Better Care Fund

Overview

Lynda Bowen — Rotherham MBC
Dominic Blaydon — Rotherham CCG

NHS
Rotherham
Clinical Commissioning Group

Rotherham
Metropolitan
Borough Council

Rotherham Better Care Fund

- Plan agreed by NHS England January 2015
- Formalised in a section 75 Partnership Framework Agreement in April 2015
- Strengthened governance

What does the BCF Plan aim to achieve?

- Better patient/customer experience
- Integrated service provision- seamless services
- More effective provision
- Fewer admissions to permanent care and unplanned emergency hospital admissions
- Shorter lengths of stay in hospital
- Effective reablement

BCF Metrics

- Reduction in non-elective admissions
- Permanent admissions of older people to care homes
- Delayed transfers of care from hospital
- No. of older people at home 91 days after discharge from hospital into rehabilitation

Governance…..

- Health and Wellbeing Board
- Strategic Vision
- Strategic Executive
- Operational Executive

Current BCF

- Complex plan:-
- 72 lines of funding
- 16 workstreams
- 2 pooled funds
- Mixture of new and existing services
- Fragmented data collection
- Fragmented reporting lines
- Potential overlap/gaps in provision

Review of Workstream 13

First review of this workstream showed:-

- Lack of clarity
- Historic grants/funding lines
- Segments of services funded from other budgets
- diverse reporting and governance
- overlap with separate funding areas

Service Review methodology …

72 funding streams each reviewed to identify:

- strategic relevance
- areas for merging funding
- areas for reallocating funding
- services receiving funding from outside BCF
- services require detailed review

Outcomes from the Service Review

- Directory of Services
- Simplified Structure for BCF
- Clear measures for metrics
- Revised governance for BCF services
- Recommendations for integrating BCF governance
- Recommendations for future integration and joint commissioning

Key Drivers for the new BCF plan

- Improving services for people of Rotherham
- Complementing transformational change underway in social care and with secondary and community health providers
- Integration with Children's services
- Framed by…
- Role and requirements of NHS England and Better Care Fund team
- Ability to impact on metrics and meet performance targets

Directory of Services

Category 1	Mental Health
Category 2	Rehabilitation and Reablement
Category 3	Intermediate Care
Category 4	Protecting Social Care
Category 5	Case Management and Integrated Care Planning
Category 6	Supporting Carers

Category 1: Mental Health

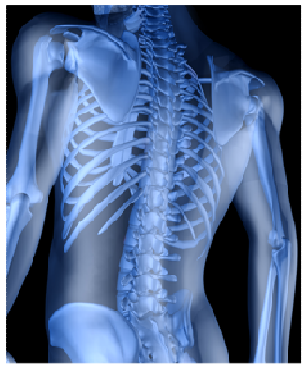
Mental Health Liaison Service

- Dedicated mental health expertise provided to A&E 24 hours/day
- Clinically led and operates from The Woodlands
- Supports 16 – 18 year olds overnight and at weekends.
- Works alongside the Crisis Intervention Service
- Links in with the Emergency Centre Development

Category 2: Rehabilitation and Reablement

- Home Improvement Agency
- Falls and Bone Health Service
- Home Enabling Service
- Community Stroke Team
- Stroke Association – Community Integration
- Community Neuro-Rehabilitation Service
- Rotherham Equipment and Wheelchair Service
- Community Occupational Therapy
- Age UK Hospital Discharge Service

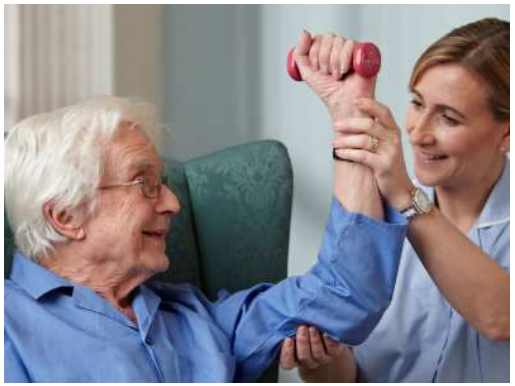
Good Practice: Integrated Falls and Bone Health



