Wednesday 5th March 2014

Better Care Fund Plans

Lead Executive:	*Keely Firth*
Lead Officer:	*Dominic Blaydon*
Lead GP:	*Julie Kitlowski*

Purpose:

The purpose of this paper is to inform the Governing Body of the first submission of the Better Care Fund to NHS England on 14th April 2014 and to give details of the next steps.

Background:

The enclosed documents and templates formed the Better Care Fund submission which was co-produced with RCCG and Local Authority (RMBC) colleagues and approved by the Health and Wellbeing Board on 11th Feb 2014.

Analysis of key issues and of risks

There is a range of nationally prescribed outcomes which are measured by specific metrics such as service user/patient satisfaction, avoidable emergency admissions, reduction in delayed discharges - the detail is enclosed. The metrics will be reviewed by the joint task group and it is possible that these will be modified – a discussion will be required with NHSE prior to the final submission being made at the beginning of April.

NHSE will undertake a review of the documentation shortly and are likely to seek clarity or further information where appropriate.

Patient, Public and Stakeholder Involvement:

Details of patient feedback for current services are included in the attached documents.

Equality Impact:

Equality impact assessments are inherent within the services commissioned from the fund therefore no additional assessment is required at this stage.

Financial Implications:

- The Integration Transformation Fund is £3.8 billion worth of funding in 2015/16 to be spent locally on health and social care;
- This is not new money;
- The total fund is £22m of which the Health component is £18.5m;
- £8.5m of the health component has been identified nationally as allocations previously passed through to LAs for Social Care, Re-ablement and Breaks for Carers via section 75 arrangements.

Human Resource Implications:

There are no direct HR implications.

Procurement:

The fund does not create a need for a procurement process as currently commissioned services will fall within existing contracts.

Approval history:

Health and Wellbeing Board 11th Feb 2014

Recommendations:

Members of the Governing Body are asked to note the details of the Better Care Fund, the metrics and outcomes and the ongoing action plan.

HEALTH AND WELLBEING BOARD

Venue: **Town Hall, Moorgate Street, Rotherham S60 2TH**

Date: **Tuesday, 11th February, 2014**

Time: **9.30 a.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972.

2. To determine any item which the Chairman is of the opinion should be considered as a matter of urgency.

3. Better Care Fund (Pages 1 - 61)
   - report attached

4. Date of Next Meeting
   - Wednesday, 19th February, 2014, commencing at 1.00 p.m.

Rotherham Better Care Fund

Planning template – Part 1

Local Authority
Rotherham Metropolitan Borough Council

Clinical Commissioning Group
Rotherham Clinical Commissioning Group

No boundary differences

Date agreed at Health and Wellbeing Board
11 February 2014

Date submitted
14 February 2014

Minimum required value of ITF pooled budget	2014/15	**£20,101,000.00**
	2015/16	**£20,318,000.00**
Total agreed value of pooled budget:	2014/15	**£21,838,000.00**
	2015/16	**£22,055,000.00**

Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Rotherham Clinical Commissioning group**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	**Rotherham MBC**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	**Rotherham Health and Wellbeing Board**
By Chair of Health and Wellbeing Board	Cllr Ken Wyatt
Date	<date>

Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

This first draft submission reflects a number of ways in which health and social care providers have been engaged in the planning process for the Better Care Fund (BCF), and in developing our local priorities.

The Rotherham Health and Wellbeing Board includes the main local health providers (Acute and Community Foundation Trust and Mental Health Trust) as well as representation from the voluntary sector (Voluntary Action Rotherham), this has ensured that they are fully signed up to the principles and vision of the BCF and are aware of the potential impact on services and the local community.

In addition to this, full discussions on the BCF have taken place at The Adults Partnership Board, which acts as a commissioner / provider interface on jointly commissioned services. The board is coordinated jointly by the council and Rotherham CCG and includes representation from Rotherham Foundation Trust, RDASH and the voluntary/community sector. The board agrees commissioning plans which address outcomes identified in the local Health and Wellbeing Strategy, makes recommendations about commissioning priorities to the Health and Wellbeing Board, and oversees performance on jointly commissioned services. The Rotherham urgent care working group, which has cross system membership, has also reviewed the BCF outline plans. We intend to have further detailed discussions with providers before the final submission in April.

Local health providers understand that Rotherham CCG has identified a range of services which will be transferred into the Better Care Fund, and that the commissioning arrangements for these services are going to change significantly. Locally the BCF will affect services delivered by Rotherham Foundation Trust (RFT) and key voluntary sector partners and all provider organisations have expressed a willingness to work under the

new commissioning framework, recognising the potential opportunities. RFT is committed to delivering integrated health and social care pathways and regard the BCF as a vehicle through which these can be achieved. Voluntary sector partners have already developed services which form part of integrated care pathways in stroke and dementia care, and we see the BCF as an enabler to embed voluntary sector services into other condition specific care pathways.

We have engaged with social care providers to raise awareness of the implications of the BCF and to better understand some of the issues and good practices already taking place. This has been done through an online survey and round-table discussion, using their experiences to explore potential solutions. A number of common themes have been identified which have informed the plan:

- There needs to be a greater focus on prevention and early intervention, with appropriate information and signposting to community-based services at a much earlier stage
- Better communication between agencies is needed to identify individuals who are most vulnerable and at risk of crisis (particularly in relation to mental health)
- Equipment, adaptations and support services need to be provided quickly before cases become critical and people reach crisis point
- Better 7-day (weekend) provision is needed to support discharge from hospital and transition between services
- We need more step up and step down beds to support transition between services
- Carers and workers need to have the right skills to deal with changes in care packages
- We need to reduce bureaucracy and make it easier for all providers to link up and work together
- GPs are often the first point of contact for people and commissioners need to work with GPs to ensure that preventative solutions are utilised
- Commissioners of health and social care need to communicate more and see the whole person (not just single issues in isolation) as well as the whole system, avoiding duplication
- We need more opportunities for people to engage in their community; reducing the reliance on more formal 'services' for social interaction

Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our Better Care Fund vision is based on what Rotherham people have told us is most important to them.

We have used a variety of methods to involve service users and the public in the development of the plan including:

- Better Care Fund consultation– Healthwatch Rotherham was commissioned by the Health and Wellbeing Board to consult with the local community and engage them in the envisaged transformation of services between December 2013 - January 2014
- RMBC Customer Inspection Group – During January 2014 Rotherham Council consulted with a group of mystery shopper volunteers regarding the proposed vision, priorities and their views of health and social care services

We have also collated responses from a range of consultation exercises and surveys previously completed, and used these to help shape our vision and priorities, including; Joint Health and Wellbeing Strategy consultation July – August 2012, ASCOF Adult Social Care User Survey 2011/2, Personal Social Services annual Survey of Adult Carers in England 2012/13, Health Inequalities consultation 2011 and staff consultation regarding the hospital admission to discharge process. In addition, the council continually works to improve services through customer insight activities and learning from customer complaints, ensuring that service users are at the heart of service delivery. The annual Local Account is also used to inform members of the public how the council is meeting the needs of service users and improving outcomes.

Rotherham CCG co-ordinates a Patient Participation Network that brings together patient representatives from GP Practices across Rotherham. Patient Participation Groups have been meeting throughout the year, providing feedback on local health services. The Patient Participation Network meets on a quarterly basis, bringing together patients' views from across the local health economy. As part of an exercise to develop the patients' view of the CCG's five year strategy, the network identified a number of priorities that could be addressed as part of the Better Care Fund Plan.

Through service user, patient and public engagement, we have been able to identify a number of common areas for improvement including:

- Patients and service users do not always feel central to decision making, they want to be in the driving seat when it comes to their own care
- Services, local groups and organisations are not accessible due to a lack of information and advice, availability 7 days a week and long waiting times
- There needs to be better education and information available for people, particularly those with long term conditions
- People often feel unclear of expectations regarding the service they should receive and customer pathways due to a lack of advice and support and conflicting information. They are also not always signposted to appropriate services. Better staff training and education is required
- There is a lack of communication and information sharing resulting in poor joined up working between patient/service user, family and carers, health and social care services, GP, hospital, providers and partners
- Service users feel that they have to chase health and social care professionals, causing delay in the delivery of care and support
- Service users and patients would like an allocated key worker/professional; inconsistency of workers makes individuals feel unsafe
- There needs to be more of a focus on preventative, community/home-based services to reduce the number of people going into hospital and residential and nursing care. Nursing services are also critical for home-based support.
- Better after care is required. Examples provided included people felt alone, socially isolated, found it difficult to access services, no support for carers who are left behind
- Service users have a level of distrust using external health and social care providers

Further information regarding the consultation can be found in Appendix 1.

Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Ref.	Document or information title	Synopsis and links
A1	**Summary of consultation**	A summary of all the consultations which have taken place as part of the BCF planning and wider health and wellbeing agenda.
A2	**Rotherham Better Care Fund Action Plan**	Includes the detail and intended outcomes (including related 'I Statements') of the schemes to be delivered through the BCF, and shows how these align with the local health and wellbeing strategy priorities and objectives,
A3	**Health and Wellbeing Strategy**	The joint strategy which sets out the priorities of the health and wellbeing board for 2013 – 2015.
A4	**Joint Strategic Needs Assessment**	Assessment of the health and social needs of the Rotherham population. http://www.rotherham.gov.uk/jsna/
A5	**Overarching Information Sharing Protocol**	This protocol complements and supports wider national guidance, professional body guidance and local policies and procedures to improve information sharing across services in Rotherham. Signed up to by HWB September 2012.

1) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcomes?*

The Rotherham Health and Wellbeing Strategy sets out our overarching vision to improve health and reduce health inequalities in the borough. Through the strategy, the Health and Wellbeing Board has made a commitment to more integrated, person-centred working, to improve health outcomes for local people.

The Better Care Fund plan will contribute to 4 of the strategic outcomes of the local Health and Wellbeing Strategy:

- **Prevention and early intervention**: Rotherham people will get help early to stay healthy and increase their independence

- **Expectations and aspirations**: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community

- **Dependence to independence**: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

- **Long-term conditions**: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

Our vision for integration is based on the experiences, values and needs of our service users, patients and carers. Through mapping these and understanding the journeys people take in and out of health and social care, we have identified a number of 'I statements' which demonstrate the outcomes local people want from better integrated, person-centred services. From 2015/16 our Better Care Fund plan will work towards the following:

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

'I only have to tell my story once'
Service users, patients and carers want all organisations and services to talk to each other and share access to their information, so that they only ever have to tell their story once.

'I feel part of my community, which helps me to stay healthy and independent'
People want to feel independent and part of their community and want organisations to provide better information and support to help them to do this, understanding that this reduces social isolation and avoids the need for more formal care services later on.

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

'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'
People want a greater focus on preventative services and an increased capacity in community activity to prevent high intensity use of services and more formal care, and to help them better manage their conditions. They also want services to be available 7 days a week and information and advice to be more accessible. Understanding the journeys that people take into health and care services will help us to provide more appropriate information and support at times when people need it most.

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

As a result of the changes we will make, all service users, patients and their carers will have confidence in the care they receive and feel supported to live independently, manage their conditions and participate in their community. They will feel well and less likely to rely on acute services, resulting in a reduction in overall pressure on the hospital and health budgets. Although, when acute care is the best option for people, they are helped to move quickly back into their community when they are ready to do so. We will see a greater shift from high cost reactive care, to lower cost, high impact preventative activity.