- Targets people over 55 years with fragility fracture
- Multi-Factoral Falls Assessment and therapy input
- 12 week falls and fracture prevention programme
- Follow-up exercise programmes commissioned by RCCG
- Patients under 75 years undergo bone density scanning
- Establish fracture probability and prescribe bone active tablets
- Follow up patients at 3 months, 6 months and 1 year.
- Check modifiable risk factors and adherence to medication

Category 3: Intermediate Care

- Rotherham Intermediate Care Centre
- Integrated therapy team with physiotherapists and OTs
- 3 residential units with 50 beds
- Community Rehabilitation Service
- Day Rehabilitation and Community Integration
- GP contract for intermediate care
- Intermediate Care Social Work Service
- Specialist Mental Health OTs



Good Practice: Community Integration

- 6 week programme led by occupational therapy
- Addresses social isolation and activities of daily living
- Access and utilization of public transportation
- Development of social networks
- Leisure or recreational activities
- Educational and training activities.
- Health and wellness promotion

Category 4: Protecting Social Care

- Hospital social work services
- Supporting Direct Payments and Personal Budgets
- Residential respite care
- Supporting people with learning disabilities

Category 5: Case Management and Integrated Care

- GP Case Management
- Integrated Rapid Response Service
- Care Home Support Service
- Otago Exercise Programme
- Social Prescribing Programme
- Death in Place of Choice

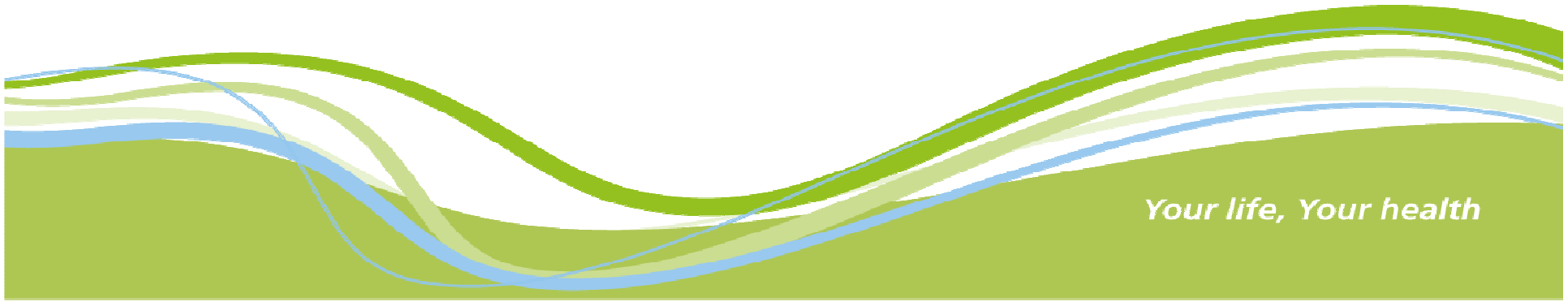
Good Practice: Integrated Rapid Response

- Merge Fast Response Advanced Nurse Practitioners and OOHs
- Provides early supported discharge at home
- Identifies stable hospital patients who can be supported at home
- Respond to patients who are at risk of hospital admission
- Co-ordinates care for up to 5 days
- Supported by home care enabling service
- Incorporates community rehabilitation

Next Steps

- Service review outcomes: options paper to be taken to BCF Executive in October
- Decisions to be taken on strategic priorities for future BCF, based on review findings
- Service Integration – greater focus on joint commissioning and service delivery
- Links with other transformational agendas, especially prevention and early intervention
- Build on best practice
- Nominate lead and accountable officers.

Social Prescribing



Why are we doing it?