To achieve this, we have agreed a number of actions that will begin this journey and result in changes short and medium term. However our longer term, 5 year plan, will see health and social care teams working in an increasingly integrated way. We will move to a whole-system commissioning model, which has services commissioned in line with our health and wellbeing strategy principles that are coordinated across all agencies to ensure they are person-centred and we maximise local spend. We will explore the benefits and efficiencies that can be made through having joint approaches to call centres, including an increased use of assistive technologies, and joint teams for commissioning and assurance.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

Our aim is for an integrated system, that provides care and support to people in their home or community, which focuses on prevention, early intervention and maximising independence. To do this, we have identified a number of key objectives set out in our health and wellbeing strategy which have been used to inform our plan. We have demonstrated below where these will impact on the specific outcome measures of the BCF:

To deliver our vision on Prevention and Early Intervention (PE)	
What we will do	**Related measures**
We will coordinate a planned shift of resources from high dependency services to early intervention and prevention	N1, N2, N4, N5, L1
Service will be delivered in the right place at the right time by the right people	N1, N2, N3, N4, N5, L1

To deliver our vision on Expectations and Aspirations (EA)	
What we will do	**Related measures**
We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes	N1, N2, N3, N4, N5, L1
We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions	N1, N2, N3, N4, N5, L1

To deliver our vision on Dependence to Independence (DI)	
What we will do	**Related measures**
We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and self-care	N1, N2, N3, N4, N5, L1
We will support and enable people to step up and step down through a range of statutory, voluntary and community services, appropriate to their needs	N1, N2, N3, N4, N5, L1

To deliver our vision on Long-term Conditions (LC)	
What we will do	**Related measures**
We will adopt a coordinated approach to help people manage their conditions	N1, N2, N3, N4, N5, L1
We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual	N3, N4, N5, L1

Outcome measures (key):

- **N1 Admissions into residential care -** Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000
- **N2 Effectiveness of reablement** - Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement/rehabilitation services
- **N3 Delayed transfers of care** - Delayed transfers of care from hospital per 100,000 population (average per month)
- **N4 Avoidable emergency admissions** - Avoidable emergency admissions
- **N5 Patient and service user experience**
- L1 Emergency readmissions

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

Achieving our vision will mean significant change across the whole of our current health and care landscape. Commissioners and providers will need to adapt and change the way they do things. The following actions demonstrate the commitment both the council and CCG have made to transforming services and working in a more integrated way for the benefit of Rotherham people.

A more detailed action plan is attached as Appendix 2.

What we want to achieve: Rotherham people will get help early to stay healthy and increase their independence

We will use the BCF to:

- Commission mental health liaison provision, ensuring it is aligned to health and social care priorities for prevention and early intervention.
- Review the falls service to ensure its primary focus is delivering a preventive community-based service
- Implement a joint approach to an integrated rapid response service, including out of hours, capable of meeting holistic needs of identified individuals to reduce hospital admission.
- Review and evaluate existing arrangements against potential increase in demand arising from 7 day working across the community, social care and mental health.

What we want to achieve: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community

We will use the BCF to:

- Review the social prescribing pilot to ensure it is delivering on prevention, avoidance and delaying access to formal care services, and commit to mainstreaming this service subject to findings.
- Undertaken a deep dive exercise conducted on cases of high social care and health users, to identify opportunities to improve pathways, and explore where better preventative action earlier on may help avoid or delay access to health and care services in the future.
- Carry out a full evaluation of Rotherham's risk stratification tool, and develop a mechanism for identifying high intensity users of health and social care services.

Want we want to achieve: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

We will use the BCF to:

- Commit to giving personal budgets to as many people as possible
- Develop self-care and self-management, working with voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes,
- Develop and implement a person centred, person held plan, in partnership with key stakeholders.
- Identify the cost and activity pressures resulting from the implementation of the care bill and develop a plan to meet these pressures.

Want we want to achieve: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life

We will use the BCF to:

- Undertake a project to review all existing S75 and S256 agreements and pooled budget arrangements.
- Develop portal technology to share data in a secure way that is in the best interest of people who use care and support. Use of the NHS number as a unique identifier across health and social care will create the starting point for the development of shared IT capacity.

Aligning to other plans

We have based our BCF plan on the joint commitments that have already been made through the local Health and Wellbeing Strategy. Doing this also ensures that our BCF plan aligns with the CCG commissioning plan and that of health and care providers in the borough, who have been integral to the development of the Health and Wellbeing Strategy and are all fully signed up to its priorities.

Timeline

Feb – April 14: We will further develop our BCF action plan, setting out timescales, delivery leads and the specific governance arrangements for each scheme.

April 14 – March 15: We will undertake detailed planning to ensure the schemes in the action plan are implemented.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

NHS Rotherham CCG's share of the national efficiency challenge is around £80 million over five years and is referred to as QIPP (Quality, Innovation, Productivity and Prevention). QIPP has two components:

Provider QIPP; Efficiencies passed onto health service providers. For the last three years and for the foreseeable future, providers have been expected to provide the same services with less funding. For example in 2014/15 providers will be given 2.1% uplift for inflation but are then expected to make 4% efficiencies. The efficiency requirement is **£8.8m**.

System Wide QIPP; NHS financial allocations are expected to rise by around 1-2% each year over the next 5 years. The underlying rate of growth in health service activity and costs prior to 2010 was around 6%. Without QIPP we anticipate growth will continue at around 6% a year because of the ageing population, rising expectations and new medical technologies. System wide QIPP programmes are the actions required to keep overall growth at an affordable 1-2% level rather than the historical 6%.

The Unscheduled Care QIPP target will be partially reliant upon the success of the BCF. The initiatives will provide more alternatives to hospital admission, treat people with the same needs more consistently and deal with more problems by offering care at home or close to home - value is **£2.5m**.

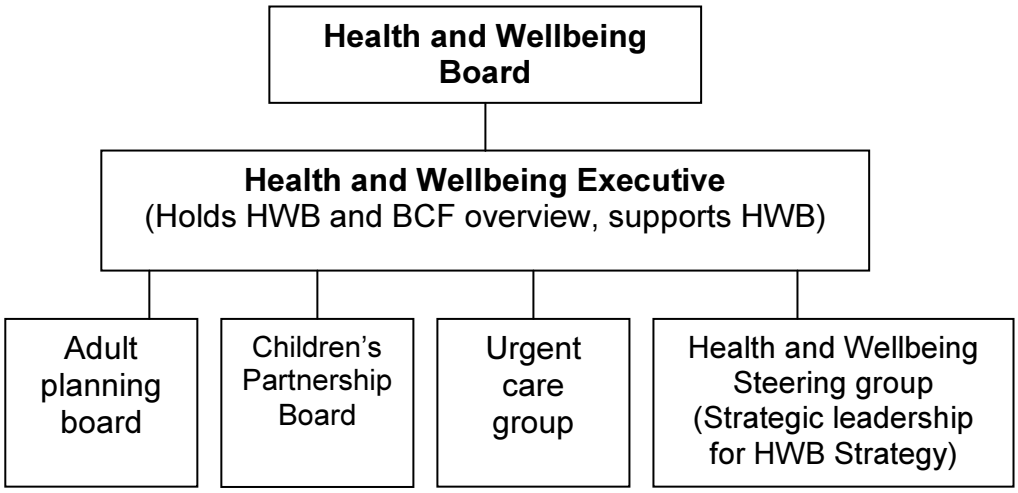
e) Governance

Please provide details of the arrangements in place for oversight and governance for progress and outcomes

The CCG and RMBC have co-terminus boundaries and already have a layer of governance and delivery mechanisms in place. There is clear agreement to the need to maintain a simple clear governance framework which does not add to the burden of any of the agencies or partnership mechanisms.

The delivery of the BCF will be fully integrated with the delivery of the Health and Wellbeing Strategy and as a result, the existing mechanisms with some adaptation should be fit for purpose to ensure effective governance, accountability and delivery.

The framework outlined below brings together the existing partnership and single agency arrangements into a coherent whole system approach and integrates the existing mechanisms to ensure that there remains a clear focus on the health and wellbeing strategy.



The Health and Wellbeing Board will:

- Monitor performance against the BCF Metrics (National/ Local) and receive exception reports on the BCF action plan
- Ratify the Better Care Fund Commissioning Strategy
- Ratify decisions on commissioning or decommissioning of services, in relation to the BCF

The HWB executive provides support to the board and holds the overview role for delivery of the BCF through the 4 key groups below.

Our final submission will include more detailed information about how the 4 groups will deliver the actions in the BCF plan.

Audit

The use of the funds and other finance issues arising will be audited with the final scope to be agreed by RCCG Chief Finance Officer and RMBC Finance Director.

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

Key to the delivery of integrated person centred services, in the context of reduced revenue and increased demand for health and social care services, is a core offer of social care services including:

- Advice, guidance and information sharing
- Preventive services such as telecare/assistive technology, reablement, intermediate care – all designed to support independence
- Ongoing care provision including personalised services which offer choice and control to the individual to enable them to lead as independent a life as possible
- Good quality domiciliary and residential care

It is known that cuts to social care services increase pressure on the NHS, and protecting the NHS is a key priority for central government. Without the support that is achieved through the Better Care Fund, social care reductions will negatively impact on the local NHS community. RMBC has taken the following actions to date:

- A rational approach to setting reasonable fees for provider services, including tackling high cost fees for learning disability residential placements and supporting the quality of care in older people's residential care services
- Increases in charges for care
- A greater use of reablement services that offer support to people to enable them to remain independent
- Implementation of personalised support, alongside effective commissioning of services

To date it is clear that these efforts have enabled the council to manage increasing demand due to demographic pressures – these approaches cannot be effective indefinitely, and in 2013/14 there are indications that demand, despite the actions taken to reduce demand through reablement etc, is beginning to increase significantly.

In order to prevent further cuts to services, it is essential that the Better Care Fund is used to support those care services which in turn protect the NHS.

Please explain how local social care services will be protected within your plans

The fund itself does not address the financial pressures faced by local authorities and CCGs. The Better Care Fund brings together the NHS and local authority resources that are already committed to existing core activity. The Better Care Fund will be used in the first instance to protect the funding to existing services, allowing the local council to maintain its current eligibility criteria, under Fairer Access to Care Services (FACS). Current services will be reviewed and evaluated to ensure that they address the key aims of the Better Care Fund. Where they are not seen to be delivering against this, they will be recommissioned or decommissioned and the funding reinvested in services that support improvements in health and wellbeing, independence, and prevents admission to care services or hospital, as well as information and signposting services for people who are not eligible for services, to prevent or delay their need for such services. Assessment, care management, and commissioned support for those who meet eligibility criteria needs to be maintained at current level, with the potential that this investment will need to increase to maintain the offer in the light of developing 7 day services and additional responsibilities that the Care Bill will bring when enacted in 2015.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

There is a commitment in our plan to the achievement of 7 day working in all parts of the health service, parity of esteem for people living with mental health issues and better care for people requiring integrated health and social care services. This is a key element in our contract negotiations with providers.

There is also a commitment from the CCG to support GP practices in transforming the care of patients aged over 75 in line with national planning guidance. This is being developed in year to compliment our strategy for vulnerable people which is also included in our plan.

Existing services, including out of hours support by social workers, access to enabling care and intermediate care, will be reviewed and strengthened where necessary in response to emerging patterns of demand.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All Rotherham NHS correspondence uses NHS number as primary identifier.

RMBC does not currently use the NHS number as primary identifier.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The NHS Number can be recorded in SWIFT/AIS as a specific 'Other Reference' which then appears in the person's context banner in the most commonly used screens.

From May 2014, we will begin a piece of work with Northgate to use a facility provided by them to batch load NHS numbers into SWIFT/AIS. Steps in the process are as follows:

A script will be provided to extract all clients without a validated NHS number into the correct csv file format for submission. SWIFT Identifiers will be provided with names, address, data of birth and gender for matching purposes. This will initially be used for a bulk update and can then be run on an automated regular basis to pick up new clients or clients where the initial match attempt has failed (since their SWIFT details may be updated to achieve a match eg as part of data quality work). The file will be encrypted and transferred from the local authority server to the secure Northgate server via secure ftp.

Northgate has a secure server with an N3 connection to the NHS Spine who will run the client software on that server to submit each customer's clients in an encrypted file to the Demographics Batch Service. The returned file will then be transferred back to the local authority by sftp. Northgate will automate this process to run on a nightly basis and keep

records of runs. The returned file will identify those Persons for whom no match was found. We will have in place a process for dealing with those cases, eg checking & amending the demographic details and re-submitting.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

All Rotherham NHS platforms are Information Governance Toolkit compliant.

RMBC is committed to adopting systems that are based upon open APIs.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

All Rotherham NHS Organisations use the IG toolkit and provide annual assurance on this.

Rotherham CCG will complete assurance on Caldicott 2 compliance by 31 March 2014

The Rotherham Health and Wellbeing Board has jointly approved and signed up to an overarching information sharing protocol (appendix ..)

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

There is an initiative in place to improve the case management of the 5% (12,000) of patients at risk of hospitalisation which is key to our unscheduled care efficiency plan. In 2013/14 the pilot was solely for patients identified by a computer tool as being at the highest risk of admission to hospital. In 2014/15 the tool will still be used to identify the first 3% of patients eligible to be on the scheme. An additional 2% of each practices population will be eligible for the scheme, this will also include all patients in nursing and residential homes and other patients selected on the basis of clinical judgment.

In light of the planning guidance requirement to provide addition GP services for patients over the age of 75 the CCG will add an additional component to the LES to provide services for all 20,000 people in Rotherham over 75. The CCG will make the case management and over 75 services funding recurrent so that practices can make permanent appointments as the current shortage of locums is affecting the stability of current services.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Governance is deemed by NHS England not to meet requirements to deliver the BCF change	Medium	Task group to agree the most appropriate governance structure for BCF, which includes the HWB as the accountable body.
A lack of detailed data / baseline data means finance and performance targets are unachievable	High	Validated financial data from both organisations enabling interpretation and auditing of information. Performance Management Framework that includes SMART measures to evidence progress against improving outcomes
Shifting of resources could destabilise current service providers.	High	Joint working with stakeholders to develop implementation plans and timelines that include contingency planning. Assessment of the potential impacts on the provider to be collated as integral to the implementation plan
Unintended consequences of achieving savings in one area of the system could result in higher costs elsewhere.	High	All partners have made a commitment to ensure that if evidence of these consequences is seen, cash will flow to the right place across the system that all partners will benefit from.
Failure to receive 50% of the pay-for-performance element at the beginning of 2015/16 due to the HWBB not adopting a plan that meets the national conditions by April 2014	High	HWB to ensure plan meets the national requirements and is fully adopted by April. Performance management framework in place to monitor progress throughout 2014/15 to ensure meet agreed targets.
Failure to receive the remaining 50% of the pay-for-performance element mid 2015/16 due to not meeting the in-year performance targets.	High	Performance management process in place, accountable the HWB
Introduction of the Care Bill resulting in an increase in cost of care provision from April 2015, impacting on social care services and funding	High	Working group established and initial impact assessment undertaken of the potential effects of the Care Bill.

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Rotherham MBC	Y	3,453	1,968	3,670
NHS Rotherham CCG	Y	18,385	18,350	18,385
BCF Total		**21,838**	**20,318**	**22,055**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this

The BCF plans are based on robust methods of working which will be further enhanced by targeted investment to deliver the outcomes. Failure to reduce emergency admissions or social care costs will be mitigated in the first instance by any underspends in the BCF funds and CCG/RMBC contingency plans thereafter.

Contingency plan:		2015/16	Ongoing
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes per 100,000 population	Planned savings (if targets fully	TBC	TBC
	Maximum support needed for other services (if targets not achieved)		
Proportion of older people (65 & over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Planned savings (if targets fully achieved)	TBC	TBC
	Maximum support needed for other		
Delayed transfers of care from hospital per 100,000 population (average per month)	Planned savings (if targets fully achieved)	TBC	TBC
	Maximum support needed for other		
Avoidable emergency admissions	Planned savings (if targets fully achieved)	2,000	TBC
	Maximum support needed for other	600	
Patient / service user experience	Planned savings (if targets fully achieved)	208	TBC
	Maximum support needed for other	62	
Reduced Emergency Re-admissions	Planned savings (if targets fully achieved)	310	TBC
	Maximum support needed for other	93	

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
BCF01 - Mental Health Service	MH FT	1479		507		1479		507	
BCF02 - Falls prevention	RFT	903		310		914		310	
BCF03 - Integrated rapid response team	RFT/RMBC	610		209		610		209	
BCF04 - 7 day community social care and mental health provision to support discharge and reduce delays	RFT/RMBC	4186				4186			
BCF05 - Social Prescribing	Voluntary Sector	605		208		605		208	
BCF06 - Learn from experiences to improve pathways and enable a greater focus on prevention	RFT/RMBC	27				27			
BCF07 - Personal health and care budgets	RMBC	1268				1268			
BCF08 - Self-care and self management	RFT	50				50			
BCF09 - Person-centred services	Primary Care	3739		1283		3739		1283	
BCF10 - Care Bill preparation	RMBC	1351				1351			
BCF011 - Review existing jointly commissioned integrated services	RMBC	6607				6607			
BCF12 - Data sharing bewteen health and social care		0				0			
Disabled Facilities Grant	RMBC	1013				1219			
Total		**21838**	0	**2517**	0	**22055**	0	**2517**	0

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population - We plan to reduce admissions by 12%
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services - We plan to increase these services by 6%.
Delayed transfers of care from hospital per 100,000 population (average per month) We plan to reduce delayed transfers by 14%
Avoidable emergency admissions (composite measure). We plan to reduce avoidable admissions by 15% over the 5yr strategic planning period which equates to an average of 3% per annum.
Emergency readmissions - there is a plan to reduce the rate of emergency readmissions where clinically appropriate. This is supported by community services which are currently being reviewed to ensure that seven day and locally designed services are in place.

A range of outcomes and benefits from our schemes will be provided via our action plans. All measures will benefit from aspects of :
- Integrated rapid response team - will provide a joint approach to an integrated rapid response service, ensuring a coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital.
- 7-day community, social care and mental health provision to support discharge and reduce delays, ensuring appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care.
- Social Prescribing pilot findings that deliver on prevention, avoidance and delaying access to formal care services with the outcomes of the need for more formal care services being reduced.
- Learning from experiences (of high social care and health users) to improve pathways and enable a greater focus on prevention that sustains users within the community.
- Care Bill preparations, will result in Rotherham adult social care being able to meet the increased demand and maintain / protect the existing level of service.
- Review existing jointly commissioned integrated services (S75 and S256 agreements and pooled budget arrangements) will deliver value for money for customers and provide effective services through de-commissioning/re-commissioning as appropriate.

In addition other actions will impact on specific metrics from the six national and local suite including outcomes resulting from our actions regarding:
- Review of Mental Health provision resulting in greater investment in community based and primary care preventative activity which addresses mental health issues much earlier.
- Falls prevention service improvements identify that where a person is more at risk of a fall, they are provided with the right advice and guidance to help them prevent it.
- Personal health and care budgetsprovision will be maximised to individuals so they are provided with the right information and feel empowered to make informed decisions about their care.
- Self-care and self-management working with voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, so that Individuals are provided with the right information and support to help them self-manage their condition/s.
- Person-centred services recorded on a person held plan (using NHS number) will mean individuals will only need to tell their story once and key details are available (in home and on shared portal initially, building to shared IT capacity) which enables integrated, person-centred service delivery.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

National metric to be used

Each metric will have a performance management and assurance process in place. The overall performance management will take place at the Health and Wellbeing Executive (Holds HWB and BCF overview, supports HWB) and will be monitored by the Health and Well Being Board.

Each metric will have:

A designated senior lead ASC/Health operational manager, who will be responsible for delivery of the overall measure performance and has the 'power' to direct available resource to meet service demands within agreed limits.
An agreed action plan, with milestones and target delivery profiles
An appropriate frequency of reporting to Senior Management Teams/Executives/Boards etc
An agreed quality assurance of reported performance
An agreed remedial action plan process when a 'trigger' is activated
An agreed escalation process with sufficient 'power' to direct available resource to meet service demands within agreed limits
Satisfaction testing of outcomes achieved, which when coupled with any complaints learning will lead as appropriate to further improvements being factored into on-going arrangements

Permanent admissions - Delivery of this metric will be lead by Rotherham MBC
Reablement - Delivery of this metric will be lead by Rotherham MBC
Delayed Transfers - Delivery of this metric will be lead by Rotherham NHS
Avoidable emergency admissions - Delivery of this metric will be lead by Rotherham NHS
Emergency readmissions - Delivery of this local metric will be lead by Rotherham NHS

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not applicable

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	739.6	N/A	650.7
	Numerator	345		317
	Denominator	46645		48720
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	86.7	N/A	91.5%
	Numerator	110		119
	Denominator	130		130
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	126.6	109.1	104.7
	Numerator	256	223	215
	Denominator	202200	204480	205444
		(insert time period Apr 13 - Nov 13 [8 months]	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	499	484	528
	Numerator	2994	2,904	3169
	Denominator	6	6	6
		(April - September 2013)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		National to be used	N/A	National measure not yet available - data for October 2015 to be provided.
		(insert time period)		*(insert time period)*

Emergency readmissions within 30 days of discharge from hospital (all ages) PHOF 4.11 NHSOF 3b - Note this is a local variation to national measure, and calculates from patients registered with a Rotherham GP, not local authority population.	*Metric Value*	Definition differs from current contracting metric to better reflect recovery from episodes of ill health. Final data to be confirmed by 13th February 2013 as re-extraction and additional compiling of data required.	TBC	TBC
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

Appendix 1

Better Care Fund consultation – service user, public and provider engagement

1. Better Care Fund consultation conducted by Healthwatch December 2013 – January 2014

Healthwatch Rotherham was commissioned by Rotherham Health and Wellbeing Board to conduct consultation to undertake consultation with the local community and engage the community in the envisaged transformation of services.

The aim of the consultation was to:

- Seek views on how local people think things are working at the moment
- Get views and ideas on how we could do things better
- Ensure local people in Rotherham know about this activity

The survey was completed by 42 people between 31st December 2013 and 14th January 2014.

Of the surveys completed:

- 25.6% strongly disagreed and 18.6% disagreed some of the time, that there needs as a person were assessed and taken into account. The results show that the participants views were evenly spread across agreeing and disagreeing.
- 27.9% strongly disagreed and 18.6% disagreed some of the time, that professionals involved did not talk to each other and work as a team
- 32.6% strongly disagreed and 30.2% disagreed some of the time, that they were told about other services available and local and national organisations
- 32.6% strongly disagreed and 16.3% disagreed some of the time, that when something was planned, it happened without chasing it up
- 27.9% strongly disagreed and 14.0% disagreed some of the time, that when moved between service there was a plan in place for what happened next
- 27.9% strongly disagreed and 23.3% disagreed some of the time, that they had systems in place so that they could get help at an early stage to avoid crisis

The survey demonstrated that:

- Services are not co-ordinated around a person or family – users and carers do not feel central to decision making and assumptions are made regarding an individual's needs based on previous diagnosis
- People do not talk to each other and there are problems with communication between the patient/service user, family and carers, health and social care services, GP, private companies, housing and all services involved in the persons care. No evidence of joined up care. Good examples of joined up care mentioned included Lifeline, Mental Health Crisis Team and Portage services
- People believe that services require chasing up and agreed actions are not completed – in some cases uncertainty about referrals and what happens next
- Customers and service users are unclear of expectations regarding the service they should receive
- Lack of information provided about local and national services and organisations
- Information and education needs to be improved:
    - People feel trapped in the system falling between services
    - People are given conflicting information

    - No clarity on who the person or the department is that is looking after their health and social care needs
    - Not having their needs been looked at as a whole person or assumptions being made due to a diagnosis
    - Waiting for services/referral to respond with appointments taking too long
- Individuals have a good experience of services when there has been a dedicated key worker or professional
- Level of distrust regarding providers in health and social care
- More nurses and better community care are required to prevent the number of people going into residential and nursing care

Recommended areas for improvement:

- Communication:
    - Service contracts to be drawn up with the service user and carer regarding what is expected by each party and the consequences of failure to keep to the contract
    - Extended usage of emails from professional to professional including service users and carers
    - Health and social care staff working within the same teams with same leadership
    - Key workers to stay involved in a person's care when needed to hand over to a new team/service until the service user/carers needs are fully understood
    - Carers to write their own daily notes on their observations in an everyday setting. This can be used when care is reviewed
    - Acceptance of private assessments to avoid duplication, this should be accepted by statutory services
    - From the beginning of journey consent to share a customer's details should be sought. This could be included in a service contract
    - Decision makers to encourage challenges and to provide a clear rationale for decisions
- Reduce the number of people going into hospital and residential care:
    - Provide information on local and national services, with a quality indicator – extend home from home to provide signposting to private providers on how they get quality checked
    - Use community, family and friends to help
    - Extend roles eg porters to handover patients between wards, community nurses to monitor IV drips
    - Specialist teams to work with GPs to raise awareness and support them to understand the effects of specialist issues
    - After care to be provided for carers eg help to arrange funeral and coming to terms with adapting to not supporting the person they cared for

2. Views of the Customer Inspectors – January 2014

During January 2014 12 RMBC customer inspectors were asked a series of questions focussed around the proposed vision health and wellbeing vision including the 4 priorities, experiences of health and social care services and views on what needs to change to make services better. Key headlines are as follows:

- Do you agree with the vision? 100% of customers surveyed said Yes it is very needed

- Do you think the 4 priorities are the right ones to focus on? 100% of customers surveyed said Yes