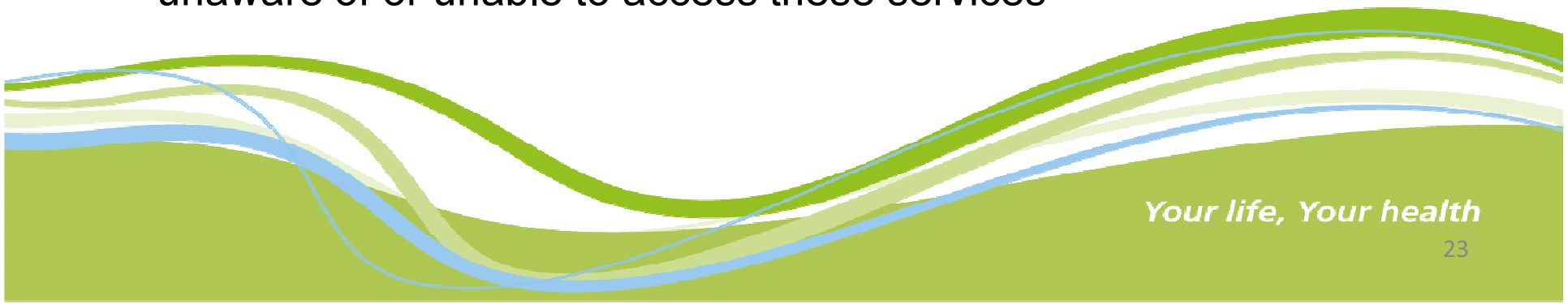
Strengthening individuals, strengthening communities

- NHS Efficiency Challenge - reduces pressure on NHS and Social Care
- Improves outcomes for patients with long term conditions and their carers
- Recognition that patients need support with non-medical issues - creates a wider range of options for primary care and patient
- Shift of focus to prevention and early intervention - increases independence, resilience of individuals and communities
- Supports integration and personalisation
- Doing things differently **– 'more of the same' is not an option**