- What is your experience of health and social care services?
    - There has been a long wait for hospital appointments. They have cancelled on me three times and then I have had to chase things up myself
    - From my experience departments do not speak to each other
    - Communication is poor eg between GP's, district nurses and the hospital. There has been lots of confusion between appointments and information being faxed from one department to another has caused me a lot of upset
    - I can't fault my home care. It is brilliant and they communicate with each other
    - The Council needs to provide the care again, rather than contracting out. If it wasn't for carers I would be in a home.
    - I am not an unwell person, but when I have needed medical assistance it was there and quickly
    - Direct payments difficult to manage eg timesheets, paying for carers etc.
    - I have a friend who has had a need for social care and has been involved in making all the necessary decisions about her care and she was happy.
    - My sister was in a care home. The care she received was very good. They were brilliant. I think you need to know that your staff are people that really care and not just in it for the money. Can't fault the private home care or the council residential home care at all

- What needs to change to make services better?
    - Some people are too proud to admit they need care when they are having a tough time so they refuse it. We need to be able to put care in place for a person even when they say no. the council need more power to be able to do this
    - Better communication between all services to ensure joined up working. Customer should not have to chase services up. More focus needed on the client eg better training and better communication within the NHS particularly your own doctors.
    - Better care services available in the home and more staff to cope with demands so people can remain independent
    - Better after care is needed. You are just left to it once services are put in place. There needs to be more support available for people. Services are just too difficult to access
    - More accessible information needs to be available to people. I had to find out about what services were available to me, no one told me
    - So much care is external to Council and they don't know what is happening most of the time
    - There needs to be consistency of same workers. Too many services are cut back which means people have different workers and feel unsafe
    - Long waiting times for GP's - It's at least 2-3 weeks before you can get into the doctors and you can get worse in that time

3. **Better Care Fund provider consultation – January 2014**

Emails were sent to 305 social care providers in Rotherham inviting them to take part in a survey around issues related to the Better Care Fund. 7 questions were asked:

- How do you think that the Council and Health could work together better?
- How could the Council and Health work together to offer more support to people to help them live independently in their own homes and communities and keep people out of hospital?
- How could the Council and Health together better support local organisations to provide services that prevent people from reaching crisis point and having to be admitted to hospital?
- What services should the Council and Health stop commissioning and/or start commissioning to support people to live independently in their own homes, manage their own care and keep out of hospital?
- Given the opportunity, how could your business / service better support people to remain independent in their own homes?
- How might your organisation support a 7 day redesigned service to support patients being discharged at weekends and prevent unnecessary hospital admissions at weekends or “out of hours”?
- Given the opportunity, how might your organisation improve the patient or service user experience?

See embedded below the responses to the questionnaire:

Results of questionnaire.xls

The questionnaire also asked providers if they wanted to attend a round table discussion on the Better Care Fund. 9 providers responded positively and the meeting took place 28th January 2014 at Riverside House.

Following a presentation that explained the Better Care Fund, the attendees were asked to discuss the following questions:

- We need to shift resources from acute to prevention, how do you as providers see this working?
- What practically could be done to prevent people going into hospital / staying too long in hospital?
- How do you want us as commissioners to change?
- What are the gaps / what does the future look like?

Below are the notes taken to capture comments on each of the questions:

- We need to shift resources from acute to prevention, how do you as providers see this working?
    - Equipment is key – much lower cost than acute services and prevents people from deteriorating mentally and physically and getting into a downward spiral where they then need an acute service. But equipment and adaptations need to be provided quickly before cases become critical.
    - There are some great funds / grants already in existence but not always marketed and fully utilised. Eg Motability Scheme where people can trade in their Mobility Allowance for a car which can then be driven by the SU, or parents, carers, PA etc. Eg Disabled Facilities Grant which is used to adapt properties. Eg NHS Costs to help people access hospital appointments.

- More information should be given at assessment stage – even when people don't fit the criteria or eligibility. Signposting to community services at this point would be key to preventative action.
- Crisis (mental health) often occurs at night, when a person may call an ambulance – need to have mechanisms in place to support this person without the need for hospital.

- What practically could be done to prevent people going into hospital / staying too long in hospital?
  - Better identification of people at risk. With better communication between agencies it will be easier to identify people who are vulnerable but not currently in receipt of any support
  - Not enough manpower at weekends. All work is geared towards a Mon- Fri week. There is no point in any one organisation working out of hours – the whole system needs to change as all the links need to be in place.
  - More step up and step down beds would be useful. Can we not work with our better performing care homes to provide this?
  - Meal service available as part of care package for a short period of time, would provide a proper meal, and a visit to help a person settle back at home after a time in hospital.
  - Not having appropriate equipment/services/medication support in place often delays discharge, but most services (for equipment etc) close at 5pm – there needs to be more out of hour services, not just 7 days.
  - Carers need to feel confident about the care package and support which the person requires after being in hospital
  - All support services (that provide equipment/social care/dom care etc) need to communicate and work better together.

- How do you want us as commissioners to change?
  - Reduce bureaucracy – example given of it being very common to experience delays in receiving a commode. People have to talk to different agencies, repeating their story and experiencing delay. In the meantime they reduce their liquid intake, find themselves dehydrated. This can result in illness and/or a fall which then leads to acute services being required.
  - Help organisations link up and work together. Eg an LD provider did not know about Community Transport.
  - GPs are often first point of contact – commissioners need to work with GPs to ensure that preventative solutions are utilised eg Social Prescribing Service.
  - Transport is not always taken into consideration when planning DP packages – rendering the package useless.
  - Commissioners of health and social care currently work separately, need them to work more joined up and see the whole person (not just single issues in isolation).
  - Savings that could be made in acute/health sector through more focused prevention/social care support should be realised by all commissioners and money could be reinvested appropriately.
  - People often deteriorate quicker in hospital than if they were at home, if social care/support provision is put in place earlier they could be prevented from going into hospital – which then has a knock-on effect, because is a person does go into hospital their social care needs may be greater when they come out
  - In dom care, when a person is assessed as needing continuing healthcare, the dom care provider loses the person because the contracts are different for

CHC, this can cause distress for a person who is familiar with their carer and comfortable with their care package – change can be difficult.

- What are the gaps / what does the future look like?
  - There should be better education around health and social care. Don't wait until people are in crisis as then they are unable to take all the information on board. People should be taught to plan their health care in the same way that people plan their finances – early on and proactively. Awareness should begin in schools
  - People use A&E/hospital for the wrong reasons – need to raise awareness about the services/support available for people when hospital is not the most appropriate place e.g. people may call 999 as they know someone will pick up the phone – and there may be a stigma to other support, such as charity organisations
  - Marketing about support organisations needs to be targeted to those most likely to use hospitals inappropriately – often if they are lonely/want some company
  - There is no longer a sense of community – people's social needs are not met in their community. People often reply on things like day centres, and when they are gone, they lose touch with other people – people need to have this social interaction in another way.
  - People attending mental health day centres, don't want to get this interaction elsewhere, as through a day centre they meet with people they are familiar with and likeminded.
  - How do we engage people more in their community – it is cheaper to fund and support community groups to establish themselves and reach out to people in the area, than a social care/health care package or hospital.
  - We have created a dependent society, where things/services are provided to people, we need to encourage independence more and help people to engage in their community.

4. Health and Wellbeing consultation – July – August 2012

Consultation on the Rotherham Joint Health and Wellbeing Strategy took place between July – August 2012 to help shape the priorities. In addition a summary of the outcomes of the consultation were fed back at a VAR/LINk hosted event which took place on 24th July 2012.

The consultation was focussed around the proposed vision and priorities, how the priorities would be achieved and barriers to achieving these.

A summary of the findings from the consultation were as follows:

- The vision and 6 priorities were the right ones, however the following suggestions were made regarding what needs to happen and change:
  - Priority 1 Prevention and early intervention:
    - Commissioning process to redirect services to prevention
    - Collaborative working and investment needs to be made into the VCS
    - Face to face/person centred approaches are important
    - Requires a shift and pooling of resources
    - Consideration to be given regarding how people who need services are reached
  - Priority 2 Expectations and aspirations:
    - Need to be clear - tailored standards required and communicated

        - Although this priority is important it should be cross cutting across the strategy
        - Training of staff required to ensure they know what is available
        - Improve partnership working
        - Develop different ways of getting information out to people
    - Priority 3 Dependence to independence:
        - Collaborative working and investment needs to be made into the VCS
        - Better promotion and use of community transport to help people access services
        - All staff need to be aware of services available to signpost individuals
        - Simpler patient pathways required
        - Support which an individual receives should decrease as an individual becomes more dependent
        - Use of telecare is crucial to support independence
    - Priority 4 Healthy lifestyles:
        - Accessible information is required in different formats
        - Small pots of funding required to make things happen
        - Better sharing of resources is required
        - Motivation is different for different people, need to look at behavioural changes
    - Priority 5 Long term conditions:
        - Protocols required to share information from VCS
        - People are not always aware of voluntary and community groups available
        - End of treatment can lead to a feeling of abandonment, need to consider transition
    - Priority 6 Poverty:
        - Need to improve job creation/entrepreneurship and improve take up of European funding
        - Carers often give up employment to provide care – flexible support is required
        - Workers need to be aware of what facilities are available to support people and improve skills
        - Funding needs to be more accessible
- Issues raised regarding some of the language used, suggested that some areas needed to be reviewed to ensure clarity regarding what was to be achieved and by when including priority 2 (Expectations and aspirations) and what this meant
- Felt that good partnership working would be required to achieve the outcomes
- Strong view that the shift from high dependency to early intervention was the right approach, however disappointed that the draft strategy did not refer to the VCS
- Concerns that not everyone could be treated through early intervention and enablement and that there should be plans in place for those that need acute care
- Comment made in relation to measuring success and whether any consideration had been given to what an undesirable outcome would be, if the outcomes were not achieved. Suggested that this needed to be built into the PMF.

5. Learning from customer complaints

Rotherham Council received a number of complaints between 2012-13 relating to Assessment and Care Management and Health and Wellbeing.

Strategic outcome	Service	Complaint
Prevention and early intervention, Dependence to Independence and	Home Enabling	Customer is not happy that their mother has to change care provider after 10 years. From in house domiciliary care to a private provider.

expectations and aspirations		
Expectations and aspirations	Hospital Social Work Team / Home Enabling	Customer was charged for care on discharge / assessment by Hospital Social Work Team as care was arranged via private provider rather than enabling care.
Expectations and aspirations	ACM – Older people	It was apparent that customer misunderstood information provided to them at assessment. This led to their care being reduced and for them to complain and challenge the assessment.
Prevention and early intervention, Dependence to Independence and expectations and aspirations	Assessment Direct/Enabling	Not happy with the assessment of their family member, how it was completed and the outcome as it left them without care. They did not want to go from 4 enabling calls to 0.
Prevention and early intervention, expectations and aspirations	Assistive Technology	Customer complained about the delay in equipment being ordered due to backlog of work caused by annual leave
Expectations and aspirations	Intermediate Care Netherfield Court	Customer complained that they had not been informed of falls suffered by a relative while in Intermediate Care
Expectations and aspirations	Unplanned Review	Customer complained about delays in assessment and submission to resource panel for a request to increase for customers mother
Expectations and aspirations	Home enabling	Customer complained about a missed call and the way a carer handled her mother
Expectations and aspirations	Unplanned Review	Customer complained about repeated unkept promises from a Social Worker to keep in contact regarding money owed for care
Expectations and aspirations, prevention and early intervention	Home Enabling	Customer complained about Missed calls from Home Enablers, the delay in sending out complaints leaflets and the lack of apology from the office in respect of a missed call

6. Customer Insight and service improvement (Continuous activities)

Rotherham Council has a strong, customer focussed performance management framework which tests services through customer experience on an ongoing basis. Techniques to gain customer insight and reality check services include:

- The Customer Inspection Service
- Customer Journey Mapping
- Customer Insight (quality checking calls, testing web pages)
- Mystery Shopping

This information regularly informs service improvements and helps to identify priorities for the council. For example, a recent Customer Insight Report which involved listening in to calls made by customers to the *Rothercare Service* identified that 4 out of 10 customers were not able to access the out-of-hours social care service due to no social worker being on duty. This highlights the need to improve our arrangements to ensure customers are provided with appropriate support out-of-hours and has fed in to our Better Care Fund Plan for action.

7. Local Account 2012/13

Customer insight is shared with the general public annually through our Local Account. This summarises how adult social care services performed in the previous year and sets out key priorities for the year ahead. The customer voice is prevalent in the account through '*you said; we did'* statements and customer case studies. The account gives a balanced view of both achievements and areas for improvement.

Last year's account celebrates the Home Enabling Service which improved the customer's experience and outcomes during 2012-13. A total of 892 people were referred to the service, of these customers 42.8% resulted in being fully enabled to live in the community.

This was achieved by joining up more effectively with our partners (Hospitals, Social Workers and Therapists) to speed up the support provided for the customer. We have improved the national measure of how effective enablement services are with the numbers of people still living independently at home 91 days after discharge, from 85.5% to 86.7% which is well above national (81.5%) and similar council comparator average of 77.7%.

Customer quotes:

- *"Very satisfied helped me to get on my feet again. Thank you very much". "The service you all gave was amazing - we were so very grateful. Please pass on my thanks.*
- *"Very pleased with the care I received"*
- *"Very useful and a godsend under the circumstances. The carers have proved themselves cheerful, helpful and very obliging"*

Last year's account also evidences where existing integrated services have worked well together, for example Intermediate Care Services are integrated step-up, step-down facilities which support people to re-gain their independence and live in the community.

Customer quotes:

- *'This is a very good place, I have had a*
- *lot of help from pleasant people; I cannot fault it'* (Lord Hardy Court)
- *"I enjoyed my stay at Netherfield Court and would recommend it to anyone. Thank you" (RICC)*
- *"The service has given me confidence" (RICC)*

The account also sets out our future intentions to support more people to live independently in the community, by:

- reducing spend on residential care by a total of £4.880m
- decommissioning 30% of residential care and commissioning community based alternatives such as Extra Care Housing and Supported Living
- increasing the amount of joint funding into intermediate care - step up step down beds

The account evidences what progress has been made on this so far; In 2012/13 we placed 78 less people in permanent residential accommodation by expanding what works - our preventative intermediate care services.

Further intentions for 213/14 included in the Local Account, which support the delivery of the BCF include:

- Support more people to live in their own homes and reduce the number of people who need to go into a residential home
- Improve the experience of customers who want to access services and need advice and information, including out of hours
- Speed up the way we assess people when their needs have changed.
- Increase the number of services and support for carers

8. ASCOF Adult Social Care User Survey 2011-12

An annual national survey carried out by the NHS Information Centre for health and social care and all local authorities with Social Services Responsibilities are required to take part. The survey asks service users about their quality of life and their experiences of the services they receive.

The survey is sent to those receiving services including service users in residential care, those who have a learning disability and those who use mental health services.

388 surveys were completed and returned.

- **Quality of life -** ASCOF Score 19.2 (Improved from 19.1 in 2011/12)

Overall the results are positive and RMBC are in the top quartile nationally however:

- 3.9% (15 out of 388) of people felt they had no control over their daily lives
- 7% felt socially isolated
- 5.8% felt they did not do anything valuable with their time
- 3.7% found it very difficult and 10.1% found it fairly difficult to find information and advice about support, services and benefits
- 2.6% don't feel safe and 18.7% do not feel that the care and support services which they receive make them feel safe

9. Personal Social Services Survey of Adult Carers in England 2012-13

An annual national survey carried out by the NHS Information Centre for health and social care and all local authorities with Social Services responsibilities. The survey asks carers of service users about their quality of life and their experiences of services they receive.

336 surveys in total were completed and returned.

- **Carer reported quality of life** – ASCOF Score 8.8 (Improved from 8.4 in 2009/10)

Overall the results are positive and RMBC are in the top quartile nationally. The majority of carers were also satisfied with the support/services they received however:

- 62.9% said that they did some things they valued with their time but not enough and 5.5% said that they don't do anything they value or enjoy with their time
- 56.8% said that they have some control over their life but not enough and 7% said that they have no control over their daily life
- 16.6% said that they have some worries about their personal safety and 2.1% said they were worried about their personal safety
- 36.5% have some social contact with people but not enough and 10.3% have little social contact with people and feel socially isolated
- 33.3% feel that they have some encouragement and support but not enough and 13.7% felt they have no encouragement and support
- 17.6% said that they had not been consulted in the last 12 months

10. Health Inequalities consultation – September 2011

The RMBC Public Health Team conducted health inequalities consultation with 426 people in September at the Rotherham Show. Key headline included:

- 41.3% of people felt that health in Rotherham had got worse and that the main contributors to this were unemployment, less money and increased costs of weekly

shops. Only 9.7% said that this was as a result of lack of health services and 20.9% as a lack of health choices.

- 52.5% of people thought that the NHS and Council should provide more information about eating healthy and 52.3% think that people should be encouraged to do more physical activity to improve people's health. However, only 29.6% of people thought that there needed to be easier access health services.

In addition a number of consultation focus groups were held and the problems and solutions suggested were as follows:

- Cost of living
  - Raise awareness of food schemes
  - Provide budgeting advice and support
  - Employers to offer flexible working arrangements
  - Teach people to cook from scratch
- Skills for life
  - Life skills are required not just employment eg cooking, budgeting
  - Provide parenting support
  - Provide opportunities for all abilities
  - Wider awareness needed regarding what is available
- Look and feel of Rotherham
  - Basic standard of housing and code of conduct for private landlords
  - Community engagement in town centre regeneration
  - Increased opening hours of shops and cafes
  - Presence in Town Centre – people, police, community wardens
- Health
  - There are confusing messages across services. Direct clear advice and support is required
  - Increase awareness of good health and prevention as there is a lack of self-awareness which impacts on behaviours
  - Standard core offer from GPs eg opening times and services
  - Offer support groups and raise awareness of what is available
  - Use of co-ops eg food crisis
  - Improve access to services
- Communities
  - Communities need to work better together/community integration
  - Improve communication about community groups and the value of these

11. Staff Consultation

A number of workshops were held in autumn 2013 to map out the process from point of admission in to hospital to discharge to recognise where the points of interface are between health and social care and identify improvements to provide the patient with a better experience.

The workshops had good joint representation from health and social care, and a number of issues were raised about the way the current system operates. The key themes emerging were as follows:

Prevention:

- 'Patients circumstances and needs can change after the pre-assessment takes place (for scheduled care) resulting in patients requiring a bed following day surgery'
- 'A&E is a fall-back position for crisis teams'

- ‘Criteria for services is not being applied flexibly resulting in patients being refused access’
- ‘Lack of capacity in the community can result in (avoidable) admission in to an acute bed’

Delay in the system – delaying discharges

- ‘Out of hours causes inappropriate admission and delayed discharges’
- ‘Patients are referred to the Hospital Social Work Team inappropriately’
- ‘Discharge planning is often not commenced until the day of discharge’

These issues will be fed in to the BCF Plan.

12. Patient Participation Network

Rotherham CCG co-ordinates a Patient Participation Network that brings together patient representatives from GP Practices across Rotherham. Patient Participation Groups have been meeting throughout the year, providing feedback on local health services. The Patient Participation Network meets on a quarterly basis, bringing together patients’ views from across the local health economy. As part of an exercise to develop the patients’ view of the CCG’s five year strategy, the Network has identified the following priorities that could be addressed as part of the Better Care Fund Plan.

- Patients should be in the driving seat when it comes to their own care
- Services should be available 7 days/week
- There should be better education and information for people with long term conditions
- Social care, healthcare and voluntary services should work closely together
- More people should be treated at home Invest in community nursing services which are critical to home-based support

Appendix 2. ROTHERHAM BETTER CARE FUND ACTION PLAN

Ref.	Scheme	Action	Outcome	Measure/s
HWB Strategy: (PE) prevention and early intervention – Rotherham people will get help early to stay health and increase their independence				
PE1 – We will co-ordinate a planned shift of resources to high dependency services to early intervention and prevention				
BCF01	Mental Health Service	Commission mental health liaison provision, ensuring it is aligned to health and social care priorities for prevention and early intervention.	A jointly agreed plan which results in a reduction in formal, high intensity use of services (including acute services and police intervention) and a greater investment in community-based and primary care preventative activity which addresses mental health issues much earlier on. *'I am listened to and supported at an early stage to avoid a crisis'*	Admissions to residential and care homes Avoidable emergency admissions Patient/service user experience Emergency readmissions
BCF02	Falls prevention	Review the falls service to ensure its primary focus is delivering a preventive community-based service, as well as targeting those most vulnerable, who are most at risk of fracture neck of femur.	Older people are aware of the risks of falls and have opportunities to remain active and healthy in their community. Where a person is more at risk of a fall, they are provided with the right advice and guidance to help prevent them. *'I feel safe and am able to live independently where I choose'*	Admissions to residential and care homes Effectiveness of reablement Avoidable emergency admissions Patient/service user experience

				Emergency readmissions
PE2 – services will be delivered in the right place, at the right time, by the right people				
BCF03	Integrated rapid response team	Implement a joint approach to an integrated rapid response service, including out of hours, capable of meeting holistic needs of identified individuals to reduce hospital admission. Incorporate community nursing, enabling and commissioned domiciliary care.	A coordinated response is provided to individuals' needs, which supports them to remain independent while reducing admissions to residential care and hospital. *'I feel safe and able to live independently where I choose'*	Admissions to residential and care homes Effectiveness of reablement Delayed transfer of care Avoidable emergency admissions Patient/service user experience Emergency readmissions
BCF04	7-day community, social care and mental health provision to support discharge and reduce delays	Review and evaluate existing arrangements against potential increase in demand arising from 7 day working across the community, social care and mental health.	Appropriate services are available 7 days a week to enable timely discharge from hospital, and avoid unnecessary admissions to hospital or residential/nursing care. *'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'*	Admissions to residential and care homes Effectiveness of reablement Delayed transfer of care Avoidable emergency admissions

				Patient/service user experience Emergency readmissions
HWB Strategy: (EA) All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community				
EA1 – We will ensure our workforce routinely prompt, help and signpost people to key services and programmes				
BCF05	Social Prescribing	Review social prescribing pilot to ensure it is delivering on prevention, avoidance and delaying access to formal care services, and commit to mainstream this service subject to findings.	The need for more formal care services is reduced, creating an opportunity to shift investment into community activity that fosters independence and encourages local people to participate in their community. *'I feel part of my community, which helps me to stay healthy and independent'*	Admissions to residential and care homes Effectiveness of reablement Delayed transfers of care Avoidable emergency admissions Patient/service user experience Emergency readmissions
EA2 – We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions				
BCF06	Learn from experiences to improve pathways and enable a greater focus on	Undertaken a deep dive exercise conducted on cases of high social care and health users. Map the journey through health and social care services to identify opportunities to improve pathways and explore where better	A shift in investment from high-cost, high-intensity users of health and social care, to low cost high impact community initiatives which focus on prevention. A co-produced (between health, public health and	Admissions to residential and care homes Effectiveness of reablement

	prevention	preventative action earlier on may help avoid or delay access to health and care services in the future. Carry out a full evaluation of Rotherham's risk stratification tool, and develop a mechanism for identifying high intensity users of health and social care services.	social care) risk stratification tool to identify high intensity users. *'I am able to access information, advice and support early that helps me to make choices about my health and wellbeing'*	Delayed transfers of care Avoidable emergency admissions Patient/service user experience Emergency readmissions
HWB Strategy: (DI) Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances				
DI1 – We will change the culture of staff from simply 'doing' things for people to encouraging and prolonging independence and self-care				
BCF07	Personal health and care budgets	Commitment to giving personal budgets to as many people as possible, and will develop our plans to do this. Extend our current plans for personal health budgets, working with patients, service users and professionals.	Individuals are provided with the right information and feel empowered to make informed decisions about their care. *'I am in control of my care'*	Admissions to residential and care homes Effectiveness of reablement Patient/service user experience
BCF08	Self-care and self-management	Develop self-care and self-management, working with voluntary and community groups to co-design, co-develop and co-produce improved health and care outcomes, including the areas of transitions from young people's services into adult care. Develop patients and practitioner skills programmes that can be implemented across health and social care.	Individuals are provided with the right information and support to help them self-manage their condition/s. Professionals are equipped with the right skills to enable self-care / self-management and promote independence. *'I am in control of my care'*	Admissions to residential and care homes Effectiveness of reablement Avoidable emergency admissions

		Development of integrated workforce development programmes and risk management courses aimed at promoting an ethos of self-management. Develop specialised psychological support services for people with long term conditions so that they are better able to self-manage their condition.		Patient/service user experience Emergency readmissions
DI2 – We will support and enable people to step up and step down through a range of statutory, voluntary and community services, appropriate to their needs				
BCF09	Person-centred services	Develop and implement a person centred, person held plan, in partnership with key stakeholders.	Each individual has a single, holistic, co-produced assessment, meaning they only need to tell their story once and key details are available (in home and on shared portal initially, building to shared IT capacity) which enables integrated, person-centred service delivery. *'I am in control of my care'* *'I only have to tell my story once'*	Patient/service user experience
BCF10	Care Bill preparation	Identify the cost and activity pressures resulting from the implementation of the care bill, including increased assessments, carers assessment and support, information advice and guidance capacity, and resulting administrative and operational costs. Develop a plan to meet these pressures.	Rotherham adult social care is able to meet the increased demand and maintain / protect the existing level of service.	The Care Bill will impact on all BCF outcome measures
HWB Strategy: (LC) Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life				
LC1 – We will adopt a co-ordinated approach to help people manage long term conditions				
BCF11	Review existing jointly	Undertake a project to review all existing S75 and S256 agreements and pooled	All jointly commissioned services provide value for money and are aligned with the BCF vision	All integrated services impact

	commissioned integrated services	budget arrangements.	and principles. Where services are not efficient and effective, a plan is developed to de-commission/re-commission as appropriate.	on BCF outcome measure/s
LC2 – We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual				
BCF12	Data sharing between health and social care	Develop portal technology to share data in a secure way that is in the best interest of people who use care and support. Use of the NHS number as a unique identifier across health and social care will create the starting point for the development of shared IT capacity.	All providers have access to integrated person-held records, which include all health and social care plans, records and information for every individual. *'I only have to tell my story once'*	Delayed transfer of care Avoidable emergency admissions Patient/service user experience Emergency readmissions

Rotherham Metropolitan Borough Council
Where Everyone Matters

NHS Rotherham

Rotherham Borough

Joint Health and Wellbeing Strategy 2012 – 2015

Introduction

The Rotherham Health and Wellbeing Strategy sets out the key priorities that the local Health and Wellbeing Board will adopt over the next three years to improve the health and wellbeing of Rotherham people.