Outcomes for patients and carers

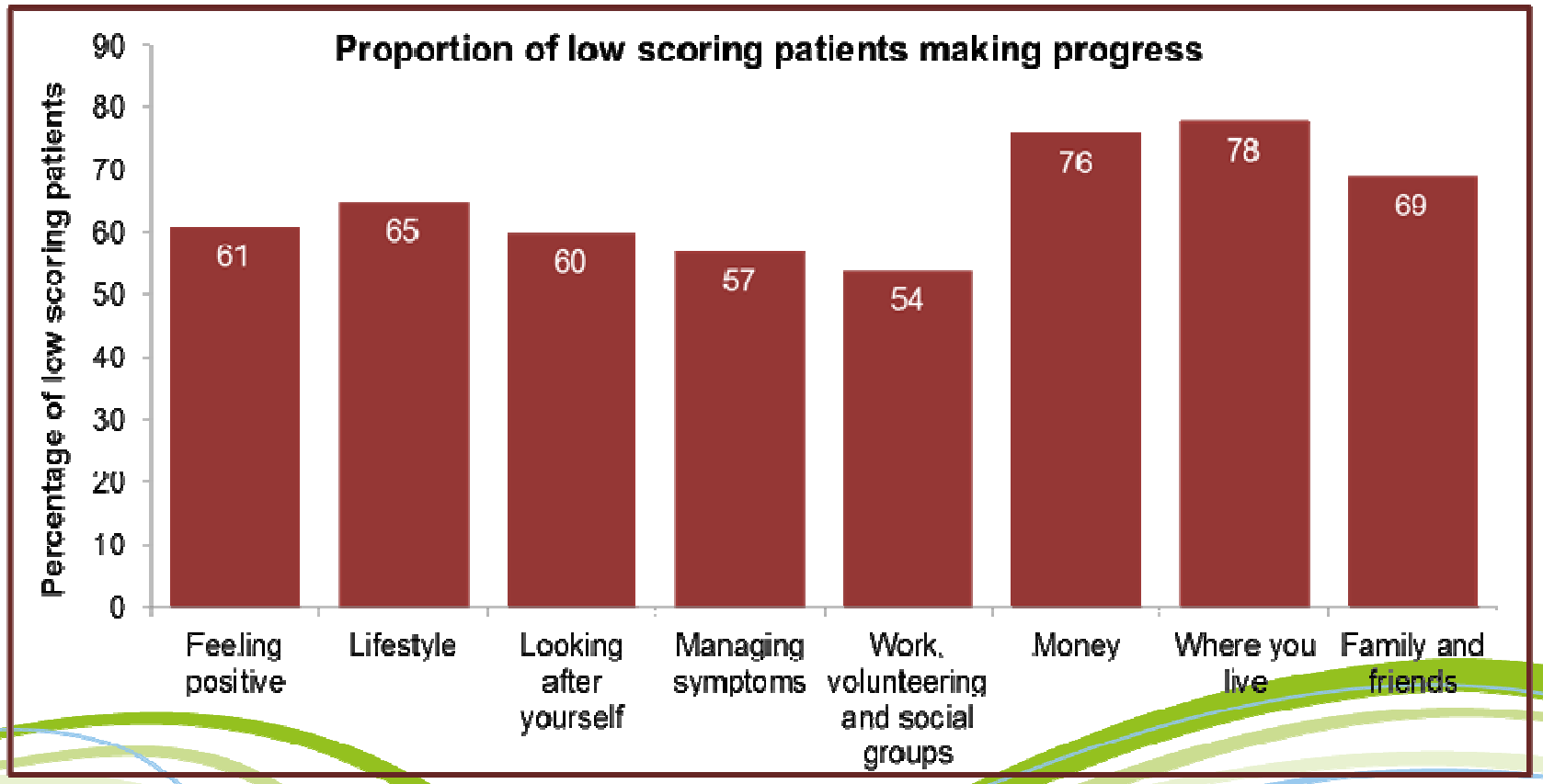
- Quantitative and qualitative evidence points to a range of improvements for patients and carers:
  - ✓ improved mental health
  - ✓ greater independence
  - ✓ reduced isolation and loneliness
  - ✓ increased physical activity
  - ✓ welfare benefits
- Social Prescribing represents an important first step to engaging with community based services and wider statutory provision

- Without Social Prescribing many patients and carers would be unaware of or unable to access these services



Wellbeing Improvements

- **83% of patients made progress in at least one outcome area**



20% reduction in A&E attendances

21% reduction in in-patient stays

21% reduction in out-patients

3500 patients referred

For every £1 spent – at least £3 saving

It is a win/win!!

- ✓ The CCG benefits, as it addresses inappropriate admissions.
- ✓ The GP's benefit, as it gives them a third option other from referral to hospital or to prescribe medication.
- ✓ The Voluntary and community sector benefit, as it supports their sustainability.
- ✓ **And most importantly -** the Patient and Carers love it as it improves quality of life, reduces social isolation and moves the patient from dependence to independence.

Case Studies

Three broad outcome themes emerged:

- ✓ **Improved well-being**: in particular mental well-being, anxiety and depression, personal confidence and self-efficacy.

  "If it wasn't for the group, I might not be here now because I'd been that down and depressed….just getting out of the house has helped me with the fear, anxiety…talking to people lifts your mood and forget about problems at home."

- ✓ **Reduced social isolation and loneliness:** linking people with limited mobility and social contact with the wider community.

  "It's someone coming to talk to me and with me and they acknowledge me…because you can sit and stare at space and people take no notice whatsoever…I feel like I belong to a society."

- ✓ **Increased independence:** linked to improvements in physical health. Includes undertaking in independent social and community action.

  "I was on my own, I was totally on my own…Each day I'm getting better and better…before I could hardly walk…I'm feeling very positive, each day I get up and I just can't believe how much I've come on."