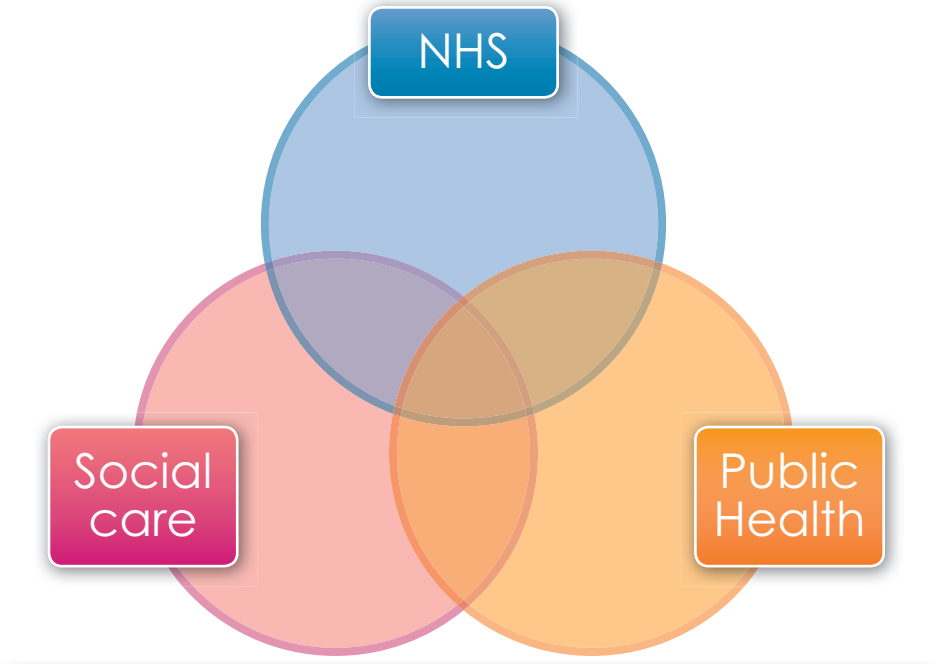
The document brings together the things that impact on people's health and wellbeing into a single, high-level framework. The strategy will be used to guide all agencies in Rotherham in developing commissioning priorities and plans in tackling the major public health and wellbeing challenges facing our communities. The document presents a shared commitment to ensure all Rotherham individuals and families are able to make positive choices to improve their physical, mental health and wellbeing, as well as helping to build strong communities. The strategy should also ensure that public services do everything we can to address the root causes of ill-health.

This strategy will sit within a set of documents which demonstrate the journey from gathering data, to understanding whether we are achieving our goals, these include:

- *Joint Strategic Needs Assessment: our intelligence*
- *Health and Wellbeing Strategy: our vision and how we will achieve this*
- *Commissioning plans: funding and leadership*
- *Performance management framework: evaluating success.*

Integrating Health and Social Care

There are obvious benefits from bringing together planning, funding, and delivery of health and social care. This is demonstrated through the publication of three frameworks of outcomes for the NHS, public health and adult social care. The diagram below shows how these frameworks overlap and how the joint priorities of the Health and Well Being Board presented in this strategy, sit within the centre of it.



Why we need a strategy

Health Inequalities

Deprivation in Rotherham is higher than average and worsening. According to the Index of Multiple Deprivation in 2007, Rotherham ranked 68th most deprived district in England.

In 2010 we had moved to 53rd. Rotherham still ranks amongst the top 20% most deprived districts nationally. The biggest causes of deprivation in Rotherham remain Education and Skills, Health and Disability and Employment. Life expectancy is lower the England average, but there is also a large gap between the least and most deprived areas in the borough; 9.9 years for men and 5.9 for women. Health inequalities in Rotherham are generally worse than the England average and our statistical neighbours.

(source: Health Profile 2011, DH)

The Marmot Review of Health Inequalities ***'Fair Society, Healthy Lives'*** provides evidence that there is a bigger impact on the health for those living in deprivation. The review suggests that there needs to be a focus across different backgrounds as well as across the life course, with appropriate levels of help given to people from different backgrounds to reduce inequalities. It also presents the positive impact of employment for the health and wellbeing of working age people, particularly for an individual's mental health and wellbeing.

Life Course Framework

The Health and Wellbeing Board have agreed a life course framework, which has been adapted from the Marmot life course. The dying well agenda is aligned to ageing well, however we recognise that end of life choices span the life course. The diagram below shows how the life course for this strategy links to the key point in people's lives:

Our Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) takes a comprehensive look at the health and social care needs of Rotherham. We refreshed and published our JSNA at the end of 2011, using factual information and evidence to identify needs.

Our JSNA has told us that the main determinants of health inequalities include deprivation and worklessness, attainment and skills, low birth-weight, infant mortality and mental health, as well as lifestyle factors such as poor diet, obesity, smoking and alcohol use, teenage pregnancy and low levels of physical activity. It also highlighted the ongoing concerns relating to the increased demands due to the ageing population, diversity and caring responsibilities and this poses challenges for service delivery.

Health Inequalities Consultation

To ensure that we fully understand the needs and demands of our local population, we have undertaken a comprehensive consultation on health inequalities with local people. This identified five themes: increased cost of living, quality health services, having the skills for life, Rotherham communities' assets and the look and feel of Rotherham, with an overarching theme of the raising aspirations of Rotherham people and communities.

The most common issues raised included:

- *Families felt challenges in their daily lives led to difficulties in prioritisation and a lack of long-term planning.*
- *Many felt trapped in a cycle of poverty with little prospect of escape.*
- *People felt that young people had poor skills for life and work.*
- *A welfare culture of dependency had become the norm for some people, which was also reflected in rising concerns about welfare reform and expected reductions in benefit.*
- *Low aspirations and expectations were evident across all age groups.*
- *There was little common identity in Rotherham, mainly in the outer areas of the Borough.*
- *Black and Minority Ethnic people still faced discrimination and negative perceptions from services.*
- *Older people often felt isolated and unsafe but also offered untapped potential to help others*
- *People identified the skills they had to offer, but found the opportunity to use them difficulty to find.*
- *People want clear, direct and simple messages on health to encourage people to make changes.*

What we want to achieve

Our Vision:

To improve health and reduce health inequalities across the whole of Rotherham.

Our 'Strategic Outcomes'

The Health and Wellbeing Board have agreed six areas of priority and associated outcomes for the strategy, which represent a desired state for what we want Rotherham to look like in three years:

Priority 1 - Prevention and early intervention

Outcome: Rotherham people will get help early to stay healthy and increase their independence.

Priority 2 - Expectations and aspirations

Outcome: All Rotherham people will have high aspirations for their health and wellbeing and expect good quality services in their community, tailored to their personal circumstances.

Priority 3 - Dependence to independence

Outcome: Rotherham people and families will increasingly identify their own needs and choose solutions that are best suited to their personal circumstances

Priority 4 - Healthy lifestyles

Outcome: People in Rotherham will be aware of health risks and be able to take up opportunities to adopt healthy lifestyles.

Priority 5 - Long-term conditions

Outcome: Rotherham people will be able to manage long-term conditions so that they are able to enjoy the best quality of life.

Priority 6 - Poverty

Outcome: Reduce poverty in disadvantaged areas through policies that enable people to fully participate in everyday social activities and the creation of more opportunities to gain skills and employment.

What we will do - tackle the 'Big Issues'

The Health and Wellbeing Board will prioritise and tackle the 'big issues' highlighted by the JSNA and health inequalities consultation, these are:

Starting Well	• *Low birthweight & high infant mortality* • *High smoking rates in pregnancy* • *Low breastfeeding rates* • *High teenage conceptions* • *High obesity rates* • *High levels of oral disease*
Developing Well	• *Low attainment, skills and aspirations* • *Low levels of physical activity* • *High levels of lifestyle risks – alcohol, smoking, substance misuse, obesity* • *High rates of teenage pregnancy* • *High rates of emotional, behavioural or attention deficit disorders* • *High emergency admissions* • *Meeting the needs of increasingly diverse minority ethnic and migrant communities* • *High levels of oral disease*
Living and Working Well	• *High levels of lifestyle risks – smoking, alcohol, diet, obesity* • *High levels of worklessness and benefit culture* • *Low levels of physical activity* • *Low qualification and skill levels* • *High levels of depression and anxiety* • *High deprivation* • *Rising fuel poverty* • *High rates of disability* • *Increasing need for carer support* • *Meeting the needs of increasingly diverse minority ethnic and migrant communities*
Ageing and Dying Well	• *Increase in age related conditions such as; dementia, mobility & hearing impairment, diabetes, falls* • *High levels of depression* • *Low levels of physical activity* • *Rising number of older & disabled people living alone & feeling isolated* • *Ageing carers and growing care gap* • *High pensioner poverty* • *Rising fuel poverty* • *High demand for acute care* • *High levels of lifestyle risks – smoking, alcohol, diet, obesity* • *Big gap in the life expectancy in least and most deprived areas in Rotherham*

How we will do it

To achieve an improvement in health and wellbeing across Rotherham, the Health and Wellbeing Board have agreed a set of actions to reduce health inequalities.

PE Prevention and Early Intervention

- We will coordinate a planned shift of resources from high dependency services to early intervention and prevention.
- We will focus on motivating people to change behaviours and design our campaigns around prevention and early intervention.
- Service will be delivered in the right place at the right time by the right people
- We will develop a joint approach to maximise the use of assistive technology to benefit people.
- We will develop a common approach to identifying and addressing risks across all services and organisations.

EA Expectations and Aspirations

- We will provide much clearer information about the standards people should expect and demand.
- We will train all people who work towards reducing health inequalities to respond to the circumstances of individual people, families and the local community.
- We will ensure all our workforce routinely prompt, help and signpost people to key services and programmes.
- We will co-produce with Rotherham people the way services are delivered to communities facing challenging conditions.

DI Dependence to Independence

- We will change the culture of staff from simply ‘doing’ things for people to encouraging and prolonging independence and self care.
- We will seek out the community champions and support them with appropriate resources, to take action and organise activities.
- We will support and enable people to step up and step down through a range of statutory, voluntary and community services, appropriate to their needs.
- We will properly enable people to become independent and celebrate independence.

Healthy Lifestyles

- We will work together to understand our community assets; identifying what and where they are across the borough and how we use them effectively.
- We will use the health and wellbeing strategy to influence local planning and transport services to help us promote healthy lifestyles.
- We will promote active leisure and ensure those who wish to are able to access affordable, accessible leisure centres and activities.

Long-term Conditions

- We will adopt a coordinated approach to help people manage their conditions.
- We will develop a common approach to data sharing so we can provide better support across agencies and put in place a long-term plan for the life of the individual.
- We will ensure all agencies work together to make transitions between services for those with long term conditions seamless and smooth.
- We will work jointly to review our eligibility criteria thresholds and ensure we are able to escalate and de-escalate people through services as their needs change.

Poverty

- We will make an overarching commitment to reducing health inequalities, particularly in areas suffering from a concentration of disadvantage.

We will ask the Rotherham Partnership:

- To look at new ways of assisting those disengaged from the labour market to improve their skills and readiness for work.
- To ensure that strategies to tackle poverty don't just focus on the most disadvantaged, but there is action across the borough to avoid poverty worsening.
- To consider how we can actively work with every household in deprived areas to maximise benefit take-up of every person.

Linking the life stages with our strategic outcomes

Bringing about improvement in health and wellbeing is incredibly challenging and we see the need to drive actions forward. We have therefore identified a lead professional who will be accountable for each outcome and life stage.

The table shows the lead professional for each outcome and life stage, but also which agencies will provide the main supporting and advising role for each area. Along with the main statutory organisations, there will be a range or voluntary, community sector and private organisations that we will need to work with to help us achieve our vision.

	Prevention & Early Intervention	Expectations & Aspirations	Dependence to Independence	Healthy Lifestyles Independence	Long-term Conditions	Poverty
Starting Well	Led by Public Health Supported by CCG, CYPS	Led by CYPS Supported by CCG Advised by PH	Led by CYPS Supported by CCG	Led by PH Supported by CCG & CYPS	Led by CYPS Supported by CCG Advised by PH	Advised by All
Developing Well	Led by CYPS Supported by CCG & PH	Led by CYPS Supported by CCG Advised by PH	Led by CYPS Supported by CCG	Led by PH Supported by CCG & CYPS	Led by CYPS Supported by CCG Advised by PH	Advised by All
Living and Working Well	Led by Public Health Supported by CCG & AS Advised by CYPS	Led by AS Supported by CCG Advised by PH	Led by AS Supported by CCG	Led by PH Supported by CCG & AS	Led by CCG Supported by AS Advised by PH	Advised by All
Ageing and Dying Well	Led by AS Supported by CCG & PH	Led by AS Supported by CCG Advised by PH	Lead by AS Supported by CCG	Led by PH Supported by CCG & AS	Led by AS Supported by CCG Advised by PH	Advised by All

AS = Adult Services *CYPH = Children and Young People Services*
PH = Public Health *CCG = Clinical Commissioning Group*

Having agreed Accountable lead professionals will ensure a coordinated approach across all the life stages. This will help us to work towards breaking the 'cycle' of poor health. We see that we cannot simply shift our resources to 'Starting Well' to prevent poor health, but we need to address the determinants of health at each life stage to ensure young people do not become unhealthy adults and adults do not become unhealthy older people.

What Next?

In order to meet the strategic objectives and outcomes we will require a picture of assets and services that we have available across Rotherham. Continuing to develop this will ensure it provides a clear and comprehensive picture of how services in Rotherham are delivered to meet need, based on the Joint Strategic Needs Assessment.

Delivering the Strategy

Six strategic lead officers from the Local Authority and NHS will be responsible for the delivery of each of the strategy's priorities. Their role will be to provide leadership and accountability for each priority workstream, ensuring a workplan is in place to deliver the actions within the life of the strategy. The table on page 8 will be a tool used by the strategic leads to develop their plans, ensuring the right people and agencies are involved.

Commissioning Plans

We will use this strategy to inform commissioning plans for all health and wellbeing partner agencies; including public health, NHS and social care. Commissioning plans will identify who will do the work to help us achieve our goals.

Performance Management Framework

In order to understand whether we have been successful, we will develop a performance management framework using the life stage and strategic outcomes matrix. This will include key indicators from each of the national outcomes frameworks, along with any local measures, which will demonstrate whether we are achieving improvements for each of the big issues, and ultimately our strategic outcomes.

Future Joint Strategic Needs Assessments and the Index of Multiple Deprivation 2016 will also demonstrate whether this strategy has had an impact on deprivation and health inequalities, in line with the national average.

Reviewing the Strategy

The strategy presented here is a three year plan and we will formally review it annually. Over the course of the three years we will continue to build up a much clearer picture of the needs of our population; through our Joint Strategic Needs Assessment, as well as how we commission services. We will also use local people and future developments such as Healthwatch, to help us understand our population's needs and how services are actually delivered. This annual review process will help us recognise how well we are doing and show if we are off track and allow us to change direction as needed.

Rotherham people will remain at the centre of the strategy and a continued consultation plan will ensure that the strategy remains focused on listening to the views and improving the health of all Rotherham people.

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Overarching Information Sharing Protocol

Integrated working to improve outcomes for the people of Rotherham

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Contents

1 Introduction

1.1 Background

This protocol complements and supports wider national guidance, professional body guidance and local policies and procedures to improve information sharing across services in Rotherham.

Government policy places a strong emphasis on the need to share information across organisational boundaries in order to ensure effective co-ordination of services, specifically in ensuring that there are integrated health and wellbeing services across the locality. Agencies arranging services to people within Rotherham are continually processing information about them. At times a single agency working with an individual may identify a range of issues that need to be addressed, some of which are outside its scope or expertise. Conversely, more than one agency could become involved with a service user but they are unaware of each other.

These agencies will be gathering the same basic information, undertaking similar assessments, producing and implementing plans of action that are appropriate to the agencies perceived response rather than the whole need of the individual. As a result there is often unnecessary duplication of effort, poor co-ordination and a lack of a coherent approach to the particular issues facing an individual which could be potentially detrimental.

The Health and Social Care Act states that Health and Wellbeing Boards, will need to look more widely at issues such as crime reduction, violence prevention and reducing offending along with the wider responsibility of ensuring there are integrated health and wellbeing services.

In these circumstances it has been recognised that a multi agency response is the best way of ensuring that service users receive the type and level of support most appropriate to their needs. In order to achieve this it is essential to have in place a framework that will allow the sharing of relevant information between professionals, when it is needed, with a degree of confidence and trust.

For the government statement on Information Sharing Protocols please see Appendix B.

1.2 Summary

The protocol is an overarching framework for sharing information between agencies which provide services to the people of Rotherham. It focuses on the sharing of personal information about service users. The protocol:

- Outlines the objectives and principles being achieved through the Rotherham Information Sharing Framework
- Summaries the legal background on information sharing
- Provides practical supporting guidance on how to share information

- Provides a framework within which services can develop service level information sharing protocols
- Includes arrangements for the monitoring, review and approval of the protocol

The protocol and supporting guidance provides the following benefits:

- Helping to promote information sharing
- Helping to ensure compliance with legislation and guidance
- Raising awareness of the key information sharing issues
- A comprehensive document that is relevant to all information sharing arrangements, allowing service level information protocols to focus on day to day specific information exchanges
- Establishes clear lines of responsibility

1.3 Purpose of the protocol

This protocol provides an overarching framework that enables partner organisations to utilise well established, appropriate and transparent information sharing systems (either manual or electronic) and processes that place the service user at the centre of how their information is processed in line with their rights to privacy and confidentiality.

It is a statement of the principles and assurances which govern information sharing by ensuring clarity and consistency in practice and in accordance with the:

- Data Protection Act 1998
- Human Rights Act 1998
- Common Law Duty of Confidentiality
- Caldicott Principles
- Any other relevant legislation and guidance

and upholds the rights of all the parties involved in a fair and proportionate manner. The key provisions of the above acts are summarised in HM Government national guidance, Information Sharing:

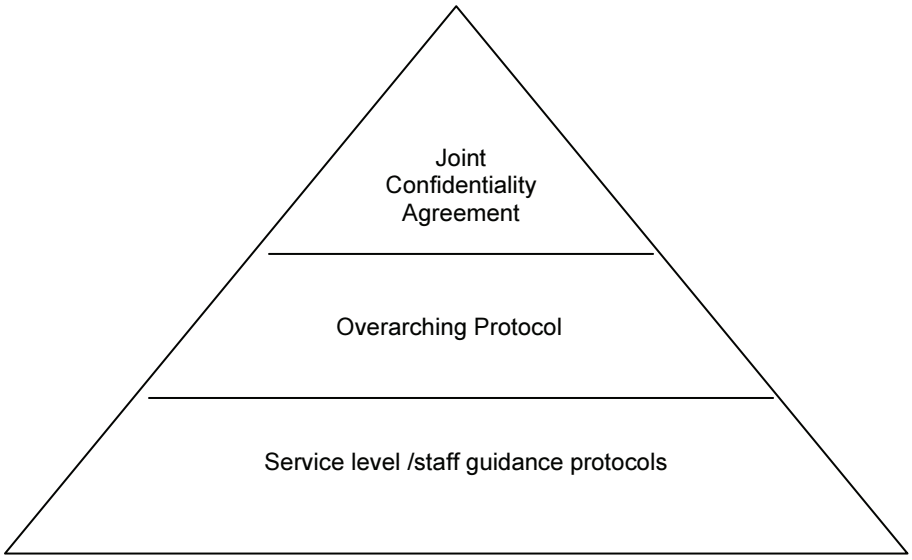
1.3.1 Rotherham Information Sharing Framework

This protocol forms part of the wider Rotherham Information Sharing Framework which aims to deliver a planned and structured approach to information sharing at all levels across the partner organisations. This will be achieved through Rotherham's information sharing framework.

The diagram below illustrates how the Rotherham Joint Confidentiality Agreement provides a high level agreement which identifies a common set of principles under which organisations share information. It commits those who sign it to facilitate the sharing of information whilst protecting the rights of the individual.

A middle tier of overarching information sharing protocols underpins this. At this level information sharing communities are established, the type of

information shared is defined and the purpose for which it is shared is identified. This protocol is an overarching protocol, in which children and young people's services are identified as an information sharing community. The third tier is made up of specific information sharing procedures and staff guidance, which can be used at service level to help staff make day to day decisions and support good practice. They are detailed information sharing agreements between individual agencies within the information sharing community at an operational level.



1.3.2 Other Protocols and contractual arrangements

Where other 'protocols' already exist between organisations then, if appropriate, this protocol and associated service level protocols will run concurrently with them and parties can continue to adhere to existing protocols.

If it is a requirement to disclose personal service user information between organisations as part of a funding/contractual arrangement then all parties (including NHS Independent contractors) should be made aware of this as part of the funding/contractual process. It is a recommended that all new partnerships entered into should be covered by an appropriate service level information sharing protocol.

1.4 Objectives of the protocol

The objectives in relation to this information sharing protocol are to:

- Facilitate the lawful and appropriate sharing of information between all organisations and departments in an efficient and effective manner
- To encourage commitment by all agencies to work together to develop information sharing arrangements and working practices that will improve outcomes

- To reduce uncertainty as to the legal basis upon which information can be shared and help foster a shared understanding of legal and statutory duties
- To help organisations and professionals to understand when you need to get consent before sharing information and when you can share without consent or knowledge of the service user
- To develop consistency in information sharing
- To help organisations to develop clear service level protocols that set out the basis upon which they share information and of their respective responsibilities and duties

1.5 Information Sharing Principles

This section sets out the general principles governing the sharing of information as set out in the Rotherham Joint Confidentiality Agreement. They are:

Staff at the initial point of contact with a service user should: -

- Explain the purpose of information collection
- Explain that information may need to be shared between partner organisations
- Seek consent for sharing of such information

A service user's request that information is not shared must be respected unless: -

- Disclosure is in the public interest, including for the purpose of prevention or detection of crime, apprehension or prosecution of offenders
- Disclosure is to protect the vital interest of the service user
- Disclosure is enabled by legislation

All agencies should: -

- Facilitate the exchange of information wherever such exchange is lawful
- Ensure that collected data is complete, accurate and relevant to the care of the individual
- Disclose the minimum amount of relevant information on a strict need to know basis only
- Notify the data owner of information that is discovered to be inaccurate or inadequate for purpose
- Rectify inaccurate or inadequate data and notify all other recipients who should ensure the correction is made
- Ensure that shared information is physically secure, and password protected where held on electronic systems
- Ensure that, as part of their ongoing development, staff are made aware of their responsibilities and rights in respect of service user information
- Ensure that information is readily available to service users on their rights in respect of personal information held including complaints procedure

- Ensure that alleged breaches of confidentiality are investigated under their respective agencies complaints procedures, liaising with partner agencies where shared information or care is involved
- Work together to develop frameworks, procedures and protocols for the sharing of information and to facilitate partnership arrangements

1.6 Purposes for which information may be shared

"Whilst the law rightly seeks to preserve individuals' privacy and confidentiality, it should not be used (and was never intended) as a barrier to appropriate information sharing between professionals. The safety and welfare of children is of paramount importance, and agencies may lawfully share confidential information about the child or the parent, without consent, if doing so is in the public interest. A public interest can arise in a wide range of circumstances, including the protection of a child from harm, and the promotion of child welfare. Even where the sharing of confidential medical information is considered inappropriate, it may be proportionate for a clinician to share the fact that they have concerns about a child."

The Protection of Children in England: A Progress Report
Lord Laming (March 2009)

"*The key factors in deciding whether or not to share confidential information are necessity and proportionality, ie whether the proposed sharing is likely to make an effective contribution to preventing the risk and whether the public interest in sharing information overrides the interest in maintaining confidentiality. In making the decision you must weigh up what might happen if the information is shared against what might happen if it* is not *and make a decision based on professional judgement."*

Information sharing: Guidance for practitioners and managers
HM Government (2008)

"*The Director of Public Health will work closely with local partners and the new Police and Crime Commissioners to promote safer communities. And he/she will engage with wider civil society to enlist them in fostering health and wellbeing. In short the Director of Public Health will be the critical player in ensuring there are integrated health and well being services across the locality."*

Public Health in Local Government: The role of the Director of Public Health. Health and Social Care Act 2012

This protocol applies to the sharing of information between organisations for the following purposes:

- Improve the well being and life opportunities through educational, health and social care opportunities
- Protect peoples and communities
- Supporting people in need
- Crime reduction
- Violence reduction

- Preventing Health inequalities
- Provide seamless provision of children and young people's services
- Enabling service users to access universal and specialist services
- Enabling staff to meet statutory duties across organisations
- Prevention and detection of crime
- Data integrity and information quality improved
- Investigating complaints
- Managing and planning services
- Commissioning and contracting services
- Developing inter agency strategies
- Performance management and audit
- Research relating to clinical, educational or social care objectives

Information Sharing Protocols are not required before frontline practitioners can share information about a person. By itself, the lack of an Information Sharing Protocol must never be a reason for not sharing information that could help a practitioner deliver services to a person.

2 Parties to the protocol

The Rotherham Health and Wellbeing Board will own Rotherham Overarching Information Sharing Protocol on behalf of their respective organisations. Participating partners commit their organisation to following the approach to information sharing which is detailed within.

3 Statutory powers and duties relevant to information sharing

The legal basis that underpins this protocol to facilitate the lawful sharing of information Appendix A

The powers and duties identified, when taken together, create a framework for the sharing of information between different groups of professionals and agencies including the voluntary sector and professionals working across service area and local authority boundaries. Used pro-actively, they can facilitate the collection and sharing of information in many of the situations where people are most in need of help and targeted services. These situations are not limited to those where risks have materialised or where the client is at risk of imminent or serious harm. Indeed it is a responsibility to share information in order to prevent risk materialisation.

However, we must ensure that information is shared in a lawful way and that we do not infringe the right of the service user to privacy.

The issue of consent is fundamental to appropriate information sharing.

Even if there is no legal requirement to obtain consent before sharing information it is often good practice to do so. This might be done for example when it has been decided that a service should be offered to the client and their voluntary cooperation is needed. Consent will always be needed at the

stage where services are offered unless there are child protection concerns where there is a statutory duty to intervene.

In most cases telling the client, family, young person or their carers that information has been shared about them or seeking their consent will help build up a relationship of trust.

In some situations consent will be required to comply with the Data Protection Act 1998 to entitle you to use personal information. In other cases it will be a matter of professional judgement as to whether your primary aim of securing the best outcome for the young person is more likely to be achieved if you seek permission to share information or not.

But there are many situations where you can and must share information legally without obtaining the consent of the client, family, young person or their carers. For example where doing so would:

- Place a child at increased risk of significant harm
- Place an adult at increased risk of serious harm
- Prejudice the prevention, detection or prosecution of a serious crime
- Lead to unjustified delay in making enquiries about allegations of significant harm or serious harm.

All information sharing must be undertaken in a manner that is compatible with the requirements of the Freedom Of Information Act , the Data Protection Act, the common law duty of confidentiality and the Human Rights Act , and any other specific statute that authorises or restricts disclosure Service level protocols will be developed which will set out the specific procedures to be followed to ensure these requirements are met.

4 Implementation of the protocol

4.1 Development Process

This protocol has been developed by the Rotherham Metropolitan Borough Council's Information Governance Officer.

4.1.1 Formal approval of the protocol and associated responsibilities

Partner agencies, will be requested to approve and adopt the overarching protocol formally.

4.1.2 Dissemination

4.1.3 A number of copies of the protocol will be provided to all partner agencies for circulation to relevant staff.

4.1.4 Partner agencies will ensure copies of the protocol are available to members of the public through their Freedom of Information Publication Schemes.

4.1.5 Review

Reviews will be carried out every two years:

4.2 Reporting breaches

4.2.1 Breaches should be reported to following each organisations internal policy

4.2.2 If an organisation receives a complaint about an information disclosure from a service user this should be investigated in accordance with the organisation's complaints procedure. If any disciplinary action is felt to be necessary this will be an internal matter for the organisation concerned.

4.3 Adoption of the protocol

The parties to the Overarching Information Sharing Protocol agree that the procedures detailed in the document provide a secure framework for the sharing of information between their respective organisations in compliance with their professional responsibilities.

Agencies that are party to this protocol will undertake to:

- Implement procedures within their organisations to ensure confidentiality of service user related information is in line with the Joint Confidentiality Agreement
- Ensure that staff adhere to the procedures and structures set out in this protocol
- Implement and audit compliance with this protocol within their organisations
- Ensure that where these procedures are adopted, no restriction will be placed on the sharing of information other than those specified within this protocol
- Ensure that all service level protocols established between partner agencies are consistent with this protocol

5 Document Control

Status	Final
Version Number	1
Author(s)	Susan Gray Information Sharing Officer, Children and Young People's Services
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Document Revision Record				
Version	Description of change	Reason for change	Author	Date
1.1	Document Refresh & Review	Legislative Update & Refresh	Gary Walsh	Nov 2008
2.0	Document Changes Review	Final Comments from Rotherham District Information Governance Group	Gary Walsh	Dec 2008
2.1	Update to include Lord Laming references and include Safer Rotherham Partnership	To widen coverage of protocol to include Safer Rotherham	Gary Walsh	June 2009
3.0	Update to become more generic and include new Public Health Responsibilities	To widen coverage and include Public Health resposibilities as detailed with Health and Social Care Bill	Gary Walsh	Jan 2012

Appendix A: Statutory powers and duties relevant to information sharing

The legal basis that underpins this protocol and the duties and powers to facilitate the lawful sharing of appropriate information between agencies are summarised below. Details of the key legislation and guidance affecting the sharing and disclosure of information are set out in HM Government national guidance, **Information Sharing: Further Guidance on Legal Issues**

The key pieces of legislation that allow information sharing to take place and determine the extent to which it can be shared are:

- The Children Act 1989 (sections 17, 27, 47)
- The Children Act 2004 (sections 10, 11)
- The Education Act 1996 (sections 13 and 434)
- The Education Act 2002 (section 175)
- Learning and Skills Act (sections 117 and 119)
- Education (SEN) Regulations 2001 (Regulation 6 and 18)
- Children (Leaving Care) Act 2000
- Protection of Children Act 1999
- Immigration and Asylum Act 1999 (section 20)
- Local Government Act 2000 (Part 1, section 2 and 3)
- Criminal Justice Act 2003 (section 325)
- National Health Service Act 1977 (section 2)
- The Health Act 1999 (section 27)
- The Adoption and Children Act 2002
- The Crime and Disorder Act 1998 (sections 17, 37, 39 and 115)
- Housing Act 1985 & 1988 (schedule 2, grounds 2 & 14)
- The Protection from Harassment Act 1997
- The Homelessness Act 2002
- The Civil Evidence Act 1995
- The Crime and Disorder Act 1998 (section 115)
- Common Law Powers of Disclosure
- The Rehabilitation of Offenders Act 1974
- The Human Rights Act 1998 (article 8)
- The Data Protection Act 1998 (sections 29(3) & 35(2))
- Housing Act 1996 (sections 135, 152 & 153)
- Mental Health Act 1983
- The Law of Confidentiality
- The Health and Social Care Act 2001/2008
- *The Health and Social Care Bill*
- Limitation Act 1980

A good deal of information can be shared within the existing legal framework. But there is considerable confusion among agencies and practitioners about this. Sometimes, fear of breaking the law means practitioners share less than they can - and not enough to ensure the service user's needs are properly met.

Appendix B: Statement on Information Sharing

Sharing personal information: How governance supports good practice Agreements and Protocols (Aug 2008)

This statement aims to summarise how information sharing governance can support good practice at the front-line and to clarify the role of information sharing protocols.

To provide effective and efficient services, agencies and practitioners need to share personal information, particularly when it would help prevent an individual's life or life chances being jeopardised. Practitioners recognise the importance of information sharing and there is much good practice. However, it appears that in some situations they feel constrained from sharing personal information by uncertainty about when they can do so lawfully. In addition, practitioners need to understand their organisation's position and commitment to information sharing and to have confidence in the continued support of their organisation where they have used their professional judgement and shared information professionally.

This statement will be relevant to information officers and implementation managers who are responsible for information sharing governance or protocols. It will also help to provide clarity to practitioners at the front line who have to make case-by-case decisions about sharing personal information and for the managers and advisors who provide support them in this decision making.

Information sharing governance frameworks

It is good practice to establish an information sharing governance framework to provide clarity to all staff of the organisation's position on information sharing. An information governance framework must always recognise the importance of professional judgement in information sharing at the front-line and should focus on how to improve practice in information sharing within and between agencies. These should be communicated to the frontline so that practitioners have confidence in their organisation's commitment and support for professional information sharing.

An information sharing governance framework would be expected to include:

- An **Information Sharing Code of Practice**, which outlines the principles and standards of expected conduct and practice of the organisation and staff within the organisation. The Code of Practice establishes the organisation's intentions, commitment and level of acceptability of practice of sharing information.
- **Information Sharing Procedures**, which describe the chronological steps and considerations required after a decision to share personal information has been made, e.g. the steps to be taken to ensure that information is shared securely. Information Sharing procedures set out, in detail, good practice in sharing personal information.
- **Privacy, confidentially, consent (service users)** The organisation should have in place a range of processes and documentation for service users including 'Privacy/Confidentiality Statement', 'Fair Processing Notice', 'Consent', 'Subject Access'. Relevant staff within the organisation must understand these processes and be able to access documentation when required.

Applicability of Information Sharing Protocols (ISPs)
There has been some uncertainty about the applicability of ISPs to information sharing practices at the front line. This section aims to provide clarity on this issue.

An ISP is sometimes taken to mean a document that sets out principles and general procedures for sharing information. However there are also definitions and templates for ISPs that include detailed specification of what data fields will be shared, what the storage and archive principles are, etc. The latter type of ISP is designed to support bulk or regular sharing of information between IT systems or organisations.

Although neither type of ISP is required for information sharing at the front-line, the first is good practice and is covered in the definitions of Codes of Practice and Procedures above; the second is unsuitable for front-line practices. It is misunderstandings around what is involved in an ISP and a potential reliance on ISPs over professional judgement that we are seeking to address.

Where practitioners have to make decisions about sharing information on a case-by-case basis that are not clearly covered by statute, the decision to share or not share information must always be based on professional judgement. It should be taken in accordance with legal, ethical and professional obligations, supported by cross-Government information sharing guidance and informed by training and experience.

Information Sharing Protocols are not required before frontline practitioners can share information about a person. By itself, the lack of an Information Sharing Protocol must never be a reason for not sharing information that could help a practitioner deliver services to a person.

This approach is supported by the Information Commissioner's Office – see below:

"*All organisations can accomplish information sharing lawfully by adhering to governing legislation and the principles of the Data Protection Act whether an Information Sharing Protocol is in place or not. An Information Sharing Protocol is a useful tool in some circumstances. It is not a legal requirement.*

There are two distinct types of information sharing. Organisations may share large amounts of data with one or more partner organisations on a regular basis, or practitioners may share information with each other on an ad hoc basis as individual situations require.

An Information Sharing Protocol is a useful tool with which to manage large scale, regular information sharing. It creates a routine for what will be shared, when and with whom and provides a framework in which this regular sharing can take place with little or no intervention by practitioners.

It is not a useful tool for managing the ad hoc information sharing which all practitioners find necessary. Most importantly it is not intended to be a substitute for the professional judgement which an experienced practitioner will use in those cases and should not be used to replace that judgement." Information Commissioner's Office